



2334 S. 41st Street • Wilmington, NC 28403
(910) 815-3122 • FAX: (910) 815-3111

SUMMER PETITION FOR A COUNTY NEED DETERMINATION FOR FIFTY-NINE (59) OUTPATIENT DIALYSIS STATIONS AT A NURSING HOME FACILITY IN MECKLENBURG COUNTY IN THE 2024 STATE MEDICAL FACILITIES PLAN

1. Name, address, email address, and phone number of the Petitioner:

Name: Long Term Care Management Services, LLC d/b/a Liberty Healthcare and Rehabilitation Services (“Liberty”)

ATTN: Timothy Walsh, Director of Business Development and David Holmes, Vice President of Business Development

Address: 2334 S 41st Street, Wilmington, NC 28451

Email Address: Timothy: TWalsh@libertyseniorliving.com; David: DHolmes@libertyhcare.com

Phone Number: (910)-815-3122

Background

Liberty has been taking care of North Carolinians since the late 1800s. The family-owned company began as a small hometown pharmacy in Whiteville, North Carolina. The values, traditions, and trust established by the McNeill family in 1875 continue to be passed down from generation to generation. The principal owners, John A. “Sandy” McNeill, Jr. and Ronnie McNeill, are proud to call North Carolina home, and are the fourth generation of McNeills dedicated to the healthcare industry.

Over the past century, Liberty has expanded from a single retail pharmacy to now offer a broad continuum of care through its family of integrated products and services throughout North Carolina, South Carolina, Virginia, Tennessee, Louisiana and Florida. Today, the Liberty family owns, operates, and/or manages nursing homes, home health care and hospice agencies, independent living communities, assisted living communities, continuing care retirement communities, Liberty Medical Specialties (which provides durable medical equipment and infusion therapy services), the Liberty Medicare Advantage HMO insurance plan, and McNeill’s Pharmacy.

Liberty’s comprehensive approach to senior care gives patients, residents, and their loved ones the peace of mind of that Liberty understands and can support their needs and lifestyle choices as they age. Liberty’s philosophy remains simple: to offer the communities we serve a complete senior care continuum, close to home and family.

2. Statement of Requested Change

Long Term Care Management Services, LLC d/b/a Liberty Healthcare and Rehabilitation Services (“Liberty”) respectfully requests the addition of a county need determination for fifty-nine (59) outpatient dialysis stations at a nursing home facility in Mecklenburg County in the 2024 State Medical Facilities Plan (“SMFP”). To be abundantly clear, this Summer Petition seeks a change only to the 2024 draft need methodology for Mecklenburg County. As such, this Petition is consistent with the description and definition of Summer Petitions contained at pages 8-9 of the 2023 SMFP. Liberty does not believe the SMFP’s standard methodology for ESRD stations in Mecklenburg County meets the need described in this Petition.

This proposal would represent a modification to Chapter 9 of the SMFP, and specifically to Table 9C, which would include the following:

Table 9C: Dialysis Station Need Determination by Facility

County Service Area*	Dialysis Station Need Determination	Certificate of Need Application Deadline	Certificate of Need Beginning Review Date
Mecklenburg*	59	TBD	TBD

*In response to a petition, the State Health Coordinating Council approved an adjusted need determination for fifty-nine (59) outpatient dialysis stations located at a nursing home facility in Mecklenburg County, with the following conditions:

- 1) a licensed nursing home facility shall propose to develop at least the minimum number of stations required for Medicare-certification by the Centers for Medicare and Medicaid (CMS) as a dialysis facility; and
- 2) the new stations must be sited within a nursing home facility or “proximate to the nursing home building,” i.e., on the same property as the nursing home facility; and
- 3) the dialysis facility must comply with the federal life safety and building code requirements applicable to a nursing home if located within it and the life safety and building code requirements applicable to dialysis facilities if located within the nursing home or “proximate to the nursing home building;” and
- 4) the CON will include a condition requiring the dialysis facility to document that it has applied for Medicare-certification no later than three years from the effective date of the CON; and
- 5) dialysis stations developed pursuant to this need determination are excluded from the planning inventory in the SMFP and excluded from the county and facility need methodologies; and
- 6) outpatient dialysis facilities developed pursuant to this need determination shall report utilization to the Agency in the same manner as other outpatient dialysis facilities.

3. Reasons for the Proposed Change

Liberty recognizes the long-standing opportunity to submit petitions to the Acute Care Services Committee and the State Health Coordinating Council (“SHCC”) for requests for changes to the SMFP that have the potential for a statewide effect, such as the addition, deletion or revision of policies or need determination methodologies. Liberty has attempted to utilize the petition process to create a nursing home ESRD Policy as well as a nursing home dialysis pilot demonstration project. All three (3) of Liberty’s petitions were denied. They can be summarized as follows:

1. **2022 Spring Petition:** Liberty Healthcare & Rehabilitation Services requests the creation of Policy ESRD-4 to allow for the development or expansion of a kidney disease treatment center at a skilled nursing facility. **Exhibit 1** includes the 2022 Spring Petition.
2. **2022 Summer Petition:** Liberty Healthcare & Rehabilitation Services requests a nursing home pilot demonstration project of six outpatient dialysis stations in Mecklenburg County to be located at Royal Park of Matthews Rehabilitation and Health Center (“Royal Park”). **Exhibit 2** includes the 2022 Summer Petition.
3. **2023 Spring Petition:** Liberty Healthcare & Rehabilitation Services requests the creation of Policy ESRD-4 to allow for the development or expansion of a kidney disease treatment center at a skilled nursing facility. **Exhibit 3** includes the 2023 Spring Petition.

The 2022 Spring Petition, 2022 Summer Petition, and 2023 Spring Petition can be referred together as “Previous Liberty Petitions”.

In the Previous Liberty Petitions, Liberty based the reasons for the proposed change on several factors, including:

- Advancing American Kidney Health initiative
- Basic Principles outlined in Chapter 9 of the SMFP
- Policy addition has the potential for a statewide effect
- Agency and SHCC set precedent when creating Policy ESRD-3
- Larger dialysis organizations are reporting the need for dialysis in SNFs
- Innovative dialysis technology
- CKD and ESRD most common in people aged 65 years and older
- Transportation to outpatient (offsite) dialysis clinics are challenging for nursing home facilities and residents
- Difficulty hospitals face in finding placement for high acuity residents, including seniors, needing dialysis services
- Unsustainable contracting models with dialysis centers
- CON regulation of dialysis in other states
- Liberty Dialysis Experience

Greater detail regarding these factors can be found in Previous Liberty Petitions and remain in effect for this 2023 Summer Petition. However, through the process of the Previous Liberty Petitions, which included listening to and presenting at SHCC and Acute Care Services Committee meetings, it has been made clear the SHCC would like to see more supportive quantitative data to support the requests. Therefore, this 2023 Summer Petition contains detailed quantitative data, including:

- Mecklenburg SNF Dialysis Data
- Nursing Home ESRD Dialysis Station Need Determination by Planning Area
- Comparison to State and National Averages

Mecklenburg SNF Dialysis Data

The Centers for Medicare & Medicaid Services (“CMS”) provides information on clinical and patient measures (including data on patient characteristics applicable to nursing home facility

patients receiving dialysis treatment) for Medicare-certified ESRD facilities¹. The dataset is compiled using the University of Michigan Kidney Epidemiology and Cost Center (“UM-KECC”) ESRD patient database. The FY 2023 CMS Dialysis Facility Report (“DFR”) dataset contains data measures from January 2018 to December 2021. Liberty utilized the following datasets to create a methodology to demonstrate the current SNF dialysis need for skilled nursing facility residents in Mecklenburg County:

- Medicare Dialysis Facilities Data – FY 2023
- Medicare Dialysis Facilities Data Dictionary
- 2023 SMFP

Step 1: Liberty utilized the Medicare Dialysis Facilities Data Dictionary to understand the various terms and their definitions. Liberty utilized the following variables contained in the Medicare Dialysis Facilities Data:

- pahy4_f - F: Prevalent Patients - End of Year Status: Number of patients alive in this facility, 2021
- nrshomey4_f - F: Prevalent Patients - Nursing Home: % of Nursing Home Facility Patients During Year, 12/31/2021

Step 2: Liberty utilized the “Medicare Dialysis Facilities Data – FY 2023” dataset to locate North Carolina Medicare-certified ESRD facilities’ information on Prevalent Patients - End of Year Status: Number of patients alive in this facility, 2021 and Prevalent Patients - Nursing Home: % of Nursing Home Facility Patients During Year, 12/31/2021.

Step 3: Liberty multiplied the Prevalent Patients - End of Year Status: Number of patients alive in this facility, 2021 with the Prevalent Patients - Nursing Home: % of Nursing Home Facility Patients During Year, 12/31/2021 to get the Number of Nursing Home Facility Patients During Year (12/31/2021).

Step 4: Liberty totaled the Prevalent Patients - End of Year Status: Number of patients alive in this facility, 2021 per county.

Step 5: Liberty totaled the Number of Nursing Home Facility Patients During Year (12/31/2021) per county.

Step 6: Liberty calculated the % of Nursing Home Facility Patients During Year, 12/31/2021 per county by dividing the county Number of Nursing Home Facility Patients During Year (12/31/2021) by the Prevalent Patients - End of Year Status: Number of patients alive in this facility, 2021 per county.

Please refer to **Exhibit 4**, which is the North Carolina Medicare Dialysis Facilities Data – FY 2023 Medicare-certified ESRD facilities information used to display the data on a county basis.

¹ <https://data.cms.gov/quality-of-care/medicare-dialysis-facilities>

Step 7: Liberty utilized the 2023 County Need Determination Methodology found in Chapter 9 of the SMFP to project the number of needed outpatient dialysis stations located at a nursing home facility in Mecklenburg County. Liberty divided the Number of Nursing Home Facility Patients During Year (12/31/2021) in Mecklenburg County (*Step 5*) by 3.2.

The table below displays the details for the current County Station Need Determination located at Nursing Home methodology:

Table 1: 2021 NC Nursing Home ESRD Dialysis Data

County	Number of patients alive in this county, 2021	Number of Nursing Home Facility Patients During Year (12/31/2021)	% of Nursing Home Facility Patients During Year (12/31/2021)	County Station Need Determination located at Nursing Home
Mecklenburg	1692	198	11.70%	62

Nursing Home ESRD Dialysis Station Need Determination by Planning Area

Liberty then utilized the CMS datasets for the past five years (2017-2021) to create a nursing home ESRD dialysis station need determination by planning area that mimics Table 9B of the SMFP, which would project the need determination of nursing home dialysis stations.

The Nursing Home ESRD Dialysis Station Need Determination Methodology was calculated as follows:

Step 1: Multiply the average annual change in the total number of nursing home dialysis patients residing in each county for the past five reporting dates (Columns B through F) by the county’s total number of nursing home dialysis patients for the current reporting date (Column F).

- (i) Determine the total number of nursing home dialysis patients reported on each of the last five reporting dates.
- (ii) Calculate the difference in the number of total nursing home dialysis patients from year to year.
- (iii) Determine the percent change from the previous reporting date by dividing the calculated difference in nursing home dialysis patients by the number of nursing home dialysis patients on the previous reporting date [(number of total nursing home dialysis patients as of the current reporting date – number of total nursing home dialysis patients as of the previous reporting date) / number of total nursing home dialysis patients as of the previous reporting date].
- (iv) Total the annual percent change and divide by four to determine the Average Annual Change Rate (AACR) (Column G).

Step 2: Add the result of Step 1 to the county’s total number of nursing home dialysis patients for the current reporting date (Column F). The sum is the county's projected total number of nursing home dialysis patients (Column H).

Step 3: Divide the result of Step 2 by 3.2. The quotient is the projected number of nursing home dialysis stations needed in the county (Column I).

Step 4: Subtract from the result of Step 3 (Column I) the county's number of nursing home dialysis stations certified for Medicare, stations that are CON-approved and awaiting certification, stations awaiting resolution of CON appeals, and stations for which a need determination in the SMFP is pending review or appeal (Column J). The remainder is the county's projected station surplus or deficit (Column K).

Step 5: If the result of Step 4 is a deficit of 4 or greater, the nursing home dialysis county station need determination is the same as the projected station deficit rounded to the nearest whole number (round fractions of 0.5 or greater to the next highest whole number) (Column L). If a county's projected station deficit is less than 4, the county has no need for additional stations. When a county has a need determination, applicants may apply for any number of stations up to and including the number of stations in the need determination.

Liberty utilized 4 (as opposed to the SMFP of 10) as the number that creates a need determination due to a report from Forvis detailing that, in most cases, the nursing home dialysis den model treats four residents per session².

Table 2: Nursing Home ESRD Dialysis Station Need Determinations by Planning Area

A	B	C	D	E	F
County	2017 Nursing Home Facility Patients	2018 Nursing Home Facility Patients	2019 Nursing Home Facility Patients	2020 Nursing Home Facility Patients	2021 Nursing Home Facility Patients
Mecklenburg	175	173	181	148	198
G	H	I	J	K	L
Average Annual Change Rate for Past Five Years	Projected 12.31.22 NF Patients	Projected 12.31.22 NF Dialysis Station Utilization	Projected Total Available Stations	Projected Station Deficit or Surplus	County Station Need Determination
0.048	207.4	65	6*	Deficit of 59	59

*In response to a petition, the State Health Coordinating Council approved an adjusted need determination for six outpatient dialysis stations located at a nursing home facility in Mecklenburg County in the 2023 SMFP. Therefore, the six stations are included in the above available stations.

Comparison to State and National Averages

CMS also provides information regarding Medicare dialysis facilities state and national averages. Utilizing the “Medicare Dialysis Facilities State and National Averages 2023” dataset, Liberty was able to locate the following information:

United States (“US”) % of Nursing Home Facility Patients During Year (12/31/2021): 16.08%
 North Carolina (“NC”) % of Nursing Home Facility Patients During Year (12/31/2021): 14.51%

² <https://www.forvis.com/alert-article/2020/03/nursing-home-based-hemodialysis-opportunity-broaden-snf-patient-populations>

Please see **Exhibit 5**, which displays the Medicare Dialysis Facilities State and National Averages 2023 dataset for nursing home facility dialysis patients.

Table 9B of the 2023 SMFP provides the following county totals for patients served from 2017-2021:

Table 3: ESRD Dialysis Patients for Past Five Years

	12.31.17 Total Patients	12.31.18 Total Patients	12.31.19 Total Patients	12.31.20 Total Patients	12.31.21 Total Patients
Mecklenburg Patients	1,710	1,792	1,819	1,878	1,871

Utilizing these patient totals along with the national (US) and state (NC) nursing home facility patients’ percentages from CMS, the following assumptions can be made:

Table 4: Average (Utilizing NC and US %) Nursing Home ESRD Dialysis for Past Five Years

	12.31.17 Total Patients	12.31.18 Total Patients	12.31.19 Total Patients	12.31.20 Total Patients	12.31.21 Total Patients
Mecklenburg Patients	1,710	1,792	1,819	1,878	1,871
Mecklenburg Nursing Home Dialysis Patients (utilizing NC 14.51% Average)	248	260	264	272	271
Mecklenburg Nursing Home Dialysis Patients (utilizing US 16.08% Average)	275	288	292	302	301

This means, based on national and North Carolina averages, Mecklenburg County can expect between 248 to 302 nursing home dialysis patients on average per year. Given the increase in the 65-and-older population, the number of nursing home dialysis patients will continue to increase. The need is clear.

a. Statement of the Adverse Effects if Change Not Made

If this Petition is not approved, dialysis options for residents will continue to be limited, specifically in ways that are not beneficial or easily accessible to nursing home residents or economically affordable for the nursing facility. The residents requiring dialysis treatments would need to continue disruptive transportation and lengthy off-site dialysis center treatments, causing residents to miss scheduled treatments, therapy, meals, medications, and family visits while continuing to place the transportation cost burden on the nursing home operator.

b. Statement of Alternatives to the Proposed Change

As referenced above, Liberty has attempted to utilize the petition process to create a nursing home ESRD Policy as well as a nursing home dialysis pilot demonstration project. All three (3) of Liberty’s petitions were denied. At this point, Liberty has exhausted all alternatives available. The need for North Carolina dialysis nursing home residents to have an option to receive dialysis at the nursing home is clear, and Liberty will continue to submit Spring and/or Summer petitions until their needs are met.

4. Evidence Proposed Change Would Not Result in Unnecessary Duplication of Health Resources in the Area

Since there are currently no outpatient dialysis stations located within a nursing home in North Carolina, this proposed need determination is not intended to replace outpatient dialysis facilities in the community. Currently, ESRD services have two methodologies to determine the need for a CON: (i) the county need methodology which projects need for the county; and (ii) the facility need methodology which projects need for a specific facility. When a county need determination exists, any qualified applicant may apply to add stations in an existing facility or apply to develop a new facility. When a facility need determination exists, only the facility that generated the need may apply to add stations. Liberty is also proposing having conditions added to this adjusted need determination, which includes excluding the dialysis stations that would be created by this proposed special need allocation in Mecklenburg County from the planning inventory in the SMFP and excluded from the county and facility need methodologies. Therefore, current outpatient dialysis facilities or county need projects will remain unaffected by this proposal.

The proposed adjusted need determination will not result in an unnecessary duplication of services. Instead, the proposed adjusted need determination will serve to expand access to dialysis services for special nursing home patient populations that are otherwise underserved or served in sub-optimal conditions and settings.

5. Evidence Requested Change is Consistent with Three Basic Principles Governing the Development of the SMFP (Safety and Quality, Access and Value)

The requested adjustment is consistent with the three Basic Principles governing the development of the North Carolina State Medical Facilities Plan: (i) Safety and Quality, (ii) Access and (iii) Value.

Safety and Quality

Liberty agrees with the State of North Carolina and the SMFP's acknowledgement of "the importance of systematic and ongoing improvement in the quality of health services." Additionally, the SHCC "recognizes that while safety, clinical outcomes, and satisfaction may be conceptually separable, they are often interconnected in practice." This proposal maximizes all three elements:

Safety: This proposal would allow residents more time for treatments, therapies, meals, family time, and social activities while decreasing the risk of infection and complications associated with offsite travel.

Clinical outcomes: This proposal would allow residents needing nursing and therapy services to receive their care while their dialysis schedule is adjusted around the resident's nursing and therapy. Residents would no longer miss meals and medications. The dialysis team and the nursing home team will work collaboratively to ensure that the care of each patient is consistent and individualized.

Satisfaction: With transportation risks eliminated and more time for treatments, therapies, meals, family time, and social activities, this proposal would increase satisfaction of dialysis for nursing home residents.

Access

Liberty fully supports the principle of “equitable access to timely, clinically appropriate and high-quality health care for all the people of North Carolina.” As discussed above, this new model will address the current nursing home need for in-house dialysis care, greatly improving patient access to care consistent with this principle. The SMFP states, “the formulation and implementation of the Plan seeks to reduce all of these types of barriers to timely and appropriate access. The first priority is to ameliorate economic barriers and the second priority is to mitigate time and distance barriers.”

Approval of this Petition results in both priorities being met. As discussed in the SMFP, a competitive marketplace should favor providers that deliver the highest quality and best value care, but only in the circumstances where all competitors deliver like services to similar population. In this instance, the services would be provided to a similar population (ESRD patients), and the nursing home can deliver the highest quality and best value of care by eliminating transportation risks and costs as well as better coordination of care and greater comfort and service for the residents. This adjusted need determination would additionally mitigate time and distance barriers, as it would allow the care to happen onsite (or at home through bedside care), which would eliminate the time and distance barriers.

Value

Liberty additionally agrees with the policy stated in the annual SMFP to “encourage the development of value-driven health care by promoting collaborative efforts to create common resources such as shared health databases, purchasing cooperatives, and shared information management, and by promoting coordinated services that reduce duplicative and conflicting care. The SHCC also recognizes the importance of balanced competition and market advantage in order to encourage innovation, insofar as those innovations improve safety, quality, access, and value in health care delivery.” This added adjusted need determination to the SMFP would permit better collaboration of care, fewer hospital readmissions, a stronger relationship with hospital and dialysis partners (through referrals of high acuity residents), while also eliminating the associated high transportation costs.

Conclusion

Liberty again stresses that there is no intention to use the proposed adjusted need determination to replace outpatient dialysis facilities in the Mecklenburg County community. Liberty sees a need for both. However, Liberty has identified significant issues involving barriers to safe and convenient care, disruption of the lives of, and costs to nursing home residents that this proposed model will address. We urge the SHCC to approve Liberty’s Petition for the special need allocation in Mecklenburg County that we have requested.

EXHIBIT 1

Liberty 2022 Spring Petition



Liberty Healthcare & Rehabilitation Services

Caring with Excellence

2334 S. 41st Street • Wilmington, NC 28403
(910) 815-3122 • FAX: (910) 815-3111

PETITION FOR ADJUSTED FACILITY NEED DETERMINATION FOR NURSING HOME DIALYSIS PILOT DEMONSTRATION PROJECT IN MECKLENBURG COUNTY IN THE 2023 STATE MEDICAL FACILITIES PLAN

1. Name, address, email address, and phone number of the Petitioner:

Name: Long Term Care Management Services, LLC d/b/a Liberty Healthcare and Rehabilitation Services (“Liberty”)
ATTN: David Holmes, Vice President of Business Development and Timothy Walsh, Director of Business Development
Address: 2334 S 41st Street, Wilmington, NC 28451
Email Address: David: DHolmes@libertyhcare.com; Timothy: TWalsh@libertyseniorliving.com
Phone Number: (910)-815-3122

Background

Liberty is an experienced family-owned company that has been helping people manage their healthcare needs for more than 145 years. The principal owners, John A. “Sandy” McNeill, Jr. and Ronnie McNeill, are proud to call North Carolina home, and are the fourth generation of McNeill’s dedicated to the healthcare industry. The company founders, who opened their first pharmacy in 1875, established Liberty’s core values of quality, honesty, and integrity that guide Liberty to this day.

Liberty built its first nursing home in 1994 and has since expanded and worked tirelessly to provide residents with high quality levels of care through a broad range of healthcare services. Over the last three decades, Liberty has expanded its’ operations from a single nursing home to become a fully integrated post-acute healthcare provider. Today, Liberty owns, operates, or manages thirty-seven nursing homes, eight assisted living facilities, two independent living communities, six Continuing Care Retirement Communities, a home health and hospice company with twenty-nine locations, two long-term care pharmacies, a medical equipment and IV therapy company, a healthcare management company, a Medicare Advantage institutional special needs plan healthcare insurance company and the original 145-year old retail pharmacy.

Liberty’s philosophy remains simple: to offer the communities we serve a complete senior care continuum, close to home and family.

