THE KIDNEY CARE COUNCIL

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William N. Parham, III
Director, Division of Information Collections and Regulatory Impacts
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services

Department of Health and Human Services

RE: CMS-2744 and CMS-10905: Information Collection: End Stage Renal Disease Annual Facility Survey Form - OMB control number: 0938-0447

Dear Director Parham:

We write today to provide comments on the Information Collection Request related to the CMS-2744: End Stage Renal Disease Annual Facility Survey Form (herein the CMS-2744) to the Office of Management and Budget (OMB) and Centers for Medicare and Medicaid Services (CMS.)

The Kidney Care Council (KCC) members collectively provide life-sustaining dialysis treatment and kidney care to 95 percent of individuals living with kidney failure, or End Stage Renal Disease (ESRD) in the United States. KCC members[1] 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 the continued collection of data through the annual completion of the CMS-2744 for each individual ESRD facility. However, we also support the goals of President Trump's Executive Order: "Unleashing Prosperity Through Deregulation"[2] which aims "to promote prudent financial management and alleviate unnecessary regulatory burdens." Specifically, the President's Executive Order indicates that "[t]he ever-expanding morass of complicated Federal regulation imposes massive costs on the lives of millions of Americans, creates a substantial restraint on our economic growth and ability to build and innovate, and hampers our global competitiveness." The Executive Order laments that complex regulatory burdens have the effect of "increasing compliance costs and the risk of costs of non-compliance." KCC supports many of the goals of this Executive Order and its stated policy goals "to significantly reduce the private expenditures required to comply with Federal

[1]KCC Membership 2025: Atlantic Dialysis Management Services, Centers for Dialysis Care, DaVita, Dialysis Clinic, Inc., Fresenius Medical Care North America, Innovative Renal Care and American Renal Associates, Northwest Kidney Centers, The Rogosin Institute, Satellite Healthcare, and U.S. Renal Care.

[2] Executive Order Available at: https://www.whitehouse.gov/presidential-actions/2025/01/unleashing-prosperity-through-deregulation/

regulations…" In the sections that follow, we explain why several proposed changes to the CMS-2744, notably those related to new data collection regarding shifts and calculation of patient to staff ratios, are clearly not aligned with the President's executive order and will increase, rather than alleviate, regulatory burdens and costs on ESRD facilities without delivering meaningful benefit to Medicare or the beneficiaries it serves.

As you know, the CMS-2744 is a mandatory form, completed annually by End Stage Renal Disease (ESRD) facilities and collects information related to the provision of dialysis and kidney care for CMS. The CMS-2744 solicits both provider-specific and aggregate patient population data on ESRD beneficiaries treated by ESRD facilities including provider certification and type of ownership; aggregated dialysis patient data such as the number of patients, number of deaths, and number of patients using different dialysis modalities; and data regarding the staffing of dialysis facilities. The CMS-2744 was once a paper form, manually completed by facilities. However, it has been more than 10 years since that manual process was retired and CMS and facilities moved towards electronic completion of the CMS-2744, relying on data contained within the End Stage Renal Disease Quality Reporting System (EQRS.)

CMS and OMB are proposing several changes to the CMS-2744 including modifications to current data collection elements and notable new proposed data collection elements. As KCC member organizations complete most of the CMS-2744 forms required to be submitted annually to CMS, we appreciate the opportunity to comment publicly on proposed changes to the CMS-2744. Overall, we find many of the proposed changes to the CMS-2744 are either those that we support or do not oppose, and we do not provide comment on those elements in this letter. However, we do have several important areas of concern on which we focus in this letter, including several proposed additions and changes to the CMS-2744 that should not be finalized. Specifically:

CMS should fully align the CMS-2744 with the End Stage Renal Disease Quality Reporting System (EQRS). The CMS-2744 has for more than 10 years been completed by drawing data electronically from EQRS. CMS and OMB should not make changes to the CMS-2744 that require manual data entry. All fields of the CMS-2744 should call for data that is contained within EQRS and definitions and instructions should be aligned between the CMS-2744 and EQRS. In the proposed CMS-2744, we find two proposed changes are not aligned with this principle (proposed changes related to "shifts" and "staff to patient ratios") and, as discussed in detail below, those proposals should not be finalized. We also ask OMB and CMS to review the CMS-2744 and its instructions and remove language that suggests a manual data process or completion of the CMS-2744 as a paper form, such as asking facilities to "enter" or "write" information in fields on the CMS-2744. These instructions should be revised to instruct facilities on the transmission of requested data from EQRS to the CMS-2744 and how to resolve any issues that may arise through that process. We provide several technical changes that should be made to the CMS-2744 and related instructions in the sections that follow. We also ask CMS to better align the processes between EQRS and the CMS-2744, which for some facilities, can result in a mismatch of data when the CMS-2744 for a facility is due to CMS before the requisite data in EQRS has been updated and validated.

