ConnectedHealthInitiative

August 24, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, District of Columbia 20201
Submitted electronically via www.regulations.gov, Docket No. CMS-2026-2245

RE: Comments of the Connected Health Initiative to the Centers for Medicare & Medicaid Services on Medicare Program; CY 2027 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Acute Kidney Injury (AKI) Dialysis Payment, and ESRD Quality Incentive Program (CMS-1846-P; 91 FR 38784)

Dear Administrator Oz:

The Connected Health Initiative (CHI), an initiative of the Association for Competitive Technology (ACT), appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) on its proposed rule updating the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for calendar year (CY) 2027.[1] CHI focuses these comments on the Requests for Information (RFIs) at section V of the proposed rule, which ask how Medicare payment policy can increase home dialysis uptake, advance palliative dialysis, and support alternative dialysis schedules.[2] Each of those goals depends in substantial part on connected health technology that the ESRD PPS does not yet adequately recognize or pay for, and the comments below are directed at closing that gap.

## I. Introduction & Statement of Interest

CHI is the leading multistakeholder policy and legal advocacy effort driven by a consensus of stakeholders from across the connected health ecosystem. CHI aims to realize an environment in which Americans can see improvement in their health through policies that allow for the potential of connected health technologies to enhance health outcomes and reduce costs. CHI members develop and use connected health technologies across a wide range of use cases, including in kidney care.

[1] Medicare Program; CY 2027 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Acute Kidney Injury (AKI) Dialysis Payment, and ESRD Quality Incentive Program, 91 FR 38784 (proposed June 26, 2026) (CMS-1846-P).

[2] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.

We are active advocates before Congress, numerous U.S. federal agencies, and states, where we seek to advance responsible pro-digital health policies and laws in areas including reimbursement/payment, privacy/security, effectiveness/quality assurance, U.S. Food and Drug Administration (FDA) regulation of digital health, health data interoperability, and the rising role of artificial/augmented intelligence (AI) in care delivery. For more information, see www.connectedhi.com.

CHI is a longtime advocate for the increased use of digital health tools (telehealth, remote monitoring, AI, etc.) across the Department of Health and Human Services (HHS) as well as before other agencies and the U.S. Congress. CHI is also engaged in leading public-private partnerships themed in responsibly advancing the use of digital health tools, including as a current appointed member of the American Medical Association's (AMA) Digital Medicine Payment Advisory Group, an initiative bringing together a diverse cross-section of nationally recognized experts that identifies barriers to digital medicine adoption and proposes comprehensive solutions revolving around coding, payment, coverage, and more.[3]

Generally, CHI is committed to an ESRD PPS, and a broader Medicare program, that serves beneficiaries effectively by responsibly leveraging the full range of digital health tools available today, consistent with other major Medicare payment systems.

## II. Digital Health's Integral Role in the Future of Medicare and Kidney Care

Data and clinical evidence from a variety of use cases continue to demonstrate how connected health technologies improve patient care, prevent hospitalizations, reduce complications, and improve patient engagement, particularly for the chronically ill. Connected health tools, including wireless health products, mobile medical devices, software as a medical device (SaMD), mobile medical apps, and cloud-based portals and dashboards, can fundamentally improve and transform American healthcare. That potential carries particular weight in kidney care, where beneficiaries receive treatment three or more times each week for the remainder of their lives or until they receive a transplant.

Further, CMS should seek to enable the use of health data and patient-generated health data (PGHD) through AI. There are varied applications of AI systems in healthcare such as research, health administration and operations, population health, practice delivery improvement, and direct clinical care. Payment and incentive policies must be in place to invest in building infrastructure, preparing personnel and training, as well as developing, validating, and maintaining AI systems with an eye toward ensuring value. Payment policies must incent a pathway for the voluntary adoption and integration of AI systems into clinical practice as well as other applications under existing payment models, and those policies should reinforce the transparency, clinical validation, and qualified clinician oversight on which responsible development, deployment, and use of AI in health care depends.

[3] https://www.ama-assn.org/delivering-care/digital-medicine-payment-advisory-group

As a community, we continue to support CMS' efforts to use advanced technology to augment care for every patient, including those living with kidney disease. CMS' continued efforts to advance the range of connected health innovations that will help American healthcare improve outcomes and achieve cost savings are essential.

Despite the demonstrated benefits of connected health technology to the American healthcare system, statutory restrictions and CMS regulatory-level policy decisions, among other constraints, inhibit use of these solutions. CMS' coverage of remote monitoring began in CY2018, when it unbundled Current Procedural Terminology (CPT®) Code 99091. In the calendar year 2019 and 2020 Physician Fee Schedules (PFS), CMS took significant steps forward in activating and paying for four remote *physiologic* monitoring codes, followed beginning in CY2022 by a new family of remote *therapeutic* monitoring use cases. CMS also ensured utilization of RPM in existing alternative payment models such as Medicare Advantage, where RPM has been eligible for inclusion as a basic benefit. Most recently, in the CY 2026 PFS final rule, CMS priced a new set of remote physiologic and remote therapeutic monitoring codes recognizing device supply for as few as two days of data collection within a thirty-day period and treatment management in ten-minute increments, retiring the sixteen-day and twenty-minute thresholds that had made these services unusable for episodic, short-duration, and post-acute monitoring.[4] In that same rule CMS eliminated the provisional and permanent distinction on the Medicare Telehealth Services List and made permanent its policy allowing virtual direct supervision through real-time audio-video communications. Through the CMS Health Technology Ecosystem initiative and the CMS Interoperability Framework, CMS has committed to a more open, standards-based flow of health data.[5]

