Medicare Program
End-Stage Renal Disease Prospective Payment System Final Rule for 2026

On November 24, 2025, the Centers for Medicare & Medicaid Services (CMS) published the calendar year 2026[1] Medicare End-Stage Renal Disease Prospective Payment System (ESRD PPS) final rule **(CMS-1830-F)** in the *Federal Register*. The 2026 ESRD final rule provides routine updates to the ESRD PPS, payment updates for renal dialysis services to individuals with acute kidney injury (AKI), and updates for the ESRD Quality Incentive Program (QIP). The rule also terminates the CMMI ESRD Treatment Choices (ETC) Model. Lastly, CMS summarizes responses to two requests for information (RFIs) in the proposed rule specific to the ESRD PPS, and it also invokes the Administration's standing regulatory relief RFI issued pursuant to Executive Order 14192, "Unleashing Prosperity Through Deregulation."

Addenda provided by CMS on the ESRD PPS provide wage index files and facility-level impact analysis. These are available at https://www.cms.gov/medicare/payment/prospective-payment-systems/end-stage-renal-disease-esrd/esrd-payment-regulations-and-notices/cms-1830-f.

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[1] Henceforth in this document, a year is a calendar year unless otherwise specified, although "CY" is used in subheaders where CMS uses that convention in the final rule.

I. Executive Summary

The final rule updates and revises the ESRD PPS for 2026 including the payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI. CMS estimates that the finalized revisions to the ESRD PPS will increase payments to ESRD facilities by 2.2 percent, or approximately $180 million in 2026 (slightly higher than the 1.9 percent increase projected in the proposed rule). CMS finalizes a 2026 ESRD PPS base rate of $281.71, compared with the final 2025 rate of $273.82. The rule also continues add-on payment adjustments for certain renal dialysis drugs and biological products in existing ESRD functional categories after the end of the transitional drug add-on payment adjustment (TDAPA) period.

Beginning with payment year (PY) 2027, CMS will remove three measures from the ESRD QIP: (1) Facility Commitment to Health Equity Reporting, (2) Screening for Social Drivers of Health, and (3) Screen Positive Rate for Social Drivers of Health. Beginning with PY 2028, CMS is also updating the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey clinical measure. The rule also finalizes a proposal to terminate the ETC Model effective December 31, 2025. In addition, the agency summarizes comments received in response to a proposed rule RFI on advancing digital quality measurement, and an RFI on future measure concepts for consideration in the ESRD QIP.

II. CY 2026 ESRD PPS

A. Background

Under the ESRD PPS, a single, per-treatment payment is made to an ESRD facility for all defined renal dialysis services furnished in the treatment of ESRD in the ESRD facility or in the patient's home. Payment consists of a base rate adjusted for characteristics of both adult and pediatric patients. The adult case-mix adjusters are age, body surface area (BSA), low body mass index (BMI), onset of dialysis, and four co-morbidity categories, while the pediatric patient-level adjusters consist of two age categories and two dialysis modalities. In addition, the ESRD PPS provides for three facility-level adjustments: one for differences in area wage levels, another for facilities furnishing a low volume of dialysis treatments, and a third for facilities in rural areas.

The ESRD PPS provides six additional payment adjustments: (1) a training add-on for home and self-dialysis modalities; (2) an additional payment for high-cost outliers; (3) a transitional drug add-on payment adjustment for certain new renal dialysis drugs and biological products; (4) a transitional add-on payment adjustment for new and innovative equipment and supplies (TPNIES) for certain qualifying new and innovative renal dialysis equipment and supplies; (5) a transitional pediatric ESRD add-on payment adjustment (TPEAPA); and a post-TDAPA add-on payment for certain new renal drugs and biologics after the end of their TDAPA status.

B. Provisions of the 2026 ESRD PPS

1. Market Basket, Productivity Adjustment, and Labor-Related Share

In the proposed rule for the 2026 ESRD PPS, CMS proposed an ESRD market basket update of 2.7 percent, reduced by a productivity adjustment of 0.8 percentage points, for a net payment rate increase of 1.9 percent. CMS proposed these amounts based on IHS Global Inc.'s (IGI) first quarter 2025 projections.

CMS reports that several commenters suggested this amount was insufficient given general inflation and workforce shortages facing this sector. Some commenters suggested that the ESRD market basket is "systematically flawed," given that it typically produces updates lower than the market baskets for other provider sectors. Commenters also stated that "the ESRD market basket updates have been under-forecast for four consecutive years from 2021 through 2024," and suggested that CMS implement a forecast error correction policy under the ESRD PPS. CMS rigorously defended its use of the market basket, pointing to analyses and data promulgated in prior rulemaking, and noted that since it had not proposed a forecast error correction policy, the agency cannot finalize such a policy in this final rule.

Therefore, CMS finalizes an ESRD market basket increase of 2.9 percent, using the most recently available data at the time of rulemaking—IGI's third quarter 2025 forecast. By statute, the market basket update is reduced by the 10-year moving average of changes in annual economy-wide, private nonfarm business total factor productivity (TFP). Based on IGI's third quarter 2025 forecast, the final productivity adjustment for 2026 is 0.8 percentage points. **The net final update is the market basket of 2.9 percent less TFP of 0.8 percentage points, or 2.1 percent.**

The ESRD PPS adjusts the labor-related portion of the base rate to reflect geographic differences in labor costs using wage index values based on the most recent pre-floor, pre-reclassified hospital wage data collected annually under the inpatient PPS. In the 2026 proposed rule, CMS proposed to continue to use the labor-related share of 55.2 percent that it has used since the 2023 ESRD PPS final rule. CMS indicates that several commenters stated that the ESRD PPS labor share should be higher, and the agency indicated it will consider these suggestions during the next rebasing of the ESRD market basket. **For this final rule, however, CMS finalizes its proposal to continue to use the labor-related share of 55.2 percent**.

2. CY 2026 ESRD PPS Wage Indices

Historically, the ESRD PPS has adjusted the labor-related portion of the base payment rate to reflect geographic differences in labor costs using wage index values based on the most recent pre-floor, pre-reclassified hospital wage data collected annually under the inpatient PPS. That is, the ESRD PPS wage index values were calculated without regard to geographic reclassifications authorized under paragraphs (8) and (10) of section 1886(d) of the Social Security Act (the Act) for hospitals only and utilized pre-rural and imputed floor hospital data that are unadjusted for occupational mix. CMS uses the Office of Management and Budget's (OMB) Core-based Statistical Area (CBSA) geographic area definitions to define the labor markets in which dialysis

facilities operate. CMS incorporates a floor wage index of 0.6000 under the ESRD PPS. Wage index values can change annually due to the nature of the hospital data used to calculate them; under the ESRD PPS, year-over-year reductions in wage index values are capped at 5 percent.[2]

CMS notes that over time, many stakeholders (including the Medicare Payment Advisory Commission (MedPAC)) have raised concerns about the appropriateness of using the hospital wage index to adjust payments under the ESRD PPS, arguing that this wage index does not accurately reflect the dialysis facility labor market.[3] In 2019, CMS convened a technical expert panel (TEP) to model and review alternatives to the current wage index; the panel favorably reported out an approach similar to that recommended by MedPAC.[4]

In the CY 2025 ESRD PPS final rule (89 FR 89116), CMS replaced the ESRD PPS wage index with one based on the approach recommended by MedPAC. The new wage index uses publicly available Occupation Employment and Wage Statistics (OEWS) data from the Bureau of Labor Statistics (BLS) as the source of wage data, coupled with occupational mix data from Medicare cost reports filed by free-standing dialysis facilities.[5] CMS proposed to continue the use of that wage index in the 2026 ESRD PPS proposed rule, and proposed to update the wage index using wage data from the May 2024 BLS OEWS. The agency indicated it would use more recent data should it become available before the issuance of the final rule, as appropriate.

CMS uses full-time equivalent (FTE) positions reported on Medicare dialysis facility cost reports from 2023 to calculate the occupational mix for all free-standing ESRD facilities (the national ESRD facility occupational mix, or NEFOM).[6] CMS reports this occupational mix in Table 2 of this final rule, reproduced here:

[2] There is no corresponding cap on year-over-year increases in wage index values.

[3] In its June 2023 report to the Congress, MedPAC recommended a comprehensive overhaul of Medicare's approach to wage adjustment, recommending that CMS use all-employer occupation specific data from the Bureau of Labor Statistics (BLS) to calculate a base wage index, which would be applied to different provider sectors using sector-specific occupational weights. See https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf

[4] https://www.cms.gov/files/document/end-stage-renal-disease-prospective-payment-system-technical-expert-panel-summary-report-may-2020.pdf.

[5] For a detailed explanation of the current ESRD PPS wage index methodology, see the discussion in the CY 2025 ESRD PPS final rule (89 FR 89108 through 89117), and for a detailed explanation of the steps used to calculate the ESRD PPS wage index according to this methodology see Addendum C in the CY 2025 ESRD PPS proposed rule available here: https://www.cms.gov/files/document/addendum-c-cms-1805-p-esrd-pps-proposed-wage-index-construction-methodology.pdf.

