FORUM OF END STAGE RENAL DISEASE NETWORKS

August 21, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1846-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1846-P: Medicare Program; End-Stage Renal Disease (ESRD) Prospective Payment System, Acute Kidney Injury Dialysis (AKI) Payment, and ESRD Quality Incentive Program

Dear Administrator Oz:

The National Forum of ESRD Networks appreciates the opportunity to comment on the changes proposed in CMS-1846-P. We have primarily limited our comments to those sections of the proposed rule that specifically relate to renal dialysis services insofar as they potentially constrain access to care via the impact on the ESRD Quality Incentive Program (QIP) and via aspects of the ESRD PPS payment as published in the Federal Register on June 24, 2026. Keeping in mind the Department of Health and Human Services updated objectives for the Meaningful Measures Initiative 2.0 as a component of the CMS Quality Measurement Action Plan, and the commitment to person-centered care, we have highlighted those changes that can be anticipated to affect quality of care and access to ESRD treatment.

The Kidney Patient Advisory Council (KPAC), a committee of the National Forum of ESRD Networks, represents the voices and lived experiences of people receiving dialysis and living with kidney disease throughout the United States and its territories. KPAC appreciates the opportunity to comment on the Calendar Year 2027 End-Stage Renal Disease Prospective Payment System Proposed Rule.

KPAC also wishes to acknowledge the longstanding and valued relationship between the Centers for Medicare & Medicaid Services (CMS), particularly the Division of Kidney Health, the National Forum of ESRD Networks, and KPAC. Over the years, CMS has consistently welcomed the patient perspective and has shown meaningful respect for the experiences and contributions of KPAC members. We are grateful for the opportunities we have had to participate in discussions that help shape kidney care policy and for CMS's continued willingness to listen directly to people living with kidney disease.

It is in that spirit of partnership that KPAC offers their comments. We support CMS's continued efforts to improve the quality, safety, accessibility, and person-centeredness of dialysis care, and we hope our recommendations will contribute practical patient perspectives to the development of the final rule. Our comments focus on phosphate binder payment, comprehensive phosphorus management, the proposed hyperphosphatemia clinical measure, home and self-dialysis training, and the dialysis workforce.

Thank you for your consideration and commitment to person-centered care along with aligning or reducing quality measures when they are excessive and identifying gaps where new measures may need to be developed. In addition, the KPAC notes that **a policy is not truly patient-centered merely because it measures an outcome. It becomes patient-centered when it gives patients and care teams the tools to improve that outcome.**

Sincerely,

Daniel Landry, DO, FASN, President

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1. **Proposed Update to the ESRD PPS base rate for CY 2027:** The original proposal for CY 2011 was a PPS base rate of $229.63. We recognize the statutory requirements with which CMS must comply regarding the calculation and determination of reimbursement under the ESRD PPS. The present proposal for CY 2027 is for a base rate of $299.55. This represents an increase of $69.92 over a duration of sixteen years. If the proposed increase related to the incorporation of phosphate binders ($15.96) is removed, this leaves an increase of $1.88. If one were to keep up with the most recently available adjusted rate for healthcare inflation since 2011, then the current rate should be $339.44 ignoring all the drugs that have been added to the bundle. Of course, including all those drugs, the rate should have been even higher. If the proposed increase for the incorporation of phosphate binders is removed, then the proposed increase for CY 2027 would be $282.94 far from $339.44. Deviating from inflation too much will be problematic over the long term. The current proposal for CY 2027 represents a 6.3% increase over the current rate for CY 2026 of $281.06; however, without the addition of the increase for phosphate binders, the actual increase is only 0.7%. We have concerns regarding how this will impact independent and hospital-based dialysis providers. We have witnessed the unprecedented closure of facilities across the country, some of which have occurred in locations that serve the most at-risk beneficiaries leading to further exacerbations of health inequities. Staffing of dialysis facilities has seen challenges at every level given the unique multi-disciplinary team of providers that is necessary to provide excellent care to these most medically complex and vulnerable kidney patients.

   ESRD Forum Recommendations:

   - Given the proposed PPS base rate of $299.55, which represents only a modest increase over the rate first finalized for CY 2011, and the recent trend of dialysis facility closures outpacing de novo openings, the Forum is concerned that insufficient reimbursement for dialysis care will only exacerbate dialysis unit closures in areas where the most vulnerable patients receive care. The Forum respectfully requests reconsideration of the PPS base rate adjustment to better reflect the costs of providing dialysis care and to help preserve access for patients who depend on these facilities, particularly in underserved communities. We are especially concerned that, if hospital cost reports are not used to calculate the Wage-Index Budget Neutrality Adjustment for hospital-based facilities, it will be difficult to reconcile the higher expenses these facilities often incur compared with freestanding dialysis clinics. Although hospital-based facilities represent only 4–5% of dialysis clinics in the United States, some currently operate at annual deficits of several million dollars when they do not have privately insured patients.

2. **Incorporation of Phosphate Binders into the ESRD PPS beginning January 1, 2027:** The CY2027 ESRD PPS Proposed Rule has a proposed amount of $15.96 to be added to the base rate for the inclusion of phosphate binders as the 2-year TDAPA period will end on December 31, 2026. The methodology for calculating this amount is contained in the proposed rule which initially uses a total expenditure amount of $269,634,396 based on utilization data between 4/1/2025-12/31/2025, multiplied by 1.06 to account for the $36.41 monthly add-on payment for administrative costs resulting in an adjusted phosphate binder expenditure amount of $285,812,460. This is then divided by the total number of hemodialysis treatments paid for between 4/1/2025-12/31/2025 or 17,733,591. This yields a value of $16.12 which is reduced by the application of the budget neutrality adjustment for the Outlier policy of 1% yielding a final amount of $15.96. Our recommendations follow below.

ESRD Forum Recommendations:

- The Forum acknowledges the statutory requirement for the delayed inclusion of oral-only drugs into the ESRD PPS beginning on January 1, 2025; however, we remain concerned that this will significantly limit the availability of phosphate binders for patients receiving dialysis with facilities looking to control costs and expenditures. We feel that there is a significant potential for unintended consequences that will likely result in the resumption of calcium-based phosphate binders with their inherent risks for increased vascular calcification. This risk is only exacerbated by the recent removal of the calcium measure. We would ask that CMS closely monitor selected laboratory studies (e.g., addition of intact parathyroid hormone and phosphorus, potentially at the clinical measure level) related to achieving optimal bone and mineral metabolism outcomes along with rates of calciphylaxis and parathyroidectomies. Potential avenues could include ESRD QIP measures and/or Network QIAs. These would allow Networks to work with and assist facilities in both monitoring and reporting.
- Although we also note that CMS does not expect the previously finalized proposal concerning Unused/Discarded Amounts of Renal Dialysis Drugs/Biologicals Paid for Under the ESRD PPS to apply to oral phosphate binders, we remain concerned that this measure places an unfunded burden on dialysis facilities currently under significant strain with other data collection mandates while struggling to maintain adequate staffing. Under the current proposal, many facilities—often located in underserved areas—would face a high risk of closure, likely reducing access to care for the most vulnerable patients.
- KPAC appreciates CMS's proposal to incorporate phosphate binders into the ESRD PPS bundled payment. Phosphate binders are important and effective in reducing serum phosphorus, but the scientific literature does not support treating them as a stand-alone solution. Clinical guidelines describe phosphorus lowering as a comprehensive strategy that includes individualized nutrition counseling, appropriate phosphate-lowering medication, and adequate dialysis.[1-3]
- KPAC notes that the finite binding capacity of these medications is an important practical consideration. In a national cross-sectional study of hemodialysis patients, investigators concluded that many binder prescriptions appeared insufficient to maintain phosphorus balance, particularly in the presence of substantial phosphorus intake from processed foods and additives.[4] This evidence should not be interpreted to mean that binders are unimportant. Rather, it confirms that medication cannot reasonably be expected to compensate for every dietary phosphorus load.
- KPAC therefore encourages CMS to protect individualized binder selection and shared clinical decision-making. Patients differ in calcium balance, vascular calcification risk, gastrointestinal tolerance, pill burden, nutritional needs, preferences, and treatment goals. Binder selection should be guided by the patient's clinical circumstances and response to therapy—not by acquisition cost alone.[1-3]
- KPAC feels that calcium-based phosphate binders remain an appropriate treatment option for some patients, but calcium exposure should be considered as part of the treatment decision. KDIGO recommends restricting the dose of calcium-based phosphate binders in adults receiving phosphate-lowering treatment.[1] Randomized trials have raised concern that calcium-containing binders may be associated with greater progression of coronary and aortic calcification than sevelamer in some hemodialysis populations, particularly among patients with existing calcification.[10] Other randomized evidence, including the CARE-2 trial, found similar progression of coronary artery calcification between calcium acetate and sevelamer under conditions of intensive lipid control.[11] Taken together, the evidence supports caution and individualized selection rather than a one-size-fits-all

approach. Payment policy should not create an incentive to default patients to a calcium-based binder solely because it is less expensive.

