THE KIDNEY CARE COUNCIL

January 12, 2026

Michael Chernew, PhD.
Chairman
Medicare Payment Advisory Commission
425 Eye Street, NW, Suite 701
Washington, DC 20001

Paul B. Masi, M.P.P.
Executive Director
Medicare Payment Advisory Commission
425 Eye Street, NW, Suite 701
Washington, DC 20001

Dear Dr. Chernew and Executive Director Masi:

The Kidney Care Council (KCC) writes today to respectfully urge the Medicare Payment Advisory Commission (MedPAC) to ensure continued access to life-saving dialysis services for Medicare beneficiaries and to recommend that Congress and the Centers for Medicare and Medicaid Services (CMS) provide an update to the CY 2027 Medicare base payment rate for outpatient dialysis services consistent with current law.

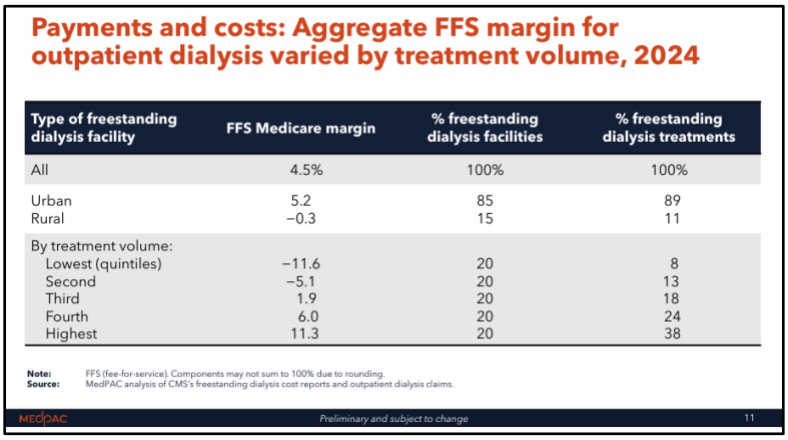
End Stage Renal Disease (ESRD) is a serious and complex medical condition for which individuals must receive either dialysis or a kidney transplant to survive; without treatment, patients die from kidney failure. Congress affirmed the extraordinary medical vulnerability of this population in 1972 by creating a unique entitlement to Medicare coverage for individuals with ESRD, regardless of age or disability status, which for many decades was the only diagnosis-based Medicare eligibility pathway in statute.[1] According to the most recent Annual Data Report of the United States Renal Data System (USRDS)[2], in 2023, approximately 76 percent of Americans with ESRD receiving dialysis as prevalent patients were Medicare beneficiaries, 43 percent of whom were dually eligible for Medicare and Medicaid, underscoring the safety-net nature of the ESRD program. By contrast, only about 4 percent of Americans with ESRD receiving dialysis as prevalent patients had coverage through an Employer Group Health Plan.[3] As such, Americans with ESRD are uniquely reliant upon the Medicare program as their primary source of coverage for life-saving dialysis care.

Unfortunately, the Medicare ESRD Prospective Payment System (PPS) has historically failed to keep up with the rising costs of care. Indeed, in MedPAC's most recent Report to Congress, the Commission indicated that Medicare margins for dialysis facilities were *negative* 1.1 percent in 2022, *negative* 0.2 percent in 2023, and projected to be *zero* in 2025.[4] We were therefore surprised to learn, as observers at the December 2025 public meeting, that MedPAC staff may find positive Medicare margins for dialysis facilities in CY 2024. While we have not been able to replicate MedPAC's complex analysis, we urge the Commission to consider that its own

[1]Social Security Amendments of 1972, Pub. L. No. 92-603, § 299I, 86 Stat. 1329, 1463 (codified as amended at 42 U.S.C. § 426-1).
[2] The United States Renal Data System (USRDS) is the national ESRD registry funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health. See: https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/usrds.
[3] USRDS, 2023 Annual Data Report, Table 1.4: "Characteristics of people with established ESKD, 2023." Available at: https://usrds-adr.niddk.nih.gov/2025/end-stage-renal-disease/1-incidence-and-prevalence.
[4]MedPAC, *Report to the Congress: Medicare Payment Policy*, ch. 5, at 149 (Mar. 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch5_MedPAC_Report_To_Congress_SEC.pdf.

analysis within the past year shows multiple, successive years of zero to negative margins for dialysis facilities. A single, potentially positive Medicare margin should not result in a recommendation to eliminate the statutory update for a payment system that delivers only life-saving care.

