

Dialysis Facility Quality of Patient Care Technical Star Ratings Expert Panel Summary Report

May 2026

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Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with The University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) to act as the quality measure developer and technical content support contractor for Dialysis Facility Care Compare (DFCC) on Medicare.gov, under the Kidney Disease Quality Measure Development, Maintenance, and Support contract (contract number 75FCMC18D0041, task order number 75FCMC23F0001).

As part of CMS' broader initiative for Care Compare on Medicare.gov (www.medicare.gov/care-compare/), CMS developed the Star Rating to make quality information more accessible to patients, caregivers, providers and policymakers. The Star Rating is also meant to help consumers (including patients and caregivers) understand CMS quality measures and more easily identify differences in overall quality when selecting dialysis facilities. The Medicare.gov website displays two different Star Ratings: (1) the Quality of Patient Care Star Rating (Star Rating) and (2) the Survey of Patients' Experiences Star Rating. Eleven of the quality measures currently reported on the Medicare.gov website are used to calculate the Quality of Patient Care Star Rating. The Survey of Patients' Experiences Star Rating was not covered as a discussion topic during this TEP.

As part of their contract, UM-KECC convenes technical expert panels (TEPs) to obtain consumer and provider input for quality measure development and the Medicare.gov Dialysis Facility Quality of Patient Care Star Rating (Star Rating). A Star Rating TEP was first convened in 2015 to review the original methodology and presentation of the Star Rating on the Medicare.gov website. The TEP provided several recommendations that were implemented in the updated Star Rating methodology, released in October 2016. A second TEP was convened in 2017. TEP members provided recommendations on candidate measures proposed for inclusion in the Star Rating and defined concepts such as rebaselining (establishing new scoring cut-offs for a new baseline period) and resetting (establish new baseline period, scoring cut-offs *and* star rating distribution) and resetting. A third TEP was convened in 2019 to provide recommendations on options for resetting the Star Rating and reweighting one of the quality domains in the calculation of the Star Rating. A fourth TEP was convened in 2022 to obtain recommendations related to the first public release of the Star Rating since the start of the COVID-19 pandemic public health emergency. See the respective 2015, 2017, 2019, and 2022 Star Rating TEP reports for a summary of the deliberations and TEP recommendations, available at: <https://dialysisdata.org/content/esrd-measures>

The 2026 TEP was charged with evaluating candidate quality measures for possible addition or removal to the Star Rating. UM-KECC sought nominations from individuals with relevant clinical and methodological experience, expertise, and perspectives, including patients with chronic dialysis experience to serve on this 2026 TEP.

Technical Expert Panel Composition

A public call for nominations opened on Tuesday, December 23, 2025 and closed on Friday, January 23, 2026. Nominations were sought from individuals with the following areas of expertise or experiential perspectives:

- Individuals with end-stage kidney disease and care partners of individuals with ESKD
- Experts with subject matter expertise, e.g., scientists in nephrology care; clinicians and nurses; consumer testing; communication of star rating systems in patient perspectives
- Experts with methodological expertise, e.g., statisticians/biostatisticians with expertise in score or scale development, multivariate analysis, risk assessment, latent variable modeling
- Individuals with dialysis facility quality improvement expertise
- Individuals with health care disparities expertise

The following individuals listed in Table 1 were selected to serve on the TEP:

Table 1: Technical Expert Panel Composition and Contractor Staff

Name and Credentials	Organizational Affiliation, City, State	Conflicts of Interest Disclosed
Paul T. Conway, BA Patient Advocate Chair, Policy and Global Affairs, Immediate Past President	American Association of Kidney Patients, Falls Church, VA	None reported
Francesca Tentori, MD Outcomes Research & Patient Empowerment	DaVita Kidney Care, Denver, CO	Employed by DaVita Kidney Care
Quiana L. Bishop President, Board of Directors	Dialysis Patient Citizens, Detroit, MI	None reported
Lorien S. Dalrymple, MD, MPH Senior Vice President, Head of Population Health and Medicine, Global Medical Office	Fresenius Medical Care, Waltham, MA	Employee of and owns share options/stock in Fresenius Medical Care
Candria (Candee) Denzmore Patient Advocate, Kidney Transplant Recipient	Granite City, IL	None reported
Brittany Dickerson The Training Academy and Certified Coaches Alliance, Life Purpose Coach and Kidney Health Advocate	Columbia, SC	None reported
Mary Dittrich, MD, FASN Nephrologist, Chief Medical Officer	US Renal Care, Satellite Healthcare, Boise, ID	Shareholder and CMO of US Renal Care
Stephanie Dixon Patient Advocate	Kidney Patient Advisory Council, Rutherford, NJ	None reported
Christina Gilchrist Patient	Roy, UT	None reported
Michael Gilchrist Care Partner	Roy, UT	None reported

Name and Credentials	Organizational Affiliation, City, State	Conflicts of Interest Disclosed
Debra Hain, PhD, APRN, AGPCNP-BC, PMHNP-BC, CNN-NP Executive Team Member, Psychiatric Nurse Practitioner for ActivateCR Professor, Florida Atlantic University, Christine E Lynn College of Nursing	ActivateCR, Herriman, UT	None reported
Shekeila Harris, LPN, MBA, CALA Patient Advocate, Board of Directors	Dialysis Patient Citizens, Vineland, NJ	None reported
David Henner, DO Division Chief of Nephrology/Medical Director of Dialysis, Berkshire Medical Center Medical Director of Dialysis, Southwestern Vermont Medical Center Past President, National Forum of ESRD Networks	Berkshire Medical Center, Pittsfield, MA	None reported
Donna M Hoffman Dialysis Patient	Glen Allen, VA	None reported
Donald Morgan Transplant Patient, Patient Advocate Coordinator	ESRD Network 16, Hayden, ID	None reported
José Navarrete, MD Associate Professor of Medicine, Emory University School of Medicine, Division of Renal Medicine, Nephrology Section Chief-EUHM, Medical Director Dialysis Services EHC	Emory University, Atlanta, GA	None reported
Jesse Roach, MD Senior Vice President, Government Relations	National Kidney Foundation, Washington, DC	None reported
Janice Starling, MBA Network 7 Patient Expert, AAKP Ambassador, Kidney Patient Advocate, NKF Ambassador	Kidney Patient Advisory Council, St. Petersburg, FL	None reported
Cheryl (Cher) Thomas, RDH Patient	Renal Support Network, Galveston, TX	None reported

Name and Credentials	Organizational Affiliation, City, State	Conflicts of Interest Disclosed
Curtis Warfield, MS Patient Health Advocate	National Kidney Foundation, KHI Patient and Family Partnership Council, Indianapolis, IN	None reported
<i>Contractor Staff</i>		
Jonathan Segal, MD	Professor, Internal Medicine, Nephrology	None
Yi Li, PhD	Professor, Biostatistics Professor, Global Public Health	None
Joseph Messana, MD	Professor, Internal Medicine, Nephrology	None
Claudia Dahlerus, PhD	Associate Research Scientist, Internal Medicine, Nephrology	None
Richard Hirth, PhD	S. J. Axelrod Collegiate Professor, Health Management and Policy Professor, Internal Medicine	None
Eileen Yang, MS	PhD Candidate, Biostatistics	None
Tao Xu, PhD	Senior Analyst	None
Ashley Eckard, MS	Senior Analyst	None
Jennifer Sardone, BA, PMP	Senior Lead Project Manager	None
Ashley Garcia, BA	Project Manager Point of Contact: garciash@umich.edu	None

1. Introduction

This report summarizes the discussions and recommendations of the Dialysis Facility Star Rating TEP meeting convened on April 9, 2026. This meeting was public and held virtually via Zoom video-conference. The TEP provided advice and expert input on four specific questions:

1. Should the Standardized Fistula Rate (SFR) be removed from the Star Rating?
2. Should the Hypercalcemia measure be removed from the Star Rating and be replaced with the Hyperphosphatemia measure?
3. Should the Standardized Emergency Department Encounter Ratio (SEDR) and Standardized Ratio of ED Encounters Occurring Within 30 Days of Hospital Discharge (ED30) measures be added to the Star Rating?
4. Should the Standardized Modality Switch Ratio (SMoSR) be added to the Star Rating?

2. TEP Charter

The Dialysis Facility Star Rating TEP Charter (Appendix A) was distributed to the TEP members for review prior to the first meeting. At the first meeting, key elements of the charter were highlighted, focusing on the process for developing and updating the Star Rating methodology. In particular, the role of the TEP was outlined, and the following responsibilities were highlighted:

- Review evidence to determine the basis of support for topics identified in the TEP charter
- Review and approve summary report of the TEP Meeting and provide input on other necessary technical documentation required for public reporting or for responses to public comments
- TEPs are advisory to the contractor (UM-KECC), and not CMS; it is the responsibility of UM-KECC to accurately report AND consider recommendations received from the TEP; however, recommendations made to CMS are made by UM-KECC, and not by the TEP
- If UM-KECC makes recommendations to CMS that are not consistent with the recommendations from the TEP, it is UM-KECC's responsibility to explain the rationale for any differences

No objections were raised regarding the TEP charter.

3. Overview of the Dialysis Facility Star Rating Methodology

An overview of the Star Rating system was presented to the TEP by UM-KECC staff. The Star Rating is intended to be an easy-to-interpret summary of the quality of care provided by dialysis facilities, and to give patients, families, and caregivers information to easily compare dialysis facilities. Since the Star Rating was first released in January of 2015, UM-KECC has facilitated four prior TEPs to seek recommendations on updates to the Star Rating methodology. The TEP was presented with general definitions of terms frequently used in discussion of the Star Rating:

- **Measure Value:** The original value of a facility's clinical quality measure, as reported on Care Compare, which represents a ratio or a percentage
- **Measure Score:** Values obtained by standardizing the original measure values for each measure, so that no measure has undue influence on the Star Rating and so that the range and direction of standardized values are consistent (with mean 0, variance 1)
- **Domain Score:** A score which summarizes a facility's performance on a group of correlated clinical quality measures. It is an average of the individual measure scores in that group (domain)
- **Final Score:** A continuous score calculated for each facility, which summarizes its performance on the reported clinical quality measures. It is an average of the domain scores
- **Cutoff:** A value of the final score that defines the boundary between two adjacent Star Rating categories (e.g., the cutoff between 4 and 5-stars is 1.36 and facilities with a final score > 1.36 receive 5 stars)

The TEP members were provided with a brief overview of how the Star Rating is calculated:

1. Measure values on different scales are standardized against the baseline period to form measure scores with the same interpretation
2. Individual measures are grouped into different measure domains based on statistical factor analysis
3. Measure scores within a domain are averaged to form domain scores
4. Domain scores are averaged to form a final score for each facility
5. Final scores are grouped into five different star categories based on pre-established Star Rating cutoff values

Subsequently, the distinction between and justifications for rebaselining (establishing new scoring cut-offs for a new baseline period) and resetting (establish new baseline period, scoring cut-offs *and* star rating distribution) were reviewed in the context of prior Star Rating TEP decisions. This TEP was not asked to consider rebaselining or resetting the Star Rating at this time.

4. Current Star Rating Measures

TEP members were provided summary information about the current Star Rating measures. Within Domain 1 are four measures: Standardized Transfusion Ratio for Dialysis Facilities (STrR), Standardized Mortality Ratio for Dialysis Facilities (SMR), Standardized Hospitalization Ratio for Dialysis Facilities (SHR), and Standardized Readmission Ratio for Dialysis Facilities (SRR). Domain 2 has two measures: Hemodialysis Vascular Access: Standardized Fistula Rate (SFR), and Hemodialysis Vascular Access: Long-Term Catheter Rate (LTC). Domain 3 has two measures: Total KT/V (KT/V), and Proportion of Patients with Hypercalcemia (Hyp.). Finally, Domain 4 includes two measures: Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR), and Percentage of Prevalent Patients Waitlisted (PPPW).

5. Removing Standardized Fistula Rate (SFR) from the Star Rating

UM-KECC provided the TEP with background information on SFR and introduced a discussion about removing the measure from the Star Rating.

5.1 Background

For about 20 years, the Fistula First campaign emphasized increasing arteriovenous (AV) fistula use in hemodialysis patients. Two long-standing measures supported this goal: SFR, with the primary goal of maximizing fistulas, and the long-term catheter rate (LTC), with the primary goal of minimizing long-term catheter use. AV grafts are treated as neutral and are not counted in either measure. Both measures are currently part of Domain 3.

With the updated Kidney Disease Outcomes Quality Initiative (KDOQI) 2019 vascular access guidelines, earlier studies favoring fistulas were reinterpreted as having overstated benefits compared to grafts. The guidelines now emphasize a catheter-avoidance strategy rather than prioritizing fistulas over grafts. Because of the updated guidelines and reconsideration of the evidence base, SFR lost Consensus-Based Entity (CBE) endorsement when it came up for re-evaluation in 2020. In addition, ESRD networks have deprioritized fistula-focused quality improvement, and SFR has recently been removed from the ESRD Quality Incentive Program (QIP).

5.2 Discussion

The co-chairs began the discussion by asking TEP members if they see an equipoise between grafts and fistulas, and if so, if it still makes sense to have a measure that incentivizes or prioritizes fistula. One TEP member noted that they support removal of the measure from the star ratings for logistical reasons; since the measure is no longer in the QIP and has lost endorsement, removing it from the star ratings would support more parsimonious measure sets. Another patient advocate TEP member agreed with removal and emphasized home dialysis should be included in the equation as fistula failure can occur with low-flow, long treatments in home dialysis, while catheters may be ideal for nocturnal dialysis.