- KPAC notes that as phosphate binders are fully incorporated into the ESRD PPS bundle, KPAC also encourages CMS to monitor implementation for unintended barriers to individualized treatment. This should include prescribing patterns, medication substitutions, denials, shortages, beneficiary cost-sharing, tolerability, and relevant health outcomes. Payment policy should preserve shared decision-making between patients and clinicians and should not make the least expensive option the automatic first choice when another binder is more appropriate for the individual patient.[12]
- KPAC feels that patient education must extend beyond medication instructions. Patients need practical guidance on phosphorus additives, ingredient labels, portion choices, the timing and purpose of binders, and the importance of completing the prescribed dialysis treatment. A randomized controlled trial found that teaching dialysis patients to identify and avoid phosphorus additives improved label-reading behavior and produced a greater reduction in serum phosphorus than usual care.[5] A systematic review and meta-analysis of seven randomized trials likewise found that educational interventions reduced serum phosphorus, with stronger effects in interventions lasting four months or longer.[6]
- **Finally, KPAC notes that food choices influence how much phosphorus enters the body. Binders reduce how much is absorbed. Dialysis removes what has already been absorbed. Patients need all three parts of the plan.**

3. **Proposed Changes to the Adjuster for the Home and Self-Dialysis Training Add-On Payment:** We gratefully acknowledge the proposal to increase the current home and self-dialysis training add-on payment from $95.60 to $138.22 since this was last updated in the CY 2017 ESRD PPS final rule. CMS is assuming that each session requires 2.66 RN hours with an expected RN hourly wage of $51.96. The current proposal also would allow training sessions to occur during the ONSET period or the first 120 days of ESRD dialysis. This proposed adjustment requires budget neutrality with a proposed adjustment factor of 0.99884. Our recommendations follow below.

   ESRD Forum Recommendations:

   - KPAC supports CMS's proposal to increase the Home and Self-Dialysis Training Add-On Payment from $95.60 to $138.22 and to allow the add-on payment during the first 120 days of ESRD dialysis.[12] High-quality home dialysis training requires sufficient staff time, effective education, hands-on practice, and flexibility to meet different learning needs.
   - KPAC does not believe that effective training must always occur in a one-patient, one-nurse format. Group training may be appropriate for some portions of home dialysis education and can allow patients to learn from one another's questions and experiences while building confidence and peer connection. Other skills and assessments may require individual instruction and evaluation.
   - The important standard should be whether each patient receives enough instruction, practice, reinforcement, and individualized assessment to understand the treatment and perform it safely—not whether every hour of training occurs individually.
   - Training is also the beginning of the home dialysis journey, not the end. Patients may need additional instruction, retraining, troubleshooting support, or clinical guidance as they begin treating at home and as their circumstances change.

- **The goal is not simply for a patient to leave training knowing how to operate a machine. The goal is for the patient to leave believing, with good reason, that they can succeed at home.**
- KPAC appreciates CMS's attention to dialysis labor costs and staffing inputs in the proposed rule. CMS's workforce-related data recognize technicians as a significant component of ESRD facility staffing and compensation.[12] This is important because technical personnel are already a substantial and essential part of dialysis care.
- As CMS continues to promote home dialysis, KPAC encourages consideration of how appropriately trained technical personnel can support patients with non-clinical equipment and operational needs. Technical support may include equipment troubleshooting, replacement parts, water testing within an appropriate scope, inventory and delivery coordination, and other tasks that do not require a nurse's clinical license.
- Thoughtful use of the existing workforce could reduce treatment burden, improve confidence and retention, and allow nurses to devote more time to clinical assessment, education, and care management. **Let nurses do nursing. Let technical staff provide technical support. Let patients spend less of their lives managing the machinery of illness.**

4. **Proposed Expansion of the Low-Volume Payment Adjustment (LVPA):** The CY 2011 ESRD PPS final rule included an LVPA adjustment factor of 18.9% to encourage small facilities to continue providing access to care. This adjustment was applied to facilities performing < 4,000 treatments per year for 3 cost-reporting years. The CY 2016 ESRD PPS final rule updated the adjustment to 23.9%. This update was implemented with budget neutrality along with multiple other changes to the case-mix and facility-level adjusters. In the CY 2021 ESRD PPS final rule, flexibility was allowed due the COVID-19 PHE. The CY 2024 ESRD PPS final rule allowed flexibility in the setting of natural disasters and other emergencies. The CY 2025 ESRD PPS final rule finalized a two-tiered LVPA with a 28.9% adjustment for facilities performing < 3,000 treatments annually with a 18.3% adjustment for those facilities performing 3,000-3,999 treatments annually. The CY 2027 proposed rule is presenting an expansion of the LVPA in response to previous comments along with an RFI and multiple TEPs. The current proposal is expanding the LVPA to 6 tiers, furnishing up to 7,999 treatments annually with budget neutrality. This proposal includes 4 new categories to include 4,000-4,999 treatments annually, 5,000-5,999 treatments annually, 6,000-6,999 treatments annually and 7,000-7,999 treatments annually. Our recommendations follow below.

   ESRD Forum Recommendations:
   - The Forum appreciates CMS' expansion of its graded approach to the Low-Volume Payment Adjustment (LVPA), which recognizes the financial challenges faced by low-volume dialysis clinics and supports efforts to help these facilities maintain access to care for people living in more rural areas. The Forum agrees that preserving access in rural and low-volume settings is an important policy goal, particularly where facility closures could leave patients with few practical alternatives for receiving life-sustaining dialysis care. Nevertheless, the Forum urges caution regarding the potential unintended effects of applying this expansion with budget neutrality, particularly if doing so results in lower reimbursement for large-volume inner-city clinics. These clinics often support the largest number of at-risk dialysis patients, including individuals with complex medical needs, limited transportation options, and fewer resources to absorb disruptions in care. Accordingly, the Forum respectfully requests that CMS consider whether the proposed LVPA expansion and related budget-neutrality adjustments could inadvertently shift

resources away from high-volume facilities serving vulnerable urban populations, and ensure that efforts to strengthen access in rural areas do not unintentionally weaken access for patients in underserved inner-city communities.

5. **Measures for PY2027-2028:** The ESRD Forum acknowledges that the CY 2027 ESRD PPS Proposed Rule does not add, delete, or modify any of the measures finalized in the CY 2026 ESRD PPS Final Rule for PY2027-2028. As we have previously noted, we gratefully acknowledge the ongoing commitment to maintain a meaningful Quality Payment Program for ESRD and have previously commented that the ESRD QIP is in the vanguard of the CMS initiatives for this endeavor to build value-based care in our healthcare system.

   We wish to emphasize that reduction in the regulatory burden and the unique burden of maintaining multiple different reporting requirements each intended to ensure the same quality of care and incentivize excellence, will enhance the ability of all providers to work with the ESRD networks to fulfill their work on behalf of CMS and of the patients, to further enhance quality. Additionally, we wish to emphasize that this central task of the ESRD networks is critically dependent on reliable, accurate, and timely data. Optimizing the parsimonious collection of data to serve multiple purposes will enable achievement of the highest fidelity of the data and allow for timely interventions.

