Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1830–P
P.O. Box 8010
Baltimore, MD 21244–8010

RE: CY 2026 ESRD Prospective Payment System Proposed Rule (CMS-1830-P)

Dear Administrator Oz:

On behalf of the American Nephrology Nurses Association (ANNA), I appreciate the opportunity to comment on the CY 2026 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) proposed rule. Please note that ANNA fully supports the comments made by both the Kidney Care Partners (KCP) and the Alliance for Home Dialysis (AHD). In addition to comments on the proposed rule, we have also highlighted important issues facing nephrology nurses to provide you with additional context.

About ANNA

The American Nephrology Nurses Association improves members' lives through education, advocacy, networking, and science. Since it was established as a nonprofit organization in 1969, ANNA has been serving members who span the nephrology nursing spectrum. ANNA has a membership of over 8,000 registered nurses and other health care professionals at all levels of practice. Members work in areas such as conservative management, peritoneal dialysis, hemodialysis, continuous renal replacement therapies, transplantation, industry, and government/regulatory agencies. ANNA is committed to advancing the nephrology nursing specialty and nurturing every ANNA member. We achieve these goals by providing the highest quality educational products, programs, and services. Our members are leaders who advocate for patients, mentor each other, and lobby legislators, all to inspire excellence.

ANNA Comments to ESRD Proposed Rule

1. **ESRD Prospective Payment System (PPS): Inflation and Workforce Sustainability**

While we appreciate the proposed 2.7% ESRD market basket increase and the resulting payment update, we remain concerned that current reimbursement

levels are insufficient to support a sustainable nursing workforce in dialysis settings. Inflation and severe workforce shortages continue to impact care, pushing wages upward and creating access to care challenges, especially in underserved communities.

Facilities report ongoing difficulty maintaining adequate staffing to start treatments on time, ensure full treatment durations, and uphold regular patient schedules. These staffing challenges have led to the reduction of dialysis shifts, site closures, and extended wait times for care. As a result, patients report having to travel long distances for treatment, a burden for those with limited transportation in rural communities. Additionally, some beneficiaries experience prolonged hospital stays simply because local dialysis facilities cannot accommodate new admissions, which only adds burden to the system as a whole.

Furthermore, dialysis units are often unable to offer competitive salaries, making it difficult to recruit and retain qualified registered nurses. This is particularly problematic in nephrology, where specialized expertise is required (but is frequently lacking) due to limited exposure in nursing education programs. The shortage is exacerbated by the retirement of experienced staff or nurses leaving the profession altogether, resulting in the loss of mentors critical to developing new talent. Further compounding the issue are the impending deep cuts to Medicaid, which could reduce resources for a large portion of dialysis patients who are dually eligible for Medicare and Medicaid. This financial strain may further limit dialysis units' ability to offer competitive salaries, worsening the challenges of recruiting and retaining qualified nurses.

Addressing these issues will require deliberate investment. We urge CMS to consider how reimbursement policy can better support the development of a strong nursing workforce, including:

- Sustainable and competitive salary structures,
- Reasonable shift lengths and manageable nurse-to-patient ratios, and
- Healthy work environments that provide adequate breaks, paid time off, and protections against workplace violence or harassment.

Demonstrating that nephrology nurses are supported and valued is essential to addressing burnout, reducing turnover, and reversing workforce attrition in this vital area of care.

2. Quality Incentive Program

The ESRD Quality Incentive Program (QIP) plays a central role in promoting performance improvement across dialysis facilities. As CMS considers updates to the QIP for PY 2027 and beyond, we offer the following comments on provisions likely to impact both the nursing workforce and patient care.

- *Removal of Health Equity Measures*

ANNA supports the Administration's focus on improving healthcare by focusing on nutritional and environmental impacts on health as these are critical to preventing kidney disease. They become even more important when managing kidney disease. ANNA remains committed to a comprehensive, holistic approach to healthcare and applauds the Administration's spotlight on **preventative** measures, as opposed to measures that only reflect the quality of care in a dialysis facility.

However, this philosophy does not always translate into how measures are developed for dialysis facilities. For example, the Facility Commitment to Health equity measure and the two health-related social needs (HRSNs) screening measures are problematic because they create an administrative burden and take time away from patient care. As KCP states in its letter, "while it is important to identify barriers that affect the delivery of kidney care to individuals, the right balance must be struck to ensure that these barriers to accessing healthcare are identified and addressed without inadvertently disincentivizing the provision of care to more medically complex patients". Specifically, it is unclear whether these measures would help individuals choose a facility, since they likely reflect the socioeconomic challenges of the patient population more than the care provided. As such, ANNA supports the removal of the Facility Commitment to Health equity measure and the HRSNs.

