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National Consensus Development and Strategic Planning for Health Care Quality Measurement

# Fall 2025 Cycle Endorsement Meeting Summary

## ADVANCED ILLNESS AND POST-ACUTE CARE COMMITTEE

**March 2026**

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# Fall 2025 Advanced Illness and Post-Acute Care Endorsement Meeting Summary

## Overview

Battelle, the consensus-based entity (CBE) for the Centers for Medicare & Medicaid Services (CMS), convened the Recommendation Group of the Advanced Illness and Post-Acute Care committee on February 9, 2026, for discussion and voting on measures under endorsement consideration for the Fall 2025 cycle. Meeting participants joined virtually through a Zoom meeting platform. Measure stewards/developers and members of the public also attended.

The objectives of the meeting were to:

- Review and discuss measures submitted to the committee for the Fall 2025 cycle;
- Review staff preliminary assessments, Advisory and Recommendation Group feedback, public comments, and developer responses regarding the measures under endorsement review; and
- Render endorsement decisions using a virtual voting platform.

The Recommendation Group voted to endorse four measures (Table 1). This summary provides an overview of the meeting, the Recommendation Group deliberations, and the endorsement decision outcomes. Full measure information, including all public comments, staff preliminary assessments, Advisory Group feedback, and committee independent reviews can be found on the project committee's webpage on the Partnership for Quality Measurement (PQM) website. In the discussion summaries below, the number of individuals who shared similar comments, feedback, and/or questions during the meeting is represented as "a few" (two to three individuals), "several" (four to six individuals), and "many" (more than six individuals).

After the endorsement meeting, measures and endorsement decisions enter an appeals period for 3 weeks, from February 25-March 17, 2026. Any interested party may submit an appeal, which Battelle will review for eligibility according to the criteria within the Endorsement and Maintenance (E&M) Guidebook. If eligible, the Appeals Committee, consisting of all co-chairs from the five E&M project committees, will convene to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.

## Welcome, Roll Call, and Disclosures of Interest

Brenna Rabel, MPH, PQM technical director, welcomed the attendees to the meeting and introduced the committee co-chairs, Soojin Jun, PharmD, BCGP, CPPS, CPHQ, patient co-chair, and Tipu Puri, MD, PhD, technical co-chair, who each provided welcoming remarks. The co-chairs' role is to summarize feedback from the Advisory Group for the Recommendation Group to consider during their deliberations. Additionally, the co-chairs confirm the proposed conditions placed on measures. They also actively engage with and support patient representatives on the committee. Battelle facilitators summarize the deliberations of the Recommendation Group and confirm any proposed conditions before proceeding to an endorsement vote.

Elena Hughes, MS, social scientist III, then conducted roll call, and members disclosed any perceived conflicts of interest regarding the measures under review. No members were recused from voting based on Battelle's conflict of interest policy.

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After roll call, Battelle staff established whether quorum was met and outlined the procedures for discussing and voting on measures. The discussion quorum requires the attendance of at least 60% of the active Recommendation Group members (n=10). Voting quorum requires at least 80% of active Recommendation Group members who have not recused themselves from the vote (n=14). Voting quorum was maintained for five of the six measures under review but lost for CBE #2979. Consequently, endorsement decisions were not finalized during the meeting. The Recommendation Group members who were present discussed the measures and submitted their endorsement votes. After the endorsement meeting, the E&M team shared the meeting recording with Recommendation Group members who were not present during the meeting and requested they submit their endorsement vote via an offline voting tool within 2 business days.

## Evaluation of Candidate Measures

Matthew Pickering, PharmD, E&M task lead, provided an overview of the five measures under review. For Fall 2025, the Advanced Illness and Post-Acute Care committee reviewed one new measure and four measures undergoing maintenance endorsement review (Figure 1). The measures focused on infection prevention control, kidney disease, risk-standardized mortality and transfusion.

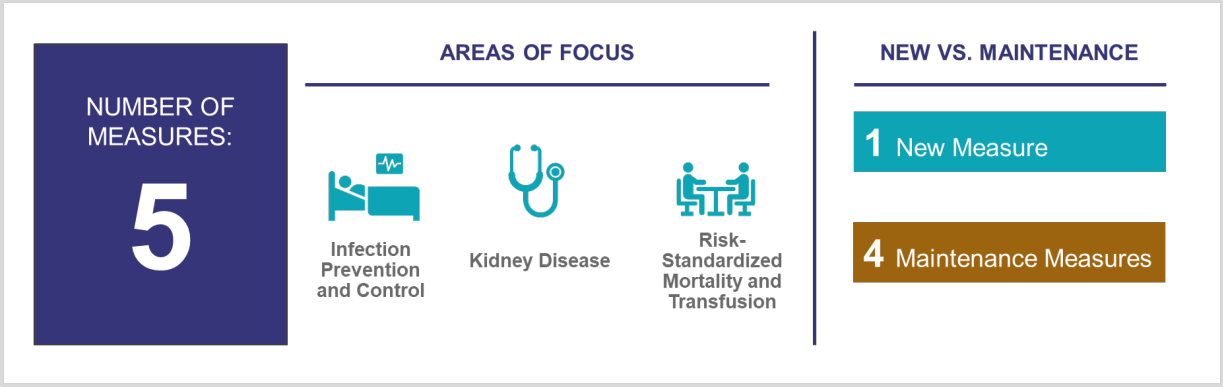


*Figure 1. Advanced Illness and Post-Acute Care Measures for Fall 2025*

Battelle convened a public Advisory Group meeting on December 3, 2025, to gather initial feedback and questions about the measures under endorsement review. Developers had the opportunity to provide additional clarifications following the Advisory Group meetings. Battelle then shared the Advisory Group feedback and questions, along with the developer/steward responses, with the Recommendation Group a week prior to the endorsement meeting.