CMS should not finalize the proposed new data collection fields requiring the calculation and reporting of "Staff to Patient Ratios." Staff data and Patient data are contained within EQRS and are already reported on the CMS-2744. EQRS is not equipped to calculate Staff to Patient Ratios for electronic population of the CMS-2744. Compliance with these new data collection fields would require each facility to calculate the Staff to Patient Ratio manually and then manually enter the result of their calculation for each of the six types of staff.

This proposed requirement is overly burdensome, likely to yield errors, and not consistent with the President's directive to reduce regulatory burdens. If CMS wishes to have Staff to Patient Ratios expressed on the CMS-2744 or otherwise available for policymakers, CMS can make appropriate changes to EQRS to collect the relevant data and calculate the desired ratios and ESRD facilities can then draw those values into the CMS-2744 without calculations or manual entry. In the alternative, CMS could use the data stream provided by the CMS-2744 or EQRS to calculate the desired ratios using an internal CMS process. Further, the instructions proposed for this section are contradictory and create confusion. CMS should not finalize the proposed changes to the CMS-2744 regarding Staff to Patient Ratios.

CMS should not finalize the proposed new data collection fields related to "shifts" available at dialysis facilities. While similar data is collected in EQRS, the questions proposed on the CMS-2744 do not align precisely with the data available in EQRS. To comply with these new data collection fields, individual facilities would need to manually review 36 new fields and enter up to 15 responses. This represents a significant new burden that is not consistent with the President's directive to reduce regulatory burdens. Manual entry and the vagueness of the question and instructions are likely to yield errors, non-standardized answers across facilities and organizations, and a data set that is unreliable. Further, the proposed questions will not give CMS policymakers a true picture of the access to care issues they seek to understand. We would be pleased to work with CMS to explore other vehicles to better understand the complex and nuanced issues related to shift availability, but do not support using the CMS-2744 for this purpose. CMS should not finalize the new proposed data collection on the CMS-2744 related to "shifts" as proposed at this time. To the extent it is deemed necessary to collect such data through the CMS-2744 process, only data that is available for transmission from EQRS should be required and all definitions and instructions should be fully aligned with EQRS data and standards.

Taken together, the proposed changes regarding "shifts" and "staff to patient ratios" add 42 new data fields (36 for shift schedules and 6 for staff-to-patient ratios) to the CMS-2744, which require some degree of manual data entry. Across the estimated 7,500 facilities in the United States, the burden scales up to 315,000 possible manual entries. This volume of manual data entry is inconsistent with the President's directive to reduce regulatory burden and introduces significant risk of error and inconsistency. KCC provides greater detail on these comments in the sections that follow. Throughout this letter, we include excerpts from the proposed new CMS-2744 form and instructions, which CMS has made available for review for the purpose of public comment.[3]

Further, as the Administration considers the President's Executive Order, we suggest a more probative review of the CMS-2744. Decades ago, submission of this form, then on paper, to CMS was a mechanism for facilities to provide important information about their facility operations to CMS on an annual basis. However today, the information on the CMS-2744 is available to CMS at any time through EQRS. When considering changes to the CMS-2744 at present and in the future, we ask OMB and CMS to consider what data elements are most essential to be reconciled and consolidated for submission through the CMS-2744 and what data points would be better evaluated through EQRS or other means.

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[3] Available by download at: https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-2744.

A. CMS should not finalize the proposed new data collection fields requiring the calculation and reporting of "Staff to Patient Ratios" on the CMS-2744.

