

August 24, 2026

Re: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model

Dear Administrator Oz,

The National Kidney Foundation is pleased to submit comments on the Calendar Year (CY) 2027 ESRD Prospective Payment System. This letter includes comments that are in-scope and out of scope. Our purpose is to both respond to the immediate provisions of the proposed rule for CY2027 while noting areas where the PPS could be modernized, understanding that many of the reforms to the PPS that are needed require new Congressional authority.

Summary Comments:

- NKF supports the proposed \$299.55 base rate and believes it is generally adequate for most facilities, while urging continued monitoring of facilities serving high-need, rural, pediatric, and home dialysis populations.
- NKF supports updating the ESRD bundled market basket and increasing the labor-related share to 63.5 percent.
- NKF supports the outlier policy but is concerned that increasing the adult fixed-dollar loss amount from \$14.80 to \$114.98 could weaken protections for patients with complex needs.
- NKF supports continuing the post-TDAPA add-on but urges CMS to ensure that payment is sufficient for smaller and independent facilities.
- NKF supports incorporating phosphate binders into the ESRD PPS using the proposed \$15.96 base-rate increase and 6 percent operational adjustment. CMS should ensure access and medication choice are preserved and revise the adjustment if it does not cover real-world dispensing, shipping, counseling, and adherence-support costs.
- NKF supports expanding the LVPA to six tiers and providing higher adjustments to the lowest-volume facilities.
- NKF urges CMS to establish permanent pediatric payment protections, including making the TPEAPA permanent. The LVPA is not an adequate substitute because treatment volume does not reliably reflect the unique costs of pediatric dialysis.
- NKF strongly supports increasing the home and self-dialysis training add-on from \$95.60 to \$138.22 and allowing training during the onset period. CMS should consider finalizing these changes without applying budget neutrality.
- Within the ESRD QIP, NKF supports replacing the Hypercalcemia reporting measure with a hyperphosphatemia clinical measure, provided CMS carefully evaluates its threshold, risk adjustment, and effects on access, equity, and patient experience.
- NKF supports including the Discussion of Patient Life Goals measure in the QIP as a meaningful, iterative assessment, complemented by patient-reported measures of symptoms, function, treatment recovery time, and quality of life.

- To address barriers to home dialysis, CMS should require a standardized suitability and barrier assessment, a barrier-remediation plan, a time-bound transition plan, and periodic reassessment. Payment should support care-partner training, early monitoring, remote support, supply logistics, and temporary or ongoing assistance based on patient need.
- CMS should establish payment for time-limited staff-assisted home dialysis during initiation and following hospitalization, caregiver disruption, or functional decline; respite assistance for caregiver strain; and longer-term assistance for patients with ongoing impairments. Facilities should remain accountable for eligibility, safety, services, and reassessment.
- CMS should define palliative dialysis according to the patient's documented goals, comfort, quality of life, symptom relief, and acceptable treatment burden—not by modality, hospice eligibility, or a required prognosis. Policy should support staff-assisted care, clear provider responsibilities, voluntary shared decision-making, periodic reassessment, and a written goal-concordant care plan.
- CMS should consider a daily or hybrid payment framework that better supports clinically appropriate short-daily, nocturnal, and four-to-six-times-weekly home hemodialysis. Any change must preserve individualized prescriptions, avoid incentives for undertreatment, and include clinical and patient-reported quality oversight.

Overview of the ESRD Program: Challenges and Opportunities

The ESRD bundle and the ESRD Quality Incentive Program (QIP) are now over ten years old. The ESRD Conditions for Coverage have only been updated once since 1976. It has been more than fifteen years since the last update. Meanwhile, traditional Medicare covers a decreasing proportion of ESRD beneficiaries each year. A new vision for ESRD payment and quality is needed to keep pace with changes to coverage, advances in technology, and new opportunities to advance care delivery.

NKF is sensitive to the context in which the ESRD bundle operates. The dynamic in which the federal government is overbilled for products and services has not changed since dialysis companies settled lawsuits related to billing for more Epoetin, a drug that stimulates the production of red blood cells used to treat anemia, than was administered in 2012 and 2013. As HHS Secretary Robert F. Kennedy has noted, fraud, waste, and abuse drive up program expenditures while leaving fewer resources for patients who rely on the Medicare program. Any future oriented vision for the ESRD program must acknowledge CMS' interest in and an obligation to steward the Medicare Trust Funds and ensure resources are used in an evidence-backed manner. Additionally, any future iteration of the ESRD program must place greater emphasis on the needs and goals of patients. There is a duty for CMS to enable the highest quality of care while controlling costs.

The ESRD bundle has been both a successful and unsuccessful program. From the perspective of the overall stability of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds, inflation adjusted fee-for-service ESRD expenditures have consistently accounted for

between 5 and 7.5 percent of total Medicare spending over the past decade.¹ Inflation adjusted per-person per-year spending on dialysis across Medicare only, dual eligible, and Medicare Advantage (MA) beneficiaries has either been consistent or has fallen since 2013.² CMS has achieved this while operationalizing add-on payment adjustments for services inadequately accounted for by Composite Rate Services, including the Transitional Drug Add-on Payment Adjustment (TDAPA), the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES), a transitional pediatric ESRD add-on payment adjustment (TPEAPA), a post-TDAPA add-on payment adjustment to support adoption of new injectable, intravenous, or oral drugs and biologics at the conclusion of the TDAPA period, and an add-on payment for home and self-care dialysis.

In some dimensions, ESRD care for patients has improved. While the bundled payment system is not directly attributable to the improvements we describe here, it is notable that ESRD care has overall improved on some indicators while CMS has held per-patient costs steady in the fee-for-service program. All-cause mortality in all adult ESRD patients, ESRD patients using HD, and ESRD patients using PD decreased between 2013 and 2019. Further, mortality is trending back down to levels not seen since before the COVID-19 Pandemic.³ Meanwhile, access to home dialysis has increased after falling precipitously from a peak of approximately 40 percent of ESRD patients using home modalities in the mid-1970s.^{4,5} Since 2013, the percentage of new dialysis patients using home modalities has increased more than 60%, from 9.4% to 15%. Home dialysis among prevalent patients has also grown since 2013, although more slowly. Critically, access to home modalities has grown while the complications associated with home dialysis have fallen. The US Renal Data System (USRDS) finds that hospitalizations for peritonitis and vascular access infections have steadily declined since 2013.⁶

Kidney transplantation has also increased.⁷ Multiple interventions targeted at increasing kidney transplant waitlisting have been implemented over the years with limited results, although the number of candidates added to the waitlist in 2023 was the highest number in a decade.⁸ CMS has tested three demonstrations of kidney care delivery innovations, two of which made or are making demonstrable improvements in ESRD care. The End-Stage Renal Disease Seamless Care Organization (ESCO) Model demonstrated that a coordinated care design around dialysis could reduce Medicare spending, hospital utilization and readmission, and improve dialysis adherence and some dialysis quality measures.⁹ The Kidney Care Choices (KCC) Model is showing early promise at improving optimal starts and increasing access to home modalities, among other

¹ <https://usrds-adr.niddk.nih.gov/2025/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd>

² Ibid.

³ <https://usrds-adr.niddk.nih.gov/2025/end-stage-renal-disease/6-mortality>

⁴ United States Renal Data System. 2024 *USRDS Annual Data Report: Epidemiology of kidney disease in the United States*. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2024.

⁵ Blagg CK. A Brief History of Home Hemodialysis. *Advances in Renal Replacement Therapy*. 1996;3(2):99-105. doi:[10.1016/S1073-4449\(96\)80048-3](https://doi.org/10.1016/S1073-4449(96)80048-3)

⁶ United States Renal Data System. 2025 *USRDS Annual Data Report: Epidemiology of kidney disease in the United States*. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2025.

⁷ <https://srtr.hrsa.gov/adr/2024/Kidney/>

⁸ Ibid.

⁹ <https://www.cms.gov/priorities/innovation/data-and-reports/2022/cec-annrpt-py5-fg>

important indicators of high quality care for individuals with late stage Chronic Kidney Disease (CKD) such as preemptive waitlisting.¹⁰

Challenges related to the bundle persist. From a dialysis market perspective, the ESRD bundle is a driver of mergers and acquisitions that have led to significant market consolidation.¹¹ The two largest dialysis organizations own more than 70 percent of the market with resulting impacts on dialysis prices, particularly for commercial insurers, efficiency, and patient access.¹² The bundle has not kept pace with inflation. Highly efficient LDO facilities can withstand these pressures on their margins, but low-volume facilities, many of which operate in rural areas, cannot. MedPAC's finding that the lowest treatment-volume facilities have a -19.0% Medicare margin exemplifies this point.¹³

While home dialysis has grown, it has not achieved the target set by the Advancing American Kidney Health initiative of 80% of the ESRD population using a home dialysis or being transplanted nor approached a more modest goal of 25 percent home dialysis utilization to align with other comparable nations like Canada, Australia and New Zealand, and some Scandinavian countries.¹⁴
^{15 16} Most of the growth in home dialysis is from peritoneal dialysis (PD) while home hemodialysis (HHD) has not grown as quickly. The reasons for this are anecdotal and likely multifactorial, including HHD programs being more difficult to implement and scale, patient fear of self-cannulation, and vertical integration among dialysis companies and dialysis machine manufacturers that may limit patient choice. NKF is very encouraged by the inclusion of a home dialysis training add-on payment increase and detailed home dialysis request for information in the CY27 proposed payment system rule.

Among US dialysis patients, differences in home dialysis access persist. More White and Asian patients are accessing peritoneal dialysis (PD) whereas in-center dialysis continues to be more common among Hispanic and Black patients.¹⁷ The reasons for unequal access have been well characterized and involve patient-level factors like delayed referral to nephrology care, dialysis-facility factors like provider bias, and system-level factors like the lack of staff support once a patient has transitioned to home.¹⁸

¹⁰ <https://www.cms.gov/priorities/innovation/data-and-reports/2025/kcc-2nd-annual-report-preview>

¹¹ https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch5_MedPAC_Report_To_Congress_SEC.pdf

¹² Erickson KF, Eck C. Considering the Effects of a Recent US Supreme Court's Ruling on Dialysis Care Costs. *Clinical Therapeutics*. 2023;45(3):272-276. doi:10.1016/j.clinthera.2023.01.015

¹³ <https://www.medpac.gov/document/july-2025-data-book-health-care-spending-and-the-medicare-program/>

¹⁴ Damasiewicz MJ, Polkinghorne KR. Global Dialysis Perspective: Australia. *Kidney360*. 2020;1(1):48-51. doi:10.34067/KID.0000112019

¹⁵ Borkum M, Bevilacqua M, Romann A, et al. A Province-Wide Home Dialysis Program Review: Challenges, Strengths, and Future Strategies. *Can J Kidney Health Dis*. 2025;12:20543581251324560. doi:10.1177/20543581251324560

¹⁶ Lundström UH, Meeus G, Aronsen T, et al. Increasing the adoption of home dialysis through improved advanced kidney care patient education: a call for action. *Clinical Kidney Journal*. 2025;18(4):sfaf087. doi:10.1093/ckj/sfaf087

¹⁷ United States Renal Data System. 2024 *USRDS Annual Data Report: Epidemiology of kidney disease in the United States*. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2024.

