DPC
DIALYSIS PATIENT CITIZENS

Improving Life Through Empowerment

August 24, 2026

The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20001

Re: CMS-1846-P: CY 2027 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Acute Kidney Injury Dialysis (AKI) Payment, and ESRD Quality Incentive Program

Dear Dr. Oz

Dialysis Patient Citizens (DPC) offers comments on the above referenced Rule.

DPC's membership, currently about 35,000, is restricted to kidney disease patients and their family members. DPC is a patient-led organization. Our by-laws require that the President, Vice President and at least 51% of the Board be current dialysis patients. The non-dialysis patients serving on our Board are former dialysis patients with kidney transplants. Our volunteer board members have represented their peers on CMS technical expert panels and/or advisory committees of other health care organizations such as the National Quality Forum and Patient-Centered Outcomes Research Institute. DPC also conducts periodic Membership Surveys to ascertain patients' experiences with their care and views on health policy issues. DPC is committed to promoting access to high-quality dialysis care for individuals with ESRD; to prevention of, delayed onset of, and safe transition to ESRD among individuals with chronic kidney disease; and access to kidney transplantation as well as to other alternatives to dialysis that may emerge.

I. We remain concerned that Medicare payments are inadequate to fund a robust kidney care infrastructure, as this year's update again trails rising input costs.

While we appreciate CCPG personnel speaking to our policy conference in June, much of what we heard about payment policy was unsettling. We are certain that staff is sincere in its belief that beneficiary access must be "balanced" with stewardship of Medicare funds, but a policy of invidiously chipping away at payments has no legal support in Medicare statutes. In essence, our patients were told that they must endure an austerity posture, justified in part by dialysis provider overbilling that took place decades ago, long before today's beneficiaries experienced kidney failure.

The productivity adjustment is the lawful mechanism for imposing austerity, and it is plenty severe on its own. But the pattern of continued deficiencies in cost forecasts leads us to believe that these unrealistically low estimates result not from random errors but a thumb on the scale, where the contractor has been explicitly instructed to deliver, or is being implicitly rewarded for, lowball updates to Medicare providers.

The current inflation rate is 3.4%. The *Wall Street Journal'*s expert panel of economists forecasts 3.4% inflation for the next year. The most recent producer price index was 4.7%. As such, we think the NPRM's market basket forecast of 2.6% is as unrealistic as previous years' updates and feels contrived. Unless CMS payment rules can also abolish wage/price spirals, we can expect health care sector workers to demand 3.4% pay increases in the next year, and find other work if providers can't offer them.

We believe the consequences of this parsimony are now being felt by patients.

Dialysis facility closures outnumbered openings in 2024.

The number of U.S. dialysis facilities closing has been rising since 2018, according to a study published in *American Journal of Kidney Diseases*. Author Shuchi Anand told *Nephrology News and Issues***,** "For the first time in decades, dialysis facilities are closing rather than opening at a rapid pace,"

The study, using CMS data from 2018 to 2024, found that among 8,343 dialysis facilities, 16.3% opened and 9.6% closed, with the annual opening-to-closure ratio decreasing from 8.9 in 2018 (401 openings vs. 45 closures) to 0.8 in 2024 (56 openings vs. 74 closures).

This change in trend over the past 5 years coincides with the string of update deficiencies, which can be traced back to 2019 since when the difference between forecast costs and actual costs has been a cumulative 6 percent.

Facility closures impact every patient in the sense that competition and choice are reduced. But patients in sparsely populated regions are impacted directly and harshly.

This spring, NPR reported on the closure of the dialysis unit at Chadron Hospital in rural Nebraska and its effects on 16 displaced patients.

Some patients have moved to live closer to care, including several nursing home residents, while others are making long drives to far-flung dialysis centers. One patient profiled was Mark Pieper of Hay Springs, who transferred his treatment in Scottsbluff, a small town but the biggest in western Nebraska. This is an hour-and-a-half drive amounting to more than nine hours each week. Patient Alan Simonson must travel more than four hours round trip to Scottsbluff. Jim Wright rented a small home near Rapid City, South Dakota to live, on weekdays, close to a dialysis facility there.

Jon Reiners, CEO of Chadron Hospital, told NPR that dialysis services lost $1 million a year due to low reimbursement rates that didn't cover operational costs.

The article noted that home dialysis is not necessarily a solution to such problems. The nearest facility to Chadron that offers training for peritoneal dialysis is in Scottsbluff, and the nearest offering training for home hemodialysis is three hours away in Cheyenne, Wyoming.

WSET Radio reported on how UVA Health closed its Appomattox Dialysis Center on April 18.

The healthcare system said they're consolidating care into larger regional hubs, citing "significant staffing challenges and rising costs at their smaller dialysis centers."

With the center closed, 39 patients have to travel to locations such as Lynchburg (30 minutes), Amherst (39 minutes) or Farmville (31 minutes).

Disadvantaged communities are harmed the most.

But closures have even more severely impeded access to dialysis facilities in disadvantaged communities according to a research letter published in *JAMA Internal Medicine*.