Building on its incremental support for the use of digital health tools in the ESRD PPS, and on the more substantial support extended to these tools in the other Medicare programs noted above, CMS should take all steps possible to further ease the use of digital health tools for beneficiaries with ESRD and for those receiving dialysis for acute kidney injury (AKI). For example, remote monitoring technologies can detect changes in the turbidity of peritoneal dialysate effluent in beneficiaries receiving peritoneal dialysis, allowing clinicians to diagnose peritonitis and initiate antibiotic treatment earlier than the current standard of care permits. Published experience with remote patient management of automated peritoneal dialysis likewise reports reductions in technique failure, unscheduled clinic visits, overhydration episodes, and hospitalization.[6] A

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CY 2026 Medicare Physician Fee Schedule final rule, CMS-1832-F, published November 5, 2025, available at https://www.federalregister.gov/documents/2025/11/05/2025-19787/, establishing payment for device supply covering as few as two days of data collection in a thirty-day period and for treatment management reported at ten minutes.

[5] See CMS, Health Technology Ecosystem, https://www.cms.gov/initiatives/health-technology-ecosystem/overview; CMS, White House and Tech Leaders Commit to Create Patient-Centric Healthcare Ecosystem (July 30, 2025).

[6] Milan Manani S, et al., Remote Patient Management in Peritoneal Dialysis Improves Clinical Outcomes, Contrib Nephrol. 2019;197:124-132, doi:10.1159/000496319 (single-center cohort); see also Impact of

cluster-randomized trial conducted across twenty-one centers has since reported lower all-cause mortality, fewer fluid balance and cardiovascular events, and fewer hospitalizations for fluid overload among patients whose automated peritoneal dialysis was remotely monitored.[7] These use cases demonstrate that, for the ESRD PPS, digital health tools are valuable in (1) augmenting the services in a patient's plan of care, (2) enabling clinical staff to identify changes in a patient's clinical condition more rapidly and to monitor adherence to treatment plans, which in turn enables more effective and efficient review and appropriate alteration of plans of care, and (3) augmenting the care of ESRD PPS beneficiaries in their homes. CHI therefore encourages CMS' thoughtful deliberation of the benefits of remote monitoring technologies under the substantial clinical improvement criterion that governs new equipment and supplies in this program.[8]

While the progress described above represents important and long-overdue pro-digital health policy change, the pace of uptake for digital health innovations in the ESRD PPS continues to lag behind the well-established benefits and efficiencies these technologies offer, and behind their uptake in other Medicare payment systems, notwithstanding the evidence of benefit that emerged during the COVID-19 pandemic and the substantial body of published experience that has accumulated since.[9]

It is essential that ESRD facilities and the beneficiaries they serve be able to leverage the wide range of connected health tools and services available today, as well as those in development, to advance care and lower costs. The RFIs in this proposed rule give CMS a timely opportunity to align ESRD payment policy with that objective.

## III. Recommendations on Specific Provisions of the Proposed CY 2027 ESRD PPS

CHI offers the following views on provisions of the proposed CY 2027 ESRD PPS that affect the use of digital health technologies, particularly remote monitoring, in light of the priority to advance innovative value-based care while protecting the integrity of the Medicare program:

- **Relax In-Person Monthly Visit Requirements:** CHI calls on CMS to remove or mitigate outdated barriers to the use of digital health technology in the ESRD PPS that no longer serve the public interest. Section 1881(b)(3)(B)(ii) of the Social Security Act permits a

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telehealth interventions added to peritoneal dialysis care: a systematic review, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9396599/.

[7] Paniagua R, Ramos A, Ávila M, et al., Remote monitoring of automated peritoneal dialysis reduces mortality, adverse events and hospitalizations: a cluster-randomized controlled trial, Nephrology Dialysis Transplantation, vol. 40, no. 3, pp. 588-597 (2025), doi:10.1093/ndt/gfae188 (21 centers, 801 patients).

[8] 42 C.F.R. 413.236(b)(5), which incorporates the criterion at 42 C.F.R. 412.87(b)(1) defining a new medical service or technology that "represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries."