A provider TEP member asked whether removing SFR would have meaningful impact and if LTC alone is sufficient to assess facilities. UM-KECC did not have specific analysis results available at the time, but emphasized that assessing changes resulting from adding or removing measures will be a future step in the decision-making process. UM-KECC suggested keeping this particular discussion centered on clinical rationale.

A provider panelist supported removal to align with the QIP and recent NKF data, but raised concerns about a one-size-fits-all approach and suggested excluding certain patients from the denominator, such as those with steal syndrome or who are unable to undergo surgery. Another panelist agreed with removing SFR, also emphasizing best access for each person. They noted the aging population may not be successful with fistulas as they tend to spend more time hospitalized

with fistula issues. Another provider strongly supported removal, noting patients having to go through multiple fistula creation attempts when grafts are acceptable, and surgeons refuse grafts due to perceived penalties. Several other TEP members, from both clinical and patient perspectives, emphasized the importance of patient-centered care and informed decision-making.

Some TEP members raised concerns about the LTC measure not excluding patients who have exhausted access options and become catheter-dependent. UM-KECC explained that the LTC measure was recently substantially revised and re-endorsed through the CBE endorsement process. Although not yet implemented, the newly endorsed version is intended to account for two key issues: patient choice and patients with no remaining vascular access options. It does this by incorporating how long the catheter has been in place; long durations are interpreted as signaling either sustained patient choice not to pursue permanent access or lack of feasible alternatives.

UM-KECC inquired about whether the group's collective rationale for removing the measure was based on how well it honored patient choice. One provider TEP member responded clarifying the key reason to remove the fistula-focused metric for them is that growing evidence shows AV grafts can be a legitimate, safe long-term access and the current metric setup wrongly discourages graft use, with not as much attribution to patient choice or simplifying measures. Another TEP member agreed patient choice matters for engagement and compliance, but argue it's secondary. Both patients and providers agree the main driver should be the science, and newer evidence suggests the difference in outcomes between fistulas and grafts is not as large as previously believed, either because evidence has evolved or was misinterpreted.

5.3 Vote

The TEP co-chairs asked the TEP to vote on the question, "Should SFR be removed from the Star Rating?" All 17 TEP members present on the call (100%) voted in favor of removing SFR from the Star Rating.

6. Removing Proportion of Patients with Hypercalcemia (Hyp.) and replacing it with Percentage of Patients with Hyperphosphatemia in the Star Rating

UM-KECC provided the TEP with background information on a recently CBE-endorsed dialysis facility quality measure focused on hyperphosphatemia. The TEP was asked to consider if this measure should replace the hypercalcemia measure that is currently included in the Star Rating. Of note, the hypercalcemia measure is used in both Star Ratings and the QIP as well as being reported on DFCC. Although there is a statutory requirement to include at least one mineral and bone disorder (MBD) measure in the QIP, that requirement does not exist for DFCC and Star Ratings.

6.1 Background

The hyperphosphatemia measure is defined as the percentage of adult patients in a dialysis facility whose phosphorus is persistently high, operationalized as having a 6-month rolling average phosphorus value of at least 6.5 mg/dL. It applies to adult patients across all dialysis modalities (in-center hemodialysis, home hemodialysis, and peritoneal dialysis). To be counted, patients must have been treated at the facility for the entire reporting month and must have kidney failure with at least 90 days on dialysis. Performance is interpreted such that a higher percentage reflects worse quality (and a lower percentage reflects better quality), making it an intermediate outcome measure.

UM-KECC noted that while the measure is CBE endorsed, the hyperphosphatemia measure is not yet publicly reported, which means if it were added to Star Rating, there would be a delay before it could be implemented. UM-KECC shared current facility performance data to illustrate the measure's distribution: in the referenced dataset, the mean is about 24% and the median about 23%, meaning that for the median facility, roughly 23% of patient-months show a 6-month average phosphorus at or above 6.5. Meaningful variation was shown across facilities, with a noticeable spread between the lowest and highest-performing quartiles.

A TEP member raised a question about whether these were the most recent data, pointing out that phosphate binders were added to the dialysis payment bundle and that this change might have disrupted phosphorus management and affected facility performance. UM-KECC responded that the displayed data were from October 2025, describing them as an early look after binders were incorporated, and added that prior years did not appear dramatically different. UM-KECC reiterated the main takeaway is that a substantial number of dialysis patients experience persistently elevated phosphorus over a six-month period.

Hypercalcemia has been used for years in public reporting, the Star Rating, and the QIP, but it is now considered topped out, meaning most facilities perform similarly well and it no longer differentiates performance effectively. UM-KECC also noted that when facilities do poorly on hypercalcemia, it is often due to missing data rather than truly high calcium levels, leading some stakeholders to view it as less useful than when it was first introduced.

In contrast, UM-KECC described hyperphosphatemia as potentially more meaningful in the current era. A previous clinical TEP supported it as a better alternative measure, and UM-KECC highlighted that dialysis care teams already devote substantial effort to phosphorus management through monthly monitoring, dietary counseling, and medications such as phosphate binders, along with related therapies like calcimimetics and vitamin D. The measure's design is intended to focus on patients with persistent, significant elevations by using a longer (six-month) rolling average and setting the threshold at 6.5 mg/dL, which is above typical clinic targets often around 5.5 mg/dL. Because the previous TEP was concerned that overemphasis on lowering phosphorus could

unintentionally increase malnutrition risk, the measure excludes patients with low body mass index and low albumin as proxies for poor nutritional status.

6.2 Discussion

One provider TEP member started the discussion by asking whether the hyperphosphatemia measure would be reporting-only, similar to the way hypercalcemia is in QIP, or performance-based. They raised a concern about removing hypercalcemia when facilities are doing well on it, which may be a testimony to the attention given to this measure. UM-KECC clarified that while hypercalcemia is reporting-only in QIP, Star Ratings currently use it as a performance measure (percent of patients with calcium > 10.2). For the purposes of the Star Ratings discussion, hyperphosphatemia would also be performance-based (percent with 6-month average phosphorus ≥ 6.5).

One of the co-chairs followed up by asking whether there are anticipated QIP changes related to hyperphosphatemia and/or hypercalcemia, and whether CMS is considering updates. They emphasized the practical concern that stakeholders may face two different frameworks (QIP vs Star Rating) and that CMS may need to sort out that alignment, particularly given patient-facing implications (e.g., pill burden, payment policy, and transplant readiness). UM-KECC was unable to comment about future QIP considerations or policy changes and reiterated that QIP decisions are separate from Star Ratings decisions for this meeting.

One provider TEP member supported adding hyperphosphatemia due to its correlation with survival, which was thought of as important with binders now in bundle to ensure facilities appropriately treat patients. They proposed considering a combined (composite) measure with calcium, phosphorus, and parathyroid hormone (PTH) in the future. They also felt it would be reasonable to communicate to CMS that alignment with the QIP is important, despite this discussion being limited to the Star Rating.

Another provider panelist supported replacement but initially raised caution about timing. While the hypercalcemia data shows it is topped out, it may not reflect future patterns after binders entered the bundle. They expressed concern about potential increased use of calcium-based binders, but later noted data shows calcium-based binder use actually decreased from 30-40% to lower levels and indicated they would be comfortable with the monitoring approach previously suggested.

Several patient TEP participants were also supportive of the replacement. One patient emphasized that as long as it does not affect their bone health, they would be comfortable replacing the hypercalcemia measure. Another patient noted that not including hyperphosphatemia would weaken clinical oversight of major ESRD risk as the measure is strongly linked to vascular calcification, cardiovascular mortality, and secondary hyperparathyroidism, all of which are

important for transplant consideration. Other patients supported the new measure and acknowledged its importance for teeth and bones for those with kidney disease.

Another patient panelist supported the hyperphosphatemia measure but questioned 6-month period versus current 3-month period. Their primary concern was about timely and accurate reporting as people start to understand phosphate measures and binders. UM-KECC clarified the measure uses a 6-month rolling average of phosphorus that is recalculated every month (i.e., each month looks back at that month plus the prior five). Six-months was decided upon for two main reasons: (1) it better matches more recent evidence linking sustained high phosphorus to worse outcomes, and (2) it reduces patient-provider tension in the clinic by smoothing out short-term elevations in phosphorus. The longer window helps avoid overreacting to transient elevations (e.g., travel or a special event) and instead flags patients with persistent phosphorus ≥ 6.5 mg/dL over time.

Given concerns that bundling phosphate binders might push facilities toward more calcium-based binders (potentially increasing hypercalcemia), a provider panelist suggested that CMS could add the hyperphosphatemia measure without removing the hypercalcemia measure, at least temporarily. A patient expert panelist supported using both measures if possible. They noted phosphorus was very difficult for them to control and often requires a large pill burden to do so.

A provider panelist asked how the 6-month rolling average works for incident patients who have only been in the clinic for two to three months: are they scored with only a few phosphorus values, or are they excluded until they have enough data? UM-KECC explained that patients must have at least four phosphorus values within the six-month window to be included, allowing for some missed labs. As a result, new dialysis patients do not count toward the measure until they have seven consecutive months of treatment (first 90 days excluded, then 4 months of phosphorus values).

A provider panelist questioned how the hypercalcemia metric has performed over the years and whether performance gap has changed. UM-KECC explained that the performance gap had initially been much wider, but has narrowed over time.

6.3 Vote

In response to the comments expressing concern about removing the hypercalcemia measure, UM-KECC asked the TEP to vote on two independent questions. Rather than asking, “Should the Hypercalcemia measure be removed AND replaced with the Hyperphosphatemia measure?” the TEP was asked to vote on two distinct questions and responded as follows:

- a. Should the Hypercalcemia measure be removed from the Star Rating?
 - Yes: 10 votes (56%)
 - No: 8 votes (44%)
- b. Should the Hyperphosphatemia measure be added to the Star Rating?

- Yes: 17 votes (94%)
- No: 1 vote (6%)

7. Adding Two Emergency Department Measures to the Star Rating

Next, UM-KECC introduced two emergency department (ED) dialysis facility measures as complements to existing hospitalization measures.

7.1 Background

The first of the two measures presented was the Standardized Emergency Department Encounter Ratio (SEDR), which counts outpatient ED encounters over a one-year reporting period among a facility's patients. The measure compares a facility's observed ED use to an expected number of ED encounters that is risk-adjusted for patient and facility characteristics. A key detail is how it separates outpatient from inpatient events: ED visits that lead to hospital admission are not counted in SEDR. Instead, those ED encounters are considered part of the hospitalization pathway and are a part of the Standardized Hospitalization Ratio (SHR) measure currently already included in the Star Rating. SEDR does include ED encounters that end in discharge from the ED as well as observation stays, because observation stays are considered outpatient care. This paradigm maintains a clean differentiation between outpatient and inpatient utilization.

UM-KECC then described the second measure, Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30) for Dialysis Facilities, which captures ED encounters occurring 4 to 30 days after hospital discharge over a two-year period. Like the readmission measure, ED30 assesses care transitions between inpatient and outpatient settings. Its denominator includes eligible Medicare dialysis patients, with risk adjustments for patient, facility, and hospital characteristics.

In summary, the SHR and SRR measures address avoidable hospitalizations and readmissions on the inpatient side, while SEDR and ED30 are analogous measures focused on the outpatient side, providing complementary information.

A co-chair noted the wide variation of access to ED care across the country (e.g., fewer urgent care alternatives in some regions) and asked how these two measures will account for this. While UM-KECC adjusts the denominator to the extent possible, there will inevitably be some geographic variation that cannot be fully accounted for. It was noted that since the Star Rating is intended to support patient choice, patients typically compare local facilities. Therefore, if an area has generally higher ED use due to local healthcare infrastructure, the facilities a patient is choosing among are likely affected similarly, which partially mitigates the concern when making local comparisons. The co-chair also asked whether urgent care visits are included. UM-KECC clarified these measures only include emergency department visits, not urgent care clinic visits.

7.2 Discussion

A provider panelist asked whether facilities decreasing hospitalization and readmission rates showed corresponding increase in ED usage and questioned the correlation between the measures. UM-KECC acknowledged the relationship between lower hospitalization/readmission rates and ED use is difficult to interpret. One reason is the administrative shift toward more observation stays, which affects what gets counted as outpatient ED/observation versus inpatient admission. Additionally, the reasons patients visit the ED and are discharged or placed in observation often differ from the reasons that lead to hospital admission, so there isn't complete overlap. Overall, analyses show some correlation between ED use and hospitalization, but many confounding factors make the correlation difficult to interpret.

Another provider raised concern about dialysis facilities discouraging appropriate ED referrals out of fear of poor measure performance and asked if these measures include all diagnoses. UM-KECC confirmed this is an all-cause measure with no subset of diagnoses.

A patient TEP member asked if these measures are intended to capture utilization, which could be driven by access issues like distance to hospitals, or quality of care (e.g., poor outpatient management leading to avoidable ED visits), noting the distinction matters for how they should interpret the question and vote. UM-KECC clarifies that the measure is strictly an ED utilization measure and only records whether an ED encounter occurred (yes/no), not the quality of care delivered during the visit. ESRD Networks have worked with facilities to reduce ED use, implying there are potentially modifiable facility-level factors that can help patients avoid ED visits, even though the measure itself is simply counting encounters.

A provider TEP member expressed significant concerns, noting 60-70% of ED visits by dialysis patients result in admission are already captured in hospitalization metrics. They were worried about the dramatic socioeconomic and demographic influences on ED use, affecting access to primary care, age, food insecurity, etc. They were concerned these measures would penalize populations and facilities needing more resources and noted there are too many confounding factors to discriminate quality versus utilization.