At the December meeting, MedPAC staff shared a breakdown of Medicare dialysis margins by treatment volume[5] that adds important context to the discussion.



Payments and costs: Aggregate FFS margin for outpatient dialysis varied by treatment volume, 2024

Type of freestanding dialysis facility	FFS Medicare margin	% freestanding dialysis facilities	% freestanding dialysis treatments
All	4.5%	100%	100%
Urban	5.2	85	89
Rural	−0.3	15	11
By treatment volume:			
Lowest (quintiles)	−11.6	20	8
Second	−5.1	20	13
Third	1.9	20	18
Fourth	6.0	20	24
Highest	11.3	20	38

Note: FFS (fee-for-service). Components may not sum to 100% due to rounding.
Source: MedPAC analysis of CMS's freestanding dialysis cost reports and outpatient dialysis claims.

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This distribution shows that the reported average Medicare margin of 4.5 percent does not reflect the experience of most dialysis facilities. In fact, **60 percent of freestanding dialysis facilities have Medicare margins below the reported average**, meaning that a clear majority of facilities are doing worse than the headline figure suggests. Raising further concerns, **40 percent of facilities are operating with negative Medicare margins**, indicating that Medicare payments do not fully cover the cost of providing care at those facilities. The remaining facilities below the reported average are likely earning only modest positive margins, well below 4.5 percent and clustered near break-even. Looking at the distribution another way, the median facility falls between the second and third treatment-volume quintiles, where margins range from *negative* 5.1 percent only to positive 1.9 percent. This suggests that the typical dialysis facility is operating at or near break-even, and likely below zero, rather than experiencing the positive margins implied by the reported average.

This distribution matters for policy because dialysis facilities are not interchangeable, and care is inherently delivered locally. When a substantial share of facilities is operating at a loss or barely breaking even, reliance on an average margin analysis risks overlooking real financial stress and emerging access challenges for beneficiaries. If the lowest-margin facilities were to reduce capacity or exit the market, reported average margins could appear to improve, but only because facilities closed in their communities, not because payment adequacy had meaningfully improved. From a beneficiary access perspective, this would increase travel burdens, strain remaining facilities, and disproportionately affect rural and medically complex populations who depend on

[5] MedPAC. *Assessing payment adequacy and updating payments: Outpatient dialysis services.* Public meeting presentation, December 5, 2025, Presented by Nancy Ray and Grace Oh. Available at: https://www.medpac.gov/wp-content/uploads/2025/01/Tab-J-Dialysis-Dec-2025.pdf.

reliable, thrice-weekly treatment to survive. For these reasons, a single average margin should not be the basis for recommending the elimination of the statutory update for a payment system that delivers life-sustaining care.

For example, we are concerned about access implications for dialysis facilities that are geographically isolated or serve an essential safety-net function in their communities, where the loss of a single facility - or constraints on its ability to maintain capacity - would create meaningful barriers to care. While MedPAC's publicly available analysis from the December 2025 meeting does not directly identify such facilities, the reported rural Medicare margin data provides the closest available proxy for assessing access risk using the Commission's framework. MedPAC reports that **rural freestanding dialysis facilities had an aggregate Medicare margin of *negative* 0.3 percent** in 2024, operating well below MedPAC's reported average Medicare margins despite facility level adjusters that provide added support for Rural and Low-Volume facilities. Eliminating the CY 2027 ESRD PPS update would further erode already thin margins for the most vulnerable facilities, increase the risk of service reductions or closures, and directly harm beneficiaries who rely on these facilities for local access to life-sustaining care.

MedPAC's margin analysis may also inadvertently overstate the Medicare margin due to persistent limitations in the CMS ESRD Facility Cost Report. As you know, the statute requires CMS to reduce each ESRD claim by $0.50 per treatment to fund the ESRD Networks;[6] however, this required revenue reduction is not reflected on the cost report, resulting in an overstatement of Medicare payments and margins. KCC would welcome MedPAC's support in calling on CMS to correct this long-standing issue with the ESRD Facility Cost Report[7] and respectfully requests that the Commission consider including a clarification regarding the mandatory ESRD Network Fee in the upcoming March report.

