The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8010

Sept. 14, 2026

Re: CMS-1848-P: Medicare and Medicaid Programs; CY 2027 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 2027 Payment Policies Under the Physician Fee Schedule (PFS) proposed rule. The Alliance is a coalition of kidney dialysis stakeholders representing individuals with kidney failure, clinicians, providers, and manufacturers. We have come together to promote and advance policies to facilitate treatment choices in dialysis care while addressing barriers that limit access for individuals with kidney failure and their families to the many benefits of home dialysis.

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

We are pleased to offer the following comments in response to the proposed PFS rule for 2027. In addition, we have included our answers to a number of questions from the Request for Information (RFI) on home dialysis within the proposed 2027 ESRD Prospective Payment System (PPS) rule that are more appropriate for the PFS context.

Remote Patient Monitoring (RPM) and Remote Technological Monitoring (RTM)

The Alliance understands that CMS is looking at potential policy changes to RPM and RTM broadly. Because our organization is narrowly focused to solutions related to home dialysis uptake and access, we will tailor our comments only to that patient population. We urge CMS to maintain access to RTM and RPM for patients performing dialysis at home regardless of what other policy changes are enacted.

For individuals dialyzing at home, RPM is an essential supportive tool that can help ensure long-term success on a home modality. RPM provides the clinical care team with information directly related to a patient's dialysis treatment, including adherence, ultrafiltration, effective dialysis time, treatment alarms, and other treatment data.[1] This information is available on a cycle-by-cycle and day-by-day basis and can help the care team make timely adjustments to a patient's treatment.[2] This is far more specialized than certain other types of RTM or RPM or consumer devices, like Apple watches or Fitbits.

Specific to home dialysis, a randomized controlled trial of more than 800 patients initiating automated peritoneal dialysis (APD) found lower all-cause and cardiovascular mortality among patients using remote monitoring.[3] The study also found fewer hospitalizations and adverse events related to cardiovascular disease, fluid overload, and insufficient dialysis efficiency.[4] Another study found that RPM was associated with 0.36 fewer hospitalizations per patient-year and 6.57 fewer hospitalization days per patient-year among patients receiving APD.[5] For individuals performing dialysis at home, RPM can therefore make a meaningful positive impact on treatment.

In addition, the clinical intensity related to RPM for home dialysis patients, such as in the case of connected APD (described above) is high. CMS should consider the resources required for clinicians to provide this, and we urge you to provide a payment mechanism for this specialized clinical management that considers all costs associated with software, Wi-Fi connectivity, cybersecurity and other infrastructure, and clinical support (typically physicians and nurses). This all exists independent of the cost of the device.

Specifically, as we have stated in our response to the ESRD PPS Request for Information, current CMS guidance is unclear for when RPM can be concurrently billed. Successful deployment of

RPM requires significant investment in technology by dialysis facilities and requires clinical time and oversight. It would be helpful if CMS could clarify whether and how providers can concurrently bill with other care management codes in the Physician Fee Schedule, specifically in the ESRD space.

Longitudinal Care

The Alliance is supportive of CMS' proposal to transition HCPCS code G2211 from a separate add-on code to a modifier that can be added to the associated E/M base code. We agree with CMS that this change will better recognize the additional work and coordination required when clinicians see complex patients over a period of time. CKD is a long-term, complex, and progressive condition that requires treatment and monitoring over time; the clinical work related to these individuals often extends outside the individual office visit as the care team works to coordinate monitoring, medication management, and communication with multiple specialties. We believe that the proposed change will better recognize the value of longitudinal care and support clinicians in ensuring that patients can be managed clinically over many years. The change could also support earlier intervention and care coordination, which will give patients the opportunity to seek kidney disease education sooner and maintain autonomy when it comes time to make a decision about dialysis. Specific to home dialysis, changes like this can contribute to the culture shift the Alliance often references: the shift in care from a reactive model- where critical decisions are made at the onset of kidney failure- to one that supports earlier education, coordinated care, and patient-centered planning, including consideration of home dialysis and other treatment options

Primary Care

The Alliance is encouraged to see so much focus on primary care in the proposed rule, including the Request for Information. In order to increase home dialysis across the country, patients must have the opportunity to be diagnosed earlier (avoiding so-called "crashes" into dialysis in the emergency room) and have comorbidities addressed. To do this successfully, the broader care team, including primary care, must be involved in the management of patients at risk for kidney disease, individuals living with kidney disease, and individuals who have transitioned into kidney failure and must begin dialysis or receive a transplant.

