July 1, 2014

Marilyn B. Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1609-P
P.O. Box 8013
Baltimore, MD 21244-8016

Re: CMS-1609-P: 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; Proposed Rule.

Dear Administrator Tavenner:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease. We are writing to provide comments on the implications of the proposed rule for the FY 2015 Hospice Wage Index and Payment Rate Update on patients with end-stage renal disease (ESRD).

RPA is specifically concerned about the potential impact of the provision in the proposed rule that offers broader definitions for the terms “terminal illness” and “related conditions”. We appreciate the fact that CMS is soliciting comment on these definitions prospectively, and that CMS is seeking to provide greater clarity on the concepts of holistic and comprehensive hospice care as defined by the Medicare hospice benefit. Further, we recognize that all of these steps are being taken to appropriately pursue the Agency’s fiduciary responsibilities as stewards of the Medicare program.

However, RPA believes that if the needs of Medicare ESRD beneficiaries who also fulfill the criteria for the hospice benefit are not accounted for as the definitions of “terminal illness” and “related conditions” are clarified, this exceptionally vulnerable patient population could have their access to Medicare hospice services compromised. It is worth noting that under current Medicare policy ESRD beneficiaries that do not wish to withdraw from dialysis do have access to the hospice benefit if their terminal diagnosis is other than ESRD. However, there is variable interpretation by Medicare carriers of the terminal diagnosis provision required for ESRD beneficiaries to also receive the hospice benefit. Further, there continues to be confusion as to
whether or not withdrawal from dialysis is required in order for ESRD patients to receive the hospice benefit and the role of the terminal diagnosis in determining eligibility. Because a patient cannot receive two benefits for the same diagnosis, for patients who wish to withdraw from dialysis, the terminal diagnosis of ESRD may be used to access the hospice benefit. By contrast, for patients who wish to continue dialysis and receive the ESRD benefit, a terminal diagnosis other than ESRD must be used to access the hospice benefit. Chapter 11 of the Medicare Benefit Policy manual addressing ESRD issues states that:

“If the patient’s terminal condition is not related to ESRD, the patient may receive covered services under both the ESRD benefit and the hospice benefit. Hospice agencies can provide hospice services to patients who wish to continue dialysis treatment.”

To address concerns regarding ESRD patient access to the hospice benefit, we would recommend several changes. First, we urge the Agency to maintain the current policy specifically stating that Medicare ESRD beneficiaries can utilize the benefit. Second, we believe that the phrase in the provision above that states “if the patient’s terminal illness is not related to ESRD” is ambiguous and variably interpreted. RPA suggests that the terminal diagnosis for ESRD patients receiving the hospice benefit should be "a diagnosis other than ESRD," rather than one "unrelated." A classic example of where the lack of clarity could be problematic is the diabetic dying of gangrene whose ESRD is from diabetic nephropathy. RPA believes that using criteria of “a diagnosis other than ESRD” would resolve much of the current ambiguity and increase the utilization of hospice among patients with ESRD.

More broadly, RPA urges CMS to take a longer view regarding ESRD patients and hospice care by assuring that dialysis patient access to hospice services is maintained and in addition, not influenced by misunderstanding of regulatory policy. Current literature indicates that hospice is greatly underutilized by dialysis patients (22 percent), even when they withdraw from dialysis (44 percent) (Murray, et al, CJASN, 2006) and nearly half of all dialysis patient deaths occur in hospital (Wong, et al, Arch Intern Med, 2012) [full references below]. Reduced hospice access for these patients would exacerbate the chance that death will occur in hospital and could further increase costs to the system. RPA therefore believes that current hospice policies for ESRD should be not only maintained also but clarified so as to facilitate ESRD patient access to hospice services. Such change is likely to both improve patient care and produce savings for the Medicare program, thus advancing toward the Triple Aim aspirations of lower cost, improved patient outcomes, and improved population health.

As always, RPA welcomes the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation’s kidney patients, and we stand ready as a resource to CMS in its future endeavors. Any questions or comments regarding this correspondence should be directed to RPA’s Director of Public Policy, Robert Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.
Thank you,

Rebecca Schmidt, DO
President

References
