The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1846-P
P.O. Box 8016
Baltimore, MD 21244-8010

August 24, 2026

Re: CMS-1846-P: 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

Dear Administrator Oz:

The Alliance for Home Dialysis (the Alliance) appreciates the opportunity to comment on the CY 2027 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) proposed rule. The Alliance is a coalition of kidney dialysis stakeholders representing individuals with kidney failure, clinicians, providers, and manufacturers. We have come together to promote and advance policies to facilitate treatment choices in dialysis care while addressing barriers that limit access for individuals with kidney failure and their families to the many benefits of home dialysis.

Home dialysis, both peritoneal (PD) and home hemodialysis (HHD), offers important clinical and quality of life advantages, and we appreciate President Trump and CMS' commitment to increasing access to this important therapy. We recognize that individuals with kidney failure need access to the treatment option that best meets their clinical needs, whether that is PD, HHD, or in-center dialysis. We thank CMS for supporting home modalities and urge continued growth in this area.

We are committed to working with CMS to increase access to and uptake of home dialysis and are pleased to offer the following comments on this year's proposed rule. We were particularly

encouraged to see the comprehensive Request for Information (RFI) on home dialysis in this year's proposed rule and look forward to working with you to develop policies based on stakeholder answers to these important questions.

While we are pleased to submit the following comments today, we also believe that a more robust process including direct conversations with stakeholders in this space could be helpful as CMS considers potential policy changes to increase access to home dialysis. In addition, there are some specific areas of focus in the RFI, such as the questions about the Monthly Capitated Payment and the Conditions for Coverage (CfCs), that have an impact on home dialysis access and uptake but require additional discussion within our organization before providing comments. If CMS moves forward on developing new policies in these areas, we would very much like to be part of the discussion in the future.

Our comments are as follows:

Payment for Training During Dialysis Onset and Payment Adjustment

The Alliance appreciates CMS' efforts to remove a longstanding, but inadvertent, limitation to starting home dialysis for certain patients through updating how the home and self-dialysis add-on payment can be used. Currently, this add-on payment is not paid during the ESRD onset period, which usually includes the first 4 months of dialysis, but instead CMS pays only the ESRD onset adjustment. Because of this, facilities have been unable to bill the separate training add-on payment during this time period. This gap is highly consequential, as PD is very often prescribed as an initial dialytic modality after diagnosis of ESRD.

We were pleased to see the proposed update in this year's rule that would allow the home and self-dialysis training add-on payment to be paid during the onset period. We agree with CMS that training an individual to perform home dialysis successfully requires staff time and resources regardless of when the training occurs and should be recognized through the payment system.

In addition, we support CMS' proposal to increase the training add-on payment from approximately $96.50 to $138.22. We agree that this update better reflects the actual costs associated with training an individual to perform home dialysis and we appreciate that not only has CMS proposed to update the amount, but they have also proposed to update the methodology so payment in future years will continue to reflect the real costs of providing training. In addition, we request that CMS pursue this update without applying budget neutrality to ensure providers can deliver home training, home dialysis, and in-center dialysis care to vulnerable Medicare beneficiaries.

RFI on Increasing Home Dialysis Uptake

Thank you for the opportunity to provide comments on how the government can incentivize access to home dialysis, and thereby increase uptake across the country. We appreciate that the questions cover a large swath of issues from payment to education and more. The Alliance strongly believes that low uptake of home dialysis does not result from one single barrier, but is rather a continuum of issues that work together to reduce access. As CMS' RFI inherently recognizes, concurrent policy solutions will be needed to address issues relating to timely diagnosis, patient modality education, transition to dialysis care, clinical attitudes, workforce limitations, payment challenges, innovation support, delays in dialysis access placement, and more. We support policy changes across the kidney health care ecosystem that will be explained throughout our RFI response.

a. Patient-Level Barriers to Home Dialysis

Through our membership, the Alliance is able to communicate directly with individuals living with kidney failure who have had transplants or are on a dialysis modality, either in-center or at home. We recently conducted a patient survey to gather information relevant to this RFI to provide the perspectives of those directly impacted by the policies considered here. The survey received 58 responses representing a range of kidney care experiences. Of the 58 respondents, 45% had received a kidney transplant, 29% were currently on home hemodialysis, 5.17% were on peritoneal dialysis, and 29% had previously been on dialysis.[1] Most respondents were age 55 or older, and 34% had been on dialysis for more than five years.

Relevant responses:

We asked respondents about their experiences receiving education about home dialysis. Nearly 39% of respondents said they first received information about home dialysis after they had already started dialysis, and 10% reported never receiving information about home dialysis. These answers align with our long-held belief that earlier education is key for informed decision-making, and that many people with kidney failure are not currently getting adequate opportunities to learn about all dialysis modalities. This concept will be explored more in the RFI.

[1] This demographic breakdown is interesting because of the high percentage of respondents on home hemodialysis. In the US, according to USRDS, about 12.1% of patients are on PD and 2.4% are on HHD.

When asked why they chose a home dialysis modality, either HHD or PD, respondents cited maintaining good health (85%), exercising patient choice (81%), their health or medical condition (78%), training or education (76%), and their doctor's recommendation (76%) as factors encouraging home dialysis.

Respondents also shared that additional support would have been helpful when starting and continuing dialysis at home. Nearly 47% said temporary in-home assistance would have been helpful, and 49% said they worried or sometimes worried about having enough support at home. Among respondents identifying ways to increase confidence at home, 50% selected real-time phone or video support, 50% selected a temporary caregiver during the first few months, and 32.35% selected greater availability of remote monitoring/technologies.

We included open-ended questions for respondents to weigh in on what the government and dialysis care teams could have done to make home dialysis easier for themselves or their loved ones. Across both questions, respondents frequently called for more education about home dialysis options and additional support for patients receiving dialysis at home, including in-home assistance and continued support after training.

- What patient-level barriers directly prevent incident ESRD beneficiaries from selecting home dialysis?

One major patient-level barrier is simply lack of knowledge about dialysis modalities. Incident ESRD beneficiaries often do not choose to dialyze at home because they are unaware that the option exists. A significant number of patients still "crash" into dialysis through an unplanned start at the emergency room, never having seen a nephrologist in the months beforehand. As a result, many patients begin dialysis without receiving timely, comprehensive education about all available treatment options, thus limiting their ability to make informed decisions about modality choice.

