Nonprofit Kidney Care Alliance

March 16, 2026

Michael E. Chernew, PhD
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: NKCA Comments on March 2026 Session – "Access to hospice and certain complex palliative services under the hospice benefit for beneficiaries with end-stage renal disease and beneficiaries with cancer"

Dear Dr. Chernew:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), we appreciate the opportunity to offer our comments on the March 2, 2026, Medicare Payment Advisory Commission (MedPAC) session titled, "Access to hospice and certain complex palliative services under the hospice benefit for beneficiaries with end-stage renal disease or cancer." NKCA represents eight nonprofit dialysis providers: Centers for Dialysis Care; Central Florida Kidney Centers, Inc.; Dialysis Center of Lincoln, Inc.; Dialysis Clinic, Inc.; Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; Puget Sound Kidney Centers; and The Rogosin Institute. Collectively, we serve more than 22,500 patients at more than 326 facilities in 32 states. In an effort to keep patients off dialysis, NKCA members also serve more than 10,000 patients with chronic kidney disease (CKD), with the goal of avoiding, or at least delaying, the onset of end-stage renal disease (ESRD).

We want to begin by thanking MedPAC for both including this topic in three recent public meetings and engaging with NKCA on this critical issue over the years. **We applaud your efforts to pursue sound reforms to improve the well-being of our patients and look forward to continued engagement on this topic.**

Overview

Approximately 80 percent of our patients are covered by Medicare fee-for-service or Medicare Advantage (MA). Hence, access to Medicare's hospice benefit is of critical importance. NKCA members strongly believe that dialysis patients should have the choice to elect hospice with the knowledge that dialysis treatment, not "maintenance dialysis," will be available as needed to address symptom management and provide comfort as they approach the end of life. This includes *all* patients, not just those who have a hospice provider who is able and willing to provide it.

Unfortunately, for many years Medicare's rules posed an obstacle for ESRD patients to elect hospice care, making it difficult for patients on dialysis to access this care at the end of their

lives. During the September 2025 session, MedPAC staff indicated that the Centers for Medicare & Medicaid Services (CMS) has clarified that select services for certain hospice patients (specifically dialysis for beneficiaries with ESRD, radiation for those with cancer, and blood transfusions for certain patients) can be covered under the hospice benefit if the hospice physician determines they are palliative for an individual patient. However, we believe broader coverage and payment of concurrent hospice and dialysis are critical. Without an intentional, scheduled accommodative transition off dialysis, ESRD patients can experience extreme discomfort in their transition to end of life.

Voluntary Transitional Program

During the April 2025, September 2025, and March 2026 MedPAC public meetings on this topic, Commissioners discussed the concept of a "voluntary transitional program," and we were encouraged to see it presented as one of the three potential policy directions shared. Based on our experience, **NKCA still believes that the proposed voluntary transitional program is the best option.** This option aligns with how NKCA member companies have approached this policy over the years in their existing programs. CMS already covers concurrent dialysis and hospice for those with other fatal conditions. A transitional program would avoid the "on/off switch" concern voiced by Commissioners during the March 2026 meeting—giving ESRD patients the ability to benefit from a set amount of palliative dialysis treatments that would allow ESRD patients to experience the true benefit of hospice and approach end of life in a dignified manner.

Payment

NKCA strongly believes that if CMS chooses to pursue a voluntary transitional program, the payment should go directly to the dialysis facilities. Currently, CMS allows patients with ESRD who elect hospice based on another diagnosis to continue receiving full dialysis treatment while on hospice. In these cases, the patient continues to receive care at their own dialysis facility, where payment is made directly to the facility by the Medicare Administrative Contractor (MAC). **For the sake of consistency, payment should continue to flow from the MACs to the dialysis facilities for patients in the transitional program.** Moreover, as noted by some of the Commissioners during the September 2025 public meeting, the cost of providing dialysis treatment could be prohibitive to hospice providers, thereby creating a scenario where the hospice providers must contract with an ESRD provider for dialysis services. Such contracting arrangements would limit patient choice. **Direct payment to the dialysis facilities is the most straightforward and commonsense approach.** Members of NKCA have experience with this approach and can share more with MedPAC if helpful.

CMMI-KCC Model

During the meeting, a Commissioner referenced the possibility of a CMS Innovation Center (CMMI) model to test a transitional program. When it comes to ESRD, within the Kidney Care Choices (KCC) Model, entities can waive the requirement that beneficiaries who elect the Medicare hospice benefit give up their right to receive curative care as a condition of electing the hospice benefit. All expenditures incurred by Medicare for these beneficiaries would be included as part of the total cost of care for the performance year.

CMS Case Study

In November 2022, CMS published a case study describing how Dialysis Clinic, Inc. (DCI) partnered with the University of Pittsburgh Medical Center (UPMC) and UPMC's Family Hospice to design and implement a concurrent care program (see Appendix A). By removing the dilemma of having to choose between starting hospice and stopping dialysis, DCI and UPMC aimed to improve their patients' experience with end-of-life care. Between January 2018 and December 2021, DCI and UPMC enrolled 43 beneficiaries in the concurrent care program—those who sought hemodialysis received 3.5 dialysis treatments on average, with none using all 10 available sessions, and those that sought peritoneal dialysis received 19.2 sessions on average.

