The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8010

Re: CMS-1832-P; Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

The Alliance for Home Dialysis (the Alliance) appreciates the opportunity to comment on the CY 2026 Physician Fee Schedule proposed rule. The Alliance is a coalition of kidney dialysis stakeholders representing individuals with kidney failure, clinicians, providers, and industry. We have come together to promote and advance policies to facilitate treatment choices in dialysis care while addressing barriers that limit access for individuals with kidney failure and their families to the many benefits of home dialysis.

As we stated in our comment to the proposed 2026 ESRD Prospective Payment System rule, we are grateful for President Trump's courageous leadership that prioritized kidney disease treatment in the 45th administration and are eager to work with the 47th administration to continue that principled commitment.

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

Specifically, HHD allows for intensive customization of patient dialysis prescription, including the ability to increase the hours and frequency of treatment; sometimes this is called more frequent dialysis and is known as a gentler option than in-center HD.[1] While a healthy individual's kidneys function 24/7, in-center patients typically receive only 9 to 15 hours per week of renal replacement therapy on average. More frequent home hemodialysis has been shown to provide greater solute clearance, better volume control, and improved nutrition, among other clinical benefits.[2] PD has been shown to improve survival in the first year in nondiabetic individuals with comorbidities and within the first 24 months for nondiabetic individuals over 65 without comorbidities.[3] At 9 years of follow-up, a similar survival between PD and HHD/HD was seen.[4]

Home dialysis also offers significant lifestyle and mental health benefits, including faster recovery after treatment. This enables patients to participate more fully in daily life, continuing to work or attend school, engaging in community and personal activities, pursuing hobbies, and meeting family responsibilities, including caregiving.[5] Individuals with kidney failure are also often able to take fewer medications while dialyzing at home, experience improvements in neuropathy, sleep better, and feel more energetic.[6] Many people who dialyze at home are even able to resume traveling or take vacations with family, bringing along their dialysis supplies.[7]

While we understand that decisions are made related to the ESRD payment bundle through the yearly ESRD PPS, there are many elements of the physician fee schedule that are key to the practice of nephrology and can influence patient ability to access home dialysis therapies. We are pleased to offer the following comments to this year's proposed rule.

I. Medicare Telehealth Services List: Dialysis Codes 90935, 90937, 90945, 90947

The Alliance appreciates CMS' thorough review of the clinical circumstances involved with CPT codes 90935, 90937, 90945, and 90947 and how they could be performed when furnished via telehealth.

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[1] Walker, R. C., Howard, K., & Morton, R. L. (2017). Home hemodialysis: a comprehensive review of patient-centered and economic considerations. *ClinicoEconomics and Outcomes Research*: CEOR, 9, 149–161. https://doi.org/10.2147/CEOR.S69340

[2] *See id*.

[3] François, Karlien & Bargman, Joanne. (2014). Evaluating the benefits of home-based peritoneal dialysis. *International Journal of Nephrology and Renovascular Disease*, 7, 447-455. https://doi.org/10.2147/IJNRD.S50527

[4] *See id*.

[5] Shivakumar, Oshini. (2023). Home Dialysis the Advantages. *National Kidney Federation*. www.kidney.org.uk/home-dialysis-the-advantages

[6] Home Hemodialysis. (2023). *National Kidney Foundation*. https://www.kidney.org/atoz/content/homehemo

[7] Health Equity: Home Dialysis. (2023). *American Kidney Fund*. www.kidneyfund.org/kidney-health-for-all/home-dialysis

As you are aware, in our comments to last year's proposed rule, the Alliance requested that CMS add these codes to the telehealth list for home dialysis patients. At the time, based on advice from our clinician members, we understood that these codes would likely need to be utilized for acute kidney injury (AKI) patients dialyzing at home for the first time post the ESRD PPS rule change allowing this treatment option.

For your reference, the specific language we included is as follows: "In order to properly reimburse for home dialysis in this patient population, we request that CMS clarify that services related to codes 90935, 90937, 90945, and 90947 can be used for home dialysis patients. Currently, the home is not listed in the approved sites of service for these codes, but we understand from our clinician members that these codes are the most likely to be used for AKI patients at home. Therefore, we ask that CMS clarify that this is appropriate."

Now that providers have been able to prescribe and bill for home dialysis services for AKI patients for almost a year, we have determined that CPT codes 90935, 90937, 90945, and 90947 are not as integral as originally anticipated. Instead, most providers are comfortable billing E/M codes 99213, 99214, and 99215, which are already approved for the telehealth setting, for AKI patients using home dialysis modalities.

While we are always supportive of broader access to telehealth services, especially for home dialysis patients who may not be able to easily access a clinic setting, we no longer believe it is essential to include the listed procedure codes for the purpose of ensuring AKI patients can access home dialysis. Again, we thank CMS for their responsiveness to our request in last year's comment letter and appreciate the opportunity to provide more details this year.