[6] In this proposed rule, CMS is silent on whether it has updated the data used to construct the occupational mix, but these values appear to be rounded versions of the percentages finalized previously using 2022 ESRD facility cost reports.

Table 2: Crosswalk of BLS Occupation Codes to ESRD Facility Cost Reports Occupation Classifications and the CY 2026 ESRD PPS Proposed Rule NEFOM			
Occupation	BLS Occupation Title	Occupation Code	ESRD Freestanding Facilities FTE Percentage (rounded)
Registered Nurses (RN)	Registered Nurses	29-1141	29.5%
Licensed Practical Nurses (LPN)	Licensed Practical and Licensed Vocational Nurses	29-2061	3.6%
Nurse Aides	Nursing Assistants	31-1131	3.2%
Technicians	Health Technologists and Technicians, All Other	29-2099	37.7%
Social Workers	Healthcare Social Workers	21-1022	4.8%
Administrative Staff	Medical Secretaries and Administrative Assistants	43-6013	11.2%
Dietitian	Dietitians and Nutritionists	29-1031	4.6%
Management	Medical and Health Services Managers	11-9111	5.4%

In the proposed rule, CMS noted that BLS did not include data for the state of Colorado in the May 2024 release due to data integrity concerns, and proposed to use Colorado wage data from the May 2023 BLS OEWS file, and update the occupation-specific wage data by national inflation factors (May 2023 to May 2024) for each category. Subsequent to the issuance of the proposed rule, however, BLS published May 2024 Colorado wage data, and the agency now uses that data in the calculation of the wage index for this final rule.

The final CY 2026 ESRD PPS wage index is found in Addendum A of this final rule, along with a crosswalk between the CY 2025 the CY 2026 wage indices. Addendum B provides a facility-level impact analysis. Both Addendum A and Addendum B are available on the CMS website here.

CMS solicited comments on its proposal to use May 2024 BLS OEWS wage data and 2023 freestanding dialysis facility cost reports as the basis for the 2026 ESRD PPS wage index. The agency also solicited comments on its proposal to use May 2023 BLS OEWS wage data, projected to May 2024, to calculate occupation-specific wage values for Colorado, but again, this proposal has been rendered moot by the subsequent availability of these data.

Comment/Response: Comments on CMS' wage index proposals were mixed. Some stakeholders - including a national kidney nonprofit organization and a large dialysis organization - supported the current ESRD-specific methodology as more appropriate than the pre-2025 IPPS index, while others favored the legacy approach and raised concerns about perceived variance, decreases in wage index values, data limitations, and geographic impacts. CMS responded that the current methodology remains the most appropriate measure of geographic wage variation for ESRD facilities, noting that county-level analyses can misrepresent impacts, that many decreases in 2026 reflect capped reductions from the 2025 transition year, and that the 5-percent cap on year-over-year wage index reductions continues to mitigate volatility. CMS acknowledged data limitations, pointing to an explicit discussion of these in the CY 2025 ESRD PPS proposed (89 FR 55769) and final (89 FR 89099, 89116) rules. The agency also explained why contract labor and overtime are not directly incorporated,

clarified the inclusion of hospital-based facilities in the wage index and budget neutrality calculations, and addressed concerns about specific urban regions such as New York. CMS expressed openness to continued stakeholder input and potential future refinements through rulemaking.

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 BLS OEWS mean wage data and CY 2023 cost report data. CMS is also 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/payment/prospective-payment-systems/end-stage-renal-disease-esrd/esrd-payment-regulations-and-notices/cms-1830-f.

3. 2025 Update to the Outlier Policy

a. Background

An ESRD facility is eligible for outlier payments if its actual or imputed Medicare Allowable Payment (MAP) per treatment for ESRD outlier services exceeds a threshold. That threshold is equal to the facility's predicted ESRD outlier services case-mix adjusted MAP amount per treatment plus a fixed-dollar loss (FDL) amount. The average ESRD outlier services MAP amount per treatment is based on utilization from all ESRD facilities, whereas the calculation of the predicted MAP amount for a claim is based on the individual ESRD facility and patient characteristics of the monthly claim. ESRD facilities are paid 80 percent of the per treatment amount by which the imputed MAP amount for outlier services exceeds this threshold for both adult and pediatric dialysis patients, but MAP amounts and FDL amounts are different for adult and pediatric patients due to differences in the utilization of separately billable services.

ESRD outlier services are defined as specified items and services included in the ESRD PPS bundle. CMS updates the national adjusted average MAP amounts and FDL amounts each year using the latest available data. The rule preamble discusses CMS' longstanding methodology for calculating the national average MAP amount and establishing the FDL amount at a level that results in projected outlier payments that equal 1.0 percent of total payments under the ESRD PPS.

CMS explains that for 2023 and subsequent years it changed its methodology for calculating the adult FDL amounts; those adult FDL amounts were based on the historical trend in FDL amounts that would have achieved the 1.0 percent outlier target in the three most recent available data years. It made no change to its calculation of the pediatric FDL amounts. For 2025, CMS finalized a number of methodological and policy changes to the ESRD PPS outlier policy: 1) an expansion of the definition of outlier services to include composite rate drugs and biologics, 2) the inclusion of the case-mix adjusted post-TDAPA add-on payment adjustment amount in the calculation of the MAP amounts when applicable, and 3) changes to the inflation factors for outlier eligible drugs and biological products, laboratory tests, and supplies.

b. CY 2026 Update to the Outlier Services MAP Amounts and FDL Amounts

In the 2026 ESRD PPS proposed rule, CMS proposed to update the MAP amounts for adult and pediatric patients using the latest available CY 2024 claims data, to update the ESRD outlier services FDL amount for pediatric patients using the latest available CY 2024 claims data, and to update the ESRD outlier services FDL amount for adult patients using the latest available claims data from CY 2022, CY 2023, and CY 2024, in accordance with the methodology finalized in the CY 2023 ESRD PPS final rule (87 FR 67170 through 67174).

Comment/Response: Comments on CMS's ESRD PPS outlier policy proposals were mixed, with some commenters supporting CMS's proposals, and others opposing and suggesting alternative approaches (*e.g.*, some commenters suggested that an outlier percentage of 0.5 percent would be preferable, while others suggested excluding TDAPA and TPNIES payments from the calculation of total ESRD PPS payments).

After considering comments received, in this final rule CMS finalizes the 2026 MAP amounts for adult and pediatric patients using claims data from 2024. The ESRD outlier services pediatric FDL amounts are also derived from 2024 claims data. CMS derived the adult FDL amounts for 2026 from the projected FDL trend for 2022, 2023 and 2024, as proposed. Table 3, reproduced below, compares the outlier services MAP and FDL amounts finalized for 2026 with 2025 amounts.

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

As shown in the table, the estimated FDL amount per treatment that determines the 2026 outlier threshold amount for adults (column II; $14.80) is substantially lower than that used for the 2025 outlier policy (column I; $45.41). The lower threshold is accompanied by a decrease in the adjusted average MAP for outlier services from $31.02 to $23.68.

For pediatric patients, there is a decrease in the FDL amount from $234.26 to $162.43 with a corresponding decrease in the adjusted average MAP for outlier services among pediatric patients, from $59.60 to $50.19. CMS attributes the decrease in part to the application of the ESRD PPS drug inflation factor following the methodology finalized in the CY 2025 ESRD PPS final rule (89 FR 89127 through 89130), which resulted in a lower inflation factor than would typically occur under the agency's prior methodology. CMS estimates that the percentage of patient months qualifying for outlier payments in 2026 will be 14.10 percent for adult patients and 7.58 percent for pediatric patients.

c. Outlier Percentage

A claim is eligible for outlier payment when its imputed MAP amount exceeds the sum of the predicted MAP amount and the fixed dollar loss threshold, and as noted earlier, the predicted MAP amount for a claim is based on the national average MAP amount, adjusted by the case-mix adjustment factors that apply for that claim's patient-level and facility-level characteristics. So, when a claim's adjustment factors increase the amount of payment per treatment, the claim's predicted MAP also increases. This ensures that only unusually costly cases are considered for outlier payment.

Comment/Response: CMS did not seek comments on the updates to the ESRD PPS outlier policy parameters discussed in the proposed rule, and is finalizing them as proposed. Interestingly, however, CMS notes that 2024 claims data suggests that outlier payments represented only 0.8 percent of total payments, slightly below the 1.0 percent target that has been in effect since the CY 2011 ESRD PPS final rule (75 FR 49081).

4. Impacts to the CY 2026 ESRD PPS Base Rate

CMS proposed to update the 2026 base payment rate by 1.9 percent, to $281.06.

Comment/Response: In this final rule's preamble, CMS reports that many commenters indicated that this rate would be insufficient to keep pace with ESRD facilities' rising costs, particularly the cost of labor and the difficulty in attracting and retaining staff. CMS points to the Medicare Payment Advisory Commission's (MedPAC) assessment of payment adequacy under the ESRD PPS, noting that MedPAC found that payments were adequate in 2025. Others commented on the financial difficulties of small dialysis facilities; CMS noted that such facilities are specifically targeted by the low-volume payment adjustment under the ESRD PPS.