People who begin dialysis through urgent pathways are often placed on in-center hemodialysis by default, even when home dialysis may ultimately align better with their preferences and lifestyle. Because of how many patients begin their dialysis journey in this way, associated lack of time to complete kidney disease education, evaluate home readiness, train patients and caregivers, and address concerns about safety and support can make optimal starts on home dialysis very difficult. Thus, the default option is often in-center dialysis even if it is not the modality that would best reflect an informed decision. Early interventions to prevent urgent dialysis starts, expanding early-stage kidney disease education, improving coordination between nephrology care and dialysis initiation, and creating pathways that allow appropriately selected

patients who start urgently to elect home modalities, like urgent start PD, may help ensure that an emergency dialysis start does not eliminate future opportunities for patient choice.

Other patient-level barriers include challenges around living situations like device and supply storage obligations, lack of access to clean water, reliable electricity, and internet access, lack of confidence or fear of the unknown, care partner/giver availability, patient functional needs or need for in-home assistance, fear of self-cannulation, issues related to digital literacy impacting telehealth and other connectivity, physical limitations and more. While progress has been made over the last ten years, there is still a need for a cultural shift to prioritize home dialysis.

Many of these barriers are addressable through earlier education, shared decision-making, robust training, remote patient monitoring, telehealth support, and payment policies that ensure patients and caregivers have the resources needed to successfully transition to and remain on home therapies. These will be discussed in more detail throughout the RFI.

- What payment or regulatory mechanisms would effectively mitigate these patient-level barriers within existing authority?

CMS can mitigate patient-level barriers to home dialysis by ensuring that Medicare payment and regulatory policies appropriately recognize the resources required to support patients throughout their home dialysis journey. This includes strengthening reimbursement for home dialysis training, which is proposed in this rule, expanding payment recognition for remote patient monitoring and connected health technologies (which we understand are paid through another payment system, not the ESRD PPS), and ensuring that telehealth flexibilities remain available for home dialysis patients.

CMS should promote patient-centered policies that expand access to home dialysis education, like kidney disease education, and shared decision-making between the patient and clinical team. Ensuring that patients receive timely and ongoing information about all treatment options, including home modalities, and that providers have the resources to support individualized modality selection can help patients choose the therapy that best aligns with their clinical needs, lifestyle, and support system.

Further, to address practical living barriers, CMS should recognize alternative treatment settings such as community dialysis houses and community-based self-care dialysis centers. Deployed successfully in other countries, this model allows patients to perform self-care treatments independently using home equipment in a shared, non-traditional community space. This

approach addresses constraints of crowded living environments, while providing patients with valuable peer support and reducing feelings of isolation associated with dialyzing at home.

- What temporary or ongoing support would effectively enable beneficiaries to initiate and sustain home dialysis?

CMS should support a comprehensive approach that begins with early kidney disease education and continues throughout the patient's home dialysis journey. Initial support should include timely modality education, adequate training for patients and caregivers, and individualized preparation that allows patients to build confidence before transitioning home. This is particularly important for patients who initiate dialysis urgently, as "crash starts" often limit opportunities for education and preparation and may unintentionally result in patients initiating in-center dialysis.

Ongoing support should include continued access to dialysis professionals, telehealth, remote patient monitoring, and connected health technologies that allow care teams to maintain visibility into patients' treatments and intervene when needed. These tools can help address patient concerns about safety and isolation by ensuring that home dialysis patients remain connected to their providers and have timely access to assistance when challenges arise. CMS should also consider policies that support staff-assisted home dialysis models, which can help expand access for patients who may benefit from home therapies, but face barriers related to physical limitations, caregiver availability, or the complexity of managing treatment independently.

- How can CMS structure payment under the ESRD PPS to support beneficiaries who lack adequate care partner support?

While family members and other caregivers can provide valuable support, not all patients have access to a reliable care partner, and the absence of one should not automatically exclude patients from considering home modalities. Payment policies should recognize that additional clinical support may be necessary to enable these beneficiaries to successfully initiate and sustain home dialysis.

One approach would be for CMS to explore additional non-budget-neutral payment mechanisms that support staff-assisted home dialysis models, in which trained dialysis professionals provide in-home assistance to patients who may otherwise face barriers due to physical limitations, caregiver availability, or other circumstances. Staff-assisted models have the potential to expand equitable access to home dialysis by providing patients with the support

they need while preserving the flexibility and quality-of-life benefits associated with treatment at home.

- What policies could mitigate caregiver burnout and improve retention of home modalities?

The Alliance strongly believes that home dialysis education and training is not a one-time event or "check the box" exercise, but rather that patients and care partners must receive continued access to education, troubleshooting, and support even after initial training is complete. CMS could also consider targeted payment for care partners, perhaps based on the GUIDE payment mode for dementia.

Another idea is allowing temporary in-center peritoneal dialysis or hemodialysis as respite options to allow patients and care partners to take a temporary break from dialyzing at home when needed. Care must be taken if this approach is pursued to ensure that it does not inadvertently result in a permanent transition away from home dialysis, but rather a temporary break.

In addition, technology, like RPM (which will be discussed in the next question), that allows for contact with the care team can help increase care partner confidence by reducing their responsibility to be the sole responder to emergencies or complications.

- What approaches could reduce patients' fear of abandonment or lack of real-time support in the home setting?

Patients are more likely to choose and remain on home dialysis when they know they are not alone and have confidence that help is available when they need it. Patients' fear of abandonment can be reduced by ensuring that home dialysis is supported by a robust, connected care model rather than viewed as care delivered in isolation. Remote patient monitoring (RPM) and other technologies allow clinicians to monitor treatment data in real time, identify potential issues early, and intervene before problems escalate. These technologies provide patients with confidence that their care team remains actively engaged in their treatment, even when they are dialyzing at home.

The Alliance supports the utilization of RPM as a critical tool for expanding access to home dialysis. In addition to enabling the transmission of treatment and device data, RPM can facilitate timely communication between patients and their care teams, reinforce adherence, and improve clinical oversight without requiring unnecessary travel to the dialysis facility. For

patients who are new to home dialysis or who have more complex clinical needs, these capabilities can significantly reduce anxiety during the transition to home therapy. We urge CMS to consider policy changes to Medicare payment structures in the Physician Fee Schedule that can financially support the adoption of RPM across the country.

Current billing guidance is unclear for when RPM can be concurrently billed. Successful deployment of RPM requires significant investment in technology by facilities and requires clinical time and oversight. It would be helpful if CMS could clarify whether and how providers can concurrently bill with other care management codes in the Physician Fee Schedule, specifically in the ESRD space.

In addition to provider-level costs, CMS should recognize the heavy out-of-pocket utility and infrastructure expenses borne by home dialysis patients. These include electricity and water bills, medical waste disposal, and leak mitigation supplies. Furthermore, payment policy should address patient-level digital health tools, high-speed internet connectivity, signal boosters, and emergency power generation to maintain connection during severe weather events.