[9] See, e.g., Coffey JD, Christopherson LA, Glasgow AE, et al., Implementation of a Multisite, Interdisciplinary Remote Patient Monitoring Program for Ambulatory Management of Patients with COVID-19, npj Digit. Med. 4, 123 (2021), https://doi.org/10.1038/s41746-021-00490-9.

beneficiary receiving home dialysis to elect to receive monthly ESRD-related clinical assessments via telehealth, but only where the beneficiary also receives a face-to-face assessment at least monthly during the initial three months of home dialysis and at least once every three consecutive months after that period.[10] CMS asks in this proposed rule how greater telehealth flexibility for home dialysis patients would improve retention and quality of care within the first sixty days.[11] In CHI's view, the initial three months are the period in which the burden of travel, transportation cost, and caregiver time weighs most heavily on beneficiaries and their families, and in which the risk that a patient abandons the home modality is greatest, so permitting telehealth to satisfy the monthly assessment during that window would improve retention while preserving the clinical oversight the statute was designed to secure. CHI accordingly asks CMS to do three things:

  - Support an amendment to section 1881(b)(3)(B)(ii)(I) of the Act that would allow a telehealth assessment to satisfy the monthly requirement during the initial three months of home dialysis where the treating physician documents that a telehealth assessment is clinically appropriate for the beneficiary.
  - Exercise its waiver authority under section 1115A(d)(1) of the Act in the interim, within a qualifying Innovation Center model, to test that flexibility, so that CMS can evaluate the effect on retention, infection rates, hospitalization, access complications, modality switching, and caregiver burden before any permanent change in law.
  - Update Chapter 8 of the Medicare Claims Processing Manual and the accompanying Medicare Administrative Contractor guidance, which continue to describe monthly capitation payment (MCP) visits in exclusively face-to-face terms and remain silent on the telehealth election that Congress authorized in 2018.[12] The resulting ambiguity in subregulatory guidance, as much as the statute itself, deters clinicians from using flexibility that is already available to them.

- **Transitional Add-On Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES):** The TPNIES pathway was created to pay for equipment and supplies that represent an advance substantially improving, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries,[13] and CHI has long supported it as a route by which genuinely new home dialysis technology can reach beneficiaries ahead of the ordinary bundled payment cycle. The record in this proposed rule indicates that the pathway is not presently performing that function for home dialysis technology, because CMS reports that no capital-related assets that are home dialysis

[10] Social Security Act section 1881(b)(3)(B)(ii), 42 U.S.C. 1395rr(b)(3)(B)(ii), as added by section 50302 of the Bipartisan Budget Act of 2018, Pub. L. No. 115-123. See also 42 C.F.R. 410.78(b)(3)(ix) and (x).

[11] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.j, asking how greater telehealth flexibility for home dialysis patients would improve retention and quality of care, including infection rates, within the first 60 days.

[12] See Medicare Claims Processing Manual, Pub. 100-04, ch. 8, sections 140 through 140.1.1; see also, e.g., Noridian Healthcare Solutions, Monthly Capitation Payment and the Medical Record (rev. Sept. 11, 2025).

[13] 42 C.F.R. 413.236(b)(5), incorporating the criterion at 42 C.F.R. 412.87(b)(1).

machines are set to receive TPNIES for CY 2027, that the last such payment period ended on December 31, 2023, and that CMS received no TPNIES applications at all for CY 2027.[14]

Two features of the design help explain why a pathway intended to draw innovation forward has drawn no applicants across consecutive payment years. The first is duration, in that TPNIES payment lasts only two years, after which the ESRD PPS base rate is not adjusted and the item becomes eligible for outlier payment, with home dialysis machines expressly excluded from outlier eligibility, so that support for the very technology CMS says it wants to promote falls to zero at the end of the second year.[15] The second is scope, in that the exclusion of capital-related assets other than home dialysis machines leaves the connected components that make a modern home dialysis machine useful, including remote monitoring hardware, connectivity, and the software platforms that transmit and analyze treatment data, without a clear route to payment.

CHI asks CMS to do the following:

- Identify which digital health technology services and components fall within the scope of TPNIES, so that developers can assess their eligibility before committing to the application process.
- Clarify whether, and under what circumstances, remote monitoring services furnished to ESRD beneficiaries may be separately billed from the ESRD PPS bundled payment and the monthly capitation payment, including where the monitoring supports but is not itself a component of a bundled renal dialysis service, and identify the services CMS regards as already included in the bundle.
- Address the payment cliff that follows the TPNIES period for home dialysis machines and their connected components, most directly by extending outlier eligibility to those connected components and by making a transitional adjustment to the base rate for a defined period after TPNIES payment ends, though a successor add-on payment would serve the same purpose.

- **Quality Indicators and Program Integrity:** CHI appreciates CMS' continued consideration of quality indicators for patients who dialyze at home. CMS has appropriately recognized that while home-based dialysis may not meet the needs of every patient, it offers clear benefits for suitable candidates, is often more convenient, and produces survival outcomes comparable to in-center hemodialysis. CMS has also recognized that dialyzing at home is associated with lower overall medical expenditures than dialyzing in-center, driven by potentially lower rates of dialysis-associated infection, fewer hospitalizations, cost differentials between peritoneal dialysis (PD) and hemodialysis (HD) services and supplies, and lower facility operating costs. Beyond those cost savings, we urge CMS to weigh the broader benefits of the responsible use of remote monitoring, which include improved

[14] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section II.C, stating that there are no capital-related assets that are home dialysis machines set to receive the TPNIES for CY 2027, that the TPNIES payment period for the Tablo System ended on December 31, 2023, and that there are no TPNIES applications for CY 2027.