¹⁸ Rivara MB, Mehrotra R. The changing landscape of home dialysis in the United States: *Current Opinion in Nephrology and Hypertension*. 2014;23(6):586-591. doi:10.1097/MNH.0000000000000066

As we note further on in this letter, we believe it is time to consider significant refinements to the policies for incorporating new drugs and technologies into the PPS. As CMS is aware, studies demonstrate that bundling drugs into the PPS causes utilization to decrease.¹⁹ While we appreciate the intent of the TDAPA and TPNIES policies and believe there are dimensions on which these policies have succeeded, we continue to be concerned by reports that patients face extra burden in accessing the products that they need. Only one hemodialysis machine has secured approval for payment under the Transitional Add-On Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) in six years although four dialysis machines have been cleared through FDA's 510(k) pathway during that same period (Quanta Dialysis System, VersiHD with GuideMe Software and two clearances for the Fresenius 5008X CAREsystem). We are also uncertain about the extent to which the TDAPA and TPNIES policies can accommodate technologies like wearables, remote-patient monitoring, the wearable or implantable kidney, and technologies and devices to support cannulation. Additionally, the current post-TDAPA policy of applying the payment across all patients and reimbursing at 65% is not feasible for most medium, small, and individual providers. We believe the time is right to revisit these policy frameworks.

Additionally, adequate registered dietitian (RD) staffing is essential to ensuring that dialysis patients receive individualized medical nutrition therapy, medication counseling, and ongoing support. The ESRD Conditions for Coverage require facilities to employ a qualified dietitian, assess each patient's nutritional status, and provide the nutrition care and counseling necessary to achieve and sustain an effective nutritional status. However, the requirements do not establish a federal patient-to-dietitian caseload standard. The 2000 KDOQI Clinical Practice Guidelines for Nutrition in Chronic Renal Failure observed that, based on the experience of renal dietitians, one dietitian should generally be responsible for approximately 100 maintenance dialysis patients and almost certainly no more than 150. KDOQI further noted that caseloads should be lower when dietitians assume broader responsibilities, such as quality improvement and protocol development.

Adequate RD capacity will become increasingly important as facilities implement the incorporation of phosphate binders into the ESRD PPS bundle, the proposed hyperphosphatemia measure, and policies intended to expand home dialysis. These changes will require sufficient time for nutrition assessment, patient education, medication and dietary counseling, adherence support, and coordination with the broader interdisciplinary care team. NKF therefore urges CMS to revise the ESRD Conditions for Coverage to require at least one full-time-equivalent RD for every 100 in-center dialysis patients. CMS should also evaluate whether tailored or lower caseloads are appropriate for home-dialysis programs, rural and low-volume facilities, and facilities serving patients with more complex nutritional needs. CMS should continue collecting data and supporting research to refine these standards while ensuring that ESRD PPS payments adequately support the staffing necessary to meet patients' needs.

¹⁹ Karaboyas A, Zhao J, Ma J, et al. Incorporation of Calcimimetics into End-Stage Kidney Disease Bundle: Changes in Etelcalcetide Utilization and Parathyroid Hormone Control following End of Transitional Drug Add-On Payment Adjustment Designation. *CJASN*. 2025;20(2):218-228. doi:[10.2215/CJN.0000000583](https://doi.org/10.2215/CJN.0000000583)

Finally, we note with concern the rapid transition of ESRD beneficiaries into Medicare Advantage (MA), which is now the largest aggregate payor for ESRD services. This shift has significant implications for CMS' ability to assess payment adequacy, patient access, and quality of care across the dialysis system. While the ESRD PPS and ESRD QIP provide a relatively transparent framework for traditional Medicare, far less information is publicly available about MA contracting practices, payment levels, home dialysis uptake and supports, transplant referral and waitlisting rates, patient complaints, supplemental benefits, and access barriers experienced by ESRD beneficiaries enrolled in MA plans.

As detailed in Appendix I, some ESRD QIP measures can capture data on beneficiaries enrolled in MA. However, several important measures do not capture MA enrollees, specifically measures that rely on Medicare claims data. This limited visibility strips CMS, patients, providers, and advocates of the ability to understand whether MA enrollment, and specific MA plans, are improving or impeding access to high-quality dialysis care. In particular, CMS should examine whether MA plans are supporting access to home dialysis, transplant evaluation, transportation, nutrition services, care coordination, and other services that are essential for people living with kidney failure. Additionally, small dialysis facilities may have a higher than average percentage of patients that utilize Medicare Advantage. This means many of their QIP measures may only include a small number of patients. In this case, one or two outliers can move facility level measures out of compliance on QIP measures.

NKF urges CMS to develop a more robust data and oversight strategy for ESRD beneficiaries enrolled in MA. This strategy should include collecting and publicly reporting MA-specific data on dialysis modality, home dialysis uptake, transplant referral and waitlisting, access to supplemental benefits, patient complaints and appeals, network adequacy, prior authorization, and quality outcomes. As MA becomes increasingly central to ESRD care, CMS must ensure that payment and quality oversight keep pace with the shift to MA enrollment. All ESRD beneficiaries must be guaranteed access to high-quality, patient-centered care regardless of traditional Medicare or MA enrollment status.

B. Proposed Provisions of the CY 2027 ESRD PPS

1. Proposed CY 2027 ESRD Bundled (ESRDB) Market Basket Percentage Increase; Labor-Related Share; and Productivity Adjustment

NKF thanks CMS for updating the ESRDB market basket to current data. This update will better address costs for home dialysis infrastructure, medication dispensing, and non-clinical patient support. The 2024 cost data are likely to better reflect post-pandemic labor markets and inflation. Overall, we urge CMS to validate whether the Medicare cost report fully captures current resource needs, especially workforce, home dialysis, medication management, and pediatric care.

The ESRDB market basket update has allowed the labor related share to increase to 63.5%, a level that NKF believes will allow facilities to better hire and retain staff. Staff limitations continue to have implications for the patient experience, particularly the ability of patients who express an interest in home dialysis to be able to train for it and move home in a timely fashion. The proposal to raise the labor-related portion of the base rate to 63.5% would support dialysis facility staffing needs, particularly in rural and underserved areas. CMS should produce future analyses on the impact of the increased labor related share on both access to dialysis in these areas and reduction of staff limitations that result in existing dissatisfaction of patient experience.

As CMS is aware, staffing costs are one of the highest operational costs associated with delivering dialysis. Dialysis facility staffing is enormously important to how patients experience dialysis. A facility with well-trained, confident, compassionate staff can be the difference between a patient feeling safe or not safe, heard or not heard, able to raise concerns or remain quiet for fear of retaliation, successfully transition to home dialysis, and/or secure a place on the kidney transplant waitlist with the goal of remaining active on the list, being successful with treatment, and receiving a kidney transplant.

NKF supports the proposed productivity adjustment but cautions that productivity reductions may not reflect dialysis facility realities amid staffing shortages and other constraints.

2. Proposed CY 2027 ESRD PPS Wage Indices

NKF does not have specific comments on the proposed CY 2027 ESRD PPS wage indices or the National ESRD Facility Occupational Mix (NEFOM). We wish to offer our continued thanks to CMS for its attention to creating and maintaining an ESRD-specific wage index, which was finalized in the CY 2025 ESRD PPS final rule and better reflects dialysis facility staffing costs than the prior hospital-based wage data methodology. We also appreciate CMS's transparency in publishing the NEFOM and its continued efforts to account for geographic variation in wages under Section 1881(b)(14)(D)(iv)(II) of the Act.

Given ongoing dialysis workforce challenges and the proposed increase in the labor-related share to 63.5 percent, NKF encourages CMS to continue monitoring whether the wage index and NEFOM accurately reflect real-world dialysis staffing needs and system-wide fluctuations in labor costs.

3. Proposed CY 2027 Update to the Outlier Policy

NKF reiterates our longstanding support for the ESRD PPS outlier policy as an important protection for patients whose care requires laboratory tests, supplies, and other medically necessary services.

We appreciate CMS' continued efforts to refine the methodology to better target outlier payments but remain concerned that the proposed increase in the adult fixed-dollar loss amount from \$14.80 in CY 2026 to \$114.98 in CY 2027 could weaken high-cost protection for patients with more complex clinical needs. As phosphate binders are incorporated into the ESRD PPS bundle and become

eligible ESRD outlier services beginning in CY 2027, NKF urges CMS to monitor whether the outlier policy appropriately supports access to these therapies without crowding out other high-cost ESRD outlier drugs, biological products, supplies, or services. Functionally, the outlier policy cannot serve as a substitute to adequate drug reimbursement policy. NKF also encourages CMS to conduct and share an access analysis for high-need patients, including whether higher outlier thresholds affect facility drug and supply utilization patterns or inadvertently discourage facilities from furnishing medically necessary care.

4. Proposed Impacts to the CY 2027 ESRD PPS Base Rate

NKF supports the proposed CY 2027 ESRD PPS base rate of \$299.55 and appreciates CMS's continued work to update the base rate using the best available data, including the proposed incorporation of phosphate binders into the ESRD PPS bundle.²⁰ NKF continues to believe that, for most facilities, the ESRD PPS base rate is generally adequate to support access to dialysis care; however, payment adequacy should continue to be monitored closely, particularly for facilities serving high-need patients, rural communities, pediatric patients, and patients receiving home dialysis.

At the same time, NKF urges CMS to consider beneficiary cost-sharing implications of increasing the base rate, especially for patients without supplemental coverage who may face higher out-of-pocket costs. When beneficiaries are asked to pay more, those additional costs should be tied to clear improvements in access and quality of dialysis services. As the ESRD PPS bundle continues to absorb new drugs, biological products, equipment, supplies, and other services, CMS should evaluate whether current payment mechanisms are sufficiently providing innovative products and services in a way that is sustainable for patients.

NKF encourages CMS, and Congress where statutory authority may be needed, to consider whether the ESRD PPS should evolve toward a more precise framework that better directs payment to support patient access, facility viability, home dialysis, high-cost patients, and timely access to innovation. While NKF supports the base-rate increase, we continue to believe that CMS should evaluate whether current policies for incorporating new drugs, biological products, equipment, and supplies into the ESRD PPS adequately support timely patient access to innovation.

