August 24, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Medicare Program; CY 2027 End-Stage Renal Disease Prospective Payment System, Acute Kidney Injury Dialysis Payment, and ESRD Quality Incentive Program Proposed Rule (CMS-1846-P)

Dear Administrator Oz:

On behalf of the American Nephrology Nurses Association (ANNA), thank you for the opportunity to comment on the Calendar Year (CY) 2027 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) Proposed Rule. ANNA appreciates CMS's continued commitment to improving the quality, accessibility, and sustainability of care for individuals living with kidney disease and supports the agency's ongoing efforts to modernize the ESRD payment system while promoting patient-centered care. Our comments on the proposed rule are outlined below.

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 on ESRD Proposed Rule

Please note that ANNA fully supports the comment 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.

1. Market Basket Update and Workforce Sustainability

We applaud CMS's recognition of the increasing role labor costs play in furnishing dialysis services and appreciate CMS's proposal to rebase the ESRD market basket using more recent cost data. We further appreciate CMS recognizing that labor now represents a substantially greater share of dialysis facility costs. We have concerns, however, about the combined effect of the significant increase in the labor-related share and substantial changes to many facilities' wage indexes, particularly for facilities with a wage index below 1.0. Increasing the portion of the payment rate subject to the wage index may place additional financial pressure on these facilities at a time when labor costs continue to rise nationwide. We also continue to urge CMS to address the cumulative impact of prior market basket forecasts that have understated actual cost growth and resulted in years of inadequate payment updates.

These payment pressures are particularly concerning in light of the significant workforce challenges that continue to affect dialysis facilities. Recruiting and retaining experienced nephrology nurses remains one of the greatest challenges facing dialysis providers nationwide. Rising labor costs, competition from other healthcare settings, and an aging workforce continue to place pressure on dialysis facilities, particularly those serving rural and medically underserved communities.

Nephrology registered nursing is a highly specialized practice requiring expertise in a number of areas including dialysis technology, patient education, chronic disease management, medication management, infection prevention, and emergency response. Developing this expertise requires significant investment to retain and provide continuing education for nephrology nurses.

As such, ANNA encourages CMS to continue evaluating whether Medicare payment policies adequately support investments specifically in the nephrology workforce, including competitive compensation, education, workforce development, retention initiatives, and staff safety. A sustainable dialysis delivery system depends not only on appropriate facility payment but also on maintaining a skilled workforce capable of delivering increasingly complex care.

2. Home and Self-Dialysis Training

ANNA strongly supports CMS's proposal to increase the home and self-dialysis training add-on payment and to allow payment for training during the onset period.

Home dialysis continues to be an important component of patient-centered kidney care. Successful home dialysis depends upon comprehensive patient and caregiver education provided primarily by nephrology registered nurses. Registered nurses assess patient readiness,

teach technical skills, monitor patient progress, and serve as an ongoing clinical resource long after formal training concludes.

The proposed increase to the home dialysis training payment more accurately reflects the registered nursing time and expertise required to safely prepare patients for independent dialysis. Updating the payment to better align with current nursing wages recognizes the value of this work.

ANNA also supports allowing payment for home dialysis training during the onset period. Patients beginning dialysis often have limited opportunity to consider all treatment options because dialysis is initiated under urgent or stressful circumstances. Allowing reimbursement for training during this early period allows individuals more time to transition to home therapies if clinically appropriate.

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.

3. Low-Volume Payment Adjustment (LVPA)

ANNA supports CMS's proposal to expand the LVPA as it recognizes that the higher costs associated with lower treatment volumes are not limited to facilities that qualify under the current LVPA threshold.

Small dialysis facilities frequently serve communities where patients have limited alternatives for receiving dialysis care. These facilities often experience the greatest workforce challenges and may have difficulty recruiting and retaining experienced nephrology nurses because of geographic isolation and limited financial resources. Expanding the LVPA can therefore help preserve patient access to dialysis services while supporting the stability of the workforce needed to provide that care.

ANNA also agrees with KCP that CMS should not fund the expanded LVPA through a budget-neutral reduction to the ESRD PPS base rate. Reducing payments to other facilities to finance an adjustment intended to address payment inadequacy would undermine the broader goal of maintaining a stable and accessible dialysis delivery system.