2. Statement of Requested Change

Long Term Care Management Services, LLC d/b/a Liberty Healthcare and Rehabilitation Services (“Liberty”) respectfully requests the addition of a need for a nursing home dialysis pilot demonstration project of six outpatient dialysis stations in Mecklenburg County in the 2023 State

Medical Facilities Plan (“SMFP”). This would represent a modification to Chapter 9 of the SMFP, and specifically to Chapter 9D, which would include the following:

Table 9D: Dialysis Station Need Determination by Facility

A	B	C	D	E
County	Facility Identification Number	Provider Number	Facility	Facility Station Need Determination
Mecklenburg	TBD	TBD	Royal Park of Matthews	6**

***In response to a petition from Liberty on behalf of Royal Park of Matthews, the State Health Coordinating Council approved an adjusted need determination for six dialysis stations in Mecklenburg County to be included in a demonstration nursing home-only dialysis facility. This is a nursing home dialysis demonstration pilot project that is in the inventory but is not included in need determination calculations.*

3. Reasons for the Proposed Change

Liberty recognizes the long-standing opportunity to submit petitions to the Acute Care Services Committee and the State Health Coordinating Council (“SHCC”) for requests for changes to the SMFP that have the potential for a statewide effect, such as the addition, deletion or revision of policies or need determination methodologies. Liberty wants to be clear that this proposed demonstration project is not intended to displace outpatient dialysis facilities in the community. Liberty sees a need for the delivery of dialysis services in both environments. After careful assessment, Liberty has determined that there are unique circumstances that necessitate this proposed new End-Stage Renal Disease (“ESRD”) facility demonstration project. Approval of this petition will provide Liberty the opportunity to submit a Certificate of Need (“CON”) application pursuant to the facility need methodology.

Liberty requests the proposed facility need determination based on several factors, including:

- Advancing American Kidney Health initiative
- Basic Principles outlined in Chapter 9 of the SMFP
- Innovative dialysis technology
- CKD and ESRD most common in people aged 65 years and older
- Transportation to outpatient (offsite) dialysis clinics are challenging for nursing home facilities and residents
- Difficulty hospitals face in finding placement for high acute residents including seniors needing dialysis services
- Unsustainable contracting models with dialysis centers
- CON regulation of dialysis in other states
- Liberty Dialysis Experience

Advancing American Kidney Health initiative

In 2019, the Federal government launched the Advancing American Kidney Health Initiative, which was designed to advance American kidney health. As part of the Initiative, the President signed Executive Order 13879, which directed the U.S. Department of Health & Human Services (“HHS”) to take bold action to transform how kidney disease is prevented, diagnosed, and treated within the next decade. The Executive Order identified the following goals, among others:

- a) prevent kidney failure whenever possible through better diagnosis, treatment, and incentives for preventive care;
- b) increase patient choice through affordable alternative treatments for ESRD by encouraging higher value care, educating patients on treatment alternatives, and encouraging the development of artificial kidneys.

A nursing home dialysis pilot demonstration project of six outpatient dialysis stations in Mecklenburg County allowing the development or expansion of a kidney disease treatment center at Royal Park of Matthews will help meet the goals set forth in the American Kidney Health Initiative.

Basic Principles outlined in Chapter 9 of the SMFP

The Basic Principles of Chapter 9, End-Stage Renal Disease Dialysis Facilities, of the 2022 SMFP provide as follows:

“Basic Principles

1. New facilities must have a projected need for at least 10 stations to be cost effective and to assure quality of care.
2. **As a means of making ESRD services more accessible to patients, one goal of the N.C. Department of Health and Human Services is to minimize patient travel time to and from the facility.** Therefore, end-stage renal disease treatment should be available within 30 miles from the patients’ homes. In areas where it is apparent that patients currently travel more than 30 miles for in-center dialysis, proposed new facilities that would serve patients who are farthest away from operational or approved facilities should receive favorable consideration.
3. **The State Health Coordinating Council encourages applicants for dialysis stations to provide or arrange for: home training and backup for facility-based patients suitable for home dialysis or in a facility that is a reasonable distance from the patient’s residence;** “ESRD dialysis service availability at times that do not interfere with ESRD patients’ work schedules; and services in rural areas.”

Royal Park of Matthews has the necessary infrastructure to house outpatient dialysis stations, and therefore would request a waiver of the SMFP requirement that a new dialysis facility have at least 10 stations. We believe that requirement was based on the presumed size (*i.e.*, number of dialysis stations) needed to make a new ESRD center viable, a concern not present in the proposed demonstration project which would be housed in an existing, viable skilled nursing facility.

A nursing home dialysis pilot demonstration project for six outpatient dialysis stations in Mecklenburg County allowing the development of a kidney disease treatment center at Royal Park of Matthews helps meet the Basic Principles that are set forth in the SMFP, which include making

ESRD services more accessible to patients as well as encouraging home dialysis that is a reasonable distance from the patient's residence.

Innovative dialysis technology

If this Petition is approved, Liberty plans to ensure the highest quality of care is being provided to nursing home ESRD patients using leading edge technology.

Liberty plans to use a state-of-the-art Tablo dialysis machine, which is designed to offer a better experience for patients and providers. As an innovative technology, the machine comes with the following features:

1. Wireless Connectivity, which allows for two-way data communication to automatically send treatment data to the cloud, facilitating the efficient sharing of information with the patient's medical team;
2. Treatment modalities, which allow flexible renal replacement therapy options including extended therapy (XT), sustained low-efficiency dialysis (SLED), intermittent hemodialysis (IHD), and ultrafiltration (UF) only;
3. Touchscreen Guidance, which comes with animations and conversational instructions for a user-friendly experience;
4. Cart which is specifically designed to cut down on set-up and takedown time by removing manual steps;
5. Sensor-based automation, which helps to automate much of the setup, treatment, management, and maintenance of the machine;
6. Dialysate on demand, which purifies water and produces dialysate in real-time;
7. Mobility, as all that is required is an electrical outlet and tap water;
8. Automatic, regular updates to activate new capabilities and feature enhancements, which ensures that patients and providers have access to the latest optimizations without the need to replace existing hardware.
9. Flexible treatment duration, which can range anywhere from 30 minutes to 24 hours with no supply changeover;
10. Automated self-clean;
11. Integrated blood pressure cuff;
12. Schedule saline flush;
13. One-touch rinse back; and
14. Compatibility with high-flux dialyzers;

Through use of these designs and features, Royal Park of Matthews will be able to deliver efficient and cost-effective treatment through:

- Ease of use and reduced clinical training requirements for the equipment;
- Lower product costs than other currently available technology; and
- Use of safe tap water, eliminating reliance on expensive water treatment facilities.

The leading-age equipment would be able to offer an innovative technological approach that delivers high-quality dialysis treatment through simplified processes in a cost-efficient way.

CKD and ESRD most common in people aged 65 years and older

The Centers for Disease Control and Prevention (“CDC”) has identified that chronic kidney disease (“CKD”) affects 15% of US adults. In people age 65 and older, that prevalence is 38%¹. According to the CDC National Center for Health Statistics, 83.5%² of nursing home residents are 65 years of age or older.

ESRD is the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own. A patient with end-stage renal failure must receive dialysis or kidney transplantation in order to survive for more than a few weeks. As of 2019, 809,103 people in the U.S. were living with end-stage renal disease³. Almost 43% of ESRD patients are 65 or older⁴.

With nearly four in ten seniors affected by chronic kidney disease and 43% of ESRD patients being 65 and older, many skilled nursing patients are or will be in need of dialysis. However, traveling to offsite dialysis can be very disruptive to the health and welfare of this population, most of whom are already frail and often have multiple health problems. The goal of the proposed nursing home dialysis pilot demonstration project is to enable Royal Park of Matthews to meet the needs of this vulnerable population safely while simultaneously eliminating the need for uncomfortable patient transports, lengthy patient wait times at community dialysis centers and treatments at off-site dialysis center which disrupt patient care, meals, socialization and comfort.

Transportation to outpatient (offsite) dialysis clinics is challenging for Royal Park of Matthews and residents

Providing quality of care for all residents, inclusive of a positive dialysis treatment experience, is Liberty’s number one priority. Additionally, the cost of providing these services must also be taken into account. Royal Park of Matthews contracts with Non-Emergency Medical Transportation (“NEMT”) operators for transportation. Given that nursing home patients typically have multiple co-morbidities, a NEMT ambulance service is usually the preferred method of transport. For Royal Park of Matthews, the average cost of providing ambulance transportation to an outpatient dialysis clinic may be up to \$104 per round trip. With dialysis being performed a minimum of 3 times per week, the cost is significant. For example, one long-term resident requiring dialysis 3 times per week (for 52 weeks) would total \$16,224 per year just in transportation costs. There is no reimbursement mechanism for these transports, and, depending on the payor source, these costs fall directly on the nursing facility.

Nationwide staffing shortages, especially where operating in rural areas, impacts the availability of both in-house and outside transportation providers. This has significantly burdened nursing homes, and in some cases, nursing homes are unable to accept resident admissions due to the unavailability of transportation.

¹ https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fkidneydisease%2Fpublications-resources%2F2019-national-facts.html

² https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf

³ <https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities> (Table 1.2)

⁴ <https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities> (Figure 1.10)

Perhaps most importantly, and as discussed in further detail below, the dialysis transport and off-site dialysis is disruptive and time-consuming. Typically, the transport and off-site dialysis causes residents to miss scheduled treatments and therapies/rehab, meals, medications, and family visits. Moreover, off-site dialysis causes additional exposures and, therefore, infection risks for COVID-19 and other illnesses for an already highly vulnerable patient group.

This proposal is effective and beneficial for residents and nursing home operators, with transportation risks and costs greatly reduced while offering better coordination of care and a much improved patient experience.

Difficulty hospitals face finding placement for high acute residents

Oftentimes, hospitals struggle to find placement at outpatient centers for high acuity residents needing dialysis. Many skilled nursing communities cannot accept these higher acuity residents due to the travel demands to and cost associated with community based dialysis centers, and the outpatient centers are unable to support patients with multiple comorbidities. Therefore, upon discharge from the dialysis center, these residents end up being readmitted to the hospital.

Having the availability to discharge patients with dialysis needs to a nursing home and have one facility address both skilled and dialysis care would be a clinical innovation. Same-location care would allow for safe delivery of dialysis services, better collaboration of care, fewer hospital readmissions, and stronger relationships between nursing home operators and hospitals. As noted above, it would also reduce or eliminate a number of well-known risks attendant to frequent travel from nursing homes to community-based dialysis centers including loss of patient routine and socialization opportunities; infections; bodily wear-and-tear; and van or ambulance accidents; among others.

Unsustainable contracting models with dialysis centers

Medicare reimbursement for dialysis services is available to certified ESRD facilities. All dialysis patients must be under the care of a certified ESRD facility to have their outpatient dialysis care and treatments reimbursed by Medicare. According to a memo from CMS regarding home dialysis services in a Long Term Care (LTC) Facility, residents of a nursing home may receive chronic dialysis treatments through two options:

1. In-Center Dialysis: This may involve either:
 - a. Transporting the resident to and from an off-site certified ESRD facility for dialysis treatments; or
 - b. Transporting the resident to a location within or proximate to the nursing home building which is separately certified as an ESRD facility providing in-center dialysis.
2. Home Dialysis in a Nursing Home: The resident receives dialysis treatments in the nursing home. These dialysis treatments are administered and supervised by personnel who meet the criteria for qualifications, training, and competency verification as stated in this guidance and are provided under the auspices of a written agreement between the nursing home and the ESRD facility.

Currently, under the existing SMFP, development of an outpatient dialysis facility at a nursing facility in North Carolina would require that there be a county need determination in the county where a nursing home wishing to develop such a program is located. However, county need determinations are very rare and have been for many years. Therefore, the only way nursing home residents can receive dialysis treatments is for the resident to be transported to an off-site ESRD facility or to have the resident receive dialysis treatment in the nursing home by a currently-certified ESRD facility. We have previously detailed the difficult patient circumstances and costs related to traveling to offsite dialysis centers. Consequently, the only true current alternative would be to contract with dialysis providers to provide the dialysis treatments in the nursing home. Accordingly, Liberty has had discussions with providers and were, disappointingly, offered terms that are not economically viable and were, in fact, cost-prohibitive.

One goal of the proposed pilot demonstration project is to enable Royal Park of Matthews to be reimbursed for providing outpatient or home dialysis to patients that are better suited to being served in the nursing home. The project will also demonstrate, consistent with similar experiences in other states, that dialysis can be provided to nursing home residents safely, cost-effectively and in an environment much more comfortable and familiar to these vulnerable seniors. To receive Medicare reimbursement for outpatient dialysis, the Centers for Medicare and Medicaid Services (“CMS”) requires that the nursing home⁵ own the outpatient dialysis facility.

CON regulation of dialysis facilities in other states

Per communications with Azzie Conley, Chief of the Acute and Home Care Licensure and Certification Section, there are currently no outpatient dialysis stations located within a nursing home in North Carolina. As previously noted the development of an outpatient dialysis clinic at a nursing facility currently requires a county need determination in that county in the SMFP, which almost never exists. As such, without a special need determination, as requested in this Petition, N.C. nursing homes will never be able to follow a growing national trend based on the model Liberty is requesting permission to demonstrate.

Liberty has analyzed other CON states to determine whether the nursing home dialysis model works. Currently, thirty-five (35) states operate a CON program, with variations from state to state. Of the thirty-five (35) CON states, only eleven (11) have some form of CON program that regulates kidney disease treatment centers (including North Carolina). Liberty believes it is important to note that the three (3) states contiguous to North Carolina (South Carolina, Tennessee, and Virginia) are all CON states that do not regulate dialysis under their CON laws.

One of the states that is leading the nursing home dialysis model is Illinois. The Health Facilities Planning Act (the “Act”) (20 ILCS 3960), established Illinois’ CON program, which includes dialysis centers. The Act provides an exemption to dialysis units that are located in licensed nursing homes. The Act specific to this provides:

⁵ An independently certified End-Stage Renal Disease (“ESRD”) facility may be located within or proximal to an independently certified nursing home. Each facility is responsible for meeting the Medicare conditions or requirements for Medicare participation for the specific provider/supplier type and would be separately surveyed. Therefore, the certified ESRD facility must be owned by the same individual or parent company as the nursing home.

5) Kidney disease treatment centers, including a free-standing hemodialysis unit required to meet the requirements of 42 CFR 494 in order to be certified for participation in Medicare and Medicaid under Titles XVIII and XIX of the federal Social Security Act.

(A) This Act does not apply to a dialysis facility that provides only dialysis training, support, and related services to individuals with end stage renal disease who have elected to receive home dialysis.

(B) This Act does not apply to a dialysis unit located in a licensed nursing home that offers or provides dialysis-related services to residents with end stage renal disease who have elected to receive home dialysis within the nursing home.

(C) The Board, however, may require dialysis facilities and licensed nursing homes under items (A) and (B) of this subsection to report statistical information on a quarterly basis to the Board to be used by the Board to conduct analyses on the need for proposed kidney disease treatment centers.

To qualify under the Illinois statute, a nursing home must provide the Illinois Health Facilities and Services Review Board an exemption request that includes the name and address of the long-term care facility, the number of stations requested, who will be operating the stations, and the cost. The nursing home will then receive an approval letter stating that a CON is not needed. North Carolina already has a similar CON exemptions process for certain types of health care projects and equipment.

According to The United States Renal Data System (“USRDS”), Illinois is the leading provider of home hemodialysis, with 4.6% of ESRD patients utilizing in-home hemodialysis⁶. All other states, and Network reporting dialysis utilization (as defined in the USRDS report), report rates of ESRD patients who performed in-home hemodialysis between 0.5% and 2.0%. According to the USRDS, “this outlying value is likely attributable to a large population of skilled nursing facility residents utilizing on-site hemodialysis, which is indistinguishable from home dialysis in claims.” This pilot demonstration project will allow North Carolina to join Illinois at the forefront of providing dialysis services for this special nursing home patient population within the nursing home, which will directly correlate to an increase in home dialysis.

Liberty Dialysis Experience

The current SMFP and related CON limitations on dialysis treatment centers do not allow Liberty facilities to provide optimal quality health care services to the residents and communities Liberty serves by providing dialysis services in nursing homes.

Currently, twenty-seven (27) of Liberty’s nursing home facilities have at least one dialysis resident, serving 80 total dialysis nursing home residents. We spoke with Royal Parks Administrator, Director of Nursing, and Rehab Director and some of the quotes from those

⁶ <https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities>

discussions point to the significance this pilot demonstration project would have on their nursing home dialysis residents.

On the importance of maintaining continued quality care: “An in-house dialysis program would help Royal Park maintain continued quality care for our patients by allowing the nursing staff to provide all of the necessary care and support to the patients. Additionally, by staying in-house, the patients would not have to worry about traveling to and from the dialysis center, which could be a burden for some. The in-house dialysis program would also allow Royal Park to monitor the patients’ progress better and ensure they receive the best possible care. Additionally, by staying in-house, the patients would have more time to rest and recover between dialysis treatments, improving their overall well-being.” – Chase Flowers, Administrator

On the physical toll it takes on residents: “The patients at Royal Park would likely have a better experience if they stayed in-house for their dialysis treatments. This is because they would be able to receive all of the necessary care and support from the nursing staff, which could improve their overall well-being. Additionally, by staying in-house, the patients would not have to worry about traveling to and from the dialysis center, which could be a burden for some.” – Mary Poston, Director of Nursing

On how dialysis affects a resident’s therapy program: “Dialysis can affect a patient’s ability to participate in their therapy program by making them tired and weak. This can make it difficult for the patients to participate in their therapy sessions. The dialysis treatments can also be quite time-consuming, so the patients may not have enough time to do everything they need during their therapy program. However, if the patients stayed in-house for their dialysis treatments, they would be able to receive the care and support they need from the nursing staff, which could help them to participate more fully in their therapy program. Staying in-house would also allow patients more time to rest and recover between dialysis treatments, which could improve their overall health and well-being.” – Melinda Butler, Rehab Director

The consistent theme of these statements is that the current community-based ESRD centers for nursing home dialysis residents is unpleasant and punishing for them. The vast majority of nursing home residents needing dialysis cannot transport themselves. For the resident, the ride is disruptive, confusing and time-consuming. Many times, this causes residents to miss their scheduled and necessary treatments, therapies/rehab, meals, medications, and family visits. This proposal would allow residents to continue receiving their necessary care, treatments and therapy while their dialysis schedule is integrated into the resident's on-site care plans. Residents would no longer miss meals and medications or family visits. The dialysis and nursing home teams will work collaboratively to ensure that the care of each patient is consistent and individualized.

a. Statement of the Adverse Effects if Change Not Made

If this Petition is not approved, dialysis options for Royal Park residents will continue to be limited, specifically in ways that are not beneficial or easily accessible to Royal Park residents or economically affordable for the nursing facility. The residents requiring dialysis treatments would need to continue disruptive transportation and lengthy off-site dialysis center treatments, causing residents to miss scheduled treatments, therapy, meals, medications, and family

visits while continuing to place the transportation cost burden on the nursing home operator.

b. Statement of Alternatives to the Proposed Change

Liberty has discussed only one other alternative to the proposed change, which included:

1. Submit Spring Petition for the creation of Policy ESRD-4 to allow to for the development or expansion of a kidney disease treatment center (“outpatient dialysis facility”) at a skilled nursing facility

Earlier this year, Liberty presented a Spring Petition to the State Health Coordinating Council requesting the addition of Policy ESRD-4 to the 2023 SMFP which would allow the provision of dialysis services to skilled nursing facility residents at the facility where they live rather than requiring them to be loaded onto transport vans multiple times each week and driven to a community dialysis center for treatment. The dialysis services being proposed would be provided via an approved dialysis provider and in accord with all applicable state and federal regulations governing dialysis services.

The Healthcare Planning and Certificate of Need staff recommended denial of Liberty’s Petition, largely because they believed that the SMFP’s existing summer petition process is sufficient to allow Liberty to develop the proposed services. The Acute Care Services Committee, while noting support for the notion that this request would be positive for North Carolina residents, voted to accept the Agency recommendation and deny the Petition. Based on those votes and that guidance, Liberty is now bringing this demonstration project before the SHCC as a Summer Petition.

Liberty has great respect for the work of the Agency staff and the SHCC and its committees, and based on the staff’s and SHCC’s suggestions, is moving forward with this Summer Petition for a nursing home dialysis pilot demonstration project of six outpatient dialysis stations in Mecklenburg County. Liberty believes the demonstration project proposed will demonstrate to the Agency staff and the SHCC that a program like the one being proposed will work.

4. Evidence Proposed Change Would Not Result in Unnecessary Duplication of Health Resources in the Area

Since there are currently no outpatient dialysis stations located within a nursing home in North Carolina, this proposed pilot demonstration project is not intended to replace outpatient dialysis facilities in the community. Currently, ESRD services have two methodologies to determine the need for a CON: (i) the county need methodology which projects need for the county; and (ii) the facility need methodology which projects need for a specific facility. When a county need determination exists, any qualified applicant may apply to add stations in an existing facility or apply to develop a new facility. When a facility need determination exists, only the facility that generated the need may apply to add stations. Liberty proposes to exclude the Mecklenburg County

nursing home dialysis demonstration pilot project from need determination calculations. Therefore, current outpatient dialysis facilities or county need projects will remain unaffected by this proposal.

The proposed pilot demonstration project will not result in an unnecessary duplication of services. Instead, the proposed pilot demonstration project will serve to expand access to dialysis services for special nursing home patient populations that are otherwise underserved or served in sub-optimal conditions and settings.

5. Evidence Requested Change is Consistent with Three Basic Principles Governing the Development of the SMFP (Safety and Quality, Access and Value)

The requested adjustment is consistent with the three Basic Principles governing the development of the North Carolina State Medical Facilities Plan: (i) Safety and Quality, (ii) Access and (iii) Value.

Safety and Quality

Liberty agrees with the State of North Carolina and the SMFP's acknowledgement of "the importance of systematic and ongoing improvement in the quality of health services." Additionally, the SHCC "recognizes that while safety, clinical outcomes, and satisfaction may be conceptually separable, they are often interconnected in practice." This proposal maximizes all three elements:

Safety: This proposal would allow residents more time for treatments, therapies, meals, family time, and social activities while decreasing the risk of infection and complications associated with offsite travel.

Clinical outcomes: This proposal would allow residents needing nursing and therapy services to receive their care while their dialysis schedule is adjusted around the resident's nursing and therapy. Residents would no longer miss meals and medications. The dialysis team and the nursing home team will work collaboratively to ensure that the care of each patient is consistent and individualized.

Satisfaction: With transportation risks eliminated and more time for treatments, therapies, meals, family time, and social activities, this proposal would increase satisfaction of dialysis for nursing home residents.

Access

Liberty fully supports the principle of "equitable access to timely, clinically appropriate and high-quality health care for all the people of North Carolina." As discussed above, this new model will address the current nursing home need for in-house dialysis care, greatly improving patient access to care consistent with this principle. The SMFP states, "the formulation and implementation of the Plan seeks to reduce all of these types of barriers to timely and appropriate access. The first priority is to ameliorate economic barriers and the second priority is to mitigate time and distance barriers."