Another provider TEP member asked if the ED measures are limited to Medicare fee-for-service patients; UM-KECC confirmed this is correct. The panelist then asked about PQM endorsement timing. UM-KECC cites a 5-year cycle, noting the measures were last endorsed in 2020 but are on the docket for future endorsement activity this year. UM-KECC also adds that while these measures originally applied only to fee-for-service, CMS now has the ability for many standardized measures to include Medicare Advantage patients and is working to broaden the population.

One of the co-chairs asked whether, if Medicare Advantage (MA) patients are added to these standardized measures, CMS or UM-KECC could compare outcomes between MA and traditional fee-for-service populations. UM-KECC noted they have previously analyzed differences between MA

and fee-for-service for other standardized measures, but once MA is incorporated into the measure it is combined into a single Medicare population so the measure results will not be reported separately by coverage type. The co-chair comments that, from a patient advocacy perspective, separating MA from fee-for-service would be valuable and informative for CMS because many patients report concerns and quality issues with MA plans.

One provider TEP member suggested the ED measures should focus on diagnoses that dialysis facilities can realistically influence, similar to how ESRD Networks previously identified “controllable” diagnoses for ED and hospitalization work. They questioned whether it’s fair to hold facilities accountable for ED visits unrelated to dialysis care. The panelist also noted that, because dialysis units sometimes send patients to the ED, an ED-use measure could unintentionally discourage appropriate referrals if facilities fear being penalized, potentially harming patient care. UM-KECC acknowledged the point but for purposes of this TEP, the measure specifications cannot be changed and the measures should be discussed as written. Any revisions, including expanding the patient population, would need to occur during an upcoming re-endorsement process.

Another provider TEP member echoed earlier concerns that the ED measures may not meaningfully reflect dialysis facility quality. They emphasize that Star Ratings should give patients useful, clear information to choose high-quality facilities, but ED use can be driven by many factors outside a facility’s control (e.g., appropriate ED referrals, local access to care, Medicare Advantage utilization patterns). Because of these confounding factors, they worry the measures may not provide a clear quality signal for patient decision-making. Two additional patient panelists agreed the ED measures appear too broad and generalized. They were concerned about the measures representing inaccurate data for patients, particularly because reasons for an ED visit could be unrelated to a patient’s kidney disease. Another provider noted research showing the highest readmission rates from skilled nursing facilities despite receiving care. They shared concern about the broadness of the measure, as well as responsibility for care coordination since many factors contribute to ED visits, including early hospital discharge.

7.3 Vote

The TEP was asked to vote on the question, “Should SEDR and ED30 be added to the Star Rating?” and responded as follows:

- Yes: 7 votes (39%)
- No: 11 votes (61%)

8. Adding Standardized Modality Switch Ratio (SMoSR) to the Star Rating

Finally, UM-KECC provided background information on the SMoSR measure as the final topic, and invited discussion on whether to include it in the Star Rating.

8.1 Background

SMoSR is an outcome measure focusing on incident dialysis patients (in their first year of treatment) who start their dialysis treatment on in-center hemodialysis. It counts patient switches from in-center hemodialysis to a home modality, either peritoneal dialysis or home hemodialysis. Performance is expressed as a ratio comparing a facility's observed number of switches to an expected number based on the national average and the facility's patient case mix. A higher SMoSR result indicates more switching to home therapies. The SMoSR distribution is skewed, with many facilities having zero switches, from in-center hemodialysis to home therapies.

UM-KECC shared additional context, including that home dialysis has historically been underutilized and many patients still start in-center, often with a catheter. Broader policy and quality efforts are underway that encourage home modalities (e.g., Kidney Care Choices Model and ESRD Network initiatives). The SMoSR measure is already publicly reported on Dialysis Facility Care Compare, and the TEP is tasked with discussing whether it should be added to Star Ratings.

Several TEP members asked clarifying questions, including whether the measure is restricted to centers with a home program, how "credit" is assigned when the switch involves transferring to another facility at the same time, and whether the measure captures patients who start directly on home dialysis. UM-KECC explained that in-center-only facilities can still be included; even if they do not provide home modalities themselves, they often provide modality education and can refer patients to another facility for home therapy. Specifically, the in-center-only facility will receive credit for the modality switch if the patient starts on a home modality within 30 days of changing dialysis clinics. If the modality change occurs after 30 days, then the receiving facility will be credited. Lastly, the measure only captures those who start in-center and then transition to a home modality. Analyses suggest facilities with high rates of incident home patients also tend to have high switch rates, implying the measure still tracks with broader home-dialysis capability/performance.

8.2 Discussion

One provider started by expressing strong support of the addition of SMoSR given that the path of least resistance tends to be in-center modalities. This measure was thought to adequately capture the process of managing patients, including patient education and buy-in.

A patient panelist asked if the measure counts only patients who actually switch to home dialysis, not those merely advised to. UM-KECC confirmed that is correct and adds that, to be counted, the patient must remain on the home modality for a minimum "durability" period (30 days). When asked how that durability period was chosen, UM-KECC noted it was heavily debated in the previous TEP, with patients favoring shorter minimum timeframes (valuing any time at home) and providers favoring longer periods. The panelist then asked whether the measure accounts for the level of support provided at home (e.g., home visits or in-home help during the first 30 days). UM-

KECC answered that the measure does not capture that level of detail; it simply counts the transition and meeting the minimum duration requirement.

One provider panelist expressed concern that this measure would incentivize providers to send patients in-center first when they could go directly home. For a practice that is roughly 36% home, for example, they would not want to incentivize starting in-center then moving to home for metric performance. The panelist also questioned how the measure can credit an in-center only facility for referring a patient to a home program, noting that facilities may be disincentivized to send patients elsewhere, clinicians (not centers) typically make referrals, and the approach could invite “gaming” of the metric. UM-KECC responded that a substantial share of U.S. dialysis clinics (about 40%) are in-center only and do not offer home therapies, but they are still required under the CMS Conditions for Coverage to provide modality education. If a patient chooses home dialysis, the patient must then transfer to another facility that can provide home therapy, regardless of whether the process is framed as a physician or facility referral.

Another panelist supported idea of getting patients from in-center to home quickly, but were concerned that 30 days is not enough time for referring facilities without home programs to transition patients due to transportation and access issues. UM-KECC explained this was heavily debated by the TEP that developed the measure and is meant to reflect which facility did the bulk of the work to enable the transition. The TEP had settled on 30 days as the cutoff, acknowledging it is somewhat arbitrary and that there is likely some practical flexibility in how transition timing plays out.

Another patient TEP member raised concerns about rural populations, citing Native American dialysis patients that face additional challenges as an example.

A provider panelist raised concern that home dialysis is not appropriate for everybody and used an example of an older woman who wants socialization at the dialysis center. They were concerned about aging population awareness of right to refuse, and referenced research from Thailand showing quality of life is not as good with PD versus in-center and higher infection rates in rural communities. UM-KECC clarified that this measure isn’t aiming to get 100% of patients on home dialysis. It benchmarks facilities against national peer rates to flag outliers performing much better or worse than average, recognizing home therapy isn’t appropriate for everyone.

A provider panelist asked about CBE endorsement history. UM-KECC explained the modality switch measure was recently reviewed for endorsement but was not endorsed, largely due to concerns about the measure’s evidence base. The measure was confirmed to already be publicly reported on Dialysis Facility Care Compare. Another provider panelist was also opposed adding the measure, citing concerns about perverse incentives, data quality, and inequities in access.

One of the co-chairs supported aligning measures with national policy promoting home dialysis and improving patient choice, especially in rural and underserved communities, while acknowledging

gaming risks that must be controlled. One of the patient panelists warned the measure could push inappropriate patients toward home dialysis without adequate safeguards. A patient expert shared mixed personal experience, noting home modalities can be excellent but require suitability (e.g., training, capability, and often a care partner), and supported adding the measure to expand choice.

8.3 Vote

The TEP was asked to vote on the question, “Should SMOsR be added to the Star Rating?” and responded as follows:

- Yes: 10 votes (56%)
- No: 8 votes (44%)

9. Public Comments

No public comments were received.

10. Summary

The TEP engaged in thoughtful discussion around the four main potential changes to the Star Ratings. The group unanimously agreed to remove SFR from the Star Ratings noting that the measure was no longer CBE-endorsed, it has been removed from the QIP, and that the focus of vascular access discussions should center on patient choice and minimizing the use of long-term catheters. The group also widely agreed that the hyperphosphatemia measure should be added to the Star Ratings, especially in light of the recent changes with phosphate binders being included in the bundled payment system. However, there was some concern expressed with removing the hypercalcemia measure, despite the minimal performance gap, due to concerns that hypercalcemia rates could increase based on how dialysis facilities approach phosphate binder use.

The Emergency Department measures had the lowest level of support for inclusion in the Star Ratings due to concerns that some ED encounters are for non-dialysis related care, access to urgent care is limited in some parts of the country, and facilities may be discouraged from appropriate ED referrals. Finally, just over half of TEP members supported the inclusion of SMOsR in the Star Ratings given the recent emphasis on access to home dialysis (related to the 2019 Executive Order, the AAKHI) and supporting patient choice in modality options.

11. Appendices

- A. TEP Charter
- B. TEP Meeting Slide Presentation

Technical Expert Panel (TEP) Charter

Project Title: Dialysis Facility Quality of Patient Care Star Rating Technical Expert Panel (TEP)

TEP Expected Time Commitment and Dates:

We anticipate the TEP will consist of 1-3 meetings held via a secure video conferencing platform (e.g. Zoom). The duration of each meeting will be between 2 to 3 hours. Meetings are tentatively scheduled to begin in February 2026 with subsequent meetings occurring between March and April 2026.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with The University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) to act as the quality measure developer and technical content support contractor for Dialysis Facility Care Compare (DFCC) on Medicare.gov, under the Kidney Disease Quality Measure Development, Maintenance, and Support contract (contract number 75FCMC18D0041, task order number 75FCMC23F0001). As part of this contract, UM-KECC convenes technical expert panels (TEPs) to obtain consumer and provider input for quality measure development and the Medicare.gov Dialysis Facility Quality of Patient Care Star Rating (Star Rating). We seek nominations from individuals with relevant clinical and methodological experience, expertise, and perspectives, including patients with chronic dialysis experience to serve on this TEP.

A Star Rating TEP was first convened in 2015 to review the original methodology and presentation of the Star Rating on the Medicare.gov website. The TEP provided several recommendations that were implemented in the updated Star Rating methodology, released in October 2016. A second TEP was convened in 2017. TEP members provided recommendations on candidate measures proposed for inclusion in the Star Rating and defined concepts such as rebaselining and resetting. A third TEP was convened in 2019 to provide recommendations on options for resetting the Star Rating and reweighting one of the quality domains in the calculation of the Star Rating. A fourth TEP was convened in 2022 to obtain recommendations related to the first public release of the Star Rating since the start of the COVID-19 pandemic public health emergency. See the respective 2015, 2017, 2019, and 2022 Star Rating TEP reports for a summary of the deliberations and TEP recommendations, available at:

<https://dialysisdata.org/content/esrd-measures>

As part of CMS' broader initiative for Care Compare on Medicare.gov, CMS developed the Star Rating to make quality information more accessible to patients, caregivers, providers and policymakers and to help consumers (including patients and caregivers) understand CMS quality measures and more easily identify differences in overall quality when selecting dialysis facilities. The Medicare.gov website displays two different Star Rating: (1) the Quality of Patient Care Star Rating (Star Rating) and (2) the Survey of Patients' Experiences Star Rating. Eleven of the quality measures currently reported on the Medicare.gov website are used to calculate the Quality of Patient Care Star Rating (Star Rating). The discussion focus for the upcoming TEP will be on the Quality of Patient Care Star Rating. The Survey of Patients' Experiences Star Rating will not be covered as a discussion topic during this TEP. Broadly, the TEP will be expected to review and provide input on options and considerations for updating and public reporting of the Star Rating. These considerations fall under two categories:

- (1) Reviewing Star Rating distribution trends to determine if resetting and/or rebaselining in the next release is necessary.
- (2) Evaluating candidate quality measures for possible addition or removal to the Star Rating based on clinical/public health importance.

The TEP will be chosen to represent a diversity of perspectives and backgrounds. Members will be selected based on their personal experience as patients, caregivers and providers, or based on methodological expertise. Our intent is to ensure the TEP will have ample representation from patients and patient advocates to allow fair representation of their perspectives.

Project Objectives:

UM-KECC, through its contract with CMS, will convene a TEP to inform possible expansion of the measure set used in the Star Rating and establishment of a new baseline period if the measure set is modified. The final methodology developed is intended to ensure that the Star Rating continues to be informative by reflecting meaningful performance differences among facilities.

Technical Expert Panel (TEP) Objectives:

The 2026 Star Rating TEP is expected to focus on:

- (1) Evaluation of candidate quality measures for possible addition to the Star Rating.
- (2) Reviewing Star Rating distribution trends to provide opinions about potential need for resetting and/or rebaselining of the DFCC Star Rating.

TEP Requirements:

A TEP of approximately 10-16 individuals will meet to discuss and provide recommendations on the above topics to UM-KECC. The TEP will be composed of individuals with differing areas of expertise and perspectives, including:

- Individuals with end-stage kidney disease (ESKD) and care partners of individuals with ESKD
- Experts with subject matter expertise, e.g., scientists in nephrology care; clinicians and nurses; consumer testing; communication of Star Rating systems from the patient perspectives
- Experts with methodological expertise, e.g., statisticians/biostatisticians with expertise in score or scale development, multivariate analysis, risk assessment, latent variable modeling
- Individuals with dialysis facility quality improvement expertise
- Individuals with health care disparities expertise

Scope of Responsibilities:

UM-KECC is seeking balanced representation of dialysis stakeholders and clinical experts, including patients/patient-advocates and dialysis providers, as well as clinical, statistical, and public health experts to provide input on the topics described above. The TEP will be led by one or two Chairpersons, whose responsibility is to lead the discussion and attempt to develop consensus opinions from TEP membership regarding discussion topics. The TEP is intended to be advisory to UM-KECC, as UM-KECC continues to develop and refine the Star Rating.