II. Streamlining the Medicare Telehealth Services List

The Alliance has consistently supported expanded access to telehealth and remote patient monitoring, which are crucial for patients with end-stage kidney disease (ESKD). In fact, our organization was instrumental in advocating for the change in law that allowed the home to be included as an originating site for the monthly capitated payment visit for dialysis patients. We have also worked extensively with CMS to ensure that patients and providers would have access to telehealth during the public health emergency and after. We appreciate CMS' continued commitment to expanded telehealth so that patients can continue to have access to essential health services even if they are unable to attend a clinic visit in person.

In this year's proposed rule, CMS included changes to streamline how new codes would be added to the Medicare Telehealth Services List. We are broadly supportive of the proposed changes to the 5-step process and appreciate CMS' focus on clinical decision-making and professional judgment in determining when and how telehealth can be appropriate for patients. We also agree that removing the "provisional" status will help to simplify the process and are

pleased to see a number of ESRD related codes moving from provisional to permanent status under this change.

These codes include:

90953	Esrd serv 1 visit p mo <2yrs
90956	Esrd srv 1 visit p mo 2-11
90959	Esrd serv 1 vst p mo 12-19
90962	Esrd serv 1 visit p mo 20+

III. Addressing Chronic Disease in America

The Alliance applauds the Trump administration's focus on preventing and effectively managing chronic disease, including chronic kidney disease (CKD) and ESKD, as seen in the Trump Administration's previous executive order on Kidney Health and current order on the Make America Healthy Again agenda.

ESKD is a pervasive and serious chronic disease that places a significant and growing burden on America's families and the U.S. economy. Taxpayers spend billions in Medicare costs each year, while patients lose years of productive work, educational and community engagement opportunities, and quality time with loved ones. In-center dialysis keeps patients alive, but it limits independence and drains physical and mental strength. Patients often receive only 9 to 15 hours of dialysis a week, the bare minimum renal replacement therapy to survive, leaving them exhausted and ill for hours after each session. This robs individuals of their ability to work, contribute to their communities, and fully participate in family life.

Home dialysis offers a path forward that aligns with the Make America Healthy Again vision. It gives patients control over their health journey and the flexibility to fit treatment into their lives rather than the other way around. At home, patients can work with their providers to build personalized care plans that integrate nutrition guidance, mental health support, and wellness practices. This model strengthens self-reliance, restores quality of life, and supports the prevention of further health decline. By empowering individuals and reducing costly medical complications and hospitalizations, home dialysis allows individuals to contribute economically to their families and communities.

IV. Kidney Disease Education

The Alliance urges CMS to make changes to increase access to the Kidney Disease Education (KDE) benefit. The Alliance has advocated for changes to the KDE benefit that we believe would

increase uptake, and we appreciate CMS's attention to this issue, particularly through finalizing expansions of KDE within the ESRD Treatment Choices (ETC) Model. We believe that there are additional steps, described below, that CMS can take to make KDE more accessible to patients.

i. Waiving the KDE coinsurance requirement

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

ii. KDE access

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

V. The Importance of Supporting Vascular Access Codes

Vascular access is required for both in-center and home hemodialysis patients; options include surgically or percutaneously creating fistulas (connecting an artery to a vein) or less preferred methods like inserting a central line catheter or arteriovenous grafts (AVGs). Simply stated, safe and effective hemodialysis depends on timely vascular access. The Alliance urges CMS to prioritize sustainable reimbursement for vascular access codes.

VI. Incentives for PD Catheter Placement

Currently, PD catheter procedures are generally reimbursed at a much lower rate than fistula creation. We believe that CMS should consider equalizing the reimbursement between PD catheter placement procedures and other vascular access placement procedures. This difference in reimbursement helps to explain a motivation to perform more vascular procedures as opposed to PD catheter insertions. It also raises the question of whether, should the reimbursement be equalized, more PD catheter insertions would be performed.

VII. Adjusting Home Dialysis Related Codes for Inflation

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

KDE: The Alliance urges CMS to consider increasing the payment for HCPCS codes G0420 and G0421, which are used for individual face-to-face education services and group face-to-face education services related to CKD. We understand from our members that by inflationary standards (note that the codes have not been meaningfully updated in about a decade), the codes are not current and should be updated. Further, we believe that the current payment level is not reflective of CMS' commitment to home dialysis. As you are aware, studies have shown that when patients receive education, they are more likely to choose a home modality.[8] A code update could therefore incentivize more KDE, which aligns with CMS' ultimate goal of increasing home dialysis uptake.

Thank you again for your continued commitment to improving access to home dialysis. We appreciate your consideration of our point of view.

Sincerely,

Michelle Seger
Managing Director
Alliance for Home Dialysis

[8] https://pubmed.ncbi.nlm.nih.gov/35801188/

Alliance for Home Dialysis Members

American Association of Kidney Patients
American Kidney Fund
American Nephrology Nurses Association*
American Society of Nephrology*
American Society of Pediatric Nephrology
Centers for Dialysis Care
DaVita*
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Dialysis Patient Citizens*
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