CMS is thus increasing the ESRD PPS base rate from $273.82 in CY 2025 by approximately 2.1 percent to $281.71 in CY 2026, using the same methodology as proposed, but with updated data from IHS Global Insight. This update is the product of the 2025 ESRD rate adjusted by 0.905 percent for wage index budget neutrality, a budget neutrality adjustment

for the Non-Contiguous Payment Adjustment (NAPA) of -0.1 percent and the ESRD market basket for CY 2026 of 2.9 percent less 0.8 percentage points for productivity (2.1 percent).

2025 ESRD Base Rate	$273.82
Wage Index Budget Neutrality Adjustment	1.00905
NAPA Budget Neutrality Adjustment	0.99860
Market Basket Net of Productivity	1.021
Final 2026 ESRD Base Rate	$281.71

5. Update to the Average per Treatment Offset for Home Dialysis Machines

In the 2021 ESRD final rule,[7] CMS expanded eligibility for transitional add-on payment adjustment for new and innovative equipment and supplies (TPNIES) to capital-related assets that are home dialysis machines used by a single patient. The methodology used by the Medicare Administrative Contractors (MACs) to establish the TPNIES payment for these items accounts for the cost of the home dialysis machine that is already in the ESRD PPS base rate ("TPNIES offset amount"). The TPNIES for capital-related assets that are home dialysis machines is based on 65 percent of the MAC-determined pre-adjusted per treatment amount, reduced by the TPNIES offset amount, and is paid for two years.

The methodology for calculating the TPNIES offset amount is annually updated by the ESRD bundled market basket percentage increase factor (2.9 percent for 2026) reduced by the productivity adjustment factor (0.8 percentage points for 2026), for a net increase of 2.1 percent. **The finalized 2026 TPNIES offset amount is $10.43 (or the 2025 offset amount of 10.22 increased by 2.1 percent)**. There are no capital-related assets that are home dialysis machines set to receive TPNIES for 2026.

6. Post-TDAPA Add-on Payment Adjustment Updates

In the 2024 ESRD PPS final rule, CMS finalized an add-on payment adjustment for certain new renal dialysis drugs and biological products, which would be applied for three years after the end of the TDAPA period (88 FR 76388 through 76397). The post-TDAPA add-on payment is adjusted by the patient-level case-mix adjuster and applied to every ESRD PPS claim contingent on continued receipt of the latest full calendar quarter of Average Sales Price (ASP) data.

For 2026, three drugs were eligible to be included in the calculation of the post-TDAPA add-on payment adjustment. However, ASP had not been reported in the third quarter of 2025 for Jesduvroq making this drug ineligible to be included in the calculation of the post-TDAPA adjustment.

For the remaining two drugs, for 2026, CMS proposed an add-on of $0.2633 for Korsuva® based on the most recently available full year of utilization data. CMS was unable to present an estimate of the post-TDAPA add-on payment adjustment amount for DefenCath® but showed an adjustment of $1.4780 based on the first 6 months utilization. CMS proposed to update these calculations in the final rule.

[7] 85 FR 71427.

Comment/Response: CMS received numerous requests to modify its methodology for calculating the post-TDAPA add-on payment adjustment. In response, CMS reviewed its TDAPA and post-TDAPA goals for supporting access to new renal dialysis drugs or biological products used to treat or manage a condition in an ESRD PPS functional category. CMS believes the current methodology meets its goals and therefore does not agree that modifications to its methodology are necessary at this time; however, CMS indicates it will take commenter suggestions into consideration for future rulemaking.

CMS also received comments stating that CMS' proposed per-treatment amount for Korsuva® was too low when compared to the ASP of the drug. In response, CMS acknowledges that many commenters do not believe the agency's established methodology provides enough payment; however, CMS strongly disagrees that the post-TDAPA add-on payment adjustment amount would disincentivize the drug's utilization. CMS continues to believe that its methodology results in appropriate and adequate payment for such drugs in the short-, medium-, and long-term.

Regarding DefenCath®, commenters raised concerns that the final post-TDAPA add-on payment adjustment amount would be too low and requested that CMS include data from quarters 3 and 4 of 2025 in the calculation so as to include a full year of data. In response, CMS expresses appreciation for the concerns but notes that the period of higher utilization will be included when CMS calculates the 2027 post-TDAPA add-on payment adjustment for DefenCath®, assuming continued receipt of ASP data.

In summary, after consideration of comments, **CMS is finalizing a post-TDAPA add-on payment adjustment amount** of $0.2633 for Korsuva®, which will be applied to ESRD PPS claims for each quarter of 2026. The final post-TDAPA add-on payment adjustment amount for DefenCath® is $2.3710 which will be applied to ESRD PPS claims for the third and fourth quarter of 2026.

7. Changes to the TDAPA Eligibility Criteria

a. Background on the TDAPA

In the 2016 ESRD PPS final rule, CMS finalized a process to recognize when an oral-only renal dialysis service drug or biological product is no longer oral-only and include new injectable and IV products into the ESRD PPS bundled payment, and when appropriate, modify the ESRD PPS payment amount (80 FR 69013 through 69027). The process allows a product to be either added to an ESRD functional category, a functional category to be revised to include the new drug or a new functional category to be created for the drug. A functional category is a distinct grouping of drugs or biologicals whose end action effect is the treatment or management of a condition or conditions associated with ESRD.

TDAPA provides additional payment for certain new drugs and biological products under the ASP pricing mechanism for up to two years until sufficient claims data are available for ratesetting purposes. In the 2019 ESRD PPS final rule (83 FR 56927 through 56949), CMS

expanded the TDAPA to all new renal dialysis drugs and biological products, not just those in new ESRD PPS functional categories. CMS modified the definition of "new renal dialysis drug or biological product" to specify that the drug or biological product must be approved by the FDA on or after January 1, 2020.

The 2020 ESRD PPS final rule established the transitional payment for new and innovative equipment and supplies (TPNIES), a non-budget neutral add-on payment adjustment for certain new and innovative equipment and supplies (84 FR 60681 through 60699). When TPNIES was established, CMS defined "new" as receiving FDA marketing authorization on or after January 1, 2020. CMS also indicated that equipment and supplies would only be new for TPNIES, if a complete application for the product was submitted within 3 years of the date of the FDA marketing authorization (88 FR 71414 through 76415).

b. Modification to the Eligibility Timeframe for the TDAPA

In the proposed rule, CMS noted that the regulatory definition for "new renal dialysis drug or biological product" does not specify a date when it is no longer considered new. For this reason, the current regulatory definition of a new renal dialysis drug or biological product could apply to drugs with FDA approval dates that are increasingly old. CMS does not believe that the original intention of this requirement was to ensure that renal dialysis drugs and biological products approved on or after January 1, 2020, would continue to be eligible for the TDAPA in perpetuity after their FDA approval. In the 2021 ESRD PPS final rule, when CMS changed the TPNIES eligibility criteria set forth at §413.236(b)(2), CMS stated that it did not believe newness should be tied to the effective date of the TPNIES, and that a 3-year eligibility window would be consistent with the timeframe for the new-technology add-on payment (NTAP) under the IPPS.

Therefore, CMS proposed to modify the regulatory language at §413.234 to reflect that a TDAPA application must be submitted within three years of FDA approval for a new renal dialysis drug or biological product to be eligible for the TDAPA. In making this proposal, CMS indicated its belief that three years would strike a balance between allowing drug manufacturers flexibility in the timing of the rollout for their new renal dialysis drugs and biological products and ensuring the TDAPA is only available for drugs and biological products that are new to the renal dialysis market. Also, a three-year timeframe is generally consistent with how "new" is defined for new technology add-on payments under the inpatient prospective payment system (IPPS) and TPNIES.

The proposed 3-year timeframe for TDAPA eligibility would apply for renal dialysis drugs and biological products for which a TDAPA application is submitted on or after January 1, 2028. This later implementation date recognizes that there may be renal dialysis drugs or biological products which were approved by the FDA on or after January 1, 2020, and before January 1, 2023, but for which a TDAPA application has not yet been submitted due to the established eligibility criteria. CMS explained that it did not know of any such drugs and did not expect that any would be affected by the proposal as the agency's experience has been that manufacturers generally apply for the TDAPA within the first few months after receiving FDA approval for their products. CMS solicited comments on all aspects of the proposal and on the TDAPA eligibility requirements more broadly.

Comment/Response: CMS notes that nearly all commenters supported its proposals pertaining to TDAPA eligibility. CMS clarifies that its longstanding eligibility criteria for the TDAPA does not exclude FDA New Drug Application (NDA) Type 10 drugs[8] that receive a new indication, and that manufacturers of drugs or biological products that receive an ESRD or dialysis-related indication after a previous non-ESRD or dialysis-related FDA marketing approval will, under the new eligibility criteria, have three years from when the ESRD or dialysis-related indication was granted by FDA to apply for the TDAPA. CMS also clarifies that if a drug or biological is being paid for or has previously been paid for under the TDAPA under one FDA indication, CMS does not provide for TDAPA eligibility to restart or reapply if the drug or biological product were to obtain a new indication. In other words, a new renal dialysis drug or biological product may only qualify for one TDAPA period.