Approval of this Petition results in both priorities being met. As discussed in the SMFP, a competitive marketplace should favor providers that deliver the highest quality and best value care, but only in the circumstances where all competitors deliver like services to similar population. In this instance, the services would be provided to a similar population (ESRD patients), and the nursing home can deliver the highest quality and best value of care by eliminating transportation risks and costs as well as better collaboration of care and greater comfort and service for the residents. This pilot demonstration project would additionally mitigate time and distance barriers, as it would allow the care to happen onsite (or at home through bedside care), which would eliminate the time and distance barriers.

Value

Liberty additionally agrees with SHCC to “encourage the development of value-driven health care by promoting collaborative efforts to create common resources such as shared health databases, purchasing cooperatives, and shared information management, and by promoting coordinated services that reduce duplicative and conflicting care. The SHCC also recognizes the importance of balanced competition and market advantage in order to encourage innovation, insofar as those innovations improve safety, quality, access, and value in health care delivery.” This added pilot demonstration project to the SMFP would permit better collaboration of care, fewer hospital readmissions, a stronger relationship with hospital and dialysis partners (through referrals of high acuity residents), while also eliminating the associated high transportation costs.

Conclusion

Liberty again stresses that there is no intention to use the proposed pilot demonstration project to replace outpatient dialysis facilities in the community. Liberty sees a need for both. However, Liberty has identified significant issues involving barriers to safe and convenient care, disruption of the lives of, and costs to nursing home residents that this proposed model will address. We urge the SHCC to approve Liberty’s Petition for the demonstration project we have requested.

EXHIBIT 2

Liberty 2022 Summer Petition



Liberty Healthcare & Rehabilitation Services

Caring with Excellence

2334 S. 41st Street • Wilmington, NC 28403
(910) 815-3122 • FAX: (910) 815-3111

PETITION FOR ADDITION OF ESRD POLICY TO THE 2023 STATE MEDICAL FACILITIES PLAN

1. Name, address, email address, and phone number of the Petitioner:

Name: Long Term Care Management Services, LLC d/b/a Liberty Healthcare and Rehabilitation Services (“Liberty”)

ATTN: David Holmes, Vice President of Business Development and Timothy Walsh, Senior Financial Analyst

Address: 2334 S 41st Street, Wilmington, NC 28451

Email Address: David: DHolmes@libertyhcare.com; Timothy: TWalsh@libertyseniorliving.com

Phone Number: (910)-815-3122

Background

Liberty is an experienced family-owned company that has been helping people manage their healthcare needs for more than 145 years. The principal owners, John A. “Sandy” McNeill, Jr. and Ronnie McNeill, are proud to call North Carolina home, and are the fourth generation of McNeill’s dedicated to the healthcare industry. The company founders, who opened their first pharmacy in 1875, established Liberty’s core values of quality, honesty, and integrity that guide Liberty to this day.

Liberty purchased its’ first nursing home in 1990 and has since expanded and worked tirelessly to provide residents with high quality levels of care through a broad range of healthcare services. Over the last three decades, Liberty has expanded its’ operations from a single nursing home to become a fully integrated post-acute healthcare provider. Today, Liberty owns, operates, or manages thirty-seven nursing homes, eight assisted living facilities, two independent living communities, six Continuing Care Retirement Communities, a home health and hospice company with twenty-nine locations, two long-term care pharmacies, a medical equipment and IV therapy company, a healthcare management company, a Medicare Advantage institutional special needs plan healthcare insurance company and the original 145-year old retail pharmacy.

Liberty’s philosophy remains simple: to offer the communities we serve with a complete senior care continuum, close to home and family.

2. Statement of Requested Change

Long Term Care Management Services, LLC d/b/a Liberty Healthcare and Rehabilitation Services (“Liberty”) requests for a Policy to be added to the 2023 State Medical Facilities Plan (“SMFP”), Policy ESRD-4, which will allow for the development or expansion of a kidney disease treatment

center at a skilled nursing facility. Liberty has provided the proposed language associated with Policy ESRD-4 in Attachment 1.

3. Reasons for the Proposed Change

Liberty recognizes the long-standing opportunity to submit petitions to the Acute Care Services Committee and the State Health Coordinating Council (“SHCC”) for requests for changes to the SMFP that have the potential for a statewide effect, such as the addition, deletion or revision of policies or need determination methodologies. Liberty wants to be clear that this proposed policy is not intended to displace outpatient dialysis facilities in the community. Liberty sees a need for the delivery of dialysis services in both environments. After careful assessment, Liberty has determined that there are unique circumstances throughout the state, specifically in nursing homes, that necessitate the new End-Stage Renal Disease (“ESRD”) Policy proposed. Approval of this petition will provide Liberty and other nursing facilities (“NF’s”) throughout the State the opportunity to submit a Certificate of Need (“CON”) application to help address the needs of a growing nursing home population.

Liberty justifies the proposed new Policy based on several factors, including:

- Advancing American Kidney Health initiative
- Basic Principles outlined in Chapter 9 of the SMFP
- Innovative dialysis technology
- CKD and ESRD most common in people aged 65 years and older
- Transportation to outpatient (offsite) dialysis clinics are challenging for nursing home facilities and residents
- Unsustainable contracting models with dialysis centers
- CON regulation of dialysis in other states
- Liberty Dialysis Experience

Advancing American Kidney Health initiative

In 2019, the Administration launched the Advancing American Kidney Health Initiative, which was designed to advance American kidney health. As part of the Initiative, the President introduced Executive Order 13879, which directed the Department of Human Services (“HHS”) to take bold action to transform how kidney disease is prevented, diagnosed, and treated within the next decade. The Policy of this Executive Order stated (in part) the following goals:

- a) prevent kidney failure whenever possible through better diagnosis, treatment, and incentives for preventive care;
- b) increase patient choice through affordable alternative treatments for ESRD by encouraging higher value care, educating patients on treatment alternatives, and encouraging the development of artificial kidneys.

A new Policy to the SMFP allowing the development or expansion of a kidney disease treatment center at a skilled nursing facility will help meet the goals set forth in the Executive Order.

Additionally, the Advancing American Kidney Health initiative has an ambitious goal to see 80 percent of new ESRD patients either start on home dialysis or receive a preemptive transplant by 2025.

As will be detailed throughout this Petition, the nursing home dialysis model approach will help facilitate the current nursing home need for in-house dialysis care, which would directly meet the Advancing American Kidney Health initiative.

Basic Principles outlined in Chapter 9 of the SMFP

The Basic Principles of Chapter 9, End-Stage Renal Disease Dialysis Facilities, of the 2022 SMFP provides as follows:

“Basic Principles

1. New facilities must have a projected need for at least 10 stations to be cost effective and to assure quality of care.
2. **As a means of making ESRD services more accessible to patients, one goal of the N.C. Department of Health and Human Services is to minimize patient travel time to and from the facility.** Therefore, end-stage renal disease treatment should be available within 30 miles from the patients’ homes. In areas where it is apparent that patients currently travel more than 30 miles for in-center dialysis, proposed new facilities that would serve patients who are farthest away from operational or approved facilities should receive favorable consideration.
3. **The State Health Coordinating Council encourages applicants for dialysis stations to provide or arrange for: home training and backup for facility-based patients suitable for home dialysis or in a facility that is a reasonable distance from the patient’s residence;** ESRD dialysis service availability at times that do not interfere with ESRD patients’ work schedules; and services in rural areas.”

Similar to hospitals and their permitted use of outpatient dialysis clinics under Policy ESRD-3, Liberty and other nursing homes throughout the state have the necessary infrastructure to house outpatient dialysis stations, and therefore would request to waive the requirement for a new dialysis facility to have at least 10 stations.

As will be discussed throughout this Petition, allowing for the development or expansion of a kidney disease treatment center at a skilled nursing facility helps meet the Basic Principles that are set forth in the SMFP, which include making ESRD services more accessible to patients as well as encouraging home dialysis that is a reasonable distance from the patient’s residence.

Innovative dialysis technology

If this Petition is approved, Liberty plans to ensure the highest quality of care is being provided to nursing home ESRD patients using leading edge technology.

Liberty plans to use a state-of-the-art dialysis machine, which is designed to offer a better experience for patients and providers. As an innovative technology, the machine comes with the following features:

1. Wireless Connectivity, which allows for two way data communication to automatically send treatment data to the cloud, facilitating the efficient sharing of information with the patient’s medical team;

2. Treatment modalities, which allow flexible renal replacement therapy options including extended therapy (XT), sustained low-efficiency dialysis (SLED), intermittent hemodialysis (IHD), and ultrafiltration (UF) only;
3. Touchscreen Guidance, which comes with animations and conversational instructions for a user-friendly experience;
4. Cart which is specifically designed to cut down on set-up and takedown time by removing manual steps;
5. Sensor-based automation, which helps to automate much of the setup, treatment, management, and maintenance of the machine;
6. Dialysate on demand, which purifies water and produces dialysate in real-time;
7. Mobility, as all that is required is an electrical outlet and tap water;
8. Automatic, regular updates to activate new capabilities and feature enhancements, which ensures that patients and providers have access to the latest optimizations without the need to replace existing hardware.
9. Flexible treatment duration, which can range anywhere from 30 minutes to 24 hours with no supply changeover;
10. Automated self-clean;
11. Integrated blood pressure cuff;
12. Schedule saline flush;
13. One-touch rinse back; and
14. Compatibility with high-flux dialyzers;

Through use of these designs and features, a nursing home may deliver efficient and cost-effective treatment through:

- Ease of use and reduced clinical training requirements for the equipment;
- Lower product costs than other currently available technology; and
- Use of safe tap water, eliminating reliance on expensive water treatment facilities.

The leading-age equipment would be able to offer an innovative technological approach that delivers high-quality dialysis treatment through simplified processes in a cost-efficient way.

CKD and ESRD most common in people aged 65 years and older

The Centers for Disease Control and Prevention (“CDC”) has identified that chronic kidney disease (“CKD”) affects 15% of US adults. In people age 65 and older, that prevalence is 38%¹. Critically, according to the CDC National Center for Health Statistics, 83.5%² of nursing home residents are 65 years of age or older.

ESRD is the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own. A patient with end-stage renal failure must receive dialysis or kidney transplantation in order to survive for more than a few

¹ https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fkidneydisease%2Fpublications-resources%2F2019-national-facts.html

² https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf

weeks. As of 2019, 809,103 people in the U.S. were living with end-stage renal disease³. Almost 43% of ESRD patients are 65 or older⁴.

With nearly four in ten seniors affected by chronic kidney disease and 43% of ESRD patients being 65 and older, many skilled nursing patients are or will be in need of dialysis. However, traveling to offsite dialysis can be very disruptive to the health and welfare of this population, most of whom are already frail and often have multiple health problems. The intent of the proposed policy will enable nursing homes to meet the needs of this vulnerable population by eliminating the necessity for uncomfortable patient transports, lengthy patient wait times and treatments at off-site dialysis center disrupting patient care, meals and comfort.

Transportation to outpatient (offsite) dialysis clinics are challenging for nursing home facilities and residents

Providing quality of care for all residents, inclusive of a positive dialysis treatment experience, is Liberty's number one priority. Additionally, the cost of providing these services must also be taken into account. Many of Liberty's nursing homes have their own in-house transportation to drive residents to appointments. For those residents who are wheelchair-bound or who can ambulate freely, Liberty is able to transport these individuals to and from their dialysis appointment. When in-house transportation is not available, or if a resident needs to be transported via stretcher, Liberty contracts with Non-Emergency Medical Transportation ("NEMT") operators for transportation. Given that nursing home patients typically have multiple co-morbidities, a NEMT ambulatory service is usually the preferred method of transport. For Liberty, the average cost of providing ambulatory transportation to an outpatient dialysis may cost up to \$200 per round trip. With dialysis being performed 3 times per week, the cost is significant.

Nationwide staffing shortages, especially where operating in rural areas, impacts the availability of both in-house and outside transportation providers. This has significantly burdened nursing homes, and in some cases, nursing homes are unable to accept resident admissions due to the unavailability of transportation.

Perhaps most importantly, and as discussed in further detail below, the dialysis transport and off-site dialysis is disruptive and time-consuming. Typically, the transport and off-site dialysis causes residents to miss scheduled treatments and therapies/rehab, meals, medications, and family visits. Moreover, off-site dialysis causes additional exposures and, therefore, infection risks for COVID-19 and other illnesses for an already highly vulnerable patient group.

This proposal is effective for residents and nursing home operators, with transportation risks and costs greatly reduced while offering better coordination of care and a much improved patient experience.

³ <https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities> (Table 1.2)

⁴ <https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities> (Figure 1.10)

Unsustainable contracting models with dialysis centers

Medicare reimbursement for dialysis services is available to certified ESRD facilities. All dialysis patients must be under the care of a certified ESRD facility to have their outpatient dialysis care and treatments reimbursed by Medicare. According to a memo from CMS regarding home dialysis services in a Long Term Care (LTC) Facility, residents of a nursing home may receive chronic dialysis treatments through two options:

1. In-Center Dialysis: This may involve either:
 - a. Transporting the resident to and from an off-site certified ESRD facility for dialysis treatments; or
 - b. Transporting the resident to a location within or proximate to the nursing home building which is separately certified as an ESRD facility providing in-center dialysis.

2. Home Dialysis in a Nursing Home: The resident receives dialysis treatments in the nursing home. These dialysis treatments are administered and supervised by personnel who meet the criteria for qualifications, training, and competency verification as stated in this guidance and are provided under the auspices of a written agreement between the nursing home and the ESRD facility.

Under normal circumstances, development of an outpatient dialysis facility at a nursing facility in North Carolina would require a county need determination. However, county need determinations are very rare. Therefore, the only way nursing home residents may receive dialysis treatments would be to either have the NF transport the resident to and from an off-site ESRD facility or to have the resident receive dialysis treatment in the nursing home by a currently certified ESRD facility. We have previously detailed the difficult patient circumstances and costs related to traveling to offsite dialysis. Consequently, the only true current alternative would be to contract with dialysis providers to provide the dialysis treatments in the nursing home. Accordingly, Liberty has had discussions with providers and were, disappointingly, offered terms that are not economically viable and even financially exploitative.

The intent of the proposed policy is to enable nursing homes to be reimbursed for providing outpatient or home dialysis to patients that are better suited to being served in the nursing home. To receive Medicare reimbursement for outpatient dialysis, the Centers for Medicare and Medicaid Services (“CMS”) requires that the nursing home⁵ own the outpatient dialysis facility.

CON regulation of dialysis facilities in other states

Per communications with Azzie Conley, Chief of the Acute and Home Care Licensure and Certification Section, there are currently no outpatient dialysis stations located within a nursing home in North Carolina. The development of an outpatient dialysis clinic at the nursing facility would require a rarely issued county need determination.

⁵ An independently certified End-Stage Renal Disease (“ESRD”) facility may be located within or proximal to an independently certified nursing home. Each facility is responsible for meeting the Medicare conditions or requirements for Medicare participation for the specific provider/supplier type and would be separately surveyed. Therefore, the certified ESRD facility must be owned by the same individual or parent company as the nursing home.

Therefore, Liberty analyzed other CON states to review whether the nursing home dialysis model works. Currently, thirty-five (35) states operate a CON program, with variations state to state. Of the thirty-five (35) CON states, only eleven (11) have some form of CON program that regulates kidney disease treatment centers (including North Carolina). Liberty believes it is important to note that the three (3) states contiguous to North Carolina (South Carolina, Tennessee, and Virginia) are all CON states that do not regulate dialysis under their CON laws.

One of the states that is leading the nursing home dialysis model is Illinois. The Health Facilities Planning Act (the “Act”) (20 ILCS 3960), established Illinois’ CON program, which includes dialysis centers. The Act provides an exemption to dialysis units that are located in licensed nursing homes. The Act specific to this provides:

5) Kidney disease treatment centers, including a free-standing hemodialysis unit required to meet the requirements of 42 CFR 494 in order to be certified for participation in Medicare and Medicaid under Titles XVIII and XIX of the federal Social Security Act.

(A) This Act does not apply to a dialysis facility that provides only dialysis training, support, and related services to individuals with end stage renal disease who have elected to receive home dialysis.

(B) This Act does not apply to a dialysis unit located in a licensed nursing home that offers or provides dialysis-related services to residents with end stage renal disease who have elected to receive home dialysis within the nursing home.

(C) The Board, however, may require dialysis facilities and licensed nursing homes under items (A) and (B) of this subsection to report statistical information on a quarterly basis to the Board to be used by the Board to conduct analyses on the need for proposed kidney disease treatment centers.

To qualify under the Illinois statute, a nursing home must provide the Illinois Health Facilities and Services Review Board an exemption request that includes the name and address of the long-term care facility, the number of stations requested, who will be operating the stations, and the cost. The nursing home will then receive an approval letter back stating a CON is not needed.

According to The United States Renal Data System (“USRDS”), Illinois is the leading provider of home hemodialysis, in which 4.6% of patients with ESRD utilized in-home hemodialysis⁶. All other state and Network (as defined in the USRDS report) rates of ESRD patients who performed in-home hemodialysis varied between 0.5% and 2.0%. According to the USRDS, “this outlying value is likely attributable to a large population of skilled nursing facility residents utilizing on-site hemodialysis, which is indistinguishable from home dialysis in claims.” This Policy would allow North Carolina to join Illinois at the forefront of providing dialysis services for this special

⁶ <https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities>

nursing home patient population within the nursing home, which will directly correlate to an increase in home dialysis.

Liberty Dialysis Experience

The current permitted structure for dialysis treatment for nursing facility residents does not allow Liberty facilities to provide optimal quality health care services to the residents and communities Liberty serves.

Currently, twenty-seven (27) of Liberty's nursing home facilities have at least one dialysis resident, serving 80 total dialysis nursing home residents. We spoke with our communities and some of the quotes point to the significance this Policy would have on the nursing home dialysis resident.

On the importance of maintaining continued quality care: “We have a good plan of action to support residents while they are in our facility. However, when they leave to go out for the day – and that day may be a full eight hours or more – when they come back, they are at a different level of distress. They might have been sitting in their soiled undergarments all day and they may have been without food for a period of time. It would be great if we had a program that would keep them in-house because it would be able to afford the resident a continued quality of care. The same dedicated staff would be with them from the beginning to the end of their day. They would have their ADLs (activities of daily living) taken care of and they would have their nourishment through meals and snacks while they are resting comfortably in their room surrounded by all the things that bring them peace and comfort while in our care.” – Charles Duff, Administrator

On the physical toll it takes on residents: “It's a draining process, literally. When they come back six or more hours later, they are wiped out. The core of dialysis is cleaning the blood, so any time there is filtering of the blood, it's exhausting for them. Sometimes we can't get them back to the facility right when they are done because we may have another transport. It feels like an all-day process for us. I can't even imagine what it feels like for them.” – Terri King, RN, Director of Nursing

On how dialysis affects a resident's therapy program: “Typically, our patients have dialysis three times a week. We try to do therapy five days a week. A lot of times we run into difficulty working with the patients because of their dialysis times. We also run into smaller windows of time where we are able to work with them on dialysis days. If a patient has dialysis at 10 o'clock in the morning, we are trying to get occupational, physical and sometimes speech therapy to see that person prior to going out. That is sometimes difficult if you have someone who has a low activity tolerance. The inability to have flexibility with patients who are going out for dialysis is often a problem. Sometimes I will have someone come in the afternoon, say a PRN therapist, and if the patient is out for dialysis they are unable to be seen. It affects their ability to participate in therapy. Typically, they are wiped out afterwards so we might not get as much out of them when they come back that day.” – Michael Write, Occupational Therapist

The consistent theme of these statements is that the current structure for nursing home dialysis residents is unpleasant and punishing for them. The vast majority of nursing home residents needing dialysis cannot transport themselves. For the resident, the ride is disruptive, confusing and

time-consuming. Many times, this causes residents to miss their scheduled and necessary treatments, therapies/rehab, meals, medications, and family visits. This proposal would allow residents to continue receiving their necessary care, treatments and therapy while their dialysis schedule is integrated into the resident's care, treatment and therapy needs. Residents would no longer miss meals and medications or family visits. The dialysis and nursing home teams will work collaboratively to ensure that the care of each patient is consistent and individualized.

a. Statement of the Adverse Effects if Change Not Made

If this Petition is not approved, dialysis options for nursing home residents will continue to be limited, specifically in ways that are not beneficial or easily accessible to nursing facility residents or economically affordable for nursing facilities. The residents requiring dialysis treatments would need to continue disruptive transportation and lengthy off-site dialysis center treatments, causing residents to miss scheduled treatments, therapy, meals, medications, and family visits while continuing to place the transportation cost burden on nursing home operators.

b. Statement of Alternatives to the Proposed Change

Liberty has discussed several possible alternatives. These included:

1. Petition for adjusted need determination in specific service area(s)
2. Include ACH facilities in proposed Policy ESRD-4 Policy

Petition for adjusted need determination in specific service area(s)

Liberty considered petitioning for an adjusted need determination in specific service areas/counties, as current county need determinations in the SMFP are very rare. However, this approach is problematic. The need for outpatient dialysis stations at nursing homes is not based on just one specific county or even just a few counties. These troubling circumstances are statewide, specifically in nursing homes, which necessitate a new ESRD Policy as opposed to specific county need determinations.

Additionally, a county need determination would not be bound to meet the exclusive situation for outpatient dialysis stations within the nursing home. A county need determination would allow an established or new outpatient dialysis provider to potentially apply and win the Certificate of Need, which would then defeat the purpose of this Petition's intent.

Include ACH facilities in proposed Policy ESRD-4 Policy

As discussed on page 1, Liberty is an experienced healthcare provider, as it currently owns, operates, or manages thirty-seven nursing homes and eight assisted living facilities. Therefore, Liberty also considered if including adult care home ("ACH") facilities to the proposed Policy ESRD-4 Policy would be beneficial to residents. It was determined that the vast majority of ACH residents are still able to travel to outpatient dialysis facilities within the community with less harmful disruption to daily needs and routines, as these residents are still active and oftentimes do not have the multiple health problems nursing home residents face.

The needs of nursing home residents with dialysis are not being met or are being met in ways that are not the most beneficial to residents or cost-effective. Therefore, Liberty determined that the policy proposed (ESRD-4) by this petition is the most effective way to provide dialysis treatment for nursing home residents.

4. Evidence Proposed Change Would Not Result in Unnecessary Duplication of Health Resources in the Area

Since there are currently no outpatient dialysis stations located within a nursing home in North Carolina, this proposed policy is not intended to replace outpatient dialysis facilities in the community. Currently, ESRD services have two methodologies to determine the need for a CON: (i) the county need methodology which projects need for the county; and (ii) the facility need methodology which projects need for a specific facility. When a county need determination exists, any qualified applicant may apply to add stations in an existing facility or apply to develop a new facility. When a facility need determination exists, only the facility that generated the need may apply to add stations. Liberty proposes to exclude existing and newly developed outpatient dialysis facilities in a nursing home from the county and specific facility need determination methodologies. Therefore, current outpatient dialysis facilities or county need projects will remain unaffected by this proposal.

The proposed policy will not result in an unnecessary duplication of services. Instead, the proposed policy will serve to expand access to dialysis services for special nursing home patient populations that are otherwise underserved or served in sub-optimal conditions and settings.