   ESRD Forum Recommendations:

   - We urge CMS to be cognizant of the unfunded regulatory burden on dialysis facilities to track and monitor these many measures, especially independent and hospital-based facilities because they do not often have data managers, or the individuals working for large dialysis organizations that can assist with these functions. The burden for compliance often results in taking dialysis staff away from critical direct patient care activities to perform this extra work. We recommend aligning measures in the QIP with those in DFR, DFC, Core Survey, Network QIAs and the Advancing American Kidney Health initiative to the extent possible. Although the data sources for most of these programs are the same, the burden on facility staff to enter this data into EQRS, and to track all of these measures is quite significant.

   We do have additional comments concerning the Long-term Catheter Rate Clinical Measure, STrR Clinical Measure and the SHR Clinical Measure as follows:

   Long Term Catheter Rate Clinical Measure: CMS previously finalized removal of the Standardized Fistula Ratio (SFR) Measure which we supported. In the current proposed rule, The Long-Term Catheter Rate Clinical Measure remains at 12% of the TPS for PY 2027-2028.

   We do agree that reduction in catheter use in hemodialysis patients overall is beneficial to most dialysis patients, and that Nephrologists play an important role in helping to educate patients and refer patients for appropriate vascular access. We acknowledge the exclusions of patients on Peritoneal Dialysis, patients under hospice care, patients with metastatic cancer, patients with end stage liver disease, and patients with coma or anoxic brain injury in the past 12 months.

   Both the Kidney Patient Advisory Council (KPAC) and Medical Advisory Council (MAC) of the National Forum of ESRD Networks expressed concern that patient choice is not incorporated into this measure, and in keeping with the Meaningful Measures Initiative concept of patient-centered measures that are meaningful to patients, we believe that patient choice can and should

be incorporated into this measure. We believe that the life goals of patients need to be considered when considering which type of vascular access to pursue. At a certain age or time in a patient's life, she/he just may not wish to go through the process of evaluation or await the maturation of an arteriovenous (AV) fistula (AVF) and/or associated multiple revisions in some cases, or for valid clinical reasons may not wish to pursue an AV access including AVF or AV graft (AVG). Furthermore, patients who have been on dialysis for many years and have had many vascular access surgeries may be suffering and choose not to pursue any more vascular surgery. We healthcare providers and payers all should respect our patients'/beneficiaries' life goals and choices.

Also, when considering patient-centered care that safeguards the public, we believe that patients that have exhausted all possible sites for potential AVF or AVG placement will be excluded from these measures. In addition, we believe that patients that have suffered significant complications from AVF or AVG placement in the past, including steal syndrome and patients with severe vascular disease of their hands (gangrene of fingers) affecting the partial or complete use of a limb, should be excluded from this measure. In many of these cases, further attempts of AVF or AVG placement may jeopardize the health of our patients, and we don't believe the CMS should incentivize facilities to pursue further potentially harmful interventions for these patients. Keeping our patients safe is one of our primary goals, and we also feel that avoiding unnecessary or potentially dangerous vascular access surgeries in some patients is best for certain beneficiaries and should be considered in the measure. For example, in patients with severe cardiovascular disease, in whom the risk of undergoing AV access surgery exceeds the possible benefit, patients should be excluded from this measure. In addition, there are patients in whom the vascular surgeon has determined there are no viable vessels for AV access. In these patients, attempting to place AV access may lead to unnecessary and preventable harm to beneficiaries. There are also many patients with medical or psychiatric contraindications to having AV access used on dialysis, such as some patients with schizophrenia or other psychiatric disorders in which use of an AV access on dialysis could potentially be dangerous. In these patients, a catheter may be the safest option.

In general, we believe that well-informed patient choice is critical when considering placement of AV accesses. The appropriate access needs to be individualized for each patient based on both patient choice and the safest option. The recently released KDOQI guidelines also focus on choosing the most appropriate vascular access for each patient.

ESRD Forum Recommendations:

- The Forum would recommend excluding patients from the denominator that have exhausted most to all potential sites for AVF or AVG placement, or in whom there are no viable vessels for AVF or AVG placement from these measures. We believe that facilities can report such patients in EQRS if a checkbox to indicate such patients is added.
- We recommend excluding patients from the denominator that have suffered severe steal syndrome affecting the partial or complete use of a limb.
- We also recommend excluding patients with conditions such as severe congestive heart failure, severe psychiatric illness, or other conditions in which the risk of surgery to place AV access, or use of AV access on dialysis is deemed to be unacceptable by their Physician. We believe that facilities can report such patients in EQRS if a checkbox to indicate such patients is added.
- We recommend excluding patients from the denominator that refuse consideration of AVF or AVG placement or use, despite >2 attempts spanning a 3-month period at

education on the risks of catheters and benefits of AVF or AVG by their+ Nephrologist and RN. Educational attempts should be documented by having the patients sign forms indicating that they have been informed and declining that option after repeated education has been completed. The patient's declination should be indicated by documentation in EQRS. We believe that facilities can report such patients in EQRS if a checkbox to indicate patient refusal was added.

- For such patients that would be excluded from the denominator due to the patient's informed decision not to have AV access, we also recommend requiring facilities to continue attempts at education on the risks of catheters and benefits of AVF or AVG by their Nephrologist and RN at least annually. This ongoing education attempt could be indicated by an additional checkbox in EQRS.
- We believe including the above exclusions would help achieve the goal of making these measures more patient-centered and meaningful and would help to safeguard the health of ESRD patients.
- Our recommendations align with the updated KDOQI Vascular Access Guidelines, which emphasize that a patient's access needs stem from the creation of an individualized ESKD life-plan. Rather than a "fistula-first, catheter-last" approach, the guideline reflects that the "right" vascular access is different for every patient.

STrR Clinical Measure: The ESRD Forum acknowledges the statutory requirement for the ESRD QIP to include an anemia measure. The Forum also believes that blood transfusions are significant clinical outcomes for dialysis patients. However, the Forum does not believe that blood transfusions are an accurate reflection of anemia management in the dialysis facility. Most blood transfusions result from a patient suffering from a GI bleed or following surgery. Also, most blood transfusions happen outside of the dialysis unit, and it often becomes difficult to determine if a patient has received a transfusion. Inadequate anemia treatment with ESAs or intravenous iron does not always result in patients requiring blood transfusions. The Forum also is concerned that excessive treatment with intravenous iron to treat anemia may result in worse outcomes for dialysis patients, as evidenced by DOPPS data. The Forum believes that direct measurement of hemoglobin levels which are already reported in EQRS would not be an additional burden on dialysis facilities, would meet the statutory requirement to include anemia measures in the QIP, and would most accurately reflect day to day anemia management in dialysis facilities.

ESRD Forum Recommendations:

- Replace STrR clinical measure with anemia measure including Hemoglobin level. We would recommend either using a clinically significant minimum hemoglobin measure such as <9.0 g/dL or a range of hemoglobin levels such as % of hemoglobin levels between 9.0-11.5 g/dL.
- Consider also monitoring iron including ferritin levels to ensure dialysis facilities are not overtreating patients with IV iron which may be harmful. One measure to consider would be % of patients with ferritin level >1,000 ng/mL in patients who received IV iron on date after the level (exclude patients not receiving IV iron, or patients who had their IV iron held when ferritin level was high)

SHR Clinical Measure: The ESRD Forum acknowledges that hospitalizations are significant outcomes for patients on dialysis and lead to increased cost of the Medicare program. We applaud efforts by CMS to try to decrease hospitalizations. However, the Forum believes that dialysis facilities only have the ability to impact certain hospitalizations, but not all

hospitalizations. If dialysis facilities attempt to have patients avoid clinically indicated hospitalizations it may result in patient harm. The ESRD Networks worked with CMS previously to track hospitalizations in dialysis patients related to diagnoses we believed were relevant to dialysis facilities. Included in these diagnoses are hospitalizations related to volume overload and dialysis-related infections as examples.

ESRD Forum Recommendations:

- Limit the SHR Clinical Measure to diagnoses that dialysis facilities may be able to impact, including those that ESRD Networks were tracking.