On December 15, 2025, Battelle provided Recommendation Group members the full measure submission details for each measure up for review, including all attachments, the PQM Measure Evaluation Rubric, the public comments received for the measures under review, and the staff preliminary assessments.

Recommendation Group members conducted independent reviews for each measure against the PQM Measure Evaluation Rubric. Recommendation Group members assigned a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. In addition, Recommendation Group members provided associated rationales for each domain rating, which were based on the rating criteria listed for each domain. Battelle staff aggregated and summarized the results and distributed them back to the Recommendation Group and to the respective measure developers/stewards.

**Table 1. Fall 2025 Advanced Illness and Post-Acute Care Measure Endorsement Decisions[1]**

| CBE ID | Measure Title | New or Maintenance | Endorsement Decision | Endorse n (%) | Endorse with Conditions n (%) | Not Endorse/ Remove Endorsement n (%) | Recusals |
|---|---|---|---|---|---|---|---|
| #5320 | Percentage of Chronic Hyperphosphatemia in Dialysis Patients | New | Endorse | 13 (93%) | N/A | 1 (7%) | 0 |
| #2978 | Hemodialysis Vascular Access: Long-Term Catheter Rate (LTC) | Maintenance | Endorse | 15 (100%) | N/A | 0 (0%) | 0 |
| #1463 | Standardized Hospitalization Ratio for Dialysis Facilities | Maintenance | Endorse | 13 (87%) | N/A | 2 (13%) | 0 |
| #0369 | Standardized Mortality Ratio for Dialysis Facilities | Maintenance | Endorse | 11 (79%) | N/A | 3 (21%) | 0 |
| #2979 | Standardized Transfusion Ratio for Dialysis Facilities | Maintenance | Endorse | 16 (94%) | N/A | 1 (6%) | 0 |

[1] Percentages may not add up to 100%.

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## CBE #5320 – Percentage of Chronic Hyperphosphatemia in Dialysis Patients [University of Michigan Kidney Epidemiology and Cost Center (UM-KECC)/CMS]

Specifications | Comment Summary Guide

**Description:** Percentage of adult dialysis patients with a rolling average phosphorus value greater than or equal to 6.5 mg/dL and pediatric dialysis patients with a rolling average phosphorus value greater than or equal to 7.0 mg/dL.

**Committee Vote:** Endorse

**Vote Count:** Endorse (13 votes; 93%), Do Not Endorse (1 vote; 7%), Recusals (0).

**Advisory Group Comments:** The Advisory Group:

- Asked whether the End Stage Renal Disease Quality Reporting System (EQRS) is used as a data source and why significant variation exists across facilities.
- Expressed concerns about the thresholds (6.5 mg/dL adult; 7 mg/dL pediatric) and potential nutrition-related unintended consequences.
- Inquired about rolling average rules, number of measurements required, and proportion of patients who remain above the threshold.
- Called for the consideration of facility levers (e.g., dialysis adequacy/prescription, diet counseling, and phosphate binders) against patient pill burden and nutrition trade-offs.
- Expressed concern that the measure focuses on lab values rather than clinically important outcomes (e.g., cardiovascular, bone disease).
- Expressed concerns about validity, including risk adjustment adequacy and whether phosphorus reduction accurately reflects patient outcomes.

**Public Comments:** Battelle received one comment from the American Society of Nephrology (ASN) prior to the meeting. ASN suggested adding exclusions such as 1) expected life span of < 6 months who are not enrolled in hospice and 2) patients bridging to a transplant that is expected within 6 months. They suggested incorporating a definition of frailty, similar to how CMS approached community-based elder care models.

**Measure Discussion:**

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Importance** | • A patient partner expressed support for the measure, noting that greater specificity in treatment recommendations and thresholds helps facilities maintain consistent care. |
| **Phosphorus Threshold** | • A committee member asked for clarification on the strength of evidence supporting the threshold (e.g., 6.5 mg/dL and 7.0 mg/dL), given the absence of randomized controlled trials in this area.<br>• The developer explained that decades of large observational studies have consistently shown that higher phosphorus levels are associated with increased cardiovascular morbidity and mortality among dialysis patients.<br>• The developer indicated that the technical expert panel (TEP) |