The role of each TEP member is to provide advisory input to UM-KECC by reviewing materials provided prior to meetings and actively participating in TEP discussions based on their experience, knowledge, and (where applicable) training.

Role of UM-KECC: As the CMS measure development contractor, the UM-KECC moderators will work with the TEP chair(s) to ensure the panel discussions focus on the review of draft measure specifications, as recommended by the contractor. During discussions, UM-KECC moderators may advise the TEP and chair(s) on the needs and requirements of the CMS contract and the timeline, and may provide specific guidance and criteria that must be met with respect to CMS policy. UM-KECC will prepare a summary report of the TEP proceedings. UM-KECC is responsible for ensuring that the summary report accurately reflects the TEP discussion and recommendations. Although the TEP is advisory only, it is important that CMS is informed of the TEP's recommendations in an objective fashion.

Role of TEP chair(s): Prior to the TEP meetings, one or two TEP members are designated as the chair(s) by the measure contractor and CMS. The TEP chair(s) are responsible, in partnership with the moderator, for directing the TEP to meet the expectations for TEP members, including provision of advice to the contractor regarding methodological issues.

Duties and Role of TEP members: According to the CMS Measure Management System Blueprint, TEPs are advisory to the measure contractor. TEP members are expected to attend conference calls in 2026 and be available for additional follow-up teleconferences and correspondence as needed. The TEP will review, edit (if necessary), and adopt a final charter at the first teleconference. A discussion of the overall tasks of the TEP and the goals/objectives of the project will be described. The key deliverable includes a summary report documenting the discussions and proposed recommendations that are made during the group meetings.

Guiding Principles:

Participation as a TEP member is voluntary and the measure developer records the participant's input in the meeting minutes, which the measure developer will summarize in a report that they may disclose to the public. If a participant chooses to disclose private, personal data, then related material and communications are not covered by patient-provider confidentiality. Patient/caregiver participants may elect to keep their names confidential in public documents. TEP organizers will answer any questions about confidentiality.

The TEP may use both verbal consensus and formal voting by secret ballot for decision-making, depending on the context of the decision. For administrative and other decisions about agenda, direction of discussion, and other minor operational decisions, informal verbal consensus directed by the TEP chair(s) will be utilized. In order to objectively record TEP recommendations about the validity of the quality measures presented and recommended changes, formal votes will utilize secret ballots.

All potential TEP members must disclose any significant financial interest or other relationships that may influence their perceptions or judgment. It is unethical to conceal (or fail to disclose) conflicts of interest. However, there is no intent for the disclosure requirement to prevent individuals with particular perspectives or strong points of view from serving on the TEP. The intent of full disclosure is to

inform the measure developer, other TEP members, and CMS about the source of TEP members' perspectives and how that might affect discussions or recommendations.

Estimated Number and Frequency of Meetings:

One to three meetings held via a secure video conferencing platform (e.g., Zoom). The duration of each meeting will be between 2 to 3 hours. Meetings are tentatively scheduled to begin in February 2026 with subsequent meetings occurring between March and April 2026.

Date Approved by TEP:

TBD

TEP Membership:

TBD

Dialysis Facility Quality of Patient Care Star Rating

Technical Expert Panel
Thursday, April 9, 2026

Agenda

1. Introductions
2. TEP Charter
3. Star Rating Overview
4. Potential Changes and TEP Discussion
5. Public Comment

Introductions

UM-KECC Team

Name and Credentials	Organizational Affiliation	Conflict of Interest Disclosure
Jonathan Segal, MD	Professor, Nephrologist, Internal Medicine, Nephrology	None
Yi Li, PhD	Professor, Biostatistics Professor, Global Public Health	None
Joseph Messana, MD	Professor, Internal Medicine, Nephrology	None
Claudia Dahlerus, PhD	Associate Research Scientist, Internal Medicine, Nephrology	None
Richard Hirth, PhD	S. J. Axelrod Collegiate Professor, Health Management and Policy Professor, Internal Medicine	None
Tao Xu, PhD	Senior Analyst	None
Ashley Eckard, MS	Senior Analyst	None



UM-KECC Team

Name and Credentials	Organizational Affiliation	Conflict of Interest Disclosure
Jennifer Sardone, BA, PMP	Senior Lead Project Manager	None
Eileen Yang, MS	PhD Candidate, Biostatistics	None
Ashley Garcia, BA	Project Manager Point of Contact: garciash@umich.edu	None



CMS Representatives

- Stephanie Clark, MD
- Darrick Hunter, MS
- Wilfred Agbenyikey, PhD

TEP Introductions and Conflicts of Interest

- We request that TEP members disclose any current and past activities that may cause a conflict of interest (COI). This includes financial interests or other relationships that may influence their perceptions or judgement.
- The disclosure requirement is not intended to prevent individuals with potential COI from serving on the TEP. The intent of full disclosure is to inform the measure developer, other TEP members, and CMS about the source of TEP members' perspectives and how that might affect discussions or recommendations.
- If a member's status changes and a potential conflict of interest arises at any time while a member is serving on the TEP, the TEP member is required to notify the measure developer and the TEP chair.

TEP Members

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Conflict of Interest Disclosure
*Paul T. Conway, BA Patient Advocate Chair, Policy and Global Affairs, Immediate Past President	American Association of Kidney Patients Falls Church, VA	None
*Francesca Tentori, MD Outcomes Research & Patient Empowerment	DaVita Kidney Care Denver, CO	Employed by DaVita Kidney Care
Quiana L. Bishop President, Board of Directors	Dialysis Patient Citizens Detroit, MI	None
Lorien S. Dalrymple, MD, MPH Senior Vice President, Head of Population Health and Medicine, Global Medical Office	Fresenius Medical Care Waltham, MA	Employee of and owns share options/stock in Fresenius Medical Care
Candria (Candee) Denzmore Patient Advocate, Kidney Transplant Recipient	Granite City, IL	None
Brittany Dickerson The Training Academy and Certified Coaches Alliance Life Purpose Coach and Kidney Health Advocate	Columbia, SC	None

* TEP Co-chair

TEP Members

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Conflict of Interest Disclosure
Mary Dittrich, MD, FASN Nephrologist, Chief Medical Officer	US Renal Care, Satellite Healthcare Boise, ID	Shareholder and CMO of US Renal Care
Stephanie Dixon Patient Advocate	Kidney Patient Advisory Council Rutherford, NJ	None
Christina Gilchrist Patient	Roy, UT	None
Michael Gilchrist Care Partner	Roy, UT	None
Debra Hain, PhD, APRN, AGPCNP-BC, PMHNP-BC, CNN-NP Executive Team Member and Psychiatric Nurse Practitioner for ActivateCR (providing mental health care for persons with CKD and ESKD) Professor (tenured), Florida Atlantic University, Christine E Lynn College of Nursing	ActivateCR Herriman, UT	None
Shekeila Harris, LPN, MBA, CALA Patient Advocate, Board of Directors	Dialysis Patient Citizens Vineland, NJ	None

TEP Members

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Conflict of Interest Disclosure
David Henner, DO Division Chief of Nephrology/Medical Director of Dialysis, Berkshire Medical Center Medical Director of Dialysis, Southwestern Vermont Medical Center Past President, National Forum of ESRD Networks	Berkshire Medical Center Pittsfield, MA	None
Donna M Hoffman Dialysis Patient	Glen Allen, VA	None
Donald Morgan Transplant Patient, Patient Advocate Coordinator	ESRD Network 16 Hayden, ID	None
José Navarrete, MD Associate Professor of Medicine, Emory University School of Medicine, Division of Renal Medicine, Nephrology Section Chief-EUHM, Medical Director, Dialysis Services EHC	Emory University Atlanta, GA	None

TEP Members

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Conflict of Interest Disclosure
Jesse Roach, MD Senior Vice President, Government Relations	National Kidney Foundation Washington, DC	None
Janice Starling, MBA Network 7 Patient Expert, AAKP Ambassador, Kidney Patient Advocate, National Kidney Foundation Ambassador	Kidney Patient Advisory Council St. Petersburg, FL	None
Cheryl (Cher) Thomas, RDH Patient	Renal Support Network Galveston, TX	None
Curtis Warfield, MS Patient Health Advocate	National Kidney Foundation, KHI - Patient and Family Partnership Council Indianapolis, IN	None

Role of the TEP

- Review evidence to determine the basis of support for topics identified in the TEP charter
- Review and approve summary report of the TEP Meeting and provide input on other necessary technical documentation required for public reporting or for responses to public comments
- Be available for follow up conference calls, as needed

Role of the TEP

- TEPs are advisory to the contractor (UM-KECC), and not CMS
- It is the responsibility of UM-KECC to accurately report AND consider recommendations received from the TEP; however, recommendations made to CMS are made by UM-KECC, and not by the TEP
- If UM-KECC makes recommendations to CMS that are not consistent with the recommendations from the TEP, it is UM-KECC's responsibility to explain the rationale for any differences

Role of the TEP Chairs

- Disclose potential conflicts of interest
- In partnership with UM-KECC, direct the TEP to meet its expectations, including provision of advice to the developer/contractor regarding methodology updates to the Star Rating
- Conduct the meeting according to the agenda
- Recognize speakers and call for votes when needed

Role of UM-KECC

- Support the development of methods that are used in CMS quality programs for public reporting
- Work with the TEP chairs to ensure the panel discussions focus on the proposed methodological updates, as recommended to the developer/contractor
- Advise the TEP and the TEP chairs on the needs and requirements of the CMS contract and the timeline, and provide specific guidance and criteria that must be met with respect to CMS review of methodological updates
- Develop a draft TEP summary that accurately summarizes the TEP deliberations
- Develop recommendations regarding TEP deliberations for use by CMS, as the agency considers policy decisions related to TEP content

TEP Charter

TEP Charter

Project Objectives

- Inform possible expansion of the measure set used in the DFCC Star Rating and establishment of a new baseline period if the measure set is modified.
- Ensure that the final methodology developed for the Star Rating continues to be informative by reflecting meaningful performance differences among facilities.

TEP Objective

Evaluate candidate quality measures for possible removal, replacement, or addition to the Star Rating

Questions

Any questions about the TEP charter and objectives?

Star Rating Overview

Eileen Yang, PhD Candidate, Biostatistics



Star Rating Overview

The Centers for Medicare & Medicaid Services (CMS), through a contract with UM-KECC, developed the Dialysis Facility Quality of Patient Care Star Rating System (Star Rating):

- To rate the quality of care provided by dialysis facilities
- To provide patients, families, and caregivers information to easily compare dialysis facilities

Since the Star Rating was first released in January 2015, UM-KECC has facilitated periodic TEPs to provide recommendations on updates to the Star Rating methodology

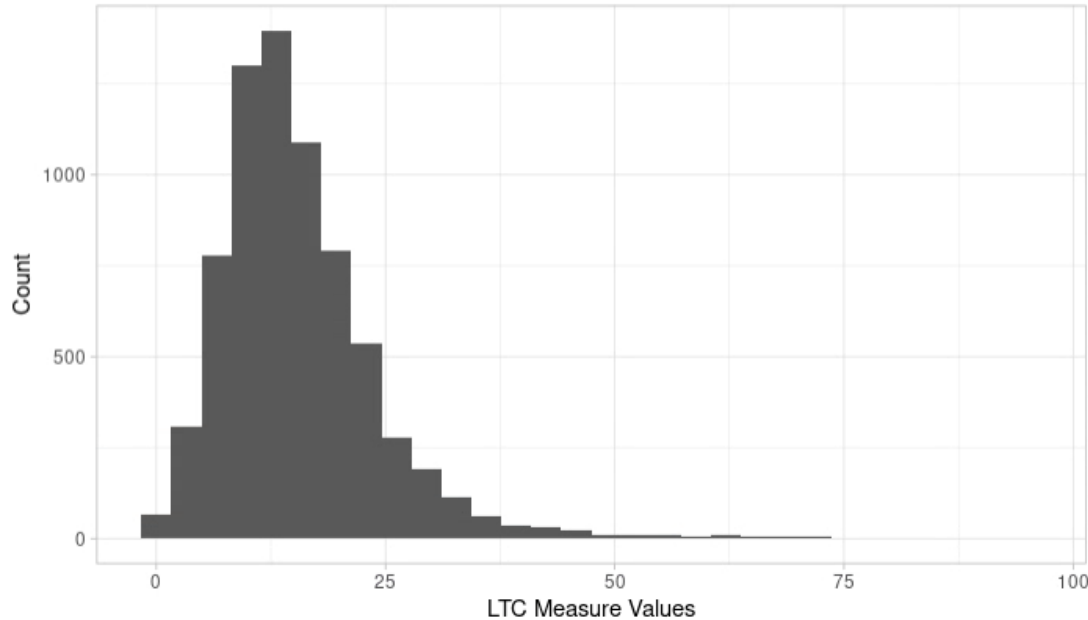
Key Concepts and Terminology

Term	Definition
Measure Value	The original value of a facility’s clinical quality measure as reported on DFC, which represents a ratio or a percentage
Measure Score	A standardized score applied to a specific measure, so that no measure has undue influence on the Star Rating, and so that the range and direction of scores are consistent (mean 0, variance 1)