6. **Additional Measures for PY2027:** While the Forum recognizes that this year's proposed rule makes no changes to the QIP, the Forum would like to take the opportunity to offer suggestions for future rule changes based upon current and prior concerns for best practices to assess dialysis clinic quality of care:

   a. **Replacement of the Dialysis Adequacy Comprehensive Clinical Measure with a Kt/V Dialysis Adequacy Measure Topic:** We understand the statutory requirement for the ESRD QIP to evaluate facilities based on dialysis adequacy. CMS is proposing to remove the Dialysis Adequacy Comprehensive Clinical Measure under previously finalized Measure Removal Factor 5 in that a more optimal measure exists. The proposal is to use a Kt/V Dialysis Adequacy Measure Topic that would use four individual Kt/V measures with individual performance standards if applicable to a given facility. These would include an Adult HD Kt/V, Adult PD Kt/V, Pediatric HD Kt/V and Pediatric PD Kt/V. CMS has provided data in this year's proposed rule that when looking at PY 2024 reflecting performance year 2022, the number of eligible (> qualifying patients) facilities using these individual metrics have significantly increased compared to when the Comprehensive Measure was enacted in the CY 2016 ESRD PPS Final Rule replacing a Kt/V Dialysis Adequacy Measure Topic being used since CY2013 at that time. Pediatric HD facilities have increased from three to twenty-one while Pediatric PD facilities have increased from six to twenty-eight. Adult HD facilities have increased from 6,117 to 6,793 while Adult PD facilities have increased from 1,402 to 2,538. The intention in 2016 was to increase the number of facilities that would be eligible for measure scoring thereby allowing the evaluation of care provided to a greater number of ESRD patients. The total weight of the measure would remain unchanged at 11% of a facility's TPS.

   ESRD Forum Recommendations:

   - The Forum would like to take this opportunity to advocate for a consideration of including a measurement of residual kidney function (RKF) when appropriate in the determination of the HD Kt/V. Failure to take adequate RKF into account can lead to the unintended consequence of prescribing a greater duration of HD than is actually required resulting in a more rapid loss of RKF with decreased survival and other poorer outcomes. In addition, we would like to acknowledge the role that incremental dialysis can play in the preservation of RKF with the aforementioned benefits. Not only is this also an important approach to patient care with respect to consideration for prolongation of RKF, it is also a critical approach to improving person-centered care.

   b. **Removal of the NHSN Dialysis Event (DE) Reporting Measure:** The NHSN DE Reporting Measure was first introduced in the CY 2012 ESRD PPS Final Rule. At that time, it was felt that reporting dialysis events to the NHSN by all facilities supported the national

goals for patient safety including a reduction in Hospital Acquired Infections. In the CY 2014 ESRD PPS Final Rule, this reporting measure was replaced with the NHSN Bloodstream Infection (BSI) Reporting measure to hold facilities accountable for monitoring and preventing infections in dialysis patients. The CY 2017 ESRD PPS Final Rule reintroduced the NHSN DE Reporting Measure to incentivize facilities to report complete and accurate monthly DE data in compliance with the NHSN DE protocol. Eligible facilities are now reporting NHSN DE measure data annually and consistently. The proposal is to remove this reporting measure under Measure Removal Factor 1 in that it no longer discriminates meaningful differences in performance between facilities.

ESRD Forum Recommendations:

- The Forum supports these previous changes.
- While the Forum supports removal of the NHSN Dialysis Event Reporting Measure, the Forum does remain concerned about the burden on dialysis facilities in reporting to NHSN for the NHSN BSI Clinical Measure. There is a significant amount of work and time involved for dialysis staff to report each month to NHSN. Currently, if a dialysis facility fails to report to NHSN on only 1 out of 12 months (reports successfully on 11 out of 12 months), the dialysis facility will receive a score of 0 on this measure, even if their clinical performance in this measure is excellent.
- The current NHSN BSI Clinical Measure currently includes all positive blood cultures in the numerator including positive blood cultures from contaminants, and infections not related to dialysis including osteomyelitis, urinary tract infections, pneumonias and other infections. The Forum believes that if this measure is optimally measuring care in the dialysis facility, it should be limited to dialysis-related BSIs including catheter related BSIs and access related BSIs.
- The Forum recommends limiting this measure to only catheter- related BSIs and access-related BSIs and excluding contaminants and sources other than catheters or dialysis access.
- The Forum also recommends that BSI reporting data be included in EQRS instead of NHSN to lessen the burden of dialysis facilities reporting to 2 separate sites.
- The Forum is also concerned that dialysis facilities may not accurately report BSIs to NHSN, and therefore this measure may not be an accurate measure of actual BSIs in dialysis facilities.
- The Forum recommends CMS consider utilizing claims data from Medicare and Medicare Advantage plans including claims for catheter-related BSIs (outpatient), and access-related BSIs instead of using facility reporting for this measure.

c. We do feel that data collection regarding race and ethnicity is important for the purposes of monitoring health outcomes given the recognition that health disparities and socioeconomic disadvantages do exist to higher degrees in certain populations.

7. **POST-TDAPA Add-On Payment for CY 2027:** We gratefully acknowledge the fact that a post-TDAPA add-on payment was finalized in the CY 2024 ESRD PPS Final Rule to be applied to all ESRD PPS payments for 3 years, not budget neutral beginning in January 2024. Korsuva® (difekalin) is receiving a post-TDAPA add-on payment from January 1, 2026-December 31, 2026, of $0.26 per treatment and is proposed to continue a payment of $0.11 per treatment in CY 2027. Defencath® (taurolidine/heparin sodium) is receiving a post-TDAPA add-on payment per treatment from July 1, 2026-December 31,2026 of $1.48 per treatment and is proposed to continue a payment of $5.60 per treatment in CY 2027. Vafseo® (vadadustat) is proposed to

begin a post-TDAPA add-on payment for CY 2027 of $0.94 per treatment when TDAPA ends on December 31, 2026. Our recommendations follow below.

ESRD Forum Recommendations:

- The Forum is appreciative of CMS' finalization of a post-TDAPA add-on payment but feels that the adjustment value will have little impact on making this medication available to those most in need of it. As described above, the Forum is concerned that the TDAPA period used to assess medication utilization is too short and does not accurately reflect the number of patients who have appropriate indications for new, innovative therapies that could impact quality of life and physical well-being. In addition, the Forum is concerned that home dialysis patients (who often require more frequent dosing of some affected therapies under TDAPA) may be impacted disproportionately. If these patients have less access to more novel therapies, it could disincentivize the adoption of home-based therapies. There should be continued monitoring of the degree of use of drugs post TDAPA. If a drug is suddenly shown to be more beneficial post-TDAPA, then facilities may be resistant to using it because of prohibitive cost concerns, (e.g. Defencath, if shown to decrease infection rates significantly, may have a much wider utility after it is post-TDAPA).

8. **Measures for PY2029:** The ESRD Forum acknowledges the proposed changes to the ESRD QIP in the CY 2027 ESRD PPS proposed rule and our responses and recommendations concerning the proposed changes are below.

   a. **Proposed Replacement of the Hypercalcemia Reporting Measure with the Facility-Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients (Hyperphosphatemia) Clinical Measure:** We understand the statutory requirement to include a measure of bone mineral metabolism in the ESRD QIP. The Hypercalcemia clinical measure was adopted in the CY 2014 ESRD PPS final rule and was converted to a reporting measure in the CY 2023 ESRD PPS final rule. There were concerns that the Hypercalcemia measure was approaching being "topped out" and this year's proposed rule acknowledges this along with many other concerns raised in previous proposed rule comments. The proposal is to replace this measure with the Hyperphosphatemia clinical measure with removal of the Hypercalcemia measure under measure removal factor 5. As stated in the proposed rule, the Hyperphosphatemia clinical measure will"…more directly assess patient-focused clinical outcomes." This will measure the percentage of adult patients to include those receiving in-center hemodialysis, home hemodialysis, hemodiafiltration and peritoneal dialysis with a 6-month rolling average serum phosphorus > 6.5 mg/dL. The equation for each facility will measure: (number of patient reporting months with phosphorus average > 6.5 divided by the total number of patient reporting months for the facility) x 100. Proposed exclusions include a 6-month rolling average serum albumin < 3.5 mg/dL or a BMI < 18.5. The measure was endorsed by the Partnership for Quality Measurement.