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| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| | elected the 6.5 mg/dL, 6-month average threshold for adults because it identifies a high-risk group with clearly demonstrated adverse outcomes. The developer emphasized that clinical practice generally targets <5.5 mg/dL and that the measure threshold identifies elevated risk rather than a recommended clinical goal.<br>• A few committee members noted that 20% of patients are chronically above the phosphorus threshold, with one member asking whether the developer had examined characteristics of these patients for potential insights.<br>• The developer explained that stratified analysis of this subgroup had not been completed. |
| **Nutrition-Related Risks and Exclusion Criteria** | • A committee member discussed potential unintended consequences of the measure, particularly regarding its impact on patients at nutritional risk (i.e., patients with indicators suggesting they are at risk for malnutrition). They asked whether the measure excludes patients who could experience harm from dietary phosphorus restriction.<br>• The developer explained that adults with low serum albumin (less than 3.5 mg/dL) or very low body mass index (BMI) are excluded from the measure, as these indicators reflect high nutritional vulnerability.<br>• The committee member asked whether more advanced nutrition measures (e.g., protein catabolic rate) could be used to refine exclusions.<br>• The developer stated these data are not available across all payer types, limiting feasibility. |
| **Pill Burden, Patient Adherence, and Dialysis Modality** | • A committee member asked whether the measure applies across all dialysis modalities, including in-center hemodialysis, home hemodialysis, and peritoneal dialysis. The developer confirmed that this was correct.<br>• The same committee member, noting personal caregiving experience, raised concerns regarding high pill burden and the potential impact on patient adherence.<br>• The developer acknowledged that pill burden can be substantial, with some patients taking up to 18 phosphate binders per day, depending on dietary habits.<br>• The developer explained that dialysis facilities may face trade-offs between reducing pill burden and managing the cost of higher-potency binders under the end stage renal disease (ESRD) payment model. Effective phosphorus management requires comprehensive strategies including dietitian support and optimization of dialysis prescriptions. |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Dialysis Time and Patient Burden** | • A patient partner asked whether the mix of the dialysis solution used in hemodialysis affects phosphorus levels.<br>• The subject matter expert (SME) explained that dialysate does not contain phosphorus and therefore cannot be altered to remove more phosphorus; instead, treatment duration is the primary mechanism for phosphorus reduction.<br>• The SME noted that increasing treatment time is burdensome and typically met with resistance from patients.<br>• Another committee member added that phosphorus rapidly re-equilibrates after dialysis, making it difficult to achieve substantial reductions from dialysis alone and reinforcing the need for combined approaches such as diet modification and binder therapy.<br>• The patient partner shared a personal experience of an extended dialysis session, which improved both well-being and phosphorus control. |
| **Validity and Risk Adjustment** | • The Battelle facilitator noted that the validity domain rating reflected concerns about the lack of risk adjustment.<br>• The patient co-chair noted that another patient partner had specifically asked the developer to consider race and sex as potential variation factors. The developer confirmed that these variables had been evaluated.<br>• The developer explained that analyses examining race and sex at the patient level produced inconsistent or unexpected results, and facility-level analysis showed no meaningful change in results when risk adjustment was applied. Given these findings, the TEP determined that risk adjustment was not appropriate for this measure. |

**Committee members who voted to remove endorsement cited the following key concerns:**

- There is more work to be done to improve validity of the measure.
- This appears to be a surrogate marker for dialysis quality, but the threshold marker is not clearly associated with poor clinical outcomes.

## CBE #2978 – Hemodialysis Vascular Access: Long-Term Catheter Rate (LTC) [UM-KECC/CMS]

Specifications | Comment Summary Guide

**Description:** Percentage of adult hemodialysis patient-months using a catheter continuously for three months or longer for vascular access.

**Committee Final Vote:** Endorse

**Vote Count:** Endorse (15 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

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**Advisory Group Comments:** The Advisory Group:

- Noted a 50% rise in long-term catheter use (2018–2022) and suggested this may reflect shared decision-making and patient preferences.
- Requested clearer definitions of long-term catheter use.
- Sought clarification on how exclusions serve as proxies for patient choice or exhausted access options.
- Raised concerns about rising long-term catheter use, including roles of patient preference, aging population, and access limitations.
- Asked about whether financial factors and access to specialists may influence catheter decisions and persistence.
- Expressed concern that expanded exclusions (age ≥85, 1000 days on dialysis + sole catheter) may reduce applicability or fairness but could help protect against coercion.
- Discussed whether dialysis facilities are the appropriate accountable entity, given the role of vascular/transplant surgeons and referral coordination.

**Public Comments:** Battelle received one comment from ASN prior to the meeting. ASN suggested adding exclusions such as 1) expected life span of < 6 months who are not enrolled in hospice 2) patients bridging to a transplant that is expected within 6 months. They suggested incorporating a definition of frailty, similar to how CMS approached community-based elder care models.

**Measure Discussion:**

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Importance and Measure Refinement** | • A patient partner stated that, based on what they had read, the measure "seems okay."<br>• The patient partner emphasized that implementing a measure is an iterative process that will likely require ongoing evaluation and adjustments as care delivery evolves. |
| **Access to Vascular Surgeons and Impact on Vascular Access Outcomes** | • A patient partner raised concerns about limited access to vascular surgeons, emphasizing that vascular access outcomes can be heavily influenced by the skill and availability of these specialists.<br>• The patient partner shared personal experience related to limited access to a high-quality vascular surgeon, noting that once they had access to a skilled surgeon, their long-term outcomes greatly improved. They described this disparity as a major real-world barrier to optimal vascular access, stating that it is unclear how a measure can account for such geographic and workforce variation.<br>• Another patient partner supported this perspective, describing similar experiences with high variability in surgeon quality across multiple states where they had lived and received vascular access procedures. They stressed that surgeon expertise has a direct effect on the durability, safety, and overall success of vascular access for dialysis patients.<br>• The same patient partner emphasized the need for more vascular |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| | surgeons in high-need areas to ensure equitable access to high-quality care. |
| **Catheters vs. Grafts and the Role of Patient Choice** | • A patient partner shared their perspective that in their extensive personal experience across several states, they believe catheters are often safer and more feasible than grafts. They expressed concerns about grafts and their long-term risks and encouraged the measure developer to consider these lived experiences more directly.<br>• A few committee members discussed the evidence base supporting the use of grafts over catheters. A committee member acknowledged that catheters may be essential for patients who "crash" into dialysis but emphasized that long-term use generally leads to poorer outcomes than transitioning to fistulas or graft. The same committee member raised whether patients nearing kidney transplant may warrant special consideration or exclusion, given that they may not benefit from switching access types shortly before transplant.<br>• The developer explained that the measure includes a pathway to respect patient choice. After a defined period, a patient maintaining a catheter by preference would be excluded from the measure to avoid penalizing facilities for honoring patient autonomy.<br>• The developer framed the revisions to the measure as explicit efforts to reflect patient voice and choice in vascular access decision-making. |
| **Exclusions** | • A committee member asked whether recommended exclusions suggested by ASN in their public comment (e.g., excluding patients with limited life expectancy or those imminently awaiting transplant) should be incorporated into the measure and how such decisions should be operationalized.<br>• Another member asked whether these exclusions were even feasible given available data sources.<br>• The developer stated that, while the recommended exclusions are conceptually reasonable, they are difficult to implement because no available data source reliably identifies patients with limited life expectancy or estimated time to transplant.<br>• The developer expressed concern that asking clinicians to predict life expectancy could introduce errors and administrative burden.<br>• The developer also explained that short-term dialysis before transplant (under 3 months) is already excluded because of how the measure is structured, but longer intervals remain difficult to capture.<br>• The Battelle facilitator asked whether being enrolled in hospice could be used.<br>• The developer agreed hospice enrollment is a feasible exclusion, though such data are not consistently available for all payer types. |