6. Post-TDAPA Add-On Payment Adjustment Updates

NKF understands the policy and methodology applied to the post-TDAPA add-on payment adjustment, but we would like to reiterate our comments on the CY 2026 ESRD PPS that explain how the current post-TDAPA policy does not meet the needs of non-LDO dialysis organizations. NKF supports continuation of the post-TDAPA add-on payment adjustment but urges CMS to ensure that payment rates are sufficient to prevent access disruptions when the TDAPA period ends, particularly for smaller and independent dialysis facilities that may have less ability to absorb

²⁰ See page 9 for detailed analysis of the inclusion of phosphate binders in the bundle rate

uncompensated costs. An example relating to difelikefalin (Korsuva-brand name), a medication to treat itching during dialysis, from an NKF volunteer who runs an independent dialysis facility in Mississippi follows:

*“My cost is \$1800/case (12 vials/65 mcg/vial) = \$150/vial. 1 vial = 1 dose for anyone who weighs less than 120 kg (we have a few that weigh more). The usual dose around 45 mcg. The post-TDAPA payment for Korsuva would be .263 cents per .1 mcg or or \$118.49 for 45 mcg. We are not reimbursed for the 20 mcg we did not use (single-use vial). That is a **loss** of \$31.51 per dose, or \$409.63 per month, or \$4,915.56 per year per patient. We also lose the cost of syringes/disposables and nursing time dedicated to administration.”*

NKF also supports CMS’ proposal to update post-TDAPA add-on payment adjustment amounts quarterly as an important patient-access safeguard and encourages CMS to publish these updates in a transparent, predictable, and timely manner so facilities can make informed decisions about furnishing medically necessary therapies

7. Proposal to Incorporate Phosphate Binders into the ESRD PPS Base Rate

NKF supports the proposal to incorporate phosphate binders into the ESRD PPS base rate and continuing to cover phosphate lowering therapies under part B. However, CMS must ensure that this incorporation does not restrict patient access or choice among clinically appropriate binders. We are supportive of the use of updated ASP in the expenditure calculation and the *likely* adequate increase of \$15.96 to the base rate, but NKF urges CMS to employ safeguards to preserve clinically appropriate medication selection.

Further, NKF supports the 6% operation cost adjustment to the calculation for incorporating phosphate binders. We ask that CMS ensure the per-treatment amount adequately covers real-world dispensing, coordination, shipping, storage, counseling, adherence support, and exceptions. If the proposed adjustment is found to be inadequate, CMS should revise in future rule making to ensure patient access is fully maintained.

8. Proposed Changes to the Low-Volume Payment Adjustment (LVPA)

NKF supports CMS’ proposal to expand the Low-Volume Payment Adjustment (LVPA) and appreciates CMS’ continued attention to the financial pressures facing small dialysis facilities. Maintaining access to dialysis care depends on keeping small facilities viable, particularly in rural and underserved areas where patients may have few or no reasonable alternative treatment options.

Expanding the LVPA to six volume-based tiers could improve support for both small and medium-sized facilities and reduce the cliff effect that may occur when facilities approach the current treatment threshold. At the same time, because CMS proposes implementing this change budget-neutrally across the ESRD PPS, NKF urges CMS to monitor whether the resulting budget-neutrality

offset undermines broader payment adequacy or access to care at facilities that do not qualify for the LVPA.

NKF supports finalizing the LVPA expansion and higher adjustment factors for the lowest-volume facilities, while encouraging CMS to continue evaluating whether additional refinements are needed to protect access in rural, isolated, and otherwise underserved communities.

9. Proposed Payment for Pediatric Patients with ESRD Receiving Renal Dialysis Services

NKF urges CMS to establish permanent pediatric payment protections that should include making the Transitional Pediatric ESRD Add-on Payment Adjustment (TPEAPA) permanent. Recognizing that pediatric dialysis programs serve a very small and clinically complex population with specialized staffing, equipment, and care needs, there is a clear need for a consistent and reliable increase in payment.

CMS's proposal to extend LVPA to pediatric populations is not a viable solution to address the TPEAPA expiration. NKF has concerns about using low volume as a proxy for pediatric dialysis costs. Specifically, there are pediatric dialysis centers that will not qualify for the lowest volume tier (<3,000 treatments) and thus would fall below the 30–33 percent higher cost threshold. Pediatric dialysis is different from adult dialysis, specifically in the cost savings realized by higher treatment volumes. The programs that fall into higher LVPA tiers will not be adequately reimbursed; an issue compounded by the fact that pediatric dialysis is fundamentally different than adult dialysis, specifically in the cost savings realized by higher treatment volumes.

Further, pediatric dialysis programs are often operated by children's hospitals or other small dialysis providers. Many of these programs do not have other dialysis facilities to rely on for recouping losses. Because the margins for providing pediatric dialysis are so thin, no pediatric dialysis provider can afford to receive lower payments than current policy. Yet, the proposed rule states "Under this proposed approach, low-volume facilities would receive higher payments for treatments furnished to pediatric ESRD patients, while high-volume facilities would receive somewhat lower payments relative to current policy".

NKF urges CMS to address pediatric payment policy, so it directly reflects the unique costs of pediatric dialysis care rather than relying primarily on facility volume.

10. Home and Self-Dialysis Training Add-on Payment Adjustment

NKF strongly supports CMS' proposal to increase the home and self-dialysis training add-on payment adjustment from \$95.60 to \$138.22 and to allow training sessions during the onset period. Training capacity remains a key barrier to home dialysis uptake, and underpayment for training can discourage facilities from investing in the staff time, education, and infrastructure needed to support patients who choose home modalities. NKF particularly appreciates CMS' recognition that early training is critical during the first 120 days of ESRD dialysis, when patients who experience

urgent starts or limited pre-ESRD education may otherwise default to in-center dialysis without a meaningful opportunity to consider home dialysis. Because this proposal directly advances CMS' and NKF's shared goal of increasing appropriate home dialysis access, NKF encourages CMS to consider finalizing the training add-on changes without applying budget neutrality.

E. Continuation of Approved Transitional Drug Add-On Payment Adjustments for CY 2027

NKF urges CMS to consider extending the TDAPA period to a full three years for products in existing functional categories. For the CY2027 rule, this would include DefenCath and Vafseo. Providing an additional year of TDAPA payments will update the ESRD PPS with other CMS systems. Further, two years of TDAPA payments is not adequate for fully understanding the impact of innovative products on patients. When a product falls within an existing functional category, it tends to be underutilized when incorporated into the bundle. Without the base rate increase of a new functional category, patients lose access to the innovation.

IV. Proposed Updates to the End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

The National Kidney Foundation (NKF) has been involved with the ESRD QIP since its implementation. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Public Law 110-275, Section 153(c)) authorizes the ESRD QIP and requires CMS to include measures of anemia management and dialysis adequacy. NKF has been closely involved with the implementation of the QIP since then, particularly through National Kidney Foundation's Kidney Disease Quality Initiative Clinical Practice Guidelines (NKF-KDOQI). We most recently gathered an expert group for a 2022 Kidney Disease Outcomes Quality Initiative (KDOQI) Workshop on Patient-Centered Quality Measures for Dialysis Care. Among the recommendations from that workshop was a consensus-based recommendation that dialysis facilities report through the End-Stage Renal Disease Quality Reporting System (EQRS) on key data elements related to social risk.²¹

B. Proposed Updates to Requirements Beginning with the PY 2029 ESRD QIP

2. Proposed Replacement of the Hypercalcemia Reporting Measure with the Facility-Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients Clinical Measure

NKF supports CMS' proposal to retire the Hypercalcemia reporting measure, which has limited value as a reporting-only measure, and appreciates CMS' focus on phosphorus management as a clinical component of mineral and bone disorder care. However, NKF urges CMS to ensure that the proposed Hyperphosphatemia clinical measure is implemented in a way that is fair, clinically appropriate, and patient-centered. Phosphorus control is influenced not only by facility care, but also by diet, medication access and affordability, adherence challenges, food insecurity, patient

²¹ Weiner DE, Delgado C, Flythe JE, et al. Patient-Centered Quality Measures for Dialysis Care: A Report of a Kidney Disease Outcomes Quality Initiative (KDOQI) Scientific Workshop Sponsored by the National Kidney Foundation. *American Journal of Kidney Diseases*. 2024;83(5):636-647. doi:[10.1053/j.ajkd.2023.09.015](https://doi.org/10.1053/j.ajkd.2023.09.015)

burden, and facility or pharmacy workflows. NKF encourages CMS to closely evaluate the measure threshold, risk adjustment, and potential unintended consequences so that facilities are not penalized for factors outside their control and patients are not subjected to inappropriate pressure or additional burden. NKF supports continued attention to phosphorus management but urges CMS to monitor whether the measure improves care without creating access, equity, or patient-experience concerns.

4. Proposed Removal of Two Measures from the ESRD QIP Measure Set

NKF appreciates CMS's efforts to focus on outcomes-based measures. However, while the Medication Reconciliation reporting measure and the COVID-19 Vaccination Coverage Among Healthcare Personnel reporting measure are topped out reporting measures, these are issues particularly important to dialysis patients who manage a high number of medications and also need increased protection from infectious diseases.

NKF emphasizes that medication safety, infection prevention, and vaccination access remain critically important for people with kidney failure, who often have complex medication regimens and heightened vulnerability to infectious disease. NKF encourages CMS to continue monitoring whether removal of these measures affects facility practices and to ensure that dialysis patients continue to have access to appropriate vaccination, infection prevention, and medication safety supports.

5. Proposed Updates to Measure Domains and to the Domain and Measure Weights used to Calculate the Total Performance Score

NKF supports CMS' continued effort to orient the ESRD QIP toward meaningful clinical outcomes and to reduce reliance on reporting-only measures. Because domain and measure weights can significantly influence facility behavior, NKF urges CMS to ensure that measures carrying greater weight are actionable, equitable, and patient-centered. NKF supports removing the Reporting Measure Domain if reporting-only measures are being removed from the program but encourages CMS to monitor whether the proposed redistribution of weight toward the Care Coordination and Clinical Care domains creates unintended consequences for facilities serving medically complex, high-need, or socially at-risk patients. NKF also urges CMS to ensure that future QIP measure weighting reflects outcomes that matter to patients and supports improvement without increasing burden or penalizing facilities for factors outside their control.

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

NKF supports patient-centered quality measurement that moves beyond clinical targets and captures whether care reflects what matters to patients. The Discussion of Patient Life Goals (D-PaLS) measure should assess a meaningful, iterative discussion rather than a one-time checkbox. This measure would support documentation of the patient's stated preferences and whether they

are revisited over time, and it should complement patient-reported measures of symptom burden, functional status, treatment recovery time, and quality of life. Implementation should also avoid penalizing clinically appropriate modality changes or temporary interruptions in therapy.