ESRD and Hospice Concurrent Legislative Efforts

While MedPAC continues to discuss concurrent policies related to ESRD, NKCA would like to reiterate that we are working with Congress on legislation that:

- Establishes Medicare coverage and payment of concurrent palliative dialysis and hospice for those electing hospice due to ESRD
- Directs payment to dialysis facilities, not hospice *(same as when ESRD patients elect hospice for non-ESRD terminal conditions)*
- Allows up to 10 palliative dialysis sessions
- Clarifies how home peritoneal dialysis would be treated compared to hemodialysis for the 10-session count
- Allows the Secretary to adjust the cap starting at three years after enactment
- Allows the Secretary to create a payment for palliative dialysis that may be less than the cost of the traditional ESRD maintenance bundle
- States that the Secretary may consider coverage for patients to continue receiving non-emergency transportation services under ESRD treatment coverage
- Clarifies that this new policy will not impact ESRD patients electing hospice for non-ESRD terminal conditions

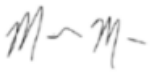
Peritoneal Dialysis

In the September 2025 meeting, a number of Commissioners raised the possibility of patients transitioning to peritoneal dialysis (PD) as they prepare to enter hospice. Given that multiple NKCA members operate concurrent dialysis programs of their own, we would like to stress that it is not best practice, or even practical, to transition an ESRD patient to PD in the last few days or weeks of life. The PD catheter must be placed, which takes two to three weeks to heal, and there must be several weeks of training. **We urge MedPAC to reach out to NKCA as a clinical resource while exploring potential recommendations to Congress.**

We do note that patients currently dialyzing at home have been able to successfully participate in concurrent dialysis and hospice care. If a patient has already been trained on home dialysis and already has a PD catheter placed, we have seen that a patient who dialyzes at home and chooses concurrent care has less burden of therapy because there is no need to travel for dialysis.

Thank you for the opportunity to comment on the March public meeting. This area is of great importance to NKCA and a top policy priority. Again, we appreciate MedPAC's work to better understand this issue, and we look forward to continued engagement, including serving as a resource to address questions and concerns that the Commissioners and/or staff had during the meeting. If you have any questions, please feel free to contact me at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,



Monica Massaro
Executive Director

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Case STUDY

Value Based Care
Learning System

Under traditional Medicare policy, a terminally ill beneficiary with six months or less to live (as certified by a provider) may elect to begin hospice under the Medicare Hospice Benefit. Even though hospice offers patients and their families greater assistance with day-to-day care and emotional support, many people are reluctant to begin hospice because doing so often means stopping other curative or life-prolonging treatments, like dialysis for end-stage renal disease or radiation for cancer. To help people transition to hospice care, some organizations have begun offering concurrent care services that allow some palliative care treatments to continue after a beneficiary elects hospice.

Under a few of its value-based care models, CMS is testing whether offering concurrent care encourages more beneficiaries to begin hospice sooner.[1] CMS recognizes that earlier use of hospice might improve patients' care experience at the end of life while helping them to avoid inpatient and ICU admissions in their final days.

Dialysis Clinic, Inc.'s Concurrent Care Program

This case study describes how Dialysis Clinic, Inc. (DCI) partnered with the University of Pittsburgh Medical Center (UPMC) and UPMC's Family Hospice to design and implement a concurrent care program. This program allows beneficiaries with end-stage renal disease (ESRD) to receive as many as 10 hemodialysis sessions after beginning hospice. By removing the dilemma of having to choose between starting hospice and stopping dialysis, DCI and UPMC aim to improve their patients' experience with end-of-life care. Accountable care organizations (ACOs) and value-based care organizations interested in integrating palliative and hospice care to better support terminally ill patients might wish to consider DCI and UPMC's approach.

BACKGROUND ON DCI REACH

DCI is a nonprofit organization headquartered in Nashville that operates more than 200 outpatient dialysis clinics nationwide. Since its founding in 1971, DCI has prioritized the health and well-being of its beneficiaries. However, an extended conversation with two patient advocates in 2010 prompted DCI to rethink its approach to kidney care. "We learned from them how broken the system is because of how narrowly kidney care focused on dialysis," recounted Dr. Doug Johnson, DCI's Vice Chairman and Director of the Board. "They said, 'DCI, you are part of the problem. You are running dialysis clinics, but what are you doing to empower patients?'" This conversation catalyzed DCI's transition to value-based care and the formation of Reach Kidney Care (DCI Reach) in 2011.

DCI Reach is a nonprofit subsidiary that specializes in care management for beneficiaries with chronic kidney disease (CKD) and ESRD. From 2016 to 2021, DCI Reach operated six ESRD Seamless Care Organizations (ESCOs) under the Centers for Medicare & Medicaid Services' (CMS's) Comprehensive ESRD Care (CEC) Model. In 2022, DCI Reach transitioned to CMS's Kidney Care Choices (KCC) Model. Under KCC, they operate three Kidney Contracting Entities (KCEs) in Tennessee, Alabama, Pennsylvania, New York, and New Jersey that serve approximately 1,900 attributed Medicare beneficiaries with CKD and ESRD.