[15] 42 C.F.R. 413.236(b)(6) and 413.237.

patient engagement, better clinical outcomes, and a better experience for the caregivers on whom home dialysis so often depends.[16] In developing quality indicators for home dialysis, CHI urges CMS to ensure that the benefits of ongoing remote monitoring, and the real-time trending and intervention that it makes possible, are recognized and incentivized.[17]

CHI also supports measures to avoid waste, fraud, and abuse in the ESRD PPS. The use of connected and digital health modalities, including remote monitoring technology, does not inherently mean greater waste, fraud, and abuse, and the data these technologies generate can create additional auditable records that, where the payment policy is appropriately designed, may facilitate program-integrity monitoring. CHI is mindful that the HHS Office of Inspector General has examined billing patterns in Medicare remote patient monitoring and has developed measures to identify potentially problematic billing.[18] At a minimum, CMS should:

- Reaffirm the capacity of connected health technologies to reduce programmatic waste in the ESRD PPS.
- Apply existing and developing program integrity tools and metrics in a modality-neutral manner, adding modality-specific measures only where a heightened risk particular to that modality has been demonstrated.
- Condition any ESRD-specific payment for remote monitoring on defined conditions of payment, including documented medical necessity, an identifiable clinician responsible for the service, minimum data-collection and review requirements, documentation of interpretation and of patient communication where clinically indicated, prohibition of duplicate billing, auditable records, response-time and escalation standards, appropriate privacy and cybersecurity controls, and monitoring for anomalous utilization.

- **Kidney Disease Patient Education Services and Telehealth:** CHI supported the ESRD Treatment Choices (ETC) Model's waiver, at 42 C.F.R. 512.397, of the geographic and originating site requirements in sections 1834(m)(4)(B) and 1834(m)(4)(C) of the Act for kidney disease patient education (KDE) services furnished via telehealth, together with CMS' waiver of the originating site facility fee.[19] That waiver made this vital education substantially more accessible to beneficiaries who would otherwise have had to travel in order to receive it. With the termination of the ETC Model effective December 31, 2025, the

[16] Pronovost PJ, Cole MD, Hughes RM. Remote Patient Monitoring During COVID-19: An Unexpected Patient Safety Benefit. JAMA. 2022;327(12):1125-1126. doi:10.1001/jama.2022.2040; Coffey, J.D., Christopherson, L.A., Glasgow, A.E. et al. Implementation of a multisite, interdisciplinary remote patient monitoring program for ambulatory management of patients with COVID-19. npj Digit. Med. 4, 123 (2021). https://doi.org/10.1038/s41746-021-00490-9.

[17] See, e.g., https://www.appliedclinicaltrialsonline.com/view/quality-remote-monitoring-tools-game.

HHS Office of Inspector General, Billing for Remote Patient Monitoring in Medicare, OEI-02-23-00261 (Aug. 2025), https://oig.hhs.gov/reports/all/2025/billing-for-remote-patient-monitoring/ (reporting Medicare payments exceeding $500 million for remote patient monitoring in 2024).

[19] 42 C.F.R. 512.397(b)(5).

waiver has ceased to have operative effect even though its text remains codified.[20] The consequence is that at the very moment CMS is asking how it can improve access to and utilization of KDE services prior to dialysis initiation, one of the few tools that demonstrably improved that access has lapsed.[21] We ask CMS to take three steps:

  - Restore telehealth delivery of KDE services on a program-wide basis, so that access to this education no longer depends on a beneficiary's participation in a particular model.
  - Revisit the payment amounts for HCPCS codes G0420 and G0421 so that they reflect the cost of comprehensive modality education in whatever format it is delivered.
  - Confirm that the definitions of clinical staff and qualified staff developed under the Model continue to inform who may furnish KDE services consistent with 42 C.F.R. 410.48(a).

- **ESRD QIP and the Dialysis Facility Discussion of Patient Life Goals (D-PaLS) PRO-PM (Section IV.C):** CHI supports CMS' consideration of the D-PaLS patient-reported outcome performance measure.[22] A measure of whether facilities discuss and act on patient life goals is in practice a measure of whether facilities are having the modality conversation that drives home dialysis uptake, and it complements the existing ESRD QIP measure set. CHI's recommendations concern how the measure would be collected, and we ask CMS to address the following points:
  - CMS should specify from the outset that the eight-item survey may be administered electronically as well as on paper, including through patient portals, tablets in the facility, and the same remote platforms that beneficiaries already use for home dialysis, and that facilities may use multi-modal administration. Electronic patient-reported outcome collection improves response rates, shortens the interval between a patient's response and clinical action on it, and reduces the information collection burden that CMS estimates in section VI of the proposed rule.
  - CMS should require that D-PaLS responses be returned to the facility in a structured, machine-readable form that can be written directly to the medical record and the plan of care, so that the information reaches the clinical workflow where it can be acted upon.

[20] CY 2026 ESRD PPS final rule, 90 FR 53068 (Nov. 24, 2025) (CMS-1830-F), amending 42 C.F.R. 512.320 so that ETC Model payment adjustments apply only to claims with service dates on or before December 31, 2025.

[21] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.b, asking how CMS can improve access to and utilization of Kidney Disease Education services prior to dialysis initiation and whether CMS should consider revisions to payment amounts for HCPCS codes G0420 and G0421.

[22] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section IV.C, describing the D-PaLS PRO-PM survey as containing a total of eight items and taking approximately two minutes to complete. Measure specifications are available at https://p4qm.org/prmr-measures/muc2025-011.

