Issue Brief

FEDERAL ISSUE BRIEF

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CMS Issues Final CY 2026 ESRD PPS Update

The Centers for Medicare and Medicaid Services (CMS) have released the Calendar Year (CY) End-Stage Renal Dialysis (ESRD) PPS Program Update. A copy of the 233-page document is available from CMS at: https://public-inspection.federalregister.gov/2025-20681.pdf.

The rule is scheduled for publication in the ***Federal Register*** on November 24.

Comments

The rule does have an overall table of contents. Nonetheless, we are adding page numbers, in red. This rule is highly fragmented with issues first being presented as a summary in Section I and then being shown in Section II in detail. Our analysis below is trying to avoid being redundant.

The rule does provide "Final Rule Action" sections, and we are showing all.

I. Summary of Select Major Provisions

Update to the ESRD PPS Base Rate for CY 2026:

The CY 2026 ESRD PPS base rate will be **$281.71**, an increase from the current CY 2025 ESRD PPS base rate of $273.82.

This final amount reflects the application of a wage index budget neutrality adjustment factor (1.00905), the budget neutrality factor for the final non-contiguous areas payment adjustment (NAPA)

(0.99860), and a final ESRD Bundled (ESRDB) market basket update of 2.1 percent as required by section 1881(b)(14)(F)(i)(I) of the Act, equaling $281.71 (($273.82 × 1.00905 × 0.99860) × 1.021 = $281.71). (Pages 6 and 20)

Final Rule Action: After consideration of public comments, CMS is finalizing a CY 2026 ESRD PPS base rate of $281.71. (Page 69)

Update to the Dialysis Payment Rate for Individuals with AKI:

The CY 2026 AKI payment rate is **$281.71**, which is the same as the final CY 2026 ESRD PPS base rate. (Page 8)

CMS is finalizing its proposal to not apply the NAPA to Medicare payments for renal dialysis services furnished to beneficiaries with AKI. (Page 123)

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Annual Update to the Outlier Policy:

For pediatric beneficiaries, the Fixed Dollar Loss (FDL) amount will decrease from $234.26 to $162.43, and the MAP amount would decrease from $59.60 to $50.19, as compared to CY 2025 values.

For adult beneficiaries, the FDL amount would decrease from $45.41 to $14.80, and the MAP amount will decrease from $31.02 to $23.68.

The 1.0 percent target for outlier payments was not achieved in CY 2024, as outlier payments represented approximately 0.8 percent of total Medicare payments. (Page 7)

Comment

Making estimated predictions is difficult, if not impossible. Year after year, CMS cannot accurately predict outlier payments. The CY 2024 underpayment is 20 percent of the outlier target.

And, again, CMS does not address fixing these yearly errors on a prospective basis. Rather, the agency believes that simply adjusting overall outlier thresholds compensates for the inability to forecast such errors.

There are instances in which CMS has noted that in correcting certain estimation errors can lead to incorrect adjustments involving individual provider amounts. Continuing to adjust outlier errors, as presented, in fact, may provide inaccurate payments to providers since a providers' year-to-year outlier incurred costs may vary.

Non-Contiguous Areas Payment Adjustment (NAPA):

CMS is finalizing a new payment adjustment, the NAPA, for ESRD facilities in certain high-cost, non-contiguous states and territories to account for certain non-labor costs which are not captured in the ESRD PPS wage index. This payment adjustment will apply to ESRD PPS claims submitted by ESRD facilities in Alaska, Hawaii, and the U.S. Pacific Territories of Guam, American Samoa, and the Northern Mariana Islands. CMS is also finalizing its proposal that the NAPA will be budget neutral and will apply a corresponding budget neutrality factor of **0.99860** to the CY 2026 ESRD PPS base rate. (Page 8)

Final Rule Action: CMS is finalizing the proposed Non-Contiguous Areas Payment Adjustment (NAPA) with a 25 percent cap as proposed. CMS says it continues to believe that the capped NAPA strikes an appropriate balance between increasing payments to ESRD facilities in non-contiguous areas for which CMS has evidence of relatively higher non-labor costs and mitigating the impact of this payment adjustment on ESRD facilities located in the contiguous U.S. and the Caribbean territories of Puerto Rico and the U.S. Virgin Islands.

ETC Model:

CMS is terminating the ETC Model and modifying the duration during which CMS will apply the payment adjustments described in 42 CFR part 512, subpart C to claims with claim service dates beginning on or after January 1, 2021, and ending on or before December 31, 2025. (Page 9)

Summary of Costs and Benefits: (Page 10)

The Table below summarizes the impacts of each provision in this CY 2026 ESRD PPS final rule.