CMS proposes to add a new data collection requirement to the CMS-2744 that requires the ESRD facility to calculate the "Staff to Patient Ratio" for RNs, LPN/LVNs, PCTs, APNs, Dietitians, and Social Workers. CMS proposes to collect this data in the below excerpted table[4]:

Staffing					
Position	Number of Staff		Number of Open Positions		Staff to Patient Ratio
	Full Time	Part Time	Full Time	Part Time	
a. RNs					
b. LPN/LVNs					
c. PCTs					
d. APNs					
e. Dietitians					
f. Social Workers					
	37	38	39	40	41

KCC does not support these proposed changes related to a new requirement for facilities to calculate and report "Staff to Patient Ratios" on the CMS-2744 and we urge CMS not to finalize these proposals.

(1) EQRS is not equipped to calculate Staff to Patient Ratios for electronic reporting on the CMS-2744. The proposed new data collection requiring reporting of Staff to Patient Ratios will require individual facilities to manually calculate each ratio and manually enter each value on the CMS-2744. This represents a significant increase in burden that is inconsistent with the President's Executive Order.

The CMS-2744 already requires reporting for the number of patients and the number of staff. Staff reporting is broken out by type of staff (RNs, LPN/LVNs, PCTs, APNs, Dietitians, and Social Workers) and granular reporting of Full Time and Part Time staff. Facilities also report on the number of open positions for each of the aforementioned staff types, which is also granularly reported to distinguish between Full and Part Time staff openings.

While some data related to staffing and patients are contained within EQRS, the precise data points required to complete the new proposed fields related to Staff to Patient Ratios will require manual calculations and data entry. Staff counts and data regarding Open Positions are not included in EQRS and EQRS is not equipped to *calculate* Staff to Patient Ratios for electronic population of the CMS-2744. The proposed new requirement for

[4] Available by download at: https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-2744.

each facility to calculate a Patient to Staff Ratio imposes a burden on facilities to engage in several complex calculations and report the results of these calculations on the individual facility CMS-2744. As this cannot be done through EQRS, these calculations and data entry will need to be done manually by each individual facility, creating a significant new burden for facilities. This manual process introduces the opportunity for both mathematical and keystroke error, undermining the quality of the data CMS hopes to receive. These burdens are not at all aligned with the President's Executive order to reduce, not increase, regulatory burdens across all agencies, including CMS.

If CMS wishes to have Staff to Patient Ratios expressed on the CMS-2744 or otherwise available for policymakers, they can either facilitate the calculation of these values by making appropriate changes to EQRS such that facilities can then draw those values into the CMS-2744 without calculations or manual entry, or they can use the data stream provided by the CMS-2744 to calculate the desired ratios using an internal CMS process. It is not appropriate, however, to require facilities to manually calculate these ratios and then manually enter those results on each individual CMS-2744, turning back more than a decade of streamlined, electronic completion of this form through EQRS.

(2) The proposed instructions related to the calculation of Staff to Patient Ratio are contradictory, create confusion, and require greater clarity.

CMS provides the following instructions[5] to guide compliance with the proposed new requirements for facilities to calculate and report "Staff to Patient Ratios."

> • **Field 41: Enter Staff to Patient Ratio as of December 31:** Enter the number of patients each a) Registered Nurses, b) Licensed Practical Nurses/Licensed Vocational Nurses, c) Patient Care Technicians, d) Advanced Practice Nurses, e) Dietitians, and f) Social Workers is responsible for at this facility.

KCC members find these directions to not only be unclear, but contradictory. The instructions direct facilities to "Enter the Staff to Patient Ratio as of December 31" but in the next sentence, the instructions direct facilities to "Enter the Number of Patients each [type of facility staff] is responsible for at this facility." Read together, these instructions direct facilities to enter two completely different values into the provided field: the "Staff to Patient Ratio as of December 31" and "the Number of Patients each [[type of facility staff] is responsible for at this facility." Note that there is no field in the table titled "Number of Patients" as that data is collected elsewhere on the CMS-2744. We shared these instructions with our experts who regularly complete the CMS-2744 and a variety of other CMS forms for submission, and all were highly confused regarding these conflicting instructions and do not understand what CMS is requiring facilities to report given these directions. CMS must not finalize the CMS-2744 with these instructions, which need to be reviewed and clarified in the event CMS finalizes the requirement for facilities to calculate and report Staff to Patient Ratios over the objections of the provider community.

[5] Available by download at: https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-2744.