Measure Values vs. Measure Scores

Example: Long-term Catheter Rate Measure

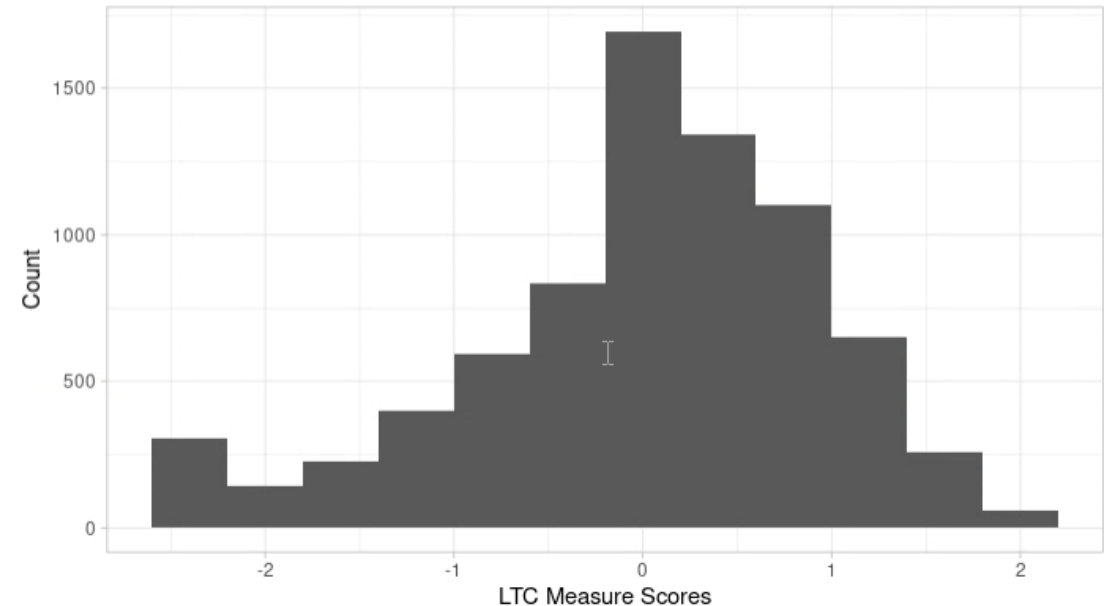
Distribution of Long-term Catheter Rate Measure Values: October 2023



*After realignment
and standardization:*



Distribution of Long-term Catheter Rate Measure Scores: October 2023



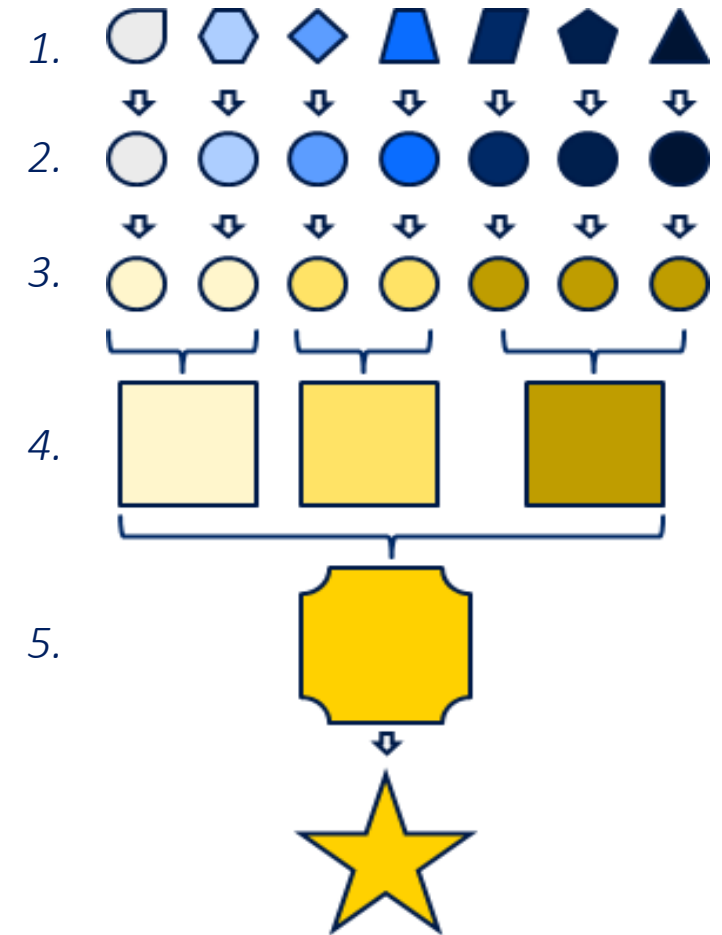
- The long-term catheter rate measure (LTC) is realigned so that higher values represent better quality
- The realigned version of LTC is then standardized to create measure scores between -2.58 to 2.58, with a mean of 0 and variance of 1
- If a facility had LTC measure value of 15.52 (the average LTC), its LTC measure score would be 0

Key Concepts and Terminology

Term	Definition
Domain Score	A score which summarizes a facility's performance on a group of correlated clinical quality measures. It is an average of the individual measure scores in that group (domain)
Final Score	A continuous score calculated for each facility, which summarizes its performance on the reported clinical quality measures. It is an weighted average of the domain scores
Cutoff	A value of the final score that defines the boundary between two adjacent Star Rating categories (e.g., the cutoff between 4- and 5-stars is 1.36 and facilities with a final score > 1.36 receive 5 stars)

Star Rating Overview

1. *Measure values* on different scales are standardized to form *measure scores* with the same interpretation
2. *Individual measures* are grouped into different measure domains based on their correlations
3. *Measure scores* within a domain are averaged to form *domain scores*
4. *Domain scores* are averaged to form a *final score* for each facility
5. *Final scores* are grouped into five star categories based on pre-established Star Rating *cutoff* values



Key Concepts and Terminology

Term	Definition
Baseline Period	The time period (e.g., calendar year) in which data are collected for computing measure scoring criteria and defining cutoff values for Star Rating categories. The cutoffs will be used to rate facilities in future evaluation periods
Evaluation Period	The time period (e.g., calendar year) in which data are collected for calculation of measure results and facility Star Rating scores, reported on DFC. Final scores in the evaluation period are compared against cutoffs established in the baseline period in order to rate facilities
Rebaselining	Establish a new baseline period and scoring cutoffs. These cutoffs let the Star Rating distribution remain unchanged from the past release to allow for continuity over time when updating measures
Resetting	Establish a new baseline period, scoring cutoffs, and Star Rating distribution. These cutoffs define a new Star Rating distribution to better differentiate facility performance

Current Star Rating Measures

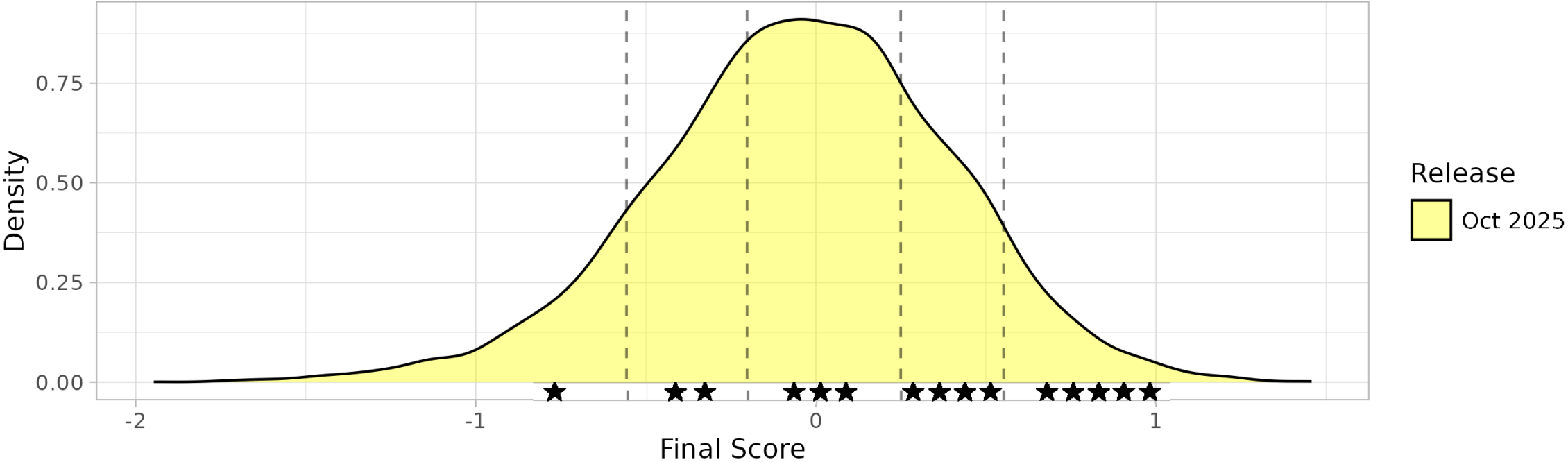
Domain	Measure
1	Standardized Transfusion Ratio for Dialysis Facilities (STrR)
	Standardized Mortality Ratio for Dialysis Facilities (SMR)
	Standardized Hospitalization Ratio for Dialysis Facilities (SHR)
	Standardized Readmission Ratio for Dialysis Facilities (SRR)
2	Hemodialysis Vascular Access: Standardized Fistula Rate (SFR)
	Hemodialysis Vascular Access: Long-Term Catheter Rate (LTC)
3†	Total Kt/V (Kt/V)*
	Proportion of Patients with Hypercalcemia (Hyp.)
4	Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR)
	Percentage of Prevalent Patients Waitlisted (PPPW)

**Four Kt/V percentage measures (adult/pediatric, HD/PD) are combined into a single, Total Kt/V measure*

† Domain 3 has a reduced weight

Star Rating Distribution

Star Rating Final Score Distributions in Oct 2025

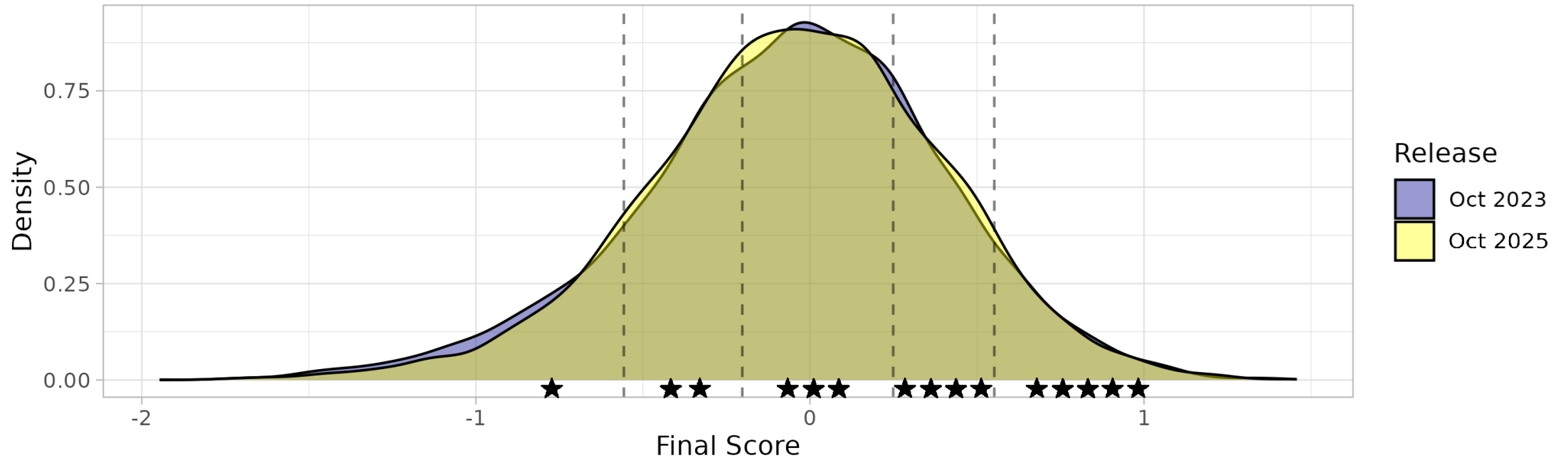


Star Rating

	★	★★	★★★	★★★★	★★★★★
Number of facilities (%)	837 (12%)	1603 (22%)	2883 (41%)	1229 (17%)	566 (8%)

Star Rating Distribution

Star Rating Final Score Distributions in Oct 2023 vs. Oct 2025



	Star Rating				
	★	★★	★★★	★★★★	★★★★★
Oct 2023	940 (13%)	1575 (22%)	2852 (40%)	1221 (17%)	576 (7%)
Oct 2025	837 (12%)	1603 (22%)	2883 (41%)	1229 (17%)	566 (8%)



Star Rating Distribution

- The Star Rating distribution remains relatively unchanged since the last reset took place
 - The Star Rating distribution was last reset using calendar year (CY) 2021 data as the baseline, with the October 2023 release (which used CY 2022 data) being the first evaluation period after the reset
 - The 2023, 2024, and 2025 Star Rating releases have had almost identical Star Rating distributions
- We are not asking the TEP to consider resetting the Star Rating in the next release

Questions

Any questions about the Star Rating or methodology?