5. Evidence Requested Change is Consistent with Three Basic Principles Governing the Development of the SMFP (Safety and Quality, Access and Value)

The requested adjustment is consistent with the three Basic Principles governing the development of the North Carolina State Medical Facilities Plan: (i) Safety and Quality, (ii) Access and (iii) Value.

Safety and Quality

Liberty agrees with the State of North Carolina and the SMFP's acknowledgement of "the importance of systematic and ongoing improvement in the quality of health services." Additionally, the SHCC "recognizes that while safety, clinical outcomes, and satisfaction may be conceptually separable, they are often interconnected in practice." This proposal maximizes all three elements:

Safety: This proposal would allow residents more time for treatments, therapies, meals, family time, and social activities while decreasing the risk of infection and complications associated with offsite travel.

Clinical outcomes: This proposal would allow residents needing nursing and therapy services to receive their care while their dialysis schedule is adjusted around the resident's nursing and therapy. Residents would no longer miss meals and medications. The dialysis team and the nursing

home team will work collaboratively to ensure that the care of each patient is consistent and individualized.

Satisfaction: With transportation risks eliminated and more time for treatments, therapies, meals, family time, and social activities, this proposal would maximize satisfaction of dialysis nursing home residents.

Access

Liberty fully supports the principle of “equitable access to timely, clinically appropriate and high-quality health care for all the people of North Carolina.” As discussed above, this new model approach will facilitate the current nursing home need for in-house dialysis care, greatly improving patient access to care consistent with this principle. The SMFP states, “the formulation and implementation of the Plan seeks to reduce all of these types of barriers to timely and appropriate access. The first priority is to ameliorate economic barriers and the second priority is to mitigate time and distance barriers.”

Approval of this Petition results in both priorities being met. As discussed in the SMFP, a competitive marketplace should favor providers that deliver the highest quality and best value care, but only in the circumstances where all competitors deliver like services to similar population. In this instance, the services would be provided to a similar population (ESRD patients), and the nursing home can deliver the highest quality and best value of care by eliminating transportation risks and costs as well as better collaboration of care and greater comfort and service for the residents. This policy would additionally mitigate time and distance barriers, as it would allow the care to happen onsite (or at home through bedside care), which would eliminate the time and distance barriers.

Value

Liberty additionally agrees with SHCC to “encourage the development of value-driven health care by promoting collaborative efforts to create common resources such as shared health databases, purchasing cooperatives, and shared information management, and by promoting coordinated services that reduce duplicative and conflicting care. The SHCC also recognizes the importance of balanced competition and market advantage in order to encourage innovation, insofar as those innovations improve safety, quality, access, and value in health care delivery.” This added Policy to the SMFP would permit better collaboration of care, fewer hospital readmissions, a stronger relationship with hospital and dialysis partners (through referrals of high acuity residents), while also eliminating the associated high transportation costs.

Conclusion

Liberty again wants to make certain, it is not the intent to use the proposed policy to supplant outpatient dialysis facilities in the community. Liberty sees a need for both. Approval of this Petition will provide Liberty and other SNF’s throughout the State the opportunity to develop or expand kidney disease treatment centers at skilled nursing facilities for the benefit of ESRD residents.

ATTACHMENT 1

PROPOSED POLICY ESRD-4

Policy ESRD-4: Development or Expansion of a Kidney Disease Treatment Center in a Nursing Home

Licensed nursing homes (see stipulations in 131E-102 (e1)) may apply for a certificate of need to develop or expand an existing Medicare-certified kidney disease treatment center (outpatient dialysis facility) without regard to a county or facility need determination if all the following are true:

1. The nursing home proposes to develop or expand the facility on any campus on its license where nursing home beds are located.
2. The nursing home must own the outpatient dialysis facility*, but the nursing home may contract with another legal entity to operate the facility.
3. The nursing home must document that the patients it proposes to serve in an outpatient dialysis facility developed or expanded pursuant to this policy are appropriate for treatment in an outpatient dialysis facility located in a nursing home.
4. The nursing home must establish a relationship with a hospital-based dialysis facility (where applicable) to assist in the transition of patients from the hospital dialysis facility to the nursing home facility wherever possible.

*An independently certified End-Stage Renal Disease (“ESRD”) facility may be located within or proximal to an independently certified nursing home. Each facility is responsible for meeting the Medicare conditions or requirements for Medicare participation for the specific provider/supplier type and would be separately surveyed. Therefore, the certified ESRD facility must be owned by the same individual, parent or affiliated company as the nursing home.

The nursing home shall propose to develop at least the minimum number of stations allowed for Medicare certification by the Centers for Medicare & Medicaid Services (CMS). Certificate of Need will impose a condition requiring the nursing home to document that it has applied for Medicare certification no later than three (3) years from the effective date on the certificate of need.

The performance standards in 10A NCAC 14C .2203 do not apply to a proposal submitted by a nursing home pursuant to this policy.

Dialysis stations developed pursuant to this policy are excluded from the inventory in the State Medical Facilities Plan and excluded from the facility and county need methodologies.

Outpatient dialysis facilities developed or expanded pursuant to this policy shall report utilization to the Agency in the same manner as other facilities with outpatient dialysis stations.

EXHIBIT 3

Liberty 2023 Spring Petition



Liberty Healthcare & Rehabilitation Services

Caring with Excellence

2334 S. 41st Street • Wilmington, NC 28403
(910) 815-3122 • FAX: (910) 815-3111

PETITION FOR ADDITION OF ESRD POLICY TO THE 2024 STATE MEDICAL FACILITIES PLAN

1. Name, address, email address, and phone number of the Petitioner:

Name: Long Term Care Management Services, LLC d/b/a Liberty Healthcare and Rehabilitation Services (“Liberty”)

ATTN: David Holmes, Vice President of Business Development and Timothy Walsh, Director of Business Development

Address: 2334 S 41st Street, Wilmington, NC 28403

Email Address: David: DHolmes@libertyhcare.com; Timothy: TWalsh@libertyseniorliving.com

Phone Number: (910)-815-3122

Background

Liberty has been taking care of North Carolinians since the late 1800s. The family-owned company began as a small hometown pharmacy in Whiteville, North Carolina. The values, traditions, and trust established by the McNeill family in 1875 continue to be passed down from generation to generation. The principal owners, John A. “Sandy” McNeill, Jr. and Ronnie McNeill, are proud to call North Carolina home, and are the fourth generation of McNeills dedicated to the healthcare industry.

Over the past century, Liberty has expanded from a single retail pharmacy to now offer a broad continuum of care through its’ family of integrated products and services throughout North Carolina, South Carolina, Virginia, Tennessee, Louisiana and Florida. Today, the Liberty family owns, operates, and/or manages nursing homes, home health care and hospice agencies, independent living communities, assisted living communities, continuing care retirement communities, Liberty Medical Specialties (which provides durable medical equipment and infusion therapy services), the Liberty Medicare Advantage HMO insurance plan, and McNeill’s Pharmacy.

Liberty’s comprehensive approach to senior care gives patients, residents, and their loved ones the peace of mind knowing that Liberty understands and can support their needs and lifestyle choices as they age. Liberty’s philosophy remains simple: to offer the communities we serve a complete senior care continuum, close to home and family.

2. Statement of Requested Change

Long Term Care Management Services, LLC d/b/a Liberty Healthcare and Rehabilitation Services (“Liberty”) requests that a Policy to be added to the 2024 State Medical Facilities Plan (“SMFP”), Policy ESRD-4, which will allow for the development or expansion of a kidney disease treatment

center in skilled nursing facilities across the state. Liberty has provided the proposed language associated with Policy ESRD-4 in Attachment 1.

3. Reasons for the Proposed Change

Liberty recognizes the long-standing opportunity to submit petitions to the Acute Care Services Committee and the State Health Coordinating Council (“SHCC”) for requests for changes to the SMFP that have the potential for a statewide effect, such as the addition, deletion or revision of policies or need determination methodologies. Liberty wants to be clear that this proposed policy is not intended to displace outpatient dialysis facilities in the community. Liberty sees a need for the delivery of dialysis services in both environments. After careful assessment, Liberty has determined that there are unique circumstances throughout the state, specifically in nursing homes, that necessitate the new End-Stage Renal Disease (“ESRD”) Policy being proposed. Approval of this petition will provide Liberty and other nursing facilities (“NF’s”) throughout the State the opportunity to submit a Certificate of Need (“CON”) application to become an ESRD provider and help address the needs of a growing nursing home population.

Liberty justifies the proposed new Policy based on several factors, including:

- Chronic Kidney Disease and ESRD most common in people aged 65 years and older
- Policy addition has the potential for a statewide effect
- Agency and SHCC set precedent when creating Policy ESRD-3
- Larger dialysis organizations are reporting the need for dialysis in SNFs
- Difficulty hospitals face in finding placement for high acute residents including seniors needing dialysis services
- Innovative dialysis technology
- Transportation to outpatient (offsite) dialysis clinics is challenging for nursing home facilities and residents
- Unsustainable contracting models with dialysis centers

CKD and ESRD most common in people aged 65 years and older

The Centers for Disease Control and Prevention (“CDC”) has identified that chronic kidney disease (“CKD”) affects 15% of US adults. In people age 65 and older, that prevalence is 38%¹. Critically, according to the CDC National Center for Health Statistics, 83.5%² of nursing home residents are 65 years of age or older.

ESRD is the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own. A patient with end-stage renal failure must receive dialysis or kidney transplantation in order to survive for more than a few weeks. As of 2020, 807,920 people in the U.S. were living with end-stage renal disease³. Almost 43% of ESRD patients are 65 or older⁴.

¹ <https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html>

² https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf

³ <https://usrds-adr.niddk.nih.gov/2022/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities> (Table 1.2)

⁴ <https://usrds-adr.niddk.nih.gov/2022/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities> (Figure 1.10)

With nearly four in ten seniors affected by chronic kidney disease and 43% of ESRD patients being 65 and older, many skilled nursing patients are or will be in need of dialysis. However, traveling to offsite dialysis can be very disruptive to the health and welfare of this population, most of whom are already frail and often have multiple health problems. The intent of the proposed policy is to enable nursing homes to meet the needs of this vulnerable population by eliminating the necessity for uncomfortable patient transports, lengthy patient wait times and treatments at off-site dialysis centers disrupting patient care, meals and comfort.

Policy addition has the potential for a statewide effect

In 2022, Liberty presented a similar Spring Petition to the SHCC requesting a similar Policy ESRD-4. The Healthcare Planning and Certificate of Need staff (the “Agency”) recommended denial of Liberty’s Spring Petition, primarily due to the belief that the SMFP’s existing summer petition process was sufficient to allow Liberty to develop the proposed services. The Acute Care Services Committee, while noting support for the notion and acknowledging that this request would be positive for North Carolina residents, voted to accept the Agency recommendation and deny the Petition. Based on the Agency’s and SHCC’s suggestions, Liberty moved forward with a Summer Petition in 2022 for a nursing home dialysis pilot demonstration project of six outpatient dialysis stations in Mecklenburg County. The SHCC recommended denial of Liberty’s 2022 Summer Petition, and instead recommended an adjusted need determination for six outpatient dialysis facility stations in Mecklenburg County to be allocated for development within a nursing home facility or proximate to the nursing home building.

However, continuing to submit petitions in the summer for need determinations is problematic. The need for outpatient dialysis stations at nursing homes is not based on just one specific county or even a few specific counties. The troubling circumstances leading Liberty to submit this petition exist statewide nursing homes, and not just in one facility, county or region, which necessitates a new ESRD Policy as opposed to specific county need determinations. Additionally, a county need determination would allow an established outpatient dialysis provider to potentially apply for and win the Certificate of Need, which would then defeat the purpose of this Petition’s goal of providing a more patient-centered dialysis experience in the safest, least disruptive environment. Though established dialysis providers in North Carolina currently may partner with a nursing home to provide home and/or in-center dialysis services in the nursing home, that approach requires the community-based dialysis center to relocate dialysis stations from an existing facility to the nursing home. Liberty seeks a method to develop new dialysis stations at nursing homes without, in effect, forcing the relocation of existing community-based stations or being forced to partner with an outpatient dialysis provider (under economically onerous terms, as referenced in this petition).

Agency and SHCC set precedent when creating Policy ESRD-3

A portion of the analysis of the Agency report for the Liberty 2022 Spring Petition states that “although the Petitioner requested a policy as the means to “open the door” to the provision of dialysis in nursing homes, an existing option currently available to providers is to submit a summer petition to the SHCC for an adjusted county need determination.”

However, neither the Agency nor the SHCC has taken this same position in the past in similar situations. The following is a timeline regarding the creation of Policy ESRD-3, which allows

hospitals to develop kidney disease treatment centers on a hospital campus without the requirement of a need determination.

Summer 2019

1. UNC Hospitals (“UNCH”) submitted a Summer Petition for an adjusted need determination for four outpatient dialysis stations in an acute care setting for Orange County in the North Carolina 2020 SMFP.
2. The Agency, Acute Care Services Committee, and the SHCC recommend approval of the request for an adjusted need determination for four outpatient dialysis stations located on the campus of an acute care hospital in Orange County.

November 2019

1. Governor Roy Cooper sends a Memo approving the 2020 SMFP, which includes a need determination of 4 dialysis stations in Orange County, listed in Table 9D of Chapter 9. A note under Table 9D in reference to the 4 dialysis station need determination includes the following: “In response to a petition, the State Health Coordinating Council approved the adjusted need determination for four outpatient dialysis stations located on the campus of an acute care hospital in Orange County. Certificate of Need shall impose a condition requiring the approved applicant to document that it has applied for Medicare certification no later than three (3) years from the effective date on the certificate of need.”
2. The Certificate of Need Beginning Review Date for the 4 outpatient dialysis stations in an acute care setting for Orange County was set for April 1, 2020. A Certificate of Need Application would be due March 16th, 2020.

March 2020

1. The Certificate of Need Application Log for April 1, 2020 Reviews shows that no facility or applicant applied for the four outpatient dialysis stations located on the campus of an acute care hospital in Orange County.

April 2020

1. The Agency proposes Policy ESRD-3 to allow hospitals to develop kidney disease treatment centers (“outpatient dialysis facility”) on hospital campuses without the requirement of a need determination. The Agency moved forward with the Policy proposal allowing development of an outpatient dialysis facility on a hospital campus. According to the Agency request, “discussions with the committee and within the Agency favored creation of a policy to enable any hospital to offer outpatient dialysis services to patients who are not appropriate for community-based facilities...”

October 2020

1. Governor Roy Cooper sends a Memo approving the 2021 SMFP, which includes the new Policy ESRD-3 ((Development or Expansion of a Kidney Disease Treatment Center on a Hospital Campus).

In summary, after UNC Hospitals filed a Summer Petition for a special need allocation for dialysis stations in Orange County and no one applied to fill that need, the SHCC then proceeded to develop

a statewide Policy, Policy ESRD-3, which allows for the development of outpatient dialysis facilities on a hospital campus.

A mechanism existed in the SMFP through the summer petition process for hospitals to develop outpatient dialysis facilities on a hospital campus, and was utilized by UNC Hospitals. However, no provider ever applied for this additional need determination. Nonetheless, the Agency still moved ahead with the creation of a new Policy. Liberty contends that precedent has been set in the past that the existence of a mechanism in the SMFP, namely the Summer Petition process, does not preclude the SHCC from utilizing the mechanism of approving a new statewide policy.

Large dialysis organizations are reporting the need for dialysis in SNF's

NxStage, a subsidiary of Fresenius Medical Care, reports on its website “there are over 520,000 dialysis patients in the United States and approximately 65,000 of them reside in Skilled Nursing Facilities annually.”⁵

DaVita Kidney Care also acknowledges on its website the potential SNF-dialysis benefits, stating a patient will have “improved quality of life” and SNF’s will have “reduced care costs and readmissions”⁶ through a dialysis SNF setting.

It is clear that large dialysis organizations see a need for dialysis in SNF’s based on their promotion of their own skilled nursing dialysis programs. However, the opposition comments filed against past Liberty petitions (and expected opposition for this petition) make clear that it is competition that these larger dialysis organizations seek to avoid, even if this Petition would provide the highest quality and best value care to dialysis patients residing in SNF’s. Further, competition is recognized in the basic principles governing the development of the SMFP, in which “the SHCC also recognizes the importance of balanced competition and market advantage in order to encourage innovation, insofar as those innovations improve safety, quality, access, and value in health care delivery.”⁷

Liberty has been clear throughout each petition that any policy or need determination request is not intended to displace outpatient dialysis facilities in the community. In fact, it is Liberty’s belief that this Policy would be a benefit to the larger dialysis organizations as well as SNF providers. Though established dialysis providers in North Carolina currently may partner with a nursing home to provide home and/or in-center dialysis services in the nursing home, that would require the dialysis provider to relocate dialysis stations from an existing facility to the nursing home (in order to create the den model which Liberty seeks). Liberty seeks a method to develop new dialysis stations at a nursing home without the need for dialysis providers to relocate stations. This Policy would not preclude dialysis providers from collaborating with other SNF providers throughout the

⁵ <https://www.nxstage.com/administrators/snf-facilities/>

Reference to data: DataDialysis.org. FY2017 Dialysis Facility Report Data. 3. Yang A, Lee WY, Hocking K, Xelay Acumen, Inc., Affiliated Dialysis. Survival comparison of daily home hemodialysis vs conventional dialysis in the nursing home setting. Nephrology News & Issues. February 17, 2015.

⁶ <https://www.davita.com/partners/skilled-nursing-facilities>

⁷ https://info.ncdhhs.gov/dhsr/ncsmfp/2023/2023_SMFP_COMPLETE_v3_w_covers_signed_sec_memo_signed_gov_approval.pdf (Chapter 1, Basic Principles Governing the Development of the SMFP, pages 3-4)

state. Liberty is simply proposing a Policy whereby a SNF provider is not forced to partner with an outpatient dialysis provider and may develop its own dialysis program.

Difficulty hospitals face finding placement for high acute residents

Hospitals frequently struggle to find placement at outpatient centers for high acuity residents needing dialysis. Many skilled nursing communities cannot accept these higher acuity residents due to the travel demands to and cost associated with community based dialysis centers, and the outpatient centers are unable to support many patients with multiple comorbidities. Therefore, upon discharge from the hospital, these residents end up being readmitted to the hospital.

Having the availability to discharge patients with dialysis needs to a nursing home and have one facility address both skilled nursing, therapy and dialysis care would be a clinical innovation. Same-location care would allow for safe delivery of dialysis services, better coordination of care, fewer hospital readmissions, and stronger relationships between nursing home operators and hospitals. As noted above, it would also reduce or eliminate a number of well-known risks attendant to frequent travel from nursing homes to community-based dialysis centers, including negative impact on patient routine and socialization opportunities; infections; bodily wear-and-tear; and van or ambulance accidents; among others.

Innovative dialysis technology

If this Petition is approved, and Liberty applies for and obtains a CON under the new policy, Liberty plans to ensure the highest quality of care is being provided to nursing home ESRD patients using leading edge technology.

Liberty plans to use a state-of-the-art Tablo dialysis machine, designed to offer a better experience for patients and providers. As an innovative technology, the Tablo machine comes with the following features:

1. Wireless Connectivity, allowing for two-way data communication to automatically send treatment data to the cloud, facilitating the efficient sharing of information with the patient's medical team;
2. Treatment modalities, which allow flexible renal replacement therapy options including extended therapy (XT), sustained low-efficiency dialysis (SLED), intermittent hemodialysis (IHD), and ultrafiltration (UF) only;
3. Touchscreen Guidance, which comes with animations and conversational instructions for a user-friendly experience;
4. Cartridge, which is specifically designed to cut down on set-up and takedown time by removing manual steps;
5. Sensor-based automation, which helps to automate much of the setup, treatment, management, and maintenance of the machine;
6. Dialysate on demand, which purifies water and produces dialysate in real-time;
7. Mobility, as all that is required is an electrical outlet and tap water;
8. Automatic, regular updates to activate new capabilities and feature enhancements, ensuring that patients and providers have access to the latest optimizations without the need to replace existing hardware.

9. Flexible treatment duration, ranging anywhere from 30 minutes to 24 hours with no supply changeover;
10. Automated self-clean;
11. Integrated blood pressure cuff;
12. Schedule saline flush;
13. One-touch rinse back; and
14. Compatibility with high-flux dialyzers;

Through use of these designs and features and/or similar technology that is available in the market, North Carolina SNFs will be able to deliver efficient and cost-effective treatment through:

- Ease of use and reduced clinical training requirements for the equipment;
- Lower product costs than other currently available technologies; and
- Use of safe tap water, eliminating reliance on expensive water treatment facilities.

While Liberty plans to use a state-of-the-art Tablo dialysis machine to deliver high-quality dialysis treatment, other applicants may use a different technology. The important part is that there is technology out there that SNFs can use to deliver high quality, safe dialysis.

Transportation to outpatient (offsite) dialysis clinics are challenging for nursing home facilities and residents

Providing quality of care for all residents, inclusive of a positive dialysis treatment experience, is critical. Additionally, the cost of providing these services must also be taken into account. Many of Liberty's nursing homes have their own in-house transportation to drive residents to appointments. For those residents who are wheelchair-bound or who can ambulate freely, Liberty is able to transport these individuals to and from their dialysis appointments. When in-house transportation is not available, or if a resident needs to be transported via stretcher, Liberty contracts with non-emergency medical transportation ("NEMT") operators for transportation. Given that nursing home patients typically have multiple co-morbidities, a NEMT ambulatory service is usually the preferred method of transport. For Liberty, the average cost of providing ambulatory transportation to an outpatient dialysis may cost up to \$200 per round trip. With dialysis being performed 3 times per week, the cost is significant. There currently is no state or federal reimbursement mechanism for SNFs which have to incur these transportation costs.

Nationwide staffing shortages, especially where operating in rural areas, impacts the availability of both in-house and outside transportation providers. This has significantly burdened nursing homes, and in some cases, nursing homes are unable to accept resident admissions due to the unavailability of transportation.

Most importantly, the dialysis transport and off-site dialysis is disruptive and time-consuming. Typically, the transport and off-site dialysis causes residents to miss scheduled treatments and therapies/rehab, meals, medications, and family visits. Moreover, off-site dialysis causes additional exposures and, therefore, infection risks for COVID-19 and other illnesses for an already highly vulnerable patient group.

This proposal would greatly benefit residents and nursing home operators, with transportation risks and costs greatly reduced while offering better coordination of care and a much improved patient experience.

Unsustainable contracting models with dialysis centers

Medicare reimbursement for dialysis services is available to certified ESRD facilities. All dialysis patients must be under the care of a certified ESRD facility to have their outpatient dialysis care and treatments reimbursed by Medicare. According to a memo from CMS regarding home dialysis services in a Long Term Care (LTC) Facility, residents of a nursing home may receive chronic dialysis treatments through two options:

1. In-Center Dialysis: This may involve either:
 - a. Transporting the resident to and from an off-site certified ESRD facility for dialysis treatments; or
 - b. Transporting the resident to a location within or proximate to the nursing home building which is separately certified as an ESRD facility providing in-center dialysis.

