May 23, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1810-P
P.O Box 8010
Baltimore, MD 21244-1850

Submitted Electronically Via **http://www.regulations.gov**

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

Dear Ms. Brooks-LaSure:

The Association for the Advancement of Blood & Biotherapies (AABB), America's Blood Centers (ABC) and the American Red Cross (ARC) appreciate the opportunity to submit comments in response to Centers for Medicare & Medicaid Services' (CMS) hospice wage index, payment rate, and hospice conditions of participation update proposed rule for fiscal year 2025. Our comments focus on the request for information (RFI) on the payment mechanism for high intensity palliative care services. Collectively, our organizations represent the nation's blood collection establishments, transfusion services, and transfusion medicine professionals.

Our organizations commend CMS for the focused attention on removing barriers and expanding access to palliative blood transfusions for Medicare beneficiaries under the hospice benefit. Palliative blood transfusions relieve debilitating symptoms that negatively impact patients' quality of life. Recognizing and explicitly acknowledging the coverage of palliative blood transfusions under the hospice benefit constitutes a crucial step forward in enhancing access to this essential therapy. However, to truly optimize access to palliative blood transfusions, revisions to Medicare's payment policy are imperative.

We are aware that comprehensive, holistic care for terminally ill patients has been shown to decrease costs at the end of life, reduce hospitalizations, and increase quality of life.[1] While hospice organizations can provide blood transfusions, very few offer this essential palliative care. The Medicare per diem payment amount is far too low to cover costly yet helpful palliative interventions, such as blood transfusions.

The intricacies of the blood transfusion process underscore its resource-intensive and complex nature. From sourcing to administration, the transfusion chain involves specialized personnel including physicians, medical technologists, nurses, and support staff who contribute essential expertise at each stage. Additionally, the process encompasses critical medical equipment and supplies, along with stringent safety measures and monitoring protocols to mitigate risks and address adverse events. Consequently, the existing per diem payment structure proves inadequate in meeting the financial

[1] https://jamanetwork.com/journals/jama/fullarticle/1930818

demands of blood transfusions. As a result, hospice providers are not incentivized to deliver these vital, yet costly palliative services for the limited number of patients for whom transfusions are palliative. Furthermore, hospice providers lack accurate data on the number of patients who would benefit from palliative transfusions, as many of these patients never even contact the hospice provider after being told by their treating physician that transfusions will be unavailable. This uncertainty further complicates the justification for the infrastructure and staffing costs required to provide blood transfusions.

As a result, Medicare beneficiaries reliant on blood transfusions may experience delays in hospice enrollment, premature exit from hospice care, or frequent transitions in and out of hospice settings. Such outcomes not only compromise the quality of care but also contribute to increased overall costs. Regrettably, the requisite decision making generates unnecessary emotional burdens for patients, their families, and attendant healthcare providers. Delayed enrollment in hospice has been shown to lead to a greater number of emergency room visits and hospital admissions in the last 30 days of life, with patients much more likely to die in the hospital or intensive care unit.[2] Notably, transfusion-dependent patients exhibit shorter hospice stays, with an average of six days for a transfusion dependent leukemia patient[3] compared to the national average stay of 89.6 days.[4] Furthermore, when patients with leukemia utilized hospice care services, performance on end-of-life quality measures improved and Medicare spending was lower ($7,662 vs $17,783) compared with those not in hospice.[5]

In light of these considerations, AABB, ABC, and ARC urge CMS to improve Medicare beneficiaries' access to end-of-life care by providing incremental, separate payments, leveraging the established blood product HCPCS code sets and associated rates for palliative blood transfusions furnished under the Medicare hospice benefit. Together with continued education about the availability of blood transfusions under the hospice benefit, carving out payments for blood transfusions from the per-diem payment will remove a substantial barrier to care and improve end of life care for patients and their families.

Thank you for the opportunity to provide comments on the proposed rule. If you have any questions, please contact Susan Leppke (301-547-3962, sleppke@aabb.org), Diane Calmus (202-654-2988, dcalmus@americasblood.org), or Julie Manes (202-417-5147, Julie.manes@redcross.org).

Sincerely,

Debra BenAvram
Chief Executive Officer
AABB

Kate Fry
Chief Executive Officer
America's Blood Centers

J. Chris Hrouda
President, Biomedical Services
American Red Cross

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[2] https://ascopubs.org/doi/10.1200/jop.2014.001537#:~:text=Patients%20with%20hematologic%20malignancies%20had,hospitals%20and%20intensive%20care%20units.
[3] https://www.sciencedirect.com/science/article/pii/S0006497120319832.
[4] https://www.nhpco.org/hospice-facts-figures/.
[5] https://www.medscape.com/viewarticle/889858#:~:text=Blood%20Transfusions%20in%20Leukemia%20a%20Deterrent%20to%20Hospice,receiving%20hospice%20care%20for%20less%20than%203%20days.