



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

March 9, 2026

Dear Administrator Oz:

The Alliance for Home Dialysis (the Alliance) is a coalition of kidney dialysis stakeholders representing individuals with kidney failure, clinicians, providers, and manufacturers. We have come together to promote and advance policies to facilitate treatment choices in dialysis care while addressing barriers that limit access for individuals with kidney failure and their families to the many benefits of home dialysis. We are grateful for President Trump's courageous leadership that has prioritized kidney disease treatment throughout both of his presidencies. We appreciate the opportunity to continue to work with CMS to advance home dialysis priorities and wanted to provide you with a letter covering many of our 2026 regulatory priorities.

Home dialysis, both peritoneal (PD) and home hemodialysis (HHD), offers important clinical and quality of life advantages, and we appreciate the administration's 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.

In particular, we appreciated CMS' willingness to work with us and take into account the experience of home dialysis advocates as the agency finalized a policy permitting home dialysis for patients with acute kidney injury (AKI). This change gives patients more treatment options and solidifies the importance of clinical decision-making by giving nephrologists more freedom to work with patients on the right treatment pathway for them.

We understand from our members that this change has resulted in an increase in patients electing home dialysis treatment and appreciate CMS enacting this change.

In addition, the Alliance has long advocated for including the home dialysis patient experience in the ICH CAHPS survey or a similar mechanism. We have appreciated collaborating with CMS on further developing this idea over the last year. We are encouraged to see that CMS has also created a dedicated technical expert panel and look forward to seeing the outcomes from that project. We stand ready to continue to collaborate with CMS on patient experience metrics.

### **The Alliance's 2026 Priorities**

#### **Incentivizing PD Catheter Placement**

Several barriers impact timely PD catheter placement, many of which CMS has previously identified, including: 1) challenges scheduling operating room time in the hospital setting for PD catheter placement, 2) the need for additional training on PD catheter placement for both surgeons and interventional nephrologists, and 3) the lack of dedicated PD catheter insertion teams in the hospital setting who can immediately place catheters for patients who “crash” into dialysis and would benefit from urgent start PD. But perhaps the biggest barrier is the low reimbursement for PD catheter placement compared to vascular access procedures. Taken together, these barriers often result in patients who would be good candidates for PD receiving in-center hemodialysis due to factors outside their control.

We encourage CMS to develop a demonstration to test the impact of policy changes on mitigating these barriers. Specifically, the demonstration's design could equalize the reimbursement between PD catheter placement procedures and vascular access placement procedures. As stated above, CMS currently reimburses vascular access procedures at a higher rate, which incentivizes the delivery of more vascular procedures as opposed to PD catheter insertions. It also raises the question of whether equalizing the reimbursement would increase the number of catheter insertions. Equalizing the reimbursement in a demonstration model setting would allow CMS to study how doing so impacts rates of PD catheter placements as compared to vascular access procedures. CMS could also compare rates inside and outside of the model to evaluate whether the payment increase within the model increased the rate of PD catheter placement.

As mentioned briefly above, too many patients in the US are crashing into dialysis, or unexpectedly start dialysis with a visit to an emergency department with little or no

preparative nephrology care. According to one report, as many as 60%<sup>1</sup> of patients crash into dialysis in the hospital, which usually results in poorer outcomes and more expense<sup>2</sup> than a planned start. The Alliance suggests that CMS consider a model with a focus on this patient population, including incentives geared toward hospitals who are willing to prioritize PD catheter placements through urgent start PD programs. Urgent start programs can provide an opportunity for patients who crash to get a PD catheter and start dialyzing almost immediately, or at least within 14 days of placement.<sup>3</sup> While some patients who crash into dialysis are medically frail and not clinically suited for home dialysis, others who would prefer to elect home therapy cannot receive a timely PD catheter placement. Since the majority of patients who begin dialysis in the hospital continue on the same therapy as outpatients, currently mostly in-center hemodialysis, incentivizing immediate PD catheter placement through urgent start PD programs means it's likely that these patients will continue on PD post-discharge. Not only could a program like this incentivize PD catheter placement, but it could also increase home dialysis uptake overall.

Finally, we urge CMS to consider the role of outpatient or stand-alone ambulatory surgery centers in PD catheter placement. Placing PD catheters in this setting can avoid some of the common barriers found in the hospital setting, like issues reserving operating room time. We ask you to be careful not to inadvertently disincentivize PD catheter placement through policies created to impact these outpatient surgical centers.

#### Incentivizing Skilled Nursing Facilities to offer PD

The Alliance understands that all dialysis performed in a skilled nursing facility (SNF) is considered home dialysis, but most patients perform hemodialysis, oftentimes leaving the SNF setting to receive therapy at a dialysis facility three times per week.<sup>4</sup> These patients typically continue to receive in-center treatments post-discharge. We believe there is an opportunity for CMS to incentivize SNFs to work with patients to perform PD when clinically appropriate. PD is advantageous in the SNF setting for a number of reasons, including the fact that PD is often performed overnight, leaving the entire day for patients to spend participating in rehabilitation programs, attending physical therapy, and other activities

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<sup>1</sup> Fresenius Case Study. (2020). CMS.