The following are key elements of a successful primary care strategy:
-identify CKD earlier at the primary care level through routine lab testing
-ensure patients receive timely nephrology referral once diagnosed with CKD
-ensure patients receive timely modality education, ideally beginning at Stage 3b CKD

In addition, individuals with kidney disease often present to primary care more management of comorbidities, like diabetes, hypertension, and heart disease. Kidney screenings could take place during these visits to ensure that kidney function is being adequately monitored. Incentives from CMS could encourage clinicians in the primary care setting to focus on screening, education, and referral to nephrology when appropriate.

We are also encouraged by CMS' focus on SMAs, which can help clinicians deliver quality care in community-based settings, essentially meeting patients where they are. While we do not have specific requests related to this topic at this time, we urge CMS to continue thinking about innovative ways to reach individuals who need care.

ESRD PPS: RFI on Home Dialysis

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

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

The Alliance supports the utilization of RPM as a critical tool for expanding access to home dialysis. In addition to enabling the transmission of treatment and device data, RPM can facilitate timely communication between patients and their care teams, reinforce adherence, and improve clinical oversight without requiring unnecessary travel to the dialysis facility. For patients who are new to home dialysis or who have more complex clinical needs, these capabilities can significantly reduce anxiety during the transition to home therapy. We urge CMS to consider policy changes to Medicare payment structures in the Physician Fee Schedule that can financially support the adoption of RPM across the country.

Current billing guidance is unclear for when RPM can be concurrently billed. Successful deployment of RPM requires significant investment in technology by facilities and requires clinical time and oversight. It would be helpful if CMS could clarify whether and how providers

can concurrently bill with other care management codes in the Physician Fee Schedule, specifically in the ESRD space.

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

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

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

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

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

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

more time before beginning dialysis or needing a transplant, with the opportunity for education and collaboration with the care team.

CMS should support policies that promote stronger coordination between primary care providers and nephrologists throughout the progression of kidney disease. Clear referral pathways, improved communication, and shared accountability between care teams can help ensure that patients are referred to nephrology at an appropriate stage of disease progression, rather than only when kidney failure is imminent. Earlier nephrology involvement provides additional time for risk reduction, education, vascular access planning, and meaningful discussions about treatment options, including home dialysis, transplantation, and conservative care.

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

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

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

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

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

The Alliance believes that several barriers impact timely PD catheter placement, and should all be addressed by CMS. However, we also agree that equalizing payments between PD catheter placement and vascular access placement would be an essential first step to incentivizing more

and quicker placement of PD catheters- and would also likely positively impact the other issues we see in this space, like lack of operating room time, the need for additional training, and exploration of alternative sites of service outside the hospital. Taken together, these barriers often result in patients who would be good candidates for PD receiving in-center hemodialysis due to factors outside their control.

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

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

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

In general, nephrologists work with access specialists to do this, and do not perform the placements themselves. While the managing clinician could establish and maintain these relationships with surgeons and other specialists like radiologists, the ETC Model did not provide direct incentive for these specialists to participate with the managing clinician. Consequently, the ETC Model did not specifically address the providers involved in the placement of PD catheters and their role in encouraging the uptake of home dialysis.

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

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

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

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

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

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

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

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

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

Monthly Capitation Payment (MCP) Structure for Home Dialysis Patients

The Alliance recognizes that the Monthly Capitated Payment (MCP) is an important component of Medicare's approach to supporting and expanding home dialysis. Given the complexity of the policy considerations surrounding the MCP and its potential role in further advancing home dialysis uptake, however, we would welcome the opportunity to continue evaluating these issues and to discuss potential policy recommendations with CMS and other stakeholders at a later date.

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

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

Sincerely,

Michelle Seger
Managing Director
Alliance for Home Dialysis

Alliance for Home Dialysis Members

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