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May 30, 2023

The Honorable Chiquita Brookes LaSure
Administrator, Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements [CMS-1787-P]

Dear Administrator Brooks LaSure,

The National Kidney Foundation (NKF) thanks the Centers for Medicare and Medicaid Services (CMS) for its Request for Information (RFI) about the hospice benefit, its intersection with the Medicare End-Stage Renal Disease (ESRD) benefit, and implications for end-of-life care for individuals needing renal replacement therapy. This is an important topic and one that significantly affects individuals with kidney failure as they approach the end of their lives.

As you note in the Request for Information, individuals with kidney failure are half as likely to elect the Medicare hospice benefit as the general population and experience much shorter median lengths of stay. As a result, individuals with kidney failure are far less likely to receive appropriate pain management, psychosocial supports, spiritual counseling, family support, or other services than hospice patients. This takes a financial toll on our health care system, as fifty-three percent of kidney failure patients die in a hospital¹, with Median Medicare Parts A and B spending for ESRD patients averaging approximately \$175,000 per patient in the last year of life².

Barriers to hospice care for kidney patients are obvious and glaring, notably that individuals with kidney failure have to forgo maintenance dialysis in order to elect the hospice benefit. Many kidney patients fear that, no matter how outstanding the pain and symptom care provided under hospice, forgoing dialysis will likely lead to volume overload with subsequent shortness of breath and diminished quality of life. This is simply not a choice they are willing to make.

We appreciate the RFI's focus on enrollment policies, staff and patient education policies, and efforts to mitigate the cost of care outside the hospice benefit. Unfortunately, prospective outcomes of this inquiry -

¹ Wachterman M, Lipsitz S, Marcantonio E, et al. End-of-Life Experience of Older Adults Dying of End-Stage Renal Disease: a Comparison with Cancer. *J Pain Symptom Manage*. 2017; 54(6):789-797. doi:10.1016/j.jpainsymman.2017.08.013

² O'Hare A, Hailpern S, Wachterman M, et al. Hospice Use and End-Of-Life Spending Trajectories In Medicare Beneficiaries on Hemodialysis. *Health Affairs*. 2018; 37(6):980-987. doi:10.1377/hlthaff.2017.1181

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- presumably better enrollment policies or greater clarification of whether kidney failure is related to the patient's terminal prognosis -- will not result in better end of life care for individuals with kidney failure because they would not resolve the fundamental challenge -- the fundamental injustice -- that patients must forgo dialysis if they elect the Medicare hospice benefit.

We understand and appreciate the underlying hospice philosophy that care should not be curative in nature but instead should focus on preserving a patient's quality of life. Dialysis is not a cure. In this case, it preserves quality of life. However, that does not nor should it equate with removal of *all* care. Hospice patients with a variety of terminal prognoses receive maintenance medications and interventions that treat their terminal prognosis because they also alleviate symptoms and improve quality of life. For example, hospice patients with terminal chronic obstructive pulmonary disease typically continue to receive oxygen therapy. Hospices do not remove oxygen tanks and allow COPD patients to suffer needlessly at the end of life -- to do so would be unspeakably cruel.

Yet we do exactly that to kidney patients. Rather than forcing kidney patients into a Hobson's choice, NKF strongly supports initiatives that expand access to *palliative dialysis* -- dialysis treatments that aim to improve quality of life but not necessarily meet the same stringent requirements as maintenance dialysis -- while simultaneously allowing kidney patients to access the wrap-around services afforded under the Medicare hospice benefit. This powerful combination would alleviate the symptoms of kidney failure while allowing patients time to get their affairs in order, say good-bye to family and friends, and access care that affords them autonomy, dignity, and quality of life.

We strongly urge CMS to continue exploring alternative payment models that expand access to palliative care for patients with kidney failure. We also support legislation that allows patients to receive ESRD and hospice benefits concurrently. By pursuing these common-sense measures, we can better serve kidney patients, reduce stress on the health care system, and potentially reduce health care costs in the final weeks of life.

Thank you, again, for your inquiry into these important issues and for your consideration of priorities important to patients. Please contact Sharon Pearce, Senior Vice President, at sharon.pearce@kidney.org with any questions.

Sincerely,



Kevin Longino
CEO and Transplant Patient



Sylvia E. Rosas MD, MSCE
President