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CMS Proposes 1.1 Percent Payment Increase for ESRD Facilities in CY 2027

On June 24, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) proposed rule (CMS-1846-P) for calendar year (CY) 2027. See the fact sheet here.

This rule proposes to:

- Increase ESRD payment rates by 1.1 percent;
- Update transitional drug add-on payment adjustment (TDAPA) policies, including updating eligibility timing and modifying the post-TDAPA add-on payment methodology;
- Increase the home and self-dialysis training add-on payment;
- Expand the Low-Volume Payment Adjustment (LVPA) to include more tiers with different adjustment factors;
- Update the transitional add-on payment adjustment for new and innovative equipment and supplies (TPNIES), although no applications were received; and
- Make updates to the ESRD Quality Incentive Program (QIP), including updates to performance standards and quality measures.

CMS is also seeking feedback on strategies to advance dialysis care, including increasing home dialysis uptake, improving palliative care, and enhancing the efficiency of dialysis service delivery.

The rule is scheduled to be published in the *Federal Register* on June 26, 2026, and comments are due August 25, 2026.

CMS PROPOSES A 1.1 PERCENT PAYMENT UPDATE FOR ESRD FACILITIES

Pages 18-71, 78- 151, and 220-224[1]

The ESRD PPS provides a single case-mix adjusted payment to ESRD facilities for renal dialysis services provided in an ESRD facility or in a Medicare beneficiary's home. This

[1] All page numbers listed are from the unpublished proposed rule.

bundled payment includes most drugs, services, supplies, and capital-related costs related to maintenance dialysis services. CMS adjusts ESRD PPS facility rates for geography, low-volume service delivery, and other factors.

For CY 2027, CMS proposes an ESRD PPS base rate of $299.55, a $17.84 increase from the CY 2026 base rate. CMS proposes the same base rate for renal dialysis services for individuals with acute kidney injury (AKI). CMS also proposes updates to the ESRD PPS wage index and its outlier policy, based on the most recently available data.

This proposed updated base rate includes an increase of $15.96 from CMS's proposal to include phosphate binders in the base rate, marking the completion of their integration into the bundled payment. Since January 1, 2025, these drugs have been paid for through the TDAPA, with CMS using this period to collect utilization data. To calculate the payment rate, CMS used TDAPA utilization data and the most recently available Average Sales Price (ASP) for each of the six phosphate binders and added an additional 6 percent to the payment rate to account for operational costs. CMS proposes to update its analysis for the CY 2027 ESRD PPS final rule using the most recently available data. CMS seeks feedback on proposed rate-setting methodology.

The agency estimates that total payments to ESRD facilities will increase by 1.1 percent from CY 2026. Hospital-based ESRD facilities are projected to see a 2.0 percent increase in total payments, while freestanding facilities are projected to see a 1.1 percent increase. CMS estimates that Medicare will pay $6.2 billion to ESRD facilities in CY 2027, reflecting a projected 1.5 percent decrease in fee-for-service Medicare ESRD beneficiary enrollment in CY 2027.

While CMS is largely maintaining its existing approach to ESRD base rate updates, the permanent inclusion of phosphate binders represents a planned policy shift, in which dialysis facilities will need to account for the inclusion of phosphate binders in the bundled rate.

CMS PROPOSES POST-TDAPA ADD-ON PAYMENT ADJUSTMENTS FOR CY 2027

Pages 72-75

TDAPA is a payment adjustment under the ESRD PPS meant for certain new renal dialysis drugs and biological products. In the CY 2026 ESRD PPS final rule, CMS established a new timeline for TDAPA eligibility. Specifically, to be eligible for TDAPA, a drug or biologic must have been approved by the FDA within the past 3 years at the time of submission, effective on or after January 1, 2028.

CMS identifies four drugs included in the post-TDAPA add-on payment adjustment: DefenCath® (taurolidine and heparin sodium), Vafseo® (vadadustat), Korsuva®, and Jesduvroq®. CMS proposes excluding Jesduvroq® from the calculation because it did not receive ASP data for the third quarter of 2025. CMS also proposes including Korsuva® only for the first quarter of CY 2027 because its add-on payment adjustment period began on April 1, 2024. The proposed add-on amounts are outlined in Table 1 below.[2]

Table 1. Estimated Post-TDAPA Add-on Payment Adjustment Amounts for CY 2027 by Quarter

Quarter	Proposed add-on amount for Korsuva®	Proposed add-on amount for DefenCath®	Proposed add-on amount for Vafseo®	Total proposed post-TDAPA add-on payment adjustment amount
Q1 (January – March)	$0.1068	$$5.5951	$0.9437	$6.6456
Q2 (April – June)	$0	$5.5951	$0.9437	$6.5388
Q3 (July – September)	$0	$5.5951	$0.9437	$6.5388
Q4 (October – December)	$0	$5.5951	$0.9437	$6.5388

Proposed Modifications to the Post-TDAPA Add-on Payment Adjustment Methodology

Pages 75-78

For CY 2027, CMS proposes to calculate post-TDAPA add-on payment adjustments quarterly rather than annually. If finalized, the change would not alter the calculation methodology, and CMS would publish the updated amounts each quarter through change requests (CRs). CMS explains that this approach would allow it to use the most recent data in its calculations and help ESRD facilities estimate payments more accurately in advance.