Potential Changes to the Star Rating Measure Set

Candidate Measures for Addition to the Star Rating

- Several measures are being considered for addition to the Star Rating measure set
 - Goal: cover more aspects of dialysis care to better inform patient decision-making and more completely represent dialysis facility care quality
- Candidate measures:
 - Standardized Emergency Department Encounter Ratio (SEDR)
 - Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30)
 - Standardized Modality Switch Ratio (SMoSR)
 - Hyperphosphatemia (not yet publicly reported; if added, would be in future years)

Potential Measures for Removal from Star Rating Measure Set

- Percentage of Patients with Hypercalcemia (Current Domain 3)
 - Percent of patient reporting months with 3 mo. rolling average blood calcium >10.2 mg/dL or missing
 - Very high achievement of this measure goal, with sizeable fraction of “flagged” patient months due to missing values rather than documented >10.2
 - Removal could be in conjunction with addition of hyperphosphatemia quality measure
- Standardized Fistula Rate (SFR; current Domain 2)
 - Risk-adjusted Percentage of patients with functioning AV fistula being used for hemodialysis vascular access
 - Recent changes to international vascular access guidelines emphasize use of AV fistula or AV graft, resulting in loss of consensus endorsement
 - SFR is no longer included in the Quality Incentive Program

Potential Measures for Removal/Replacement from the Star Rating

Removal of SFR

- Prior Vascular Access paradigm: Maximized AVF and Minimize LTC. AVG considered neutral.
- Star Rating: currently has both SFR and LTC measures
- Current Vascular Access paradigm
 - Recent update to KDOQI guidelines: Evidence to support AVF not as strong as once thought to be.
 - Standardized Fistula Rate:
 - Lost endorsement by NQF
 - No longer focus of ESRD Network quality improvement activities
 - Removed from QIP

Discussion question: Should SFR be removed from the Star Rating?

Hyperphosphatemia

Measure Definition: *Percentage of adult dialysis patients with a 6-month rolling average phosphorus value greater than or equal to 6.5 mg/dL*

Numerator: Number of patient reporting months in the denominator with a 6-month rolling average phosphorus greater than or equal to 6.5 mg/dL

Denominator: Number of patient reporting months among adult (greater than or equal to 18 years old) in-center hemodialysis, home hemodialysis, or peritoneal dialysis patients under the care of the dialysis facility for the entire reporting month who have had ESRD for greater than 90 days.

Interpretation: Higher Percentage = Better Quality

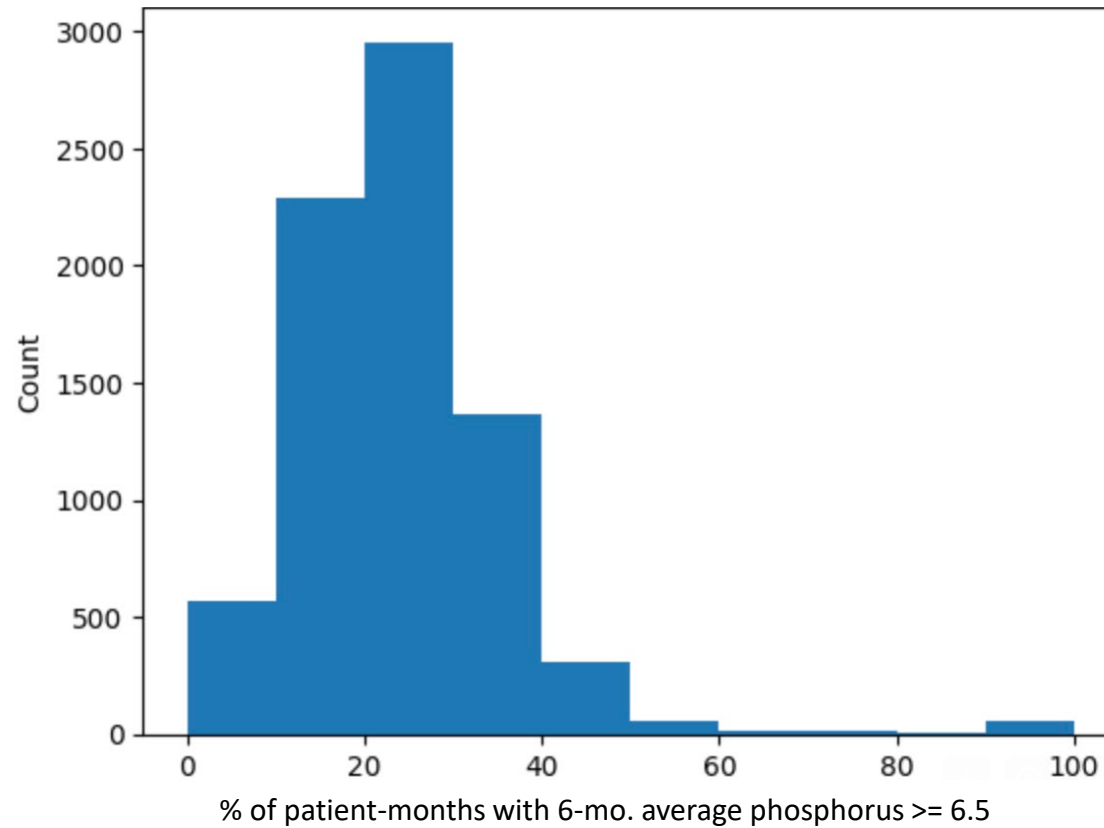
Measure Type: Intermediate Outcome

Note: This measure is not yet publicly reported. It would be under consideration for Star Rating addition next year.

Note: Hyperphosphatemia calculation is restricted to facilities with >10 eligible patients.

Hyperphosphatemia

Distribution of Hyperphosphatemia (Oct 2025)



Min.	1st Qu.	Median	Mean	3rd Qu.	Max.
0	16.67	23.08	23.91	29.48	100

Replacement of Hypercalcemia with Hyperphosphatemia

- There is a statutory requirement to have a measure of Mineral Bone Disorder.
- Hypercalcemia has been publicly reported on DFCC, included in the Star Rating, and in QIP, but is largely topped-out (minimal performance gap)
 - Often reflects missing data rather than actual elevated calcium levels
- Hyperphosphatemia was developed as an alternative to hypercalcemia
 - Decades of measuring phosphorus monthly, patient nutrition education, phosphate binders, calcimimetics, and vitamin D to address targets, but no prior quality measure
 - Measure focuses on those with persistent and significant elevation in phosphorus
 - Hyperphosphatemia measure endorsed by PQM, but not yet publicly reported
- Discussion question: Should the Hypercalcemia measure be removed from the Star Rating AND be replaced with the Hyperphosphatemia measure?

Candidate Measures for Addition to the Star Rating

Standardized Emergency Department Encounter Ratio (SEDR)

Measure Definition: *Observed / Expected outpatient ED encounters*

Numerator: Observed number of outpatient Emergency Department (ED) encounters during the reporting period (one calendar year) among eligible patients at a facility

Denominator: Expected number of ED encounters among eligible patients at the facility during the reporting period adjusted for the characteristics of the patients at the facility

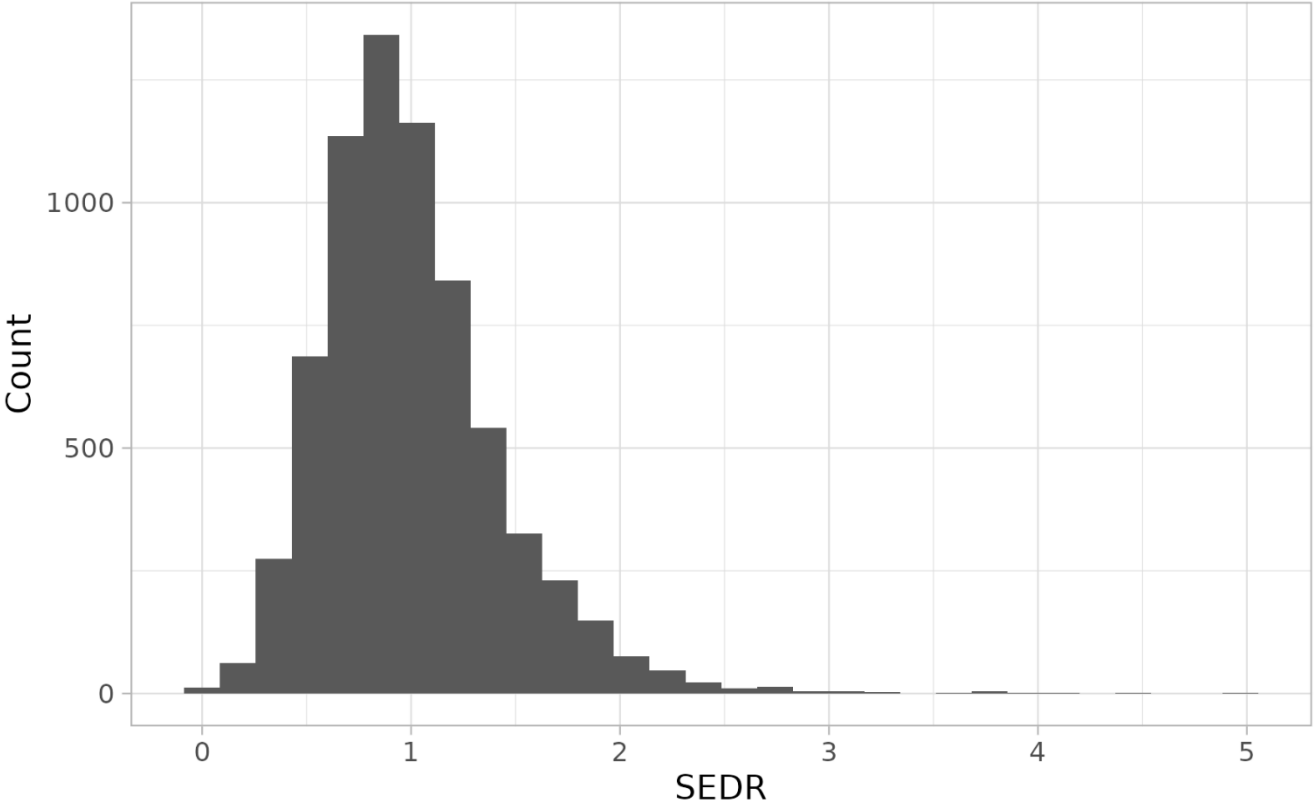
Interpretation: Lower Score = Better Quality

Measure Type: Outcome

Note: SEDR is not calculated for facilities with < 5 patient-years at risk

Standardized Emergency Department Encounter Ratio (SEDR)

Distribution of SEDR (Jan 2026)



Min.	1st Qu.	Median	Mean	3rd Qu.	Max.	NA's
0	0.71	0.94	1	1.22	4.97	664



Standardized Ratio of ED Encounters Occurring Within 30 Days of Hospital Discharge (ED30)

Measure Definition: *Observed / Expected hospital discharges followed by ED encounters within 30 days*

Numerator: Observed number of index hospital discharges followed by an ED encounter within 4–30 days of discharge among eligible adult Medicare patients at a facility in the two year period

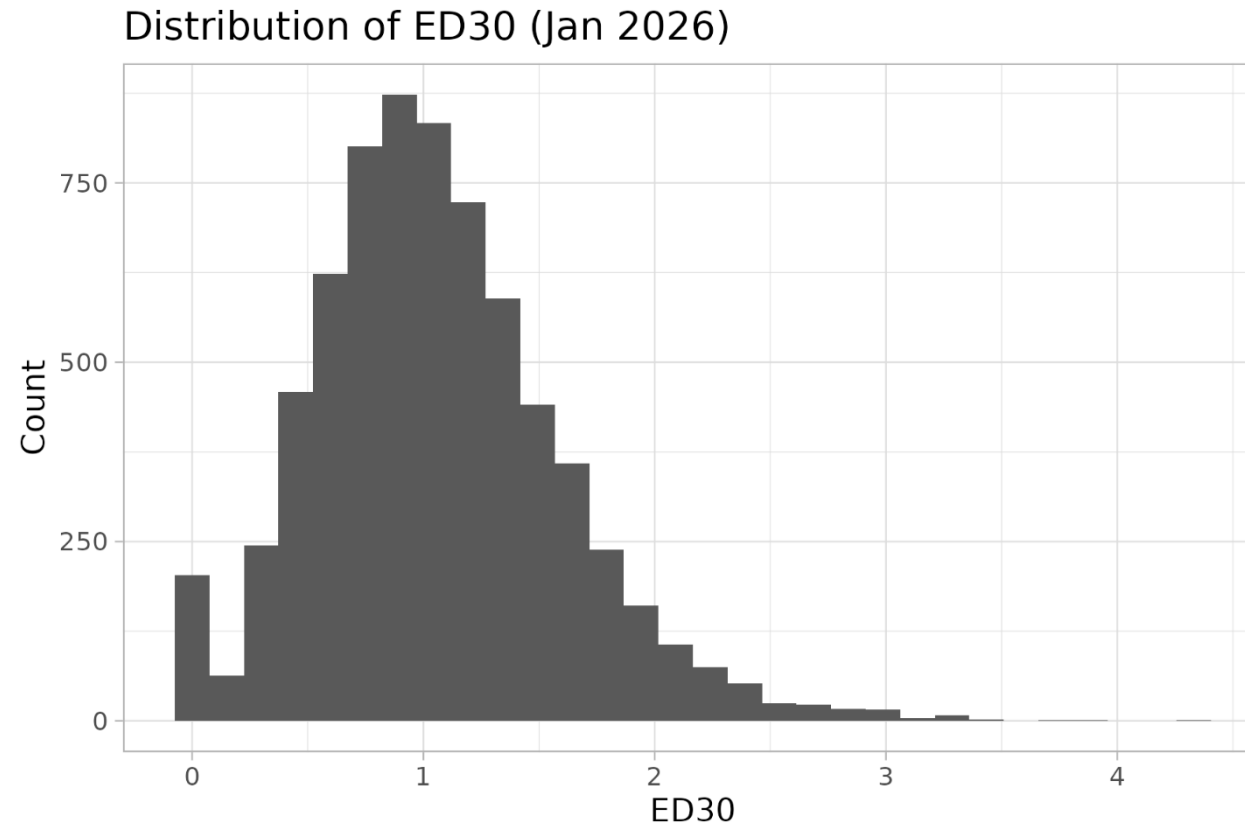
Denominator: Expected number of index hospital discharges for eligible adult Medicare ESRD dialysis patients in the two year period that are followed by an ED encounter within 4-30 days of the discharge among eligible patients at a facility, adjusting for patient, facility and hospital characteristics

Interpretation: Lower Score = Better Quality

Measure Type: Outcome

Note: ED30 is only calculated for facilities with >10 eligible index discharges in the reporting year

Standardized Ratio of ED Encounters Occurring Within 30 Days of Hospital Discharge (ED30)



Min.	1st Qu.	Median	Mean	3rd Qu.	Max.	NA's
0	0.7	1.01	1.06	1.36	4.33	677

Addition of SEDR and ED30

- SHR and SRR help facilities address avoidable hospitalizations (SHR) and coordination of care after discharge (SRR).
 - Do not address ED encounters that do not lead to admission or observation stays.
- SEDR and ED30 are analogous measures that focus on outpatient acute care
 - Provide complementary information compared to SHR and SRR

Discussion question:

Should the SEDR and ED30 be added to the Star Rating?