In summary**, CMS is finalizing, as proposed, 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**.

The following table[9] illustrates the application of this policy:

FDA Approval Date	TDAPA Application Date	TDAPA Eligibility
January 10, 2020	December 10, 2027	Eligible
January 10, 2020	January 2, 2028	Not Eligible
January 20, 2025	January 19, 2028	Eligible
January 20, 2025	January 21, 2028	Not Eligible

8. Payment Adjustment for ESRD Facilities in Certain Non-Contiguous States and Territories

a. Background

In the CY 2025 ESRD PPS proposed rule, CMS discussed the impacts of the proposed new ESRD PPS wage index methodology (89 FR 55778 through 55780). CMS highlighted the payment reductions for the U.S. Pacific Territories, which were larger in magnitude compared to most other regions. Two comments representing Guam, American Samoa, and the Northern Mariana Islands (89 FR 89114) expressed specific concern that these isolated island territories had higher costs than other regions for certain goods and services. Other commenters, including MedPAC in its June 2020 Report to Congress,[10] reiterated that the ESRD PPS payment adjustments, including the low-volume payment adjustment (LVPA), do not accurately target remote or isolated facilities. Those parties (but not MedPAC) requested that the Secretary establish a new payment adjustment for the U.S. Pacific Territories, outside of the LVPA, to account for the higher cost of providing renal dialysis services in remote areas.

[8] NDA is an FDA classification for drugs
[9] This example table was provided by CMS in the proposed rule.
[10] jun20_reporttocongress_sec.pdf

b. Estimating Higher Costs for ESRD Facilities in Non-Contiguous Areas

As a result of the comments on the CY 2025 ESRD PPS proposed rule, CMS conducted an analysis of non-labor costs in areas that are not contiguous to the United States: Alaska, Hawaii, Guam, the Northern Mariana Islands, American Samoa, Puerto Rico, and the U.S. Virgin Islands. CMS performed a logarithmic regression using data from freestanding and hospital-based ESRD facility cost reports for cost reporting years beginning between January 1, 2020, and December 31, 2022 with facility-level average non-labor cost per treatment as the dependent variable. As cost report data includes both Medicare and non-Medicare dialysis treatments and costs, this analysis encompasses all treatments furnished by ESRD facilities, controlling for various facility-level characteristics. The technical details of CMS' regression model were discussed the proposed rule and repeated in this final rule.

CMS' analysis showed higher non-labor costs for ESRD facilities in Alaska, Hawaii, and the U.S. Pacific Territories relative to the contiguous U.S. Non-labor costs were higher than the contiguous U.S. by 56 percent in Alaska, 31 percent in the Pacific Territories and 21 percent in Hawaii. Based on these results, CMS believes there is reasonable evidence that ESRD facilities in Alaska, Hawaii and the Pacific Territories face higher non-labor costs compared to ESRD facilities in the contiguous U.S. CMS observed that non-labor costs for ESRD facilities in Puerto Rico and the U.S. Virgin Islands were lower than in the contiguous U.S. but the results were not statistically significant.

c. A Non-Contiguous Area Payment Adjustment (NAPA)

CMS indicates that the LVPA and rural adjustment may compensate non-contiguous ESRD facilities in Alaska, Hawaii and the Pacific Territories for a portion of their higher non-labor costs, but not all of them. To address the higher costs of ESRD facilities in these areas, CMS proposed a new facility-level payment adjustment. The proposed non-contiguous areas payment adjustment (NAPA) would apply only to the non-labor portion of the ESRD PPS base rate, which is 44.8 percent. The proposed NAPA would apply to all ESRD PPS claims for renal dialysis services furnished by ESRD facilities in areas eligible for the adjustment including treatments furnished at home and to pediatric ESRD beneficiaries.

Absent a proposed cap on the NAPA, the adjustment would be budget neutral requiring a reduction to the proposed ESRD PPS base rate of approximately 0.2 percent, or $0.47. However, CMS proposed a cap of 25 percent on the NAPA adjustment to reduce the impact on the ESRD base rate for other facilities, while considering that the LVPA and rural adjustment may partially compensate ESRD facilities in Alaska, Hawaii and the Pacific Territories for a portion of their higher costs.

CMS further believes that ESRD facilities in Alaska, Hawaii and the Pacific Territories were being compensated for their higher non-labor costs under the prior wage index system. The NAPA, with a 25 percent cap will replace the higher non-labor costs previously being compensated by a higher wage index. The 25 percent cap is consistent with the IPPS cost of living adjustment applied to the non-labor related share of payments to hospitals in Alaska and Hawaii.

With the proposed cap of 25 percent, the budget neutrality factor would be -0.1 percent or $0.35. The proposed adjustments were 25 percent for Alaska, Guam, the Northern Mariana Islands and American Samoa, and 21 percent for Hawaii.

Comment/Response: Commenters generally supported CMS' proposal, while many requested that it not be adopted on a budget neutral basis to avoid a reduction in payment for providers not receiving the NAPA. However, if the proposal were adopted on a budget neutral basis, commenters supported the 25 percent cap. Other comments indicated that the NAPA should apply in Puerto Rico or the U.S. Virgin Islands and New York City and other high-cost regions in the contiguous U.S.

The Medicare Payment Advisory Commission (MedPAC) was among these commenters supporting applying the NAPA more broadly. MedPAC indicated that that grouping all the ESRD facilities in the contiguous U.S. into a single reference group would not account for variation in costs between contiguous ESRD facilities. The Commission reiterated its support for replacing LVPA and rural facility adjustment with a single payment adjustment for low-volume and isolated ESRD facilities as it has recommended since 2020. MedPAC further indicated that the adjustment should apply at the facility level, not by geographic area as some ESRD facilities CMS proposed to receive the NAPA have above average service volume.

In response to comments about applying the NAPA in areas other than Alaska, Hawaii and the Pacific Territories, CMS indicates the non-labor cost structures of these non-contiguous areas are not meaningfully reflected in existing contiguous-United States geographic payment mechanisms. The results of CMS' extensive analysis of non-labor costs do not support expanding the NAPA to non-contiguous areas outside of Alaska, Hawaii, and the U.S. Pacific Territories. In response to MedPAC's suggestion to apply the adjustment at the facility level rather than based on geography, CMS responded that the NAPA is intended to address higher non-labor costs in certain non-contiguous areas that are broader than those that would apply at the facility level. In response to concerns about the impact of facilities not receiving the adjustment, the ESRD PPS has existing payment adjustments and program protections, including a wage index floor and the low-volume payment adjustment, which can provide payment protections to facilities in Puerto Rico, the U.S. Virgin Islands and other areas not receiving this adjustment.

CMS responded that implementing the NAPA in a non-budget-neutral manner would not be consistent with the longstanding framework within the ESRD PPS to apply case-mix and facility-level payment adjustments in a budget-neutral manner (88 FR 42451). Implementing the NAPA with a 25 percent cap would strike an appropriate balance between increasing payments to areas for which CMS has evidence of relatively higher non-labor costs and mitigating the impact of this payment adjustment on ESRD facilities in other areas. CMS further notes that the budget neutrality adjustment is small mitigating any change in payments to other ESRD facilities necessary to implement the NAPA.

There were also comments concerned about the potential overlap between ESRD facilities receiving the LVPA and rural facility adjustment and ESRD facilities that would receive the

proposed NAPA. CMS responded that there were only 2 LVPA-eligible ESRD facilities found in non-contiguous areas, which furnish less than 1 percent of renal dialysis treatments in NAPA-eligible areas.

CMS is finalizing its NAPA adjustment as proposed. The adjustment will be 1.25 for Alaska, 1.21 for Hawaii, and 1.25 for the Pacific Territories. The NAPA adjustment will require a -0.14 percent reduction to the ESRD rate for budget neutrality or a reduction of $0.39.

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

CMS did not receive any TPNIES applications for 2026.

D. Continuation of Approved Transitional Add-On Payment Adjustment for New and Innovative Equipment and Supplies for CY 2026

There are no TPNIES items approved in prior years that are continuing into 2026.

E. Continuation of Approved Transitional Drug Add-On Payment Adjustments (TDAPA) for CY 2026

A new renal dialysis drug or biological product that is considered included in the ESRD PPS base rate is paid the TDAPA for 2 years. In April 2024, CMS approved DefenCath® (taurolidine and heparin sodium) for TDAPA, effective July 1, 2024. This product will continue to receive TDAPA in 2025 through June 30, 2026. In October 2024, CMS approved Vafseo® (vadadustat) for TDAPA effective January 1, 2025. This product will continue to receive TDAPA in 2025 through December 31, 2026.

The following oral-only phosphate binders were also approved for the TDAPA under the ESRD PPS effective January 1, 2025: sevelamer carbonate, sevelamer hydrochloride, sucroferric oxyhydroxide, lanthanum carbonate, ferric citrate, and calcium acetate. These drugs were paid separately beginning in 2011 through December 31, 2024. Beginning January 1, 2025, these oral-only phosphate binders will be paid using the TDAPA under the ESRD PPS for two years or until sufficient data are available for rate setting.

