Coalition for Kidney Supportive Care
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Response of the Coalition for Kidney Supportive Care to:

Request for Information (RFI) on the Inclusion of the Dialysis Facility Discussion of Patient Life Goals Patient-Reported Outcome Performance Measure in the ESRD QIP and

RFI on Palliative Dialysis and

RFI on Concurrent Hospice and Dialysis

Medicare Program; CY 2027 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Acute Kidney Injury Dialysis (AKI) Payment, and ESRD Quality Incentive Program

CMS-1846-P RIN 0938-AV81 91 FR 38784

The Coalition for Kidney Supportive Care ("Coalition"), housed at The George Washington University, is a leading research and training group with decades of experience developing and implementing patient-centric models of care for those with kidney disease. The Coalition applies palliative care principles throughout the care continuum for patients with kidney disease to ensure shared decision-making, trauma-informed care, and holistic symptom management. Led by clinical subject matter experts, public health researchers, and patient advocates, the Coalition works with champions around the globe to transform care for patients with kidney disease.

The Coalition is grateful for this opportunity to provide comments regarding the ESRD QIP and information about ways to improve the delivery of palliative dialysis (Hereinafter, the term “supportive” is used instead of “palliative” as it is generally preferred by patients and health care professionals). The complexities of modern health care can leave patients with overwhelming treatment decisions. Kidney supportive care can ensure that patients are informed, engaged, and co-equals in decisions so that their treatment wishes are respected.

Summary of Comments

- Thank you for acknowledging that palliative dialysis exists and that there are seriously ill patients with kidney disease whose needs would be better met if palliative dialysis was a treatment option in the Medicare ESRD Program.
- Thank you for recognizing the need for more patient-reported outcomes measures in the ESRD QIP. The Coalition recommends CollaboRATE, which has been endorsed by the Partnership for Quality Measurement, rather than the Dialysis Patient Life Goals survey.
- The Coalition defines palliative dialysis and presents objective measures to identify seriously ill patients appropriate for it.

- Many patients who are appropriate for palliative dialysis have an estimated prognosis longer than the hospice 6-month eligibility criteria. Therefore, patients appropriate for palliative dialysis should NOT be limited to those who meet Medicare hospice eligibility criteria.
- The goal of treatment for patients receiving palliative dialysis is to prioritize quality of life over quantity of life. They should not be held to metrics appropriate for patients on maintenance dialysis who have a much longer life expectancy. Patients receiving palliative dialysis should NOT be included in a dialysis facility's ESRD QIP metrics.
- Compensation for dialysis facilities providing dialysis to patients on hospice should be paid to the dialysis facility.

I. General Approach & Guiding Principles for our Comments

- **Patient-Centered Focus:** Policy changes *must* prioritize the patient's goals, values, and preferences. Palliative dialysis is fundamentally about improving quality of life and reducing treatment burden consistent with the patient's goals.
- **Goal Concordance:** Policies should actively promote alignment between dialysis treatment decisions and the patient's overall goals of care, as defined in goals of care conversations and shared decision-making.
- **Interdisciplinary Collaboration:** Robust interdisciplinary teams (nephrologists, advanced practice providers, nephrology nurses, social workers, palliative care specialists, home health nurses, hospice physicians and hospice teams) working collaboratively and at the top of their licenses are needed.
- **Eliminate Perverse Financial Incentives and Avoid Unintended Consequences:** Perverse financial incentives currently exist to discourage dialysis facilities from offering palliative dialysis since it detracts from their ESRD QIP metrics and potentially jeopardizes their reimbursement. Caution must be exercised against policies that could inadvertently discourage patients from accessing their preferred modality (whether maintenance dialysis or palliative dialysis) or create perverse incentives for providers to either withhold palliative dialysis or inappropriately encourage it.

II. Detailed Comments by Section

Regarding C. Request for Information on the inclusion of the Dialysis Facility Discussion of Patient Life Goals Patient-Reported Outcome Performance Measure in the ESRD QIP

We applaud CMS for recognizing the importance of discussing life goals with patients and for moving towards inclusion of a quality measure that tracks whether this is happening as a regular part of dialysis care. We have had extensive discussion with patient members of the Coalition regarding the proposed Dialysis Patient Life Goals Survey, and the Coalition including our patients do not think it is an appropriate measure. The Coalition's primary concern with the proposed Dialysis Patient Life Goals Survey is that it risks reducing a deeply personal human conversation into a passive, administrative exercise. As expressed directly by our patient community, individuals newly initiating dialysis are frequently navigating acute shock and survival mode, focusing on immediate day-to-day adjustment rather than long-term life trajectories. Forcing patients to select from a static list of life goals without

measuring whether those goals actually shape their clinical care plan creates administrative burden without driving meaningful quality improvement [1].