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## CBE #1463 – Standardized Hospitalization Ratio for Dialysis Facilities (SHR) [UM-KECC/CMS]

Specifications | Comment Summary Guide

**Description:** The standardized hospitalization ratio is the ratio of the number of hospital admissions that occur for Medicare ESRD dialysis patients (both Fee For Service and Medicare Advantage) treated at a particular facility to the number of hospitalizations that would be expected given the characteristics of the dialysis facility's patients and the national norm for dialysis facilities. This measure is calculated as a ratio but can also be expressed as a rate.

**Committee Vote:** Endorse

**Vote Count:** Endorse (13 votes; 87%), Remove Endorsement (2 votes; 13%), Recusals (0).

**Advisory Group Comments:** The Advisory Group:

- Asked whether the data sources are standard practice and whether they apply to pediatric and non-Medicare patients.
- Shared methodological concerns similar to those expressed for CBE #0369, regarding reliability and selection bias.
- Raised questions about whether SHR accounts for advance care planning (Physician Orders for Life-Sustaining Treatment /Medical Orders for Life-Sustaining Treatment), which influences hospitalization.
- Suggested measuring reasons for hospitalization or distinguishing potentially avoidable versus all-cause events.
- Pointed out confusion in public reporting thresholds (sample size differences) and confidentiality criteria.
- Questioned why length of stay is not incorporated into the hospitalization count.
- Raised concerns about the role of socioeconomic and systemic factors contributing to hospitalization risk.

**Public Comments:** Battelle received one comment from ASN prior to the meeting. ASN suggested implementing a more rigorous risk adjusted-hospitalization rate measure, as conditions distinct from kidney disease are often drivers of hospitalizations for patients with dialysis. They indicated that this measure should be modified to be a true risk-standardized rate as opposed to a ratio.