Further, we urge CMS to include home dialysis patient experiences in the ICH-CAHPS survey, which does not currently reflect the perspectives of these patients. We appreciated CMS' statement in last year's ESRD PPS rule, reflecting a commitment to include these patients, and urge CMS to continue working toward this goal.

Finally, patients can benefit from regular telehealth check-ins, 24/7 access to the clinical team for questions, and ongoing education opportunities for patients and their care partners or family members.

- What approaches, including dialysis in a home setting, would improve ESRD beneficiaries' abilities to meet their life goals, as discussed in section IV.D. of this proposed rule?

Home dialysis is a key tool that helps patients meet their life goals.

Home dialysis provides important clinical benefits. While a healthy individual's kidneys function 24/7, in-center patients generally receive an average of 9 to 15 hours per week of renal replacement therapy. Research has shown that more frequent home hemodialysis can provide greater solute clearance, volume control, and improved nutrition, among other clinical

benefits.[2] Studies demonstrate favorable survival outcomes for patients receiving PD compared to traditional in-center hemodialysis. A 2025 review found that patients under age 65 receiving PD had a lower mortality rate than those receiving traditional in-center hemodialysis.[3] When patients feel better and have better health outcomes, they are better able to pursue the things they care about, participate in the workforce and care for family.

Specifically, home dialysis has significant lifestyle and mental health benefits, including more time for friends, family, hobbies, and leisure, and the ability to work or care for dependents.[4] Individuals with kidney failure are also often able to take fewer medications while dialyzing at home, experience improvements in neuropathy, sleep better, and feel more energetic compared to patients on traditional in-center hemodialysis.[5] Many people who dialyze at home can also resume travel or take vacations with family, bringing along their dialysis supplies.[6]

In further support of these goals, CMS should also specifically design payment policies that encourage the adoption of nocturnal home therapies — including nocturnal home hemodialysis (NHD) and automated peritoneal dialysis (APD), both of which are typically performed overnight while the patient sleeps. These modalities allow patients to maintain daytime employment, caregiving responsibilities, and family commitments with minimal disruption to normal waking hours. NHD offers clinical survival outcomes comparable to deceased donor transplantation, and APD similarly enables longer, gentler, more physiologic dialysate cycling than is practical during waking hours, supporting improved solute clearance and patient tolerance. CMS should support these overnight home modalities by establishing non-budget-neutral payment adjustments that account for the unique infrastructure, extended treatment durations, and intensified clinical oversight required for nocturnal home programs, regardless of whether the modality is hemodialysis- or peritoneal dialysis-based.

Finally, it is key to recognize that shared decision-making between a patient and their care team is essential for home dialysis to be successful. Ensuring that patients have access to the dialysis modality that best aligns with their individual needs, preferences, and circumstances should be the ultimate goal.

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[2] *See id.*
[3] Nardelli, L., Passerini, M., Zubidat, D. *et al.* (2025). Association of incident dialysis modality with patient survival: a systematic review and meta-analysis. BMC Nephrol 26, 588. https://doi.org/10.1186/s12882-025-04530-4
[4] National Kidney Foundation (2025). Home Dialysis. https://www.kidney.org/kidney-topics/home-dialysis
[5] *Ibid.*
[6] Evans, V. (2021). 10 getaway takeaways: A Q&A with home hemodialysis and travel expert Vanessa Evans. https://homedialysis.org/news-and-research/blog/453-10-getaway-takeaways-a-q&a-with-home-hemodialysis-and-travel-expert-vanessa-evans

b. Kidney Disease Education and Upstream Modality Preparation

- How can CMS improve access to and utilization of Kidney Disease Education (KDE) services prior to dialysis initiation?

The Alliance applauds CMS' interest in policies that can improve access to and utilization of KDE services. KDE uptake outside the ETC model has remained low, and we believe that clinical and beneficiary eligibility limitations contribute to this outcome- specifically limitations on both who can provide it and who can receive it. We know that kidney failure patients who receive early, comprehensive, and accurate modality education, such as the content provided through KDE, are more likely to choose a home modality.

CMS should expand access to KDE by allowing a broader range of qualified health care providers to furnish KDE services and by extending eligibility for KDE to patients with Stage 5 chronic kidney disease (CKD). CMS could base this on the changes made by the ETC Model. CMS should also support earlier access to KDE services, allowing reimbursement for KDE for CKD starting at stage 3b. CMS should also consider allowing primary care providers to bill for KDE and potentially integrate KDE into the Welcome to Medicare visit and Annual Wellness Visit. We expand on these ideas in a later comment.

Currently, Medicare beneficiaries are responsible for the 20% copay associated with KDE as a Part B benefit. For some beneficiaries, the 20% coinsurance is prohibitive to accessing these important educational services. We recommend that CMS waive the coinsurance requirement that would otherwise be applicable under section 1833(a)(1) of the Social Security Act concerning KDE services for beneficiaries.

As stated above, the Alliance is concerned that the coinsurance associated with KDE disincentivizes both providers and patients from taking advantage of this education. Providers are reluctant to bill patients for a service that was provided for free in the past, and patients may not have the resources to pay the coinsurance. However, CMS has the authority to add full coverage for preventive services in Medicare through the National Coverage Determination process if the new service meets certain criteria. We believe that KDE meets these criteria and encourage CMS to support the inclusion of KDE as a preventive service.

- Whether CMS should consider revisions to payment amounts for HCPCS codes G0420 and G0421 to better support comprehensive modality education.

The Alliance urges CMS to consider increasing the payment for HCPCS codes G0420 and G0421, which are used for individual face-to-face education services and group face-to-face education services related to CKD. We understand from our members that, by inflationary standards (note that the codes have not been meaningfully updated in about a decade), the codes are not current and should be updated. Further, we believe that the current payment level is not reflective of CMS' commitment to home dialysis. As noted throughout, studies have shown that when patients receive education, they are more likely to choose a home modality. A code update could therefore incentivize more KDE, which aligns with CMS' ultimate goal of increasing home dialysis uptake.

- Whether ESRD facilities should be permitted to furnish and bill for KDE services with appropriate safeguards.

We believe that dialysis facilities should be allowed to provide and bill for KDE for CKD stages 3b to 5 with appropriate guardrails to prevent patient steering and marketing. CKD and ESRD patients who need KDE should have access to the best clinical experts possible to deliver that education, regardless of whether that expert is employed at a dialysis facility or elsewhere. To avoid "patient steering" and "marketing" in such instances, we encourage CMS to implement balanced guardrails. For example, educational materials should not be branded with the name of a dialysis provider. The substance of the education should only be clinical information. When facilities are involved in conducting KDE sessions, those sessions should be conducted in a provider-neutral manner. CMS should consider a role in approving educational material or modules before they are deployed.