2. Home Dialysis in a Nursing Home: The resident receives dialysis treatments in the nursing home. These dialysis treatments are administered and supervised by personnel who meet the criteria for qualifications, training, and competency verification as stated in this guidance and are provided pursuant to a written agreement between the nursing home and the ESRD facility.

Under normal circumstances, development of an outpatient dialysis facility at a nursing facility in North Carolina would require a county need determination. However, county need determinations are very rare. Therefore, the only way nursing home residents may receive dialysis treatments would be to either have the SNF transport the resident to and from an off-site ESRD facility or to have the resident receive dialysis treatment in the nursing home by a currently certified ESRD facility. We have previously detailed the difficult patient circumstances and costs related to traveling to offsite dialysis. Consequently, the only true current alternative would be to contract with dialysis providers to provide the dialysis treatments in the nursing home. Accordingly, Liberty has had discussions with providers and were, disappointingly, offered terms that are not economically viable and even financially exploitative.

The intent of the proposed policy is to enable nursing homes to be reimbursed for providing outpatient or home dialysis to patients that are better suited to being served in the nursing home. To receive Medicare reimbursement for outpatient dialysis, the Centers for Medicare and Medicaid Services (“CMS”) requires that the nursing home⁸ own the outpatient dialysis facility.

Previous Public Comments Filed in Opposition to Liberty’s Petition

⁸ An independently certified End-Stage Renal Disease (“ESRD”) facility may be located within or proximal to an independently certified nursing home. Each facility is responsible for meeting the Medicare conditions or requirements for Medicare participation for the specific provider/supplier type and would be separately surveyed. Therefore, the certified ESRD facility must be owned by the same individual or parent company as the nursing home.

In the 2022 Spring and Summer petitions filed by Liberty, a number of commenters consisting primarily of existing non-SNF dialysis providers, filed comments in opposition to Liberty's Petition. The majority of these opposing comments focused on the issue of quality of care and suggested that providing dialysis services to SNF residents at the nursing facility as proposed in Liberty's Petition raised quality of care concerns.

Liberty respectfully disagrees with these comments. In fact, one of the driving factors behind Liberty's petition is the well-documented negative physical and emotional risks to SNF residents from being loaded into vans multiple times each week for transport to nearby dialysis centers where they often wait extended periods of time for treatment, endure the long dialysis process, miss meals, become exhausted and return to the nursing facility too depleted to eat or take part in activities. The fact that several other states permit the precise type of dialysis in nursing facilities being proposed by Liberty indicates that those states have found this type of care to be safe for nursing facility residents. Liberty also notes the following points that address the quality of care issue:

- The proposed services will be provided via an approved ESRD provider who is responsible for the provision of all equipment, supplies and staff. Only ESRD employees may perform dialysis activities, and only the ESRD staff RN is permitted to initiate and terminate the dialysis treatment. Numerous other requirements for both the ESRD provider and facility designed to ensure the safe and effective delivery of care are detailed in regulations governing these services issued by the U.S. Centers for Medicare and Medicaid Services.
- There have been a number of articles and studies reported in reputable publications documenting the safety of the model being proposed by Liberty. See, for example, the following article: <https://www.bkd.com/alert-article/2020/03/nursing-home-based-hemodialysis-opportunity-broaden-snf-patient-populations>
 - The model proposed by Liberty is not new and has been successfully implemented in other states, As of 2020, at least 25 states offer either home hemodialysis or in-center dialysis in skilled nursing facilities.
- Illinois appears to be the most comparable model, as Illinois regulates kidney disease treatment centers, but provides an exemption for dialysis units.
 - During the preparation of its petition to the SHCC, Liberty reached out to health care regulators in Illinois. Liberty was informed by Mike Constantino, Public Service Administrator for Illinois, that Illinois allows SNFs to provide dialysis services in SNFs and that they require no CON. Rather, SNFs are permitted to obtain an Exemption to provide these services. Mr. Constantino told Liberty: "I can tell you since 2018 we have seen more nursing homes ask for that exemption and usually it is for four stations."
- Further, the CON application form which any entity seeking a CON under the proposed new policy would have to complete, includes multiple questions which require the application to demonstrate how it will ensure quality and further the goals of access, cost and quality of care. As such, the CON Section has the authority to ensure that any proposal filed under the proposed new policy includes mechanisms and safeguards to ensure safety and achieve quality of care. The CON Section also has the power to impose conditions upon its approval of a CON applicant's approval. In short, the CON Section has the legal authority to review any CON application filed under the proposed new policy to ensure

that any concerns about quality of care and patient safety are addressed and satisfied. The comments filed by community-based opponents of Liberty’s prior petitions alleging quality-of-care concerns are without foundation and should be recognized for what they are—competition-based comments. Liberty’s focus in this petition is on the safety of SNF residents across the State and how to deliver to them the highest quality of care in the safest, least disruptive environment.

Conclusion

Liberty believes the Policy presented should be incorporated into the 2024 SMFP for the benefit of our State’s most vulnerable citizens, those residing in skilled nursing facilities and respectfully requests that the SHCC vote to approve Liberty’s Petition.

a. Statement of the Adverse Effects if Change Not Made

If this Petition is not approved, dialysis options for nursing home residents will continue to be limited, specifically in ways that are not beneficial or easily accessible to nursing facility residents or economically affordable for nursing facilities. The residents requiring dialysis treatments would need to continue disruptive transportation and lengthy off-site dialysis center treatments, causing residents to miss scheduled treatments, therapy, meals, medications, and family visits while continuing to place the transportation cost burden on nursing home operators.

b. Statement of Alternatives to the Proposed Change

Liberty has discussed several possible alternatives. These included:

1. Petition for adjusted need determination in specific service area(s)
2. Include ACH facilities in proposed Policy ESRD-4 Policy

Petition for adjusted need determination in specific service area(s)

Liberty considered petitioning again for an adjusted need determination in specific service areas/counties, as was done in the Summer 2022 Petition. However, as stated above, this approach is problematic. The need for outpatient dialysis stations at nursing homes is not based on just one specific county or even just a few counties. These troubling circumstances are statewide, specifically in nursing homes, which necessitate a new ESRD Policy as opposed to specific county need determinations.

Include ACH facilities in proposed Policy ESRD-4 Policy

As discussed on page 1, Liberty is an experienced healthcare provider, which includes the operation of assisted living facilities (in addition to the skilled nursing facilities it operates). Therefore, Liberty also considered if including adult care home (“ACH”) facilities to the proposed Policy ESRD-4 Policy would be beneficial to residents. It was determined that the vast majority of ACH residents are still able to travel to outpatient dialysis facilities within the community with less harmful disruption to daily needs and routines, as these residents are still active and oftentimes do not have the multiple health problems nursing home residents face.

The needs of nursing home residents with dialysis are not being met or are being met in ways that are not the most beneficial to residents or cost-effective. Therefore, Liberty determined that the policy proposed (ESRD-4) by this petition is the most effective way to provide dialysis treatment for nursing home residents.

4. Evidence Proposed Change Would Not Result in Unnecessary Duplication of Health Resources in the Area

There are currently no outpatient dialysis stations located within a nursing home in North Carolina. Further, as discussed above, this proposed policy is not intended to replace outpatient dialysis facilities in the community. Currently, ESRD services have two methodologies to determine the need for a CON: (i) the county need methodology which projects need for the county; and (ii) the facility need methodology which projects need for a specific facility. When a county need determination exists, any qualified applicant may apply to add stations in an existing facility or apply to develop a new facility. When a facility need determination exists, only the facility that generated the need may apply to add stations. Liberty proposes to exclude existing and newly developed outpatient dialysis facilities in a nursing home from the county and specific facility need determination methodologies. Therefore, current outpatient dialysis facilities or county need projects will remain unaffected by this proposal.

The proposed policy will not result in an unnecessary duplication of services. Instead, the proposed policy will serve to expand access to dialysis services for special nursing home patient populations that are otherwise underserved or served in sub-optimal conditions and settings.

5. Evidence Requested Change is Consistent with Three Basic Principles Governing the Development of the SMFP (Safety and Quality, Access and Value)

The requested adjustment is consistent with the three Basic Principles governing the development of the North Carolina State Medical Facilities Plan: (i) Safety and Quality, (ii) Access and (iii) Value.

Safety and Quality

Liberty agrees with the State of North Carolina and the SMFP's acknowledgement of "the importance of systematic and ongoing improvement in the quality of health services." Additionally, the SHCC "recognizes that while safety, clinical outcomes, and satisfaction may be conceptually separable, they are often interconnected in practice." This proposal maximizes all three elements:

Safety: This proposal would allow residents more time for treatments, therapies, meals, family time, and social activities while decreasing the risk of infection and complications associated with offsite travel.

Clinical outcomes: This proposal would allow residents needing nursing and therapy services to receive their care while their dialysis schedule is adjusted around the resident's nursing and therapy. Residents would no longer miss meals and medications. The dialysis team and the nursing

home team will work collaboratively to ensure that the care of each patient is consistent and individualized.

Satisfaction: With transportation risks eliminated and more time for treatments, therapies, meals, family time, and social activities, this proposal would maximize satisfaction of the needs of dialysis nursing home residents.

Access

Liberty fully supports the principle of “equitable access to timely, clinically appropriate and high-quality health care for all the people of North Carolina.” As discussed above, this new model approach will facilitate the current nursing home need for in-house dialysis care, greatly improving patient access to care consistent with this principle. The SMFP states, “the formulation and implementation of the Plan seeks to reduce all of these types of barriers to timely and appropriate access. The first priority is to ameliorate economic barriers and the second priority is to mitigate time and distance barriers.”

Approval of this Petition results in both priorities being met. As discussed in the SMFP, a competitive marketplace should favor providers that deliver the highest quality and best value care, but only in the circumstances where all competitors deliver like services to similar population. In this instance, the services would be provided to a similar population (ESRD patients), and the nursing home can deliver the highest quality and best value of care by eliminating transportation risks and costs as well as better collaboration of care and greater comfort and service for the residents. This policy would additionally mitigate time and distance barriers, as it would allow the care to happen onsite (or at home through bedside care), which would eliminate the time and distance barriers.

Value

Liberty additionally agrees with the aim of the SHCC to “encourage the development of value-driven health care by promoting collaborative efforts to create common resources such as shared health databases, purchasing cooperatives, and shared information management, and by promoting coordinated services that reduce duplicative and conflicting care. The SHCC also recognizes the importance of balanced competition and market advantage in order to encourage innovation, insofar as those innovations improve safety, quality, access, and value in health care delivery.” Adding this Policy to the SMFP would permit better collaboration of care, result in fewer hospital readmissions, and help build a stronger relationship with hospital and dialysis partners (through referrals of high acuity residents), while also eliminating the associated high transportation costs.

Conclusion

Liberty again wants to stress that it is not the intent to use the proposed policy to supplant outpatient dialysis facilities in the community. Liberty sees a need for both. Approval of this Petition will provide Liberty and other SNF’s throughout the State the opportunity to develop or expand kidney disease treatment centers at skilled nursing facilities for the benefit of ESRD residents.

ATTACHMENT 1

PROPOSED POLICY ESRD-4

Policy ESRD-4: Development or Expansion of a Kidney Disease Treatment Center in a Nursing Home

Licensed nursing homes (see stipulations in 131E-102 (e1)) may apply for a certificate of need to develop or expand an existing Medicare-certified kidney disease treatment center (outpatient dialysis facility) without regard to a county or facility need determination if all the following are true:

1. A licensed nursing home facility shall propose to develop at least the minimum number of stations required for Medicare-certification by the Centers for Medicare and Medicaid (CMS) as a dialysis facility; and.
2. The new stations must be sited within a nursing home facility or “proximate to the nursing home building,” i.e., on the same property as the nursing home facility; and.
3. The dialysis facility must comply with the federal life safety and building code requirements applicable to a nursing home if located within it and the life safety and building code requirements applicable to dialysis facilities if located within the nursing home or “proximate to the nursing home building;”.

Certificate of Need will impose a condition requiring the nursing home to document that it has applied for Medicare certification no later than three (3) years from the effective date on the certificate of need.

The performance standards in 10A NCAC 14C .2203 do not apply to a proposal submitted by a nursing home pursuant to this policy.

Dialysis stations developed pursuant to this policy are excluded from the inventory in the State Medical Facilities Plan and excluded from the facility and county need methodologies.

Outpatient dialysis facilities developed or expanded pursuant to this policy shall report utilization to the Agency in the same manner as other facilities with outpatient dialysis stations.

EXHIBIT 4

**North Carolina Medicare Dialysis
Facilities Data – FY 2023 Medicare-
certified ESRD facilities Data Within
the County**

provfs	dfr_provname	provcity	County	chainnam	pahy4_f - F	nrshomey4_f	Number of Nursing Home Facility Patients During Year (12/31/2021)
342306	CAROLINAS MEDICAL CENTER	CHARLOTTE	Mecklenburg	INDEPENDENT	12	0	0
342503	FMC CHARLOTTE	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	134	14.18	19
342523	SOUTH CHARLOTTE DIALYSIS	CHARLOTTE	Mecklenburg	DAVITA	64	12.5	8
342548	CHARLOTTE DIALYSIS	CHARLOTTE	Mecklenburg	DAVITA	88	10.23	9
342549	BMA OF NORTH CHARLOTTE	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	113	11.5	13
342552	DSI CHARLOTTE LATROBE DIALYSIS	CHARLOTTE	Mecklenburg	US RENAL CARE, INC.	71	19.72	14
342554	BMA - WEST CHARLOTTE	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	74	14.86	11
342581	BMA BEATTIES FORD	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	89	13.48	12
342591	DSI GLENWATER DIALYSIS	CHARLOTTE	Mecklenburg	US RENAL CARE, INC.	101	18.81	19
342594	BMA NATIONS FORD	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	75	13.33	10
342605	BMA OF EAST CHARLOTTE	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	62	9.68	6
342627	CHARLOTTE EAST DIALYSIS	CHARLOTTE	Mecklenburg	DAVITA	145	11.03	16
342654	INS FREEDOM DIALYSIS	HUNTERSVILLE	Mecklenburg	FRESENIUS MEDICAL CARE	50	0	0
342655	INS CHARLOTTE	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	85	3.53	3
342663	NORTH CHARLOTTE DIALYSIS CENTER	CHARLOTTE	Mecklenburg	DAVITA	80	11.25	9
342681	FMC MATTHEWS	MATTHEWS	Mecklenburg	FRESENIUS MEDICAL CARE	67	13.43	9
342692	MINT HILL DIALYSIS	CHARLOTTE	Mecklenburg	DAVITA	52	9.62	5
342707	HUNTERSVILLE DIALYSIS	HUNTERSVILLE	Mecklenburg	DAVITA	70	8.57	6
342713	FRESENIUS MEDICAL CARE SOUTHWEST CHARLOTTE	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	60	10	6
342719	FRESENIUS KIDNEY CARE REGAL OAKS	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	52	15.38	8
342731	BROOKSHIRE DIALYSIS	CHARLOTTE	Mecklenburg	DAVITA	24	12.5	3
342736	SUGAR CREEK DIALYSIS	CHARLOTTE	Mecklenburg	DAVITA	32	6.25	2
342738	FRESENIUS MEDICAL CARE ALDERSGATE	CHARLOTTE	Mecklenburg	FRESENIUS MEDICAL CARE	37	16.22	6
342747	HICKORY RIDGE DIALYSIS	CHARLOTTE	Mecklenburg	DAVITA	25	12	3
342750	FRESENIUS KIDNEY CARE SOUTHEAST MECKLENBURG COUNTY	PINEVILLE	Mecklenburg	FRESENIUS MEDICAL CARE	30	3.33	1
					1692	11.70%	198

EXHIBIT 5

**Medicare Dialysis Facilities State and
National Averages Dataset for Nursing
Home Facility Dialysis Patients**

state	Measure	Measure_Score	year	Measure_ID
US	US: COVID - % of Medicare patients initially infected with COVID, 2021-Q4	3.25	Quarter 4, 2021	allmcfcovpatPq4_u
US	US: COVID - % of Medicare patients ever infected with COVID, 2021-Q4	18.36	Quarter 4, 2021	allmccovpatPq4_u
US	US: COVID - % of deaths with patients ever infected with COVID, 2021-Q4	27.06	Quarter 4, 2021	allmccovDeaPq4_u
US	US: COVID - % of hospitalizations with patients ever infected with COVID, 2021-Q4	28.18	Quarter 4, 2021	allmccovHosPq4_u
US	US: COVID Nursing Home - % of Medicare patients initially infected with COVID, 2021-Q4	5.29	Quarter 4, 2021	nh_mcfcovpatPq4_u
US	US: COVID Nursing Home - % of Medicare patients ever infected with COVID, 2021-Q4	32.1	Quarter 4, 2021	nh_mccovpatPq4_u
US	US: COVID Nursing Home - % of deaths with patients ever infected with COVID, 2021-Q4	32.86	Quarter 4, 2021	nh_mccovDeaPq4_u
US	US: COVID Nursing Home - % of hospitalizations with patients ever infected with COVID, 2021-Q4	35.69	Quarter 4, 2021	nh_mccovHosPq4_u
US	US: Prevalent Patients - Age: Average patient age, 12/31/2021	62.95	2021	agey4_u
US	US: Prevalent Patients - Age: % Less than 18 years, 12/31/2021	0.21	2021	age1y4_u
US	US: Prevalent Patients - Age: % Between 18-64 years, 12/31/2021	50.2	2021	age2y4_u
US	US: Prevalent Patients - Age: % Greater than or equal to 65 years, 12/31/2021	49.58	2021	age3y4_u
US	US: Prevalent Patients - Primary Cause of ESRD: % Diabetes, 12/31/2021	45.57	2021	dis1y4_u
US	US: Prevalent Patients - Primary Cause of ESRD: % Hypertension, 12/31/2021	30.35	2021	dis2y4_u
US	US: Prevalent Patients - Primary Cause of ESRD: % Glomerulonephritis, 12/31/2021	9.47	2021	dis3y4_u
US	US: Prevalent Patients - Primary Cause of ESRD: % Other/Unknown Cause, 12/31/2021	14.06	2021	dis4y4_u
US	US: Prevalent Patients - Primary Cause of ESRD: % Missing Cause, 12/31/2021	0.56	2021	dis5y4_u
US	US: Prevalent Patients - Vintage: % on ESRD Therapy less than 1 year, 12/31/2021	16.67	2021	vin1y4_u
US	US: Prevalent Patients - Vintage: % on ESRD Therapy for 1-2 years, 12/31/2021	16.89	2021	vin2y4_u
US	US: Prevalent Patients - Vintage: % on ESRD Therapy for 2-3 years, 12/31/2021	13.77	2021	vin3y4_u
US	US: Prevalent Patients - Vintage: % on ESRD Therapy for 3-6 years, 12/31/2021	25.6	2021	vin4y4_u
US	US: Prevalent Patients - Vintage: % on ESRD Therapy for over 6 years, 12/31/2021	27.07	2021	vin5y4_u
US	US: Prevalent Patients - Race: % Asian/Pacific Islander, 12/31/2021	6.78	2021	rac1y4_u
US	US: Prevalent Patients - Race: % African American, 12/31/2021	34.74	2021	rac2y4_u
US	US: Prevalent Patients - Race: % Native American, 12/31/2021	1.23	2021	rac3y4_u
US	US: Prevalent Patients - Race: % White, 12/31/2021	56.97	2021	rac4y4_u
US	US: Prevalent Patients - Race: % Other/Unknown/Missing Race, 12/31/2021	0.27	2021	rac5y4_u
US	US: Prevalent Patients - Ethnicity: % Hispanic, 12/31/2021	19.35	2021	eth1y4_u
US	US: Prevalent Patients - Ethnicity: % Non-Hispanic, 12/31/2021	80.5	2021	eth2y4_u
US	US: Prevalent Patients - Ethnicity: % Unknown Ethnicity, 12/31/2021	0.16	2021	eth3y4_u
US	US: Prevalent Patients - Sex: % Female, 12/31/2021	42.33	2021	sexy4_u
US	US: Prevalent Patients - Nursing Home: % of Nursing Home Facility Patients During Year, 12/31/2021	16.08	2021	nrshomey4_u
US	US: Prevalent Patients - Vintage: Average Years of Prior ESRD Therapy, 12/31/2021	5.02	2021	vin4_u
US	US: Prevalent Patients - Modality: % on Hemodialysis, 12/31/2021	84.11	2021	modhdy4_u
US	US: Prevalent Patients - Modality: % on Home Hemodialysis, 12/31/2021	2.97	2021	modhdy4_u
US	US: Prevalent Patients - Modality: % on Continuous Ambulatory Peritoneal Dialysis, 12/31/2021	1.36	2021	modccapy4_u
US	US: Prevalent Patients - Modality: % on Continuous Cycling Peritoneal Dialysis, 12/31/2021	11.15	2021	modccpy4_u
US	US: Prevalent Patients - Modality: % Other Modality, 12/31/2021	0.42	2021	modothy4_u
US	US: Prevalent Patients - End of Year Status: Average number of patients alive in facility, 2021	57.46	2021	pahy4m_u
US	US: Calcium (Adult) - % of patient-months with uncorrected calcium < 8.4 mg/dL, 2021	18.45	2021	CWunCa1y4_u
US	US: Calcium (Adult) - % of patient-months with uncorrected calcium 8.4-10.2 mg/dL, 2021	77.74	2021	CWunCa2y4_u
US	US: Calcium (Adult) - % of patient-months with uncorrected calcium > 10.2 mg/dL, 2021	1.15	2021	CWunCa3y4_u
US	US: Calcium (Adult) - % of patient-months with uncorrected calcium Missing or Out of Range, 2021	2.66	2021	CWunCa4y4_u
US	US: Calcium (Adult) - Average uncorrected calcium in mg/dL, out of valid in range patient-months, 2021	8.9	2021	CWavgUnCay4_u
US	US: Phosphorus (Adult) - Average serum phosphorus in mg/dL, out of valid in range patient-months, 2021	5.51	2021	CWavgPy4_u
US	US: Phosphorus (Adult) - % of patient-months with serum phosphorus < 3.5 mg/dL, 2021	6.98	2021	CWP1y4_u
US	US: Phosphorus (Adult) - % of patient-months with serum phosphorus 3.5-4.5 mg/dL, 2021	22.27	2021	CWP2y4_u
US	US: Phosphorus (Adult) - % of patient-months with serum phosphorus 4.6-5.5 mg/dL, 2021	29.23	2021	CWP3y4_u
US	US: Phosphorus (Adult) - % of patient-months with serum phosphorus 5.6-7.0 mg/dL, 2021	22.45	2021	CWP4y4_u
US	US: Phosphorus (Adult) - % of patient-months with serum phosphorus > 7.0 mg/dL, 2021	16.04	2021	CWP5y4_u
US	US: Phosphorus (Adult) - % of patient-months with serum phosphorus Missing or Out of Range, 2021	3.03	2021	CWP6y4_u
US	US: Hypercalcemia (Adult) - Average uncorrected calcium > 10.2 mg/dL, out of valid in range patient-months, 2021	1.9	2021	CWunCagt102y4_u
US	US: Calcium (Adult) - Average Number of Eligible Dialysis Patients, 2021	79.03	2021	CWptdenomy4m_u
US	US: Calcium (Adult) - Average Number of Eligible Dialysis Patient-months, 2021	680.76	2021	CWptmthdenomy4m_u
US	US: Phosphorus (Adult) - Average Number of Eligible Dialysis Patients, 2021	84.18	2021	serumphospatsy4m_u
US	US: Phosphorus (Adult) - Average Number of Eligible Dialysis Patient-months, 2021	719.84	2021	serumphospmy4m_u
US	US: Hypercalcemia (Adult) - Average Number of Eligible Dialysis Patients, 2021	79.05	2021	CWhcptdenomy4m_u
US	US: Hypercalcemia (Adult) - Average Number of Eligible Dialysis Patient-months, 2021	680.9	2021	CWhcptmthdenomy4m_u
US	U: Prevalent VA Type (Adult) - % of patients receiving treatment with fistulae, 2021	60.37	2021	ppvfy4_u
US	U: Prevalent VA Type (Adult) - % of patients receiving treatment with grafts, 2021	17.09	2021	ppvgy4_u
US	U: Prevalent VA Type (Adult) - % of patients receiving treatment with catheters, 2021	20.46	2021	ppathy4_u
US	U: Prevalent VA Type (Adult) - % of patients receiving treatment with other or unknown access type., 2021	2.08	2021	ppomy4_u
US	U: Prevalent VA Type (Adult) - Long-Term Catheter Rate, 2021	15.48	2021	lscy4_u
US	U: Incident VA Type (Adult) - % of patients receiving treatment with fistulae, 2021	11.8	2021	piavfy4_u
US	U: Incident VA Type (Adult) - % of patients receiving treatment with grafts, 2021	2.75	2021	piavgy4_u
US	U: Incident VA Type (Adult) - % of patients receiving treatment with catheters, 2021	81.13	2021	picathy4_u
US	U: Incident VA Type (Adult) - % of patients receiving treatment with other or unknown access type., 2021	4.33	2021	piomy4_u
US	U: Incident VA Type (Adult) - % of patients with fistulae placed, 2021	12.34	2021	pfisty4_u
US	U: Prevalent VA Type (Adult) - Average number of HD patients, 2021	75.13	2021	phdvapty4m_u
US	U: Prevalent VA Type (Adult) - Average number of HD patient-months, 2021	637.33	2021	phdy4m_u
US	U: Incident VA Type (Adult) - Average number of HD patients, 2021	14.25	2021	ihdy4m_u
US	U: Prevalent VA Type (Adult) - Standardized Fistula Rate (SFR), 2021	59.92	2021	sfry4_u
US	U: VA infection - Average number of eligible PD patients, 2021	11.38	2021	pdpaty4m_u
US	U: VA infection - Average number of eligible PD patient-months, 2021	84.13	2021	pdptmoy4m_u
US	U: VA infection - PD catheter infection rate per 100 PD patient-months, 2018	2.48	2018	pd2inf100moy1_u
US	U: VA infection - PD catheter infection rate per 100 PD patient-months, 2019	2.48	2019	pd2inf100moy2_u
US	U: VA infection - PD catheter infection rate per 100 PD patient-months, 2020	2.55	2020	pd2inf100moy3_u
US	U: VA infection - PD catheter infection rate per 100 PD patient-months, 2021	2.64	2021	pd2inf100moy4_u

