AMERICAN SOCIETY OF HEMATOLOGY
2021 L Street, NW, Suite 900, Washington, DC 20036-4929 ph 202.776.0544 fax 202.776.0545 e-mail ASH@hematology.org

May 28, 2024

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0057-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Submitted electronically via: Regulations.gov

RE: CMS-1810-P: Medicare Program; FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updated and Hospice Quality Reporting Program Requirements.

Dear Administrator Brooks-LaSure:

The American Society of Hematology (ASH) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Program FY 2025 proposed rule for the Medicare hospice program (CMS-1810-P). We are pleased to share comments on the request for information (RFI) on Payment Mechanism for High Intensity Palliative Care Services.

ASH represents more than 18,000 clinicians and scientists worldwide who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions such as sickle cell anemia, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and continue to be innovators in the field of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy.

We thank CMS for requesting information on payment mechanisms for high intensity palliative care services. As we described in our comments on the FY 2024 proposed rule for the hospice program, the access to and use of high intensity services in palliative care, one of which is blood transfusions, is of importance to our members and the patients they treat. We reiterate that patients with hematologic malignancies, many of whom need blood product transfusions to control their symptoms, are less likely to use hospice services than patients with other cancers.[1] Additionally, patients with hematologic cancers, when compared to patients with solid tumors, have a higher rate of emergency room visits, hospital admissions, intensive care unit (ICU) admissions, hospital deaths, and deaths in the ICU. Studies show that these facility admissions are linked to a lack of hospice care.[2]

Blood transfusions, not typically recognized as palliative care, are a valuable tool to decrease pain and suffering at the end of life for patients with certain hematologic conditions. Access to high intensity/high-cost palliative services, including blood transfusions, has the potential to decrease

[1] Howell DA, Shellens R, Roman E, Garry AC, Patmore R, Howard MR. Haematological malignancy: are patients appropriately referred for specialist palliative and hospice care? A systematic review and meta-analysis of published data. Palliat Med. 2011 Sep;25(6):630-41. doi: 10.1177/0269216310391692. Epub 2011 Jan 12. PMID: 21228094.
[2] Odejide, Oreofe O. "A Policy Prescription for Hospice Care." Journal of the American Medical Association, vol 315, No. 3 (2016).

costs to the healthcare system, by better meeting the end-of-life needs of patients suffering from hematologic conditions and decreasing emerging room visits, hospital admissions, intensive care stays and other complications.

Request for Information (RFI) on Payment Mechanism for High Intensity Palliative Care Services:
The agency continues to explore avenues to improve access and value under the Medicare hospice benefit by better understanding the issues affecting the provision of high-cost palliative care. ASH offers the following in response the agency's inquiries.

1. *What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?*
   Eliminating the financial risk to hospice providers would require additional payment or carve outs that would cover the costs of providing high intensity palliative treatments, including blood transfusions. The per diem rate is not sufficient to cover the costs of complex palliative treatments, discouraging many hospice providers from offering them. An increased payment needs to be large enough to eliminate the financial risk to the hospice providers that in turn creates an incentive for the providers to accept these patients into hospice care. Additionally, it is possible that a hospice provider may accept a patient with highly complex needs, but then deny care such as blood transfusions due to the high cost.

   The Society also recommends that medications and services being provided with palliative intent (i.e., those are typically used for curative purposes) be paid separately in addition to the per diem rate. This may include payment for the additional costs associated with using blood products, including payment for the blood product, payment for specialized personnel, payment for any transportation costs, and other necessary items. Palliative intent medications like hydroxyurea are used to control stasis symptoms and palliative, limited radiation may be used for pain control.

2. *What specific financial risks or costs are of particular concern to hospices that would prevent the provision of higher-cost palliative treatments when appropriate for some beneficiaries? Are there individual cost barriers which may prevent a hospice from providing higher-cost palliative care services? For example, is there a cost barrier related to obtaining the appropriate equipment (for example, dialysis machine)? Or is there a cost barrier related to the treatment itself (for example, obtaining the necessary drugs or access to specialized staff)?*
   The cost of providing blood transfusions to a hospice patient is a significant barrier. The current payment model for hospice care has remained relatively unchanged since its inception in 1983. Hospice providers are paid a per diem rate to provide care, and the per diem rate typically does not cover the costs of care not considered to be the typical, which include comfort-focused treatments such as transfusions, radiation, and direct oral anticoagulants. Additionally, a per diem payment is not enough to cover the costs of needed specialty staff or transportation needed for complex palliative treatments. Blood transfusions may be given to patients in other settings of hospice care, however there may be times when a patient needs to return to the hospital for additional or out of the ordinary care. The per diem rate may not be enough to cover the transport. We suggest that the agency create a separate payment rate for the highly complex intervention (e.g., blood transfusions) or a provide a higher level per diem rate that would cover the all the costs associated with complex palliative treatment.