4. Pediatric ESRD Payment

ANNA believes that the higher costs of pediatric dialysis should be recognized directly through the pediatric payment methodology rather than relying on treatment volume as a basis for determining those costs. Pediatric dialysis is inherently more resource-intensive than adult dialysis, and many of those additional costs remain regardless of a facility's treatment volume.

Accordingly, ANNA urges CMS to use its existing data to establish a pediatric payment adjustment that reflects the higher costs of pediatric dialysis care. If CMS determines that additional data are needed to establish an appropriate permanent adjustment, we support convening a technical expert panel to identify the data gaps and recommend a methodology that appropriately calculates the costs of pediatric dialysis care.

5. Incorporation of Phosphate Binders into the ESRD PPS Bundle

ANNA agrees with KCP and supports CMS's proposal to incorporate payment for phosphate binders into the ESRD PPS base rate beginning in CY 2027, including the proposed methodology for determining the per-treatment payment amount. We also agree with KCP that CMS should maintain adequate funding for the operational costs associated with supplying phosphate binders as those costs are incorporated into the base rate. These operational responsibilities and associated costs will continue after the TDAPA period ends and should be appropriately reflected in ESRD PPS payments.

6. Transitional Drug Payment Policies

ANNA supports CMS's proposed refinements to the Transitional Drug Add-on Payment Adjustment (TDAPA) and post-TDAPA add-on payment adjustment. Aligning payment more closely with current Average Sales Price (ASP) data and updating the post-TDAPA add-on payment adjustment on a quarterly basis should improve payment accuracy and better reflect changes in drug pricing and utilization.

However, we share KCP's concerns regarding CMS's proposal to update the post-TDAPA add-on payment adjustment on a quarterly rather than annual basis. Predictable and appropriate reimbursement for innovative renal dialysis drugs helps ensure dialysis facilities can continue adopting new therapies that improve patient care while reducing financial uncertainty associated with rapidly changing drug costs. We therefore encourage CMS to reconsider the proposed quarterly adjustment and, more broadly, to work with the kidney care community to develop payment policies that support meaningful innovation and patient access.

As new therapies become available, nephrology registered nurses can play a central role in patient education, monitoring treatment response, and supporting medication adherence and we encourage CMS to consider this in future policymaking.

7. ESRD Quality Incentive Program (QIP)

ANNA agrees with KCP and generally supports CMS's proposed changes to the ESRD Quality Incentive Program for CY 2029. We support replacing the Hypercalcemia reporting measure with the Hyperphosphatemia clinical measure and updating the NHSN Bloodstream Infection clinical measure to use more recent baseline data and additional facility-level characteristics. Both phosphorus management and infection prevention are important components of high-quality dialysis care where nephrology nurses play a significant role.

ANNA agrees with KCP and supports CMS's proposal to remove the Medication Reconciliation reporting measure from the ESRD QIP. CMS data demonstrate consistently high performance on the measure with limited variation among facilities, diminishing its value as a measure for differentiating facility performance.

8. Request for Information: Dialysis Facility Discussion of Patient Life Goals (D-PaLS)

ANNA agrees that understanding patients' goals and incorporating those goals into care planning are important components of patient-centered kidney care. Nephrology nurses develop long-term relationships with patients and routinely engage patients and their families in discussions about treatment preferences, quality of life, and individual goals. However, ANNA shares KCP's concerns regarding the potential inclusion of the Dialysis Facility Discussion of Patient Life Goals (D-PaLS) Patient-Reported Outcome Performance Measure in the ESRD QIP.

Before considering D-PaLS for inclusion in the QIP, CMS should ensure that the measure is a reliable and valid indicator of dialysis facility performance and evaluates outcomes that facilities can reasonably influence. Patients' ability to achieve broader life goals may be affected by numerous factors outside the control of the dialysis facility. ANNA is also concerned about the additional administrative and documentation burden associated with implementing a new patient-reported measure, particularly if it does not provide meaningful information that facilities can use to improve care.

Accordingly, ANNA does not support inclusion of D-PaLS in the ESRD QIP at this time. CMS should instead continue working with patients, clinicians, and other stakeholders to determine how best to incorporate patient goals into their care. Any future approach should meaningfully advance patient-centered care without imposing unnecessary burden on dialysis facilities.