US	US: Prevalent Comorbidities - Average Number of Medicare Dialysis Patients Alive on December 31, 2021	45.23	2021 ncmy4m_u
US	US: Prevalent Comorbidities - Average % with Anemia, 2021	2.96	2021 clmanemy4_u
US	US: Prevalent Comorbidities - Average % with AIDS, 2021	0.78	2021 clmhivaidmy4_u
US	US: Prevalent Comorbidities - Average % with Alcohol Dependence, 2021	1.3	2021 clmalcomy4_u
US	US: Prevalent Comorbidities - Average % with Cancer, 2021	3.32	2021 clmcanmy4_u
US	US: Prevalent Comorbidities - Average % with Cardiac Arrest, 2021	1.01	2021 clmcamy4_u
US	US: Prevalent Comorbidities - Average % with Cardiac Dysrhythmias, 2021	18.77	2021 clmcdm4_u
US	US: Prevalent Comorbidities - Average % with Cerebrovascular Disease, 2021	7.23	2021 clmcvdm4_u
US	US: Prevalent Comorbidities - Average % with Chronic Obstructive Pulmonary Disease, 2021	13.96	2021 clmcopdm4_u
US	US: Prevalent Comorbidities - Average % with Congestive Heart Failure, 2021	29.83	2021 clmchfmy4_u
US	US: Prevalent Comorbidities - Average % with Diabetes, 2021	35.7	2021 clmdiabmy4_u
US	US: Prevalent Comorbidities - Average % with Drug Dependence, 2021	1.22	2021 clmdrugmy4_u
US	US: Prevalent Comorbidities - Average % with Gastro-Intestinal Tract Bleeding, 2021	3.02	2021 clmgtbmy4_u
US	US: Prevalent Comorbidities - Average % with Hepatitis B, 2021	0.45	2021 clmhpbmy4_u
US	US: Prevalent Comorbidities - Average % with Hepatitis Other, 2021	1.71	2021 clmhpthmy4_u
US	US: Prevalent Comorbidities - Average % with Hyperparathyroidism, 2021	19.82	2021 clmhptymy4_u
US	US: Prevalent Comorbidities - Average % with Non-Vascular Access-Related Infection, 2021	17.88	2021 clminfmy4_u
US	US: Prevalent Comorbidities - Average % with Ischemic Heart Disease, 2021	25.88	2021 clmihdm4_u
US	US: Prevalent Comorbidities - Average % with Myocardial Infarction, 2021	7.41	2021 clmmimym4_u
US	US: Prevalent Comorbidities - Average % with Peripheral Vascular Disease, 2021	16.93	2021 clmpvdm4_u
US	US: Prevalent Comorbidities - Average % with Pneumonia, 2021	3.2	2021 clmpnemy4_u
US	US: Prevalent Comorbidities - Average Number of Comorbid Conditions, 2021	2.19	2021 clmcntcomy4_u
US	US: Prevalent Comorbidities - Average % with Vascular Access-Related Infection, 2021	4.71	2021 clminfvamy4_u
US	US: Prevalent Comorbidities - Average % with Metastatic Infection, 2021	1.43	2021 clmmstinfmy4_u
US	US: Prevalent Comorbidities - Average % with Tuberculosis, 2021	0.22	2021 clmtbmy4_u
US	US (AFS): Facility Information - Average number of patients, 2021	99.69	2021 allcnty4m_u
US	US (AFS): Facility Information - Average number of all patients on 12/31/2021	65.41	2021 endcnty4m_u
US	US (AFS): Facility Information - Average % of patients transferred in, 2021	16.14	2021 transiny4_u
US	US (AFS): Facility Information - Average % of patients transferred out, 2021	16.38	2021 transouty4_u
US	US (AFS): Facility Information - Average % Medicare patients on 12/31/2021	74.61	2021 medicarey4_u
US	US (AFS): Facility Information - Average % Medicare pending on 12/31/2021	0.76	2021 medpendy4_u
US	US (AFS): Facility Information - Average % Non-Medicare on 12/31/2021	24.58	2021 nonmedy4_u
US	U (QIES): Facility Information - Average number of Condition-Level Citations/Survey	0.23	2021 cfc_U
US	U (QIES): Facility Information - Average number of Standard-Level Citations/Survey	4.32	2021 std_U
US	US: Prevalent Patients (Pediatric) - Age: % under 5 years, 12/31/2021	28.67	2021 p_age1y4_u
US	US: Prevalent Patients (Pediatric) - Age: % between 5-9 years, 12/31/2021	15.21	2021 p_age2y4_u
US	US: Prevalent Patients (Pediatric) - Age: % between 10-14 years, 12/31/2021	28.67	2021 p_age3y4_u
US	US: Prevalent Patients (Pediatric) - Age: % between 15-17 years, 12/31/2021	27.44	2021 p_age4y4_u
US	US: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Diabetes, 12/31/2021	2.06	2021 p_dis1y4_u
US	US: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Hypertension, 12/31/2021	1.75	2021 p_dis2y4_u
US	US: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Glomerulonephritis, 12/31/2021	30.32	2021 p_dis3y4_u
US	US: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Cystic Kidney, 12/31/2021	29.8	2021 p_dis4y4_u
US	US: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Congenital/Hereditary, 12/31/2021	8.84	2021 p_dis5y4_u
US	US: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Hemolytic Uremic Syndrome, 12/31/2021	0	2021 p_dis6y4_u
US	US: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Other Cause, 12/31/2021	19.42	2021 p_dis7y4_u
US	US: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Missing/Unknown Cause, 12/31/2021	7.81	2021 p_dis8y4_u
US	US: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy less than 1 year, 12/31/2021	29.91	2021 p_vin1y4_u
US	US: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy for 1-2 years, 12/31/2021	23.12	2021 p_vin2y4_u
US	US: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy for 2-3 years, 12/31/2021	13.67	2021 p_vin3y4_u
US	US: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy for 3-6 years, 12/31/2021	16.03	2021 p_vin4y4_u
US	US: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy for over 6 years, 12/31/2021	17.27	2021 p_vin5y4_u
US	US: Prevalent Patients (Pediatric) - Race: % Asian/Pacific Islander, 12/31/2021	4.21	2021 p_race1y4_u
US	US: Prevalent Patients (Pediatric) - Race: % African American, 12/31/2021	28.57	2021 p_race2y4_u
US	US: Prevalent Patients (Pediatric) - Race: % Native American, 12/31/2021	0.92	2021 p_race3y4_u
US	US: Prevalent Patients (Pediatric) - Race: % White, 12/31/2021	63.21	2021 p_race4y4_u
US	US: Prevalent Patients (Pediatric) - Race: % Other/Unk/Missing race, 12/31/2021	3.08	2021 p_race5y4_u
US	US: Prevalent Patients (Pediatric) - Ethnicity: % Hispanic, 12/31/2021	27.34	2021 p_eth1y4_u
US	US: Prevalent Patients (Pediatric) - Ethnicity: % Non-Hispanic, 12/31/2021	72.05	2021 p_eth2y4_u
US	US: Prevalent Patients (Pediatric) - Ethnicity: % Unknown Ethnicity, 12/31/2021	0.62	2021 p_eth3y4_u
US	US: Prevalent Patients (Pediatric) - Sex: % Female, 12/31/2021	43.99	2021 p_sexy4_u
US	US: Prevalent Patients (Pediatric) - Modality: % on Hemodialysis, 12/31/2021	47.48	2021 p_modhdy4_u
US	US: Prevalent Patients (Pediatric) - Modality: % on Home Hemodialysis, 12/31/2021	0.72	2021 p_modhdy4_u
US	US: Prevalent Patients (Pediatric) - Modality: % on Continuous Ambulatory Peritoneal Dialysis, 12/31/2021	0.51	2021 p_modcapdy4_u
US	US: Prevalent Patients (Pediatric) - Modality: % on Continuous Cycling Peritoneal Dialysis, 12/31/2021	50.87	2021 p_modccpdy4_u
US	US: Prevalent Patients (Pediatric) - Modality: % on Other Modality, 12/31/2021	0.41	2021 p_modothy4_u
US	US (2728): Incident Patients (Pediatric) - Percent with Medicare coverage, 2021	22.92	2021 p_allmccrmy4_u
US	US (2728): Incident Patients (Pediatric) - Percent with Medicaid coverage only, 2021	43.07	2021 p_insmcdmy4_u
US	US (2728): Incident Patients (Pediatric) - Percent with employer group coverage only, 2021	18.54	2021 p_insempmy4_u
US	US (2728): Incident Patients (Pediatric) - Percent with None, other or unknown coverage only, 2021	15.47	2021 p_insnonthmy4_u
US	US (2728): Incident Patients (Pediatric) - No Pre-ESRD Nephrologist Care, 2021	24.38	2021 p_nephnomy4_u
US	US (2728): Incident Patients (Pediatric) - Pre-ESRD Nephrologist Care Less Than 6 months, 2021	19.56	2021 p_neph6my4_u
US	US (2728): Incident Patients (Pediatric) - Pre-ESRD Nephrologist Care Between 6 and 12 months, 2021	15.47	2021 p_neph612my4_u
US	US (2728): Incident Patients (Pediatric) - Pre-ESRD Nephrologist Care Greater Than 12 months, 2021	30.95	2021 p_neph12my4_u
US	US (2728): Incident Patients (Pediatric) - Unknown Pre-ESRD Nephrologist Care, 2021	9.64	2021 p_nephunkmissmy4_u
US	US (2728): Incident Patients (Pediatric) - Percent of Patients Informed of Transplant Options, 2021	87.88	2021 p_ptinfmy4_u
US	US (2728): Incident Patients (Pediatric) - Percent of Incident HD Patients: AV Fistula, 2021	2.52	2021 p_mefavfmy4_u
US	US (2728): Incident Patients (Pediatric) - Percent of Incident HD Patients: AV Graft, 2021	1.15	2021 p_mefgrftmy4_u
US	US (2728): Incident Patients (Pediatric) - Percent of Incident HD Patients: Catheter, 2021	96.33	2021 p_mefcathmy4_u
US	US (2728): Incident Patients (Pediatric) - Percent of Incident HD Patients: Other/Unknown/Missing, 2021	0	2021 p_mefouaccessmy4_u

US	US (2728): Incident Patients (Pediatric) - Percent of Incident Patients with Fistulae placed, 2021	6.19	2021_p_avfpresentmy4_u
US	U: Prevalent VA Type (Pediatric) - % of patients receiving treatment with fistulae, 2021	16.2	2021_p_ppavfy4_u
US	U: Prevalent VA Type (Pediatric) - Long-Term Catheter Rate, 2021	65.41	2021_p_ltcy4_u
US	US: Prevalent Waitlist (Pediatric) - % of patient-months (<18 only) on waitlist, 2021	34.65	2021_p_WLy4_u
US	US: Prevalent Waitlist (Pediatric) - % of patient-months <10 years on waitlist, 2021	33.03	2021_p_WLl10y4_u
US	US: Prevalent Waitlist (Pediatric) - % of patient-months aged 10-17 on waitlist, 2021	39.94	2021_p_WL1017y4_u
US	US: HD HGB (Pediatric) - Average hemoglobin levels (g/dL), of valid in-range patient-months, 2021	10.79	2021_p_CWhdavgHGBy4_u
US	US: HD HGB (Pediatric) - % of patient-months with hemoglobin < 10 g/dL, 2021	22.33	2021_p_CWhdrgb1y4_u
US	US: HD HGB (Pediatric) - % of patient-months with hemoglobin 10 - <11 g/dL, 2021	25.49	2021_p_CWhdrgb2y4_u
US	US: HD HGB (Pediatric) - % of patient-months with hemoglobin 11 - 12 g/dL, 2021	30.32	2021_p_CWhdrgb3y4_u
US	US: HD HGB (Pediatric) - % of patient-months with hemoglobin > 12 g/dL, 2021	15.27	2021_p_CWhdrgb4y4_u
US	US: HD HGB (Pediatric) - % of patient-months with hemoglobin Missing or Out of Range, 2021	6.59	2021_p_CWhdrgb5y4_u
US	US: PD HGB (Pediatric) - Average hemoglobin levels (g/dL), of valid in-range patient-months, 2021	10.82	2021_p_CWpdavgHGBy4_u
US	US: PD HGB (Pediatric) - % of patient-months with hemoglobin < 10 g/dL, 2021	26.76	2021_p_CWpdhgb1y4_u
US	US: PD HGB (Pediatric) - % of patient-months with hemoglobin 10 - <11 g/dL, 2021	21.78	2021_p_CWpdhgb2y4_u
US	US: PD HGB (Pediatric) - % of patient-months with hemoglobin 11 - 12 g/dL, 2021	21.75	2021_p_CWpdhgb3y4_u
US	US: PD HGB (Pediatric) - % of patient-months with hemoglobin > 12 g/dL, 2021	19.63	2021_p_CWpdhgb4y4_u
US	US: PD HGB (Pediatric) - % of patient-months with hemoglobin Missing or Out of Range, 2021	10.08	2021_p_CWpdhgb5y4_u
US	U: Albumin (Pediatric) - Average serum albumin (g/dL), of valid in range HD patient-months, 2021	3.99	2021_p_CWhdalby4_u
US	U: Albumin (Pediatric) - % of HD patient-months with Serum Albumin < 3 g/dL, 2021	2.57	2021_p_CWhdalb1y4_u
US	U: Albumin (Pediatric) - % of HD patient-months with Serum Albumin 3 - < 3.5 g/dL, 2021	8.33	2021_p_CWhdalb2y4_u
US	U: Albumin (Pediatric) - % of HD patient-months with Serum Albumin 3.5 - < 4 g/dL, 2021	29.45	2021_p_CWhdalb3y4_u
US	U: Albumin (Pediatric) - % of HD patient-months with Serum Albumin >= 4 g/dL, 2021	53.02	2021_p_CWhdalb4y4_u
US	U: Albumin (Pediatric) - % of HD patient-months with Serum Albumin Missing, 2021	6.63	2021_p_CWhdalb5y4_u
US	U: Albumin (Pediatric) - Average Serum Albumin, of valid in range PD patient-months, 2021	3.67	2021_p_CWpdalby4_u
US	U: Albumin (Pediatric) - % of PD patient-months with Serum Albumin < 3 g/dL, 2021	11.31	2021_p_CWpdalb1y4_u
US	U: Albumin (Pediatric) - % of PD patient-months with Serum Albumin 3 - < 3.5 g/dL, 2021	18.37	2021_p_CWpdalb2y4_u
US	U: Albumin (Pediatric) - % of PD patient-months with Serum Albumin 3.5 - < 4 g/dL, 2021	26.88	2021_p_CWpdalb3y4_u
US	U: Albumin (Pediatric) - % of PD patient-months with Serum Albumin >= 4 g/dL, 2021	32.49	2021_p_CWpdalb4y4_u
US	U: Albumin (Pediatric) - % of PD patient-months with Serum Albumin Missing, 2021	10.95	2021_p_CWpdalb5y4_u
US	U: PD Kt/V (Pediatric) - % of patient-months with Kt/V >= 1.8, 2021	78.58	2021_p_CWpdkvtge18y4_u
US	U: HD Kt/V (Pediatric) - % of patient-months with Kt/V >= 1.2, 2021	90.16	2021_p_CWhdkvtge12y4_u
US	US: Patient Placement - % of incident patients, 2021	17.06	2021_ppidy4_u
US	US: Patient Placement - % of patients continuing at facility, 2021	71.63	2021_ppcdy4_u
US	US: Patient Placement - % of patients that transferred into facility, 2021	11.3	2021_pptdy4_u
US	US: End of Year Status - % of patients death attributed to this facility, 2021	14.68	2021_pdhdy4_u
US	US: End of Year Status - % of patients death attributed to another facility, 2021	1.82	2021_phody4_u
US	US: End of Year Status - % of patients that received a transplant, 2021	2.93	2021_ptxdy4_u
US	US: End of Year Status - % of patients alive in this facility, 2021	68.67	2021_pahdy4_u
US	US: End of Year Status - % of patients alive in another facility, 2021	8.13	2021_paody4_u
US	US: End of Year Status - % of patients other, 2021	3.78	2021_potdy4_u
US	US (AFS): Facility Information - Average number of in-center HD patients on 12/31/2021	55.38	2021_iuhemy4m_u
US	US (AFS): Facility Information - Average number of in-center frequent HD patients on 12/31/2021	0.03	2021_iufreqy4m_u
US	US (AFS): Facility Information - Average number of in-center non-frequent HD patients on 12/31/2021	55.36	2021_iuonfreqy4m_u
US	US (AFS): Facility Information - Average number of in-center patients with other modality on 12/31/2021	0.01	2021_iuothy4m_u
US	US (AFS): Facility Information - Average number of in-center Continuous Ambulatory Peritoneal Dialysis patients on 12/31/2021	0	2021_iucapdy4m_u
US	US (AFS): Facility Information - Average number of in-center Continuous Cycling Peritoneal Dialysis patients on 12/31/2021	0	2021_iuccpdy4m_u
US	US (AFS): Facility Information - Average number of home HD patients on 12/31/2021	1.9	2021_ihemy4m_u
US	US (AFS): Facility Information - Average number of home frequent HD patients on 12/31/2021	0.69	2021_ihfreqy4m_u
US	US (AFS): Facility Information - Average number of home non-frequent HD patients on 12/31/2021	1.22	2021_ihnonfreqy4m_u
US	US (AFS): Facility Information - Average number of home patients with other modality on 12/31/2021	0	2021_ihothy4m_u
US	US (AFS): Facility Information - Average number of home Continuous Ambulatory Peritoneal Dialysis patients on 12/31/2021	0.93	2021_ihcpdy4m_u
US	US (AFS): Facility Information - Average number of home Continuous Cycling Peritoneal Dialysis patients on 12/31/2021	7.18	2021_ihccpdy4m_u
US	US (AFS): Facility Information - Average number of total staff positions on Dec 31 (full & part time), 2021	13.86	2021_staffy4m_u
US	US (AFS): Facility Information - Average number of full time nurses on 12/31/2021	4.34	2021_nurseFTy4m_u
US	US (AFS): Facility Information - Average number of full time patient care technicians on 12/31/2021	5.31	2021_ptcareFTy4m_u
US	US (AFS): Facility Information - Average number of full time renal dieticians on 12/31/2021	0.44	2021_dietFTy4m_u
US	US (AFS): Facility Information - Average number of full time social workers on 12/31/2021	0.45	2021_socwkFTy4m_u
US	US (AFS): Facility Information - Average number of part time nurses on 12/31/2021	0.92	2021_nursePTY4m_u
US	US (AFS): Facility Information - Average number of part time patient care technicians on 12/31/2021	0.83	2021_ptcarePTY4m_u
US	US (AFS): Facility Information - Average number of part time renal dieticians on 12/31/2021	0.68	2021_dietPTY4m_u
US	US (AFS): Facility Information - Average number of part time social workers on 12/31/2021	0.9	2021_socwkPTY4m_u
US	F (AFS): Facility Information - Vocational Rehab number of Patients 18-54 on 12/31/2021	33.42	2021_vocrehaby4m_u
US	US (AFS): Facility Information - Average % incident patients, 2021	16.18	2021_incpery4_u
US	US (AFS): Facility Information - % Patients 18-54 who are employed on 12/31/2021	25.89	2021_employedy4_u
US	US (AFS): Facility Information - % Patients 18-54 who are school on 12/31/2021	0.83	2021_schooly4_u
US	US: Prevalent VA Type (Nursing Home) - % of Patients Receiving Treatment with Fistulae, 2021	50.2	2021_nh_ppavfy4_u
US	US: Prevalent VA Type (Nursing Home) - Long-Term Catheter Rate, 2021	21.41	2021_nh_ltcy4_u
US	US: HD Kt/V (Nursing Home) - % of Patient-months with Kt/V < 1.2, 2021	2.05	2021_nh_CWhdkvt1y4_u
US	US: PD Kt/V (Nursing Home) - % of Patient-months with Kt/V < 1.7, 2021	8.63	2021_nh_CWpdktv1y4_u
US	US: HD HGB (Nursing Home) - % of Patient-months with Hemoglobin < 10 g/dL, 2021	28.78	2021_nh_CWhdrgb1y4_u
US	US: HD HGB (Nursing Home) - % of Patient-months with ESA Prescribed, 2021	79.45	2021_nh_CWhdesarxy4_u
US	US: PD HGB (Nursing Home) - % of Patient-months with Hemoglobin < 10 g/dL, 2021	26.45	2021_nh_CWpdhgb1y4_u
US	US: PD HGB (Nursing Home) - % of Patient-months with ESA Prescribed, 2021	55.12	2021_nh_CWpdesarxy4_u
US	US: All Patient Mortality (Nursing Home) - Observed death rate (per 100 patient-years), 2021	42.95	2021_nh_obdry4_u
US	US: All Patient Mortality (Nursing Home) - Standardized Mortality Ratio (SMR), 2021	1.05	2021_nh_smry4_u
US	US: All Patient Mortality (Nursing Home) - % of deaths from withdrawal, 2021	25.49	2021_nh_wity4_u
US	US: SHR (Nursing Home Admissions) - Observed Admission Rate (per patient-year in average facility), 2021	268.17	2021_nh_obhtry4_u
US	US: SHR (Nursing Home Admissions) - Standardized Hospitalization Ratio for Admissions, 2021	1.39	2021_nh_shtry4_u