As was discussed by several Commissioners in December, many states do not ensure that beneficiaries with ESRD under age 65 can obtain Medicare supplemental coverage to manage their coinsurance obligations in fee-for-service Medicare. We appreciate the support expressed by several Commissioners for revisiting this policy, as the current rules impose significant hardship on both patients and providers. This is one reason dialysis facilities incur substantial amounts of uncollectible bad debt that falls outside MedPAC's margin analysis. Dialysis providers are often unable to collect the full 20 percent coinsurance from fee-for-service beneficiaries, including from dual eligibles in states that limit Medicaid payments to 80 percent of Medicare, and face similar limitations for Medicare Advantage (MA) beneficiaries. These realities further reduce the resources available to deliver care beyond what is reflected in technical margin calculations. Eliminating the CY 2027 update would exacerbate these pressures and further strain access to care.

Similarly, we urge the Commission to reconsider reliance on the "all-payer margin" as part of an analysis to assess Medicare payment adequacy in Outpatient Dialysis. Medicare is by far the dominant payer for dialysis services, covering nearly 80 percent of patients due to the unique statutory entitlement associated with an ESRD

[6]Social Security Act (SSA) § 1395rr(b)(7), as added by section 9335(j)(1) of OBRA '96.
[7]To account for the Network Fee on the Cost Report, KCC recommends that CMS account for it as a "revenue reduction." A column entitled "ESRD Reductions (8.0)" would be added to Worksheet D after current column 7.02. Column 8.0 would be changed to 9.0. The instructions for Column D would read: "Enter the amount that results from Column 4 (Medicare treatments) X -$0.50 for the Network Fee." The instructions for Column 9 could read as: "Enter the sum of columns 7, 7.01, 7.02, and the negative amount from Column 8 into their corresponding line in column 9." The Provider Statistical and Reimbursement (PS&R) could be used as a reference to confirm the amounts included in the new Column 8.

diagnosis. The most recent USRDS report shows that although 15.6 percent of incident patients have employer coverage at diagnosis,[8] only 4.1 percent of ESRD patients retain such coverage as prevalent patients[9] as they likely transition to Medicare. Medicaid, whether as a supplemental or primary payer, does not provide rates sufficient to offset Medicare shortfalls. Unlike other provider sectors, dialysis facilities cannot rely on non-Medicare payers to cushion inadequate Medicare rates. Further, the reported "all-payer margin" is presented only as an aggregate average, without stratification by facility characteristics, treatment volume, or geography. As with Medicare margins, averages alone may mask substantial financial stress at the local level, where dialysis care is delivered and access is determined, and may overstate resources available to many facilities. In the Outpatient Dialysis context, the "all-payer margin" does not function as a meaningful safeguard against access risk and should not be relied upon as a basis for making policy recommendations regarding Medicare payment rates.

In parallel, although not reflected in the slide materials presented at the December 2025 meeting, we noted discussions among Commissioners referencing MA payment rates that appear consistent with analyses cited in MedPAC's March 2025 Report. We respectfully caution that these analyses rely on MA payment data from 2017[10] and 2018,[11] years that predate implementation of the 21st Century Cures Act, which expanded MA eligibility for beneficiaries with ESRD. Prior to this statutory change, MA enrollment among ESRD beneficiaries was limited, as only individuals already enrolled in MA at the time of diagnosis were permitted to remain in such plans. Since that time, substantially more beneficiaries with ESRD have enrolled in MA, and plan contracts and payment arrangements for dialysis services have likely evolved. Given these shifts, MA payment data, particularly older data, are limited and are potentially unreliable for informing decisions about the ESRD PPS update for CY 2027.

We appreciate MedPAC staff's presentation of the full history of its margin analysis, which illustrates the volatility of the ESRD PPS over time. We noted several comments raised at the December meeting regarding the CY 2019 margins. As you may recall, CMS did not provide clear instructions for the CY 2019 cost report related to reporting the Transitional Drug Add-on Payment Adjustment (TDAPA) for calcimimetics, which resulted in inconsistent reporting of revenue and costs by providers. We appreciate that MedPAC included a clarifying footnote[12] in the March 2021 Report explaining the limitations of the margin analysis for CY 2019, and we

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[8] USRDS *2025 Annual Data Report: End-Stage Renal Disease Volume, Chapter 1 – Incidence and Prevalence.* Table 1.1: Characteristics of people with new ESKD, 2018–2023. https://usrds-adr.niddk.nih.gov/2025/end-stage-renal-disease/1-incidence-and-prevalence.

[9] USRDS *2025 Annual Data Report: End-Stage Renal Disease Volume, Chapter 1 – Incidence and Prevalence.* Table 1.1: Characteristics of people with new ESKD, 2018–2023. https://usrds-adr.niddk.nih.gov/2025/end-stage-renal-disease/1-incidence-and-prevalence.