TABLE 1—Updated Estimated Total Costs/Transfers

Final Changes	Estimated total costs/transfers
Final CY 2026 ESRD PPS updates	**The overall economic impact of this proposed rule is an estimated increase of approximately $180 million in aggregate payments to ESRD facilities in CY 2026.** This includes estimated expenditures of approximately $34 million associated with the post-transitional drug add-on payment adjustment (TDAPA).
Final CY 2026 AKI dialysis payment rate update	CMS estimates that the aggregate Medicare payments made to ESRD facilities for renal dialysis services furnished to individuals with AKI, will increase by $1 million.
PY 2027 and PY 2028 QIP updates	CMS estimates that, as a result of previously finalized policies and changes to the ESRD QIP, the overall economic impact of the PY 2027 ESRD QIP will be approximately $146.6 million. CMS estimates that, as a result of previously finalized policies and changes to the ESRD QIP that are being finalized, the overall economic impact of the PY 2028 ESRD QIP will be approximately $145.6 million.
Proposed ETC Model termination	CMS estimates that, as a result of the termination of the ETC Model, the net Federal impact will be approximately $1 million in savings.

II. Calendar Year (CY) 2026 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) (Page 13)

CY 2026 ESRD Bundled (ESRDB) Market Basket Percentage Increase; Productivity Adjustment; and Labor-Related Share: (Page 20)

The final CY 2026 ESRDB market basket percentage increase is **2.9** percent. Based on IGI's third quarter 2025 forecast, the CY 2026 final productivity adjustment is **0.8** percentage point.

Therefore, the CY 2026 ESRDB market basket update is equal to **2.1 percent** (proposed 2.7 percent ESRDB market basket percentage increase reduced by a 0.8 percentage point productivity adjustment).

ESRD Labor-Related Share:

For the CY 2026 ESRD PPS payment update, CMS is proposing to continue using a labor-related share of **55.2 percent**, which was finalized in the CY 2023 ESRD PPS final rule. (Page 24)

Comment

Commentors noted that the ESRD market basket appears understated. CMS has responded that the cumulative forecast error since the inception of the ESRD PPS (calendar year 2012 to 2024) is 5.3 percent. The cumulative forecast is calculated as the product of the annual forecast errors and excludes the year 2015, as section 217(b) of PAMA required the CY 2015 ESRD PPS payment update to be 0.0 percent.

CMS does acknowledge that recent forecast errors have been larger than prior errors and have been consecutively under-forecast. "We did not propose a forecast error policy for CY 2026, and we are not finalizing such a policy in this final rule." (Page 34)

One must ask why CMS continues to be against correcting forecasting errors?

Final Rule Action: CMS did not propose and is not finalizing any changes to the ESRDB market basket methodology for CY 2026. Thus, the final ESRDB market basket update for CY 2026 is 2.1 percent, representing an ESRDB market basket percentage increase of 2.9 percent reduced by a 0.8 percentage point productivity adjustment. Additionally, CMS did not propose any changes to the LRS and are finalizing the continued use of a LRS of 55.2 percent for CY 2026. (Page 38)

CY 2026 ESRD PPS Wage Indices:

Final rule action: After consideration of public comments, CMS is finalizing the use of the CY 2026 ESRD PPS wage index according to its established methodology based on the May 2024 Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) program and occupational mix data from the most recent full CY of freestanding ESRD facility Medicare cost reports. BLS OEWS mean wage data and CY 2023 cost report data. Additionally, CMS is finalizing the use of the May 2024 BLS OEWS estimates for Colorado, which were not available at the time of proposed rulemaking but were released in July 2025. The final CY 2026 ESRD PPS wage index is set forth in Addendum A and provides a crosswalk between the CY 2025 wage index and the CY 2026 wage index. Addendum B provides an ESRD facility level impact analysis. Both Addendum A and Addendum B are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices. (Page 53)

CY 2026 Update to the Outlier Policy: (Page 53)

The estimates for the CY 2026 MAP amounts, as shown in column II of Table 3 below, were inflation adjusted to reflect projected 2026 prices for ESRD outlier services. (Page 63)

TABLE 3: Outlier Policy: Impact of Updated Data for the Outlier Policy

	Column I Final outlier policy for CY 2025 (based on 2023 data, price inflated to 2025) *		Column II Final outlier policy for CY 2026 (based on 2024 data, price inflated to 2026)**	
	Age < 18	Age >= 18	Age < 18	Age >= 18
Average outlier services MAP amount per treatment	$58.30	$32.40	$50.64	$24.83
Adjustments				
Standardization for outlier services	1.0432	0.9768	1.0113	0.9731
MIPPA reduction	0.98	0.98	0.98	0.98
Adjusted average outlier services MAP amount	$59.60	$31.02	$50.19	$23.68
Fixed-dollar loss amount that is added to the predicted MAP to determine the outlier threshold	$234.26	$45.41	$162.43	$14.80
Patient-month-facilities qualifying for outlier payment	6.09%	7.05%	7.58%	14.10%

*Column I was obtained from column II of Table 7 from the CY 2025 ESRD PPS final rule (89 FR 89130).