Table 10 reproduced from the final rule lists these products' effective date and end date for TDAPA (the end date for TDAPA for the oral-only phosphate binders is listed as January 1, 2027 in the table but probably should be December 31, 2026 as it is for Vafseo® (vadadustat). CMS did not receive any comments on the continuing approved TDAPAs for 2026.

Table 8: Continuation of Approved TDAPA			
HCPCS Code	Long Descriptor	Effective Date	End Date
J0911	Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)	7/1/2024	6/30/2026
J0901	Vadadustat, oral, 1 mg (for ESRD on dialysis)	1/1/2025	12/31/2026
J0601	Sevelamer carbonate (Renvela or therapeutically equivalent), oral, 20 mg (for ESRD on dialysis)	1/1/2025	1/1/27 or until sufficient claims data available
J0602	Sevelamer carbonate (Renvela or therapeutically equivalent), oral, powder, 20 mg (for ESRD on dialysis)	1/1/2025	1/1/27 or until sufficient claims data available
J0603	Sevelamer hydrochloride (Renagel or therapeutically equivalent), oral, 20 mg (for ESRD on dialysis)	1/1/2025	1/1/27 or until sufficient claims data available
J0605	Sucroferric oxyhydroxide, oral, 5 mg (for ESRD on dialysis)	1/1/2025	1/1/27 or until sufficient claims data available
J0607	Lanthanum carbonate, oral, 5 mg (for ESRD on dialysis)	1/1/2025	1/1/27 or until sufficient claims data available
J0608	Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to J0607 (for ESRD on dialysis)	1/1/2025	1/1/27 or until sufficient claims data available
J0609	Ferric citrate, oral, 3 mg ferric iron, (for ESRD on dialysis)	1/1/2025	1/1/27 or until sufficient claims data available
J0615	Calcium acetate, oral, 23 mg (for ESRD on dialysis)	1/1/2025	1/1/27 or until sufficient claims data available

Regulatory Impact: CMS estimates the TDAPA payment in 2026 as follows:

1. DefenCath® (taurolidine and heparin sodium). In the proposed rule, CMS estimated $40 million for six months of 2026 with approximately $10 million[11] attributable to beneficiary coinsurance. In the final rule, CMS updated its impact analysis based on most current 72x claims data and estimates approximately $50 million for 6 months of 2026 with approximately $10 million attributed to beneficiary coinsurance.

2. Vafseo® (vadadustat). In the proposed rule, CMS estimated $30 million with approximately $10 million[12] attributable to beneficiary coinsurance. CMS updated its impact analysis in the final rule based on the most current 72x claims data and estimates approximately $40 million in spending of which $10 million will be attributed to beneficiary coinsurance.

3. Phosphate Binders. In the proposed rule, CMS estimated total ESRD PPS spending for phosphate binders would be approximately $410 million in 2026 with approximately $80

[11] It appears that CMS rounded to the nearest $10M.
[12] It appears that CMS rounded to the nearest $10M.

million attributable to beneficiary coinsurance. CMS received a few comments expressing concern regarding the decrease in the estimated spending. In response, CMS states it does not agree that lower budgetary estimates reflect depressed utilization of phosphate binders under the ESRD PPS. CMS provides some reasons for why it disagrees, and notes that the agency based its spending projections for the remainder of 2025 and 2026 on monthly phosphate binder spending in March 2025, which CMS believe to be a reasonable assumption. In this final rule, CMS estimates 2026 spending using most current 72x claims data, resulting in approximately $420 million in 2026 with approximately $80 million attributable to beneficiary coinsurance.

III. Final 2026 Payment for Renal Dialysis Services Furnished to Individuals with AKI

A. Background

An individual with AKI has acute loss of renal function but does not require renal dialysis services for permanent kidney failure. The Trade Preferences Extension Act of 2015 (TPEA) (Pub. L. 114–27) was enacted on June 29, 2015, and amended the Social Security Act to provide coverage and payment for dialysis furnished by an ESRD facility to an individual with AKI. Pursuant to that legislation, since 2017, CMS has paid ESRD facilities to treat patients with AKI the ESRD PPS base rate updated by the ESRD bundled market basket, minus a productivity factor, and adjusted for wages and any other amount deemed appropriate by the Secretary.

B. Update of AKI Dialysis Payment

In the 2026 ESRD PPS proposed rule, CMS proposed to set the 2026 AKI dialysis payment rate (both for home and in-center dialysis) at the proposed 2026 ESRD PPS base rate of $286.06, adjusted by the facility's wage index, as proposed in that same rule. As with the proposed 2026 ESRD PPS base rate, CMS proposed to use more recent data to update this amount if such data became available before the publication of the 2026 final rule.

CMS also applies the wage index floor policies regarding the 0.600 wage index floor and the 5 percent cap on wage index decreases to AKI dialysis payments to ESRD facilities.[13]

CMS considered applying its proposed non-contiguous areas payment adjustment (NAPA, see page 12 above) to the base payment rate for dialysis services provided to beneficiaries with AKI. However, CMS notes that section 1834(r)(1) of the Act requires that adjustments to AKI dialysis payments, other than the ESRD PPS wage index, must be made budget neutrally across AKI dialysis payments. Currently, CMS continues to evaluate the effect of the training adjustment implemented in the 2025 ESRD PPS final rule (89 FR 89170) on AKI dialysis payments.

After consideration of public comments, **CMS is finalizing the payment rate for AKI treatment at the ESRD PPS base rate of $281.71, which reflects the application of the final CY 2026 wage index budget neutrality adjustment factor of 1.00905, the application of the**

[13] The wage index values in this final rule will be used to adjust the payment rates for dialysis services received by beneficiaries with AKI.

final budget neutrality factor for the non-contiguous areas payment adjustment (NAPA) of 0.99860, and the final CY 2026 ESRDB market basket percentage increase of 2.9 percent reduced by the final productivity adjustment of 0.8 percentage point: 2.1 percent.

IV. Updates to the ESRD Quality Incentive Program (ESRD QIP)

A. Background and Overview

The ESRD QIP is established under section 1881(h) of the Act.[14] A payment reduction of up to 2 percent is applied to facilities that fail to either submit data satisfactorily or achieve the applicable minimum Total Performance Score (mTPS). Facility performance results are displayed publicly via the *Care Compare* tool.[15] Payment years (PY) coincide with calendar years for the ESRD QIP and there is a 2-year lag between performance years and associated payment years. The baseline year is the calendar year two years prior to the performance year for the achievement threshold, benchmark, and mTPS calculations. The baseline year for the improvement threshold is the calendar year one year prior to the performance year.

Beginning with PY 2027, CMS finalizes its proposal to remove three measures: (1) Facility Commitment to Health Equity Reporting, (2) Screening for Social Drivers of Health, and (3) Screen Positive Rate for Social Drivers of Health. Beginning with PY 2028, CMS finalizes its updates to the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey clinical measure. The agency also summarizes comments received in response to its RFI on advancing digital quality measurement and its RFI on future measure concepts for consideration in the ESRD QIP (both issued in the 2026 ESRD PPS proposed rule).

CMS updates its estimated impact of each of the PY 2027 and PY 2028 ESRD QIPs from what he had provided in the 2026 ESRD PPS proposed rule, based on more recently available data. In the final rule CMS estimates that of the 7,582 ESRD facilities enrolled in Medicare, approximately 42.9 percent (or 3,256 facilities) that have sufficient data to calculate a TPS will receive a payment reduction for PY 2027. Based on the finalized policies, the total estimated payment reductions associated with the PY 2027 ESRD QIP for all the 3,256 facilities expected to receive a payment reduction will be approximately $21,652,956.[16] CMS also estimates that of the 7,582 facilities enrolled in Medicare, approximately 42 percent (or 3,160 facilities) that have sufficient data to calculate a TPS will receive a payment reduction for PY 2028. Based on the finalized policies, the total estimated payment reductions associated with the PY 2028 ESRD QIP for all the 3,160 facilities will be approximately $20,624,345.

[14] See also 42 CFR 413.177 and 413.178 for ESRD QIP policies, as well as https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP and https://qualitynet.cms.gov/esrd/esrdqip for further background information on the ESRD QIP.
[15] Accessible at https://www.medicare.gov/care-compare/?providerType=DialysisFacility&redirect=true.
[16] Table 23 of the rule shows the updated estimated distribution of PY 2027 ESRD QIP payment reductions and Table 24 shows the data used to update the estimated payment reductions.

B. Updates to Requirements Beginning with PY 2027 ESRD QIP

1. Removal of Facility Commitment to Health Equity (FCHE) Reporting Measure

The Facility Commitment to Health Equity reporting measure was adopted into the ESRD QIP measure set in the 2024 ESRD PPS final rule.[17] CMS is finalizing its proposal to remove the measure beginning with the PY 2027 ESRD QIP under removal factor 8 - the costs associated with achieving a high score on the measure outweigh the benefit of its continued use. The agency believes that without inclusion of the measure there will be more room in the measure set to enhance the program's focus on clinical outcomes and for dialysis leadership to focus on other priority quality and safety areas. Since facilities have already submitted data on the measure for PY 2026, the data and scoring information will be available on the CMS Provider Data Catalog (PDC) and used for PY 2026 payment determinations. But any data on the measure submitted for PY 2027 will not be used for public reporting nor payment purposes and any facility that does not submit data for the PY 2027 reporting period will not be penalized.