[10] MedPAC *March 2025 Report: Chapter on Outpatient Dialysis Services*, citing E. Lin et al., *Health Affairs* 41, no. 8 (Aug. 2022): 1107–1116 (analysis of 2016-20177 claims submitted by MA plans to the Health Care Cost Institute).

[11] MedPAC *March 2025 Report: Chapter on Outpatient Dialysis Services*, citing MedPAC analysis of 2018 Medicare rates.

[12] Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy.* March 2021. Chapter 6: Outpatient Dialysis Services. Available at: https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/. Footnote 39 states: "The Commission's longstanding approach to calculating the Medicare ESRD PPS margin uses only Medicare-allowable costs for ESRD services. Such an approach is consistent with the methods we use to calculate the Medicare margin for other FFS sectors. Our ESRD margin analysis relies on the cost data that freestanding dialysis facilities report on the cost reports that they submit to CMS. In 2019, there was an anomalous increase in non-ESRD drug costs compared to prior years. Consistent with our longstanding approach, non-ESRD drug costs

respectfully request that MedPAC continue to include this footnote in the upcoming March 2026 and future Reports. While we hope these cost reporting issues have improved, we note that in CY 2024 there were three TDAPA products, all reported within the same TDAPA line items on the ESRD Facility Cost Report, making it difficult to assess costs and revenues associated with individual products. We would welcome MedPAC's support in working with CMS to amend the ESRD Facility Cost Report to collect cost and revenue data for each TDAPA, post-TDAPA, and TPNIES product on separate lines, which would better facilitate uniform reporting, more accurate margin analysis, and sound payment policy.

As the Commission considers final decisions at its upcoming January meeting and prepares the annual report expected in March 2026, we urge Commissioners to consider deeply the unique role that Medicare plays in supporting the delivery of life-saving dialysis care to Americans living with ESRD. We urge the Commission to reject the draft recommendation to eliminate the update for CY 2027 based on a single potential year of positive margins following multiple, successive years of zero to negative margins and the devastating impacts of the COVID-19 pandemic. **We urge the Commission to recommend that Congress and CMS provide an update to the ESRD PPS for CY 2027 consistent with current law to protect clinically vulnerable Medicare beneficiaries and ensure continued access to life-saving dialysis care.**

We appreciate the challenging task before the Commission and appreciate the good and important work of the MedPAC staff and Commissioners. KCC is pursuing analytic work related to the ESRD PPS and its implications for provider stability and beneficiary access. We would welcome the opportunity to meet with MedPAC staff to share our findings when available and to provide additional context to inform the Commission's important work. Please contact me at ccepriano@kidneycarecouncil.org or (202) 744-2124 or Kathy Lester at klester@lesterhealthlaw.com or (202) 534-1773 if you have any questions or to discuss these or any other kidney policy issues further.

Sincerely,

Cherilyn T. Cepriano
President

CC: Nancy Ray, M.S. and Grace Oh, Ph.D., M.P.P., MedPAC

are not included in the Commission's analysis of ESRD PPS costs incurred by freestanding dialysis facilities or in our calculation of the ESRD PPS margin."

About the Kidney Care Council

The Kidney Care Council (KCC) members collectively provide life-sustaining dialysis treatment and kidney care to 95 percent of individuals living with kidney failure in the United States. KCC members constitute a diverse coalition of small, medium, and large businesses, are organized as both for- and not-for-profit organizations, employ tens of thousands of dedicated health care practitioners, and deliver quality care in urban, suburban, and rural communities across the country. KCC members deliver dialysis treatments in more than 6,000 facilities; train, support, and manage the care of thousands of patients who have elected home hemodialysis or home peritoneal dialysis; and support patients waiting for a kidney transplant.

KCC supports a bold agenda to reduce the burden of kidney disease in America. The nation's dialysis providers support: prevention and education initiatives to reduce the incidence and slow the progression of kidney disease; transplant as a first-line treatment for kidney failure for appropriate candidates; home dialysis as a supported choice for patients, and patient access to dialysis facilities staffed with expert clinicians. To achieve these important clinical outcomes will require strong programmatic structures and appropriately aligned reimbursement systems that provide stability as a foundation for future progress and investments in innovation.

KCC Members 2026
Atlantic Dialysis Management Services
DaVita
Dialysis Clinic, Inc.
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The Rogosin Institute
Satellite Healthcare
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