- What policies would encourage earlier nephrology referral and shared decision-making prior to ESRD onset?

As stated above, a large number of patients unfortunately "crash" into dialysis through emergency hospitalization without the opportunity to prepare for dialysis. It is imperative that CMS begin to prioritize screening patients early for CKD and initiating treatment within primary care to address that diagnosis and any common comorbidities like diabetes, hypertension, and heart disease. Treating these early can lengthen the "ramp" to kidney failure, giving patients more time before beginning dialysis or needing a transplant, with the opportunity for education and collaboration with the care team.

CMS should support policies that promote stronger coordination between primary care providers and nephrologists throughout the progression of kidney disease. Clear referral pathways, improved communication, and shared accountability between care teams can help

ensure that patients are referred to nephrology at an appropriate stage of disease progression, rather than only when kidney failure is imminent. Earlier nephrology involvement provides additional time for risk reduction, education, vascular access planning, and meaningful discussions about treatment options, including home dialysis, transplantation, and conservative care.

CMS should also expand access to kidney disease education and shared decision-making opportunities before ESRD onset. Patients should receive timely, unbiased information about all available treatment options from qualified members of the health care team, allowing them to consider their clinical needs, lifestyle preferences, and support systems. Earlier education is particularly important because patients who initiate dialysis urgently often have limited opportunity to prepare for home therapies or make informed modality choices.

- What approaches can CMS use to ensure that beneficiaries who initiate dialysis emergently receive timely modality education and an opportunity to transition to home dialysis when clinically appropriate?

Crash starts limit patient choice, leave little or no time for education or shared decision-making, and often default patients to in-center dialysis even if they and their care team would prefer home therapy. In order to address this paradigm, CMS must understand that the entire ecosystem – hospital administration, hospital providers, dialysis facilities, nephrology – must align to support a pathway to home dialysis for patients who present emergently. Without all of these pieces in place, it will be difficult to enable a cultural shift away from in-center hemodialysis and in favor of patient choice and home options. One potential solution that could be implemented to address these issues includes additional payment to hospitals or nephrologists who provide immediate KDE for patients who crash into dialysis. In addition, CMS should support both urgent start PD and transitional care units within outpatient dialysis facilities.

Timely placement of a dialysis access site is a major component of a successful home dialysis start. For emergent patients, this can be difficult due to challenges in accessing operating room time and scheduling the procedure, where clinicians must compete with elective and other emergent surgical needs. Access placement can often be delayed in favor of other surgeries, forcing patients to wait. Current hospital pathways are not designed to support emergent dialysis access placement. CMS should consider ways in which the PPS can mitigate these challenges.

In addition, crash starts are often a symptom of gaps earlier in the care pathway. Patients cannot participate in shared decision-making if they do not know they have kidney disease or

are not connected with appropriate providers. Kidney disease awareness is key alongside screening, primary care-nephrology coordination, and earlier referral to specialty care.

Finally, an urgent start should not permanently dictate a patient's dialysis pathway. Patients who start dialysis emergently should still have opportunities to transition to home therapies if appropriate. Stronger education, training pathways, telehealth, remote monitoring, and other support systems can help patients who did not have the opportunity to prepare before dialysis initiation. CMS should consider a standardized training pathway once emergent patients are clinically stable and support transitional care unit or bridge programs that facilitate a patient's transition to home dialysis.

- To what extent should CMS consider if IPPS or Outpatient Prospective Payment System (OPPS) payment adjustments could incentivize urgent start PD programs?

We believe that considering changes to the IPPS and/or OPPS could incentivize urgent start PD programs, but we also want to reiterate the other issues discussed above that must also be addressed. While payment is a big component in reducing crash starts, it does not exist in a vacuum. In addition, adjustments to the IPPS or OPPS would need to work in tandem with other parts of the payment system, including the ESRD PPS.

As an overarching concept, the Alliance urges CMS to ensure that payment policies within the IPPS and OPPS support timely access to home dialysis after an unplanned dialysis start. Hospitals must have the resources to devote to increasing access to home dialysis, including training staff at all levels (not just nephrology) on home modalities and creating new processes to include home dialysis in discharge plans. One idea that could be explored is a case-based add-on payment for ESRD transition support that would apply for patients who present emergently needing dialysis and begin either PD or HHD.

Additionally, disparities in reimbursement for vascular access codes within OPPS can limit patient access to timely placement of longer-term access options that can promote ease of home dialysis initiation. We strongly encourage CMS to ensure payment policies under the OPPS promote broader access to and uptake of vascular access placement procedures.

c. Home Dialysis Training and Workforce Capacity

- Whether CMS should revise payments outside of the ESRD PPS to promote home dialysis, such as for CPT® codes 90989 and 90993, to reflect current training intensity and costs.

The HCPCS code 90989 for dialysis training has not been updated since the mid-1990s. We urge CMS to adjust this code for inflation. We believe that an increase to this code's payment will result in greater utilization of home dialysis.

- Whether CMS should redefine a completed course of home dialysis training to reflect demonstrated independent treatment over a defined period.

The Alliance believes that completion of home dialysis training should be based on whether the clinical team believes and has documented that the patient is ready to perform the prescribed treatment at home safely and independently. We do not believe that CMS should define a period of time for that to take place, as every patient is different and should be treated as an individual by the clinical team. More specifically, we do not believe that CMS should define a minimum number of training sessions that patients must complete before being deemed ready to dialyze at home. At any time, once the patient is home, they should also be empowered to ask for assistance from the care team when needed and if problems or questions come up over time. Finally, we understand that clinical circumstances can change at any time and can sometimes be unexpected. We ask that CMS policy reflect this reality and that a change in treatment requirements should not negate payment for training already completed, even if the patient is ultimately unable to go home.

- Whether aspects of the ESRD PPS payment structure for home dialysis training (including payment tied to individual training sessions) create incentives or operational constraints that limit the use of alternative training models (such as group-based or hybrid approaches).

The Alliance understands that the current PPS structure does not include a billing pathway for group or hybrid training, which can limit the number of patients who can be trained at one time in some situations. The flexibility to offer group or hybrid training can also help reach patients who may prefer to learn in these settings. While we would not want to see CMS create incentives for group or hybrid training based only on the desire to reduce costs, we do think these are important options for patients to choose from alongside their care teams.