On the other hand, the routine collection of data during patient evaluations is essential for identifying and addressing disparities in kidney disease incidence, access to care, and outcomes. These data determine economic stability and access to healthy food, medications, healthcare visits and access to treatments all of which can be used to ensure timely diagnosis, better management of comorbidities like diabetes and high blood pressure, and the ability to access transportation for medical care.

For example, this data has revealed that Black Americans are nearly four times more likely to develop ESRD than White Americans, and that Black and Hispanic patients under age 65 are less likely to start home dialysis or receive a

transplant, regardless of insurance status. CMS, in response to an executive order, recently removed the race and ethnicity questions from Form CMS-2728. We believe this is an example of a removal that will severely limit the ability to monitor these trends, evaluate interventions, and allocate resources equitably. It would also undermine the U.S. Renal Data System's capacity to conduct critical demographic analyses, weakening public health research and targeted policy development. While concerns about the misuse of demographic data are valid, they should be addressed through responsible safeguards rather than by eliminating data collection altogether. **We therefore strongly urge CMS to restore the self-reported race and ethnicity questions to Form CMS-2728 to ensure data-driven, equitable improvements in kidney care.**

- *Updates to the ICH CAHPS Measure*

We support CMS's proposal to streamline the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey by removing 23 questions. Simplifying the survey may reduce respondent fatigue and improve completion rates, particularly for patients with limited health literacy or cognitive burden.

However, we encourage CMS to ensure that the revised instrument continues to capture patient experiences that reflect the care they receive, such as communication, trust, and responsiveness. Because the ICH CAHPS survey is the QIP's primary patient experience measure, it plays an outsized role in how nephrology nurses and facilities are evaluated. Many of the domains it touches are delivered directly by nephrology nurses. Ensuring that these remain represented in the shortened survey is critical to preserving a meaningful link between quality measurement and the patient experience.

Additionally, we recommend reducing the administration of this survey to once a year to lessen the burden on patients and providers while still yielding meaningful data. Annual administration would help ensure that patient feedback reflects a broader view of their care experience over time, rather than short-term fluctuations. Equally important, survey results should be shared in a timely and actionable format with providers and facilities. Transparent access to this information would allow nephrology nurses and care teams to identify specific areas for improvement, implement targeted interventions, and monitor the impact of those changes. By aligning survey frequency and data transparency with quality improvement efforts, CMS can help ensure that patient experience feedback drives tangible enhancements in dialysis care.

Lastly, given the focus on increasing home dialysis, we also encourage CMS to specifically include the experience of individuals receiving home dialysis as this will go a long way to inform how to improve the quality of care they receive.

3. **Transitional Add-On Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES)**

CMS proposes a $10.41 per-treatment offset for capital-related home dialysis machines. While we appreciate CMS's effort to support innovation and home dialysis expansion, the proposed reimbursement amount may be viewed as insufficient to cover the full costs associated with acquiring and maintaining such technologies. Nephrology registered nurses (RNs) who train and support patients on home modalities may find it difficult to scale home dialysis programs without stronger financial support for technology acquisition and staff training.

4. **Transitional Period for End-Stage Renal Disease Alternative Payment Model (TPEAPA)**

The continuation of the TPEAPA for pediatric ESRD patients at 30% is beneficial. We urge CMS to consider extending similar support to adult nephrology services, recognizing the unique challenges faced by nurses managing complex adult cases, particularly those involving new and innovative therapies.

5. **Geographic Equity: Payment Adjustments for Non-Contiguous States and Territories**

We support the proposal to establish a new payment adjustment for facilities in Alaska, Hawaii, and U.S. Pacific territories. These areas face unique cost pressures and logistical challenges, including workforce shortages that disproportionately affect nurses. Increased payment support may improve workforce stability and access in these underserved regions, and we encourage CMS to monitor outcomes to ensure the policy is achieving its intended impact.

However, as KCP states in its letter, these increases should not come at the expense of cutting rates for facilities in the rest of the country. With already narrow Medicare margins, even a $0.40 cut to the base rate could push more facilities into zero or negative margins. Just as Medicare makes special payment adjustments for critical access hospitals, super-rural ambulance services, and the geographic practice cost index (GPCI) floor in frontier states, the non-contiguous areas payment adjustment should also not be budget neutral.

We also share KCP's concern about the lack of transparency in the methodology. Relying only on cost report data leaves out important patient factors that may drive higher costs. Applying trimming rules to a small data set risks losing key information and misrepresenting actual costs. Since data suggest costs in these areas may be 30 to 50 percent higher than the rest of the country, the adjustment must accurately reflect real costs to protect access to dialysis. CMS should provide more transparency and use additional data sources in future years to ensure the adjustment is appropriate.