3. *Should there be any parameters around when palliative treatments should qualify for a different type of payment? For example, we are interested in understanding from hospices who do provide these types of palliative treatments whether the patient is generally in a higher level of care (CHC, GIP) when the decision is made to furnish a higher-cost palliative treatment? Should an additional payment only be applicable when the patient is in RHC?*
   The Society has heard from members that some of their patients, who may have significant needs at their end of life, **may choose not to enter** hospice care because they do not want to lose the care they are receiving. In other words, the patient would likely be eligible and have coverage for blood transfusions if they did not

enter hospice care, but as soon as the patient enters hospice care, access to this service would no longer be available.

For example, patients with leukemia often need blood transfusion support, with some patients requiring inpatient stays secondary to the actual transfusion care needed, and some patients requiring intermittent transfusions that cannot be performed under hospice care. In these instances, the cost for hospitalization far outweighs the palliative needs, but the palliative needs of the patient may be too complex or expensive for the hospice to provide. The patient and provider are then caught in the middle of determining which site of service to use (hospice or inpatient) to provide appropriate care at the end-of-life. If there were separate payments for highly complex palliative treatments, the patient may be able to choose hospice care, while still having access to treatments that are appropriate for their end-of-life care. Instead, decisions for the type of care provided are driven by costs. Similarly, there are some patients that require medications that may be too costly for the hospice to provide (e.g., Amicar, hydroxyurea). Without separate reimbursement for these drugs which have both curative and palliative intent, the hospice provider in unlikely to offer them due to the high cost.

4. *Under the hospice benefit, palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). In addition to this definition of palliative care, should CMS consider defining palliative services, specifically regarding high-cost treatments? (Note, CMS is not seeking a change to the definition of palliative care, but rather should CMS consider defining palliative services regarding high-cost treatments?).*
   The Society does not support creating a definition of palliative services, specifically regarding high-cost treatments. If these services were described in regulation there would be little flexibility to determine the appropriate course of treatment and may create a more prescriptive hospice benefit. Instead, the hospice benefit should remain as described, but include separate payments for highly complex palliative treatments when those treatments are deemed medically necessary.

5. *Should there be documentation that all other palliative measures have been exhausted prior to billing for a payment for a higher-cost treatment? If so, would that continue to be a barrier for hospices?*
   ASH does not support the use of restrictive policies such as exhausting all other palliative care measures (i.e., step therapy) prior to using highly complex palliative care. Instead, the Society supports the use of the appropriate hospice intervention, regardless of cost, if the intervention has a high likelihood of providing comfort and symptom relief. ASH supports the crafting a care plan that meets the needs of the patient without the trial and error of exhausting all other treatments simply because one treatment may be less expensive than another.

   Currently, as the agency noted in the rule, a patient in hospice care may not receive the optimal intervention due to cost to the hospice, or the patient may decline the optimal intervention (for example, transfusions), or disenroll from hospice entirely, strictly because the hospice cannot afford to provide the intervention under the current model and payment rate. This is precisely why ASH recommends separate payment rates or higher per diem rates for highly complex interventions, and in particular blood transfusions. A separate payment for the specific intervention or a higher per diem rate for patients that require highly complex palliative care would allow the hospice entity to provide the appropriate intervention to relieve symptoms and ease suffering, which is what the hospice benefit is designed and defined by law to do.

6. *Should there be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment that would exceed the per diem rate?*
   Yes, the agency should create different payment structures for different types of high-cost palliative care, while also continuing to pay the per diem payment for the standard hospice benefit. In last year's proposed rule, the

agency discussed the use of four different types of high-cost palliative treatments including blood transfusion, radiation, chemotherapy, and dialysis. Each of these palliative treatments have varying costs that may include use of specialized staff outside of the typical hospice provider. A standard payment for any higher-cost treatment would not alleviate problems, such as access to care, associated with the current per diem rate. The costs associated with providing these treatments are vastly different; therefore, it would not make sense to create a single or standard payment rate for each of the four high-cost treatments as outlined. Hospice providers, patients, and physicians would still be caught in decision-making that would be driven by costs, as opposed to choosing the appropriate palliative treatment for the condition, and the appropriate care for the end-of-life needs of the patient.

We thank the agency for requesting comments and information about the use of highly complex, and high-cost palliative treatments when a patient enters hospice care. We appreciate the acknowledgement that the provision of blood transfusions may be a vital component to relieve pain and suffering for patients suffering from hematologic diseases, and there may be instances when providing blood transfusions under the hospice benefit would be clinically appropriate. The Society reiterates our recommendation to develop a mechanism to pay for high-cost palliative treatments under the hospice benefit. Separate payments would allow hospice providers to deliver this care when appropriate, and at the same time increase patient access. If the agency would like to discuss this issue, we would welcome the opportunity to do so. For questions, or for more information about our comment letter please contact Suzanne Leous, ASH Chief Policy Officer at 202-292-0258 or sleous@hematology.org.

Sincerely,

Mohandas Narla, DSc
President

Mary-Elizabeth M. Percival, MD
Chair, Committee on Practice