<https://www.cms.gov/priorities/innovation/media/document/acocasestudy-fresenius>

<sup>2</sup> Azar, A (2024, March 4). US kidney care is broken. But we have the means to fix it. The Hill.

<https://thehill.com/opinion/4507306-us-kidney-care-is-broken-but-we-have-the-means-to-fix-it/>

<sup>3</sup> 11 Vogt, Braden, and Ankur D. Shah. (2024). Urgent-Start Peritoneal Dialysis: Current State and Future Directions. *Kidney and Dialysis* 4, no. 1: 15-26. <https://doi.org/10.3390/kidneydial4010002>

<sup>4</sup> Palace, Z., & Bologa, R. (2015). Development of a Peritoneal Dialysis Program in the Skilled Nursing Facility. HMP Global Learning Network.

<https://www.hmpgloballearningnetwork.com/site/altc/articles/developmentperitoneal-dialysis-program-skilled-nursing-facility>

beneficial to their health and recovery.<sup>5</sup> Further, patients performing PD in a SNF setting would be likely to continue doing so post-discharge, contributing positively to CMS' goal of increasing home dialysis across the board. Finally, incentivizing PD in a SNF could also alleviate some of the workforce burden felt by nurses and other health care professionals in this setting, as we anticipate that PD patients would dialyze mostly independently. It would also reduce the need for costly medical transport.

#### Increasing Kidney Disease Education (KDE)

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 would appreciate CMS's attention to this issue, particularly through finalizing expansions of KDE within the ESRD Treatment Choices (ETC) Model. The model allowed for additional clinical practitioners to provide KDE services under the model and broaden eligibility to beneficiaries with Stage 5 CKD. As you are aware, KDE uptake outside the model has remained low, and we believe that clinical and beneficiary eligibility limitations contribute to this outcome- specifically limitations on both who can provide it and who can receive it.

We have long advocated for applying the expanded KDE benefit outside the ETC model. We believe that KDE is a useful tool for individuals with kidney failure to learn about their disease state, options for treatment, and steps they can take to make sure that home treatment is a good option for them as they progress to ESKD. In addition, we know that kidney failure patients who receive early, comprehensive, and accurate modality education, such as the content provided through KDE, are more likely to choose a home modality.

Therefore, we urge CMS to maintain the ETC's changes to the KDE program in any future models related to increasing home dialysis. One other potential changes CMS could consider in a model environment could be waiving the 20% coinsurance related to KDE, which we understand can be a barrier to patients electing to participate.

In addition, 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

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<sup>5</sup> Id.

requirement that would otherwise be applicable under section 1833(a)(1) of the Social Security Act concerning KDE services for beneficiaries.

ii. 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.

Supporting Digital Tools for Patients

The Alliance has a strong track record of support for the use of technology to better patient lives. For example, our advocacy was instrumental in securing reimbursement for telehealth visits for the monthly capitated payment (MCP) nephrology visit. Since then, we have continued to encourage continued usage of telehealth, through certain audio-only visits, expansion of wireless internet capabilities into rural and remote areas, and remote patient monitoring (RPM).

RPM can allow clinicians to track patient data, like blood pressure, fluid weight, and temperature, in real time from the patient's home. Care teams can intervene immediately should a problem appear, and patients often feel more confident in performing treatment at home because they have a clinical "safety net" that can monitor them from the clinic.

Unfortunately, current CMS policy does not fully reflect the clinical complexity of home dialysis and creates (we believe) unintended barriers to billing for RPM. We ask that CMS clarify that nephrologists billing nephrology MCP codes can also bill for RPM codes when clinically appropriate.

Staff Assisted Home Dialysis

While the Alliance is supportive of potential congressional action to allow for reimbursement for staff assisted home dialysis, we believe all stakeholders, including CMS, should consider its role in advancing home dialysis as a whole. Staff assisted home dialysis offers patients the same clinical and quality of life benefits as traditional home dialysis. It can also provide a way for patients with "physical, mental and psychosocial limitations that make self-care difficult" or those who want to do home hemodialysis but lack a care partner to dialyze at home.

Moreover, staff assisted home dialysis can serve as a “bridge” to fully independent home dialysis; help from a nurse at home for a period of time can increase confidence in the patient and help them get more comfortable performing their treatment so that they can ultimately perform it on their own. Technological advances, like remote patient monitoring and other digital tools, can also couple with staff assisted home dialysis to connect patients to their in-office providers and increase safety and confidence.

Finally, should CMS consider action on staff assisted home dialysis, we urge you to ensure that payment is provided outside of the traditional ESRD PPS bundled payment. This would ensure adequate funding as incorporating it into the bundle would dilute existing resources and require providers to absorb additional responsibilities without sufficient reimbursement.

Thank you for your attention to these important issues. We look forward to working with CMS throughout 2026 on advancing access to home dialysis and appreciate the work the agency has continued to do in this area. In an effort to partner together with CMS, we would also appreciate the opportunity to meet with you in the next few weeks to discuss our priorities in more detail.

Sincerely,

Michelle Seger

Managing Director

Alliance for Home Dialysis

CC: Abigail Ryan, Deputy Director, Division of Chronic Care Management