   ESRD Forum Recommendations:

   - KPAC supports CMS's focus on chronic hyperphosphatemia as an important patient outcome. Persistent hyperphosphatemia is part of the broader CKD-mineral and bone disorder syndrome, which includes laboratory abnormalities, bone disease, and vascular calcification.[1,2][12]
   - KPAC notes that measurement alone will not improve phosphorus control. A facility may know that a patient's phosphorus is elevated without understanding why it remains

elevated. The measure should serve as a trigger for meaningful assessment and intervention, including review of food access and dietary phosphorus sources, binder choice and tolerability, medication burden, treatment attendance and completion, dialysis prescription, nutrition risk, health literacy, and the patient's own priorities.

- KPAC feels that dialysis time and prescription matter. Studies have demonstrated that longer dialysis sessions increase phosphate removal, including a study in which phosphate removal increased when treatment time was extended and another in which extended dialysis removed approximately 40 percent more phosphate than conventional dialysis despite similar urea-based adequacy.[7,8] These findings support counseling patients to complete prescribed treatments and remind policymakers that phosphorus control cannot be judged solely through medication use or a urea-based adequacy target.
- KPAC recommends that CMS encourage facilities to pair the measure with individualized nutrition counseling, medication review, adequate dialysis, and sustained education. Education should be considered successful when the patient understands the plan, can apply it in daily life, and receives support when barriers make the plan difficult.
- KPAC wants to emphasize **not using the phosphorus number to blame the patient. Use the number to begin the conversation, identify the barrier, and improve the care.**
- KPAC wishes to highlight that the evidence supports treating patient education as part of clinical care rather than as an administrative task. The KDOQI Nutrition Guideline supports individualized medical nutrition therapy and attention to phosphorus sources and bioavailability.[3] Randomized trials and systematic reviews demonstrate that sustained, practical education can improve knowledge, behavior, and serum phosphorus.[5,6,9]
- KPAC notes that CMS should encourage facilities to evaluate whether patients were given understandable information, whether they can explain how their treatment works, and whether they received help applying that information within the realities of their lives. Documentation that a handout was provided is not evidence that education occurred. **Education is not complete when information is delivered. Education is complete when the patient understands what to do, why it matters, and how to make it work in real life.**
- For patients, phosphorus management is not an abstract laboratory issue. Poorly controlled mineral and bone disorder can affect bones, blood vessels, cardiovascular health, mobility, treatment options, and quality of life. One KPAC member experienced the cancellation of a planned kidney transplant because extensive vascular calcification prevented the transplant from proceeding. That experience cannot establish that a particular binder, medication, or behavior caused the calcification, and the scientific evidence does not support making that conclusion. It does, however, demonstrate why calcium exposure, phosphorus control, vascular calcification risk, medication choice, nutrition, and dialysis adequacy deserve thoughtful attention over time. Patients should have access to the binder that is clinically appropriate for their circumstances, together with understandable information about the benefits, limitations, and risks of their treatment options.
- Patients should not learn only after a crisis that phosphorus, calcium balance, food additives, dialysis time, and medication choices may have serious long-term consequences. CMS has an opportunity to encourage a more complete and understandable model of phosphorus care.
- **Patients deserve more than a prescription and a warning. They deserve an understandable plan, a fair chance to follow it, and help when the plan is not working.**

- **KPAC respectfully recommends that CMS:**
  - Implement phosphate binder payment in a manner that protects access to the clinically appropriate medication for each patient and does not create a cost-driven default toward one binder class.
  - Monitor implementation of bundled phosphate binder payment for prescribing shifts, substitutions, denials, shortages, beneficiary cost-sharing, tolerability, and patient outcomes.
  - Recognize diet, medication, and adequate dialysis as complementary components of phosphorus management.
  - Pair the proposed hyperphosphatemia measure with education, individualized assessment, and barrier resolution rather than blame.
  - Encourage sustained, practical patient education and evaluate whether patients understand and can apply what they have learned.
  - Support the proposed increase in home and self-dialysis training payment and explore structured support after training.
  - Consider how the existing technical workforce can reduce non-clinical burdens for home dialysis patients while preserving nursing time for clinical care.
- KPAC offers these recommendations in the spirit of collaboration and with a shared commitment to improving kidney care for the people who depend on it every day.
- We believe that thoughtful payment policy, meaningful patient education, individualized care, and practical support can work together to improve outcomes and make the experience of living with kidney disease more manageable.
- We appreciate the opportunity to contribute the patient perspective to this important work and look forward to continuing the conversation with CMS as these policies move forward.
- A better phosphorus policy will not ask patients to carry the entire burden. It will align payment, clinical care, education, dialysis, and practical support around the patient.
- **A better phosphorus policy will not ask patients to carry the entire burden. It will align payment, clinical care, education, dialysis, and practical support around the patient.**

9. **RFI on the Inclusion of a Patient Reported Outcome Performance Measure (PRO-PM) in the ESRD QIP:** The ESRD Forum acknowledges the RFI related to the ESRD QIP in this year's proposed rule. CMS is seeking feedback on the potential future inclusion of a Dialysis Facility Discussion of Patient Life Goals (D-PaLS) PRO-PM in the ESRD QIP. The proposed rule notes that a discussion of life goals is desired by patients and is not routinely occurring. This proposed measure would align with CMS/HHS priorities to empower beneficiaries, strengthen Shared Decision Making (SDM) and improve health outcomes through person-centered care. CMS notes that the survey, as proposed, has 8 items and should take approximately 2 minutes to complete. The items include: 1. Whether at least one member of the dialysis care team knows about the patient's life goals; 2. Whether the patient believes it is important that a member of the care team discusses life goals with them; 3. Whether the patient's treatment plan is consistent with their life goals; 4. Whether a member of the care team talks with the patient about their life goals; 5. Whether the patient is comfortable discussing changes in life goals with a member of the care team; 6. Whether a member of the care team helps the patient meet their life goals. These six items are used to generate a patient-level quality of facility care team discussion quality score. The population to be included is all adults (>18 years old) on chronic dialysis at the time of the survey and includes all payer types. Higher scores (1-5) indicate greater patient agreement that the dialysis care team engages in discussions about the patient's life goals and treatment

planning. The D-PaLS PRO-PM is not intended to evaluate individual life goals or whether the patients achieve those goals; but to reflect the percentage of patients at a facility who report at least average satisfaction with discussions about life goals with their dialysis care team and the subsequent incorporation of those discussions into treatment planning. CMS includes multiple questions in the proposed rule covering this proposed PRO-PM and our recommendations are below.

ESRD Forum Recommendations:

- The Forum believes that understanding and discussing a dialysis patient's life goals is essential to delivering patient-centered care with dignity and respect. We recognize that adding this expectation may increase the workload for social workers, who are increasingly difficult to recruit and retain in dialysis facilities. However, this remains a core element of high-quality patient care. Accordingly, the Forum asks CMS to ensure that any new life-goals questionnaire requirement is balanced by reducing social work burden elsewhere. In future iterations, life-goal assessments could also inform other quality metrics. For example, when a patient's goals are more limited, it may be appropriate to consider whether AV access placement or transplant referral would meaningfully benefit the patient, rather than simply serving to satisfy a quality measure.
- The Forum respectfully asks CMS to also reconsider the changes made in last year's rule that removed patient feedback from the ICH CAHPS survey regarding care provided by their kidney doctor. Capturing patients' perspectives on nephrologist communication, trust, and overall care is an important component of assessing dialysis quality and aligns with the QIP's statutory focus on patient experience. The Forum also recommends that the survey include home dialysis and peritoneal dialysis patients, be shortened to approximately 10 highly relevant questions, and be administered more frequently—at least quarterly—using accessible formats such as a smartphone application or other easy-to-use platform. The questions should provide a concise but meaningful overview of how patients perceive care from both the dialysis facility and their nephrology providers, including global ratings of the facility, staff, and nephrology providers, along with questions about likelihood to recommend the facility or provider and whether patients feel safe during treatment. Finally, the Forum urges CMS leadership to work with dialysis patient organizations, including the Forum KPAC, as well as nephrologist dialysis experts, to identify the most pertinent questions for inclusion in the survey.
- KPAC supports CMS's consideration of the Dialysis Facility Discussion of Patient Life Goals (D-PaLS) patient-reported outcome performance measure. Asking patients about the lives they want to lead is an important step toward person-centered care. However, patients also want providers to ask whether the treatment they are receiving is helping them feel well enough to pursue those goals.
- KPAC believes that a meaningful patient-reported outcome measure should extend beyond whether a conversation about life goals occurred. Patients should also be asked about their treatment experience, including:
  - How they feel during and after dialysis.
  - Whether treatment causes pain, cramping, severe fatigue, dizziness, nausea, anxiety, or other symptoms.
  - Whether the treatment schedule or prescription interferes with work, family responsibilities, sleep, mobility, or quality of life.
  - Whether concerns raised by the patient were investigated and addressed.
  - Whether changes were offered to improve comfort, recovery time, and the patient's ability to function after treatment.