**Measure Discussion:**

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Importance and Measure Scope** | • A patient partner indicated that this measure is important for monitoring and improvement, provided that systems follow through with necessary actions, including collaboration among clinics, hospitals, and patient advocates.<br>• The same patient partner shared their experience with kidney disease and discussed several reasons patients may rely heavily on hospital care. They noted that some hospitalizations stem from patients not wanting or not being able to complete certain |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| | recommended actions, or from frustration and distrust toward clinical staff or systems.<br>• The patient partner also emphasized that transportation difficulties and lack of support navigating care logistics can also contribute to higher hospitalization rates, as patients struggle to maintain regular attendance at dialysis centers.<br>• Another patient partner indicated they were struck by the measure's detail and found the hospitalization and transfusion data to be impressive in scope.<br>• This patient partner noted that seeing a 1.5 admissions per patient per year rate for patients in the highest decile was "shocking" and emphasized how serious hospitalizations are in the dialysis population.<br>• A committee member noted that dialysis patients face high hospitalization risks but that dialysis-related interventions (e.g., dialysis adequacy, dietitian and social worker support, anemia management, vascular access management, patient education, and adherence support) can reduce them.<br>• Another committee member noted that literature on patient importance seems limited and asked how the committee should weigh this.<br>• The developer acknowledged limited literature but stressed that, based on clinical experience and patient preference, avoiding hospitalization is strongly aligned with patient goals. |
| **Reliability** | • The Battelle facilitator noted that reliability was rated "Not Met" for this measure, with only about 20% of facilities meeting the expected threshold of 0.6, though many committee members felt the issue was addressable. The Battelle facilitator asked the developer whether the mitigation strategies previously described (i.e., small facility adjustments, measure-domain composites, etc.) should be required in any program using the measure.<br>• The developer confirmed that these mitigation strategies should be used when the measure appears in any accountability program, especially for smaller facilities. |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Care Management and Facilities Role in Preventing Hospitalizations** | • A committee member asked about best practices for care management investment and whether staffing ratios or outreach efforts are incentivized to reduce preventable hospitalizations.<br>• The SME explained that across Medicare, Medicare Advantage (MA), and commercial payers, dialysis reimbursement is tied to each treatment session, creating a strong operational and financial incentive for facilities to reduce missed treatments. The SME emphasized that dialysis facilities universally focus on missed treatments, but transportation is difficult because federal regulations classify transportation assistance as a potential inducement, limiting what facilities can do directly.<br>• The SME added that no single randomized trial identifies a definitive checklist for reducing all-cause hospitalizations; instead, improvement requires a multifaceted strategy addressing fluid management, vascular access, comorbidities, medications, and staffing models.<br>• A patient partner added that many of these supportive services are not reliably provided in real-world clinics, citing long waits for transportation, high staff turnover, and inconsistent understanding of dialysis patients' needs. They emphasized that the impact on patients is profound and systemic. |
| **Validity and Driving Improvement** | • A committee member asked why the validity correlations are small to moderate. They also asked whether facilities are actually using drill-downs to improve.<br>• Another member noted that hospitalization is a system-wide issue and that hospitals have long used similar measures successfully to drive behavior change; dialysis should be no exception.<br>• The developer explained that correlations are directionally correct, but dialysis facilities vary; some excel in certain domains and struggle in others, reducing correlation strength.<br>• The developer clarified that dialysis facilities are required to conduct Quality Assessment & Performance Improvement (QAPI) reviews, including root-cause analysis of hospitalizations.<br>• The developer highlighted that ESRD Networks and alternative payment models (Comprehensive ESRD Care, ESRD Treatment Choices) have historically driven improved cultural practices such as actively rescheduling missed treatments to prevent clinical decline. |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Case-by-Case Variation and Context** | • A patient partner reiterated that their concerns were not about the measure's concept but about the complexity of individual patient situations, which can make hospitalizations appear preventable when they may not be.<br>• The partner emphasized that many hospitalizations arise from case-specific circumstances, complicated clinical situations, or socio-environmental factors not captured in the measure.<br>• The patient partner reiterated that patients' lived experiences should be seriously considered in interpreting measure results. |
| **Weighing Reliability, Validity, and Importance** | • A patient partner reflected that the emotional weight of dialysis and repeated hospitalizations makes these measures feel very serious to patients. They stated that despite discomfort, there is value for dialysis centers in examining hospitalization rates because several causes (e.g., hyperkalemia, inadequate dialysis prescriptions) are within their control. The partner expressed support for the measure, acknowledging it is a broad measure but one that smart dialysis units can meaningfully use.<br>• A few committee members discussed the tension between reliability/validity concerns and the importance of the measure. One committee member concluded the mitigation strategies and clinical importance outweighed the limitations.<br>• A committee member expressed concerns about how measures evolve over time and how valid clinician frustrations often stem from issues with reliability and case applicability.<br>• The SME explained that limitations in reliability are primarily due to small sample sizes, which cannot be modified without shifting the unit of analysis. They noted that discarding the measure due to reliability constraints would risk eliminating most dialysis outcome measures, ultimately harming public health visibility.<br>• A committee member added that because dialysis centers are similar in size, small-sample variation is shared across facilities, and differences in performance still reflect meaningful differences in care. |

**Committee members who voted to not endorse the measure cited the following key concerns:**

- For the reliability and validity concerns raised.
- The measure needs to be more focused.

## CBE #0369 – Standardized Mortality Ratio for Dialysis Facilities [UM-KECC/CMS]

Specifications | Comment Summary Guide

**Description:** The Standardized Mortality Ratio (SMR) is defined as the ratio of the number of deaths that occur for Medicare end stage renal disease (ESRD) dialysis patients (both Fee For Service and Medicare Advantage) treated at a particular facility to the number of deaths that

would be expected given the characteristics of the dialysis facility's patients and the national event rate for dialysis facilities. This measure is calculated as a ratio but can also be expressed as a rate.

When used for public reporting, the measure calculation will be restricted to facilities with at least three expected deaths in the reporting year. This restriction is required to ensure patients cannot be identified due to small cell size.

**Committee Vote:** Endorse

**Vote Count:** Endorse (11 votes; 79%), Remove Endorsement (3 votes; 21%), Recusals (0).

**Advisory Group Comments:** The Advisory Group:

- Sought clarification on several issues, including:
  - Why is public reporting limited to facilities with ≥3 expected deaths?
  - What are the exclusions related to accidental or overdose deaths?
  - How does the measure reflect actions facilities can take to reduce mortality?
  - How are patient data collected, stored, and protected, emphasizing privacy requirements?
  - Is quality of life considered or risk-adjusted for in the measure?
  - How does the measure handle hospice enrollment and dialysis withdrawal?
  - What are the mortality performance trends over time?
  - What are the age groups included and how are pediatric/non-Medicare patients handled?
- Expressed concern about selection bias, particularly facilities avoiding high-risk patients.
- Raised concern about low reliability, particularly for small facilities, noting inter-unit reliability well below preferred thresholds.

**Public Comments:** Battelle received one comment from ASN prior to the meeting. ASN supported using the measure for dialysis facilities but recommends excluding deaths from voluntary withdrawal and converting the metric to a true risk-standardized rate for accurate benchmarking and quality improvement, as opposed to a ratio.

