

Statement  
of the  
Alliance for Home Dialysis  
for the  
Committee on Finance  
of the  
U.S. Senate

“Rural Health Care: Supporting Lives and Improving Communities.”

May 16, 2024

The Alliance for Home Dialysis (Alliance) appreciates the opportunity to offer comments specifically regarding home dialysis in rural settings. We, a coalition of kidney dialysis stakeholders representing individuals with kidney failure, clinicians, and providers, have united to advocate for policies that promote and advance treatment choices in dialysis care while addressing systemic barriers limiting access to the numerous benefits of home dialysis.

Home dialysis primarily utilizes two modalities: peritoneal dialysis (PD) and home hemodialysis (HHD). Recognized as a vital treatment option, home dialysis provides individuals with kidney failure significant quality of life advantages, including meaningful improvements in physical and mental health. Moreover, it offers lifestyle benefits such as increased time for family, hobbies, and work, as patients are freed from the necessity of traveling to a clinic—the average end-stage kidney disease (ESKD) patient spends as much as five hours per session, with three sessions each week.

This freedom home dialysis offers is particularly advantageous for rural patients who often face lengthy journeys to dialysis centers. Telehealth is especially important for these patients; home dialysis patients are able to do their monthly visit with their nephrologist from home, thereby avoiding additional travel to doctors’ offices. And, most home dialysis machines are equipped with software to remotely monitor the patient, feeding information to their clinical team in real-time. Moreover, for many patients, regardless of their location, home dialysis can lead to reduced medication requirements, improvements in neuropathy, better sleep, increased energy levels, and the ability to resume traveling or take vacations with family while bringing along

dialysis supplies. Given the substantial benefit of home dialysis, we urge Members of Congress to address barriers that hinder access to home training and therapy.

### ***Kidney Disease Education***

It is crucial that chronic kidney disease (CKD) patients have access to the information they need to make informed decisions regarding their kidney care journey. Currently, Medicare covers up to 6 sessions of kidney disease education services for Stage 4 CKD patients. The benefit is currently underutilized, and we believe that policy changes could help to increase access to this important benefit. First, the Alliance supports eliminating patient cost-sharing<sup>1</sup> in an effort to make KDE more affordable. We also support expanding eligibility<sup>2</sup> through CKD Stages 3b and 5 so that more of the applicable patient population will be able to take advantage KDE. Finally, we support allowing dialysis facilities to provide KDE, with appropriate guardrails. Guardrails must be deployed to prevent patient steering and marketing, the substance of the education should just be clinical education, not information specific to a certain provider or advertising information. CMS should also play a role in approving educational materials or modules before they are deployed. We believe that all of these changes will increase the number of patients able to access KDE, which will then increase patient choice- including the choice to elect home dialysis.

### ***Strengthen the Workforce***

Especially impactful in rural communities, labor shortages persist in the dialysis workforce; inadequate payment updates worsen the problem. Labor shortages affect patient care across the healthcare system. A survey conducted by a leading ESRD patient advocacy organization found nearly two-thirds of patients reported the recent labor shortage had impacted their care, with many experiencing treatment delays.<sup>3</sup> Providers are grappling with higher labor expenses to attract, retain, and train caregivers with the necessary skills for dialysis treatments. The inadequate increase in the ESRD PPS base rate exacerbates this issue. We urge CMS to bolster payments and request Congressional attention to this matter. Additionally, we support the development of a legislative proposal to allow reimbursement for staff-assisted home dialysis, provided healthcare workforce shortages are addressed.

### ***Remove Barriers to Home Dialysis for AKI Patients***

The Alliance has a long track record of advocating for access to home dialysis for acute kidney injury (AKI) patients, including comments to CMS' proposed ESRD Prospective

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<sup>1</sup> Currently, Medicare beneficiaries are responsible for the 20% copay associated with KDE as a Part B benefit. For some beneficiaries, the 20% coinsurance is prohibitive to accessing these important educational services.

<sup>2</sup> Eligible providers of care are limited to physicians, nurse practitioners, physician assistants, clinical nurse specialists, and 'other providers' (defined as hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies or hospices).

<sup>3</sup> Williams, Jackson. (2023). Contributor: Medicare's Leadership Needs to Confront Our Shrinking US Workforce. *American Journal of Managed Care*. <https://www.ajmc.com/view/contributor-medicare-s-leadership-needs-to-confront-our-shrinking-us-workforce>

Payment System (PPS) Rules. Given the clinical and quality of life benefits associated with home dialysis, mentioned above—exponentially impactful for rural patients—the Alliance urges lawmakers to ensure that home modalities be enabled for AKI patients after hospital discharge when their providers agree that the modality is the best treatment option for the patient’s case. While not every AKI patient is an appropriate candidate for home therapy, *all* patients deserve the opportunity to work with their doctor to determine a treatment path that is not limited by payment restrictions on certain modalities.

### ***Stabilize PD Catheter Insertion Procedures***

Timely placement of PD catheters faces systemic barriers, including inadequate physician training and operating room availability. We believe Congress should direct CMS to provide stronger incentives for PD catheter placement, potentially through reimbursement adjustments. Equalizing reimbursement for PD catheters and vascular access procedures could increase home dialysis uptake, and we encourage CMS and Congress to explore this concept.

In conclusion, we are prepared to actively engage with lawmakers on efforts to enhance the lives of CKD and ESKD patients in rural and underserved areas. We encourage you to see the Alliance and our members as eager partners, ready to bring our expertise and resources to the table for these crucial initiatives. Thank you for your attention to the unique needs of rural Americans.