- What safeguards and best practices would be necessary to ensure that alternative training approaches (e.g., group training, remote modalities, or use of multidisciplinary training staff) continue to meet the individualized needs of patients and maintain patient safety?

The Alliance is supportive of alternative training approaches like group training and remote modalities. However, we believe all patients should still be able to have in-person training if that is their preference. For example, telehealth can help overcome geographic, transportation, and access barriers and allow patients to receive education earlier in the CKD continuum. We also believe that a broader set of staff should be allowed to provide KDE. At its most basic, all education should be patient-centered and tailored to what individual patients actually need to understand about dialysis options.

- What, if any, workforce development strategies would increase availability of trained home dialysis nurses, particularly in rural and underserved areas?

The Alliance recognizes the unique and critical role that qualified home dialysis nurses play in preparing and supporting patients for successful home dialysis. We also recognize that workforce shortages present a significant barrier to expanding access to home modalities and support efforts to develop workforce solutions that strengthen the home dialysis care team. Other appropriately trained members of the interdisciplinary team can and should contribute to home dialysis education, training, and patient support consistent with their qualifications, competencies, and scope of practice. As CMS considers greater flexibility in how these services are delivered, however, it is important that the respective roles and responsibilities of each member of the care team are clearly defined and that any changes preserve appropriate clinical oversight and patient safety protections. Workforce solutions should therefore complement and support—rather than inadvertently diminish—the specialized role of the qualified home dialysis nurse.

- To what extent can the patient education requirements regarding patient treatment modalities and setting (§ 494.70) be revised to ensure patients receive quality information through a process that is active, individualized, and iterative over time rather than a passive delivery of education materials?

The Alliance supports patient individuality, including training needs. Flexibility within training programs is a major aspect of patient success, so that individuals can have the training experience that is tailored to them for success. Hybrid, group, and remote components can often help patients while still allowing for appropriate clinical oversight, including by the home dialysis nurse, an expert on the care team who can help to identify evolving educational needs. Flexibility can also be helpful when patients crash into dialysis through an emergency hospital admission, but may still want to pursue home dialysis through urgent start PD. Across all training, facilities should maintain documentation of what has occurred and whether the patient has demonstrated competency with regard to the therapy.

- How frequently should this information (that is, regarding patient treatment modalities and setting) be offered to the patient? Should CMS specify format and delivery methods?

While we believe that KDE should be provided early (ideally before transition to ESKD), we have not defined a specific required frequency that we would recommend. We do believe that the 6 sessions of KDE currently offered under the benefit are adequate for the majority of patients, but could be extended if clinically appropriate for individuals who need more time to understand the information. It would also make sense for CMS to consider requiring additional education as a patient's disease progresses or their circumstances change.

In addition, retraining for home dialysis is an important component to consider here. Sometimes a patient requires additional hands-on training, but can still be successful on a home dialysis modality- they just need more training support. Current CMS policy supports retraining in some circumstances, which the Alliance also supports and urges CMS to continue.

d. Temporary and Staff-Assisted Home Dialysis

- Whether CMS should create new payment mechanisms to promote home dialysis, and what timing or clinical considerations would be relevant?

Yes, CMS should create new payment mechanisms to promote home dialysis, including a number of policies included in this proposed rule (such as the proposed changes to home training). Medicare payment policy should better recognize the resources required to initiate and sustain home dialysis, and payment mechanisms should be structured to remove barriers rather than unintentionally favor in-center dialysis.

- Whether patients returning home following inpatient hospitalization, outpatient surgery, or serious injury should be eligible for temporary staff assistance to prevent modality failure. Modality failure, commonly used in nephrology, refers to the transition from a chosen dialysis treatment (such as PD) to another form (such as HD) due to technical problems, complications, or inadequate clearance. It signifies the failure of a specific treatment method to sustain a patient's health.

Patients are vulnerable to discontinuing home dialysis therapies following hospitalization, major surgery, or serious medical events. The physical toll and cognitive strain of recovery can make independent treatment management temporarily overwhelming, leading to transitions back to

in-center clinics. Providing temporary, Medicare-covered staff-assisted home dialysis during these critical recovery windows would be essential to preserve modality continuity, prevent avoidable technique failure, and support long-term home retention. This targeted, short-term support would ensure that an acute medical setback does not permanently derail a patient's home therapy journey.

- Whether CMS should permit limited annual respite support to mitigate caregiver burnout?

The Alliance understands that care partners need support as they help home dialysis patients achieve success on therapy. However, we want to be clear that respite care should be a distinct concept from staff-assisted home dialysis. Staff assistance is intended to help patients who otherwise could not perform home dialysis for a limited period of time, rather than functioning as a caregiver break benefit. Respite care "provides a break and can help [prevent] burnout," and can look like many different options, including in-center dialysis, while staff-assisted home dialysis serves a different purpose: enabling patients who need assistance to access home therapies for a limited time.

- What eligibility criteria, staffing qualifications, and supervision requirements should be present within the CfCs for staff-assisted home dialysis to ensure patient safety and high-quality care? What clinical safeguards should be in place?

The Alliance believes that the following should be established for high-quality care within staff-assisted home dialysis: patient selection criteria, competency standards for the care team, clinical escalation protocols, and supervision, including by the home dialysis/nephrology nurse as part of the care team.

- What clinical, behavioral, or medical characteristics would make staff-assisted home dialysis inappropriate or unsafe?

The Alliance believes that these determinations are best made through shared decision-making between the clinical team and the patient. While we strongly believe in increasing access to home dialysis, we also understand that there are some patients who are not good candidates. The availability of a staff-assisted home dialysis option should enhance patient choice by allowing the opportunity for patients who may be in situations that temporarily make independent dialysis challenging to receive help as they work towards doing the therapy themselves. Staff-assisted home dialysis should never be used as a way to force a patient onto an inappropriate modality- and the best people to assess this are the clinicians and patients

involved in each individual case. In addition, CMS should ensure that staff-assisted home dialysis is distinguished definitionally from respite care, which is a different concept. While we support both of these models of care, they serve different purposes, which will be discussed more in a later question.

- What safeguards should CMS consider to mitigate risks of overutilization or inappropriate use of staff-assisted home dialysis services, while preserving appropriate access for beneficiaries?

As stated above, whether or not staff-assisted home dialysis is appropriate for an individual patient should be up to the care team in each circumstance. While a limit on usage is key to controlling the costs of the program, we suggest that the limit be based on hours of staff assist per week rather than days. Therefore, the total hours could be spread across dialysis days however the care team decides is appropriate. Additionally, frequency of staff assist should be based on physician recommendation. That would allow patients to have assistance every time they dialyze but would still provide an upper threshold on allowed hours so that the cost is controlled.