- CMS should ensure that any electronic administration is designed to recognized accessibility standards and that a non-electronic option always remains available, so that a measure intended to capture patient voice also reaches beneficiaries who have limited digital access.

## IV. Responses to the Requests for Information on Advancing Alternative Dialysis Care

CMS asks in section V of the proposed rule how Medicare payment policy can increase home dialysis uptake, advance palliative dialysis, and support alternative dialysis schedules. Across all three RFIs, CHI's central observation is that home dialysis is a technology-dependent modality delivered under a payment system built around a per-treatment, facility-based unit of payment that recognizes very little of the technology on which home dialysis actually depends. Roughly fifteen percent of dialysis patients use a home modality, measured against a federal goal of eighty percent of new ESRD patients receiving home dialysis or a transplant,[23] and by CMS' own account only about half of ESRD facilities offer a home dialysis program at all.[24] Closing that gap will require paying for the connectivity, remote monitoring, and remote clinical support on which a home dialysis program depends. CHI supports widening the set of clinically appropriate options genuinely available to a patient, and we respond below to the specific topics on which CMS sought comment.

- **Recognize Connectivity, Installation, and Remote Monitoring as Home Dialysis Costs (Sections V.B.3.e(5) and V.B.3.f):** CMS asks whether it should collect data on hidden costs such as internet connectivity, equipment installation, shipping, and remote monitoring devices on the ESRD freestanding and hospital-based cost reports.[25] CHI strongly supports doing so, and regards this as among the most consequential questions in the home dialysis RFI, because these costs are borne today by facilities and by beneficiaries and yet remain invisible in the data CMS uses to set and rebase the ESRD PPS base rate. A home dialysis program cannot be operated without reliable broadband at the patient's residence, without a device that transmits treatment data, and without a platform that receives and interprets that data, and the market basket that CMS proposes in this rule to rebase to a 2024 base year does not separately identify the home-dialysis-specific connectivity, remote monitoring, installation, and shipping costs needed to determine whether the bundled

[23] United States Renal Data System, 2024 Annual Data Report (reporting that 14.5 percent of prevalent dialysis patients used a home modality in 2022); CMS, ESRD Treatment Choices Model Second Evaluation Report (reporting home dialysis use of 15.2 percent in ETC areas and 15.9 percent in comparison areas as of the end of 2022). The 80 percent goal is set out in HHS, Advancing American Kidney Health: 2020 Progress Report, at Goal 2, available at https://aspe.hhs.gov/advancing-american-kidney-health.

[24] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.h, stating that approximately half of ESRD facilities offer home dialysis programs.

[25] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.e(5), seeking comment on "whether CMS should collect data on hidden costs such as internet connectivity, equipment installation, shipping, and remote monitoring devices."

payment reflects the resources that furnishing home dialysis actually requires.[26] The result is a circular problem in which CMS cannot pay for what it does not measure and facilities cannot justify investing in what CMS does not pay for.

CMS should take the following steps:

- Add discrete cost report lines for connectivity, remote monitoring devices and platforms, equipment installation, and supply shipping and storage, reported separately for home hemodialysis and peritoneal dialysis.
- Collect separate data on travel costs for facility staff home visits and on nursing hours per home training session, as CMS also proposes to consider.
- Commit to using the resulting data in the next rebasing of the ESRD Bundled market basket, so that facilities can see a direct connection between what they report and what CMS ultimately pays.
- Introduce the new reporting on a phased or sampled basis, with standardized definitions and a limited number of categories, and publish aggregate findings after two to three years before determining whether a market basket adjustment is warranted.

CMS asks in the same discussion whether the advantages of collecting additional data on the ESRD cost reports would outweigh the associated administrative burden.[27] CHI encourages CMS to design any new reporting with the express objective of minimizing it. Cost report preparation falls hardest on small, rural, and low-volume facilities, which have the least administrative capacity and which are the very facilities CMS is seeking to draw into home dialysis through the expanded low-volume payment adjustment proposed elsewhere in this rule.[28] Reporting requirements that consume staff time also draw that time away from patient care, and requirements that are burdensome or ambiguous tend to produce inconsistent data, which would defeat the purpose of collecting the data in the first place. New reporting obligations of this kind are best evaluated both for whether they improve patient outcomes and for the burden they place on the smallest reporting entities. CMS can honor that objective by defining a small number of clearly specified line items, by drawing on cost categories that facilities already maintain for their own budgeting and tax reporting, by permitting reasonable allocation methodologies in place of transaction-level accounting, and by phasing any new requirement in with sufficient lead time and clear instructions.

[26] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section II.B, proposing to rebase and revise the ESRD Bundled market basket from a 2020 base year to a 2024 base year.

[27] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.e(5), asking whether the advantages of collecting additional data on the ESRD cost reports would outweigh the administrative burden.

[28] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section II.B.8, proposing to expand the low-volume payment adjustment to facilities furnishing up to 8,000 treatments annually and to establish six volume-based tiers.