Furthermore, measuring whether a treatment plan is "consistent with life goals" holds dialysis facilities accountable for holistic social, economic, and personal variables that often lie entirely outside their clinical control. To achieve the true intent of the ESRD QIP, CMS must measure actionable engagement, not static status.

As an alternative to the Dialysis Patient Life Goals Survey, we suggest using the CollaboRATE measure, which has already been endorsed by the Partnership for Quality Measurement. CollaboRATE is a patient-reported measure of shared decision making which contains three brief questions that patients or their representatives complete. The CollaboRATE measure provides a performance score representing the percentage of adults 18 and older who experience a high level of shared decision making. It is brief and easy to complete. CollaboRATE achieves the goal of the ESRD QIP of measuring the clinical impact and effectiveness of a dialysis facility's patient care performance by measuring patients' perception of the shared decision-making process.

However, if CMS remains committed to capturing the content of patient life goals within future quality frameworks, we strongly recommend modifying the approach to focus on Longitudinal Goal Integration:

- **Measure Process & Quality, Not Static Outcomes:** Shift the metric from "Does the patient have a life goal on file?" to evaluating whether the care team actively engages the patient in meaningful shared decision-making regarding their priorities(Roberts 2025).
- **Combine Goal Identification with Decision-Making:** Pair brief goal-identification prompts with validated shared decision-making tools (like CollaboRATE) so facilities are rewarded for demonstrating how patient priorities actively shape their ongoing care plan.
- **Account for Patient Readiness and Trajectory:** Recognize that goal setting is a continuous process across the kidney journey. Quality metrics must accommodate patients who are focused on short-term stability or specific treatment milestones (such as transplant evaluation and living donor outreach) before exploring broader life goals.

Additional comments on quality measures related to goals of care

Core recommendation: Goals of care should be ongoing**,** not triggered only at a crisis point. Goals of care conversations should occur longitudinally, be initiated early, and not begin only when a patient reaches a particular clinical threshold. Quality measures should be sensitive to this.

- Suggested triggers for reassessment of goals of care (not first-time initiation): hospitalizations, functional decline, increasing treatment intolerance, prolonged recovery after dialysis, major prognosis change. But these indicators of progression should not be the first time we ask the patient what matters to them.
- The ongoing nature of goals of care discussions has payment implications in that the time for these discussions should be included in any bundled payment.

- However, quality measurement of goals of care should be cautious about not burdening patient or provider with excessive tracking of ongoing goals of care assessment.

In addition, one of our family member advisors, who cared for her late husband throughout his kidney disease journey including using home hemodialysis, suggested starting patient reported outcome measures about life goals 45-60 days after initiation of treatment. She advises that the initial weeks of dialysis can be overwhelming for patients and their families as they adjust to a new diagnosis, treatment schedule, medications, dietary considerations, transportation needs, financial responsibilities, and the emotional impact of living with ESRD. Administering the survey after a reasonable period of adjustment may allow patients to respond with greater thoughtfulness and provide a more accurate reflection of their experience. A delayed or appropriately timed assessment could also help reduce the cognitive and emotional burden that may occur during the early transition to dialysis.

Regarding: Requests for Information about palliative dialysis

The definition of palliative dialysis in the Proposed Rule needs refinement.

Core recommendation: Palliative dialysis should be defined by goals and intent, not by dialysis frequency or inability to tolerate maintenance dialysis. The palliative dialysis definition should be based on treatment intent and goals of care, which would include symptom relief, quality of life, and reduced treatment burden. The definition should NOT be tied to hospice or home health eligibility. As discussed below, eligibility *should* be tied to an estimated prognosis of 1 year or less if the disease takes its normal course based on validated prognostic criteria.