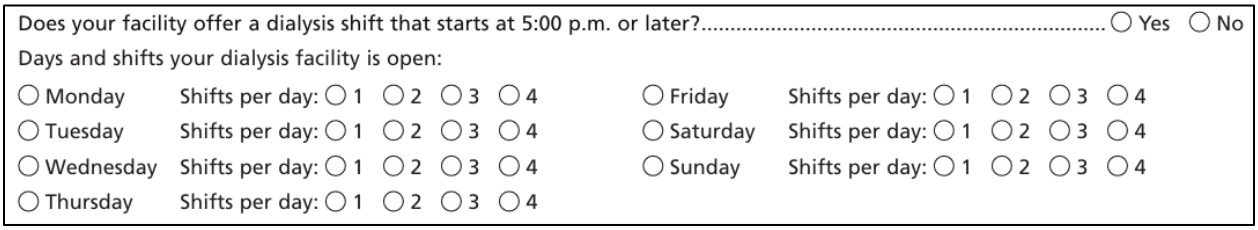
The proposed instructions direct facilities to "Enter the Staff to Patient Ratio as of December 31." As discussed in the prior section with regards to the "December 31" reference point, it is unclear what CMS means by this statement. Here are some of the questions these instructions have inspired regarding the December 31 reference:

- Does CMS want facilities to report the Staff to Patient Ratio for staff and patients present in the clinic on December 31? Given that this is New Year's Eve, it is not likely that December 31 is a useful reference point to represent the staff to patient ratio for a facility.
- Does CMS want facilities to report the Staff to Patient Ratio for the year, month, quarter, or week ending on December 31?
- Does CMS want facilities to calculate the Staff to Patient Ratio using the data reported on this table for staff and the patient census data reported elsewhere on the CMS-2744?
- Does CMS want facilities to calculate the Staff to Patient Ratio using only the Staff numbers reported on this table or should facilities include the Open Positions also reported on this table?

If OMB and CMS proceed with these instructions, the resulting data may appear uniform, but different facilities may draw different conclusions regarding CMS' instructions and intent, resulting in a variety of data submitted across facilities and providers organizations that are not actually standardized.

B. CMS should not finalize proposed new data collection elements of the CMS-2744 related to shift schedules.

CMS proposes to add new data collections to the CMS-2744 dialysis shifts. (See below excerpt[6].) Specifically, CMS proposes that facilities indicate whether they offer a shift that starts at 5:00pm or later by answering Yes or No. CMS also proposes 35 new data elements through which facilities would be required to indicate whether they have 1, 2, 3, or 4 shifts for each day of the week: Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday. These proposed changes add 36 new fields to the CMS-2744 that solicit at least 15 new fields of data from the dialysis facility.


Does your facility offer a dialysis shift that starts at 5:00 p.m. or later? ..... ○ Yes ○ No

Days and shifts your dialysis facility is open:

○ Monday	Shifts per day: ○ 1 ○ 2 ○ 3 ○ 4	○ Friday	Shifts per day: ○ 1 ○ 2 ○ 3 ○ 4
○ Tuesday	Shifts per day: ○ 1 ○ 2 ○ 3 ○ 4	○ Saturday	Shifts per day: ○ 1 ○ 2 ○ 3 ○ 4
○ Wednesday	Shifts per day: ○ 1 ○ 2 ○ 3 ○ 4	○ Sunday	Shifts per day: ○ 1 ○ 2 ○ 3 ○ 4
○ Thursday	Shifts per day: ○ 1 ○ 2 ○ 3 ○ 4		

[6] Available by download at: https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-2744.

(1) The proposed questions regarding shift data are not fully aligned with the shift data already collected in EQRS, from which facilities electronically populate the CMS-2744. The proposed new data collection on shift schedules may require ESRD facilities to manually enter up to 15 new data fields representing a significant increase in burden that is inconsistent with the President's Executive Order.

CMS has underestimated the burden associated with this new data collection. While some shift data is already collected in EQRS, the questions proposed on the CMS-2744 do not align precisely with the information available in EQRS. To comply with these new data collection fields, individual facilities would need to manually enter responses to as many as 15 new fields or possibly have some of the data transmitted from EQRS while having to manually respond to other of the new question fields.