US	US: Hospitalization (Nursing Home) - Diagnosis: % with Septicemia, 2021	22.91	2021_nh_sepjy4_u
US	US: Hospitalization (Nursing Home) - Diagnosis: % with Acute Myocardial Infarction, 2021	11.35	2021_nh_miiy4_u
US	US: Hospitalization (Nursing Home) - Diagnosis: % with Congestive Heart Failure, 2021	45.24	2021_nh_achfy4_u
US	US: Hospitalization (Nursing Home) - Diagnosis: % with Cardiac Dysrhythmia, 2021	33.52	2021_nh_acdry4_u
US	US: Hospitalization (Nursing Home) - Diagnosis: % with Cardiac Arrest, 2021	4.56	2021_nh_acary4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with AIDS, 2021	0.91	2021_nh_clmhivaidmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Vascular Access-Related Infection, 2021	7.23	2021_nh_clminfavmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Hepatitis B, 2021	0.7	2021_nh_clmhpepbmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Hepatitis Other, 2021	2.98	2021_nh_clmhhepohmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Metastatic Infection, 2021	3.28	2021_nh_clmmstinfmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Pneumonia, 2021	7.45	2021_nh_clmpnemy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Tuberculosis, 2021	0.26	2021_nh_clmtbmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Non-Vascular Access-Related Infection, 2021	34.24	2021_nh_clminfmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Cardiac Arrest, 2021	2.09	2021_nh_clmcamy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Cardiac Dysrhythmias, 2021	35.06	2021_nh_clmcdmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Cerebrovascular Disease, 2021	16.4	2021_nh_clmcdvmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Congestive Heart Failure, 2021	49.48	2021_nh_clmchfmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Ischemic Heart Disease, 2021	43.14	2021_nh_clmihdmy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Myocardial Infarction, 2021	12.36	2021_nh_clmmimymy4_u
US	US: Prevalent Comorbidities (Nursing Home) - % with Peripheral Vascular Disease, 2021	32.46	2021_nh_clmpvdmymy4_u
US	US: Prevalent Patients (Nursing Home) - Age: % Less than 18 years, 12/31/2021	0.01	2021_nh_age1y4_u
US	US: Prevalent Patients (Nursing Home) - Age: % Between 18-64 years, 12/31/2021	32.73	2021_nh_age2y4_u
US	US: Prevalent Patients (Nursing Home) - Age: % Greater than or equal to 65 years, 12/31/2021	67.26	2021_nh_age3y4_u
US	US: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Diabetes, 12/31/2021	53.89	2021_nh_dis1y4_u
US	US: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Hypertension, 12/31/2021	27.79	2021_nh_dis2y4_u
US	US: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Glomerulonephritis, 12/31/2021	4.78	2021_nh_dis3y4_u
US	US: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Other/Unknown Cause, 12/31/2021	12.77	2021_nh_dis4y4_u
US	US: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Missing Cause, 12/31/2021	0.77	2021_nh_dis5y4_u
US	US: Prevalent Patients (Nursing Home) - Race: % Asian/Pacific Islander, 12/31/2021	4.21	2021_nh_rac1y4_u
US	US: Prevalent Patients (Nursing Home) - Race: % African American, 12/31/2021	35.57	2021_nh_rac2y4_u
US	US: Prevalent Patients (Nursing Home) - Race: % Native American, 12/31/2021	1.08	2021_nh_rac3y4_u
US	US: Prevalent Patients (Nursing Home) - Race: % White, 12/31/2021	58.97	2021_nh_rac4y4_u
US	US: Prevalent Patients (Nursing Home) - Race: % Other/Unknown/Missing race, 12/31/2021	0.17	2021_nh_rac5y4_u
US	US: Prevalent Patients (Nursing Home) - Ethnicity: % Hispanic, 12/31/2021	13.29	2021_nh_eth1y4_u
US	US: Prevalent Patients (Nursing Home) - Ethnicity: % Non-Hispanic, 12/31/2021	86.55	2021_nh_eth2y4_u
US	US: Prevalent Patients (Nursing Home) - Ethnicity: % Unknown Ethnicity, 12/31/2021	0.17	2021_nh_eth3y4_u
US	US: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy less than 1 year, 12/31/2021	18.79	2021_nh_vin1y4_u
US	US: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy for 1-2 years, 12/31/2021	17.78	2021_nh_vin2y4_u
US	US: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy for 2-3 years, 12/31/2021	12.94	2021_nh_vin3y4_u
US	US: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy for 3-6 years, 12/31/2021	24.88	2021_nh_vin4y4_u
US	US: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy for over 6 years, 12/31/2021	25.6	2021_nh_vin5y4_u
US	US: Prevalent Patients (Nursing Home) - Sex: % Female, 12/31/2021	48.14	2021_nh_sexy4_u
US	US: Prevalent Patients (Nursing Home) - Modality: % on Hemodialysis, 12/31/2021	93.19	2021_nh_modhdy4_u
US	US: Prevalent Patients (Nursing Home) - Modality: % on Home Hemodialysis, 12/31/2021	3.36	2021_nh_modhhdymy4_u
US	US: Prevalent Patients (Nursing Home) - % on Continuous Ambulatory Peritoneal Dialysis, 12/31/2021	0.26	2021_nh_modcapdy4_u
US	US: Prevalent Patients (Nursing Home) - % on Continuous Cycling Peritoneal Dialysis, 12/31/2021	2.4	2021_nh_modccpdy4_u
US	US: Prevalent Patients (Nursing Home) - % on Other Modality, 12/31/2021	0.8	2021_nh_modothry4_u
US	US: Incident Patients (Nursing Home) - Percent with Medicare alone or with other insurance, 2021	82.36	2021_nh_allmdcrmymy4_u
US	US: Incident Patients (Nursing Home) - Percent with Medicaid coverage only, 2021	8.77	2021_nh_insmdcdmy4_u
US	US: Incident Patients (Nursing Home) - Percent with employer group coverage only, 2021	2.48	2021_nh_insempmy4_u
US	US: Incident Patients (Nursing Home) - Percent with Other/Unknown/No insurance, 2021	6.4	2021_nh_insonothmy4_u
US	US: Incident Patients (Nursing Home) - Percent of hemodialysis patients.: Arteriovenous Fistula, 2021	5.97	2021_nh_mefavfmy4_u
US	US: Incident Patients (Nursing Home) - Percent of hemodialysis patients.: Arteriovenous Graft, 2021	1.71	2021_nh_mefgraftmy4_u
US	US: Incident Patients (Nursing Home) - Percent of hemodialysis patients.: Catheter, 2021	90.03	2021_nh_mefcathmy4_u
US	US: Incident Patients (Nursing Home) - Percent of hemodialysis patients.: Other/Unknown/Missing Access, 2021	2.29	2021_nh_mefouaccessmy4_u
US	US: Incident Patients (Nursing Home) - Percent of patients with Arteriovenous fistulae placed, 2021	14.81	2021_nh_avfpresentmy4_u
US	US: Incident Patients (Nursing Home) - No Pre-ESRD Nephrologist Care, 2021	17.99	2021_nh_nephnomy4_u
US	US: Incident Patients (Nursing Home) - Pre-ESRD Nephrologist Care Less Than 6 months, 2021	20.49	2021_nh_nephy6my4_u
US	US: Incident Patients (Nursing Home) - Pre-ESRD Nephrologist Care Between 6 and 12 months, 2021	16.75	2021_nh_nephy612my4_u
US	US: Incident Patients (Nursing Home) - Pre-ESRD Nephrologist Care Greater Than 12 months, 2021	21.79	2021_nh_nephy12my4_u
US	US: Incident Patients (Nursing Home) - Unknown Pre-ESRD Nephrologist Care, 2021	22.98	2021_nh_nephunkmissmy4_u
US	US: Incident Patients (Nursing Home) - Percent of Patients Informed of Transplant Options, 2021	85.42	2021_nh_ptinfymy4_u
US	US (2728): Incident Patients - Percent alcohol dependent, 2021	1.7	2021_alcomy4_u
US	US (2728): Incident Patients - Percent with atherosclerotic heart disease, 2021	11.71	2021_ashdmy4_u
US	US (2728): Incident Patients - Percent with other cardiac disorder, 2021	20.97	2021_othcarmy4_u
US	US (2728): Incident Patients - Percent with cancer, 2021	6.93	2021_canmy4_u
US	US (2728): Incident Patients - Percent with congestive heart failure, 2021	27.21	2021_chfmy4_u
US	US (2728): Incident Patients - Percent with cardiovascular disease, cerebral vascular incident, and transient ischemic attack, 2021	8.48	2021_cvamy4_u
US	US (2728): Incident Patients - Percent with diabetes on insulin, 2021	42.28	2021_diabimy4_u
US	US (2728): Incident Patients - Percent with diabetes, 2021	64.3	2021_diabmy4_u
US	US (2728): Incident Patients - Percent drug dependent, 2021	1.56	2021_drugmy4_u
US	US (2728): Incident Patients - Percent with history of hypertension, 2021	88	2021_hxhtmy4_u
US	US (2728): Incident Patients - Percent inability to ambulate, 2021	6.49	2021_ambumy4_u
US	US (2728): Incident Patients - Percent inability to transfer, 2021	3.51	2021_transmy4_u
US	US (2728): Incident Patients - Percent with chronic obstructive pulmonary disease, 2021	8.38	2021_copdmy4_u
US	US (2728): Incident Patients - Percent with PVD, 2021	8.04	2021_pvdmy4_u
US	US (2728): Incident Patients - Percent smoker, 2021	6.62	2021_smokmy4_u
US	US (2728): Incident Patients - Percent Hispanic, 2021	16.83	2021_ethmy4_u
US	US (2728): Incident Patients - Percent White, 2021	63.79	2021_whitemy4_u

US	US (2728): Incident Patients - Percent African American, 2021	28.36	2021	blackmy4_u
US	US (2728): Incident Patients - Percent Native American, 2021	1.18	2021	nativmy4_u
US	US (2728): Incident Patients - Percent Asian/Pacific Islander, 2021	6.31	2021	asianmy4_u
US	US (2728): Incident Patients - Percent other/unknown/missing race, 2021	0.35	2021	racoumy4_u
US	US (2728): Incident Patients - Percent currently employed FT/PT/student, 2021	24.72	2021	cempmy4_u
US	US (2728): Incident Patients - Percent previously employed FT/PT/student, 2021	34.59	2021	pempmy4_u
US	US (2728): Incident Patients - Percent diabetes as primary cause ESRD, 2021	46.23	2021	dbprimy4_u
US	US (2728): Incident Patients - Percent glomerulonephritis as primary cause of ESRD, 2021	5.76	2021	gnprimy4_u
US	US (2728): Incident Patients - Percent hypertension as primary cause ESRD, 2021	30.43	2021	htprimy4_u
US	US (2728): Incident Patients - Percent other/missing primary cause of ESRD, 2021	17.59	2021	omprimy4_u
US	US (2728): Incident Patients - Percent female, 2021	42.11	2021	femmy4_u
US	US (2728): Incident Patients - Average age, 2021	64.16	2021	agemy4_u
US	US (2728): Incident Patients - Average serum albumin, 2021	3.37	2021	salbmy4_u
US	US (2728): Incident Patients - Average creatinine, 2021	6.43	2021	creamy4_u
US	US (2728): Incident Patients - Average hemoglobin, 2021	9.36	2021	hgmy4_u
US	US (2728): Incident Patients - GFR by MDRD formula, 2021	10.71	2021	gfrmy4_u
US	US (2728): Incident Patients - Average count of comorbidities, 2021	3.06	2021	cntcomy4_u
US	US (2728): Incident Patients - Primary Modality: Hemodialysis, 2021	86.56	2021	pdmodMEFHDmy4_u
US	US (2728): Incident Patients - Primary Modality: Peritoneal Dialysis, 2021	13.44	2021	pdmodMEFPDmy4_u
US	US (2728): Incident Patients - Primary Modality: Other/Unknown/Missing, 2021	0	2021	pdmodMEFOTHUNKmy4_u
US	US (2728): Incident Patients - Percent with Medicare coverage only, 2021	46.1	2021	insmdcrmy4_u
US	US (2728): Incident Patients - Percent with Medicaid coverage only, 2021	13.49	2021	insmdcdmy4_u
US	US (2728): Incident Patients - Percent with Medicare and Medicaid coverage only, 2021	7.49	2021	insmdccrdmy4_u
US	US (2728): Incident Patients - Percent with employer group coverage only, 2021	11.46	2021	insempmy4_u
US	US (2728): Incident Patients - Percent with no coverage, 2021	3.94	2021	insnonemy4_u
US	US (2728): Incident Patients - Percent with Medicare and other coverage, 2021	8.37	2021	insmdcromy4_u
US	US (2728): Incident Patients - Percent with other or unknown coverage, 2021	9.16	2021	insmedomy4_u
US	US (2728): Incident Patients - Percent of Patients Received ESA prior to ESRD, 2021	15.74	2021	preepomy4_u
US	US (2728): Incident Patients - No Pre-ESRD Nephrologist Care, 2021	16.32	2021	nephnomy4_u
US	US (2728): Incident Patients - Pre-ESRD Nephrologist Care Less Than 6 months, 2021	18.15	2021	nephynomy4_u
US	US (2728): Incident Patients - Pre-ESRD Nephrologist Care Between 6 and 12 months, 2021	18.98	2021	nephy612my4_u
US	US (2728): Incident Patients - Pre-ESRD Nephrologist Care Greater Than 12 months, 2021	30.4	2021	nephy12my4_u
US	US (2728): Incident Patients - Pre-ESRD Nephrologist Care Unknown, 2021	0	2021	nephynkmy4_u
US	US (2728): Incident Patients - Unknown Pre-ESRD Nephrologist Care, 2021	16.15	2021	nephunkmissmy4_u
US	US (2728): Incident Patients - Percent of Patients Informed of Transplant Options, 2021	90.91	2021	ptinfmy4_u
US	US (2728): Incident Patients - Reason Not Informed: Patient Medically Unfit, 2021	37.12	2021	ptxmedunfitmy4_u
US	US (2728): Incident Patients - Reason Not Informed: Unsuitable Due to Age, 2021	0.01	2021	ptxagedmy4_u
US	US (2728): Incident Patients - Reason Not Informed: Patient Psychologically Unfit, 2021	0	2021	ptxpsyunfitmy4_u
US	US (2728): Incident Patients - Reason Not Informed: Patient Declined Information, 2021	8.16	2021	ptxdeclinemy4_u
US	US (2728): Incident Patients - Reason Not Informed: Patient Has Not Been Assessed, 2021	53.34	2021	ptxnotassessmy4_u
US	US (2728): Incident Patients - Percent of Incident HD Patients: Arteriovenous Fistula, 2021	12.31	2021	mefavfmy4_u
US	US (2728): Incident Patients - Percent of Incident HD Patients: Arteriovenous Graft, 2021	2.45	2021	mefgraftmy4_u
US	US (2728): Incident Patients - Percent of Incident HD Patients: Catheter, 2021	84.97	2021	mefcathmy4_u
US	US (2728): Incident Patients - Percent of Incident HD Patients: Other/Unknown/Missing, 2021	0.27	2021	mefoumaccessmy4_u
US	US (2728): Incident Patients - Percent of Incident Patients with Arteriovenous fistulae placed, 2021	22.83	2021	avfpresentmy4_u
US	US (2728): Incident Patients - Median BMI for males >= 20 yrs, 2021	28.06	2021	bmimmy4_u
US	US (2728): Incident Patients - Median BMI for females >= 20 yrs, 2021	29.14	2021	bmifmy4_u
US	US (2728): Incident Patients - Average Patients Not Informed of Transplant Options, 2021	1.39	2021	ptinfmmy4m_u
US	US (2728): Incident Patients - Average Number of incident hemodialysis patients (n), 2021	13.27	2021	hemomy4m_u
US	US (2728): Incident Patients - Average Number of forms returned, 2021	15.33	2021	nmy4m_u
US	US: All Patient Mortality - Average number of patients (per year in average facility), 2018-2021	89.22	2018-21	rdszm_u
US	US: All Patient Mortality - Average years at risk for mortality (per year in average facility), 2018-2021	54.59	2018-21	dyzm_u
US	US: All Patient Mortality - Average number of deaths (per year in average facility), 2018-2021	10.53	2018-21	deazm_u
US	US: All Patient Mortality - Average expected deaths (per year in average facility), 2018-2021	10.53	2018-21	exdzm_u
US	US: All Patient Mortality - Average number deaths from dialysis, unrelated deaths (per year in average facility), 2018-2021	0.06	2018-21	dudzm_u
US	US: All Patient Mortality - Standardized Mortality Ratio (SMR), 2018-2021	1	2018-21	smrz_u
US	US: All Patient Mortality - % of deaths from withdrawal, 2018-2021	24.07	2018-21	witz_u
US	US: All Patient Mortality - % of deaths from infection, 2018-2021	10.27	2018-21	infz_u
US	US: All Patient Mortality - % of deaths from cardiac causes, 2018-2021	44.85	2018-21	cardz_u
US	US: All Patient Mortality - % of deaths from liver disease, 2018-2021	1.36	2018-21	livz_u
US	US: First-Year Mortality - Average number of new patients, 2018 - 2020	15.24	2018-20	fynmzm_u
US	US: First-Year Mortality - Average Years at risk , 2018 - 2020	10.96	2018-20	fydym_u
US	US: First-Year Mortality - Average number of deaths, 2018 - 2020	2.43	2018-20	fydeazm_u
US	US: First-Year Mortality - Average number of expected deaths, 2018 - 2020	2.43	2018-20	fyexdzm_u
US	US: First-Year Mortality - Standardized First-Year Mortality Ratio, 2018 - 2020	1	2018-20	fysmrz_u
US	US: First-Year Mortality - Percent of deaths from withdrawal, 2018 - 2020	27.29	2018-20	fywitz_u
US	US: First-Year Mortality - Percent of deaths from infection, 2018 - 2020	9.43	2018-20	fyinfz_u
US	US: First-Year Mortality - Percent of deaths from cardiac causes, 2018 - 2020	41.23	2018-20	fyCARDIACz_u
US	US: First-Year Mortality - Percent of deaths from liver disease, 2018 - 2020	2.45	2018-20	fyLivz_u
US	US: Hospitalization - Average Number of Patients (per year in average facility), 2018-2021	73.08	2018-21	rdshzm_u
US	US: SHR (Admissions) - Average Number of Hospital Admissions (per year in average facility), 2018-2021	66.52	2018-21	htazm_u
US	US: SHR (Admissions) - Average Expected Number of Hospital Admissions (per year in average facility), 2018-2021	66.54	2018-21	extzm_u
US	US: SHR (Days) - Average Days Hospitalized (per year in average facility), 2018-2021	507.45	2018-21	hdzm_u
US	US: SHR (Days) - Average Expected Days Hospitalized (per year in average facility), 2018-2021	507.62	2018-21	exhdzm_u
US	US: Hospitalization - Average Years at Risk (per year in average facility), 2018-2021	43.85	2018-21	hdyzm_u
US	US: SHR (ED) -Average Number of ED Visits (per year in average facility), 2018-2021	97.6	2018-21	hedzm_u
US	US: SHR (ED) -Average Expected Number of ED Visits (per year in average facility), 2018-2021	97.76	2018-21	exedzm_u
US	US: SHR (ED) - Average Years at Risk (per year in average facility), 2018-2021	31.51	2018-21	hdyedzm_u
US	US: SHR (Admissions) - Average Standardized Hospitalization Ratio for Admissions (per year in average facility), 2018-2021	1	2018-21	shrtz_u