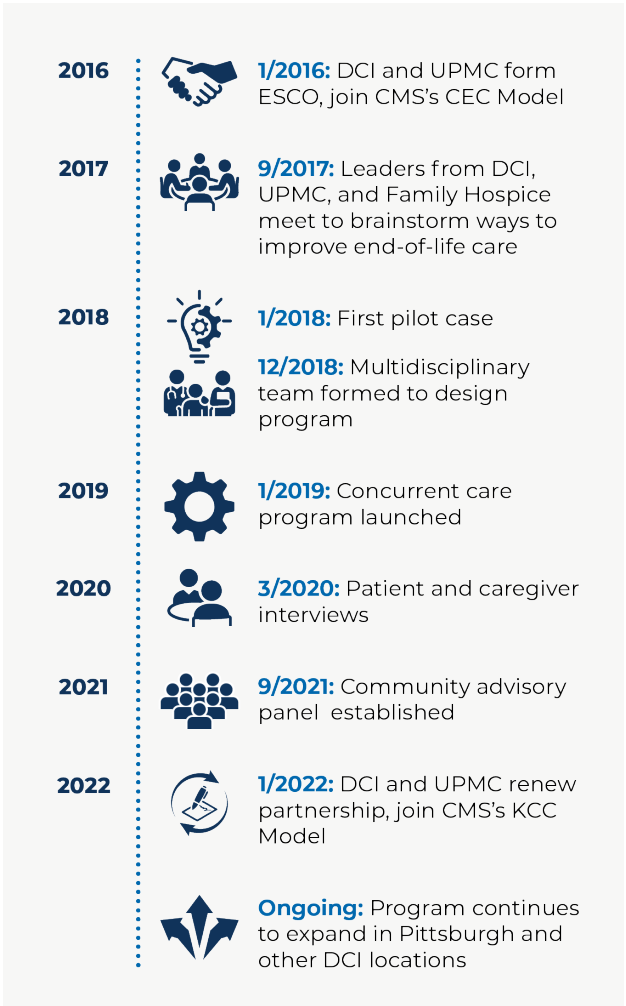
[1] Organizations participating in the Kidney Contracting option of the Kidney Care Choices Model and the Global track of the Global and Professional Direct Contracting Model can apply to use the Concurrent Care for Beneficiaries that elect the Medicare Hospice Benefit (also known as the Concurrent Care Benefit Enhancement). CMS plans to offer this benefit enhancement to organizations participating in the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model in 2023. CMS is also testing concurrent care with hospice under the Medicare Care Choices Model.

CREATION OF DCI'S CONCURRENT CARE PROGRAM

DCI Reach recognized that helping beneficiaries with ESRD transition to hospice at the end of life would improve patients' care experiences and potentially reduce utilization for their ESCOs. According to a 2018 study, only 26 percent of Medicare beneficiaries receiving hemodialysis for ESRD elected hospice care (compared with 52 percent of all Medicare beneficiaries). This study also found that beneficiaries with longer hospice stays had lower rates of hospitalizations and admissions to an intensive care unit (ICU).[2] Another study published in 2019 found that veterans who transitioned to palliative dialysis and hospice care earlier reported a higher quality of life than those who continued to pursue standard hemodialysis services.[3] For this reason, DCI sought partners that had deep experience with hospice and palliative care, such as UPMC, when establishing its ESCOs and KCEs.

Figure 1

Timeline for establishing concurrent care program



As shown in Figure 1, DCI and UPMC began their partnership in 2016, when DCI was establishing one of their first ESCOs. The UPMC hospital system brought extensive experience in palliative dialysis and owned a hospice provider, Family Hospice. The three organizations began talking early in their partnership around ways to improve end of life care for beneficiaries with ESRD in the Pittsburgh area. The concurrent care program emerged out of those discussions.

Early planning and program financing

In 2017, leaders from DCI Reach, UPMC, and Family Hospice met in person to discuss how to better support beneficiaries at the end of life. Since 2012, UPMC had operated a renal palliative care clinic under the direction of nephrologist Dr. Jane Schell. Dr. Schell shared what she had learned about the palliative needs of beneficiaries with ESRD and how to facilitate someone's transition to hospice. This sparked the idea of allowing beneficiaries to receive a small number of dialysis treatments after initiating hospice. The leaders sketched out a potential approach to program design and financing. "That conversation was beautiful," recalled Dr. Schell. "We were able to envision what a better end of life could look like [for people with ESRD]."

Financing the program was a critical component of early discussions. Under traditional Medicare policy, neither DCI nor UPMC's Family Hospice could recover the cost of dialysis treatments or transportation to dialysis. However, Dr. Johnson recalled that both organizations felt that supporting beneficiaries at the end of life was "the right thing to do." They therefore worked together to establish a financially sustainable approach to palliative dialysis for beneficiaries with ESRD receiving hospice care, which centered on:

- decreasing the duration and frequency of hemodialysis sessions,
- stopping routine blood work and labs, and
- eliminating any medications that do not address comfort, including those used to support kidney care (e.g., erythropoietin and vitamin D).