We suggest adopting the definition In "A Palliative Approach to Dialysis Care: A Patient-Centered Transition to the End of Life," the definitive article on palliative dialysis in the *Clinical Journal of the American Society of Nephrology* in 2014 (Grubbs et al. 2014). This article, on behalf of the Dialysis Advisory Group of the American Society of Nephrology, defined palliative dialysis as "a palliative approach to dialysis care as a transition from a conventional disease-oriented focus on dialysis as rehabilitative treatment to an approach prioritizing comfort and alignment with patient preferences and goals of care to improve quality of life and reduce symptom burden for maintenance dialysis patients in their final year of life. This transition aligns with palliative care in general as well as with the current demographic of the United States dialysis population."

In addition, please refer to the 2026 article by Bursic et al for an up to date and comprehensive description of palliative dialysis through the lens of one patient's case (Bursic et al. 2026).

We caution against using inability to complete 3x/week dialysis as a major eligibility criterion. A patient may still physiologically tolerate three treatments per week but determine that the burden of treatment is no longer consistent with their goals.

Clinical markers (hypotension, fatigue, frailty, missed treatments, hospitalization) should not automatically signal a shift to palliative status. These are indicators that a goals of care conversation should be encouraged. On their own, without documented palliative goal from the patient, clinical markers should not define palliative dialysis.

Dialysis prescription elements are downstream of the decision to pursue palliative dialysis, not defining of it: frequency, duration, ultrafiltration goals, and other aspects of the prescription could change to best meet patient goals (e.g. less treatment burden or alleviation of a specific symptom), but the prescription specifics shouldn't define palliative dialysis.

Terminology suggestion: replace "curative dialysis" with "conventional maintenance dialysis" or "disease-directed maintenance dialysis."

Regarding: What clinical characteristics distinguish palliative dialysis from maintenance dialysis?

Core recommendation: Clinical characteristics can help identify the target patient population for whom palliative dialysis should be considered, but they cannot replace patient preference as the bedrock requirement for providing palliative dialysis.

Since palliative dialysis is tailored to the values and needs of the individual patient who is seriously ill and typically in the last year of life, palliative dialysis is *not* a one-size-fits-all approach to achieve standard performance measures such as creation of an arteriovenous fistula or a target Kt/V. For this group, the burdens of maintenance dialysis care may outweigh its benefits, thus making desirable a palliative approach to dialysis care in which the emphasis is shifted toward maximizing comfort and minimizing physical and psychologic burdens of maintenance dialysis schedules (such as fatigue, cramping from aggressive fluid removal to control hypertension and volume overload, back pain from sitting in a dialysis chair for four hours three times a week, and travel to and from dialysis). The clinical hallmarks of palliative dialysis are:

- Designed to achieve patient goals (such as reduced treatment time and avoidance of dialysis-related symptoms such as low blood pressure and dizziness) rather than laboratory value targets
- Flexible schedule and prescription (number of times per week, length of session, intensity of fluid removal) to fit patient goals

Clinical Characteristics of Patients Appropriate for Palliative Dialysis:

- Patient/family preference for prioritizing comfort and quality of life over extending life through maintenance dialysis.
- Often older than 75 years of age
- Significant co-morbidities limiting life expectancy.
- Frailty and functional decline
- Confusion, impaired memory, and dementia
- Multiple hospitalizations over the past 6 months to one year

- Inability to tolerate treatment (such as inability to sit for long periods)

Regarding: Are there specific modalities or treatment patterns that are more consistent with palliative care?

Palliative dialysis can be performed with in-center and home hemodialysis and home peritoneal dialysis. It is more about tailoring the dialysis prescription to achieving the patient's values and goals for their limited life expectancy. Commonly, patients receiving palliative dialysis have shorter treatment times and require less fluid and kidney poison (uremic toxins) removal because they are not eating and drinking well; there is not a target Kt/V to achieve.

Regarding: What objective and auditable criteria should be used to identify beneficiaries appropriate for palliative dialysis?

Core recommendation: Anchor eligibility to validated prognostic factors predicting limited survival if the disease takes its usual course. Do *not* tie eligibility to hospice six-month eligibility or home health homebound eligibility.