Manual data entry, especially at the individual facility level, does not allow provider organizations to effectively standardize interpretation of CMS' required data fields and associated instructions across facilities. Moreover, manual data entry also increases the likelihood of keystroke errors that erode the validity and accuracy of the data. This is why CMS moved to electronic completion of the CMS-2744 using EQRS more than a decade ago. Every keystroke is an opportunity for error and every error undermines the validity and usability of the aggregated data set. Adding fields that must be manually completed is reversing more than 10 years of progress in streamlining systems and improving the accuracy of reported data. CMS should not add fields that require manual data entry to the CMS-2744, including these proposed data fields related to dialysis facility shifts.

Finally, these burdensome proposed changes are not aligned with the President's Executive Order "Unleashing Prosperity Through Deregulation." If adopted, the proposed changes to the CMS-2744 regarding shifts will impose, rather than alleviate, unnecessary regulatory burdens, and will increase compliance costs and the risk of costs of non-compliance for all ESRD facilities and their dialysis provider organizations.

(2) The proposed instructions related to the new data collection on ESRD facility shifts leave too many questions and interpretations available to deliver a standardized data set for policy analysis.

CMS provides the below instructions[7] for compliance with the proposed new data collection regarding "shifts per day." These instructions clarify that the data to be provided in response to the data collection would be "as of December 31" and that facilities should indicate all the days of the week the facility is open, and the number of shifts staffed to provide dialysis services per day.

- **Does your facility offer a dialysis shift that starts at 5:00 p.m. or later?** Provide information as to whether your facility offers dialysis shifts that begins on or after 5:00, as of December 31.
- **Days and shifts your facility is open:** Select all the days of the week your facility is open and the number of shifts staffed to provide dialysis services per day, as of December 31.

While we appreciate that CMS has provided instructions, the proposed text leaves too much open to interpretation by individual facilities and will likely result in non-standard data that undermines the goals of this data collection. For example, we asked our members – highly experienced individuals who complete most CMS-2744 forms – to share their interpretation of the proposed new shift data collection elements considered with CMS'

[7] Available by download at: https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-2744.

instruction that such data be provided "as of December 31." These are some, not all, of the interpretations we received on CMS' proposed instructions:

- Most recent facility shift schedule that was in effect on December 31.
- Facility's shift schedule used for most of the year/quarter/month ending on December 31.
- Facility shift schedule for the last seven days of the calendar year ending on December 31.

In this small study, we see a variety of interpretations of CMS's questions and instructions. While the resulting data will have the appearance of uniformity because the question is presented as check boxes, these instructions will likely result in a variety of different data being submitted that will undermine the validity of the data collection exercise. We note that each of the interpretations above may result in a variety of results, especially for anyone who reads the CMS instructions as asking for shift schedules for the week ending on December 31, a holiday-week that may not be representative of the shift schedule for most of the calendar year.

We appreciate CMS' effort to include instructions for the new proposed data collections, but these issues are so complex that these instructions are not likely sufficient to clarify the data CMS seeks across the diversity of facilities and provider organizations. As a result, the data may appear uniform since it will be a collection of checkboxes, but it may not actually be standardized because each facility director, completing this section of the CMS-2744 manually, may interpret these questions differently from their peers.

(3) ESRD Facility shifts are too complex to accurately capture on the CMS-2744. We welcome the opportunity to work with CMS to find a better mechanism to procure data of interest to policymakers. KCC urges CMS and OMB not to adopt the proposed new data collection regarding facility shifts to the CMS-2744.

KCC agrees that the availability of shifts is relevant to understanding patient access to care. Indeed, as facilities have come under increasing pressure in recent years due to the inability of the ESRD PPS to keep up with the rising costs of care and significant clinical workforce shortages, many facilities have had to reduce shifts offered to patients. However, the CMS-2744 seems ill suited to collecting this complex information – especially as this data is not contained within EQRS and may require manual data entry for the CMS-2744 at the facility level for the first time in more than a decade.

Indeed, the proposed new data collection fields are already complex, including 36 new fields for the CMS-2744, which may need to be reviewed manually to provide up to 15 responses, as discussed above. But even these complex new fields and the accompanying directions will not give CMS a fully accurate picture of shift availability for patients in ESRD facilities, including the many Medicare and Medicaid patients we serve. Our facility clinical and operational experts highlighted that, despite the 36-field complexity of the proposed addition to the CMS-2744, this question is not likely to capture the complexity of shift availability and variability within a facility. For example:

- The question assumes schedules that rotate on a 7-day basis but does not consider those that are tied to a 14-day or other rotating calendar. For example, some facilities operate shifts every other Saturday, but there is no way to indicate that pattern on the proposed question.