CMS separately asks whether the cost of small home modifications affects a patient's willingness to initiate home dialysis.[29] In CHI's experience it does, and connectivity is among the most common of those costs. Where a beneficiary's residence lacks adequate broadband, or where the beneficiary cannot afford service, a machine that depends on data transmission cannot be properly supported. CHI urges CMS to treat connectivity as part of the infrastructure that a home dialysis program requires, to coordinate with the Federal Communications Commission and the National Telecommunications and Information Administration so that existing connectivity support programs align with home dialysis initiation, and to clarify the circumstances in which an ESRD facility may furnish limited connectivity support to a beneficiary consistent with the federal fraud and abuse laws.

- **Permit Remote and Hybrid Home Dialysis Training (Section V.B.3.c):** CMS asks what safeguards and best practices would be necessary to ensure that alternative training approaches, including remote modalities, continue to meet the individualized needs of patients and maintain patient safety.[30] CHI welcomes CMS' explicit recognition of remote training, and we recommend that CMS confirm that a home dialysis training session furnished by real-time audio-video communication qualifies as a training session for purposes of the home and self-dialysis training add-on payment adjustment where the session addresses the patient's individualized training plan and the patient's competency is documented. The safeguards that carry weight in this setting are competency-based, and what protects a patient is the documented demonstration of independent and safe technique across the tasks that the modality requires.

  CHI accordingly supports CMS' consideration of redefining a completed course of home dialysis training in terms of demonstrated independent treatment over a defined period, which is a competency standard fully compatible with remote and hybrid delivery.[31] We also support CMS' proposal to increase the training add-on amount and to extend eligibility to sessions furnished during the onset period, and we note that remote delivery is what makes retraining after a hospitalization or a change in care partner practical for facilities that would otherwise be unable to schedule it.[32]

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[29] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.f, asking whether the cost of post-2011 home modifications affects a patient's willingness to initiate home dialysis and whether excess supply delivery and storage requirements deter patients from selecting home dialysis.

[30] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.c, seeking comment on what safeguards and best practices would be necessary to ensure that alternative training approaches, including group training, remote modalities, and the use of multidisciplinary training staff, continue to meet the individualized needs of patients and maintain patient safety.

[31] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.c, asking whether CMS should redefine a completed course of home dialysis training to reflect demonstrated independent treatment over a defined period.

[32] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section II.B.10, proposing to increase the home and self-dialysis training add-on payment adjustment from $95.60 to $138.22 per training session and to extend eligibility to training sessions furnished during the dialysis onset period.

On the related question concerning patient education under 42 C.F.R. 494.70, CMS asks whether it should specify format and delivery methods and how education delivery and patient response should be monitored and documented.[33] CHI recommends that CMS require education to be active, individualized, and iterative, in the terms CMS itself describes, and that CMS expressly permit digital and interactive delivery, including modality decision aids, video, and interactive modules, alongside in-person discussion, while leaving facilities free to select the format best suited to the individual patient. Documentation should capture what was offered, in what format, when it was offered, and how the patient responded, in structured fields in the medical record, so that the information flows into the patient assessment and plan of care where it can be acted upon.

- **Address Patient-Level Barriers Through Remote Support (Section V.B.3.a):** CMS asks what approaches could reduce patients' fear of abandonment or lack of real-time support in the home setting, and how CMS can structure payment to support beneficiaries who lack adequate care partner support.[34] These questions describe one of the strongest use cases for connected health technology in the entire RFI, because the fear of being alone with a machine is among the patient-level barriers CMS identifies, and it is a barrier that can be addressed directly by remote monitoring with clinician response, by two-way audio-video access to the facility during treatment, and by automated alerting on treatment parameters. CHI recommends that CMS recognize and pay for a home dialysis remote support capability, whether as an adjustment within the ESRD PPS or as a separately billable service, and that CMS condition payment on defined response-time and escalation standards that any qualifying technology must meet. A payment tied to a capability standard of that kind will remain durable as the underlying technology changes, and it will avoid the difficulties that arise when Medicare payment policy is written around a single named product.
- **Temporary and Staff-Assisted Home Dialysis (Section V.B.3.d):** CHI supports CMS' consideration of temporary staff-assisted home dialysis at initiation, following hospitalization, and during periods of caregiver strain, and we offer one recommendation on how such a benefit should be designed.[35] CMS asks what staffing qualifications and supervision requirements should apply, and CHI's view is that supervision should be permitted to occur remotely under the direction of the treating physician, who retains responsibility for the plan of care and for the clinical decisions made under it. A registered nurse supervising a trained technician in the patient's home by real-time audio-video connection can oversee substantially more patients across a wider geography than a nurse traveling between homes, and the shortage of trained home dialysis nurses that CMS

[33] 42 C.F.R. 494.70. See also CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.c, asking whether CMS should specify the format and delivery methods for patient education regarding treatment modalities and setting, and how education delivery and patient response should be monitored and documented.

[34] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.a, asking what approaches could reduce patients' fear of abandonment or lack of real-time support in the home setting and how CMS can structure payment under the ESRD PPS to support beneficiaries who lack adequate care partner support.