The eligibility criteria for palliative dialysis should be anchored in a prognostic framework validated in the literature. Dialysis tolerance (including inability to sit in chair for long periods) and patient goals should then supplement the prognostic framework. It is critical that all the suggested eligibility criteria, especially survival, be used only to screen for eligibility. None of them should be used automatically to enroll a patient in palliative dialysis nor to preclude palliative dialysis. Patient choice should be preserved, based on documented goals of care, and be the final determination of enrollment in palliative dialysis.

The *Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis (Renal Physicians Association (RPA) 2010)* clinical practice guidelines were published in 2010 and were developed after a systematic review of the evidence found that age, comorbidities, functional status, and nutritional status were statistically significant independent predictors of dialysis patients with a poor prognosis. Cohen LM et al, "Predicting Six-Month Mortality for Patients Who Are on Maintenance Hemodialysis," developed an integrated prognostic model to predict mortality in hemodialysis patients that factors in age, "No" response to the surprise question, "Would I [the nephrology clinician] be surprised if this patient died in the next year?", the comorbidities of dementia and peripheral arterial disease, and serum albumin (*CJASN* 2010). The model had a robust area under the curve statistic of 0.8. Also, Couchoud CG et al "Development of a risk stratification algorithm to improve patient-centered care and decision making for incident elderly patients with end-stage renal disease" using the Renal Epidemiology and Information Network developed a prognostic screening tool to predict 90-day mortality in dialysis patients using multivariate logistic regression (*Kidney Int* 2015). Patients at high risk had a greater than 40% risk of dying within three months of starting dialysis and constituted 2.5% of the dialysis population. The factors they identified for patients at high risk of 90-day mortality were age, low serum albumin, total dependence for physical transfers, cardiac disease, dementia, and starting dialysis on an emergency basis. The model had a strong area under the curve statistic of 0.76. More recent

studies have also specifically identified frailty and dementia as doubling the risk of death within one year of starting dialysis. For example, a 75-year-old dialysis patient with dementia, peripheral arterial disease, a serum albumin of 2.5g/dL, and a "No" response to the surprise question has a predicted 6-month survival of 9% and would be an appropriate candidate for palliative dialysis *if* it fits with their goals. https://qxmd.com/calculate/calculator_135/6-month-mortality-on-hd

Regarding: Should eligibility be limited based on indicators such as serious illness, frailty, functional impairment, or limited prognosis?

Yes, eligibility should be limited on serious illness, frailty, impaired functional status, and dementia as described in the factors predicting a poor prognosis in the above response. A prognosis of <1 year using validated screening criteria should be a screen to indicate possible eligibility, but it should not be applied to completely exclude patients who have a somewhat longer prognosis. A patient with substantial treatment burden and goals favoring a more palliative approach could appropriately choose palliative dialysis even if predicted survival is longer than one year.

It is essential that the patient's preference for comfort-directed palliative dialysis be considered. This should be confirmed through a process of shared decision making with the patient and/or the patient's medical decisionmaker in which full information about palliative dialysis compared to maintenance dialysis compared to conservative management (also known as active medical care without dialysis) is provided. Eligibility Limits should be applied cautiously. Overly restrictive criteria could deny appropriate care and keep patients tied to overly burdensome and unwanted maintenance dialysis.

Regarding: What role should existing constructs (for example, homebound status or hospice eligibility) play in defining the target population?

We strongly recommend that access to palliative dialysis *not* be limited to homebound patients or patients enrolled in hospice. Palliative dialysis is aimed at people who have poor predicted one-year survival risk (two or more of the factors predictive of a very poor one-year survival). However, these patients, although frail, may not technically be homebound and there is no reason to limit access to the homebound. Furthermore, they may not yet meet the hospice eligibility criteria of prognosis of 6 months or less if terminal disease takes its usual course. Predicating access to palliative dialysis on hospice admission would be a significant barrier to appropriate use of palliative dialysis to provide symptom management and comfort in the period prior to hospice eligibility.

Homebound status and hospice eligibility are *indicators*, not definitive criteria. Many patients may benefit from palliative dialysis without meeting full hospice requirements. **Again, we strongly recommend that access to palliative dialysis not be limited to homebound patients or patients enrolled in hospice.**

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Regarding: Should CMS consider hybrid eligibility approaches that combine functional and prognostic criteria?