Standardized Modality Switch Ratio (SMoSR)

Measure Definition: *Observed / Expected first switches from in-center to home dialysis modalities*

Population at risk: Incident in-center hemodialysis patients

Numerator: Observed number of first switches from in-center hemodialysis to a home dialysis modality (peritoneal dialysis or home hemodialysis) among eligible incident patients at the facility

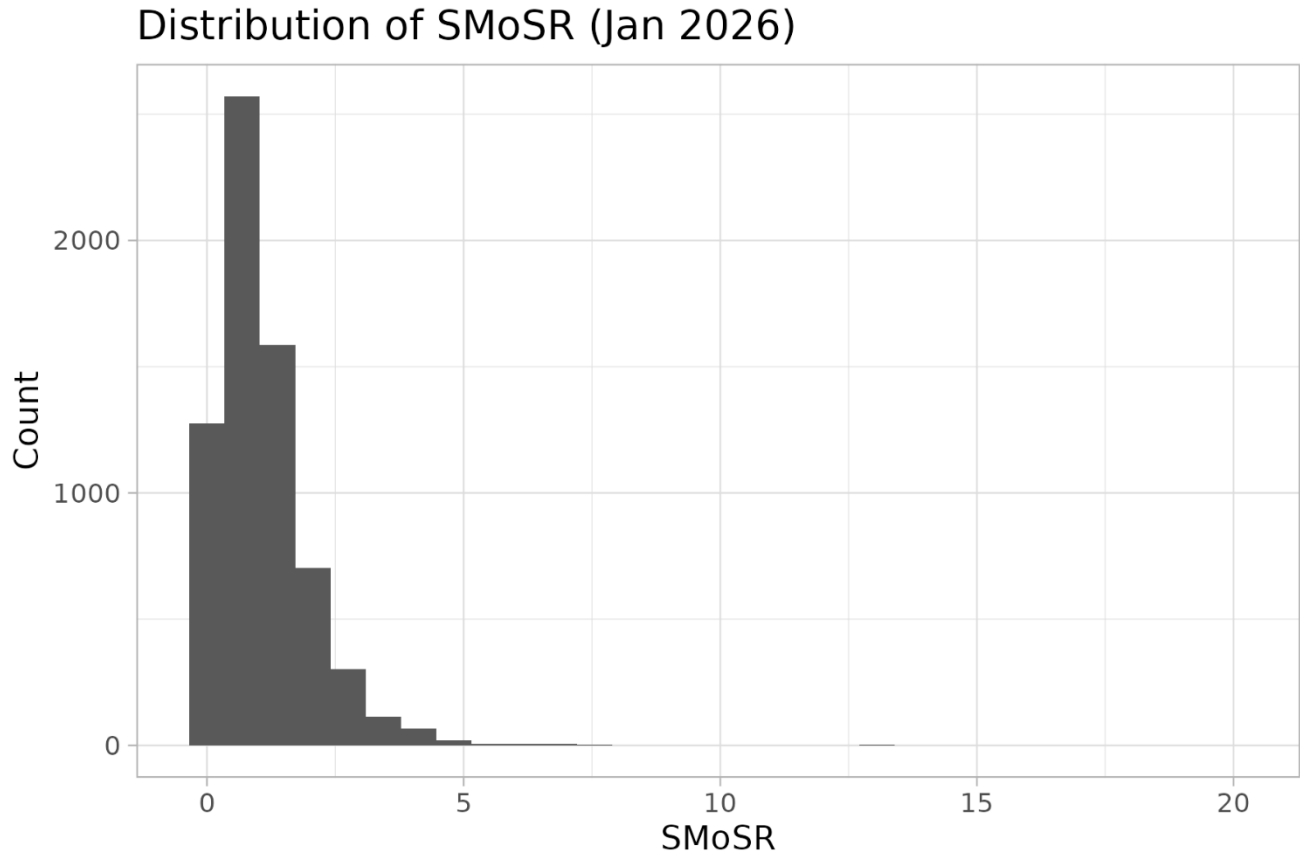
Denominator: Expected number of first modality switches from in-center to a home dialysis among eligible patients at the facility, given the national average of modality switches, and patient case-mix at the facility

Interpretation: Higher Score = Better Quality

Measure Type: Outcome

Note: SMoSR is calculated only for facilities with at least one expected modality switch in the reporting year

Standardized Modality Switch Ratio (SMoSR)



Min.	1st Qu.	Median	Mean	3rd Qu.	Max.	NA's
0	0.45	0.88	1.09	1.48	19.93	956



Addition of SMoSR

- Home dialysis is underutilized and the majority of patients continue to start in-center HD with a catheter
 - Alternative payment models (KCC) and ESRD Network activities have focused on home dialysis
 - Opportunities exist for facilities to help patients change modality
 - SMoSR is publicly reported on DFCC

Discussion question:

Should SMoSR be added to the Star Rating?

Public Comment Period

2:50pm EDT



KECC
UNIVERSITY OF MICHIGAN

Thank you for sharing you time and contributing your experiences and expertise to these TEP proceedings!

Next Steps:

- UM-KECC will review transcript of this meeting and draft the TEP summary. If we have questions about specific statements made, we may contact individuals to help us clarify the speaking point.
- After the draft TEP summary is completed, we will share with all TEP members for their review. We are committed to accurately include any insights you may have shared during the meeting. Please review and help us ensure that we have done so.
- Once consensus is reached about the accuracy of the TEP Summary, the document will be delivered to CMS for their consideration.

Appendix

Rebaselining vs. Resetting

When to Rebaseline:

- When measures are added or removed
- When current measures are updated

When to Reset:

- When the Star Rating distribution is significantly compressed
- When information provided is no longer useful in differentiating facility performance

Star Rating Agreement: January 2026 vs. October 2023

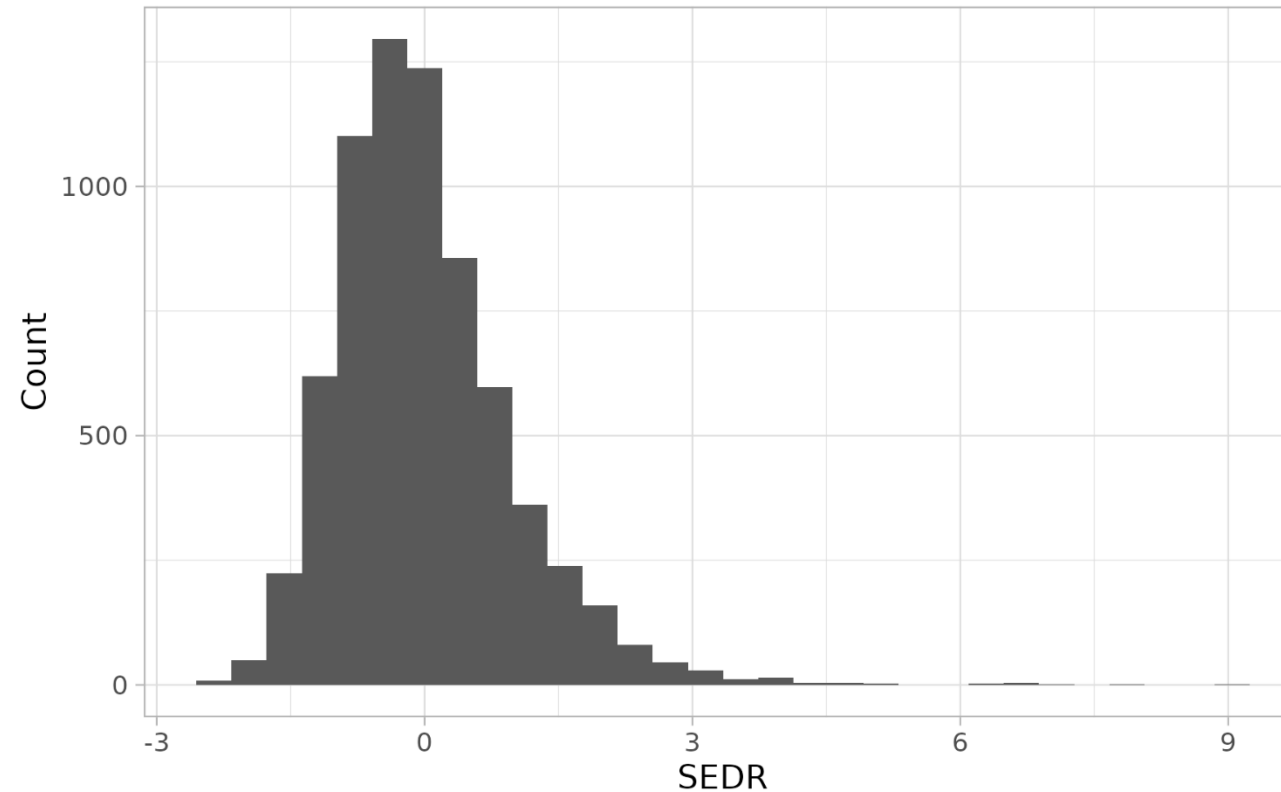
January 2026 Release

October 2023 Release		★	★★	★★★	★★★★	★★★★★
	★	430 (6.3%)	290 (4.2%)	148 (2.2%)	14 (0.2%)	0 (0%)
	★★	230 (3.3%)	588 (8.6%)	593 (8.6%)	80 (1.2%)	20 (0.3%)
	★★★	117 (1.7%)	586 (8.5%)	1455 (21.2%)	490 (7.1%)	99 (1.4%)
	★★★★	8 (0.1%)	64 (0.9%)	511 (7.4%)	419 (6.1%)	185 (2.7%)
	★★★★★	2 (<0.1%)	12 (0.2%)	102 (1.5%)	194 (2.8%)	235 (3.4%)



Standardized Emergency Department Encounter Ratio (SEDR) - Normalized

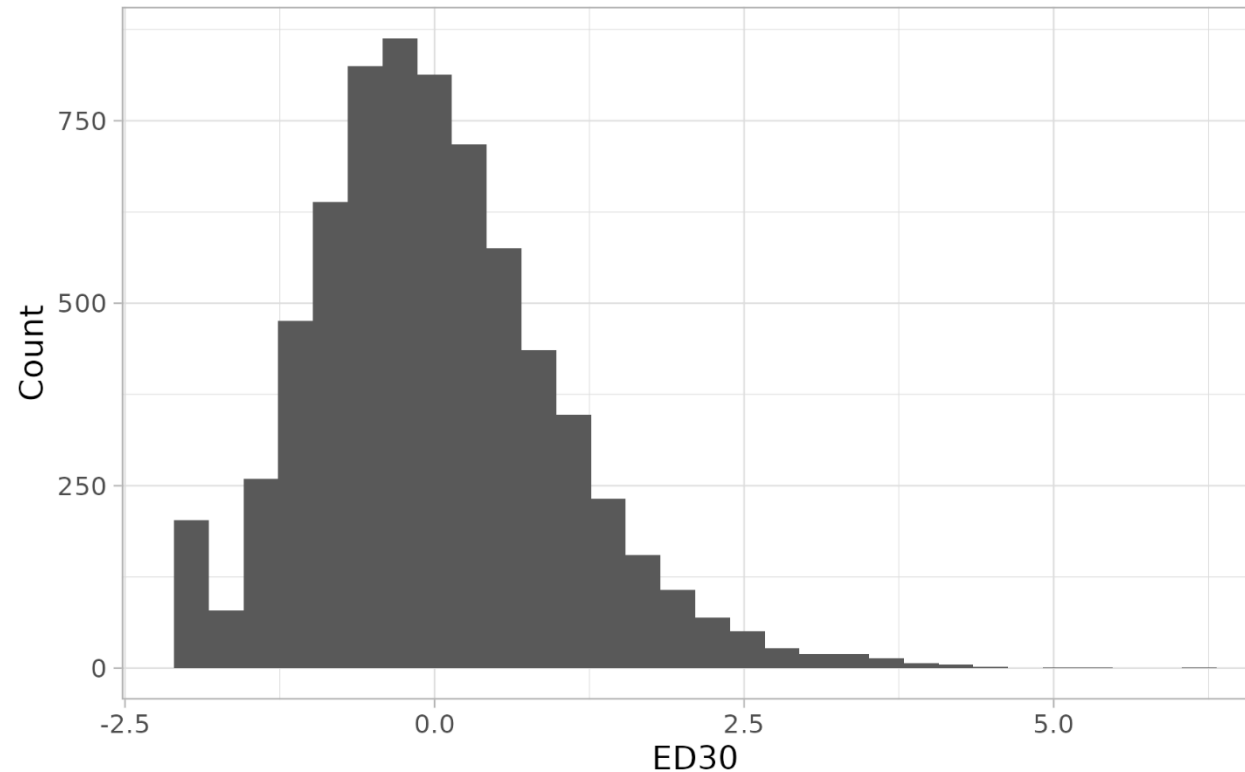
Distribution of SEDR (Jan 2026)