V. Requests for Information on Advancing Alternative Dialysis Care in Accordance with Executive Order 13879

NKF appreciates the opportunity to comment on the following requests for information. We are encouraged by the topics on which CMS has chosen to receive feedback from the stakeholder community. NKF remains committed to improving the dialysis care delivery system and remains dedicated to ensuring the patient remains at the center of care and policymaking.

B. Request for Information on Increasing Home Dialysis Uptake

a. Patient-Level Barriers to Home Dialysis

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

For many patients, barriers to home dialysis are practical rather than clinical. These include fear or lack of confidence performing dialysis at home, lack of reliable care-partner or home-based support, housing, storage, utility, and delivery constraints, language access and health literacy, limited broadband or technology access/literacy, transportation needs during training, dexterity or vision limitations, and temporary clinical or functional changes. Local workforce and training-capacity limitations can also make home dialysis unavailable even when it is the patient's preferred and clinically appropriate modality.^{22,23}

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

CMS should pair payment changes with targeted regulatory reforms. The Center for Clinical Standards and Quality (CCSQ) should update the ESRD Conditions for Coverage to require a standardized home-dialysis suitability and barrier assessment, documentation of which barriers are modifiable, a barrier-remediation plan, a time-bound transition plan for interested patients, and periodic reassessment. In tandem, the Center for Medicare should also use ESRD PPS adjustments or the Innovation Center should use its authority to support staff-assisted dialysis, care-partner training, intensive early monitoring, and home-readiness services such as minor modifications and

²² Reddy, Y. N. V., Kearney, M. D., Ward, M., Burke, R. E., O'Hare, A. M., Reese, P. P., Lane-Fall, M. B., Jones, J., Liu, F., Martin, A., McGraw, A., Neumann, J., Pettis, A., & Salenger, P. (2024). Identifying Major Barriers to Home Dialysis (The IM-HOME Study): Findings From a National Survey of Patients, Care Partners, and Providers. *American Journal of Kidney Diseases*, 84(5), 567-581.e1. <https://doi.org/10.1053/j.ajkd.2024.04.007>

²³ Trinh, E., Manera, K., Scholes-Robertson, N., & Shen, J. I. (2024). The Burden of Home Dialysis: An Overlooked Challenge. *Clinical Journal of the American Society of Nephrology*, 19(9), 1191-1197. <https://doi.org/10.2215/CJN.0000000000000413>

delivery assistance. These mechanisms would address the practical barriers that training payment alone cannot resolve.

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

Effective support should be matched to the patient's needs over time. All patients new to a home modality should have access to time-bound staff assistance and proactive clinical follow-up during the first 30 to 90 days. Ongoing assistance should be available when disability, frailty, or another impairment makes it necessary, and episodic support should be available after hospitalization, caregiver disruption, injury, illness, or temporary functional decline. Structured retraining, primary and backup care-partner training, remote monitoring, virtual support, and assistance with supply logistics would further support initiation and retention.²⁴

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

CMS should not treat the absence of a care partner as a reason to exclude an otherwise appropriate patient from home dialysis. CMS should provide coverage and reimbursement for training primary and backup care partners and **should fund staff-assisted home dialysis when reliable informal support is unavailable**. Payment should distinguish limited-duration assistance used to initiate or preserve a home modality from ongoing full assistance for patients with longer-term needs, while maintaining clear facility accountability for all services.

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

CMS should cover training for primary and backup care partners and make episodic staff assistance available when a caregiver is unavailable or fatigued. Limited respite support can help preserve the patient's chosen modality during short periods of caregiver strain, while structured retraining and readily accessible troubleshooting support can reduce the burden placed on care partners. Eligibility and ongoing need should be documented and reassessed so that support remains responsive to the patient and caregiver rather than becoming an inflexible requirement.

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

Time-bound staff assistance at the start of home dialysis can help patients overcome fear and uncertainty without forcing them to manage treatment alone immediately. CMS should pair that assistance with proactive follow-up during the first 30 to 90 days, remote transmission of treatment

²⁴ Oliver, M. J., Abra, G., Béchade, C., Brown, E. A., Sanchez-Escuredo, A., Johnson, D. W., Guedes, A. M., Graham, J., Fernandes, N., Jha, V., Kabbali, N., Kanjanabuch, T., Kam-Tao Li, P., Lundström, U. H., Salenger, P., & Lobbedez, T. (2024). Assisted peritoneal dialysis: Position paper for the ISPD. *Peritoneal Dialysis International: Journal of the International Society for Peritoneal Dialysis*, 44(3), 160–170. <https://doi.org/10.1177/08968608241246447>

data, virtual support visits when appropriate, and clear escalation protocols for missed treatments, equipment alarms, or other concerns. Ongoing technical support and structured, reimbursed retraining after a disruption in care would further reassure patients that support will remain available.

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 can help many patients preserve flexibility, independence, employment, caregiving responsibilities, and time that would otherwise be spent traveling to a facility. CMS should ensure that modality education and shared decision-making explicitly connect treatment options to each patient's goals, functional capacity, social supports, and preferences. Facilities should use a standardized, evidence-based decision aid, document the patient's stated preference and rationale, and revisit the decision as goals or circumstances change.²⁵

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?

CMS should continue to use Innovation Center authorities to broaden access to Kidney Disease Education earlier in the disease course and allow a wider range of qualified providers to furnish it. Based on Innovation Center tests, CMS should consider the extent to which KDE access can be broadened under its existing authorities.

Kidney disease education flexibilities should extend across Innovation Center models and should permit telehealth, group-based, and other technology-enabled formats. KDE should be treated as a longitudinal process that continues after dialysis initiation for people who start urgently or without prior nephrology care. In reference to regulatory quality assurance policies, documentation should capture education over time, patient understanding, and evolving preferences rather than rely on a one-time checkbox.

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

CMS should revisit payment for KDE so that it recognizes the substantial staff time and repeated patient engagement required for comprehensive, longitudinal modality education. Payment for HCPCS codes G0420 and G0421 should support culturally and linguistically appropriate education, use of a standardized decision aid, discussion of the benefits and limitations of all treatment

²⁵ Rydell, H., Caldinelli, A., Wrackefeldt, J., Kåveryd-Hult, A., Lindholm, B., Qureshi, A. R., Chesnaye, N. C., & Evans, M. (2025). Quality of life trajectories for different dialysis modalities—A nationwide study. *Clinical Kidney Journal*, 18(2), sfae420. <https://doi.org/10.1093/ckj/sfae420>

options, and delivery by qualified members of the interdisciplinary care team. Payment should not assume that a single educational encounter is sufficient.

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

CMS should broaden the qualified providers and delivery pathways available for KDE. Permitting ESRD facilities to furnish KDE could be consistent with that goal if safeguards ensure that education is standardized, balanced, not limited to services offered by the facility, and does not steer patients toward any specific dialysis provider. Facilities should disclose home-modality options available at other facilities, provide culturally and linguistically appropriate materials, give patients an opportunity to discuss tradeoffs with the interdisciplinary team, and document the patient's preference and whether it is revisited.

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

Standardized CKD screening and diagnosis should be implemented, for example through the “Welcome to Medicare” preventive visit provided to new beneficiaries within 12 months of enrollment. Many patients are unaware they are living with CKD until they crash into dialysis, leaving no opportunity for education and shared decision making before dialysis onset. Recent review of Medicare claims data shows that approximately one in three Medicare FFS beneficiaries in need of maintenance dialysis crashed into dialysis.²⁶ Patient education and decision making needs to occur before dialysis onset, something that is not possible with current CKD screening practices.

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?

Modality education should continue after dialysis initiation, particularly for patients who start urgently or without prior nephrology care. Facilities should provide structured and repeated education, conduct a standardized suitability and barrier assessment, and develop a time-bound transition plan for patients interested in home dialysis. The plan should identify modifiable barriers, document remediation efforts, and establish a reassessment interval. Patients should also receive information about other facilities when their current facility cannot support the preferred home modality.

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

²⁶ Crash Dialysis Trends Show Potential Areas for Medicare Quality and Cost Improvement. (2025, January 15). American Institutes for Research. <https://air.org/resource/brief/crash-dialysis-trends-show-potential-areas-medicare-quality-and-cost-improvement>

NKF believes that targeted IPPS and OPPS payment adjustments could help hospitals establish and maintain urgent-start peritoneal dialysis programs, but payment changes alone will not eliminate the barriers that cause patients who begin dialysis unexpectedly to default to in-center hemodialysis. Effective urgent-start PD pathways require timely modality education and shared decision-making, rapid access to PD catheter placement, trained hospital staff, coordination with outpatient dialysis facilities, and discharge processes that allow patients to continue training and treatment after leaving the hospital.

CMS should consider testing a time-limited or case-based payment adjustment that recognizes the additional resources hospitals use to evaluate patients for urgent-start PD, provide unbiased treatment education, coordinate catheter placement, and arrange a supported transition to outpatient care. Any adjustment should operate in coordination with the ESRD PPS so that outpatient facilities are also adequately reimbursed for home-dialysis training and early clinical support.

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.

Payment for professional training services should reflect the current intensity and operational resources required to prepare patients and care partners for home dialysis. In addition to increasing the home dialysis training add-on, CMS should recognize retraining after hospitalization or another disruption and training for primary and backup care partners. Any revisions to CPT codes 90989 and 90993 should support these activities and ensure that reimbursement for facilities and clinicians does not favor one modality over another.

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

A completed course should be based principally on demonstrated competency and the patient's individualized treatment plan, rather than a rigid number of sessions. The definition should accommodate different learning needs, hybrid training, solo home dialysis when appropriate, and patients who will safely use staff or care-partner assistance. CMS should also establish a structured pathway for retraining following hospitalization, caregiver disruption, temporary functional decline, or another interruption in care.

Whether any ESRD CfCs related to patient training (for example, requirements for individualized training or staff competencies) may inadvertently limit the ability of facilities to scale home dialysis training capacity; and if so, what modifications, if any, CMS should consider.

CMS should modernize the Conditions for Coverage to permit hybrid training that combines in-person and virtual components, require that some training occur in the patient's home, and clarify

that qualified interdisciplinary team members may participate under registered-nurse oversight. The CfCs should also support individualized and group-based training where feasible, alternative training settings when appropriate, structured retraining after care disruptions, and training for backup care partners. These changes would expand capacity while preserving competency and safety expectations.

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).