[35] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.d, seeking comment on temporary and staff-assisted home dialysis, including eligibility criteria, staffing qualifications, and supervision requirements.

identifies elsewhere in this RFI is the binding constraint on any staff-assisted model.[36] CHI recommends that CMS permit virtual supervision of staff-assisted home dialysis on terms parallel to the virtual direct supervision policy that CMS made permanent in the CY 2026 PFS final rule, and that any Conditions for Coverage CMS develops for staff-assisted home dialysis be written to accommodate it.[37]

- **Use Technology to Reduce Monitoring Burden While Preserving Oversight (Section V.B.3.h):** CMS asks whether changes to the requirements for home dialysis monitoring and support services could reduce burden on facilities without negatively affecting patient health and safety.[38] CHI recommends that CMS distinguish between the frequency of clinical contact and the mode of that contact, because requirements written on the assumption that monitoring means an in-person visit impose travel time that adds cost without adding clinical value, while complementary and, for certain monitoring functions, more continuous oversight is available through remote monitoring and at lower cost. CHI recommends that CMS review the home dialysis monitoring and support requirements and expressly permit remote fulfillment wherever the clinical purpose of a requirement can be met remotely, while preserving the periodic in-person contact necessary to assess the home environment, the vascular or peritoneal access site, and the equipment itself. Burden reduction of this kind would increase the continuity of clinical oversight while lowering its cost, which is the outcome CMS describes when it asks how burden can be reduced without compromising patient health and safety.
- **Interoperability and Electronic Notification at Care Transitions (Sections V.B.3.k and V.B.3.e(6)):** CMS asks whether ESRD facilities receive electronic admission, discharge, and transfer notices as patients move through hospitals and, if they do not, why.[39] CHI understands that ESRD facilities frequently encounter barriers to receiving them. Under the Conditions of Participation, a hospital whose electronic systems conform to the applicable content exchange standard must make reasonable efforts to send electronic patient event notifications to post-acute care providers and to the practitioners and entities that the patient identifies as responsible for their care.[40] ESRD facilities are not reliably among the recipients, are frequently absent from the directories that hospitals use to route those notifications, and often lack a certified electronic health record or any means of receiving a

[36] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.c, seeking comment on workforce development strategies that would increase the availability of trained home dialysis nurses, particularly in rural and underserved areas.

[37] CY 2026 Medicare Physician Fee Schedule final rule, CMS-1832-F (published Nov. 5, 2025), making permanent the policy permitting direct supervision through real-time audio-video communications.

[38] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.h, asking whether there are changes that could be made to the requirements for home dialysis monitoring or support services that would reduce burden on dialysis facilities without negatively impacting patient health and safety.

[39] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.k, asking whether ESRD facilities are receiving electronic admission, transfer, and discharge notices as patients transition through hospitals and, if not, why.

[40] 42 C.F.R. 482.24(d).

notification in usable form. The result is the sequence CMS describes, in which a beneficiary is hospitalized, the home dialysis facility does not learn of the admission promptly, the modality lapses while the patient is in the hospital, and the patient never returns to home dialysis.

CHI recommends that CMS:

- Clarify that ESRD facilities are intended recipients of electronic patient event notifications and are entitled to be listed in the provider directories used to route them.
- Align ESRD facility notification with the CMS Interoperability Framework and the Trusted Exchange Framework and Common Agreement, so that facilities can receive notifications through the same national infrastructure that other providers already use. A broad cross-section of the health care and technology sectors has already committed to advance that infrastructure, and ESRD facilities and the beneficiaries they serve should be able to share in the benefit of those commitments.[41]
- Support ESRD facility participation in that infrastructure, recognizing that ESRD facilities have never been eligible for the incentive payments that funded electronic health record adoption elsewhere in Medicare and therefore begin from a materially weaker technology base.
- Collect ESRD-specific data on whether and how facilities receive electronic patient event notifications, so that any policy response rests on measured practice and not on assumption.

On the related question concerning coordination with Accountable Care Organizations, the Medicare Shared Savings Program, and the Kidney Care Choices Model, that same national infrastructure is what would allow ESRD facilities and those participants to share modality and treatment data without building duplicative point-to-point interfaces.[42]

- **Measuring Success (Section V.B.3.l):** CMS asks whether a sixty-day continuation threshold is appropriate to ensure sustained home dialysis initiation.[43] CHI supports a duration-based measure over a simple count of initiations, and we recommend that CMS pair the sixty-day threshold with a longer measure, at one hundred eighty days or one year,

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CMS, White House and Tech Leaders Commit to Create Patient-Centric Healthcare Ecosystem (July 30, 2025), https://www.cms.gov/newsroom/press-releases/white-house-tech-leaders-commit-create-patient-centric-healthcare-ecosystem, describing commitments across the health care and information technology sectors, including networks committing to meet the CMS Interoperability Framework criteria.

[42] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.e(6), seeking comment on whether care coordination structures, data sharing practices, or operational alignment between ESRD facilities and Accountable Care Organization participants could support clinically appropriate modality education and treatment planning.

[43] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.B.3.l, asking whether a 60-day continuation threshold is appropriate to ensure sustained home dialysis initiation.

so that policy is not optimized to the first two months of a modality that patients should be able to sustain for years. We also recommend that CMS make use of the data that these programs already generate, because home dialysis machines and remote monitoring platforms produce treatment-level data continuously, and a measure of sustained home dialysis can be constructed from that data with far less burden and far less lag than a measure built from claims or chart abstraction. CMS should also account for clinical contraindication and documented patient preference, as it proposes, so that facilities serving populations for whom home dialysis is frequently inappropriate are not penalized for honoring patient choice.