6. **Acute Kidney Injury (AKI) Payment Updates**

We support the proposal to align the payment rate for dialysis services furnished to individuals with AKI with the ESRD PPS base rate. Nephrology RNs play a critical role in managing AKI patients, who often require intensive monitoring and individualized care plans. We encourage CMS to ensure that AKI payment rates are adequate to support the higher acuity and staffing intensity these patients often require.

However, we remain concerned that the statutory requirement for budget neutrality under Section 1834(r) of the Social Security Act may constrain CMS's ability to fully account for the true resource needs associated with AKI care. Particularly, if future policy changes, such as home dialysis training add-on payments, are offset by reductions elsewhere. We urge CMS to work with Congress to remove the budget neutrality constraint so that the payment system can more accurately reflect the clinical complexity and costs of delivering safe, timely care to beneficiaries with AKI.

7. **Termination of the ESRD Treatment Choices (ETC) Model**

While we understand CMS terminating the ETC model due to a lack of statistically significant improvements in home dialysis or transplant outcomes, we encourage CMS to carry forward lessons learned from all care delivery model experiences and to explore future voluntary models that include robust training for nephrology nurse and workforce support as core features of success.

<u>Additional Considerations</u>

1. **Risks of Replacing Nephrology Nurses with Other Licensed or Unlicensed Staff**

To address the nephrology nursing shortage, some facilities have attempted to substitute RNs with other licensed or unlicensed personnel. While this may

seem like a practical solution, the unintended consequences are significant and concerning. Nephrology RNs are uniquely qualified to deliver dialysis care, and shifting their responsibilities to others can jeopardize patient safety.

The scope of practice for nephrology RNs is not interchangeable. These RNs assess patient needs, interpret clinical data, develop care plans, educate patients and caregivers, and monitor outcomes, all within the exclusive domain of a RN. Fragmenting these responsibilities among non-RN staff diminishes the consistency and quality of care and places patients at risk.

It is essential that nephrology RNs are involved from the start of a patient's care journey to build trust, ensure communication, and respond quickly to therapy challenges. Early intervention and familiarity with individual patient needs are critical to successful long-term dialysis outcomes.

ANNA urges CMS to engage nephrology RNs in policy development rather than circumvent their role. Their expertise must inform decisions that affect patient care and safety, especially as policies increasingly support care delivery in the home.

2. **Home Dialysis and the Role of Nephrology Registered Nurses**

Since the launch of HHS's *Advancing American Kidney Health Initiative* in 2019, ANNA has supported efforts to expand access to home dialysis. Nephrology RNs play a central role in this shift, providing patient training, education, and ongoing management to support safe and effective therapy.

Given the complexity of home dialysis, nephrology RNs require targeted training to:

- Transition patients from in-center to home therapies,
- Ensure appropriate dialysis prescriptions,
- Identify and manage complications, and
- Support patients and caregivers in achieving independence.

ANNA continues to invest in expanding the home dialysis nursing workforce. However, the impact of the COVID-19 pandemic and persistent workforce shortages has led many nephrology RNs to leave the profession, reducing the number of experienced clinicians available to train and support patients on home therapies.

To address these challenges, ANNA has:

- Launched a *Home Dialysis Therapies Task Force* and a related *Think Tank* to define the nurse's role in the current staffing landscape;
- Created a *Home Dialysis for Nursing Home Residents Task Force* to explore safe care delivery in long-term care settings;
- Published an article on state nurse practice acts to demonstrate we are practicing within the scope of practice for each state; and[1]
- Published an article that demonstrates ANNA looking to maximize support staff within their defined scope of practice.[2]

We welcome continued collaboration with HHS and CMS to ensure policies reflect the critical role of nephrology nurses and support safe, equitable access to home dialysis care.

Conclusion

ANNA appreciates the opportunity to comment on this proposed rule. If you have any questions about ANNA's comments to the proposed provisions, please contact Jim Twaddell at JWTwaddell@venable.com. We stand ready to work with CMS on these important policy changes to ensure individuals in need receive the best care possible for kidney related issues.

Sincerely,

Faith Lynch, DNP, RN, CNN, NEA-BC, AMB-BC, FANNA
President
American Nephrology Nurses Association

[1] Cahill, M. L., Painter, D. R., Branch, J. L., & Haras, M. S. (2025). A 2025 update: The authority for certain clinical tasks performed by assistive personnel in the care of patients in hemodialysis and home dialysis settings. *Nephrology Nursing Journal, 52*(1).
[2] Haras, M. S., & Bednarski, D. (2025). *The role of the licensed practical nurse/licensed vocational nurse (LPN/LVN) in hemodialysis, peritoneal dialysis, and home dialysis care*. *Nephrology Nursing Journal, 52*(1).