9. Request for Information: Advancing Alternative Dialysis Care

- **What temporary or ongoing support would effectively enable beneficiaries to initiate and sustain home dialysis?** ANNA supports additional temporary and ongoing supports that enable appropriate beneficiaries to initiate and remain on home dialysis, including

access to a qualified nephrology RN for education, clinical assessment, troubleshooting, retraining, and ongoing support.

Given the crucial role RNs play, expansion efforts should strengthen the clinical infrastructure surrounding home patients rather than reduce the role of the nephrology RN. Home dialysis beneficiaries and caregivers need reliable access to clinicians who understand both the dialysis modality and the individual receiving dialysis, particularly when complications or changes in condition arise.

- **Whether any ESRD CfCs related to patient training or staff competencies inadvertently limit facilities' ability to scale home dialysis training capacity.** While some have suggested expanding the role of other healthcare professionals to address workforce shortages, ANNA does not believe that other clinicians can substitute for the clinical judgment, assessment skills, and care coordination responsibilities of a qualified nephrology RN. Accordingly, the requirement for qualified RN involvement in home-dialysis training should not be characterized as an unnecessary barrier to expansion.

  The existing requirements reflect the complexity of preparing a patient or caregiver to independently furnish a life-sustaining therapy outside the immediate presence of clinical staff. CMS should focus on addressing workforce shortages through workforce development, payment, recruitment, and retention strategies rather than weakening standards intended to protect patients. ANNA supports flexibility that allows other appropriately trained members of the interdisciplinary team to contribute to education and training, but the qualified nephrology RN should retain responsibility for coordinating and overseeing the patient's training and determining readiness for independent home dialysis.

- **What safeguards and best practices are necessary for alternative training approaches, including group, remote, or multidisciplinary training?** ANNA supports innovation in how training is delivered when it improves access and convenience, but alternative models must preserve individualized assessment and RN accountability. Group or remote education may supplement portions of training, but competency assessment, individualized clinical education, identification of learning barriers, and determination of starting home dialysis require direct involvement of a qualified nephrology RN. Technology and multidisciplinary staff should augment, not replace, the RN-led training process.

- **What workforce development strategies would increase availability of trained home dialysis nurses, particularly in rural and underserved areas?** CMS should focus on strengthening the pipeline and retention of qualified home-dialysis nurses, particularly in rural and underserved communities, rather than addressing workforce shortages by reducing qualification requirements. Investments in nephrology registered nursing

education and training, coupled with efforts to retain experienced registered nurses who can mentor the next generation, are essential to building sustainable home-dialysis capacity. ANNA continues to invest in strengthening the home-dialysis nursing workforce through its Home Dialysis Therapies Task Force and related Think Tank, which bought together nephrology registered nursing expertise to examine the evolving role of the registered nurse in home dialysis, identify workforce and staffing challenges, and consider strategies to support safe, sustainable expansion of home therapies.

- **To what extent can the patient-education requirements in § 494.70 be revised so education is active, individualized, and iterative?** ANNA strongly supports individualized and iterative education on home dialysis. An individual's clinical status, ability to learn, home circumstances, and education should reflect those changes. However, CMS should not weaken professional qualification requirements to achieve more meaningful education. A nephrology RN is well positioned, and the only team member with the scope of practice, to identify evolving educational needs and coordinate repeated discussions with the interdisciplinary team.

- **Should CMS revise minimum staff qualifications for those who may deliver home-dialysis education?** ANNA does not support lowering minimum qualifications in a way that substitutes other personnel for the qualified nephrology RN. Different members of the interdisciplinary team can and should contribute education within their expertise, but home-dialysis education cannot be separated from clinical assessment, evaluation of patient competency, recognition of complications, and individualized care planning and evaluating the individual's ability to complete home dialysis independently. The scope of practice of a qualified RN encompasses the clinical judgment and independent patient assessment necessary to safely oversee home dialysis training. Because scopes of practice for other licensed personnel vary by state and may not authorize the same level of independent assessment and clinical judgment, these personnel cannot simply be substituted for the nephrology RN. The qualified nephrology RN should remain responsible for overseeing the training process and determining a patient's readiness to perform home dialysis independently.