Payment policy should not disincentivize group-based, hybrid, or other alternative training models because reimbursement is tied to individual sessions. CMS should align payment with the resources needed to achieve and document patient competency, including interdisciplinary staff time, care-partner training, training in the home when appropriate, and retraining after disruptions. Flexibility in the training format should remain subject to individualized assessment and patient-safety standards.

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.

Alternative training should remain competency based. Qualified interdisciplinary staff should work under registered-nurse oversight, with clear delegation and competency standards. Hybrid programs should retain appropriate in-person instruction and include training in the patient's home when needed to identify practical barriers. Facilities should provide structured retraining, train backup care partners when feasible, use remote treatment data and proactive follow-up, and maintain escalation protocols for missed treatments, equipment alarms, or adherence concerns.

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

CMS should support ongoing mentoring and technical-assistance pathways that pair lower-volume or emerging programs with experienced home dialysis teams. A hub-and-spoke model could support nephrologists, nurses, social workers, dietitians, and facility leaders through case-based learning, peer consultation, and practical guidance on patient selection, urgent-start PD, HHD prescribing and troubleshooting, training workflows, infection prevention, remote monitoring, and early technique failure. ESRD Networks and Innovation Center models could help extend this support to underserved and lower-capacity areas.

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?

CMS should revise § 494.70 to require structured and meaningful modality education. Facilities should use a standardized decision aid, provide education at multiple points in the course of kidney disease and dialysis care, use culturally and linguistically appropriate materials, document the opportunity to discuss tradeoffs with the care team, and tell patients about other facilities that offer home modalities when the current facility cannot support the patient's preference. Education should be reinforced over time and tailored to clinical status, functional capacity, social support, and patient goals.

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?

CMS should require education at multiple points rather than prescribe a single one-time encounter. Education should begin before kidney failure, continue after dialysis initiation for urgent starters and others who lacked prior education, and be revisited when the patient's health, support system, or preferences change. At a minimum, this information should be offered to the patient quarterly, with the option for a patient to opt-out of future education sessions. CMS should permit multiple formats, including in-person, telehealth, and group-based education, but should require a standardized decision aid as well as culturally and linguistically appropriate delivery in every format.

How should education delivery and patient response be monitored and documented? What information should be captured and recorded? How should this be incorporated into the patient assessment and plan of care to address barriers to home dialysis to ensure it is acted upon?

Documentation should capture the education delivered, use of the standardized decision aid, the patient's understanding, opportunity to discuss tradeoffs, stated preference and rationale, and whether the decision is revisited over time. The patient assessment should include a standardized review of clinical and non-clinical barriers and identify which are modifiable and what interventions were offered. The plan of care should then include a time-bound transition plan, a barrier-remediation plan, and a reassessment interval, while clearly distinguishing patient preference, clinical limitations, and facility-level constraints.

Should CMS revise minimum staff qualification requirements for those who may deliver home dialysis education? What education, qualification, and experience would be most appropriate?

CMS should expand education beyond physicians to qualified members of the interdisciplinary care team, including nurses and social workers, who can provide detailed, repeated, and context-specific education. Social workers are particularly important for identifying socioeconomic barriers that affect modality feasibility. For technical home-dialysis training, CMS should maintain competency standards while clarifying that qualified interdisciplinary team members, including technicians, may participate under registered-nurse oversight. Qualifications should reflect the difference between modality education and hands-on technical training.

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?

CMS should create payment for time-bound staff-assisted home dialysis for patients new to a home modality and for episodic assistance after hospitalization, caregiver disruption, or temporary functional decline. Longer-term assistance should be available for patients who are otherwise impaired and need it to use their preferred modality. CMS could operationalize these supports through ESRD PPS adjustments, Innovation Center demonstrations, or allowable home-health support. Payment should distinguish initiation or continuity support from ongoing full assistance and should fund more intensive monitoring during the early transition period.

Whether patients returning home following in-patient 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.

Yes, patients who can generally perform home dialysis but need temporary help after hospitalization, surgery, injury, caregiver disruption, or a decline in function should be eligible for staff assistance so that a short-term disruption does not force a permanent transfer to in-center care. CMS should pair assistance with structured retraining and reassessment of ongoing need. Episodic post-hospital support is a particularly feasible starting point for preserving home-modality continuity.

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

CMS should permit limited respite support as a form of episodic staff-assisted dialysis when a caregiver is unavailable or fatigued. This support can preserve the patient's chosen modality and reduce the risk that caregiver strain leads to modality failure. It should be complemented by readily accessible training for primary and backup care partners. The assistance furnished and its duration should be documented, and continued need should be periodically reassessed.

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?

Eligibility should be based on documented clinical, functional, and support needs, including initiation of a home modality, disability or frailty, hospitalization, caregiver disruption, or temporary functional decline. CMS should maintain clear competency and safety standards and require facility oversight of staff and any contracted personnel. Safeguards should include clear facility

accountability for services, equipment, and supplies, documentation of the assistance furnished as well as defined eligibility criteria and periodic reassessment of ongoing need.

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

Patients should not be immediately deemed unsuitable for staff assisted home dialysis based on particular comorbidities, behavioral characteristics, or other patient characteristics. Suitability should be determined through an individualized clinical and safety assessment that distinguishes true limitations from modifiable logistical barriers and facility-level constraints. Facilities should document whether identified risks can be mitigated through home-readiness support, remote monitoring, or another intervention before excluding a patient.

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?

A time-bound staff assistance program would limit inappropriate long-term overutilization. Allowing only impaired beneficiaries to continue utilizing staff assistance beyond the time-limited transition period would prevent inappropriate long-term use. In the instance of respite care or return to a home modality following a disruption, staff assistance should also be time limited. However, the duration of respite care or return to home modality should be determined by the care team to ensure successful transition back onto a home modality. The additional cost of staff assistance would be wasted if this period of staff assistance is too short to adequately return the patient to home modality competency.

How should such staff-assisted dialysis payments be structured within the ESRD PPS to support initiation and retention?

The ESRD PPS should distinguish limited-duration assistance used to initiate home dialysis or preserve continuity during temporary instability from ongoing full assistance for patients with longer-term impairment. Payment should support time-bound assistance for new patients, episodic help after hospitalization or caregiver disruption, and longer-term support when clinically and functionally necessary. Regardless of duration, the dialysis facility should remain accountable for the complete service, with documented eligibility, assistance, and transition success.

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

(1) ESRD PPS Payment Structure

Whether CMS should consider adjustments to the ESRD PPS base rate or related payment components under § 413.220 to better recognize infrastructure and support costs associated with home dialysis programs.

CMS should update the ESRD PPS to recognize the resources required to build and sustain a home-dialysis program, not only the initial training session. Payment should support training and retraining, primary and backup care-partner education, care coordination and social-work activities that address non-clinical barriers, remote patient monitoring, remote support, staff assistance, and the logistics of equipment and supplies. Payment updates should accompany a regulatory pathway for home-focused and hybrid facilities so that these programs are not forced into an infrastructure and payment model designed around in-center treatment.

Whether CMS should consider a redistribution within the ESRD PPS base rate structure under § 413.220 to facilitate home dialysis uptake.

While a redistribution to facilitate home dialysis uptake is likely to have a positive impact, it is likely to be marginal unless it is coupled with corrections to the larger dialysis system outlined elsewhere in this letter.

Whether CMS should consider a refinement of case-mix adjustments under § 413.235 to facilitate home dialysis uptake.

Any refinement to case-mix policy should recognize the functional and support needs that affect whether home dialysis is feasible. Patients who are older, frail, blind, disabled, have limited mobility, or lack a reliable care partner may require staff assistance, additional supply support, or other services, but those characteristics should not exclude them from home modalities. Adjustments should be tied to documented need through a standardized assessment and should support barrier remediation and periodic reassessment rather than rely on broad categorical exclusions.

Whether CMS should consider establishing a temporary add-on payment adjustment for beneficiaries initiating home dialysis, such as during the first 90 or 120 days of treatment, and how such a payment should be structured to ensure clinical appropriateness.

CMS should consider a temporary add-on that supports the resource intensive transition to home dialysis. The recommendations call for time-bound staff assistance for new home patients and proactive clinical follow-up during the first 30 to 90 days, including remote monitoring, virtual support when appropriate, and escalation protocols. The payment should be linked to documented transition services and actions taken by dialysis facilities to ensure successful home modality initiation.

Whether CMS should consider restructuring the ESRD PPS onset add-on payment adjustment under § 413.236(a)(2) to incorporate an education component tied to successful home dialysis initiation.

The ESRD PPS should reimburse structured, standardized modality education and the support required to initiate home dialysis. If CMS uses the onset adjustment for this purpose, the education component should pay for meaningful, longitudinal education and shared decision-making,

including documentation of the patient's understanding and preference. It should not reward steering patients to home dialysis or make education payment depend solely on a particular modality choice.

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

CMS should provide payment recognition for supportive services that are central to safe home-dialysis initiation and retention. These services include remote patient monitoring and digital transmission of treatment data, proactive follow-up during the first 30 to 90 days, virtual support visits when appropriate, enhanced clinical oversight, and escalation protocols for missed treatments, equipment alarms, or adherence concerns. Payment should also recognize care coordination and social-work activities that address non-clinical barriers.

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

The costs associated with furnishing home hemodialysis are not currently adequately reimbursed. Specifically, when home HD is performed more than 3 times per week.

What costs for ESRD beneficiaries are higher for home dialysis compared to in-center modalities?

Beneficiaries may face costs and practical burdens associated with home setup, minor modifications, water or electrical requirements, broadband access, storage space, and supply delivery. These burdens can affect whether home therapy is feasible, particularly for patients with limited mobility or fewer resources. CMS should permit transparent home-readiness supports and test targeted benefits for minor modifications, delivery facilitation, smaller or more frequent deliveries, and in-home placement of supplies when functionally necessary so that patients do not bear inappropriate financial burdens.

(2) Home Dialysis Training Add-on Payment Adjustment

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

CMS should increase the home-dialysis training add-on so that it reflects the actual staff time and operational resources required for training. Payment should also recognize care-partner training and retraining after hospitalization or another disruption. At the same time, payment should support competency-based training rather than make the number of hours or sessions the sole measure of completion because patient learning needs and appropriate training formats vary.

Whether modifications to the home dialysis training add-on payment adjustment under § 413.178(b) would materially affect uptake.

Increasing and modernizing the training add-on would improve facilities' ability to invest in home-dialysis training capacity, but training payment alone will not address the social, functional, and logistical barriers that determine whether home dialysis is feasible and sustainable. Any modification should be paired with payment for retraining, care-partner education, intensive early monitoring, staff-assisted dialysis, and home-readiness and supply-logistics support.