- KPAC feels that patients cannot fully pursue their life goals when dialysis consistently leaves them too sick, weak, or exhausted to participate in daily life. CMS should encourage facilities to connect life-goal discussions with a review of whether the dialysis prescription, symptom management, treatment schedule, and clinical support are helping the patient live as well as possible.
- **KPAC notes that life-goal discussions should not become another documented conversation without action. Patients want care teams to understand their goals, deliver treatment that helps them feel well enough to pursue those goals, and respond when treatment itself becomes a barrier.**
- KPAC wants to replace blame with barrier identification and problem-solving.
  - KPAC is concerned about a persistent culture in which patients may feel blamed for missed or shortened dialysis treatments and the poor outcomes that can follow. Accountability is important, but blame does not identify or resolve the reason a patient is unable to attend or complete treatment.
  - Facilities should be expected to explore the underlying causes of missed or shortened treatments in partnership with the patient. Causes may include transportation problems, work or caregiving responsibilities, treatment-related pain or severe symptoms, depression, anxiety, distrust, scheduling barriers, housing instability, financial hardship, or previous negative experiences with care.
  - Rather than documenting nonadherence and stopping there, the interdisciplinary team should ask: **What is making it difficult for this patient to attend or complete treatment, and what can we do together to remove that barrier?**
  - CMS should encourage a supportive, problem-solving approach that helps patients receive the treatment they need, feel better afterward, and remain healthy enough to accomplish the goals that matter to them.
- KPAC notes that we need to make shared clinical decision-making continuous and honest.
  - Shared decision-making should occur throughout the kidney care continuum, not only when a patient selects a dialysis modality. Patients need full, balanced, understandable information about medications, vascular access, transplant, home and in-center dialysis, supportive care, and conservative management.
  - Patients should be told both the potential benefits and the limitations of treatment options. Truth builds trust. Patients should not discover important information later through social media, waiting-room conversations, or a medical crisis.
  - Annual care planning should include the patient's goals and priorities, whether the patient understood the plan, whether the patient's concerns were discussed, and whether the patient received a clear summary in understandable language.

10. RFI on Advancing Alternative Dialysis Care in Association with Executive Order 13879: EO 13879, Advancing American Kidney Health, was issued on July 10, 2019, and directed Federal agencies to advance policies that would increase patient choice through affordable alternative treatments for ESRD. The CY 2027 ESRD PPS proposed rule notes that the majority of dialysis patients continue to receive their treatments three times per week in an outpatient dialysis facility. CMS is soliciting public comment on three areas where potential payment and coverage policy changes could better align the ESRD PPS and AKI payment frameworks with the goals of E.O. 13879 and the evolving needs of ESRD beneficiaries. The specific areas of interest include: 1. Policies to promote greater use of home dialysis among Medicare beneficiaries; 2. Approaches to strengthen care continuity and expand beneficiary choice of renal dialysis services that could be considered palliative care for beneficiaries approaching end-of-

life; 3. Changes to the ESRD PPS to support greater flexibility for patients and nephrologists to use alternative dialysis schedules. Our recommendations concerning each of these areas of interest and the numerous topics in each area follow below.

a. **RFI on Increasing Home Dialysis Uptake:** The proposed rule is soliciting comments under multiple sections that will facilitate measuring home dialysis use in incident patients initiating home dialysis for > 60 days. The topics of interest include: Patient-level barriers, Kidney-Disease Education, Home Dialysis training and workforce capacity, Temporary and Staff-Assisted dialysis, Payment alignment to include the addition of incentives within the ESRD PPS and the ESRD PPS Cost Report, Home Dialysis machine installation along with Home Medications and Supply Chain issues, Incentives for In-Center Self-Dialysis programs, Increasing the number of facilities offering Home Dialysis, the incorporation of payment incentives within the Physician Fee Schedule and the Outpatient Prospective Payment System to impact access placement, patient referral and physician participation in home dialysis training, Changes to the Monthly Capitation Payment (MCP) structure for Home Dialysis patients, Use of PD in Skilled Nursing Facilities and Transitional settings, Measuring success. CMS includes multiple questions in the proposed rule covering these numerous topics. The Kidney Patient Advisory Council (KPAC) of the National Forum of ESRD Networks appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information on advancing dialysis care. KPAC represents the voices and lived experiences of people receiving dialysis and living with kidney disease across the United States and its territories. Our recommendations reflect recurring concerns raised by patients and families, as well as the practical lessons of people who manage kidney disease and dialysis every day. KPAC supports CMS's interest in increasing home dialysis utilization, improving access to palliative care, strengthening shared decision-making, and incorporating patient-reported outcomes into quality measurement. We encourage CMS to evaluate success not only by whether a service was offered or a conversation was documented, but by whether patients understood their choices, received treatment that helped them function, overcame barriers to care, and were able to pursue the goals that mattered to them.

ESRD Forum Recommendations:

- The Forum appreciates CMS’s continued focus on expanding home dialysis utilization and supports efforts to promote policies that make home therapies more accessible to patients. However, meaningful and inclusive growth in home dialysis will require more than encouraging modality choice; it will require patient-level support that directly addresses the practical, financial, educational, and social barriers that prevent many patients—particularly those with fewer financial resources or less family support—from succeeding at home. To ensure that vulnerable dialysis patients have the same opportunity to benefit from home therapies as patients with more robust resources, the Forum encourages CMS to consider the following barriers and support measures:
  - Expand and strengthen pre-dialysis education, including consideration of a longer education window, such as 90 days rather than 60 days, to allow the dialysis team time to better understand each patient’s needs, home environment, and available support system.
  - Address barriers related to living environment and available space, as many patients and families may decline home dialysis because they do not have sufficient room to store supplies or safely perform treatment at home.

- Reduce quality-of-life and travel barriers for home dialysis patients. Although patients are often told that home dialysis can make travel easier, many continue to face logistical and financial obstacles when traveling with supplies or equipment. Additional support, including coordination with airlines, cruise lines, and other travel providers, could help home therapy better deliver on its promised quality-of-life benefits.
- Increase support for patients who lack reliable assistance at home. The Forum believes that limited home support remains one of the most significant barriers to home dialysis acceptance and success and strongly encourages CMS to support staff-assisted home dialysis and consider streamlining requirements for solo home hemodialysis where clinically appropriate.
- Plan for the future availability of emerging dialysis therapies in the home setting. As hemodiafiltration becomes more widely available for in-center patients and is associated with improved outcomes, including reductions in all-cause mortality, CMS should consider pathways to make comparable advances available in the home setting so that home dialysis does not become less attractive over time.