We also agree that a topline limitation on time period is appropriate to avoid overutilization. Our clinicians agree that a 90-day period is clinically appropriate, but they also would highlight opportunities to cut costs while building in safeguards to ensure regular physician assessment. For example, a 45-day initial benefit period with renewal every 15 days, requiring documentation, would place guardrails around the benefit.

e. Payment Alignment, Incentives Within the ESRD PPS and ESRD PPS Cost Report

- (1) ESRD PPS Payment Structure

    i. Whether CMS should consider additional payment for supportive services, such as remote monitoring or enhanced clinical oversight, consistent with statutory authority.

The Alliance strongly supports additional reimbursement for supportive services like RPM, which are essential to helping patients achieve success on a home modality. We believe that CMS has the authority under the Physician Fee Schedule to provide for RPM-related payments in the same month as the MCP for patients on home dialysis and when clinically necessary. Specifically, we urge CMS to consider separately evaluating CPT codes 99453, 99454, 99457, and

99458, which all reflect different parts of the RPM paradigm, and consider which of these should be separately payable.

ii. What costs for ESRD facilities are higher for home dialysis which are not currently accounted for by ESRD PPS payment mechanisms?

Sometimes, home dialysis program start-up costs can be a disincentive for facilities, which may otherwise want to either expand home dialysis services or create the opportunity for patients to dialyze at home for the first time. These potential costs include elements like geographic barriers, a limited number of patients who may be interested in home dialysis in a given location, and staffing challenges that might be insufficient to justify the substantial upfront investment required to establish the necessary infrastructure.

In addition, if facilities have to consider whether expanding or creating home dialysis programs will inadvertently reduce support for other essential in-center dialysis services due to payment limitations within the PPS, that can create really difficult decision-making requirements. Any payment changes proposed by CMS should consider the entire dialysis ecosystem- both in-center and home- so that the payment system is not accidentally pitting two already under-recognized services against each other.

- (2) Home Dialysis Training Add-on Payment Adjustment

i. Whether CMS should revise the home dialysis training add-on payment adjustment under § 413.235(c) to reflect actual hours required for training.

While the Alliance appreciates CMS' desire to improve reimbursement for home dialysis training, we do not believe that tying it to actual hours would be beneficial. Requiring tracking hours would create a new and unnecessary administrative burden at a time when we already see workforce-related challenges. Asking the nursing and dialysis facility staff to perform more administrative work could potentially come at the expense of other, more imperative tasks related to patient care.

ii. Whether payment for CPT® code 90989 should be updated to reflect current inflation and training intensity.

The HCPCS code 90989 for dialysis training has not been updated since the mid-1990s. We urge CMS to adjust this code for inflation. We believe that an increase to this code's payment,

especially if done in a non-budget-neutral manner, will result in greater utilization of home dialysis.

iii. Whether CMS should redefine a "completed course" of training to reflect a patient's ability to complete a full month of home dialysis treatments independently, with the date of service defined as the last treatment date of the first full month of independent home dialysis.

The Alliance believes that completion of home dialysis training should be based on whether the clinical team believes and has documented that the patient is ready to perform the prescribed treatment at home safely and independently. We do not believe that CMS should define a period of time for that to take place, as every patient is different and should be treated as an individual by the clinical team. More specifically, we do not believe that CMS should define a minimum number of training sessions that patients must complete before being deemed ready to dialyze at home. At any time, once the patient is home, they should also be empowered to ask for assistance from the care team when needed and if problems or questions come up over time. Finally, we understand that clinical circumstances can change at any time, and can sometimes be unexpected. We ask that CMS policy reflect this reality and that a change in treatment requirements should not negate payment for training already completed, even if the patient is ultimately unable to go home.

iv. Whether CMS should increase payment for CPT® code 90993 to better reflect the resources associated with partial or interrupted training.

CMS should continue to support flexible approaches to home dialysis training, including the use of telehealth when clinically appropriate. The Alliance has previously advocated for allowing home dialysis training codes, including CPT codes 90989 and 90993, to be reimbursed when furnished through telehealth and has appreciated CMS' work in this area. At this time, we would suggest that CMS consider an increase in payment for 90993, with the understanding that home dialysis uptake comprises an entire ecosystem, and while coding is part of it, other aspects discussed in this RFI are at play as well.

v. Whether revised training payments would influence incident home dialysis uptake within the first 60 days of treatment.

We believe that the revised training payments proposed in this rule would increase incident home dialysis uptake within the first 60 days of treatment. The Alliance appreciates CMS' efforts to remove a longstanding, but inadvertent, limitation to starting home dialysis for certain

patients through updating how the home and self-dialysis add-on payment can be used. Currently, this add-on payment is not paid during the ESRD onset period, which usually includes the first 4 months of dialysis, but instead CMS pays the ESRD PPS onset adjustment. Because of this, facilities have been unable to bill the separate training add-on during this time period, even if patients are training for home dialysis.

We were pleased to see the proposed update in this year's rule that would allow the home and self-dialysis training add-on payment to be paid during the onset period. We agree with CMS that training an individual to perform home dialysis successfully requires staff time and resources, regardless of when the training occurs, and should be recognized through the payment system.

At the same time, we are concerned that the application of budget neutrality to this policy change will diminish the intended impact of the increased payment. If the additional resources CMS is allocating to this payment are offset through a corresponding reduction elsewhere, other essential areas of dialysis care could be negatively impacted. In addition, we understand that part of CMS' goal in implementing the increase is to continue to signal support for home dialysis; we are concerned that applying budget neutrality may weaken that signal to the community. We urge CMS to reconsider application of budget neutrality in this case and ensure that the intended payment truly provides a meaningful incentive to increase the investments needed for home dialysis.

- (4) ESRD PPS QIP Measures and Conditions for Coverage Requirements

    i. Whether CMS should consider a home dialysis performance-based payment adjustment under the ESRD Quality Incentive Program (QIP) established under section 1881(h) of the Act.

While the Alliance is supportive of quality metrics that measure progress towards goals relating to increasing home dialysis uptake, we also want to be clear that we support patient choice and shared clinical decision-making. Modality decision-making should be based on clinical appropriateness and patient preference, and providers should not be penalized for recognizing complex circumstances in which certain patients may not be candidates for home dialysis.

    ii. To what extent are workforce shortages limiting incident home dialysis uptake?

Workforce shortages impact the entire dialysis care system, including home dialysis uptake. Workforce shortages result in longer wait times, reduced capacity for training and other activities, and higher burnout and turnover rates among staff, for example. All of these challenges negatively impact the ability to successfully start patients on a home modality or convert them from in-center dialysis to home.