Shen and Hsia examined whether geographic variation in access to dialysis facilities correlated with community socioeconomic status measured by Area Deprivation Index, again using national CMS data, from January to December 2025.

The study found that disadvantaged communities had substantially lower access to dialysis services, with only 2.3 percent of the most advantaged communities lacking a dialysis facility within 30 minutes compared to 11.7 percent of the most disadvantaged communities.

A facility in Eastman, Ga. closed its doors at the end of March, leaving dozens of dialysis patients up in the air. Patients now must travel to Hawkinsville (20 miles) or Dublin (27 miles) which can take nearly an hour. Patient Sean Mais told WMAZ News "Imagine me now having to drive almost an hour one way. It's gonna be hard when you leave dialysis — your blood pressure is low, you're weak, you have to just lay down. It's not easy."

Two rural Alabama counties lost their only dialysis centers this past winter. First, Fresenius closed its Tuskegee clinic, the only facility in rural Macon County. Shortly afterward, it closed the only dialysis center in Wilcox County. With that Camden facility closed, the closest dialysis centers that Wilcox County residents have access to are in Selma (80 miles roundtrip), Thomasville (60 miles roundtrip), and Greenville (110 miles roundtrip).

Fresenius has historically operated clinics in poorer, rural southern locations, despite those facilities often losing out on revenues due to QIP penalties that are disproportionally assessed against centers that serve the disadvantaged. We worry that a retrenchment there, driven by rational economic decisionmaking under the circumstances, may be underway.

Restoring the 6% cumulative deficiency would hardly be extravagant. The *New York Times* reported in May that Medicaid programs are paying as much as $83 or even $144 per hour to treat autism with applied behavioral analysis—a therapy said to be backed by weak evidence and sometimes likened to babysitting. Dialysis is a livesaving treatment that requires capital expenditures and trained personnel to deliver.

We are especially concerned that these developments are occurring in the environment of a "K-Shaped Economy"—the phenomenon of half or more economic activity being driven by the wealthiest decile of Americans. Business investment is becoming concentrated in production of good and services for the affluent, with low- and middle-income consumers unable to find housing or automobile options in their price range.

What this means is that a service like dialysis occupies a disfavored position as an object of investment. The conventional wisdom on Wall Street would undoubtedly prefer dialysis clinics to be refitted as "med spas" offering Botox injections, dermal fillers, and other tweakments to the well-off. Only generous support from public programs like Medicare can overcome this grim market reality.

To ignore these dynamics is to repudiate the vow made by Congress decades ago to guarantee access to kidney care to all Americans regardless of income or perceived "merit". The inevitable result of inadequate reimbursements—in an economy where fewer than 70% of health care job openings are filled and worker supply isn't keeping pace with growth in healthcare positions due to demographic trends—will be a crisis in healthcare access. Hemingway wrote that bankruptcy comes "gradually and then suddenly." It appears CMS is content to let kidney care access decline gradually, and then step in to clean up the problem when it collapses suddenly. But this ignores the slowly unfolding impact on the most vulnerable patients until a crisis appears seemingly all at once. CMS must ensure that taking care of people on Medicare is as well paying a job as others that don't depend on government funding—now, not when acute shortages manifest.

II. This Rule again fails to address the perverse effects of strict bundling on access to new therapies.

The TDAPA policy seems to assume that the drugs dialysis patients take are extras or first class upgrades. The statute creating the PPS says no such thing. Would CMS allow a new drug that doubles the life expectancy of ESRD patients—the very purpose of ESRD care and coverage—to go unused? If not, what is the cutpoint between protecting patients and the not-so-benign neglect we are seeing today? Even if the drugs only improve quality of life, it is antithetical for one CMS component, CMMI, to hold dialysis providers accountable for patient quality of life while another, CM, is indifferent to whether important QOL-improving interventions are delivered.

During our June conference, our patients were advised by CCPG staff that if they have not received appropriate drugs covered by the bundle, they should file a complaint with CCPG. We have never heard of a CMS payment policy shop suggesting that individual casework—within CM, no less—should be a substitute for assuring, through appropriate payment and coverage levers, that patients are receiving the care they are due. Indeed, the suggestion is risible because

nephrologists, who through joint ventures with dialysis organizations are on the hook for the cost of such drugs, are disincentivized to inform patients of the drugs' existence in the first instance.

Our review of the press releases CMS has put out about beneficiary access to drugs and devices finds many diseases and drugs specifically mentioned: sickle cell and asthma, CAR T-cell treatments, GLP-1 drugs and small biotech drugs. Digital health devices are called out as are even Botox and hemp-derived products. In announcing coverage of CAR-T, a release said, "President Trump is committed to strengthening the Medicare program by ensuring that beneficiaries have access to new and potentially lifesaving treatments."

But one category that's never been mentioned is drugs for dialysis patients. Patients who have pruritis or use a catheter would be grateful if CMS were to announce to the public, our new policy guarantees that anyone who needs "new and potentially lifesaving treatments" like Korsuva or Defencath will get it.