[2] See page 74 Table 12 of the unpublished proposed rule.

CMS is also proposing to modify the conditional ASP policy to allow the use of older data when current ASP data is not available. Additionally, CMS proposes to end the post-TDAPA add-on payment adjustment the quarter after non-submission of ASP data, but maintains flexibility in using the prior quarter's data if a quarterly update cannot be issued due to operational issues.

These proposed changes respond to stakeholder recommendations submitted on the CY 2025 and CY 2026 ESRD PPS proposed rules and seek to improve payment transparency by incorporating updated data more frequently.

CMS PROPOSES TO INCREASE THE HOME AND SELF-DIALYSIS TRAINING ADD-ON PAYMENT

Pages 134-143

There are three components to the payment for home and self-dialysis training: 1) the base rate, 2) a wage-adjusted home and self-dialysis add-on payment adjustment, and 3) an allowable number of training treatments. For CY 2027, CMS proposes to increase the overall payment for home and self-dialysis from $95.60 to $138.22. CMS is also proposing to allow facilities to receive the home and self-dialysis training add-on payment adjustment during the onset period. Additionally, CMS proposes that this policy be budget-neutral.

If finalized, payment rates would better account for and capture the actual cost of training patients and caretakers.

CMS PROPOSES CHANGES TO THE LVPA

Pages 100-118

A low-volume facility is an ESRD facility that either furnished fewer than 4,000 treatments in each of the three previous cost reporting years or has not opened, closed, or received a new provider number due to a change in ownership during that period. These facilities receive an additional payment under the LVPA. In CY 2025, CMS finalized a policy creating two LVPA tiers based on each facility's treatment volume.[3]

[3] CY 2025 ESRD PPS Final Rule.

In this rule, CMS proposes to expand the LVPA threshold from 4,000 and two tiers to 8,000 and six tiers. CMS would implement the policy in a budget-neutral manner by applying a 0.98898 factor to the ESRD PPS base rate. The proposed adjustment factors are found below in Table 2.[4]

Table 2. Proposed 6-tier LVPA

Treatment Volume Tier (per year)	Number of Eligible ESRD facilities	Current Adjustment Factors	Proposed Adjustment Factors
0-2,999	189	1.289	1.389
3,000-3,999	223	1.183	1.249
4,000-4,999	299	1.000	1.173
5,000-5,999	296	1.000	1.120
6,000-6,999	307	1.000	1.080
7,000-7,999	175	1.000	1.050

This policy would be effective January 1, 2027, but CMS is specifically soliciting comments on this timeline and how to accommodate facilities that would need to properly attest for the LVPA for CY 2027.

The change to expand the tiered structure in a budget-neutral way is intended to mitigate the "cliff effect," where a facility might be incentivized to remain below the threshold of services to receive the LVPA. CMS estimates that this proposal would lower the ESRD PPS base rate by approximately 1.1 percent.

CMS RECEIVES NO APPLICATIONS FOR TPNIES FOR CY 2027

Pages 71 and 72

In the CY 2020 ESRD PPS final rule, CMS introduced TPNIES under the ESRD PPS for certain new and innovative renal dialysis equipment and supplies. While no applications were submitted for CY 2027, CMS is required to propose an average per treatment

[4] See page 115 or Table 16 of the unpublished proposed rule.

offset amount for TPNIES for capital-related assets that are dialysis machines. For CY 2027 the amount proposed is $10.60.

AGENCY PROPOSES UPDATES TO THE ESRD QIP

Pages 154-179

The ESRD QIP is designed to evaluate and improve the quality of care provided to patients with ESRD. It also requires the establishment of performance standards for selected measures each performance year, in accordance with sections 1881(h)(4)(A), (B), and (C) of the Act. These standards include levels of achievement and improvement and must be set before the performance period begins. The performance period for Payment Year (PY) 2029 is CY 2027, with the baseline period set as CY 2025. Facilities must meet minimum data requirements, and specific conditions apply based on the measure and facility size.