**Measure Discussion:**

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Interpretability and Actionability for Patients** | • One patient partner stated that this was the one measure in the set they could not support, explaining that it does not add value to how dialysis centers operate or improve care.<br>• They expressed concern that the measure is too broad and that, compared with measures like hospitalization or transfusion, mortality is less directly tied to care processes that facilities can influence.<br>• The patient partner also noted that small sample sizes make mortality unreliable even when standardized, and they questioned whether centers would have enough data to interpret performance meaningfully.<br>• They also emphasized the emotional impact of publicly reported |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| | mortality data, noting that many patients have no practical choice in dialysis center, making such statistics concerning rather than actionable.<br>• The developer explained that mortality has been a core dialysis quality measure for decades, prioritized by stakeholders during the development of Dialysis Facility Care Compare.<br>• They acknowledged that mortality differs from hospitalization or transfusions because it is a one-time event but emphasized that dialysis facilities are expected to review each patient death, assess root causes, and identify whether processes such as infection control, fluid management, or potassium management require improvement.<br>• The developer gave examples of facility-level actions that could reduce mortality, such as addressing sepsis patterns, tightening infection control procedures, improving fluid removal protocols, or preventing hyperkalemia. |
| **Drivers of Mortality and Structural Barriers** | • A patient partner stated that even good clinics struggle with communication across staff, which can affect what patients are told and ultimately affect outcomes.<br>• They explained that mortality is inherently difficult to control because patients face diverse challenges, may lack support, and may resist recommended interventions, regardless of facility quality.<br>• The patient partner emphasized that measure data do not always reflect real-world experiences, including inconsistencies in staff expertise, patient support, and follow-through.<br>• They stressed that patients often "perish for lack of knowledge or lack of help," highlighting the non-clinical drivers of mortality that a measure cannot fully capture.<br>• The patient partner stated that mortality is deeply personal and that the measure needs additional elements to be meaningful to patients. |
| **Mortality versus Targeted Measures** | • A patient partner reiterated that mortality is a gross measure, insufficiently specific to guide improvement and overshadowed by numerous other quality indicators that can more precisely drive change.<br>• They gave examples of dangerous fluid removal practices they witnessed in dialysis clinics, arguing that mortality may be the outcome but the actual root problem is better measured through targeted quality indicators.<br>• The patient partner noted that clinics often lack sufficient staffing to respond promptly when patients show early signs of distress, and worried that a mortality measure cannot capture variations in staffing or responsiveness. |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Validity and Risk Adjustment** | • The Battelle facilitator asked the developer to elaborate on validity evidence, including calibration, variation across entities, and the robustness of the risk-adjustment model.<br>• The developer explained that calibration modeling was conducted, comparing expected vs. observed mortality by decile, and found that the model is well-calibrated.<br>• The developer added that the same risk-adjustment strategy used in the hospitalization measure is used here, acknowledging natural variation in comorbidity distributions across facilities. |
| **Importance of Assessing Mortality** | • The Battelle facilitator noted that the measure is currently endorsed, prompting consideration of whether eliminating it might create harm or remove important signals from public reporting.<br>• A committee member explained that mortality differences across centers may indicate serious quality issues that warrant investigation, even if mortality is broad.<br>• They added that a mortality measure allows facilities to compare themselves with peers and identify areas needing improvement, prompting internal review and targeted drill-downs.<br>• A patient partner noted that patients often want to know why mortality differs between centers, similar to how patients consider hospital mortality data when choosing care. |

**Committee members who voted to remove endorsement cited the following key concerns:**

- The reliability results are not where they should be for a measure seeking re-endorsement. The measure would be better off as a quality improvement measure given the variables that can affect the measure score.
- The measure is too broad to be meaningful to dialysis centers and patients may have strong reactions to the measure.

## CBE #2979 – Standardized Transfusion Ratio for Dialysis Facilities [ UM-KECC/CMS]

Specifications | Comment Summary Guide

**Description:** The risk adjusted facility level Standardized Transfusion Ratio (STrR) is specified for all adult dialysis patients. It is a ratio of the number of eligible red blood cell transfusion events observed in patients dialyzing at a facility, to the number of eligible transfusion events that would be expected under a national event rate, after accounting for the patient characteristics within each facility.

**Committee Vote:** Endorsed

**Vote Count:** Endorse (16 vote; 94%), Remove Endorsement (1 vote; 6%), Recusals (0).

**Advisory Group Comments:** The Advisory Group:

- Requested clarification of the 10 patient-years at risk threshold and how reporting minimums differ across ESRD measures.
- Expressed reliability concerns similar to those for CBE #0369.
- Sought clarity on facility accountability for anemia management vs. physician decision-making.
- Suggested considering patients' clinical trajectory (e.g., near transplant) or advance care planning in transfusion likelihood.
- Questioned the relevance of the measure, since transfusions often occur for reasons outside dialysis control (e.g., GI bleed).
- Asked how the measure reflects or monitors adherence to transfusion guidelines.
- Highlighted general concerns about data quality and transfusion data completeness.

**Public Comments:** Battelle received one comment from ASN prior to the meeting. ASN argued the importance of recognizing that the need for blood transfusions is often unrelated to kidney disease, which are not under the purview of the dialysis facility. They argued that available data on transfusions are of low reliability, which compromises the accuracy and interpretability of the measure. They stated that the measure should be modified to true risk-standardized rate.