Yes, we support a hybrid approach combining functional and prognostic criteria to avoid excluding patients who could benefit. The integrated prognostic models of Cohen and Couchoud discussed above combine multiple factors. Frailty should be one of the screening tools to trigger goals of care conversation. In addition, the Clinical Frailty Scale (CFS) is another possible objective measure of advanced frailty/serious illness. We would frame frailty as a risk stratifier and a trigger for reassessment and goals-of-care discussions rather than as a stand-alone criterion for palliative dialysis.

Regarding C. Care Delivery and Settings: What are the primary barriers to delivering palliative dialysis in home or community-based settings?

The largest barrier is the reduction in payment to dialysis centers who accept patients on palliative dialysis because these patients are sicker and more likely to be hospitalized and to have lower scores on the QIP metrics.

An additional barrier is impact on scheduling in dialysis centers. Many dialysis centers have optimized to fill their "chairs" and shifts as fully as possible. A patient who only has two sessions a week leaves a chair slot unfilled for the shift that palliative dialysis forgoes.

From the patient viewpoint, a significant barrier to home dialysis may be the financial responsibility borne by patients and families. While home dialysis can offer important clinical, quality-of-life, and potentially system-level benefits, the responsibility for administering treatments outside of the initial training is largely placed on the patient and/or caregiver. CMS should consider strategies that reduce or eliminate patient cost-sharing obligations associated with home dialysis, including consideration of reductions or waivers of applicable Part B cost-sharing and/or coinsurance.

Reducing financial barriers could make home dialysis a more viable option for patients who are clinically appropriate and interested in receiving treatment at home. Financial assistance should be designed in a manner that does not create additional burdens for patients who are already managing the physical, emotional, and financial challenges associated with ESRD. As a policy consideration, CMS could examine approaches similar to patient-level ACO benefits for Part B cost sharing, including efforts being considered under the CMS CY 2027 Physician Fee Schedule, where reducing or eliminating certain copayments may be used as a mechanism to encourage participation and engagement in value-based care.

Regarding: Could access to staff-assisted home dialysis improve beneficiary experience for those receiving palliative dialysis?

Yes, dialysis at home for patients with marked functional limitations would improve beneficiary and family experience. We recommend creation of a specific pathway for staff-assisted home dialysis or other flexible dialysis delivery models for selected seriously ill or frail patients along with an appropriate payment mechanism.

Regarding: What services are necessary to support safe and effective home-based dialysis (for example, equipment setup, cannulation assistance, and monitoring)?

The same services as are presently necessary for home-based dialysis except that most patients will need a person to perform their dialysis treatments for them.

Regarding: How should CMS delineate responsibilities across ESRD facilities, home health agencies, and hospice providers?

ESRD facilities should be responsible for the delivery of palliative dialysis and for hospitalizations related to dialysis complications. Hospice should retain responsibility for all additional services that normally fall under the hospice plan of care. Hospice should NOT be responsible for palliative dialysis. Note that not all palliative dialysis patients will be receiving hospice or home health or palliative care.

Regarding: CMS also seeks comment on hospice and home health services for beneficiaries receiving dialysis. (To what extent do current Medicare coverage and payment policies affect the ability of beneficiaries to receive home health and hospice services concurrently for different conditions, and how might these policies impact access to and coordination of dialysis services, including in the home setting?)

The Coalition has been advocating for a pathway for concurrent hospice and dialysis for many years and welcomes CMS' exploration of how it could be delivered while retaining program integrity. As noted in the background section, c*urrent* hospice coverage and payment policy make it extremely difficult for hospice patients to access dialysis (even palliative dialysis) for symptom relief because most hospices cannot afford to cover the cost of dialysis under the hospice daily rate and therefore will not include palliative dialysis in the plan of care. Similarly, patients who are already on dialysis are often reluctant to transition off dialysis completely as a condition of enrolling in hospice,(Wright and Katz 2007) which hospices require because they cannot afford to pay for dialysis if they include it in the hospice plan of care. As a result, patients delay entry into hospice or decline hospice altogether. As noted in the background section, MedPAC has pointed out that changing the comparatively low rates of hospice use by dialysis patients is an opportunity to improve beneficiary end of life experience.

Under current policy, a small subset of people who want concurrent hospice and dialysis are able to obtain it. This is the population of people whose hospice terminal diagnosis is clearly different (unrelated) from their renal disease. In this specific circumstance, current regulations allow payment of both dialysis costs to the dialysis center and hospice daily rate to the hospice. However, the broadening and variable definition of what costs are considered "related to the terminal illness" has discouraged many hospices from using even this small opening for delivering concurrent hospice and dialysis.

