June 30, 2014

Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SQ
Washington, DC 20001
Attention: CMS-1609-P

Re: Medicare Program; FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice

Dear Administrator Tavenner,

The National Kidney Foundation appreciates the opportunity to comment on the Medicare Program; FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice. NKF is America’s largest and oldest health organization dedicated to the awareness, prevention, and treatment of kidney disease for hundreds of thousands of healthcare professionals, millions of patients and their families, and tens of millions of people at risk. In addition, NKF has provided evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD), including transplantation since 1997 through the NKF Kidney Disease Outcomes Quality Initiative (NKF KDOQI). NKF is concerned that the expansion of the definitions for terminal illnesses and related care would eliminate dialysis patients’, who have a terminal illness unrelated to their kidney failure, ability to obtain hospice care. NKF believes that patients or their health care proxy should maintain the right to decide about withdrawing from dialysis.

A patient’s kidney failure, which may be unrelated to the terminal illness for which they are seeking hospice care, but which may interact with the terminal illness or contribute to the symptom burden, could cause dialysis treatments to be considered as care the hospice center should provide under the proposed expanded definition for related care. However, hospice reimbursement would not cover the costs of providing dialysis treatment to patients. Hospice reimbursement for routine home care is about $156.00 per day while the average Medicare
dialysis payment is $256.50 per treatment (typically 13 treatments are provided a month). Therefore, it is unlikely that hospice providers will offer dialysis services to their patients if they are responsible for absorbing these costs. This leaves a dialysis patient, with a terminal illness, who is not ready to stop dialysis, having to forgo entering the hospice program, resulting in higher costs to the Medicare program. Past studies have indicated there is an underuse of hospice by dialysis patients leading to increased Medicare costs because dialysis patients at the end of life are more frequently hospitalized and often die in the hospital.\(^1\) Allowing dialysis patients to enter hospice while continuing to receive dialysis allows for the patient to ultimately make the decision about withdrawing from dialysis in a care setting designed to facilitate psychological support and acceptance of death.

These proposed expanded definitions eliminate patients and health care proxies from making this decision. Under this proposed rule, patients are no longer at the center of their care and instead are effectively forced to continue dialysis without access to hospice care or forgo dialysis, before they are psychologically ready, and enter hospice. A recent article published in the American Journal of Kidney disease highlights the difficulty patients and families experience when faced with the decision between dialysis and palliative care and shows that differences in decision making for withdrawing may also be attributed to cultural beliefs and customs.\(^2\) These challenges suggest that patients would benefit tremendously from the psychological support that hospice care can provide to patients and their families. If CMS decides to move forward with these new definitions, access to dialysis services paid for under Medicare Part B should receive an exception. Doing so would permit the patient, with a terminal illness, access to hospice benefits while also continuing to receive dialysis. This exception is already in place, in a limited manner, as noted in the Medicare benefits manual, chapter 11. These are not easy decisions for anyone involved and CMS should not be implementing payment policies that force a patient to suffer unnecessarily.

Thank you for the opportunity to provide comments. Please contact Tonya Saffer, Senior Federal Health Policy Director, at tonya.saffer@kidney.org or 202.244.7900 ext. 26 with questions.

Sincerely,

**Beth Piraino**

Beth Piraino, MD
President

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