**Measure Discussion:**

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Transplant-Related Data Challenges** | • A patient partner asked why it is difficult to gather transplant-related data, referencing prior comments about data limitations in earlier measures.<br>• A committee member explained that, although it is possible to know whether a patient is listed for transplant, it is very difficult to know how close they are to receiving a transplant, because timing is unpredictable and influenced by numerous clinical and system-level factors. |
| **Usability** | • The Battelle facilitator asked the developer to address Advisory Group comments requesting examples of quality improvement initiatives tied to transfusion management.<br>• The developer explained that anemia management is a highly iterative process in dialysis facilities, driven by the clinical importance of maintaining adequate hemoglobin levels and the cost and implications of using erythropoiesis-stimulating agents (ESA) medications.<br>• The developer emphasized that strong anemia management reduces transfusion risk, particularly important for patients awaiting transplant, who face sensitization risks following transfusion.<br>• The developer explained that facilities actively monitor average hemoglobin levels and make individualized medication adjustments to minimize transfusion likelihood, especially given the impact of acute hospitalizations.<br>• The developer described specific components of robust anemia |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| | management: monitoring iron stores, resuming medications after hospitalization, investigating low responsiveness to ESAs, and evaluating underlying causes of low hemoglobin. |
| **Long-Term Trends in Transfusion Rates** | • A patient partner reflected on past work related to Medicare funding changes and noted that transfusion data from those periods appeared lower today than in 2021, asking why rates might have decreased.<br>• A committee member explained that historically, ESAs were billed separately and therefore used more widely; when ESAs were bundled into the dialysis payment system, their use declined due to cost considerations.<br>• They added that guideline updates demonstrated that higher hemoglobin targets can be harmful, contributing to lower ESA use and shifts in transfusion practices.<br>• The committee member also noted that blood supplies are limited, and thresholds for when transfusions occur have decreased over time, leading to lower overall transfusion rates. |
| **Focus on Patient Outcomes** | • A committee member highlighted that this set of dialysis measures undergoing committee review is heavily oriented toward patient outcomes, aligning with patient concerns voiced earlier in the meeting.<br>• They noted that outcome measures, including transfusion, hospitalization, and mortality, reflect what happens to patients, even when the precise drivers are complex.<br>• The committee member contrasted historical reliance on process measures with the shift toward outcome measures, explaining that outcomes are more meaningful to patients and easier for them to understand.<br>• They added that outcome metrics can motivate facilities to take quality seriously because payment and public reporting are tied to them.<br>• The committee member expressed willingness to tolerate some uncertainty in reliability and validity because outcome measures prompt needed attention to patient experience and because more than half of Medicare beneficiaries are in MA plans, which previously were not included in this measure. |

| Discussion Topic/Theme | Recommendation Group Discussion |
|---|---|
| **Reliability and Validity** | • The Battelle facilitator invited the developer to address public comments from ASN asserting low reliability of transfusion data.<br>• The developer clarified that the program's methods for identifying transfusion events, particularly those occurring in hospitals, are robust, having undergone multiple refinement cycles.<br>• They explained that uncertainty may relate to the IUR, which the committee had discussed across all outcome measures, but emphasized the accuracy of transfusion capture itself.<br>• The developer also stated that the calibration process for the transfusion model showed strong alignment between predicted and observed values. |

**Committee members who voted to remove endorsement cited the following key concerns:**

- Low reliability should not be overlooked, even when a measure appears potentially important. Unreliable results may signal a risk of poor outcomes if centers develop improvement plans based on data that cannot be trusted; interventions based on such data may lead to ineffective actions or, at best, outcomes with little meaningful impact. Moreover, combining the measure with others does not improve its reliability. Poor reliability driven by small patient populations in some dialysis centers is unlikely to be mitigated through composite or combined measures, since those outcomes (such as STAR measures) are likely to be affected by the same patient population size limitations.

## Next Steps

Battelle staff shared that they would publish a meeting summary by March 9, 2026. The appeals period will run from February 25-March 17, 2026. If an eligible appeal is received, the appeals committee will meet on March 31, 2026, to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.

# Appendix A: Acronyms

Please note: The following list encompasses acronyms that Battelle commonly encounters and uses in its work as a CBE. Not all the acronyms will appear in this document.

| Acronym | Definition |
|---|---|
| ACA | Affordable Care Act |
| ACC | American College of Cardiology |
| ACO | Accountable Care Organization |
| AGC | After Government Contract |
| AHIP | America's Health Insurance Plans |
| AHRQ | Agency for Healthcare Research and Quality |
| AI | Artificial Intelligence |
| AIPAC | Advanced Illness and Post-Acute Care |
| AIR | American Institutes for Research |
| ANOVA | Analysis of Variance |
| ASCO | American Society of Clinical Oncology |
| ASCQR | Ambulatory Surgical Center Quality Reporting Program |
| ASCs | Ambulatory Surgical Centers |
| C&E | Advanced Illness and Post-Acute Care |
| CAH | Critical Access Hospital |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems |
| CBE | Consensus-Based Entity |
| CBE ID | Consensus-Based Entity Identification |
| CDC | Centers for Disease Control and Prevention |
| CDS | Clinical Decision Support |
| CDSS | Clinical Decision Support System |
| CIS | Clinical Information Systems |
| CMIT | CMS Measures Inventory Tool |
| CMMI | Center for Medicare and Medicaid Innovation |
| CMS | Centers for Medicare & Medicaid Services |
| CO | Contracting Officer |
| COIs | Conflicts of Interest |
| COR | Contracting Officer's Representative |

| Acronym | Definition |
|---|---|
| CPG | Clinical Practice Guidelines |
| CQL | Clinical Quality Language |
| CQM | Clinical Quality Measure |
| CQMC | Core Quality Measures Collaborative |
| CSAC | Consensus Standards Approval Committee |
| DEL | CMS Data Element Library |
| Del. | Deliverable |
| DOI | Disclosure of Interest |
| dQMs | Digital Quality Measures |
| DRC | Direct Reference Code |
| E&M | Endorsement and Maintenance |
| EC | Electronic Copy |
| eCQI | Electronic Clinical Quality Improvement |
| eCQM | Electronic Clinical Quality Measures |
| ED | Emergency Department |
| EHR | Electronic Health Record |
| EPC | Evidence-Based Practice Center |
| ESRD QIP | End-Stage Renal Disease Quality Improvement Program |
| EVI | Expected Value of Information |
| FAQs | Frequently Asked Questions |
| FFS | Fee-For-Service |
| FHIR ® | Fast Healthcare Interoperability Resources |
| FMS | Full Measure Submission |
| FY | Fiscal Year |
| HACRP | Hospital-Acquired Conditions Reduction Program |
| HCBS | Home and Community-Based Services |
| HCD | Human-Centered Design |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HH QRP | Home Health Quality Reporting Program |
| HH VBP | Home Health Value-Based Purchasing |
| HHS | Department of Health and Human Services |
| HIQR | Hospital Inpatient Quality Reporting |