Selected Comments/Responses. Many commenters supported the proposal to remove the measure, noting the administrative burden of reporting the measure and its limited impact on improving patient outcomes. Several commenters opposed the removal of the measure and believed it served a critical role in advancing health equity and addressing disparities in care. Some commenters recommend modifying the measure to reduce its administrative burden rather than remove it completely. CMS responds that it is prioritizing the reduction of provider reporting burden, but will consider recommendations as the agency evaluates potential future measures.

2. Removal of Two Social Drivers of Health (SDOH) Reporting Measures

CMS finalizes its proposal to, beginning with the PY 2027 ESRD QIP, remove under removal factor 8 (costs associated with the measure outweigh the benefit of its continued use)[18] the two SDOH reporting measures: (i) Screening for SDOH[19] and (ii) Screen Positive Rate for SDOH.[20] CMS points to the cost associated with screening patients via manual processes, manually storing data, and training staff. Facilities that do not report their 2025 reporting period/PY 2027 data for the measures will not be penalized and any measure data received by CMS will not be used for PY 2027 public reporting or payment purposes.

Selected Comments/Responses. Many commenters supported the proposed removal of the two SDOH measures because they believed that the measures represent the socio-economic vulnerability of patients and not the quality of care provided by facilities. Other commenters did not support the proposed removals and raised the impact that social determinants of health have on patient outcomes and the types of care patients require as part of their dialysis treatment plan. CMS notes that the removal of the measures does not prevent a facility from addressing patients' social needs as clinically appropriate.

[17] 88 FR 76437-76446.
[18] The ESRD QIP measure removal factors are under section 413.178(c)(5) of title 42, Code of Federal Regulations.
[19] Adopted at 88 FR 76466-76476.
[20] Adopted at 88 FR 76476-76480.

3. Updates to Measure Weights, mTPS, and Payment Reduction Scale to Reflect Finalized Measure Removals

Beginning for PY 2027, CMS is updating the individual measure weights in the reporting measure domain to reflect the updated number of measures in the domain with the finalized removal of the FCHE, Screening SDOH, and Screen Positive Rate for SDOH reporting measures. To take into account the updated number of measures, each measure in the domain will be weighted equally at 3.33 percent. This maintains the agency's previously finalized policy to assign equal weights to each measure in the reporting measure domain. The weight of the overall domain will remain 10 percent of TPS.

The FCHE and two SDOH measures comprised half of the measures in the reporting domain. With their removals, CMS is updating the mTPS and payment reduction scale for PY 2027 to reflect the finalized removal of the three reporting measures. A facility will need to meet or exceed an mTPS of 56 to avoid a payment reduction for PY 2027. This is revised from the mTPS of 51 that had been stated in the 2025 final rule for PY 2027, which was based on the measure set at that time. Table 12 in the rule (shown below) sets forth the finalized payment reduction scale for PY 2027 based on the most recently available data and new finalized measure set.

Table 12: Updated Payment Reduction Scale for PY 2027

Total performance score	Reduction (%)
100-56	0%
55-46	0.5%
45-36	1.0%
35-26	1.5%
25-0	2.0%

C. Updates to Requirements Beginning with PY 2028 ESRD QIP

1. PY 2028 ESRD QIP Measure Set

The following table displays the ESRD QIP measure set that would be included in the PY 2028 measure set, as finalized. The table is created by HPA from Table 13 in the rule, with material added for prior years from final rule tables for those years.

Table: ESRD QIP Measure Sets by Payment Year and Measure Status 2022-2028 Measure Status: C=Clinical Measure, R=Reporting Measure						
CBE No.	**Measure Short Descriptor**	**2022-2024**	**2025**	**2026**	**2027**	**2028**
0258^^^	In-Center Hemodialysis (ICH) CAHPS measure	C	C	C	C	C
2496	Standardized Readmission Ratio (SRR)	C	C	C	C	C
2979***	Standardized Transfusion Ratio (STrR)	R	C	C	C	C
	Kt/V Dialysis Adequacy (Comprehensive)^	C	C	C		
0323, 0321, 2706, 1423***	Kt/V Dialysis Adequacy Measure Topic, a clinical measure topic; Four measures of dialysis: adult hemodialysis (HD) Kt/V, adult peritoneal dialysis (PD) Kt/V, pediatric HD Kt/V, and pediatric PD Kt/V.^				C	C

Table: ESRD QIP Measure Sets by Payment Year and Measure Status 2022-2028 Measure Status: C=Clinical Measure, R=Reporting Measure						
CBE No.	**Measure Short Descriptor**	**2022-2024**	**2025**	**2026**	**2027**	**2028**
2977	Vascular Access: Standardized AV Fistula Rate	C	C			
2978	Hemodialysis Vascular Access: Long-term Catheter Rate	C	C	C	C	C
1454	Hypercalcemia	C	R	R	R	R
1463	Standardized Hospitalization Ratio (SHR)	C	C	C	C	C
0418***	Clinical Depression Screening and Follow-up	R	R	C	C	C
	Ultrafiltration Rate	R	R			
1460***	NHSN Bloodstream Infection (BSI)	C	C	C	C	C
	NHSN Dialysis Event^	R	R	R		
	Percentage of Prevalent Patients Waitlisted (PPPW)	C	C	C	C	C
2988	Medication Reconciliation (MedRec)	R	R	R	R	R
3636	COVID-19 HCP Vaccination		R	R	R	R
	Facility Commitment to Health Equity**			R		
^ Beginning with PY 2027, CMS previously finalized replacement of the Kt/V Dialysis Adequacy single measure with the Kt/V Dialysis Adequacy measure topic (consisting of 4 single measures) and to remove the NHSN Dialysis Event measure. ** The Facility Commitment to Health Equity reporting measure was added for PY 2026, as finalized in the 2024 ESRD PPS final rule. The measure is finalized for removal in this rule beginning with PY 2027. *** QIP measure is based on this CBE measure. ^^^ CMS finalizes updates for the ICH CAHPS clinical measure beginning with PY 2028, see IV.C.2					

2. Updates to the ICH CAHPS Clinical Measure

Background. The ICH CAHPS Survey was developed to reflect the experience of in-center hemodialysis patients and the ICH CAHPS measure was a foundational measure of the ESRD QIP measure set. Currently, an eligible facility's score on the measure is based on three composite measures and three global ratings, all of which are equally weighted. Concerns have been raised about the length of the survey and semi-annual frequency of the survey.

Final Action. CMS is finalizing, without modification, its proposal to update the ICH CAHPS clinical measure beginning with the PY 2028 ESRD QIP.

Finalized Survey Changes. CMS is finalizing the following changes to the survey used to calculate performance on the ICH CAHPS measure:

- Removal of four questions (i) Whether the dialysis center staff inserted needles with as little pain as possible, (ii) Whether dialysis center staff talked to patients about what they should eat and drink, (iii) Whether the dialysis center staff keep health information as private as possible, and (iv) 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) composite measure.
- Removal of the nephrologist rating question.

CMS is also finalizing the following changes to the survey that are not related to the ICH CAHPS measure:

- Removal of two questions not used in public reporting measures ((i) Whether the dialysis center staff asked about how kidney disease affects other parts of patient's lives, and (ii) 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.

The current ICH CAHPS Survey measure was endorsed by the consensus-based entity (CBE) in 2019. Following publication of the 2026 ESRD PPS proposed rule, the CBE endorsed the revised measures, with a condition that a robust logic model illustrating the actions accountable entities can take to improve patient experience is included in the next measure evaluation in 2030.

In order for the revised ICH CAHPS Survey to be reflected in the updated ICH CAHPS clinical measure beginning with PY 2028, CMS will implement the revised ICH CAHPS Survey beginning with the 2026 spring survey.

Impact on Measure Calculation and Public Reporting. ICH CAHPS Survey measure scores are calculated based on two rolling semiannual surveys and are published semiannually. Given the finalized change to the survey, CMS also finalizes its proposal to calculate the measure based on the composite measures that would remain after those changes – that is the revised Quality of Dialysis Center Care and Operations (QDCCO) and Providing Information to Patients (PIP) – and the remaining global ratings of the dialysis center staff and dialysis center. All the measures will be weighted equally. The ICH CAHPS measure will continue to be calculated using two rolling semiannual surveys and publicly reported for eligible facilities with 30 or more completed surveys during the reporting period. CMS will reanalyze the 2025 Fall data without the NCC measure and rating and without the four removed QDCCO measure questions and combine the reanalyzed data with the 2026 Spring data or public reporting in April 2027.

Case Mix and Mode Adjustments. ICH CAHPS Survey scores are case mix adjusted before being publicly reported. As finalized, the case-mix adjusters for the revised survey will include overall health, overall mental health, age, sex, education, language survey was conducted in, whether someone helped complete the survey, total years on dialysis, and whether diabetes was primary cause of ESRD.[21]

3. Performance Standards for PY 2028 ESRD QIP

The Secretary must (under section 1881(h)(4)(A) of the Act) specify performance standards with respect to the measures selected for a performance period. The performance standards must

[21] Current case mix adjuster variables are: overall health, overall mental health, heart disease, deaf or serious difficulty hearing, blind or serious difficulty seeing, difficulty dressing or bathing, age, sex, education, does the patient speak a language other than English at home, whether someone helped complete the survey, and total years on dialysis.

include levels of achievement and improvement,[22] and must be established prior to the beginning of the performance period.