Min.	1st Qu.	Median	Mean	3rd Qu.	Max.	NA's
-2.3	-0.67	-0.15	0	0.49	9.1	664

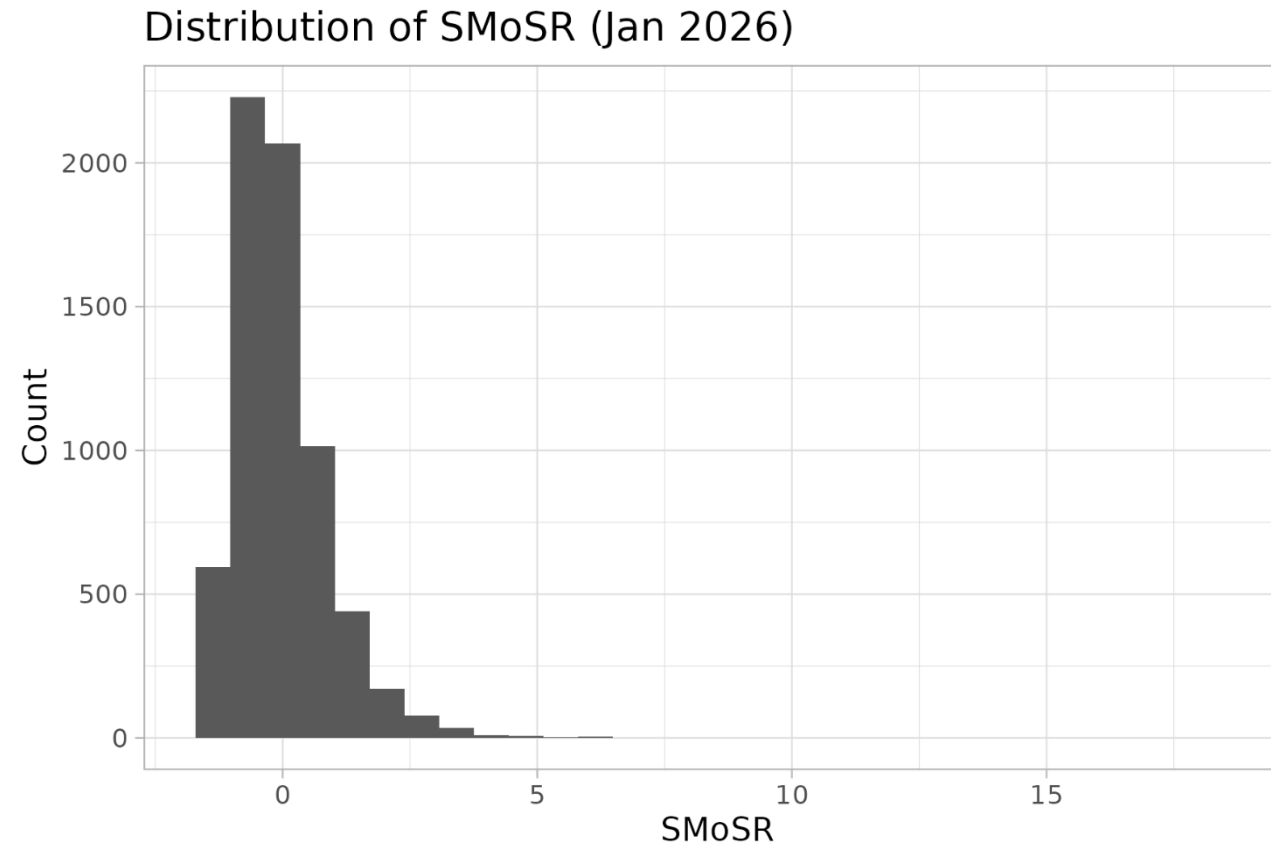
Standardized Ratio of ED Encounters Occurring Within 30 Days of Hospital Discharge (ED30) - Normalized

Distribution of ED30 (Jan 2026)



Min.	1st Qu.	Median	Mean	3rd Qu.	Max.	NA's
-1.99	-0.68	-0.09	0	0.57	6.15	677

Standardized Modality Switch Ratio (SMoSR) - Normalized



Min.	1st Qu.	Median	Mean	3rd Qu.	Max.	NA's
-1.08	-0.63	-0.21	0	0.39	18.73	956

ED Measures and the Role of Facilities

- Among the Medicare population, nearly a third of hospital admissions originating from the ED involve dialysis-related diagnoses
- There is an association between missed dialysis treatments and increased risk of ED visits
- Dialysis facility interventions to improve treatment schedule adherence may decrease ED utilization

SMoSR and the Role of Facilities

- Currently, home dialysis modalities are thought to be underutilized in the US
- Physicians and facilities play a crucial role in providing dialysis education to patients, which impacts modality selection
- More balanced and ongoing dialysis education for patients from physicians and facilities may allow more patients to make an informed decision to choose home dialysis

Measure Correlations

	SMR	STrR	SRR	SHR	SFR	LTC	Kt/V	Hyp	SWR	PPPW	ED30	SEDR	SMoSR
SMR	1	-	-	-	-	-	-	-	-	-	-	-	-
STrR	0.12	1	-	-	-	-	-	-	-	-	-	-	-
SRR	0.07	0.09	1	-	-	-	-	-	-	-	-	-	-
SHR	0.18	0.19	0.39	1	-	-	-	-	-	-	-	-	-
SFR	0.12	0.07	0.05	0.15	1	-	-	-	-	-	-	-	-
LTC	0.11	0.07	0.05	0.15	0.60	1	-	-	-	-	-	-	-
Kt/V	0.11	0.07	0.06	0.14	0.24	0.30	1	-	-	-	-	-	-
Hyp	0.09	0.03	0.02	0.07	0.25	0.29	0.58	1	-	-	-	-	-
SWR	0.07	-0.01	0.03	0.03	0.07	0.04	-0.03	-0.02	1	-	-	-	-
PPPW	0.11	0.02	0.01	0.05	0.15	0.07	-0.08	-0.02	0.41	1	-	-	-
ED30	-0.06	-0.01	0.05	0.10	0.02	0.01	0.03	0.04	-0.07	-0.09	1	-	-
SEDR	-0.11	-0.09	-0.01	-0.04	-0.03	-0.03	0.00	0.00	-0.09	-0.15	0.43	1	-
SMoSR	-0.06	-0.04	0.03	0.03	-0.03	-0.01	0.03	0.03	0.12	0.03	0.05	0.03	1

Considerations for Measure Set Changes

- Decisions to add new measures to the Star Rating are based on clinical relevance and stakeholder input
 - TEP discussion informs these decisions
- If the decision to add or remove measures is made, we will perform rebaselining to ensure continuity of the Star Rating distribution and factor analysis to determine domain structure of the new measure set

Logic Model: Facility Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients

Inputs	Activities	Outputs	Outcomes	Impacts
- Clinical guidelines (e.g., KDIGO MBD, CMS Conditions for Coverage) - Dialysis center staff (nephrologists, nurses, dieticians, social workers) - EHR systems and data analytics tools - Quality improvement team - Patient engagement resources (e.g., education materials, peer mentors)	- Regular measurement of serum phosphorus to identify patients with chronically elevated levels - Dietary Counseling: educate patients on nutritional strategies to lower phosphorus. - Use of phosphate binding medications and monitoring for adherence, side effects, pill burden. - Optimize dialysis adequate to improve phosphorus clearance. - Conduct monthly case reviews for patients with chronically elevated phosphorus.	- Number of patients receiving dietary counseling - Number of patients with elevated phosphorus who are prescribed phosphate binders - Adherence data with pharmacy refills - Quality dashboards showing hyperphosphatemia prevalence trends - Monthly case review summaries - Documentation of patient decisions/preferences	<u>Short-Term:</u> - Increased awareness among patients of phosphorus control. - Improved adherence with phosphate binders and nutrition plan. - Enhanced coordination among multidisciplinary team <u>Long-Term:</u> - Reduction in percentage of patients with chronic hyperphosphatemia - Enhanced patient satisfaction and engagement in care planning	- Decreased rates of cardiovascular events - Improvement in hospitalizations, bone fracture, and death - Reduced healthcare costs. - Improved patient quality of life

Logic Model: Standardized Emergency Department Ratio (SEDR)

Inputs	Activities	Outputs	Outcomes	Impacts
- Quality Improvement Staff (Medical Director, Nurse manager, Dietician Social Worker, RN/PCT) - Facility specific Policies and Procedures that reflect requirements in CMS' CfC 494 Conditions for Participation in the Medicare ESRD Chronic Dialysis Program - Clinical data systems (EHR, quality dashboards) - Clinic data reports (Dialysis Facility Reports, Dialysis Facility Care Compare)	- Assessment of current dialysis prescription (target weight; fluid removal rate; treatment length; BP control; control of electrolytes; adequacy of small solute clearance) - Identify high-risk patients and conduct root cause analysis for common ED visits (e.g. fluid overload, hyperkalemia, vascular access, shortened / missed treatments) - Adherence to Infection Prevention and Control Standards specified in CMS CfC494 and CDC - Reconcile medications after hospitalization or other outpatient visits - Deliver education to patients about when to obtain ED care vs. care at facility or by other providers and who they should call if questions or concerns arise between treatments - Conduct team meetings to discuss high risk patients with focus on avoiding ED encounters and strengthen staff communication between treatment sessions - Staff Training for consistent health maintenance over time, early symptom recognition and response, avoidable ED triggers, and alternative strategies.	- Root cause analysis report (proportion of ED encounters with dialysis related causes: fluid overload, vascular access, etc) - Records/logs of Staff Training in Infection Prevention - QAPI meeting output focusing on patient intradialytic adverse events (e.g. hypotension, hemorrhage) - Provider alerts or flags for high-risk patients - Reports on proportion of staff / patient education activities - Results of high-risk assessment; care management for other comorbidities - Results of medication review and reconciliation	<u>Short Term</u> Increased awareness among providers of avoidable ED visits Improved identification of high-risk patients Improved patient engagement <u>Medium-term</u> Decrease in avoidable ED visits Fewer missed/shortened dialysis treatments and blood stream infections Enhanced care coordination, staff communication, continuity of care, and use of preventative care strategies <u>Long-term</u> Sustained reduction in ED encounter rates Improved clinical outcomes (hospitalization and mortality) Sustained health maintenance	- Control escalating medical costs, support provision of cost-effective health care across inpatient and outpatient settings. - Fewer preventable emergency department visits can result in better quality of life for patients - Reduce strain on acute care providers



Logic Model: Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30)

Inputs	Activities	Outputs	Outcomes	Impacts
- Quality Improvement Staff (Medical Director, Nurse manager, Dietician Social Worker, RN/PCT) - Facility specific Policies and Procedures that reflect requirements in CMS' CfC 494 Conditions for Participation in the Medicare ESRD Chronic Dialysis Program - Clinical data systems (EHR, quality dashboards) - Clinic data reports (Dialysis Facility Reports, Dialysis Facility Care Compare)	- Assessment of current dialysis prescription (target weight; fluid removal rate; BP control; control of electrolytes; adequacy of small solute clearance) - Identify high-risk patients and conduct root cause analysis for common ED visits (e.g. fluid overload, hyperkalemia, vascular access, shortened / missed treatments) - Adherence to Infection Prevention and Control Standards specified in CMS CfC494 and CDC - Reconcile medications after hospitalization - Deliver education to patients about when to obtain ED care vs. care at facility or by other providers and who to contact if questions arise between treatments. - Conduct team meetings to discuss high risk patients with focus on avoiding ED encounters - Staff Training for avoidable ED triggers and alternative strategies. - Staff Training Programs for Infection Prevention	- Obtain patient discharge summary, see patient within 3 days of discharge - Results of post-discharge medication review; medication reconciliation - Update QAPI patient care plan if needed; follow-up appointments - Modify dialysis prescription if needed to maintain target Kt/V and support volume status - QAPI output evaluating facility-level status of electrolyte and other dialysis-specific laboratory test control (particularly potassium, magnesium, calcium, phosphorus, intact PTH) - QAPI output documenting rates of intradialytic morbidities (e.g. intradialytic hypotension, loss of consciousness, cardiac arrest, hemorrhage, etc)	<u>Short Term</u> - Increased awareness among providers of avoidable ED visits - Improved identification of high-risk patients - Improved patient engagement and education <u>Medium-term</u> - Reduced risk of return outpatient emergency encounters due to inpatient medication changes; increase in patients seen at the dialysis facility within 3days of discharge; fewer missed/shortened dialysis treatments and blood stream infections - Enhanced continuity of care and use of preventative care <u>Long-term</u> - Reduced overall average of unplanned outpatient emergency encounters that occur between 4-30 days (ED30) - Improved clinical outcomes (hospitalization and mortality)	- Control escalating medical costs, support provision of cost-effective health care across inpatient and outpatient settings. - Fewer preventable emergency department visits can result in better quality of life for patients - Reduce strain on acute care providers