- **Advancing Palliative Care for Dialysis Patients (Section V.C):** CHI does not take a position on how CMS should define palliative dialysis or determine eligibility for it, and we respond here to CMS' question as to what services are necessary to support safe and effective home-based dialysis for this population.[44] Those services must include remote monitoring, and for palliative dialysis they must include remote symptom monitoring in particular, because beneficiaries receiving comfort-focused dialysis at home need frequent assessment of symptom burden, volume status, and functional decline, and the practical alternative to remote assessment is either a burdensome trip to the facility or no assessment at all, neither of which serves a patient whose central goal is time spent at home. CHI recommends that whatever payment approach CMS develops for palliative dialysis expressly include remote monitoring and remote symptom assessment among the covered services, that electronic patient-reported outcome collection be permitted as a means of capturing symptom burden, and that CMS ensure its approach does not open a coverage gap between the ESRD PPS and the hospice benefit for the monitoring technology itself.
- **The Unit of Payment and Alternative Dialysis Schedules (Section V.D):** CMS revisits MedPAC's longstanding recommendation that it reconsider the per-treatment unit of payment.[45] From a technology perspective, the significance of that question is that a per-treatment unit of payment compensates discrete, countable, facility-based events and does not compensate the continuous management between treatments that remote monitoring provides and that makes flexible and home-based schedules safe. So long as the unit of payment is the treatment, any care that does not occur during a treatment is uncompensated overhead, and any schedule that reduces the number of treatments reduces revenue even where it improves outcomes. A weekly or monthly unit of payment, of the kind MedPAC suggested and of the kind that already applies in prorated daily form to home continuous ambulatory and continuous cycling peritoneal dialysis, would leave CMS indifferent as between treatment counts and would allow facilities to substitute continuous

[44] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.C.3.c, asking what services are necessary to support safe and effective home-based dialysis, including equipment setup, cannulation assistance, and monitoring.

[45] CY 2027 ESRD PPS proposed rule, 91 FR 38784, section V.D, noting MedPAC's recommendation that CMS reconsider the unit of payment and MedPAC's observation that a weekly unit of payment would correspond to the typical weekly interval for peritoneal dialysis, citing 75 FR 49064, and noting that the ESRD QIP and the Five-Star Quality Rating System now address the quality monitoring concern MedPAC identified.

remote management for in-person treatments where that substitution is clinically appropriate. Should CMS pursue a change to the unit of payment, CHI recommends the following:

  - Any change should be budget neutral at the outset and paired with the ESRD QIP and Five-Star measures that CMS notes now address the quality monitoring concern MedPAC originally identified.
  - Any broader unit of payment should expressly encompass remote monitoring and remote clinical management furnished between treatments, so that a change in the unit of payment does not simply relabel the existing bundle.

- **Artificial Intelligence in Kidney Care:** The proposed rule does not mention artificial intelligence (AI). Given the pace at which AI-enabled tools are entering clinical care, and given HHS' own recent Request for Information on accelerating the adoption and use of artificial intelligence as part of clinical care, CHI encourages CMS to begin considering how the ESRD PPS will accommodate AI-enabled software.[46] Several near-term applications bear directly on the goals of this rule, including predicting which patients are at risk of transitioning off a home modality, identifying candidates for home dialysis earlier in the course of chronic kidney disease, detecting peritonitis and access complications from monitoring data, and flagging volume and adherence problems between treatments. Payment and incentive policies must support the infrastructure, personnel, training, and ongoing validation and maintenance that responsible AI deployment requires. CHI has consistently urged that oversight of AI in health care be proportionate to the risk a given system presents, that developers be transparent about a tool's intended use and the evidence supporting it, and that a qualified clinician remain positioned to intervene at the points where AI influences clinical decisions. CHI recommends three steps:
  - Clarify how AI-enabled software that qualifies as a renal dialysis service is treated under the ESRD PPS and whether it may qualify for TPNIES.
  - Establish an evidence standard for AI-enabled tools that is proportionate to the risk a given tool presents, that requires disclosure of the tool's intended use, intended population, limitations, and validation evidence in the population and practice setting where it will be deployed, and that preserves qualified physician oversight of the clinical decisions the tool informs.
  - Coordinate with the Assistant Secretary for Technology Policy, the Food and Drug Administration, and the relevant clinical specialty societies, which are best positioned to identify the uses of AI-enabled technology most appropriate to nephrology practice, so that ESRD payment policy remains consistent with the broader federal approach to AI in clinical care.

[46] HHS Assistant Secretary for Technology Policy / Office of the National Coordinator for Health Information Technology, Request for Information: Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care (published Dec. 23, 2025), RIN 0955-AA13, Docket No. HHS-ONC-2026-0001.

## V. Conclusion

CHI appreciates the opportunity to submit these comments and urges CMS' thoughtful consideration of the input above. The Requests for Information in this proposed rule raise the right questions, and we would welcome the opportunity to work with CMS and other stakeholders as the agency develops policy in response to them. Please do not hesitate to contact us with any questions.

Sincerely,

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