- (6) Information-sharing and Cross Component Coordination with Accountable Care Organization and Medicare Shared Savings Program

    i. CMS recognizes that certain Medicare FFS beneficiaries with advanced chronic kidney disease (CKD) or ESRD may be aligned with Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program (Shared Savings Program) or CMS Innovation Center models, like the Kidney Care Choices (KCC) Model, that incorporate accountability for Medicare Parts A and B spending and quality. We seek comments to inform potential future rulemakings on whether care coordination structures, data sharing practices, or operational alignment between ESRD facilities and ACO participants could support clinically appropriate modality education around home dialysis and treatment planning at or prior to dialysis initiation, while preserving patient choice and avoiding duplicative or conflicting incentives across programs.

The Alliance believes that patients with CKD, including advanced stages, should be included in value-based models that include a focus on the transition to dialysis in order to facilitate optimal starts.

f. Home Dialysis Machine Installation. Home Modifications and Supply Chain Issues

- Has installation of home dialysis machines since 2011 changed significantly?

Yes, the modern-day machines available today are smaller and require less home retrofitting/renovation, especially related to specific electrical circuits. However, as stated elsewhere in the comment, some homes may still require adjustments to plumbing, the addition of wireless internet, etc.

- Does the cost of any of the post-2011 required additional small home modifications affect patients' willingness to initiate home dialysis?

Yes, as stated above, the Alliance has heard that the cost of required home modifications can negatively impact willingness to begin home dialysis. In addition to home modifications, home dialysis can also lead to recurring additional charges, like increased electric and water bills, which can be challenging for some patients.

- Do excess supply delivery and storage requirements deter patients from selecting home dialysis?

Sometimes these requirements can increase patient burden in performing home dialysis. Specifically, there are certain circumstances, such as small living spaces, that do deter patients from selecting home dialysis. However, we are also aware that many of the providers and manufacturers offer flexibility in delivery to allow for smaller and more frequent deliveries to alleviate some of this burden.

g. Incentives for In-Center Self-Dialysis Programs

- Whether CMS should consider, to the extent permitted under section 1881 of the Act and existing ESRD PPS authority, providing time-limited additional payments to ESRD facilities that establish and implement in-center self-dialysis training and support programs designed to prepare beneficiaries to independently perform dialysis and transition to home dialysis modalities.

Many patients choose in-center hemodialysis because they lack confidence in their ability to perform home treatments safely. An in-center self-dialysis training program allows patients to gradually develop essential self-care skills in a safe, supervised environment. Most importantly, it provides a supportive pathway for patients to learn supervised self-cannulation. This progressive approach addresses fear of needles that often deters patients from pursuing home hemodialysis. To support these programs, CMS should allow a flexible staffing model where a registered nurse maintains clinical oversight, but trained non-RN personnel, such as technicians or peer educators, can assist with skill reinforcement and patient coaching.

h. Payment Incentives within Physician Fee Schedule (PFS) and OPPS: Access Placement, Referral and for Physician Participation in Home Dialysis Training

- Whether CMS should test equalizing payments between PD catheter placement and vascular access placement to remove potential financial disincentives and whether demonstration authority should be used to test such alignment.

The Alliance believes that several barriers impact timely PD catheter placement, and should all be addressed by CMS. However, we also agree that equalizing payments between PD catheter placement and vascular access placement would be an essential first step to incentivizing more and quicker placement of PD catheters- and would also likely positively impact the other issues we see in this space, like lack of operating room time, the need for additional training, and exploration of alternative sites of service outside the hospital. Taken together, these barriers often result in patients who would be good candidates for PD receiving in-center hemodialysis due to factors outside their control.

In the past, we have advocated for CMMI to conduct a model testing the hypothesis that equalizing reimbursement between vascular access and PD catheter procedures would increase the rate at which PD catheter procedures are performed. We believe that CMS has the authority to simply adjust the payment levels across the board, but if the Agency would prefer to work through the model framework, we have developed an outline for consideration.

In 2021, CMS issued an RFI about future iterations of the ETC Model, and the Alliance included a request related to PD catheter placement. We stated that the difference in reimbursement is especially stark when compared to reimbursement for vascular access used for insertion of a central venous catheter. When we examined (in 2021) the most common vascular access codes (CPT 36818-36821) and the most common PD catheter insertion code equivalents (CPT 49418, 49421, and 49324), the weighted average difference in vascular access code and PD code reimbursement rates is $360.62, in favor of vascular procedures. This difference in reimbursement helps explain a motivation to perform more vascular procedures as opposed to PD catheter insertions and raises the question of whether, should the reimbursement be equalized, more PD catheter insertions would be performed.

If CMS wants to pursue a model in this space, they could create a voluntary option where participants receive a payment increase per PD placement (of at least an additional $360.62 per PD catheter procedure) to equalize the reimbursement between PD catheter insertion and vascular placement within the model. This would allow for comparison of rates of PD catheter placement within and outside the model, to evaluate whether the payment increase within the model increased the rate of PD catheter placement. Under the ETC Model, the managing clinician, who was typically a nephrologist, was required to coordinate home dialysis access creation when patients began therapy, including PD catheter insertion.

In general, nephrologists work with access specialists to do this, and do not perform the placements themselves. While the managing clinician could establish and maintain these relationships with surgeons and other specialists like radiologists, the ETC Model did not provide

direct incentive for these specialists to participate with the managing clinician. Consequently, the ETC Model did not specifically address the providers involved in the placement of PD catheters and their role in encouraging the uptake of home dialysis.

A new model could incentivize access specialists to partner with nephrologists for the purposes of placing PD catheters, thereby addressing a key barrier to home dialysis access for patients. To implement, CMS would make it known that if surgeons or other access specialists partner with nephrologists, they will be eligible for a payment bump of at least $360.62 for each PD catheter placed as part of the model. The access specialist would be able to bill as usual for each PD catheter placement, but include a modifier established by CMS to identify placements done in conjunction with the nephrologist in the model in order to receive the extra payment. Using this modifier, CMS would be able to determine whether the incentive payment increased the relative number of PD catheters placed within the model as compared to claims data showing the service mix for vascular access and PD codes outside the model.