CMS proposes updates to the ESRD QIP for PY 2029 to enhance the relevance of its reporting measures and to update performance standards, reporting requirements, and payment reduction scales. CMS invites comment on these proposals.

Two Measure Removals and One Measure Replacement Proposed for PY 2029

CMS proposes to remove the following two measures beginning with PY 2029:

- **Medication Reconciliation (MedRec) Reporting Measure (introduced in CY 2019 ESRD PPS final rule):** This measure assesses whether facilities appropriately evaluate patient medications. CMS cites limited programmatic value and a desire to better focus the measure set on the broader ESRD population.
- **COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Reporting Measure (introduced in CY 2023 ESRD PPS final rule):** This measure requires dialysis facilities to report the COVID-19 vaccination status of HCP through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). CMS cites elevated provider burden and misalignment with current clinical guidelines or practice.

CMS also proposes replacing the Hypercalcemia reporting measure with the Hyperphosphatemia clinical measure and updating eligibility requirements beginning in PY 2029, stating that the replacement measure would better assess patient-focused clinical outcomes. Updates to the National Healthcare Safety Network Bloodstream Infection in Hemodialysis Patients Clinical Measure are also proposed.

Measure Domains and Weights Used to Calculate the Total Performance Score

If the proposals to remove the MedRec and COVID-19 Vaccination Coverage Among HCP reporting measures from the ESRD QIP are finalized, the measure set would not include any measures under the Reporting Measure Domain. To reflect these proposed changes, CMS proposes removing this domain and updating the domain weights and individual measure weights in the Care Coordination Domain and the Clinical Care Domain. CMS suggests this update will address concerns about how individual performance measures affect a facility's Total Performance Score (TPS) and further encourage improvement in clinical measures.

Proposed Performance Standards for Clinical Measures

For PY 2029, CMS proposes using data from CY 2024, the most recent available, to estimate performance standards for clinical measures. CMS proposes to update these standards using CY 2025 data in the CY 2027 ESRD PPS final rule. For a complete list of performance standards for PY 2029 Clinical Measures, refer to Table 22 of the unpublished proposed rule.[5]

Proposed Payment Reduction Scale

For PY 2029, facilities must achieve a TPS of at least 51 to avoid a payment reduction. Payment reductions will be implemented on a sliding scale, with a maximum reduction of 2 percent for facilities with the lowest performance scores. These estimates are based on CY 2024 data and will be updated with CY 2025 data in the CY 2027 ESRD PPS final rule.

Request for Information on D-PaLS PRO-PM in the ESRD QIP

CMS seeks feedback on the potential inclusion of the Dialysis Facility Discussion of Patient Life Goals Patient-Reported Outcome Performance Measure (D-PaLS PRO-PM) in the ESRD QIP. The D-PaLS PRO-PM assesses whether dialysis facilities discuss patients' life goals and incorporate those discussions into treatment plans. Evidence suggests that discussions about integrating patients' life goals into treatment decisions do not consistently occur in practice among ESRD patients. Consequently, individuals with ESRD often report feeling uninformed about treatment options and not involved in decision-making.

The proposed rule represents a modest update to the ESRD QIP. CMS estimates that the proposed ESRD QIP policies will result in an overall economic impact of approximately $125.4 million, which includes payment reductions across all facilities and information collection requirements.

[5] Page 172 of the unpublished rule.

FEEDBACK SOUGHT ON ADVANCING DIALYSIS CARE

Pages 180-206

To better understand how Medicare payment policy may support care for ESRD beneficiaries while maintaining the integrity of existing prospective payment systems, CMS requests information on ways to advance dialysis care. This includes strategies to increase home dialysis uptake, improve palliative care, and enhance the efficiency of dialysis service delivery. Feedback will inform efforts to better meet the evolving needs of ESRD beneficiaries.

1. **Increasing Home Dialysis Uptake:** CMS seeks feedback on approaches to increase the percentage of incident, non-pediatric, non-Medicare Advantage ESRD beneficiaries initiating and remaining on a home modality for dialysis.
2. **Advancing Palliative Care for Dialysis Patients:** CMS seeks feedback on how to define "palliative dialysis", identify eligible beneficiaries, and structure care delivery across ESRD facilities, hospice providers, and home health agencies. CMS also seeks input on payment approaches that could support palliative dialysis without creating duplicate payment across the ESRD, Hospice, and Home Health PPS.
3. **Potential Payment Changes to Support Alternative Dialysis Schedules:** CMS seeks feedback on considerations associated with changing the ESRD PPS unit of payment from a per-treatment to a monthly (daily rate) structure.

CMS signals it is considering ways to align the ESRD PPS payment framework with "Advancing American Kidney Health" while meeting the evolving needs of ESRD beneficiaries.

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