Regarding: CMS also seeks comment on the coordination of renal dialysis services with hospice care, including in the context of palliative dialysis.

Core recommendation: For patients who are eligible for or enrolled in hospice, we strongly favor a payment and regulatory pathway that allows and pays for concurrent dialysis along with hospice care, regardless of the patient's terminal diagnosis used for hospice eligibility. While program integrity limits

will be needed, we caution against setting an overly restrictive limit on the number of dialysis sessions that would be permitted in this pathway.

Note: This should not be construed to *limit* palliative dialysis only to patients enrolled in hospice. Likewise, neither should hospice enrollment preclude patients from accessing concurrent palliative dialysis.

Due to the number of parties potentially involved: nephrologist/APP, dialysis facility, nephrology nurse, value-based care manager, primary care clinician, hospital team, hospice team, other specialists, someone needs clear responsibility for ensuring that goals of care discussion, medication changes, dialysis prescription changes, symptom-management plans, hospitalizations, and decisions about escalation or de-escalation are communicated across the continuum. There are multiple models as to which party takes the coordination lead, and we think CMS policy should remain flexible as to which party takes on this coordination responsibility. as long as someone is clearly responsible.

To answer the other operational questions CMS poses about payment policies for concurrent hospice and dialysis, we refer CMS to the careful documentation of the processes and outcomes of concurrent hospice and dialysis as demonstrated by Dialysis Clinic, Inc. (DCI) partnered with the University of Pittsburgh Medical Center (UPMC) and UPMC's Family Hospice.(D'Anello 2022; Butler et al. 2022; Ernecoff et al. 2022; Ernecoff, Motter, et al. 2023; Ernecoff, Robinson, et al. 2023). DCI and Family Hospice developed a program to offer up to 10 dialysis sessions to enrolled hospice patients. These dialysis sessions were paid for by the hospice at a contracted rate of $250 per session.

The results of the DCI/UPMC demonstration begun in 2016 were encouraging. An evaluation of the first 43 patients enrolled from 2018 to 2021 showed that a little more than half (53%) who enrolled in the program ultimately chose not to pursue further dialysis. Of the 20 people who sought dialysis, 15 people received hemodialysis (average 3.5 treatments) and 5 received peritoneal dialysis. No one used all 10 of the available hemodialysis sessions (range 1–9 sessions). Patients who used dialysis sessions had longer hospice stays than those who ultimately didn't use dialysis while on hospice (19 days in hospice compared to 7 days). 65% of people died at home and none died in the hospital.

To scale this demonstration program to a national level, we recommend a larger, *voluntary,* demonstration to help set the appropriate payment levels and to conduct a wider test of likely usage by beneficiaries. While we appreciate that CMS may wish to limit the amount of dialysis available to hospice beneficiaries (primarily to limit program costs), we caution against adopting the 10-session limit tested by DCI/UPMC as the national standard. We recommend testing a window of 2-3 months for concurrent dialysis. This would help uncertain patients experience the support of hospice, ultimately easing their end-of-life transition and hopefully reducing end-of-life ICU use.

An additional source of experience with concurrent hospice and dialysis is in the Veterans Administration system. An analysis of medical records found that the adjusted proportion of veterans receiving concurrent care was higher for those enrolled in VA inpatient hospice or VA community care hospice

than it was for those enrolled in Medicare hospice (55% and 42% vs 25%, respectively). Median hospice length of stay was 43 days for veterans who received concurrent dialysis vs 4 days for those who did not.(Wachterman et al. 2022) Again, this suggests that the Medicare conditions of participation and payment structure are a significant barrier for patients who wish to receive concurrent hospice and dialysis, and that it ultimately prevents patients from receiving needed support at the end of life.

Regarding: D. Payment Policy Considerations

Concurrent Hospice/Dialysis

We suggest that the delineation of responsibility during concurrent hospice/dialysis be as follows:

- **ESRD facility:** retains clinical oversight of the palliative dialysis prescription, equipment, and dialysis-specific training/certification of any staff performing the treatment.
- **Hospice:** retains overall interdisciplinary care coordination and symptom management for the terminal condition.