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

Payment for CPT code 90989 should be updated to reflect the current intensity and resources required for home-dialysis training. The payment should support individualized, competency-based instruction and should recognize the role of qualified interdisciplinary staff, care-partner training, home-based training when appropriate, and the operational work needed to prepare patients for safe treatment at home.

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.

CMS should not define successful completion solely as a full month of treatment without assistance. Some patients can safely and successfully use a home modality with ongoing staff or care-partner support, and temporary assistance after a disruption should not negate successful home use. Completion should instead be based on demonstrated competency relative to the individualized care plan, with appropriate recognition of solo treatment, assisted treatment, interruptions, and the need for structured retraining.

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

CMS should recognize the resources associated with partial, interrupted, and repeat training. Payment for CPT code 90993 should therefore support clinically appropriate partial or interrupted training and should not create pressure to complete training on a rigid schedule that does not reflect patient needs.

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

Revised training payments could support greater early uptake by allowing facilities to expand training capacity and provide individualized instruction. Their effect will be limited, however, unless CMS also addresses fear, caregiver availability, workforce shortages, home setup, supply logistics, and the need for intensive early support. Training payment should therefore be combined with time-

bound staff assistance, proactive monitoring during the first 30 to 90 days, care-partner training, and barrier-remediation supports.

(3) ESRD PPS Onset Adjustment

Whether CMS should consider restructuring the ESRD PPS onset add-on payment adjustment under § 413.236(a)(2) to incorporate a modality education component.

CMS should ensure that the onset period includes payment for structured, standardized modality education delivered by qualified members of the interdisciplinary care team. Education should be longitudinal, use an evidence-based decision aid, present the benefits and limitations of all treatment options, and document patient understanding, preferences, and later reassessment. It should remain available after initiation for patients who start urgently or without prior nephrology care.

Whether CMS should consider if the onset add-on payment should be divided into a care portion and an education portion.

A distinct education component could make the resources required for meaningful, longitudinal modality education visible, while a care component could support the intensive monitoring and transition services needed early in dialysis. If CMS adopts this structure, both components should be adequately funded and documented. The education payment should be based on delivery of balanced education and shared decision-making, not on whether the patient selects a particular modality.

Whether CMS should consider if a potential education portion of the onset adjustment should be paid in a later month contingent upon successful home dialysis utilization for at least one month without assistance.

CMS should not condition an education payment on a month of home dialysis without assistance. That approach could disadvantage patients who safely need staff or care-partner support and could distort informed modality choice. Payment for education should reflect meaningful delivery and patient engagement. Any separate payment tied to home initiation should account for patient preference, clinical limitations, hospitalization, temporary interruptions, and assisted home-dialysis use.

Whether CMS should consider if restructuring the onset add-on adjustment could increase incident home dialysis selection and retention beyond 60 days.

Restructuring the onset adjustment could improve selection and retention if it pays for the services that support a successful transition: repeated modality education, a documented transition and barrier-remediation plan, time-bound staff assistance, care-partner training, and proactive monitoring during the first 30 to 90 days. Payment alone is unlikely to be sufficient. CMS should

evaluate both initiation and sustained retention while accounting for clinically indicated transitions, patient preference changes, hospitalization, transplantation, and temporary interruptions.

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

Whether CMS should consider enhanced public reporting of facility-level home dialysis rates prior to any modifications to QIP scoring methodologies to emphasize home dialysis utilization or improvement.

CMS should enhance public reporting so that patients and policymakers can determine whether home dialysis is meaningfully available. Facility reporting should include modalities offered, the percentage of incident patients receiving structured education, training starts and completion, time from modality decision to home initiation, sustained retention, unplanned transfers to in-center treatment, and disparities in access. Results should account for patient choice, clinically indicated transitions, hospitalization, transplantation, and temporary interruptions.

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.

CMS should use the ESRD QIP to reinforce patient-centered home-modality access, informed choice, initiation, retention, availability of assisted home dialysis, and patient-reported experience with support. However, QIP measures alone may have limited effect because modality education is already required. CMS should pair any performance-based approach with enhanced surveys, public reporting, and model-based accountability, and should avoid penalizing facilities that serve medically or socially complex patients or that make clinically appropriate modality transitions.

Whether CMS should consider clarifications to CfC requirements related to modality education under § 494.70. What specific changes would be needed to better clarify the information related to treatment modality, treatment setting, and services not offered by the facility that would support increased use of home dialysis?

CMS should clarify section 494.70 by requiring facilities to use a standardized modality decision aid, provide education at multiple points in kidney disease and dialysis care, use culturally and linguistically appropriate materials, document the patient's opportunity to discuss modality tradeoffs with the interdisciplinary team, and provide information about other facilities that offer home modalities when the current facility cannot support the patient's preference. Documentation should capture the patient's stated preference, rationale, and whether the decision is revisited.

Whether factors such as current payment policy, operational practices, or other considerations may limit the use of alternative home dialysis training approaches (for example, group-based or hybrid models), and whether CMS should consider changes to support greater flexibility while maintaining individualized, patient-centered training and ensuring patient safety.

Current operational and payment structures can limit group-based, hybrid, home-based, and other alternative training approaches. CMS should permit hybrid training with in-person and virtual components, allow training in alternative settings when appropriate, and support individualized or group-based models without tying payment so narrowly to individual sessions that flexibility is discouraged. Safeguards should include individualized competency assessment, registered-nurse oversight, appropriate in-person and home-based components, structured retraining, and clear monitoring protocols.

Whether CMS should consider technical skills and patient evaluation to expand the types of licensed dialysis staff eligible to conduct training while maintaining patient safety.

CMS should clarify that qualified members of the interdisciplinary care team may participate in structured home-dialysis training under registered-nurse oversight. Expansion should be based on demonstrated technical skills, defined delegation, and competency standards rather than professional title alone. This approach can increase capacity while preserving individualized patient evaluation and safety protections.

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

Workforce shortages are a recurring and material constraint on home dialysis uptake. Shortages of experienced dialysis nurses can limit the number of patients a facility can train and create long waits for home initiation, particularly for home hemodialysis, which requires intensive training and ongoing technical support. CMS should address this through clearer delegation under registered-nurse oversight and ongoing hub-and-spoke mentoring and technical assistance for emerging and lower-volume home programs.

What additional ESRD PPS modifications would most directly influence incident modality selection?

The ESRD PPS modifications most likely to affect modality selection are an increased training add-on, payment for retraining and primary and backup care-partner training, recognition of care coordination and social-work activities that address non-clinical barriers, increased payments for early monitoring; reimbursement for structured interdisciplinary modality education, and coverage of time-bound and longer-term staff-assisted dialysis based on need. Reimbursement should not favor one modality over another.

What modifications should CMS consider making to the CfCs to align with currently permissible certification action or determination by creating within the CfCs a designation of a “home-only” ESRD facility which would not provide any in-center dialysis? Is there evidence and data that under the current certification action that such a designation requires less physical infrastructure to provide care?

CMS should amend section 494.10 of the CfCs to explicitly recognize home-dialysis training and support facilities, as well as hybrid facilities. A home-focused facility would primarily provide

training, ongoing clinical support, and remote monitoring as opposed to traditional in-center dialysis. Separate recognition would allow tailored oversight and payment instead of requiring every program to maintain the same infrastructure as a full in-center facility.

What would be the impact of updating the CfCs to create a designation of a “selfdialysis- only” ESRD facility which would not provide any in-center dialysis other than selfdialysis (patients perform dialysis on themselves in-center)? Would such a designation require less staffing to provide care? What other CfC requirements would be necessary or need to be modified for this type of facility to ensure patient health and safety?

There would be a significant staffing requirement to initiate patients in a “selfdialysis-only” facility. This requirement coupled with the administration and maintenance of operating a dialysis facility would result in marginal cost reduction, if any.

(5) ESRD Cost Report Modifications

Consideration as to whether modifications to the ESRD freestanding and hospital-based cost reports to capture more granular home dialysis costs will assist in aligning payment with value and encourage ESRD facilities to promote home dialysis modalities.

More granular cost information could help CMS align payment with the actual resources needed to sustain home programs. Relevant categories include training and retraining, care-partner education, early clinical oversight, remote monitoring, care coordination and social work, staff-assisted services, home-based support, and equipment and supply logistics. Data collection should be targeted to costs that current payment does not recognize and designed so that it supports payment refinement without obscuring the goal of expanding patient access.

Whether CMS should consider collecting separate data on travel costs for ESRD facility staff for home HD visits.

Yes, home dialysis patients can sometimes live multiple hours away from their facility. This can lead to home visits taking a full work day to complete for two staff members. Further, it is important to recognize the patient burden on travel to the dialysis facility in these instances. Long travel distances should not preclude patients from accessing home modalities.

Whether CMS should collect data on hidden costs such as internet connectivity, equipment installation, shipping, and remote monitoring devices.

CMS should account for costs associated with digital connectivity, remote monitoring, equipment and supply coordination, home setup and minor modifications, and shipping or delivery support. These costs can determine whether home dialysis is practically feasible and whether a facility can sustain a robust program. Collection should distinguish facility costs from beneficiary burdens and

should capture the added costs of smaller or more frequent deliveries and in-home placement of PD supplies when functionally necessary.

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

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.

Care coordination and data sharing across ESRD facilities, ACOs, and Innovation Center models should support a longitudinal education and treatment-planning pathway rather than duplicate one-time education. Programs should use a standardized decision aid, document patient understanding and evolving preferences, and carry forward the suitability assessment, identified barriers, remediation efforts, and transition plan. Model participation standards can reinforce shared decision-making, but alignment must preserve unbiased education, information about options outside the current facility, and the patient's right to choose a modality.

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

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

The need to pay for home setup or minor modifications can affect whether home dialysis is a realistic option. CMS should create a compliant pathway for home-readiness supports, including minor modifications and delivery facilitation, with clear documentation standards, limits on permissible support, and program-integrity guardrails. These supports should be targeted to practical need so that non-clinical barriers do not impose an inappropriate financial burden or determine modality choice.

Whether CMS should consider engaging with the home dialysis industry to improve supply ordering and delivery processes.

CMS should work with facilities and the home-dialysis industry to reduce the logistics burden of ordering, delivering, storing, and placing supplies. Policy should support smaller or more frequent deliveries, in-home placement when functionally necessary, and structured delivery assistance.

Payment must recognize the increased facility costs that may accompany more frequent delivery, while clear guardrails and documentation should ensure that support is based on patient need.

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

Yes, storage constraints and the burden of large supply deliveries are repeatedly identified as barriers to PD initiation and sustainability, especially for older adults and people with limited mobility or limited housing space. CMS should test an ESRD PPS adjustment or Innovation Center support benefit for smaller or more frequent deliveries, structured delivery assistance, and in-home placement of supplies when clinically and functionally necessary.