- It is not clear if the question asking about shifts starting at 5:00pm or later is intended to be limited to evening shifts after normal business hours or if it would also include overnight shifts for nocturnal dialysis patients.
- Since the CMS-2744 is a snapshot in time and the instructions direct a response tied to the date of December 31, the data submitted may not be reflective of the shift availability that was in effect or most common in that facility for most of the year.

Unfortunately, KCC simply cannot support the proposed changes to the CMS-2744 regarding shifts beginning after 5:00pm and shifts per day as they will significantly increase the burden on facilities and not provide CMS with quality data upon which they can rely for policymaking exercises. This proposed data collection is overly burdensome, may require each facility to review up to 36 fields and manually enter up to 15 new fields of data, is not aligned with the President's order to reduce regulatory burden, may result in unintended errors, and is likely to produce non-standardized data that fails to illuminate the practical and complex reality of shift availability at ESRD facilities. KCC urges CMS and OMB not to finalize the proposal to add these new required fields to the CMS-2744.

We believe this proposal is well-intentioned and as operators of dialysis facilities we understand the importance and relevance of facility shift data to understanding patient access to care. We welcome the opportunity to work with CMS on this issue and to identify appropriate mechanisms through which we can communicate the availability of dialysis facility shifts to policymakers seeking to better understand access to care for beneficiaries.

C. CMS should fully align the CMS-2744 with the End Stage Renal Disease Quality Reporting System (EQRS) and modernize language on the form and in the instructions to reflect current clinical, operational, and data practices.

(1) Data required for the CMS-2744 should be drawn from EQRS and all instructions for the CMS-2744 should be aligned to reflect that long-standing, modern practice.

The CMS-2744 has for more than 10 years been completed by drawing data electronically from EQRS. As a threshold principle, CMS and OMB should not make changes to the CMS-2744 at this time or at any time in the future that would require manual data entry, and all fields of the CMS-2744 should call for data that is contained within EQRS. As discussed above, we find two of the proposed changes to the CMS-2744 are not aligned with this principle (proposed changes related to "shifts" and "staff to patient ratios" and those proposals should not be finalized.

More broadly, the CMS-2744 deserves a thorough review of the content of the form and its related instructions to ensure they meet the needs of the government and ESRD facilities. In conducting such a review, we find relics of a time when the CMS-2744 was a paper form completed manually and mailed to CMS annually. We ask that CMS and OMB review the content and instructions related to the CMS-2744 and remove language that suggests a manual data process or completion of the CMS-2744 as a paper form. Instructions should be revised to instruct facilities on the transmission of requested data from EQRS to the CMS-2744 and how to resolve any issues that may arise through that process.

OMB and CMS should remove from the CMS-2744 outdated language such as "enter" and "write," which reflect a paper-based process that has not been in use for over a decade. Instructions should be revised to reflect the electronic nature of the CMS-2744, including guidance on how to draw data from EQRS and resolve data discrepancies. CMS should also indicate in the instructions that where any calculated values are inaccurate, the relevant data within EQRS (such as admissions, discharges, treatment summaries, etc.) should be adjusted and the CMS-2744 regenerated to update the numbers for all calculated fields. This modernization would improve clarity, reduce confusion, and support more accurate and standardized data reporting.

We also ask CMS to better align the processes between EQRS and the CMS-2744, which for some facilities, can result in a mismatch of data when the CMS-2744 for a facility is due to CMS before the requisite data in EQRS has been updated and validated. KCC member organizations often advise their facilities not to begin CMS-2744 work too early due to incomplete or unvalidated data in EQRS. For some facilities and provider organizations, there exists a misalignment between EQRS data availability and CMS-2744 reporting deadlines, which creates a compressed and error-prone reporting window. We recommend CMS publish a formal EQRS data readiness calendar each year to better allow facilities and providers to plan their data submission and CMS-2744 completion timeline. Where necessary, we also ask CMS to allow facilities to revise their CMS-2744 submission window such that the form is due to CMS after the relevant EQRS data has been confirmed to be complete and accurate.