- **The KPAC recommendations that follow are organized around a simple principle: kidney care should help patients live as well as possible, not merely complete the tasks of treatment.**

- **Detect CKD Earlier and Connect Diagnosis to Action**
  - Too many patients first learn that they have chronic kidney disease (CKD) when kidney failure is approaching or when dialysis is imminent. Earlier identification can create time for kidney-protective treatment, medication review, lifestyle support, informed decision-making, and preparation for future care.
  - KPAC recommends that CMS explore financial and quality-based incentives that encourage primary care providers to identify CKD earlier among patients at increased risk, including people with diabetes, hypertension, cardiovascular disease, a family history of kidney disease, and other recognized risk factors. Incentives should be tied to a complete kidney health evaluation, appropriate repeat testing, communication of results, and a documented follow-up plan—not merely to placing a CKD diagnosis in the medical record.
  - Earlier detection should lead to action, including management of underlying conditions, review of potentially harmful medications, kidney-protective care, referral to kidney patient education, and timely nephrology referral when clinically appropriate.
  - **Patients should not first learn that they have kidney disease when they are approaching dialysis. Earlier detection must be connected to earlier education, treatment, and support.**

- **Expand Kidney Patient Education Earlier in the CKD Process**
  - KPAC recommends expanding access to both group and one-on-one kidney patient education (KPE) earlier in the course of CKD. Patients and families need time to absorb information, ask questions, and revisit decisions as their health and readiness change. Education delivered only at the point of crisis can leave patients overwhelmed and unable to make fully informed choices.
  - Group education can reduce isolation, encourage discussion, and expose patients to the experiences of others. Individual sessions are equally important because

they allow education to be adapted to the patient's health literacy, language, culture, family circumstances, personal goals, treatment preferences, and specific barriers.
    - CMS should encourage kidney education that
        - Begins earlier and is reinforced throughout the CKD continuum.
        - Includes both group and individualized formats.
        - Uses plain language and multiple formats, including face-to-face discussion, written materials, video, and accessible digital resources.
        - Includes trained peer mentors alongside clinical educators where appropriate.
        - Assesses what the patient already knows and whether the patient understands the information provided.
        - Covers kidney disease management, nutrition, medications, laboratory results, symptoms, infection prevention, transplant, home dialysis, in-center dialysis, supportive care, palliative care, hospice, and conservative management.
    - Patient education should be treated as a therapeutic intervention. Its effectiveness should be evaluated through patient understanding, confidence, participation, self-management behavior, and clinical outcomes—not merely by documentation that information was handed to the patient.

- **Build In-Center Self-Care Pathways**
    - KPAC supports in-center self-care initiatives for patients who are interested and clinically able to participate. Self-care does not have to begin with an immediate transition to home dialysis. Patients can gradually learn skills in the safety of the dialysis facility and build confidence at their own pace.
    - Potential self-care activities may include:
        - Understanding laboratory results and treatment goals.
        - Recording weight, blood pressure, and other vital signs.
        - Preparing supplies and participating in treatment setup.
        - Recognizing symptoms and knowing when to seek help.
        - Learning medication and fluid-management routines.
        - Participating in access care and, when appropriate, learning self-cannulation.
    - These initiatives can improve patient activation, create a pathway toward greater independence, and allow patients to explore home dialysis without being asked to make an all-or-nothing decision.

- **Define Patient Readiness More Broadly**
    - Readiness for home dialysis should not be defined solely by whether a patient can operate a machine. Technical competency is essential, but successful home treatment also requires knowledge, confidence, emotional readiness, organization, problem-solving skills, and access to reliable support.
    - Training should include the practical realities of home treatment: organizing supplies, responding to alarms, managing diet and medications, recognizing complications, protecting the dialysis access, handling emergencies, and knowing when and how to contact the care team.
    - Fear should not automatically disqualify a patient. Programs should explore whether fear can be reduced through additional teaching, peer mentorship, social work, behavioral health support, supervised practice, or a slower training pace.

- **The goal should be for the patient to leave training not only knowing how to perform treatment but believing they can safely manage it.**

- **Provide Supported Independence After Training**
  - The transition from training to independent home treatment is often one of the most vulnerable periods in the home dialysis journey. Patients may perform well in a structured training environment but feel uncertain once they are responsible for treatment at home.
  - KPAC recommends a supported-independence model that provides structured follow-up during the first weeks and months after training. Support could include scheduled check-ins, peer mentoring, troubleshooting assistance, targeted home visits when appropriate, and rapid access to staff when problems arise. Support can taper as the patient's confidence and skills grow.
  - **Supported independence is not dependence, and it is not abandonment. It is a planned bridge between training and sustainable self-management.**
  - Home dialysis support must also be able to change when a patient's health, strength, dexterity, vision, cognition, or family circumstances change. A patient who has successfully dialyzed at home for years should not automatically lose that option because illness or disability makes one part of the treatment difficult or impossible to perform independently.
  - One KPAC member described her husband, who successfully performed home hemodialysis for approximately ten years. After a major stroke, he could no longer cannulate or complete all of the tasks required for treatment. Peritoneal dialysis did not provide adequate treatment, and his wife was not able to assume the full treatment burden while also managing other responsibilities and pursuing transplant-related care. Without another source of hands-on assistance in the home, he ultimately had to return to in-center hemodialysis.
  - A second KPAC member experienced the same vulnerability from the patient side. After a serious infection that required surgery, hospitalization, and rehabilitation in a nursing facility, she temporarily lost the strength needed to perform home hemodialysis independently and had to return to in-center dialysis until she recovered enough to go home. Her commitment to home dialysis had not changed; her physical ability had changed for a period of time. Years later, after an attempted kidney transplant was aborted and a complicated recovery again left her too weak to manage treatment alone, she used her own savings to hire dialysis technicians to assist with home treatments. That support allowed her to remain at home temporarily, but when the cost became unsustainable, she had to return to in-center care until she was strong enough to resume home hemodialysis independently. The barrier was not willingness, training, or commitment. It was the absence of a covered, temporary bridge of hands-on support.
  - **These two experiences illustrate the same policy gap: sometimes a patient does not leave home dialysis because home dialysis has failed. Sometimes illness or disability temporarily changes what the patient can do, and the support system fails to adapt. A short period of appropriate assistance can mean the difference between preserving a successful home modality and forcing an avoidable return to in-center care.**
  - KPAC recommends that CMS explore coverage and payment approaches for temporary or ongoing assisted home dialysis when a patient can safely remain at home with targeted help. Assistance might include treatment setup, cannulation,

connection or disconnection, selected technical tasks, and troubleshooting within an appropriate scope of practice. CMS could test these approaches through demonstrations, pilots, or alternative payment models.
    - Before a permanent transfer back to in-center dialysis, home programs should assess whether retraining, additional clinical or technical support, a temporary increase in assistance, accessibility modifications, or care-partner interventions could allow the patient to remain safely at home. A home dialysis retention plan should be part of this assessment. When the barrier is temporary loss of strength or function, the first question should be whether a time-limited support bridge can preserve the patient's established home therapy while recovery occurs.
    - CMS should also consider whether facility incentives and quality measures appropriately reward long-term home dialysis support and retention, rather than focusing primarily on the number of patients who start home therapy. Sustainable choice requires a system that can adapt as patients' lives and abilities change.
    - **Independence does not always mean doing everything alone. The goal should be to preserve safe, sustainable home dialysis whenever the patient wants it and appropriate support can make it possible.**

- **Address Barriers to Home Dialysis Access and Equity**
    - Increasing home dialysis utilization requires more than offering the modality. Facilities and care teams must identify why a patient is hesitant or unable to proceed, correct misinformation, and work with the patient to solve practical barriers.
    - CMS should encourage:
        - Functioning, adequately staffed home dialysis programs—not programs that exist only on paper.
        - Training centers located in or near underserved communities.
        - Transportation support and flexible training hours, including evening or weekend options.
        - Assistance with home requirements such as electrical or plumbing needs, lighting, storage, seating, and safe treatment space.
        - Policies that recognize the time and financial burden placed on care partners.
        - Equitable candidate evaluation based on the individual patient rather than assumptions about neighborhood, income, personality, prior behavior, or social circumstances.
    - Some patients will not be appropriate candidates for every home modality, but every patient deserves an unbiased evaluation, accurate education, and a fair opportunity to be considered.

- **Use the Dialysis Workforce More Effectively**
    - Patients depend on a multidisciplinary workforce. Nurses provide clinical assessment, education, and care management, but many burdens of home dialysis are technical or operational rather than clinical. These tasks can consume nursing time and leave patients struggling with problems that may be better addressed by trained technical personnel.
    - KPAC recommends that CMS explore models that allow appropriately trained dialysis technicians, biomedical personnel, or home-dialysis support staff to assist with non-clinical responsibilities, such as
        - Equipment setup support and basic troubleshooting.