After determining the actual costs of these services, DCI established a contracted rate of $250 per palliative dialysis session with UPMC's Family Hospice. Because Family Hospice has an average daily census of 700 people and receives some philanthropic funding for specialized hospice care, they were able to absorb the costs of the palliative dialysis services. Occasionally,

[2] Wachterman, M., et al. "Association Between Hospice Length of Stay, Health Care Utilization, and Medicare Costs at the End of Life Among Patients Who Received Maintenance Hemodialysis." JAMA Internal Medicine, vol. 178, no. 6, June 2018. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2678832

[3] Richards, C., et al. "Family Perceptions of Quality of End-of-Life Care for Veterans with Advanced CKD." Clinical Journal of the American Society of Nephrology, vol. 14, no. 9, September 2019. https://cjasn.asnjournals.org/content/14/9/1324.

a beneficiary may require an ambulance to transport them to a clinic for palliative dialysis. Family Hospice typically absorbs these costs as well. However, because transportation costs vary by patient on distance traveled, Family Hospice and DCI maintain an open dialogue about these costs. Finally, Dr. Schell also secured a grant from the Palliative Care Research Cooperative Group to implement and study the new program.

Preliminary test of program concept

Shortly after this preliminary conversation, a woman Dr. Schell had been caring for was admitted to the ICU. The patient's family was ready to initiate hospice with another area hospice until the patient's husband realized that his wife would need to stop dialysis treatments. Dr. Schell immediately called Dr. Johnson and the Family Hospice team to discuss the possibility of providing hospice and dialysis. They worked over the weekend to figure out how to meet the family's goal of beginning hospice without forgoing dialysis. After the woman enrolled with Family Hospice, she received two dialysis treatments. Those treatments enabled her to visit with loved ones and celebrate her grandson's birthday. She passed away peacefully in her home. "From that experience, we realized (1) we can do this, and (2) it really makes a difference," said Dr. Schell.

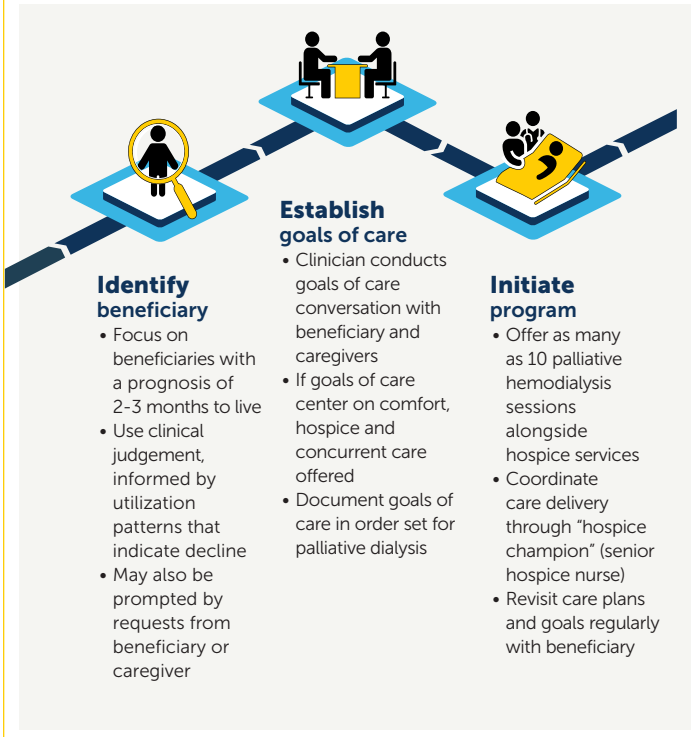
Program design and implementation

After serving that first patient in January 2018, program design and implementation began in earnest in Pittsburgh. A multidisciplinary care team from DCI, Family Hospice, and UPMC met frequently to create a structure for the program, as depicted in Figure 2. Team members included DCI's Dialysis Area Director of Operations, a corporate social worker from UPMC, a senior hospice nurse manager, plus Dr. Schell and the leadership team from DCI and Family Hospice. Dr. Schell commented, "If I could do it over, I would have put a family or patient on [those calls] too." Although DCI and UPMC solicited feedback from beneficiaries and their families after implementation, including interviewing patients and caregivers in 2020 and establishing a caregiver and patient advisory group in 2021, they agreed that seeking beneficiary input even earlier would have strengthened program design and implementation.

The care team decided to focus the program on beneficiaries with a primary diagnosis of ESRD[4] for whom the burden of dialysis might outweigh the benefit. They operationalized this

Figure 2

DCI's concurrent care program



as beneficiaries receiving hemodialysis who were closer to the end of life—typically people with a prognosis of two or three months to live. Over time, DCI and UPMC expanded the program to include beneficiaries receiving peritoneal dialysis.