Regardless of whether CMS simply changes the reimbursement or includes this in a model, we would not expect this to require additional net spending because we would expect to see PD catheter insertions replace vascular procedures that would otherwise be performed. Overall, around 53,000 vascular access code units appear in 2019 physician summary data, whereas PD code units appear slightly more than 22,000 times. Perhaps more importantly, we would not expect to see transfers in site of service. It is our understanding that most PD codes billed in the inpatient setting are due to patients "crashing" into dialysis and beginning urgent start PD. These patients are very sick, presenting to the emergency department needing immediate dialysis, and are admitted inpatient due to their status, not the intricacy or simplicity of the PD access procedure itself. Conversely, the outpatient patient population tends to be prepared for dialysis onset, so we do not anticipate a shift from outpatient vascular access or PD catheter placement procedures to inpatient procedures.

- Whether CMS should establish an additional payment recognizing the time physicians spend referring patients to home dialysis and coordinating training.

Yes, CMS should establish an additional payment mechanism to recognize the substantial time and clinical expertise physicians contribute to identifying appropriate candidates for home dialysis, counseling patients on treatment options, coordinating training, and supporting successful transitions to home modalities. Expanding access to home dialysis requires more than patient interest alone; it requires meaningful engagement from nephrologists and the broader care team to educate patients, assess readiness, coordinate resources, and ensure patients have the support necessary to succeed. A targeted payment adjustment for physician

time spent supporting home dialysis decisions would align incentives with CMS' goal of expanding patient choice and improving access to home modalities.

- Whether payment should be provided to physicians who actively participate in home dialysis training and care planning.

The Alliance believes that additional payment should be provided to physicians who actively participate in home dialysis training and care planning, specifically immediately prior to or at the time of dialysis initiation. Because this could be provided in the inpatient or outpatient setting, it could also help patients who have experienced an emergent, or crash, dialysis start to access home therapy. At the same time, we understand that there is already a home dialysis training payment for physicians within the MCP once a patient has established care with a dialysis facility. Because we want to avoid duplicative payment, we believe that any additional payment should be targeted as described above: to physicians caring for patients immediately before or at the time of the dialysis start. In addition, any new payment for these physicians should not be financed through a budget neutral mechanism, which would potentially result in a reduction in funding to other necessary parts of the care paradigm. Ideally, this could be accomplished through the creation of a new G-code.

In addition, we want to point out that this goal could also be accomplished through adjusting upward the current home dialysis training codes, 90989 and 90993, which we talk about in the question specific to these codes. Increasing reimbursement for these codes would help to reflect the home dialysis and care planning performed by physicians.

- Whether CMS should provide payment recognition for physicians supporting in-center self-dialysis programs that may serve as a transition pathway to home dialysis.

The Alliance is supportive of opportunities for patients to access self-care hemodialysis, which can be a pathway to eventual independent home dialysis. However, we do not believe that additional support is needed specific to the physician role, as these activities are provided for within the dialysis MCP. Instead, we would suggest that CMS consider ways for dialysis facilities to support successful transition from in-center self-care dialysis to home dialysis.

i. Monthly Capitation Payment (MCP) Structure for Home Dialysis Patients

The Alliance recognizes that the Monthly Capitated Payment (MCP) is an important component of Medicare's approach to supporting and expanding home dialysis. Given the complexity of the

policy considerations surrounding the MCP and its potential role in further advancing home dialysis uptake, however, we would welcome the opportunity to continue evaluating these issues and to discuss potential policy recommendations with CMS and other stakeholders at a later date.

- Acknowledging that section 1881(b)(3)(B)(ii)(I) of the Act requires that patients receiving home dialysis have face-to-face (without the use of telehealth) clinical assessments with the physician at least monthly during the initial 3 months, how would greater telehealth flexibility for home dialysis patients improve retention and quality of care, including infection rates, within the first 60 days?

The Alliance has a strong track record of advocating for additional access to telehealth for home dialysis patients, and we were instrumental in helping to implement the original change allowing for the MCP visit to be performed for home dialysis patients located in the home via telehealth. However, we also must balance the need for flexibility and other benefits of telehealth against patient safety and outcomes concerns. Therefore, we continue to believe that a face-to-face in-person visit within the first 3 months of therapy should be required, after which visits can take place via telehealth.

j. Skilled Nursing Facilities and Transitional Settings

- What policies would encourage continued use of PD in SNFs when clinically appropriate?

See the next question.

- Whether CMS should consider payment adjustments or demonstrations to incentivize SNFs to support home dialysis modalities.

Where a patient lives, whether it is a traditional home or a SNF, should not dictate whether they are able to access their chosen dialysis modality. Patients residing in SNFs often face barriers in receiving dialysis at the SNF due to staffing limitations, lack of trained personnel, and pay concerns. And yet, dialysis delivered on-site at the SNF can be an excellent option for certain patients residing in a SNF, allowing them to do a modality that helps them feel better physically and mentally and avoiding costly and time-consuming transportation to a dialysis facility multiple times per week. CMS should consider additional payment to support staff training and care coordination between SNF, dialysis facility, and clinical team, and equipment and supply management.

CMS must also address critical regulatory barriers, such as state-level pharmacy classifications that treat peritoneal dialysis solutions as drugs requiring on-site pharmacist oversight, which prevents direct hospital-SNF transitions. Furthermore, CMS should incentivize the use of advanced technologies-including premixed dialysate systems for home hemodialysis and premixed PD solutions- which reduce or eliminate the need for costly water purification systems and room modifications in the SNF setting.

Request for Information To Advance Palliative Care for Dialysis Patients

The Alliance supports palliative dialysis for patients who decide alongside their care teams that such care will alleviate symptoms and support comfort at the end of life, including patients who want to perform palliative dialysis at home. These conversations should be held as part of shared decision-making and discussion of patient life goals.

Definitionally, we believe that palliative dialysis is dialysis provided primarily to alleviate symptoms and support comfort without seeking to treat or modify the underlying disease. Under this definition, we believe that CMS should establish broad eligibility for palliative dialysis, including for patients who have been referred for dialysis while enrolled in hospice and have a prognosis of less than six months. For patients with ESRD who elect hospice, payment for palliative dialysis should be made directly to dialysis providers, consistent with how CMS pays for dialysis for hospice patients with other conditions. Direct payment would promote patient access, facilitate coordination between hospice and dialysis providers, and support efficient operations for both providers.

Importantly, patients who wish to continue dialysis at the end of life may currently forgo hospice altogether to maintain access to dialysis, meaning they will receive dialysis one way or another, but lose the benefits of hospice care. Patients who do not elect hospice may also experience more frequent hospitalizations and higher overall costs to the health care system. CMS policies should support patient-centered end-of-life care by prioritizing comfort, symptom management, quality of life, and individual goals rather than creating financial or administrative barriers that force patients to choose between hospice and dialysis.

Sincerely,

Michelle Seger
Managing Director

Alliance for Home Dialysis Members

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American Nephrology Nurses Association*
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