For the 2028 ESRD QIP, CMS adopts 2026 as the performance period and 2024 as the baseline period. CMS updates the performance standards for PY 2028 all ESRD QIP clinical measures (from its estimates in the 2026 ESRD PPS proposed rule), using 2024 data, which are the most recently available data. The updated performance standards are shown in Table 14 of the rule. Table 15 in the rule summarizes the requirements for successful reporting on the finalized reporting measures for the PY 2027 and PY 2028 ESRD QIP.

4. Eligibility Requirements for PY 2028

Table 16 of the rule shows previously finalized eligibility requirements for scoring on ESRD QIP measures beginning with PY 2028. No changes were proposed or made.

5. Payment Reduction Scale for PY 2028

Facilities that receive a TPS below the minimum TPS (mTPS) for a PY receive a payment reduction for that year. The quality incentive program payment policy at §413.177(a) provides for a 0.5 percent payment reduction for every 10 points that a facility's TPS is less than the mTPS, up to a maximum reduction of 2 percent. In the 2026 ESRD PPS proposed rule, CMS estimated that for PY 2028 a facility would need to meet or exceed an mTPS of 56 to avoid a payment reduction, based on data from 2023.

CMS has now updated for PY 2028 the mTPS and associated payment reduction ranges using 2024 data (which is the baseline period for PY 2028). As finalized, a facility will need to meet or exceed an mTPS of 57 to avoid a payment reduction for PY 2028.

The following table reflects the updated payment reduction scale for PY 2028, as shown in Table 17 of the rule.

Updated Payment Reduction Scale for PY 2028 Based on Most Recently Available Data	
Total Performance Score	**Payment Reduction**
100-57	0.0%
56-47	0.5%
46-37	1.0%
36-27	1.5%
26-0	2.0%

D. Requests for Information (RFI) on Topics Relevant to ESRD QIP

1. Request for Public Comment on Advancing Digital Quality Measurement

As part of its effort to advance digital quality measurement (dQM), CMS is considering ways to advance Fast Healthcare Interoperability Resources® (FHIR)-based reporting of patient

[22] The terms "achievement threshold," "benchmark," "improvement threshold," and "performance standard" are defined in 42 CFR 413.178(a)(1), (3), (7), and (12), respectively.

assessment data for the submission of ESRD QIP data. In the 2026 ESRD QIP proposed rule, the agency sought information on how dialysis facilities integrate technologies into existing systems and how the integration affects workflow, particularly to identify the challenges during the integration and to determine support that is needed. The agency listed many specific questions on which it is sought feedback regarding the state of health IT use in ESRD facilities.

In the final rule, CMS provided a summary of the comments it received. Several commenters noted the lack of resources and infrastructure for dialysis facilities to meet interoperability mandates. Several commenters noted challenges associated with submitting data through EQRS. Some commenters believed that FHIR-based standards would allow facilities to submit data more promptly and with less manual effort. Commenters also noted that dialysis facilities would need sufficient time to develop and integrate API for data submission and may not have sufficient resources. CMS does not respond to comments in the final rule, but states that it will take them into consideration in the future.

2. RFI on Measure Concepts under Consideration for Future Years

In the 2026 ESRD PPS proposed rule, CMS sought comment on the following five concepts for future measures for the ESRD QIP:

- Interoperability: Approaches to assess interoperability in the dialysis facility setting, such as measures that evaluate the level of readiness of interoperable data exchange or that evaluate data systems' ability to securely share information across the spectrum of care with a focus on exchange of information between dialysis facilities and both inpatient and outpatient facilities and providers.
- Well-being: Tools and measures that assess for overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, fulfillment, and self-care.
- Nutrition: Tools and frameworks that promote healthy eating habits and nutrition for patients receiving dialysis.
- Physical activity: Relevant aspects of physical activity for the ESRD QIP, noting that although dialysis therapy presents various barriers to physical activity for many patients, physical activity and purposeful movement are critical for patients on dialysis.
- Chronic kidney disease (CKD): Measures related to CKD that would encourage early detection, early and appropriate treatment, and delay of progression to ESRD.

In the final rule, CMS summarizes comments received, does not respond to the comments, but states its intent to use the feedback to inform future measure development efforts. A number of the commenters noted that additional resources would be needed for dialysis facilities to meet interoperability standards and that technical assistance and funding should be provided to facilities with limited resources. Several commenters agreed with the importance of nutrition and environmental influences in the care of people with kidney disease and several others supported inclusion of measures that assess well-being. A few commenters acknowledged the importance of well-being but stated that assessing overall health, happiness, and satisfaction in life through a measure in the ESRD QIP would be outside of the program's scope.

V. ESRD Treatment Choices (ETC) Model

A. Background

The ETC is a mandatory payment model administered by the Centers for Medicare and Medicaid Innovation (CMMI) under which payment adjustments are made to promote greater uptake of home dialysis and kidney transplantation as treatment options by ESRD beneficiaries. Model participants are (1) dialysis facilities and (2) clinicians who bill for monthly, bundled ESRD professional services ("managing clinicians"). Participants were chosen randomly from randomly selected hospital referral regions. The model also includes waivers intended to expand beneficiary access to Medicare's Kidney Disease Education (KDE) benefit (*e.g.*, coinsurance waiver.) KDE includes information about ESRD treatment options.

Participants under the model are subject to two payment adjustments. The first adjustment is the Home Dialysis Payment Adjustment (HDPA), which is an upward adjustment on certain payments made to participating ESRD facilities under the ESRD PPS on home dialysis claims, and an upward adjustment to the Monthly Capitation Payment (MCP) paid to participating managing clinicians on home dialysis-related claims. The second adjustment is the Performance Payment Adjustment (PPA), which may be positive or negative and is based on a participant's home dialysis and transplant rates during rolling 12-month Measurement Year (MY) periods.

The ETC model test began January 1, 2021. Payment adjustments under the model are applicable to claims with dates from January 1, 2021 through June 30, 2027. Both achievement and improvement scores are factored into payment adjustments. HDPAs have been applied to claims with claim service dates beginning January 1, 2021 and ending December 31, 2023. Performance Payment Adjustments (PPAs) apply to claims with claim service dates beginning July 1, 2022 and ending June 30, 2027.

B. Provisions of the Final Rule

In this year's proposed rule, CMS proposed to terminate the ETC model effective December 31, 2025 (originally scheduled to conclude June 30, 2027), under its authority at section 1115A(b)(3)(B) of the Act.[23] CMS asserted that as of the publication of the proposed rule, the ETC model had not improved the rate of home dialysis, kidney transplant waitlisting, or living donor transplantation. Further, CMS stated that not only had the model not reduced Medicare spending throughout its duration, but it had actually *increased* spending by a net of $56 million over the course of the model. Lastly, CMS indicated that other ESRD-related models (*e.g.*, Kidney Care Choices Model) have demonstrated more promising results.

[23] "The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title; reduce spending under the applicable title without reducing the quality of care; or improve the quality of care and reduce spending" (42 U.S.C. 1315a).

Given these assertions, CMS proposed to terminate the model effective December 31, 2025, and to correspondingly modify the final measurement year and performance payment adjustment timeframes, and make multiple conforming regulatory changes, to remove references to Model Years (MY) 8 through 10, and change any references to the last model year to MY7. Correspondingly, CMS proposed to stop any data sharing and ETC reports effective November 30, 2025, but states that the agency will make public the Fourth Annual Evaluation Report after the end of the ETC model.

In the context of its proposal to terminate the ETC model, CMS discussed the impacts of Hurricane Helene on the operations of Baxter International in Marion, North Carolina, in October of 2024. Baxter's plant produces 60 percent of the U.S. supply of IV fluids and peritoneal dialysis solutions, and its operations were substantially disrupted from October 2024 to February 2025. As a result, CMS theorized that disruptions in the supply of these fluids may have adversely affected ETC Model participants' performance, and the agency considered eliminating all performance adjustments (upward or downward) for MY7 and PPA7.

However, in evaluating empirical data on home dialysis rates for model participants and non-participants between October and December of 2024, CMS determined the data were not statistically different from pre-Helene rates, and thus the agency proposed *not* to make any adjustments to the methodology or schedule for the PPA due to Hurricane Helene.

Comment/Response: CMS indicates that "several" comments supported the early termination of the ETC model, and notes that some commenters offered suggestions for future ESRD-related models. **In light of public comments received, CMS is finalizing its proposal to terminate the ESRD Treatment Choices Model effective the end of this calendar year (and to make all corresponding regulatory references). Similarly, CMS is finalizing its proposal to NOT make any modifications to the model's PPA7 payment adjustments**.