As currently designed, the concurrent care program enables beneficiaries to receive as many as 10 hemodialysis sessions after electing hospice; the team estimated this number would cover at least a month of care.[5] However, Dr. Robert Taylor, DCI Reach's Co-Founder and Senior Medical Director, clarified, "It is a best guesstimate, and not a hard ending," and that DCI would adjust the ceiling if needed (see results section for data on average number of sessions used). Nevertheless, the partners felt it was important to set a limit to clarify the program's structure and to support financial planning for dialysis treatments. Peritoneal dialysis is also supported for approximately one month.

The multidisciplinary care team also developed clinical parameters to guide palliative care and support clinical decision-making around when to defer or stop dialysis. When the beneficiary transitions to concurrent care, clinicians are directed to stop routine blood draws, labs, and any medications that do not address comfort. Dietary restrictions are also lifted. Finally, clinicians are also encouraged to reduce the frequency and duration of dialysis and set more conservative ultrafiltration goals, to allow beneficiaries to spend as much time as possible at home with their families.

[4] As needed, UPMC and DCI will offer dialysis services to beneficiaries with ESRD who have another terminal illness as a primary hospice diagnosis (e.g., cancer). However, these rare cases are not considered part of the concurrent care program.

[5] Under traditional Medicare policy, the median length of hospice stay for patients with ESRD is about five days. For more information, see Schnell, J., and D. Johnson. "Challenges Providing Hospice Care for Patients Undergoing Long-Term Dialysis." Clinical Journal of the American Society of Nephrology, vol. 16, no. 3, March 2021. https://cjasn.asnjournals.org/content/16/3/473.

> *"Connecting the dots is so important, because now the team is larger: you have the nephrologist, the hospice team, the dialysis providers, the dialysis team… The biggest thing is really trying to figure out how you work through the communication and partnership."*
>
> —Jane Schell
> Associate Professor of Nephrology & Palliative Care, UPMC

COORDINATING CONCURRENT CARE

To facilitate care coordination, the team developed a Concurrent Care Order Set for care team use only, which they iterated on over time (see Appendix). The order set includes information about the patient, their care goals, and the estimated number of treatments per week. It also lists the names and phone numbers of key members of the care delivery team. To support consistent and high-quality care delivery, the order set also reinforces the clinical parameters for palliative dialysis and includes a checklist that the dialysis team, including the nephrologist, must complete as part of program enrollment. Because DCI, UPMC, and Family Hospice do not have a shared electronic health record or care coordination platform, this order sheet is faxed to the hospice and dialysis clinic, where it is added to the patient's physical chart and uploaded to each organization's respective data system.

Communication is critical to care coordination, especially because the organizations do not have a shared electronic system. UPMC and DCI created two roles designed to facilitate communication and program oversight:

- The "hospice champion" serves as the day-to-day lead of the program. This role is filled by a senior nurse manager at Family Hospice. This person facilitates goals-of-care conversations with beneficiaries and guides care coordination activities across the in-patient palliative care, hospice, and dialysis teams. This role was created shortly after program launch.
- The "dialysis champion" ensures that the care team in the dialysis clinic, including affiliated nephrologists, understand how palliative dialysis services are delivered under the program. This role is filled by a nephrologist who reviews and approves all order sets. Dr. Schell is the dialysis champion in Pittsburgh; local DCI nephologists fill this role in DCI's other program sites. DCI created this role in summer 2022 to support program expansion.

> *'We're talking about an industry that has been built over decades to focus on very specific outcomes. We're accustomed to, 'Here's your [dialysis] schedule, be on time, and here's how we're going to measure success.' You completely flip that on its head [when providing care at the end of life]….The order set really starts to signal a shift to that palliative dialysis mindset."*
>
> —Robert Taylor
> Co-Founder & Senior Medical Director, DCI Reach

For the dozen or so beneficiaries who enroll in the program each year, the hospice and dialysis champions meet to review the order set and beneficiary's care goals. The hospice champion then arranges weekly calls to proactively discuss the needs of beneficiaries currently in the program with the dialysis champion and hospice and dialysis care team members. As needed, the hospice and dialysis champions will schedule ad hoc meetings or escalate issues to DCI and Family Hospice leaders.

FACILITATING BENEFICIARY IDENTIFICATION AND ENGAGEMENT

Beneficiary identification depends largely on provider judgement and self-referrals—that is, people inquiring about the program or asking their provider how much longer they need to sustain dialysis. To help providers with identification, DCI developed a few patient examples to contextualize what someone's symptoms or utilization patterns might look like at the end of life (for example, hospitalized multiple times in the last six months). Neither DCI nor UPMC is proactively analyzing utilization and discharge data to identify beneficiaries for the concurrent care program, given the sensitivity of end-of-life care discussions.