One ESRD condition addressed by medications is phosphorus. High levels of phosphorus can cause bone and heart problems and calcification or hardening of tissues. The standard treatment for high phosphorus has been phosphate binders, large pills that must be taken in large quantities. One patient on our board had a gastric sleeve done several years ago, and found that the phosphorus binders expanded in her now much smaller stomach. She was prescribed Xphosah, a phosphate blocker, but Medicare no longer covers this drug now that it's bundled.

CMS recently issued a notice outlining a faster way for manufacturers to get new devices covered by Medicare: the Regulatory Alignment for Predictable and Immediate Device (RAPID) coverage pathway. In conjunction with the FDA, "this new Medicare coverage pathway will accelerate beneficiary access to eligible Class II FDA-designated Breakthrough Devices." While we don't begrudge Medicare covering Botox and hemp-derived products or breakthrough devices for people who are helped by them, why is there no RAPID pathway to ensure access to new therapies for kidney patients?

It is crystal clear that CMS can muster the will to overcome inertia and proactively expedite new therapies for patients. Whether it is a lack of initiative, lack of creativity, or lack of sympathy, CMS has made no such efforts on behalf of kidney patients.

Thus, the Rule makes no mention of the hemodiafiltration newly available to U.S. patients. Hemodiafiltration has the promise of improving patient survival by as much as 23%, reducing hospitalizations by 20%, and granting patients more energy and shorter recovery times. While the prospect of improved survival should theoretically incentivize dialysis organizations to adopt hemodiafiltration, we are worried that organizations that lack access to capital may be unable to re-outfit their clinics. But a greater concern is that benefits like reduced hospital days go to the Medicare program, and improved quality of life goes to patients, without a financial return to providers.

CMS needs to acknowledge the misalignments and address them by amending TPNIES to include in-center dialysis machines that would otherwise qualify for the add-on payment, and

recognize any savings to the Medicare program overall in fixing a longer-term enhancement to reimbursement.

Finally, the devices in the RAPID Pathway are a reminder of the long-run futility of strict bundling. Venture capital and research that might have gone into kidney care simply migrate to areas of unbridled fee-for-service payment. This is perverse because, unlike TDAPA or TPNIES, such devices are not subject to a Substantial Clinical Improvement requirement for coverage and could be me-too therapies that cost more while adding minimal improvement to beneficiaries' care.

III. Dialysis access for ESRD patients in hospice must be bolstered.

A MedPAC study published this summer found dialysis patients who are near the end of life are less likely than other terminally ill beneficiaries to enroll in hospice. In 2024, 31 percent of Medicare decedents with ESRD enrolled in hospice compared with 53 percent of all Medicare decedents. We presume that this is because patients fear pain and discomfort from a precipitous end to treatments, or the refusal of hospice agencies to arrange palliative treatments due to cost. MedPAC made a trenchant observation about the perils of payment bundling, one we think CMS should keep in mind when thinking about TDAPA policy, or a monthly payment for dialysis, as well:

> Complex palliative treatments could represent a substantial portion of Medicare's hospice payment (which is intended to cover all services provided during the stay); such an occurrence is not necessarily problematic in a prospective payment system (PPS) like the one used by Medicare to pay for hospice services. A PPS assumes that providers will earn a profit on some cases and incur a loss on others but that, on average, payment will be reasonably aligned with costs. However, if patients with certain conditions or characteristics are predictably more costly than others, a PPS can create incentives for providers to avoid those costs by not admitting such patients or by not furnishing costly services.

MedPAC then outlined three policy options. We find two of them appealing:

The first is "add-on payments for the provision of certain high-cost palliative services. This approach would increase incentives for hospices to furnish these services to beneficiaries but would also create incentives to furnish costly services even when they are not palliative or not aligned with the patient's plan of care." We are dubious that ESRD patients who elect hospice would like to continue 3 day per week treatments, or that hospices would find dialysis to be a profit center. Our one reservation about this approach is the need to pay the hospice rather than reimburse the dialysis provider directly.

The second is a "voluntary transitional program through the CMS Innovation Center that would offer hospice enrollees the option to receive certain services such as dialysis or blood transfusions for some transitional period, or up to a specified number of treatments, paid for outside of the hospice benefit. A voluntary transitional program could help ease the transition to

hospice for dialysis- and transfusion-dependent beneficiaries who are near the end of life and wish to enroll in hospice. A transitional program for beneficiaries with ESRD receiving maintenance dialysis or beneficiaries with cancer who are dependent on blood transfusions could give the Secretary the opportunity to, in a limited fashion, directly test transitional concurrent care for hospice enrollees for services where access concerns have been raised by stakeholders."

This last part echoes a recommendation by Natalie Ernecoff and colleagues: "Often paired with innovative payment models, concurrent care smooths practical, psychological, and physical care transitions when patient goals prioritize comfort. For example, allowing simultaneous receipt of hospice care and dialysis for people living with end-stage kidney disease-a group with relatively low hospice enrollment-can act as a bridge to hospice and potentially promote longer lengths of stay."

Thank you for your consideration of our comments and concerns. If you have any questions or would like additional information, please do not hesitate to contact me or our Vice President of Public Policy Jackson Williams (at 202-768-4506 or jwilliams@dialysispatients.org).

Respectfully submitted,

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