As the Administration reviews the CMS-2744 in the context of the President's Executive Order, we hope OMB and CMS will consider the appropriate role of the CMS-2744 as it exists within the modern framework, including the availability of data through EQRS. We recognize there may be value in an annual submission of data to CMS through the CMS-2744 that allows for consolidation of key data related to ESRD facilities nationwide. However, considering the wealth of data available to CMS throughout the year in EQRS, the CMS-2744 should be a streamlined and efficient mechanism to aggregate essential data from EQRS for CMS' annual review. The CMS-2744 does not need to convey all information about facilities to CMS, but it should instead focus on the most important information needed for CMS' annual review process associated with the CMS-2744. Other information can be reviewed in EQRS or through the many other submission vehicles throughout the year.

(2) Technical recommendations to improve clarity and update the CMS-2744.

KCC offers the following technical recommendations to improve the clarity and otherwise update the CMS-2744 and its instructions to modernize the language to be more consistent with current practices.

ESRD Facility CMS-2744

- There should be a field at the top of the form to list the location or CCN# associated with that facility.
- We recommend adding a "print" button.
- Under "Types of Dialysis Services Offered" the CMS-2744 currently has three options to select: In-center Hemodialysis, Peritoneal Dialysis, and Home Hemodialysis Training. These categories are not consistent with current available modalities. We suggest changing this language to allow facilities to indicate the following four service categories: In-center Hemodialysis, In-center Peritoneal Dialysis, Peritoneal

Dialysis Training and Home Support, and Hemodialysis Training and Home support. The instructions associated with this field should be updated to reflect these changes.

- Under "Number of Dialysis Stations," additional information is needed in the instructions to explain whether facilities should include isolation stations. We also find a discrepancy between the CMS-2744 definition, which says to provide the number of "approved" stations as compared with the EQRS data, which calls for reporting the number of "certified" stations. These definitions should be clarified, and the CMS-2744 should be aligned with EQRS.
- Under "Patients Receiving Care Beginning of Survey Period" in Field 02, the instructions should be undated to clarify that patients with Acute Kidney Injury should NOT be included in the patient census as they do not have End Stage Renal Disease.
- The "Note" under "Discontinued Dialysis" should be updated for accuracy to read as follows: "Note: these fields should contain counts of patients whose last known discharge reason was discontinued dialysis as of Dec 31st but no death date or 2746 has been entered."
- Under "Hemodialysis" Field 35, the instructions should be updated to clarify that patients with Acute Kidney Injury should NOT be included in the patient census as they do not have End Stage Renal Disease.

Transplant Center CMS-2744

- There should be a field at the top of the form to list the location or CCN# associated with that facility.
- We recommend adding a "print" button.
- In Field 45 the phrase "Non-Medicare, US Residents" conflicts with the subsequent definition limiting to U.S. Citizens. The term "Resident" should be changed to "Citizen."
- The current form includes the total number of patients who received a transplant. We believe it would be more useful for CMS to differentiate between patients receiving a transplant preemptively as well as those who received a transplant after starting dialysis. This information is available in EQRS. We recommend a change to import more granular data about transplant to the CMS-2744 so long as it is aligned with the EQRS data.
- Under "Patient Eligibility Status of Patients Transplanted During Survey Period" there is a typo in the first bullet, which refers to Fields 46 and 47 when it should refer to Fields 43 through 46.

CONCLUSION

KCC appreciates the opportunity to comment on the proposed updates to the CMS-2744. KCC takes no issue with most proposed changes. However, we take strong exception to the proposals that would require moving away from completion of the CMS-2744 with data drawn electronically from EQRS and instead require manual data entry by individual facilities. As such, we urge CMS to withdraw the proposed changes related to ESRD Facility shift data and required calculation of staff to patient ratios. We welcome the opportunity to work with CMS to explore other, more effective ways to provide and procure these data elements that may be valuable for policymaking exercises. We urge CMS and OMB to reject proposals that are wholly inconsistent with 10 years of practice as well as the President's Executive Order calling for relief from, not increasing, the regulatory burden across all agencies, including CMS.

Please contact me at ccepriano@kidneycarecouncil.org to discuss any of these issues further.

Respectfully Submitted,

Cherilyn T. Cepriano
KCC President