> *"These physicians and care teams are much more aligned with understanding when a beneficiary may be near the end of life… The more people who understand that [concurrent care] is an option, the more comfort they have around who should be considered and how to make referrals. You just start to see more traction, more referrals."*
>
> —Robert Taylor
> Co-Founder & Senior Medical Director, DCI Reach

When describing the program to beneficiaries, Dr. Schell noted, "We try not to focus on the number 10. The more you get into the minutiae, the more un-patient-centered [the program] sounds." Instead, DCI and UPMC encouraged clinicians to talk about whether dialysis is still providing the same benefits it once was when the person was stronger. This invites the beneficiary and their family to engage in shared decision-making around whether and when to reduce the frequency of dialysis. If the person wants to use dialysis only to manage symptoms for a limited time or to meet a certain goal, then the provider will offer palliative dialysis and begin a conversation about concurrent care. If the person is ready to stop dialysis, they may be transitioned to traditional hospice. In either case, providers will also offer to introduce the beneficiary to the hospice champion, to ensure the beneficiary understands their care options.

Of the 43 beneficiaries enrolled in the Pittsburgh program through 2021, about 60 percent were referred by hospitalists and palliative care team members from UPMC, typically after the provider initiated a goals-of-care conversation after an inpatient admission or early in an ICU stay. The remaining 40 percent came directly from the dialysis unit. Referrals from the dialysis unit have increased over time, as dialysis care team members became more comfortable talking about palliative dialysis with patients in their care. That said, not all beneficiaries with late-stage ESRD were offered concurrent care. If a beneficiary was ready to stop dialysis, then the care team focused on transitioning that person to traditional hospice. However, Dr. Schell caveated that, "There were patients [who] had a prognosis of a few days [who] would never have chosen hospice, had we not offered the concurrent care program."

DEVELOPING AND DELIVERING TRAINING AND RESOURCES TO SUPPORT IMPLEMENTATION

DCI and UPMC took a multi-pronged approach to engage providers in the concurrent care program:

- **Secure buy-in from nephrologists and administrative leaders.** DCI and UPMC convened multiple meetings with the nephrologists and the administrative leaders of DCI's dialysis clinics in Pittsburgh. DCI's executive team partnered with Dr. Schell and UPMC's leadership to relay the vision for the program and model both organizations' commitment to improving end-of-life care for beneficiaries.
- **Train team members working in DCI's dialysis units.** DCI's lead social worker conducted a series of monthly webinars for the social workers, nurses, and other team members working in DCI's dialysis units. DCI supplemented these webinars with tools and resources, such as a clinical workflow that depicted how dialysis care happens once a beneficiary begins concurrent care. DCI's Pittsburgh area director of operations also attended many of the early webinars, to signal DCI leadership's commitment to the program. The team has started to record these webinars to create a library of training resources.
- **Train the hospice team on concurrent care, especially how to discuss the program when electing the Medicare Hospice Benefit.** Dr. Schell recounted how a Family Hospice team member was completing their standard intake process and accidentally implied that someone enrolled in concurrent care would need to stop dialysis. The patient's family chimed in, "Wait, we're in this special program!" and was able to resolve the confusion. The hospice champion orients new hospice team members to the program to avoid these types of missteps.

Topics covered in DCI's concurrent care training webinars:

- Program overview
- Hospice 101
- Beneficiary identification
- Facilitating conversations with nephrologists about concurrent care
- Advanced care planning

"This is a change in process…but this is also a change that is so welcomed by the people who are providing care for our patients every day, because they've been worried about not really helping someone for whom the burden of treatments outweighed its benefits."

Doug Johnson, DCI

To help beneficiaries learn about the program early enough to make informed decisions about their care options, UPMC and DCI also created patient- and family-facing brochures. These brochures focus on the program's philosophy and focus on palliative dialysis and comfort, without going into too many specifics about the number of treatments offered.

RESULTS

Between January 2018 and December 2021, DCI and UPMC enrolled 43 beneficiaries in the concurrent care program in Pittsburgh. Program enrollment has been stable. After piloting the program with 4 people in 2018, DCI and UPMC have enrolled 13 people per calendar year on average. Table 1 lists the characteristics of enrollees. The race and ethnicity of program enrollees generally reflect the demographics of Pittsburgh according to 2020 Census data. Interestingly, 53 percent (n = 23) of those who enrolled in the program ultimately declined to pursue further dialysis. Of the 20 people who sought dialysis, 15 people received hemodialysis and 5 received peritoneal dialysis. People on hemodialysis received 3.5 dialysis treatments, on average. No one used all 10 of the available hemodialysis sessions (range 1–9 sessions). People on peritoneal dialysis received 19.2 sessions on average (range 3–65).

Table 2 shows the average length of hospice stay for beneficiaries participating in the concurrent care program. As expected, beneficiaries who received dialysis had a longer length of hospice stay than beneficiaries who received no dialysis (19 days compared with 7 days). Beneficiaries who enrolled in the concurrent care program but ultimately declined dialysis spent 7 days on hospice, which is slightly higher than the national average of hospice length of stay for beneficiaries with ESRD (7 days compared with 5 days).

"It's his wishes that he go home to be with his family and not die in the hospital. We're going to help him achieve that goal. That's what going on palliative care allowed him to do—to have that much more control over something he had not had control over for the most part."

—Caregiver, reflecting on the concurrent care program

UPMC also collected qualitative data from clinicians and caregivers to identify improvement opportunities and to better understand beneficiary needs. Feedback has been universally positive. Clinicians shared that the program and associated resources helped to facilitate open communication about end-of-life care and goals with their beneficiaries. Caregivers similarly praised the program and conveyed that having the option to continue dialysis made the transition to hospice easier.