VI. Regulatory Impact Analysis

A. Impact of Changes in ESRD PPS Payments

CMS estimates that the revisions to the ESRD PPS would increase payments to ESRD facilities by approximately $180 million in 2026, which includes the amount associated with the payment rate updates, the updated post-TDAPA add-on payment adjustment amounts, and the continuation of the approved TDAPA. This includes estimated expenditures of approximately $34 million associated with the post-TDAPA add-on payment adjustment. In addition, this amount includes, but is not impacted by, any budget neutral policies for CY 2026 such as the routine updates to the ESRD PPS wage index and the new non-contiguous areas payment adjustment (NAPA). These amounts are from CMS' modeling of payment rate changes holding utilization, case-mix and other variables constant. CMS estimates a beneficiary coinsurance of approximately $40 million.

Considering changes in utilization and other factors, Medicare program payments for ESRD facilities in 2026 are estimated to total $8.2 billion, reflecting an expected 0.1 percent decrease in fee-for-service Medicare dialysis beneficiary enrollment. (The final rule does not directly address

the reasons for a projected enrollment decline, but it is notable that beginning in 2021, Medicare ESRD beneficiaries may elect to enroll in a Medicare Advantage plan, pursuant to section 17006 of the 21st Century Cures Act (P.L. 114-255)).[24]

Table 21 in the final rule shows the estimated impact on ESRD payments in 2026 by various types of ESRD facilities. The estimates are based on 2024 data from the Part A and Part B Common Working Files as of August 1, 2025. A portion of that table is reproduced below. The omitted rows display facility impact by region.

Overall, CMS estimates the combined effects of all the policies in the final rule would be an increase in payments—again, holding utilization, case mix and other factors constant—of 2.2 percent across all ESRD facilities.

Impact of Final Changes in 2026 Payment to ESRD Facilities (from Table 21)							
Facility Type	**Number of Facilities Column (A)**	**Number of Treatments (millions) Column (B)**	**Routine Outlier Update Column (C)**	**Routine TDAPA and Post-TDAPA Updates (D)**	**Routine Wage Index Updates (E)**	**Budget-Neutral Non-Labor Adjustment (F)**	**Total Percent Change (G)**
All Facilities	7,608	25.2	0.0%	0.1%	0.0%	0.0%	2.2%
Type							
Freestanding	7,257	24.3	0.0%	0.1%	0.0%	0.0%	2.2%
Hospital-based	351	0.9	-0.6%	0.2%	-0.2%	0.2%	1.5%
Ownership							
Large dialysis organization	5,854	19.6	0.1%	0.3%	0.1%	0.0%	2.4%
Regional chain	900	3.1	-0.4%	-0.6%	-0.2%	0.2%	1.0%
Independent	491	1.5	0.2%	0.2%	-0.3%	-0.1%	2.0%
Hospital-based	351	0.9	-0.6%	0.2%	-0.2%	0.2%	1.5%
Geographic Location							
Rural	1,233	3.5	0.0%	0.2%	-0.1%	0.3%	2.5%
Urban	6,375	21.8	0.0%	0.1%	0.0%	0.0%	2.1%
Selected Facility Size (Treatments)							
Less than 3,000 treatments	602	0.5	-0.1%	0.2%	0.2%	0.0%	2.3%
3,000 to 3,999 treatments	414	0.6	0.0%	0.2%	0.2%	-0.1%	2.4%

[24] Nguyen, K. H., Oh, E. G., Meyers, D. J., Kim, D., Mehrotra, R., & Trivedi, A. N. (2023). Medicare Advantage enrollment among beneficiaries with end-stage renal disease in the first year of the 21st Century Cures Act. *JAMA*, *329*(10), 810. https://doi.org/10.1001/jama.2023.1426.183

Impact of Final Changes in 2026 Payment to ESRD Facilities (from Table 21)							
Facility Type	**Number of Facilities Column (A)**	**Number of Treatments (millions) Column (B)**	**Routine Outlier Update Column (C)**	**Routine TDAPA and Post-TDAPA Updates (D)**	**Routine Wage Index Updates (E)**	**Budget-Neutral Non-Labor Adjustment (F)**	**Total Percent Change (G)**
4,000 to 4,999 treatments	491	0.8	0.0%	0.2%	0.2%	0.0%	2.5%
5,000 to 9,999 treatments	2,995	7.7	0.0%	0.1%	0.2%	-0.1%	2.3%
10,000 or more treatments	3,106	15.7	0.0%	0.1%	-0.1%	0.1%	2.1%
Percentage of Pediatric Patients							
Less than 2%	7,510	25.0	0.0%	0.1%	0.0%	0.0%	2.2%
Between 2% and 19%	38	0.1	-0.1%	0.3%	0.6%	0.5%	3.3%
Between 20% and 49%	8	0.0	-1.5%	-0.3%	0.4%	-0.1%	0.3%
More than 50%	52	0.0	-1.0%	0.2%	0.7%	-0.1%	1.8%

B. Estimated Impact of ESRD AKI

CMS estimates that 2026 payments made to ESRD facilities for renal dialysis services furnished to individuals with AKI would increase by $1 million. Table 22 of the final rule shows an overall impact of the changes to be a 2.0 percent increase in payment for renal dialysis services furnished to individuals with AKI. Hospital-based ESRD facilities have an estimated 1.8 percent increase in payments compared with freestanding ESRD facilities with an estimated 2.0 percent increase.

C. Estimated Impact of ESRD QIP

1. Impacts for PY 2028

The ESRD QIP is intended to prevent reductions in the quality of ESRD dialysis facility services provided to beneficiaries. For PY 2028, CMS estimates that available data will be sufficient to calculate a TPS for 7,582 Medicare-enrolled ESRD facilities and insufficient for 157. CMS further estimates that 41.7% (3,160/7,582) of all enrolled facilities would receive payment reductions for PY 2028. Total payment reductions to the 3,160 facilities are now estimated at $20.6 million. The estimated distribution of reductions is shown in Table 26 of the rule, reproduced below.

TABLE 26: Estimated Payment Reduction Distribution for PY 2028		
Reduction	**Facilities**	**Percent of Facilities (%)**
0.0%	4265	57.4
0.5%	1865	25.1
1.0%	902	12.2
1.5%	294	4.0
2.0%	99	1.3

*157 facilities not scored due to insufficient data.

Table 28 of the rule, reproduced in part below, shows PY 2028 payment reduction impacts according to facility size, geography, and type. CMS cautions that the true impacts may be very different than shown because the performance period used for these calculations differs from the performance period for the PY 2028 ESRD QIP related to data availability.

Overall, CMS estimates the payment reductions will represent about 0.33 percent of total ESRD payments in PY 2028 or $20.6 million in payment reductions across all facilities. Reductions are shown to be largest for independently owned facilities. Costs to facilities associated with reporting of data for the ESRD QIP through the EQRS system are estimated to total $125 million for PY 2028.[25] Taken together, reporting costs and payment reductions are estimated to have an impact of $145.6 million on ESRD facilities for that year.

Estimated impact of QIP payment reductions are provided for 2028 in Table 28 (payment reduction distribution).

Estimated Impact of QIP Payment Reductions to ESRD Facilities for PY 2028 (From Table 28)			
Facility Type	**Number of Facilities with QIP Score**	**Number of Facilities Expected to Receive a Payment Reduction**	**Payment Reduction as Percent of Total ESRD Payments**
All Facilities	7,425	3,160	-0.33%
Facility Type			
Freestanding	7,119	3,007	-0.33%
Hospital-based	306	153	-0.46%
Ownership Type			
Large Dialysis	5,781	2,328	-0.29%
Regional Chain	870	334	-0.30%
Independent	455	338	-0.88%
Hospital based (non-chain)	306	153	-0.46%
Geography			
Northeast	1,015	416	-0.34%
Midwest	1,601	701	-0.35%
South	3,379	1,494	-0.34%

[25] CMS also 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 would be approximately $146.6 million. The $146.6 million estimate for PY 2027 includes $125 million in costs associated with the collection of information requirements and approximately $21.6 million in payment reductions across all facilities.

Estimated Impact of QIP Payment Reductions to ESRD Facilities for PY 2028 (From Table 28)			
Facility Type	**Number of Facilities with QIP Score**	**Number of Facilities Expected to Receive a Payment Reduction**	**Payment Reduction as Percent of Total ESRD Payments**
West	1,367	506	-0.28%
US Territories	63	43	-0.48%

D. Estimated Impact of ETC Model

To estimate the financial impact terminating the ETC model, CMS used a stochastic simulation model developed by the CMS Office of the Actuary. It relies on statistical assumptions derived from constructed ESRD facilities and Medicare dialysis claims, transplant claims, and transplant waitlist data reported during 2018 and 2019, which were the most recent years of complete data prior to the start of the ETC model.

Table 30 in the final rule shows the estimated impact of terminating the ETC Model on December 31, 2025. CMS estimates that the Medicare program spending would increase by a net total of $5 million due to the performance payment adjustment (PPA) between January 1, 2026, and June 30, 2027, less $6 million from training and education expenditures that will not occur due to the model ending. Therefore, the net impact to Medicare spending from terminating the model early is estimated to be $1 million in savings during the final 18 months of the performance period (January 1, 2026 – June 30, 2027).