    - Replacement parts and equipment exchanges.
    - Water testing and other technical procedures within an appropriate scope.
    - Inventory support, supply organization, and delivery coordination.
    - Laboratory specimen pickup and other operational tasks, where permitted.
    - Assistance with boxes, packaging, and disposal or recycling burdens.
  - Technical support should be available as an ongoing retention strategy, not only when a patient is ill or already at risk of abandoning home treatment.
  - **Using the workforce according to its strengths can allow nurses to devote more time to nursing, technical staff to provide technical support, and patients to focus on safely living their lives.**

- **Support Care Partners Without Shifting the Entire Burden to Them**
  - Care partners can be essential to home dialysis success, but they should not be treated as an unlimited unpaid workforce. Education should help family members understand the treatment, recognize emergencies, and adapt to the family's new normal, while preserving the patient's independence whenever safely possible.
  - CMS should encourage programs to assess caregiver strain, provide respite and backup planning, offer flexible training, and recognize employment and lost-wage barriers. Care partners should feel valued and prepared, not trapped or solely responsible for keeping treatment going.

- **Reduce Equipment, Supply, and Treatment Burden**
  - Home dialysis can provide freedom, but the home also becomes a treatment site, storage room, supply depot, and waste-management area. Patients may receive large deliveries, break down boxes, organize inventory, store supplies, arrange disposal, and pay for help when they are physically unable to manage these tasks.
  - CMS should encourage suppliers and providers to reduce unnecessary packaging, improve delivery coordination, offer take-back or recycling options, and provide practical assistance to patients with physical limitations.
  - Treatment burden should be considered a quality and retention issue. A therapy cannot be considered fully accessible when the non-clinical workload required to sustain it exceeds the patient's physical or financial capacity.

- **Design Home Dialysis Technology Around Human Capabilities**
  - Innovation should be evaluated not only by clinical performance but also by whether equipment is realistic for patients to use in daily life. Patients need smaller, lighter, more portable equipment; intuitive setup; accessible controls; clear instructions; and fewer tasks that require strength, fine dexterity, good vision, or the ability to reach behind heavy equipment.
  - Patient-centered innovation should prioritize:
    - Simpler setup and fewer opportunities for user error.
    - Interfaces accessible to people with limited vision, dexterity, literacy, or English proficiency.
    - Remote diagnostics and faster technical support.
    - Reduced maintenance and fewer patient-performed repairs.
    - Improved portability and travel support.
    - Safety monitoring that helps identify problems without unnecessarily restricting patient independence.

- **Make Emergency Preparedness a Core, Ongoing Competency**
  - Emergency preparedness should be taught, practiced, reinforced, and measured throughout home dialysis care. Patients need clear plans for power or water outages, supply interruptions, severe weather, natural disasters, communication failures, and situations in which treatment cannot be completed.
  - Education should clarify when a patient can safely follow a backup plan, when the home program should be contacted, and when emergency care is necessary. The default response to every disruption should not be to send the patient to a hospital without first assessing the situation and the available alternatives.

- **Measure What Matters to Patients**
  - Home dialysis success should not be measured only by the number of patients who begin training or start treatment at home. CMS should also consider long-term retention, reasons for transfer back to in-center care, whether preventable support gaps contributed to that transfer, patient confidence, quality of life, symptom burden, recovery time, ability to work or maintain family roles, achievement of personal goals, and whether patients feel the benefits of treatment.
  - Patient-reported measures should lead to action. When a patient reports pain, fatigue, depression, difficulty recovering, or an unmet life goal, the measure should prompt assessment, discussion, and an appropriate response—not simply create another completed field.

- **Identify and Share Highly Effective Practices**
  - CMS and the ESRD Networks are well positioned to identify dialysis programs that demonstrate highly effective practices and share those practices nationally. Examples may include strong home dialysis retention, low infection rates, effective patient education, successful peer-mentoring programs, support for employment, and practical approaches to reducing treatment burden.
  - Patients, care partners, and staff should also be recognized for meaningful milestones, including completing training, maintaining treatment safely over many years, returning to work, improving attendance, reaching personal goals, or supporting a loved one through care.

- KPAC appreciates CMS's continued partnership with patients and its willingness to seek input on the future of dialysis care. The recommendations in this response are grounded in a desire to help patients begin kidney education earlier, make informed decisions, receive treatment that helps them function, and remain safely supported in the setting that best meets their needs.
- Expanding home dialysis will require attention not only to training and technology, but also to retention, adaptable assistance, confidence, symptoms, workforce support, care partners, equity, treatment burden, and the practical realities of living with dialysis every day.
- **Together, we can make it easier for the next patient to succeed than it was for the last.**

b. **RFI to Advance Palliative Care for Dialysis Patients:** Under current policy, services related to the terminal condition are not separately payable outside the hospice benefit. Dialysis is life-sustaining but not curative. Dialysis may be provided consistent with palliative goals of care; however, current Medicare policy does not distinguish between maintenance and dialysis and

dialysis provided in a comfort-focused environment. This implies that current payment policy does not explicitly account for palliative care objectives within ESRD treatment. When ESRD is the terminal condition, hospice providers are responsible for furnishing dialysis services that are included in the hospice per diem payment. Since dialysis is a high-cost service, it is rarely provided under the hospice benefit. CMS is interested in soliciting comments as to whether refinements to payment policy would improve access to palliative dialysis while maintaining both ESRD PPS bundled payment and hospice per diem integrity along with ensuring safeguards against duplicative payment and risks to program integrity. The topics of interest include: Definition of Palliative Dialysis, Beneficiary Eligibility and Targeting, Care Delivery and Settings, Payment Policy Considerations, and Program Integrity and Safeguards. CMS includes multiple questions in the proposed rule covering these numerous topics and our recommendations are below.

ESRD Forum Recommendations:

- KPAC wants to emphasize the need to explain Supportive, Palliative, Hospice, and Conservative Care clearly
  - Patients and families need understandable explanations of supportive care, palliative care, hospice, and conservative kidney management, including how these approaches differ and how they may be used alongside or instead of dialysis.
  - These conversations should occur throughout the illness—not only during a crisis or at the end of life. Patients should be able to discuss symptom relief, quality of life, treatment burden, and the option to decline or discontinue treatment without judgment or abandonment.

c. **RFI on Potential Payment Changes to Support Alternative Dialysis Schedules:** The final section in this RFI is a request for information on potential changes to the current payment structure that could support alternative dialysis schedules. CMS is interested in receiving comments on the potential advantages, challenges and operational considerations associated with changing the ESRD PPS unit of payment from a per treatment to a monthly (daily rate) structure. The ESRD PPS unit of payment is a treatment, and dialysis services are billed monthly. The ESRD PPS does make a daily rate payment for CAPD and CCPD using a payment approach that has been in place since the inception of the composite rate payment system in 1983. The number of days of PD is converted to home HD-equivalent sessions by dividing the number of days of PD by 7 and multiplying the result by 3. The proposed rule provides an example using a patient receiving 30 days of home CAPD being paid by an amount equal to 12.857 home-HD equivalent treatments ((30/7) x 3 = 12.857). This complies with the monthly treatment payment limit of 13 treatments in a 30-day month and 14 treatments in a 31-day month. CMS includes multiple questions in the proposed rule and our recommendations are below.

ESRD Forum Recommendations:

- The Forum supports CMS' interest in exploring payment approaches that may better accommodate individualized and alternative dialysis schedules. However, any movement from a per-treatment payment structure to a monthly or daily rate must include explicit safeguards to ensure that patients retain timely access to medically necessary extra in-center treatments. This is particularly important for patients with fluid overload, recent missed treatments, hospitalization follow-up needs, heart failure, or other clinical instability. Without an exceptions process or supplemental payment mechanism, a fixed monthly structure could unintentionally create financial and operational incentives to limit additional treatments, potentially increasing emergency department visits,

hospitalizations, and patient harm. CMS should ensure that payment reform supports clinical flexibility rather than restricting it.

- In order to make such a proposed change safe and successful, the Forum would recommend the following considerations:
- A clear payment exception or add-on for medically necessary extra in-center treatments.
- Protection for treatments ordered due to fluid overload, hospitalization follow-up, missed treatment recovery, or other documented clinical indications.
- Monitoring for changes in hospitalization, emergency department use, ultrafiltration rates, missed treatments, and patient complaints after implementation.
- Explicit assurance that facilities should not require excessive administrative approval before providing clinically needed extra treatments.
- Patient-facing transparency so patients understand when they are entitled to additional medically necessary dialysis.
- Network-level monitoring to identify whether access to extra treatments declines after payment changes.
- Stratified analysis to detect whether vulnerable patients are disproportionately affected.

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