Table 1

Characteristics of people who enrolled in the concurrent care program

	N = 43
Age mean (range)	74 (36–97)
Female (n, %)	19 (44%)
Ethnicity (n, %)	
White	32 (74%)
Black	9 (23%)
Asian	1 (2%)
Dialysis modality (n, %)	
Hemodialysis	38 (88%)
Peritoneal dialysis	5 (11%)
Referral source	
In-patient palliative care clinician	25 (58%)
Outpatient dialysis clinician	17 (40%)
Non-nephrology outpatient clinician	1 (2%)
≥1 dialysis treatment after hospice enrollment	20 (47%)

Table 2

Average length of hospice stay for enrolled beneficiaries

	N	Mean days (range)
All patients	43	12 (1–76)
Received any dialysis	20	19 (4–76)
Hemodialysis	15	16 (5–36)
Peritoneal	5	22 (4–76)
Received no dialysis	23	7 (1–17)

LESSONS LEARNED

After four years of operating the program, DCI and UPMC reflected on their successes and challenges. The partners noted the following lessons learned, which might help other ACOs and value-based care organizations considering implementing concurrent care:

- **Create trusted partners through frequent, authentic communication.** Program implementation hinged on UPMC's Family Hospice and DCI agreeing that the benefits of improving care for beneficiaries at the end of life outweighed any financial considerations. All parties discussed their needs and concerns as they collaborated on the program design, especially as they established rates and budgets. Executives from DCI, UPMC, and Family Hospice maintain open lines of communication.
- **Create a clear program structure.** The palliative dialysis order set and champion roles were integral to program operation. The order set reinforced the program's structure and helped the hospice and dialysis champions communicate the beneficiary's goals and care plan to all care team members. The addition of the dialysis champion role in 2022 also helped DCI and UPMC strengthen communication with referring nephrologists, to ensure that patients were enrolled only when they were ready to begin tapering their dialysis treatments.
- **Implement where you're ready first.** UPMC and DCI first launched the program from the palliative care clinic, as the palliative care team was already seeing patients in the hospital at the end of life and facilitating conversations about hospice. As the program matured and DCI secured buy-in from dialysis unit teams and local nephrologists, they scaled the program to seek referrals from the dialysis units. They launched the training webinars to support this expansion. Referrals gradually snowballed, as more clinicians became aware of the concurrent care initiative or observed how the program benefited their patients.
- **Seek input from beneficiaries and caregivers.** To identify opportunities for improvement, DCI and UPMC interviewed beneficiaries and caregivers in 2020 and established a permanent community advisory group in 2021. DCI and UPMC took care to ensure that members of the community advisory group reflected the diversity of Pittsburgh. This panel has offered constructive feedback on beneficiary engagement strategies and about increasing the program's emphasis on spiritual care.
- **Invest in provider engagement to facilitate culture change.** "I will be honest," Dr. Johnson shared, "I have never done an initiative that's been so difficult to scale beyond one location." Family Hospice being owned by UPMC may have facilitated implementation in Pittsburgh. However, Dr. Johnson and Dr. Taylor theorized that some implementation challenges may stem from ingrained habits within the kidney care industry. From its experiences in Pittsburgh, DCI learned

that it needed to invest time engaging local nephrologists and administrative leaders in dialysis units, typically in one-on-one meetings, before engaging nursing teams in implementation activities. DCI executives also began spending more time discussing end-of-life care during regular monthly calls with medical directors, nephrologists, and dialysis unit leaders. The individual conversations, which are now often managed by the dialysis champion, helped to surface questions and concerns, while the group discussions reinforced DCI's commitment to improving care experiences at the end of life.

Reflecting on how challenging it can be to implement new programs and facilitate culture change, Dr. Schell encouraged other organizations to "celebrate the small wins." Every beneficiary and caregiver who has a positive experience after seeking out palliative care or hospice is a win. Every clinician who sees how concurrent care improves their patients' care experience might refer other beneficiaries in the future. Dr. Schell noted, "A win might be just making that connection with a potential partner that shares your vision, and truly celebrating the journey of implementation."

NEXT STEPS

DCI and UPMC continue to work together to expand the concurrent care program in Pittsburgh and in other DCI locations. To facilitate expansion to other locations, DCI has begun developing a toolkit outlining implementation steps and containing the order set, an example workflow, and descriptions of the hospice and dialysis champion roles. They are also developing tools to improve tracking of program referrals, including gathering data on beneficiaries who declined to enroll.

In 2022, DCI Reach plans to use CMS's new benefit enhancement—the Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit, referred to as the Concurrent Care BE—to further expand the program. This benefit enhancement will enable DCI and Family Hospice to recover the costs of the palliative dialysis services; Family Hospice will still absorb any transportation costs. This benefit enhancement is currently offered only to value-based care organizations participating in the Kidney Care Choices and Global and Professional Direct Contracting models. CMS also plans to offer this benefit enhancement under the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model in 2023.[6]

[6] To learn more about the ACO REACH Model, please see CMS's website: https://innovation.cms.gov/innovation-models/aco-reach

About this case study
This case study was prepared on behalf of the Centers for Medicare and Medicaid Services (CMS) by Kate D'Anello of Mathematica. CMS released this case study in November 2022. We are grateful to DCI and UPMC for participating in this case study.

