CY 2027 Medicare ESRD Final Rule

EXECUTIVE SUMMARY | CMS-1846-F | Effective January 1, 2027

Overview

CMS finalized CY 2027 updates to Medicare dialysis reimbursement affecting approximately 7,600 facilities. It projects roughly $7.0 billion in payments and a 2.7% aggregate payment increase, alongside expanded support for smaller facilities, home dialysis, and pediatric patients and modifications to the ESRD Quality Incentive Program (QIP).

Major Payment Changes

ESRD base payment rate	$297.52 per treatment, up from $281.71
Overall payment increase	2.7% for hospital-based and freestanding facilities
Market basket update	1.9% after productivity adjustment
Phosphate binders	$12.85 permanently incorporated into bundled base rate
Home dialysis training	Add-on increases from $95.60 to $138.00
Low-volume adjustment	Eligibility expanded from <4,000 to <8,000 treatments
Acute kidney injury dialysis	Base rate increases to $297.52

Key Policy Decisions

- **Smaller and rural facilities.** The low-volume threshold increases to 8,000 annual treatments, with six payment tiers. This budget-neutral policy redistributes payments; qualifying facilities must submit attestations by December 31, 2026.
- **Home dialysis.** The training add-on rises approximately 44% to $138 per qualifying treatment. Training can be paid during the initial 120 days of dialysis, with changes to avoid overlapping payment.
- **Drugs and outlier payments.** Phosphate binders move permanently into the bundle. CMS changes transitional drug payment policies; the adult fixed-dollar-loss outlier threshold rises from $14.80 to $90.60.
- **Pediatric dialysis.** New pediatric case-mix adjustments replace the expiring temporary add-on, and eligible facilities may qualify for low-volume adjustments for pediatric treatments.
- **Quality measures.** Beginning with payment year 2029, CMS replaces the hypercalcemia measure with a hyperphosphatemia measure, removes two reporting measures, revises bloodstream infection methodology, and redistributes measure weights.

Implications for Hospitals and Health Systems

Hospital-based programs should verify low-volume eligibility, reassess home dialysis training economics, model drug and outlier exposure, and prepare for QIP changes. The 2.7% aggregate increase does not imply a comparable margin gain because part of the higher base rate reflects inclusion of formerly separately reimbursed phosphate binders.

BOTTOM LINE CMS shifts resources toward smaller facilities and home dialysis, but individual effects depend on facility volume, case mix, drug use, wage index, and quality performance.

Sources: Federal Register, document 2026-22194; CMS CY 2027 ESRD PPS Final Rule fact sheet.