Whether CMS should consider providing time-limited additional payments to ESRD facilities that establish and implement in-center self-dialysis training and support programs, including patient education, supervised self-cannulation, and progressive independence in treatment tasks, designed to prepare beneficiaries to independently perform dialysis and transition to home dialysis modalities.

In-center self-dialysis training and support programs would be more feasible than self-dialysis-only clinics. The main limiting factor is the need for additional staff to train self-care patients and complete competency assessments. Staff also must be experienced dialysis nurses; thus, they cost more and are harder to find.

g. Incentives for In-Center Self-Dialysis Programs

What staff qualifications and supervision should be required within the in-center facility during this time of transitional dialysis when the patient is progressing toward selfdialysis?

Criteria and qualifications should be the same as for home dialysis training. Self-dialysis training would require an experienced nurse who is also a good educator.

How should CfC requirements be structured to better support patients in successfully transitioning to home dialysis? What requirements could be implemented to assist patients in reaching this goal?

The CfCs should require a time-bound transition plan for every patient who expresses interest in home dialysis, a documented plan to remediate modifiable barriers, and a defined interval for reassessment when a patient is initially deemed unsuitable. CMS should also modernize training rules to permit hybrid, group-based, and home-based components, interdisciplinary participation under registered-nurse oversight, and structured retraining after a disruption. Patient education should be repeated, individualized, and transparent about facilities that can provide the preferred modality.

h. Increasing the Number of Facilities Offering Home Dialysis

What levers CMS can employ to encourage additional facilities to establish home dialysis programs?

CMS should combine a regulatory pathway for home-focused and hybrid facilities with payment that recognizes home-program infrastructure and ongoing support. Specific levers include a larger training add-on, payment for retraining and care-partner training, intensive early monitoring, staff-assisted dialysis, home-readiness and delivery support, and care coordination and social-work activities. CMS should also use public reporting, patient-centered performance measures, and ongoing technical assistance and mentoring to encourage facilities to build and sustain home programs.

To what extent CMS should consider infrastructure payments or time-limited adjustments to potentially increase geographic access.

Payment policy should recognize that establishing a home program requires infrastructure for training, patient support, remote monitoring, equipment and supply coordination, and an experienced workforce. CMS should consider targeted or time-limited support for new or emerging programs, particularly where geographic access is limited, together with hub-and-spoke mentoring through ESRD Networks or Innovation Center models. Any adjustment should be paired with accountability for training capacity, time to home initiation, retention, and disparities in access.

Are there changes that could be made to the requirements for home dialysis monitoring and/or support services that would reduce burden on dialysis facilities without negatively impacting patient health and safety?

CMS should update section 494.100(b)-(c) to recognize remote patient monitoring and digital transmission of treatment data (and recognize potential limitations in internet connection access), permit virtual support visits when appropriate, and require proactive follow-up during the first 30 to 90 days. Facilities should maintain escalation protocols for missed treatments, equipment alarms, or adherence concerns. These changes would allow programs to use modern technology to provide timely oversight without unnecessary patient or facility burden while preserving clear clinical responsibility and safety protections.

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

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

Payment policy should recognize the clinical time required to refer patients, coordinate home-dialysis training, and participate in longitudinal modality planning. At the same time, comprehensive education should not depend exclusively on uncompensated physician effort. CMS should support standardized education delivered by the interdisciplinary team and ensure that

reimbursement does not favor one modality over another. Any physician payment should reinforce documented, unbiased shared decision-making and a time-bound transition plan.

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

CMS should recognize meaningful healthcare provider participation in home-dialysis training and care planning while using the full interdisciplinary team to deliver repeated education and support. Payment should reflect the work of coordinating training, reviewing barriers, and supporting the transition to home therapy, but it should not create an incentive to steer patients toward a modality. Documentation should include the patient's preference, the transition and barrier-remediation plan, and reassessment over time.

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

No provider should be paid to guide a patient to any specific modality.

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

Whether CMS should consider payment variations for home dialysis patients under the MCP framework. Should we establish additional coding and payment for home dialysis MCP services for different numbers of visits?

CMS should ensure that the MCP structure does not favor in-center care over home modalities and should recognize the care coordination and oversight that home patients may require. Coding and payment could distinguish periods of intensive early follow-up, retraining after a disruption, or greater documented support need from routine stable care. Any visit-based variation should preserve individualized care and allow appropriate virtual support rather than reward a greater number of visits without regard to patient need.

Whether MCP payment amounts for home dialysis patients should be higher than in-center MCP payments to reflect increased care coordination and oversight demands.

MCP payment should reflect the actual coordination and oversight required for home dialysis and should not favor one modality over another. A blanket differential may be less appropriate than targeted recognition of intensive early monitoring, remote data review, care coordination, retraining, and periods of temporary instability. Payment should support the services needed to retain patients safely at home while avoiding incentives based solely on modality or visit volume.

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?

Greater telehealth flexibility could support retention by allowing more timely follow-up, review of remotely transmitted treatment data, and rapid troubleshooting during the first 30 to 90 days. Virtual support can reduce patient burden and improve confidence, particularly when paired with clear escalation protocols for missed treatments, equipment alarms, or other concerns. Telehealth should complement, not replace, clinically necessary in-person assessment and hands-on support, and CMS should evaluate quality and safety outcomes as flexibility is expanded.

k. Skilled Nursing Facilities and Transitional Settings

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

Currently, the largest barrier to continued use of PD in SNFs is the lack of personnel to help staff daily PD. SNFs do not regularly staff for daily PD. Further, several ‘dialysis in nursing homes’ have closed because the cost was higher than reimbursement.

What recommendations would improve the transition of dialysis patients between different care settings (hospital, institutional, and home)?

Transitions should include prompt communication of the patient's home modality and support needs, temporary staff assistance when needed after hospitalization or another disruption, and a structured retraining pathway before a patient is transferred permanently to in-center care. The care plan should be reassessed when clinical or functional status or caregiver availability changes. Facilities should use remote monitoring, proactive follow-up, and clear escalation protocols to support continuity when the patient returns home. CMS should consider additional requirements for the hospital to ensure effective discharge and return to dialysis.

l. Measuring Success

Is a 60-day continuation threshold appropriate to ensure sustained initiation?

A 60-day threshold may capture early continuation, but it should not be the sole definition of success. CMS should monitor sustained home modality retention over time together with training completion, time from modality decision to home initiation, and unplanned transfers to in-center care. Measurement should account for hospitalization, transplantation, temporary interruptions, patient preference changes, and clinically indicated transitions so that a short-term event does not automatically count as failure.

To what extent CMS should consider a longer duration threshold for quality measurement purposes.

CMS should consider a longer-term retention measure in addition to any 60-day initiation threshold. A broader measurement set should assess whether home dialysis remains a real and supported option over time, including sustained retention, time to initiation, patient-reported experience with support, and unplanned transfers to in-center treatment. Longer-duration measurement must account for clinically appropriate changes, hospitalization, transplantation, patient preference, and temporary interruptions.

How should CMS account for clinical contraindications or patient choice in assessing uptake?

CMS should distinguish patient preference, true clinical limitations, modifiable non-clinical barriers, and facility-level constraints. Uptake and retention measures should exclude or otherwise account for clinically indicated transitions, preference changes, hospitalization, transplantation, and temporary interruptions. Facilities should document a standardized suitability and barrier assessment, remediation offered, and periodic reassessment so that logistical barriers or limited facility capacity are not incorrectly recorded as patient choice or clinical contraindication.

C. Request for Information to Advance Palliative Care for Dialysis Patients

a. Definition of Palliative Dialysis

How should CMS define “palliative dialysis” for purposes of Medicare policy?

Palliative dialysis should be defined as dialysis delivered to advance a patient’s documented end-of-life goals, with primary emphasis on comfort, quality of life, symptom relief, and reducing treatment burden while preserving dialysis benefits that the patient values.²⁷ Palliative dialysis should coexist with life-prolonging treatment and is not the same as dialysis withdrawal or hospice enrollment. Palliative dialysis should require an advanced care plan that records the patient’s life goals, expected benefits and burdens, intended prescription changes, and a reassessment schedule. These should build on existing ESRD care-plan requirements and CMS’s proposed patient life-goals measure.

What clinical characteristics distinguish palliative dialysis from maintenance dialysis?

Palliative and maintenance dialysis should be distinguished by treatment intent: maintenance dialysis generally prioritizes disease-oriented targets and longevity, while palliative dialysis prioritizes patient-defined comfort, function, time at home, and acceptable treatment burden. Patient goals and shared decision making will be critical in the distinction.

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

²⁷ Davison, S. N., Levin, A., Moss, A. H., Jha, V., Brown, E. A., Brennan, F., Murtagh, F. E. M., Naicker, S., Germain, M. J., O'Donoghue, D. J., Morton, R. L., & Obrador, G. T. (2015). Executive summary of the KDIGO Controversies Conference on Supportive Care in Chronic Kidney Disease: Developing a roadmap to improving quality care. *Kidney International*, 88(3), 447–459. <https://doi.org/10.1038/ki.2015.110>

No modality should be treated as inherently palliative. In-center hemodialysis, home hemodialysis, and peritoneal dialysis can each be palliative when selected and prescribed around the patient's goals and circumstances. Treatments should follow individualized patterns such as shorter or less frequent sessions, gentler filtration, less routine testing, and less dietary restrictions. These changes should serve to improve comfort without defeating the patient's goals.

b. Beneficiary Eligibility and Targeting

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

No single indicator, or group of indicators, should define eligibility for palliative dialysis. Access should depend on supportive-care need, patient goals, and whether a modified dialysis approach can reduce burden, improve quality of life, or better meet life goals than maintenance dialysis. Electing to receive palliative dialysis should not require the patient to forgo life-prolonging intent.

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

CMS should not use hospice eligibility as the gateway to palliative dialysis. Hospice's terminal-prognosis and election rules define a distinct Medicare benefit, whereas kidney palliative care can be appropriate earlier and alongside life-prolonging care. Further, CMS should not require homebound status. Palliative dialysis may be appropriate for people treated in a facility or at home, and Medicare separately excludes dialysis-related services from the home health benefit.

c. Care Delivery and Settings

What are the primary barriers to delivering palliative dialysis in home or community-based settings?

The most direct policy barrier is that Medicare does not routinely pay for ongoing staff assistance in the home, even though many candidates are frail, functionally impaired, cognitively limited, or lack an available caregiver. Other barriers include care partner workload and burden, unsuitable space or utilities, equipment setup, infection-control demands, transportation, and limited access to trained home-dialysis personnel.

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

Yes, staff-assisted home dialysis can extend access to palliative care patients who are unable to rely on a care partner. By allowing the patient to remain in the preferred setting and modality with appropriate support, this approach can promote patient dignity and reduce the burden of travel to a dialysis facility.