For more information, contact the VBC Learning System at VBCLearningSystem@mathematica-mpr.com

APPENDIX

This intake order set form was developed by DCI and UPMC to support implementation of the concurrent care program. It is shared as a sample only.

DCI ESRD CONCURRENT HOSPICE DIALYSIS PROGRAM: HEMODIALYSIS INTAKE ORDER SET

*This form must be completed by the clinicians involved in referral to the Program.

*This form must be faxed/emailed to both Family Hospice and if applicable the accepting DCI clinic.

INTAKE INFORMATION: TO BE COMPLETED BY THE TEAM INITIATING THE REFERRAL

**** Patient must receive dialysis at a DCI clinic to receive the DCI Concurrent Program**

1. Patient information (Name, DOB): _____

❒ Referral location (hospital, dialysis clinic, outpatient clinic)
❒ CKCC Patient
❒ Patient or caregiver were educated and informed of patient's treatment choices*
❒ Patient met one of the qualifying criteria for being referred for concurrent care services*
❒ Patient clearly stated goals of care to include pursuing supportive care via hospice*
❒ Patient was informed that they can stop concurrent care services at any time*
* Required questions for CKCC patients

2. ESRD Concurrent Care: Hospice Dialysis Program Checklist:

❒ Accepting DCI Clinic: _____
❒ Dialysis schedule (day, chair time): _____
❒ Nephrologist accepting patient (name/contact information): _____
❒ Hospice referral placed (contact information): _____
❒ Hospice plan of care and medications received/sent to DCI clinic
❒ Code status/advance directive updated (reflects goals that focus on comfort)
❒ Surrogate Decision maker identified (name/contact information): _____
❒ Transportation to clinic (Before access set up, would explore family/caregiver options): _____

3. Communication contact:

DCI dialysis nurse manager name and contact number: _____
Hospice team nurse name and contact number: _____
Family Hospice contact information if hospice team nurse cannot be reached: _____

GOALS OF CARE DISCUSSION:

To be completed by team having the goals of care conversation that led to the decision to do concurrent program.

1. Family meeting:

*who attended: ❒ Patient ❒ Spouse/Partner ❒ Parent ❒ Child ❒ Sibling ❒ Friend
❒ Other: _____

2. Goals of care informing decision for concurrent

❒ Patient/Family reason for electing concurrent program:
_____

❒ Patient/Family goals for continuing dialysis with hospice:
_____

PALLIATIVE DIALYSIS ORDER SET:

To be completed by the dialysis team caring for the patient at the time of referral (if referral from the hospital, inpatient dialysis team responsible for completing).

Orders must be confirmed by the local dialysis champion.

Guidance for palliative dialysis orders to achieve goals of comfort:

- Number of treatments per week depending on dialysis clinic availability: Consider decreasing to 2 per week based on patient goals and clinical status
- Treatment time: Consider shortening dialysis time to optimize quality of life
- Ultrafiltration goal: Recommend conservative goals, either increasing EDW to minimize large UF or discussing goal on a treatment-by-treatment basis.

1. Adjustments to dialysis prescription (write NA if no changes made from previous):

❒ Number of treatments per week: _____
❒ Time: _____
❒ Ultrafiltration goal: _____
❒ K bath: _____
❒ Blood pump speed: _____
❒ Dialysis flow rate: _____
❒ Other orders: _____

2. De-prescribe medications per patient goals of care (dialysis-specific medications).

❒ Notify [provider name] of MTM consult (contact: ###-###-####)
❒ Discontinue all kidney medications that do not support comfort. These include ESA, iron, phosphate binders, vitamin D analogues or calcimimetics, etc.

3. Liberalize diet per patient goals of care

❒ Discontinue renal diet
❒ Discontinue fluid restriction

4. Discontinue lab draws per patient goals of care

❒ Discontinue all routine lab draws (Labs may be drawn periodically if aligned with patient goals and plan of care)

CONCURRENT CARE:

To be completed by dialysis and hospice teams caring for patient.

1. Guidance for dialysis nurse or technician for when to hold dialysis if clinically unstable*:

❒ Hemodynamic instability (for example, blood pressure <90 systolic or symptomatic with low blood pressure)
❒ Altered mental status (for example, somnolent or agitated despite attempts to calm)
❒ Signs of dying process (all the above, including change in breathing, apnea)

2. Re-assess plan of care:

❒ Hospice and dialysis team to discuss patient care plan weekly and as needed
❒ Patient wishes to stop dialysis and confirm agreement*
❒ Patient completed 7 completed hemodialysis treatments*
❒ Patient wishes to come off the Concurrent Program and return to routine dialysis*

* Notify nephrologist and hospice team

***This form must be faxed/emailed to both Family Hospice and if applicable the accepting DCI clinic**