- **What eligibility criteria, staffing qualifications, supervision requirements, and clinical safeguards should apply to staff-assisted home dialysis?** ANNA supports thoughtful evaluation of staff-assisted home dialysis as a means of expanding access to home dialysis for patients who may benefit from additional clinical or hands-on support in the home. Any such model should establish clear patient-selection criteria, competency standards, clinical escalation protocols, and most importantly, nephrology RN supervision. A qualified nephrology RN is the only one with a scope of practice that has the ability to assess the patient, participate in determining whether staff-assisted home dialysis is appropriate, develop or coordinate the care plan, oversee the personnel furnishing assistance, and ongoing evaluation of the patient and therapy.

- **What clinical, behavioral, or medical characteristics would make staff-assisted home dialysis inappropriate or unsafe?** ANNA recommends that CMS first clearly define what staff-assisted home dialysis entails. Staff-assisted home dialysis that provides time-limited assistance that enables a patient who otherwise could not safely perform home dialysis to remain on their home modality requires a different level of care than respite care. Respite care serves a different purpose by providing temporary relief to a patient or caregiver and may include options other than assistance in the home. ANNA supports both concepts where appropriate but believes they should remain distinct. Regardless of the model, suitability for staff-assisted home dialysis should be determined through an individualized assessment by a qualified nephrology RN rather than through a rigid list of exclusions. The nephrology RN should determine whether the patient and home environment can safely support staff-assisted treatment.

- **Whether CMS should expand the types of licensed dialysis staff eligible to conduct home-dialysis training based on technical skills and patient evaluation.** ANNA strongly cautions against replacing RN-led home-dialysis training with a technical-skills model. Successful home dialysis requires more than teaching a patient how to operate equipment or perform a sequence of tasks. It incorporates independent clinical judgment, behavioral coaching, and emergency crisis management. This requires independent clinical judgment to assess changes in fluid status, vascular access, laboratory results, and medications and to help patients recognize complications and determine when they need clinical or emergency assistance. The RN must also develop an individualized education plan, evaluate whether the patient or caregiver has demonstrated competency to safely perform the therapy, and identify psychosocial or environmental barriers that could jeopardize success at home. These responsibilities extend well beyond technical proficiency and demonstrate why other dialysis staff can support the training process but should not replace the qualified nephrology RN who oversees it.

  It requires ongoing assessment, clinical judgment, evaluation of learning and competency, recognition of changes in patient condition, and modification of education and the care plan when appropriate. Technical proficiency of other staff can complement the training process, but it is not equivalent to the clinical judgment and scope of practice of the nephrology RN. ANNA's prior public position specifically rejected removal of the RN training requirement on this basis.

- **To what extent are workforce shortages limiting incident home-dialysis uptake?** ANNA recognizes ongoing workforce shortages across the dialysis car team, including RNs, LPNs/LVNs, and PCTs. As such, we encourage CMS to collect additional data to better understand the extent to which workforce availability affects patients' ability to initiate and sustain home dialysis before pursuing changes to staffing or qualification requirements. Regardless, to ensure patient safety, workforce challenges should not be

addressed by reducing existing qualification standards or diminishing the role of the qualified nephrology RN in overseeing home dialysis care.

- **What staff qualifications and supervision should be required for in-center self-dialysis programs as patients progress toward independence?** ANNA recommends that CMS maintain the existing qualification standards for self-dialysis training. Current regulations require self-dialysis training to be conducted by an RN with at least 12 months of nursing experience and an additional three months of experience in the specific dialysis modality. These requirements appropriately recognize that preparing a patient for self-dialysis requires specialized clinical expertise and should apply regardless of whether training occurs in the home or in an in-center transitional program.

  The in-center setting does not reduce the skill or clinical judgment required to prepare a patient to dialyze independently. If anything, patients progressing toward self-dialysis require careful assessment and supervision as they assume greater responsibility for their treatment. ANNA therefore does not support reducing existing qualification or supervision requirements for in-center self-dialysis programs and encourages CMS to consider whether additional safeguards may be appropriate as these programs develop.

- **How should CfC requirements be structured to better support patients transitioning successfully from in-center self-dialysis to home dialysis?** ANNA cautions CMS against assuming that reducing CfC requirements is necessary to facilitate transition to home dialysis. The existing patient-safety framework provides important protections during a period when patients are assuming responsibility for a complex, life-sustaining therapy. Any modifications should preserve qualified RN oversight of training, competency assessment, individualized care planning, and the transition to independent dialysis.

10. 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 Deepti Loharikar at DALoharikar@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,

Michelle Gilliland, MSN, RN, BSBA, CNN, FANNA
ANNA President