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| Acronym | Definition |
|---|---|
| HOPD | Hospital Outpatient Department |
| HOPE | Hospice Outcomes and Patient Evaluation |
| HOQR | Hospital Outpatient Quality Reporting |
| HQMF | Health Quality Measurement Format |
| HQR | Hospice Quality Reporting |
| HQRP | Hospice Quality Reporting Program |
| HRRP | Hospital Readmission Reduction Program |
| HSAG | Health Services Advisory Group |
| HTML | Hypertext Markup Language |
| HVBP | Hospital Value-Based Purchasing |
| IAW | In Accordance With |
| ICD | International Classification of Diseases (International Statistical Classification of Diseases and Related Health Problems) |
| IHI | Institute for Healthcare Improvement |
| IMPACT Act | Improving Medicare Post-Acute Care Transformation Act |
| IPF | Inpatient Psychiatric Facilities |
| IPF QRP | Inpatient Psychiatric Facility Quality Reporting Program |
| IPPS | Inpatient Prospective Payment System |
| IQR | Inpatient Quality Reporting |
| IR | Initial Recognition |
| IRF | Inpatient Rehabilitation Facilities |
| IRF QRP | Inpatient Rehabilitation Facility Quality Reporting Program |
| IT | Information Technology |
| ITS | Intent to Submit |
| LLMs | Large Language Models |
| LTACH | Long-Term Acute Care Hospitals |
| LTCH | Long-Term Care Hospital |
| LTCH QRP | Long-Term Care Hospital Quality Reporting Program |
| MA | Medicare Advantage |
| MACRA | Medicare Access and CHIP Reauthorization Act |
| MACS | Medicaid: Adult Core Set |
| MAQIP | Medicare Advantage Quality Improvement Program |
| MAT | Measure Authoring Tool |

| Acronym | Definition |
|---|---|
| MCCS | Medicaid: Child Core Set |
| MCO | Managed Care Organization |
| MERIT | Measures Under Consideration Entry/Review Tool |
| MIPPA | Medicare Improvement for Patients and Providers Act of 2008 |
| MIPS | Merit-based Incentive Payment System |
| MLTSS | Managed Long-Term Service and Support |
| MMS | Measures Management System |
| MS-DOI | Measure-Specific Disclosure of Interest |
| MSR | Measure Set Review |
| MSSP | Medicare Shared Savings Program |
| MUC | Measures Under Consideration |
| n | Sample Size |
| NCDC | National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract |
| NCQA | National Committee for Quality Assurance |
| NHDNG | Novel Hybrid Delphi and Nominal Groups |
| NHQI | Nursing Home Quality Initiative |
| NLP | Natural Language Processing |
| NQF | National Quality Forum |
| NQS | CMS National Quality Strategy |
| NTTAA | National Technology Transfer and Advancement Act |
| OMB | Office of Management and Budget |
| OP | Option Period |
| OY | Option Year |
| PA | Preliminary Assessment |
| PAC/LTC | Post-Acute Care/Long-Term Care |
| PaLS | Patient Life Goals Survey |
| PAM | Patient Activation Measure |
| PCHQR | PPS-Exempt Cancer Hospital Quality Reporting |
| PDF | Portable Document Format |
| PIE Form | Pre-Meeting Initial Evaluation Form |
| PL | Project Leader |
| PM | Project Manager |

| Acronym | Definition |
|---|---|
| PMP | Project Management Plan |
| POC | Point of Contact |
| PPS | Prospective Payment System |
| PQA | Pharmacy Quality Alliance |
| PQM | Partnership for Quality Measurement |
| PRA | Paperwork Reduction Act |
| PRMR | Pre-Rulemaking Measure Review |
| PRO | Patient-Reported Outcome |
| PROM | Patient-Reported Outcome Measure |
| PRO-PMs | Patient-Reported Outcome Performance Measures |
| Q&A | Question & Answer |
| QC | Quality Control |
| QCDR | Qualified Clinical Data Registries |
| QDM | Quality Data Model |
| QI | Quality Improvement |
| QMDSA | Quality Measure Developer and Steward Agreement |
| QPP | Quality Payment Program |
| REHQR | Rural Emergency Hospital Quality Reporting (Program) |
| SDOH | Social Determinants of Health |
| SES | Socioeconomic Status |
| SLIN | Subline Item Number |
| SMEs | Subject Matter Experts |
| SMP | Scientific Measures Panel |
| SNF | Skilled Nursing Facilities |
| SNF QRP | Skilled Nursing Facility Quality Reporting Program |
| SNF VBP | Skilled Nursing Facility Value-Based Purchasing |
| SOP | Standard Operating Procedure |
| SOW | Statement of Work |
| SSA | Social Security Administration |
| STAR | Submission Tool and Repository |
| SUD | Substance Use Disorder |
| TBD | To Be Determined |

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| Acronym | Definition |
|---|---|
| TEP | Technical Expert Panel |
| TL | Task Lead |
| UMLS | Unified Medical Language System |
| USCDI | United States Core Data for Interoperability |
| VSAC | Value Set Authority Center |
| Yale CORE | Yale Center for Outcomes Research and Evaluation |


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