How should CMS delineate responsibilities across ESRD facilities, home health agencies, and hospice providers? CMS also seeks comment on the potential future interaction between hospice and home health services for beneficiaries receiving dialysis.

Within current regulations, the dialysis unit is responsible for all things dialysis (including delivery) and cannot delegate any portion of dialysis care to a hospice or home health agency. Moreover, dialysis units are only responsible for delivery of safe dialysis and ESRD management. For example, nursing duties outside dialysis are not performed by a dialysis nurse (e.g., hygiene, colostomy care, wound care). Dialysis units should remain responsible for dialysis care and nothing further, because they cannot be reimbursed and there is no oversight strategy.

To what extent do current Medicare coverage and payment policies affect the ability of beneficiaries to receive home health and hospice services concurrently for different conditions, and how might these policies impact access to and coordination of dialysis services, including in the home setting?

Medicare can cover unrelated home health services while a beneficiary receives ESRD care, but dialysis-related services are excluded from the home health benefit. Thus, there is a gap for patients who need hands-on dialysis assistance rather than a separate intermittent skilled service. Hospice and ESRD benefits can operate separately when the terminal illness is unrelated to kidney failure, but when kidney failure is related, the hospice is expected to cover dialysis within its per diem. MedPAC identifies this as a major access barrier.²⁸

What factors affect the feasibility of integrating hospice and dialysis services, including care planning, payment, and provider roles?

Payment is the largest barrier to integration. Dialysis units can work with any hospice or home health agency on logistics, but each needs to be paid separately.

d. Payment Policy Considerations

To what extent are palliative renal dialysis services currently encompassed within the ESRD PPS bundled payment?

In the event of in-center palliative dialysis, the ESRD PPS covers the necessary renal dialysis services, drugs, laboratory tests, supplies, and equipment. Similarly, traditional home dialysis (without staff assistance) is likely to be adequately covered.

Are there services or supports that are not adequately reflected in current payment?

Staff assistance for home dialysis is not adequately reflected in current payment. Additionally, this population may need greater caregiver training and support as well as transportation needs which are not currently adequately covered

²⁸ https://www.medpac.gov/wp-content/uploads/2026/06/Jun26_Ch5_MedPAC_Report_To_Congress_SEC.pdf

e. Program Integrity and Safeguards

What safeguards are necessary to ensure appropriate targeting and prevent overutilization?

Palliative dialysis must be a voluntary choice made through shared decision making. Each patient when choosing this modality should receive an assessment by the interdisciplinary-team to ensure palliative dialysis fits their stated goals. Periodic or event-driven reassessment of goals, benefits, burdens, and eligibility should also occur. Safeguards must address undertreatment as well as overuse. CMS should require providers to monitor symptom worsening, emergency care, treatment withdrawal, grievances, and patient-reported goal concordance. Additionally, CMS must prohibit incentives to reduce dialysis against the patient's informed preference.

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

CMS should define comfort orientation through the patient's goals and acceptable tradeoffs, not a mandatory reduction in treatment frequency. The dialysis prescription that best relieves symptoms or preserves valued function may differ by patient. CMS should require the care plan to identify comfort objectives such as symptom relief, less travel or recovery time, reduced dietary or monitoring burden, greater time at home, or support for a personally meaningful activity.

What documentation, certification, or care planning requirements would be appropriate?

CMS should require a written plan developed alongside the patient that records the patient's goals, prognosis, intended comfort benefit, dialysis modality and prescription, covered supports, provider roles, medication and symptom responsibilities, and emergency plan. This plan should include a date at which the care team and patient will reassess the plan and ensure it is meeting the stated goals of the patient.

D. Requests for Information on Potential Payment Changes to Support Alternative Dialysis Schedules

Would it be appropriate for the ESRD PPS to adopt a daily payment rate following the methodology currently applied for home CAPD and CCPD (that is, a daily rate equal to three sevenths (3/7) of the per-treatment base rate)? What are the advantages and disadvantages of this approach compared to the current per-treatment payment structure?

NKF's central concern is that the current per-treatment structure reflects a three-times-weekly in-center paradigm and does not reliably support home dialysis payments, specifically for home hemodialysis schedules of four to six treatments per week. Further, some patients may benefit from shorter daily sessions or nocturnal dialysis, both options unsupported by current payment policies. A daily rate could help address that misalignment if it supports clinically appropriate treatment frequency and does not constrain individualized prescriptions. Any change should ensure adequate payment for the additional treatments that constitute a principal clinical and lifestyle advantage of home hemodialysis.

Should a daily rate apply to all dialysis modalities, or are there specific modalities or circumstances for which we should consider a hybrid approach? If we should consider a hybrid approach, please explain why and describe how such an approach should be structured.

CMS should preserve flexibility for different real-world treatment patterns rather than impose a single structure that fits only one modality. The payment framework must accommodate frequent and nocturnal home hemodialysis as well as clinically appropriate treatment models, such as early start PD. A hybrid payment approach may be needed where a uniform daily rate would not reflect the distinct support, treatment, and facility resources used by these models.

To what extent would a daily payment rate reduce barriers to alternative dialysis schedules, such as nocturnal dialysis, short daily home HD, or more frequent home HD? Are there specific treatment modalities or patient populations for which a daily rate would most meaningfully expand access to individualized care?

A daily rate could reduce a major payment barrier if it replaces the current assumption that dialysis is generally furnished three times per week and reliably supports clinically appropriate fourth and additional weekly home hemodialysis (HHD) treatments. That change could make shorter daily, nocturnal, and more frequent HHD more financially sustainable and expand access to individualized schedules. Payment reform should also accommodate hybrid regimens and should be paired with quality oversight that protects the prescribed frequency and intensity of treatment.

Should CMS consider changes to the patient-level adjustment factors under the ESRD PPS to account for conditions associated with differences in the number of medically necessary treatments each month? If so, which patient conditions are the primary drivers of patient-level cost variation, and how should those conditions be reflected in a daily payment framework?

While there are some medical conditions and patient choices that lead to necessary extra treatments, payments for extra treatments should not be limited to any specified list. The decision for additional dialysis should be left to the dialysis providers.

How should CMS design quality monitoring and oversight mechanisms to ensure that a shift to a daily payment rate would not create incentives for providers to reduce the frequency, duration, or intensity of dialysis services below what is clinically appropriate for individual patients? What quality measures, data reporting requirements, or audit mechanisms would be most effective in detecting and deterring underutilization of care under a daily payment structure? We seek comment on whether the current quality monitoring infrastructure, including the ESRD QIP and the Five-Star Quality Rating System, is sufficient to support a transition to a daily payment rate, and whether any enhancements to those programs would be needed.

Quality oversight should protect individualized prescriptions and monitor both clinical and patient reported outcomes. Facilities should report home training starts and completion, time to initiation,

sustained retention, unplanned transfers to in-center care, and disparities in access. CMS should also incorporate patient-reported outcomes, symptom burden, functional status, treatment recovery time, and quality of life. Measures should identify under-support or inappropriate changes in therapy while accounting for patient preference, clinically indicated transitions, hospitalization, transplantation, and temporary interruptions. Current quality systems (ESRD QIP and the Five-Star Quality Rating System) are capable of measuring effectiveness of a transition to a daily payment rate.

What steps could CMS take toward advancing value-based purchasing in ESRD and AKI care? How does the provision of high-quality ESRD and AKI care for Medicare beneficiaries impact costs for ESRD facilities providing renal dialysis services and how does it impact beneficiaries' total cost of care across settings?

CMS can advance value-based purchasing by measuring whether patients receive unbiased modality education, can access their preferred home modality, begin training without avoidable delay, and remain on therapy with appropriate support. CMS will have to recognize that increased spending on value-based care will not immediately produce cost savings. Home dialysis is generally cheaper to provide, but overcoming initial barriers requires greater investment than initializing in-center dialysis.

In summary, the National Kidney Foundation (NKF) expresses our thanks to CMS for working assiduously with the tools and authorities granted to it to improve care for people who rely on dialysis. We believe there is more to do to ensure the ESRD program can meet the need of every patient and family that relies on it while continuing to steward the taxpayer dollar. We look forward to partnering with CMS to advance this lifesaving and life enhancing work.

Sincerely,



Dr. Jesse Roach, MD
Senior Vice President, Government Relations
National Kidney Foundation

Appendix I: Proposed PY 2029 ESRD QIP Measure Visibility in Medicare Advantage (MA)²⁹

Measure	Data Source ³⁰	Visibility in MA
NHSN Bloodstream Infection in Hemodialysis Patients	1. NHSN (for Risk-Adjusted Standardized Infection Rates) 2. ESRD Quality Reporting System (EQRS) 3. Enrollment Data Base (EDB) and other CMS ESRD administrative data 4. Medicare claims (to determine patient-minimum exclusion)	Available
In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey	1. ICH CAHPS Survey 2. EQRS 3. CMS ESRD administrative data	Available
Standardized Readmission Ratio (SRR)	1. Medicare Claims 2. EQRS 3. EDB and other CMS ESRD administrative data	Limited
Standardized Transfusion Ratio (STrR)	1. Medicare Claims 2. EQRS 3. EDB and other CMS ESRD administrative data 4. Long Term Care Minimum Data Set	Limited
Standardized Hospital Ratio (SHR)	1. Medicare Claims 2. EQRS 3. EDB and other CMS ESRD administrative data	Limited
Kt/V Dialysis Adequacy (Comprehensive)	1. EQRS 2. EDB and other CMS ESRD administrative data 3. Medicare Claims	Only when EQRS is reliable; unable to utilize Medicare claims as fallback
Vascular Access Type (VAT) Long-Term Catheter (LTC) Rate	1. EQRS 2. Medicare Claims 3. EDB and other CMS ESRD administrative data	Only when EQRS is reliable; unable to utilize Medicare claims as fallback

²⁹ <https://www.federalregister.gov/d/2026-12925/page-38784>

³⁰ <https://www.cms.gov/files/document/cy-2027-proposed-rule-technical-measure-specifications-072026.pdf>

Hyperphosphatemia	1. EQRS 2. Medicare Claims 3. EDB and other CMS ESRD administrative data	Only when EQRS is reliable; unable to utilize Medicare claims as fallback
Percentage of Prevalent Patients Waitlisted (PPPW)	1. EQRS 2. Organ Procurement and Transplant Network (OPTN) 3. Nursing Home Minimum Dataset 4. Medicare hospice claims data 5. Other CMS ESRD administrative data	Available
Clinical Depression Screening and Follow-Up	1. EQRS 2. EDB and other CMS ESRD administrative data	Only when EQRS is reliable; unable to utilize Medicare claims as fallback