**The FDL amount for adults incorporates retrospective adult FDL amounts calculated using data from CYs 2022, 2023, and 2024.

Final Rule Action: CMS is finalizing its proposal to update the FDL and MAP amounts for CY 2026 based on the latest available data. The impact of this final update is shown in Table 3, above, which compares the outlier services MAP amounts and FDL amounts used for the outlier policy in CY 2025 with the updated estimates for this final rule for CY 2026. (Page 63)

Update to the Offset Amount for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) for CY 2026: (Pages 7, 73 and 113)

Final rule action: After consideration of public comment, CMS is finalizing its proposal to update the CY 2026 TPNIES offset amount. Applying the final ESRDB market basket update factor of 1.021 to the CY 2025 TPNIES offset amount results in the final CY 2026 TPNIES offset amount of $10.43 ($10.22 × 1.021 = $10.43). (Page 73)

CMS did not receive any applications for the TPNIES for CY 2026, CMS did not include any TPNIES application summaries, CMS analyses, or results in the proposed rule. (Page 113)

Update to the Post-TDAPA (Transitional Drug Add-on Payment Adjustment) Add-on Payment Adjustment Amounts: (Pages 7 & 113)

The final post-TDAPA add-on payment adjustment amount for Korsuva® is $0.1131 per treatment, which will be included in the calculation of the total post-TDAPA add-on payment adjustment for each

quarter in CY 2026. The final post-TDAPA add-on payment adjustment amount for DefenCath® is $2.3710 per treatment, which will be included in the calculation for the third and fourth quarters of CY 2026.

Final rule action: CMS is finalizing the post-TDAPA add-on payment adjustment amounts for each quarter of CY 2026 presented in the rule's Table 4 (Page 80)

Update to the Timeframe for TDAPA Eligibility: (Page 8)

CMS is modifying the timeframe for TDAPA eligibility to provide that a new renal dialysis drug or biological product must have been approved by the Food and Drug Administration (FDA) within the past 3 years at the time of submission of the TDAPA application. This revised eligibility timeframe will apply for all new drugs and biological products for which a TDAPA application is submitted on or after January 1, 2028.

Final Rule Action: CMS is finalizing the 3-year eligibility window for the TDAPA for new renal dialysis drugs and biological products in both existing and new ESRD PPS functional categories, effective January 1, 2028, as proposed. (Page 92)

Continuation of Approved Transitional Drug Add-On Payment Adjustments for CY 2026

(Page 114)

Two new renal dialysis drugs for which the TDAPA payment period as specified in § 413.234(c)(1) will continue in CY 2026: DefenCath® (taurolidine and heparin sodium) and Vafseo® (vadadustat).

III. Final Changes to the Quality Incentive Program (ESRD QIP) (Pages 8 and 125)

Removal of the Facility Commitment to Health Equity Reporting Measure Beginning with the PY 2027 ESRD QIP (Page 125)

Final Rule Action: After considering public comments, CMS is finalizing its proposal to remove the Facility Commitment to Health Equity reporting measure from the ESRD QIP beginning with the PY 2027 ESRD QIP. (Page 128)

Removal of the Two Social Drivers of Health Reporting Measures Beginning with the PY 2027 ESRD QIP (Page 129)

Final Rule Action: After considering public comments, CMS is finalizing its proposal to remove the Screening for Social Drivers of Health reporting measure and the Screen Positive Rate for Social Drivers of Health reporting measure from the ESRD QIP beginning with the PY 2027 ESRD QIP.

Updates to the ICH CAHPS Clinical Measures Beginning with PY 2028 (Page 136)

CMS is updating the ICH CAHPS clinical measure to 39 questions, reducing the length of the current survey by 23 questions.

The finalized PY 2028 ESRD QIP measure set (in Table 13), includes the previously finalized measures and the measures CMS is finalizing.