The payment streams should follow this responsibility. Payment for dialysis services (whether maintenance or palliative) should go directly to the dialysis provider, not be channeled through the hospice. The dialysis provider should continue to be responsible for access placements and costs and for hospitalizations related to dialysis complications.

The question of who should be responsible for transportation is harder, as transportation is not normally covered in the dialysis fee, but many hospice patients may need transportation if they continue in center dialysis.

The payment level should be set so that it neither incentives nor disincentives palliative dialysis over maintenance dialysis, leaving patient choice to be the main driver. For all modalities, the payment should also cover the additional care coordination and psychosocial support needed by a seriously ill and declining patient.

Palliative dialysis (which much of the time is *not* concurrent with hospice)

- **Current PPS Bundled Payment:** Likely doesn't adequately encompass palliative dialysis. Focus is on maintaining life, not necessarily improving quality of life in the context of limited prognosis. *As presently constituted with payment reductions for failing to meet ESRD QIP metrics, the ESRD QIP provides a disincentive to offering palliative dialysis.*
- **Services/Supports Not Adequately Reflected:** Palliative care interventions (pain management, symptom control), social work support, telehealth monitoring, care coordination should all be included as part of comprehensive care for a patient on palliative dialysis. Who gets paid depends on who delivers the care, nephrology clinician or palliative care clinician.

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Regarding E: Program Integrity and Safeguards (What safeguards are necessary to ensure appropriate targeting and prevent overutilization?)

Patients need to meet the poor prognosis criteria described above. Criteria could be established on the Cohen et al model or the Couchoud et al model. They could also be established on a combination of the factors predicting poor prognosis such as age, comorbidities, frailty, and functional impairment ± impaired nutrition ± dementia.

To address concerns around inappropriate targeting of patients to palliative dialysis, CMS could use palliative and concurrent care modifiers to identify outliers (eg high utilization or prolonged use), similar to how CMS uses the live discharge rate to trigger audits of hospice agencies.

Program integrity should also address undertreatment (unmanaged symptoms, unmet psychosocial needs), not just overutilization: In a capitated or total-cost-of-care model, decisions to reduce dialysis frequency need to be based on shared decision-making and documented patient goals—not financial incentives or utilization target.

Finally, **patients need a path to reverse course:** Patients also need the ability to reconsider their decisions as their circumstances or preferences change. They should not be locked into a palliative dialysis pathway just like patients on maintenance dialysis can decide to stop at some point if the burdens to them outweigh the benefits.

Regarding: How should CMS ensure that any policy remains focused on comfort-oriented care?

Patients should be encouraged to complete medical orders for comfort-focused care including do-not-resuscitate and do-not-intubate orders. POLST or comparable state-specific medical orders can indicate comfort-focused care with the patient's preference to die in their present setting unless comfort cannot be achieved without transfer to the hospital. Patients should be allowed to decide NOT to limit life-sustaining treatments while on palliative dialysis and to determine the timing that is right for them. Experience has shown that as a patient's disease progresses, the patient values treatments that will limit pain and suffering. In such cases, patients decide to forgo cardiopulmonary resuscitation and a breathing machine.

Quality reporting should focus on symptom management, quality of life, and patient satisfaction. **Recommended quality measures:**

- goal-concordant care
- symptom/treatment burden
- patient and caregiver experience
- days at home
- avoidable hospital/ED utilization
- fidelity between documented preferences and actual treatment plan.

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Workforce considerations for palliative dialysis:

Core recommendation: Nephrology nurses and Advanced Practice Providers (APPs) should be explicitly included in the interdisciplinary model and have responsibilities at the top of their licenses.

Dialysis nurses often have the most frequent longitudinal contact with seriously ill patients and are often the first to see changes. Based on training and experience, the nursing role may include goals-of-care discussions, symptom assessment, patient/family education, care planning, and cross-discipline coordination (nephrology, dialysis, hospice, other providers). In addition, APPs should be able to lead these efforts at the top of their licenses, consistent with applicable federal and state requirements.

Nephrology clinicians often need additional education to be comfortable with the serious illness communication skills needed to sensitively guide patients through these decisions. The Coalition has developed many resources for nephrology clinicians to bolster their skills in this area, some of which have been deployed in collaboration with large dialysis organizations.

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