TABLE 13: Finalized Measures for the PY 2028 ESRD QIP Measure Set

Consensus-Based Entity (CBE) #	Measure Title and Description
0258	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey Administration, a clinical measure Measure assesses patients' self-reported experience of care through percentage of patient responses to multiple survey questions.
2496	Standardized Readmission Ratio (SRR), a clinical measure Ratio of the number of observed unplanned 30-day hospital readmissions to the number of expected unplanned 30-day readmissions.
Based on CBE #2979	Standardized Transfusion Ratio (STrR), a clinical measure Ratio of the number of observed eligible red blood cell transfusion events occurring in patients dialyzing at a facility to the number of eligible transfusions that would be expected.
Based on CBE #0323, # 0321, 2706, and #1423	(Kt/V) Dialysis Adequacy Measure Topic, a clinical measure topic Four measures of dialysis adequacy where K is dialyzer clearance, t is dialysis time, and V is total body water volume. The individual Kt/V measures would be adult hemodialysis (HD) Kt/V, adult peritoneal dialysis (PD) Kt/V, pediatric HD Kt/V, and pediatric PD Kt/V.
2978	Hemodialysis Vascular Access: Long-Term Catheter Rate clinical measure Measures the use of a catheter continuously for 3 months or longer as of the last hemodialysis treatment session of the month.
1454	Hypercalcemia, a reporting measure Percentage of patient-months with total uncorrected serum or plasma calcium lab value reported in EQRS.
1463	Standardized Hospitalization Ratio (SHR), a clinical measure Risk-adjusted SHR of the number of observed hospitalizations to the number of expected hospitalizations.
Based on CBE #0418	Clinical Depression Screening and Follow-Up, a clinical measure Facility reports in ESRD Quality Reporting System (EQRS) one of four conditions for each qualifying patient treated during performance period.

Consensus-Based Entity (CBE) #	Measure Title and Description
Based on CBE #1460	National Healthcare Safety Network (NHSN) Bloodstream Infection (BSI) in Hemodialysis Patients, a clinical measure The Standardized Infection Ratio (SIR) of BSIs will be calculated among patients receiving hemodialysis at outpatient hemodialysis centers.
N/A	Percentage of Prevalent Patients Waitlisted (PPPW), a clinical measure Percentage of patients at each facility who were on the kidney or kidney-pancreas transplant waitlist averaged across patients prevalent on the last day of each month during the performance period.
2988	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities (MedRec), a reporting measure Percentage of patient-months for which medication reconciliation was performed and documented by an eligible professional.
3636	COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP), a reporting measure Percentage of HCP who are up to date on their COVID-19 vaccination.

Survey and Measure Changes (Page 137)

CMS proposed the following revisions to the ICH CAHPS Survey used to calculate performance on the ICH CAHPS clinical measure:

- Removal of four questions, which are unnecessary for the psychometric function of the Quality of Dialysis Center Care and Operations (QDCCO) multi-item measure:

  ++ Whether the dialysis center staff inserted needles with as little pain as possible,

  ++ whether dialysis center staff talked to patients about what they should eat and drink,

  ++ whether the dialysis center staff keep health information as private as possible, and

  ++ whether the patient felt the staff cared about them “as a person.”
- Removal of all six questions that make up the Nephrologists’ Communication and Caring (NCC) multi-item measure
- Removal of the nephrologist rating question.

Additionally, to further reduce the length of the ICH CAHPS Survey, CMS proposed to update the ICH CAHPS Survey to include the following non-measure changes:

- Removal of two core questions not currently used in public reporting measures:

  ++ Whether the dialysis center staff asked about how kidney disease affects other parts of patient's lives, and

  ++ whether patients made a complaint to Medicare or their State agencies.

- Removal of nine questions from the About You section and one question from the mail

  survey proxy series.

- Consolidation of the race and ethnicity questions into one question, as per OMB Statistical Policy Directive No. 15 requirements.

CMS proposed to implement the revised ICH CAHPS Survey beginning with the CY 2026 Spring survey.

Final Rule Action: After considering public comments, CMS is finalizing its proposals to update the ICH CAHPS clinical measure beginning with the PY 2028 ESRD QIP. (Page 145)

Waiver of Delayed Effective Date (Page 217)

CMS notes that it ordinarily provides a 60-day delay in the effective date of final rules after the date they are issued. The 60-day delay in effective date required by the Congressional Review Act, 5 U.S.C. 801(a)(3), can be waived, however, if the agency finds for good cause that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest, and the agency incorporates the finding and a brief statement of reasons in the rule issued, 5 U.S.C. 808(2). For the following reasons, CMS finds it would be impracticable and contrary to the public interest to delay the effective date of the ESRD PPS, AKI, ETC Model, and ESRD QIP policies in this final rule. The ESRD PPS is a calendar-year payment system, and CMS typically issue the final rule by November 1 of each year to ensure that the payment policies for the system are effective on January 1, the first day of the calendar year to which the policies are intended to apply.

Final Comments

CMS has taken a strange track in providing information. First, CMS tries to report in a summary format many of its final changes. Second, CMS provides details of its changes in another section. This leads to confusion and much redundancy.

There is still a considerable amount of unneeded history. The rule could be shortened if much duplication and history would be eliminated.

Note, a number of items are not included in this analysis. ESRD providers should review the proposal in-depth to insure they understand all the changes being proposed.

It is very interesting that CMS is terminating the ETC Model, and even more interesting that the model is being eliminated because it (1) failed to meet its initial objective, and (2) did not save monies.

As CMS continues to test various concepts and models, it should identify frequently and not wait, as in this case, five years.

Further, mandating providers participate in such tests should more limited and possibly made voluntary to prevent issues as with the ETC.