US	US: SHR (Days) - Average Standardized Hospitalization Ratio for Days (per year in average facility), 2018-2021	1	2018-21	shrdz_u
US	US: SHR (Days) - Average Length of Stay (days per admission, per year in average facility), 2018-2021	7.63	2018-21	lenz_u
US	US: SHR (Admissions) - Average % One Day Admissions (per year in average facility), 2018-2021	9.16	2018-21	onez_u
US	US: Hospitalization - Diagnosis: Average % with Acute Myocardial Infarction (per year in average facility), 2018-2021	6.4	2018-21	miiz_u
US	US: Hospitalization - Diagnosis: Average % with Septicemia (per year in average facility), 2018-2021	12.22	2018-21	sepi_z_u
US	US: Hospitalization - Diagnosis: Average % with Congestive Heart Failure (per year in average facility), 2018-2021	27.49	2018-21	achfz_u
US	US: Hospitalization - Diagnosis: Average % with Cardiac Dysrhythmia (per year in average facility), 2018-2021	18.32	2018-21	acdrz_u
US	US: Hospitalization - Diagnosis: Average % with Cardiac Arrest (per year in average facility), 2018-2021	2.54	2018-21	acarz_u
US	US: SHR (ED) -Average % Patients with at Least One ED Visit (per year in average facility), 2018-2021	59.02	2018-21	edptz_u
US	US: SHR (ED) -Average % ED Visits Resulting in Hospitalization (per year in average facility), 2018-2021	44.09	2018-21	edipz_u
US	US: SHR (ED) -Average % Inpatient Admissions Originating in ED (per year in average facility), 2018-2021	84.17	2018-21	ipedz_u
US	US: SHR (ED) -Average Standardized Hospitalization Ratio for ED (per year in average facility), 2018-2021	1	2018-21	shredz_u
US	U SRR - Standardized Readmission Ratio, 2021	1.04	2021	srny4_u
US	U: SRR - Average index discharges, 2021	57.3	2021	indexmy4_u
US	U: SRR - Average number of readmissions, 2021	15.08	2021	readmmy4_u
US	U: SRR - Average expected readmissions, 2021	15.56	2021	srrepxmy4_u
US	US: STR - Average number of eligible patients (age<75) with no previous transplant (per year in average facility), 2018-2021	65.42	2018-21	rdstzm_u
US	US: STR - Average number of patients (per year in average facility), 2018-2021	70.54	2018-21	rdsalztzm_u
US	US: STR - Average number of 1st transplant (per year in average facility), 2018-2021	1.83	2018-21	txzm_u
US	US: Transplantation - Average number of transplants (per year in average facility), 2018-2021	2.06	2018-21	txallzm_u
US	US: STR - Average number of years at risk for eligible patients (age<75) with no previous transplant (per year in average facility), 2018-21	40.28	2018-21	txyzm_u
US	US: STR - Average number of deceased donor transplant (per year in average facility), 2018-2021	1.64	2018-21	cadalltzm_u
US	US: STR - Average number of living donor transplant (per year in average facility), 2018-2021	0.46	2018-21	livealltzm_u
US	US: STR - Average number of expected 1st transplant (per year in average facility), 2018-2021	1.83	2018-21	extxzm_u
US	US: STR - Standardized 1st Transplant Ratio, 2018-2021	1	2018-21	strz_u
US	US: Prevalent Waitlist - Average number of eligible dialysis patients (age<75), 2021	61.87	2021	pppwpty4m_u
US	US: Prevalent Waitlist - % of patient-months (age<75) on waitlist, 2021	17.7	2021	WLy4_u
US	US: Prevalent Waitlist - % of patient-months < 40 years on waitlist, 2021	27.25	2021	WLlt40y4_u
US	US: Prevalent Waitlist - % of patient-months aged 40-74 on waitlist, 2021	16.64	2021	WL4074y4_u
US	US: Prevalent Waitlist - % of male patient-months (age<75) on waitlist, 2021	18.85	2021	WLMale4_u
US	US: Prevalent Waitlist - % of female patient-months (age<75) on waitlist, 2021	16.02	2021	WLFemy4_u
US	US: Prevalent Waitlist - % Hispanic White patient-months (age<75) on waitlist, 2021	18.98	2021	WLwhhy4_u
US	US: Prevalent Waitlist - % Non-Hispanic White patient-months (age<75) on waitlist, 2021	16.77	2021	WLwhhny4_u
US	US: Prevalent Waitlist - % of African American patient-months (age<75) on waitlist, 2021	16.7	2021	WLBly4_u
US	US: Prevalent Waitlist - % of Asian patient-months (age<75) on waitlist, 2021	25.91	2021	WLas4_u
US	US: Prevalent Waitlist - % of Native American patient-months (age<75) on waitlist, 2021	10.43	2021	WLnay4_u
US	US: Prevalent Waitlist - % of other/unknown race patient-months (age<75) on waitlist, 2021	17.73	2021	WLthy4_u
US	US: Prevalent Waitlist - % of diabetic patient-months (age<75) on waitlist, 2021	14.56	2021	WLDMy4_u
US	US: Prevalent Waitlist - % of non-diabetic patient-months (age<75) on waitlist, 2021	20.29	2021	WLnodmy4_u
US	US: Prevalent Waitlist - % of patient-months (age<75) without previous transplant on waitlist, 2021	16.68	2021	WLnotxy4_u
US	US: Prevalent Waitlist - % of patient-months (age<75) with prev KI transplant on waitlist, 2021	30.69	2021	WLTxy4_u
US	US: Prevalent Waitlist - % of patient-months (age<75) with <2 years of prior ESRD therapy on waitlist, 2021	13.39	2021	WLVCat1y4_u
US	US: Prevalent Waitlist - % of patient-months (age<75) with 2-4 years of prior ESRD therapy on waitlist, 2021	22.56	2021	WLVCat2y4_u
US	US: Prevalent Waitlist - % of patient-months (age<75) with 5+ years of prior ESRD therapy on waitlist, 2021	17.86	2021	WLVCat3y4_u
US	US: Prevalent Waitlist - Average number of patient-months (age<75) at risk, 2021	514.57	2021	pppwpm4m_u
US	US: Prevalent Waitlist - Age-adjusted percentage of patient-months waitlisted (age<75), 2021	17.2	2021	pppw4_u
US	U: Incident Waitlist - Average number of patients (per year in average facility), 2018-2020	9.87	2018-20	swrptzm_u
US	U: Incident Waitlist - Average number of patient-years at risk (per year in average facility), 2018-2020	7.87	2018-20	swrpyzm_u
US	U: Incident Waitlist - Average number of waitlisting or receipt of a living-donor transplant for SWR (per year in average facility), 2018-20	0.83	2018-20	swrwlmz_u
US	U: Incident Waitlist - Average number of expected transplant waitlisting or receipt of a living-donor transplant (per year in average facility)	0.82	2018-20	swrexwlmz_u
US	U: Incident Waitlist - Standardized Waitlist Ratio, 2018 - 2020	1	2018-20	swrz_u
US	US: Influenza - % of Medicare dialysis patients vaccinated, 8/1/2020-12/31/2018	80.65	2018	FVhy1_u
US	US: Influenza - % of Medicare dialysis patients vaccinated, 8/1/2018-3/31/2019	81.44	2018	FVfy1_u
US	US: Influenza - % of Medicare dialysis patients vaccinated, 8/1/2019-12/31/2019	80.57	2019	FVfy2_u
US	US: Influenza - % of Medicare dialysis patients vaccinated, 8/1/2019-3/31/2020	81.56	2019	FVfy2_u
US	US: Influenza - % of Medicare dialysis patients vaccinated, 8/1/2020-12/31/2020	82.59	2020	FVhy3_u
US	U: Influenza - % of patients vaccinated, 8/1-3/31, 2021	83.03	2020	FVfy3_u
US	U: Influenza - % of patients that declined vaccination, 8/1-3/31, 2020	7	2020	FVdeclinedfy3_u
US	U: Influenza - % of patients without vaccination due to outside vaccination reported but no documentation, 8/1-3/31, 2020	0.25	2020	FVovndfy3_u
US	U: Influenza - % of patients without vaccination due to other reason or vaccine data not available, 2020	3.84	2020	FVothrsfnfy3_u
US	U: Influenza - % of patients vaccinated, 8/1-12/31, 2021	78.18	2021	FVhy4_u
US	U: Influenza - % of Medicare patients vaccinated, 8/1-12/31, 2021	79.43	2021	FVmcarehy4_u
US	U: Influenza - % of Medicare Advantage patients vaccinated, 8/1-12/31, 2021	80.58	2021	FVmahy4_u
US	F: Influenza - % of patients with Medicare as primary insurer vaccinated, 8/1-12/31, 2021	78.94	2021	FVmpphy4_u
US	U: Influenza - % of dual Medicare/Medicaid eligible patients vaccinated, 8/1-12/31, 2021	77.59	2021	FVdualhy4_u
US	U: Influenza - % of patients with Medicare as secondary insurer vaccinated, 8/1-12/31, 2021	77.52	2021	FVmsphy4_u
US	U: Influenza - % of Non-Medicare patients vaccinated, 8/1-12/31, 2021	70.8	2021	FVnonmcarehy4_u
US	U: Influenza - % of dialysis patients <18 vaccinated, 8/1-12/31, 2021	68.1	2021	FVlt18hy4_u
US	U: Influenza - % of dialysis patients 18-39 vaccinated, 8/1-12/31, 2021	67.28	2021	FV1839hy4_u
US	U: Influenza - % of dialysis patients 40-64 vaccinated, 8/1-12/31, 2021	76.16	2021	FV4064hy4_u
US	U: Influenza - % of dialysis patients 65-74 vaccinated, 8/1-12/31, 2021	80.53	2021	FV6574hy4_u
US	U: Influenza - % of dialysis patients 75+ vaccinated, 8/1-12/31, 2021	82.45	2021	FV75uphy4_u
US	U: Influenza - % of male dialysis patients vaccinated, 8/1-12/31, 2021	78.01	2021	FVmalehy4_u
US	U: Influenza - % of female dialysis patients vaccinated, 8/1-12/31, 2021	78.3	2021	FVfemhy4_u
US	U: Influenza - % of Asian dialysis patients vaccinated, 8/1-12/31, 2021	82.86	2021	FVashy4_u
US	U: Influenza - % of Native American dialysis patients vaccinated, 8/1-12/31, 2021	80.78	2021	FVnahy4_u
US	U: Influenza - % of white dialysis patients vaccinated, 8/1-12/31, 2021	80.54	2021	FVwhhy4_u
US	U: Influenza - % of Other race dialysis patients vaccinated, 8/1-12/31, 2021	62.23	2021	FVrothy4_u
US	U: Influenza - % of black dialysis patients vaccinated, 8/1-12/31, 2021	73.24	2021	FVblky4_u

US	U: Influenza - % of Hispanic dialysis patients vaccinated, 8/1-12/31, 2021	81.56	2021	FVhisphy4_u
US	U: Influenza - % of dialysis patients with <1 year of prior ESRD therapy vaccinated, 8/1-12/31, 2021	68.09	2021	FVVCat1hy4_u
US	U: Influenza - % of dialysis patients with 1-2 years of prior ESRD therapy vaccinated, 8/1-12/31, 2021	79.1	2021	FVVCat2hy4_u
US	U: Influenza - % of dialysis patients with 3+ years of prior ESRD therapy vaccinated, 8/1-12/31, 2021	81.82	2021	FVVCat3hy4_u
US	U: Influenza - Total number of patients treated on 12/31, 2021	59.73	2021	eFVY4m_u
US	U: Influenza - Average number of patients not vaccinated due to medical contraindication, 8/1-3/31, 2021	0.61	2021	medrsnfy4m_U
US	US: HD HGB (Adult) - Average hemoglobin levels (g/dL), of valid in-range patient-months, 2021	10.73	2021	CWhdavgHGBy4_u
US	US: HD HGB (Adult) - % of patient-months with hemoglobin < 10 g/dL, 2021	22.97	2021	CWhdHgb1y4_u
US	US: HD HGB (Adult) - % of patient-months with hemoglobin 10 - <11 g/dL, 2021	34.27	2021	CWhdHgb2y4_u
US	US: HD HGB (Adult) - % of patient-months with hemoglobin 11 - 12 g/dL, 2021	28.36	2021	CWhdHgb3y4_u
US	US: HD HGB (Adult) - % of patient-months with hemoglobin > 12 g/dL, 2021	12.17	2021	CWhdHgb4y4_u
US	US: HD HGB (Adult) - % of patient-months with hemoglobin Missing or Out of Range, 2021	2.22	2021	CWhdHgb5y4_u
US	US: HD HGB (Adult) - % of patient-months with ESA prescribed, 2021	76.15	2021	CWhdesarxy4_u
US	US: PD HGB (Adult) - Average hemoglobin levels (g/dL), of valid in-range patient-months, 2021	10.96	2021	CWpdavgHGBy4_u
US	US: PD HGB (Adult) - % of patient-months with hemoglobin < 10 g/dL, 2021	22.03	2021	CWpdHgb1y4_u
US	US: PD HGB (Adult) - % of patient-months with hemoglobin 10 - <11 g/dL, 2021	28.44	2021	CWpdHgb2y4_u
US	US: PD HGB (Adult) - % of patient-months with hemoglobin 11 - 12 g/dL, 2021	26.49	2021	CWpdHgb3y4_u
US	US: PD HGB (Adult) - % of patient-months with hemoglobin > 12 g/dL, 2021	19.72	2021	CWpdHgb4y4_u
US	US: PD HGB (Adult) - % of patient-months with hemoglobin Missing or Out of Range, 2021	3.32	2021	CWpdHgb5y4_u
US	US: PD HGB (Adult) - % of patient-months with ESA prescribed, 2021	54.59	2021	CWpdesarxy4_u
US	US: HD HGB (Adult) - Average number of eligible patients, 2021	71.09	2021	CWhdptdenomy4m_u
US	US: HD HGB (Adult) - Average number of eligible patient-months, 2021	611.12	2021	CWhdptmthdenomy4m_u
US	US: PD HGB (Adult) - Average number of eligible patients, 2021	23.25	2021	CWpdptdenomy4m_u
US	US: PD HGB (Adult) - Average number of eligible patient-months, 2021	179.55	2021	CWpdptmthdenomy4m_u
US	US: STR (Adult) - Average Number of Medicare Patients, 2021	35.86	2021	rdstfy4m_u
US	US: STR (Adult) - Average Patient Years at Risk, 2021	22.01	2021	tfyy4m_u
US	US: STR (Adult) - Average Number of Transfusions, 2021	7.47	2021	tfy4m_u
US	US: STR (Adult) - Average Expected Total Number of Transfusions, 2021	7.72	2021	extfy4m_u
US	US: STR (Adult) - Standardized Transfusion Ratio, 2021	1	2021	strry4_u
US	U: Albumin (Adult) - Average Serum Albumin, of valid in range HD patient-months, 2021	3.91	2021	CWhdalb4_u
US	U: Albumin (Adult) - % of HD patient-months with serum albumin < 3 g/dL, 2021	2.24	2021	CWhdalb1y4_u
US	U: Albumin (Adult) - % of HD patient-months with serum albumin 3 - < 3.5 g/dL, 2021	8.95	2021	CWhdalb2y4_u
US	U: Albumin (Adult) - % of HD patient-months with serum albumin 3.5 - < 4 g/dL, 2021	37.56	2021	CWhdalb3y4_u
US	U: Albumin (Adult) - % of HD patient-months with serum albumin >= 4 g/dL, 2021	48.1	2021	CWhdalb4y4_u
US	U: Albumin (Adult) - % of HD patient-months with serum albumin Missing, 2021	3.15	2021	CWhdalb5y4_u
US	U: Albumin (Adult) - % of HD patient-months with Serum Albumin < 4.0 g/dL, 2021	48.75	2021	CWhdalb4y4_u
US	U: UFR (Adult) - Average UFR, of valid in range HD patient-months, 2021	7.66	2021	CWhdavgufr4_u
US	U: UFR (Adult) - % of HD patient-months with UFR <= 13, 2021	87.1	2021	CWhdufr1y4_u
US	U: UFR (Adult) - % of HD patient-months with UFR > 13, 2021	7.69	2021	CWhdufr2y4_u
US	U: UFR (Adult) - % of HD patient-months with UFR Missing or Out of Range, 2021	5.21	2021	CWhdufr3y4_u
US	U: Albumin (Adult) - Average Serum Albumin, of valid in range PD patient-months, 2021	3.67	2021	CWpdalb4_u
US	U: Albumin (Adult) - % of PD patient-months with serum albumin < 3 g/dL, 2021	6.49	2021	CWpdalb1y4_u
US	U: Albumin (Adult) - % of PD patient-months with serum albumin 3 - < 3.5 g/dL, 2021	21.81	2021	CWpdalb2y4_u
US	U: Albumin (Adult) - % of PD patient-months with serum albumin 3.5 - < 4 g/dL, 2021	41.24	2021	CWpdalb3y4_u
US	U: Albumin (Adult) - % of PD patient-months with serum albumin >= 4 g/dL, 2021	27.14	2021	CWpdalb4y4_u
US	U: Albumin (Adult) - % of PD patient-months with serum albumin Missing, 2021	3.32	2021	CWpdalb5y4_u
US	U: Albumin (Adult) - % of PD patient-months with Serum Albumin < 4.0 g/dL, 2021	69.54	2021	CWpdalb4y4_u
US	U: HD Dialysis Adequacy (Adult) - Average number of eligible patients, 2021	71.09	2021	CWhddenomy4m_u
US	U: HD Dialysis Adequacy (Adult) - Average number of Eligible Dialysis Patient-months, 2021	611.12	2021	CWhdmthdenomy4m_u
US	U: PD Dialysis Adequacy (Adult) - Average number of eligible patients, 2021	23.25	2021	CWpdndenomy4m_u
US	U: PD Dialysis Adequacy (Adult) - Average number of Eligible Dialysis Patient-months, 2021	179.55	2021	CWpdmthdenomy4m_u
US	U: PD Kt/V (Adult) - Average Kt/V, of valid in-range values, 2021	2.23	2021	CWpdavgktvy4_u
US	U: PD Kt/V (Adult) - % of patient-months with Kt/V < 1.7, 2021	4.92	2021	CWpdktv1y4_u
US	U: PD Kt/V (Adult) - % of patient-months with Kt/V 1.7-2.5, 2021	68.72	2021	CWpdktv2y4_u
US	U: PD Kt/V (Adult) - % of patient-months with Kt/V >= 2.5, 2021	23.46	2021	CWpdktv3y4_u
US	U: PD Kt/V (Adult) - % of patient-months with Kt/V missing or out of range, 2021	2.9	2021	CWpdktv4y4_u
US	U: HD Kt/V (Adult) - Average Kt/V, of valid in-range values, 2021	1.63	2021	CWhdavgktvy4_u
US	U: HD Kt/V (Adult) - % of patient-months with Kt/V < 1.2, 2021	1.55	2021	CWhdktv1y4_u
US	U: HD Kt/V (Adult) - % of patient-months with Kt/V 1.2-1.8, 2021	71.65	2021	CWhdktv2y4_u
US	U: HD Kt/V (Adult) - % of patient-months with Kt/V >= 1.8, 2021	25.47	2021	CWhdktv3y4_u
US	U: HD Kt/V (Adult) - % of patient-months with Kt/V missing or out of range, 2021	1.33	2021	CWhdktv4y4_u
US	U: HD Kt/V (Adult) - Average number of eligible patients, 2021	59.24	2021	CWhdktvptsy4m_U
US	U: HD Kt/V (Adult) - Average number of eligible patient-months, 2021	535.98	2021	CWhdktvptmthy4m_U
NC	STATE: COVID - % of Medicare patients initially infected with COVID, 2021-Q4	2.19	Quarter 4, 2021	allmcFcovpatPq4_s
NC	STATE: COVID - % of Medicare patients ever infected with COVID, 2021-Q4	16.61	Quarter 4, 2021	allmcEcovpatPq4_s
NC	STATE: COVID - % of deaths with patients ever infected with COVID, 2021-Q4	24.12	Quarter 4, 2021	allmcEcovDeaPq4_s
NC	STATE: COVID - % of hospitalizations with patients ever infected with COVID, 2021-Q4	24.34	Quarter 4, 2021	allmcEcovHosPq4_s
NC	STATE: COVID Nursing Home - % of Medicare patients initially infected with COVID, 2021-Q4	3.54	Quarter 4, 2021	nh_mcFcovpatPq4_s
NC	STATE: COVID Nursing Home - % of Medicare patients ever infected with COVID, 2021-Q4	29.29	Quarter 4, 2021	nh_mcEcovpatPq4_s
NC	STATE: COVID Nursing Home - % of deaths with patients ever infected with COVID, 2021-Q4	30.62	Quarter 4, 2021	nh_mcEcovDeaPq4_s
NC	STATE: COVID Nursing Home - % of hospitalizations with patients ever infected with COVID, 2021-Q4	31.46	Quarter 4, 2021	nh_mcEcovHosPq4_s
NC	S: Prevalent Patients - Age: Average patient age, 12/31/2021	61.91	2021	agey4_s
NC	S: Prevalent Patients - Age: % Less than 18 years, 12/31/2021	0.21	2021	age1y4_s
NC	S: Prevalent Patients - Age: % Between 18-64 years, 12/31/2021	52.99	2021	age2y4_s
NC	S: Prevalent Patients - Age: % Greater than or equal to 65 years, 12/31/2021	46.8	2021	age3y4_s
NC	S: Prevalent Patients - Primary Cause of ESRD: % Diabetes, 12/31/2021	44.11	2021	dis1y4_s
NC	S: Prevalent Patients - Primary Cause of ESRD: % Hypertension, 12/31/2021	31.61	2021	dis2y4_s
NC	S: Prevalent Patients - Primary Cause of ESRD: % Glomerulonephritis, 12/31/2021	11.55	2021	dis3y4_s
NC	S: Prevalent Patients - Primary Cause of ESRD: % Other/Unknown Cause, 12/31/2021	12.32	2021	dis4y4_s

NC	S: Prevalent Patients - Primary Cause of ESRD: % Missing Cause, 12/31/2021	0.42	2021	dis5y4_s
NC	S: Prevalent Patients - Vintage: % on ESRD Therapy less than 1 year, 12/31/2021	15.48	2021	vin1y4_s
NC	S: Prevalent Patients - Vintage: % on ESRD Therapy for 1-2 years, 12/31/2021	16.34	2021	vin2y4_s
NC	S: Prevalent Patients - Vintage: % on ESRD Therapy for 2-3 years, 12/31/2021	13.02	2021	vin3y4_s
NC	S: Prevalent Patients - Vintage: % on ESRD Therapy for 3-6 years, 12/31/2021	25.31	2021	vin4y4_s
NC	S: Prevalent Patients - Vintage: % on ESRD Therapy for over 6 years, 12/31/2021	29.85	2021	vin5y4_s
NC	S: Prevalent Patients - Race: % Asian/Pacific Islander, 12/31/2021	2.04	2021	rac1y4_s
NC	S: Prevalent Patients - Race: % African American, 12/31/2021	59.79	2021	rac2y4_s
NC	S: Prevalent Patients - Race: % Native American, 12/31/2021	1.13	2021	rac3y4_s
NC	S: Prevalent Patients - Race: % White, 12/31/2021	36.94	2021	rac4y4_s
NC	S: Prevalent Patients - Race: % Other/Unknown/Missing Race, 12/31/2021	0.1	2021	rac5y4_s
NC	S: Prevalent Patients - Ethnicity: % Hispanic, 12/31/2021	4.86	2021	eth1y4_s
NC	S: Prevalent Patients - Ethnicity: % Non-Hispanic, 12/31/2021	95.08	2021	eth2y4_s
NC	S: Prevalent Patients - Ethnicity: % Unknown Ethnicity, 12/31/2021	0.07	2021	eth3y4_s
NC	S: Prevalent Patients - Sex: % Female, 12/31/2021	43.36	2021	sexy4_s
NC	S: Prevalent Patients - Nursing Home: % of Nursing Home Facility Patients During Year, 12/31/2021	14.51	2021	nrshomey4_s
NC	S: Prevalent Patients - Vintage: Average Years of Prior ESRD Therapy, 12/31/2021	5.37	2021	viny4_s
NC	S: Prevalent Patients - Modality: % on Hemodialysis, 12/31/2021	84.17	2021	modhdy4_s
NC	S: Prevalent Patients - Modality: % on Home Hemodialysis, 12/31/2021	3.73	2021	modhdy4_s
NC	S: Prevalent Patients - Modality: % on Continuous Ambulatory Peritoneal Dialysis, 12/31/2021	0.81	2021	modcapdy4_s
NC	S: Prevalent Patients - Modality: % on Continuous Cycling Peritoneal Dialysis, 12/31/2021	10.9	2021	modccpdy4_s
NC	S: Prevalent Patients - Modality: % Other Modality, 12/31/2021	0.38	2021	modothry4_s
NC	S: Prevalent Patients - End of Year Status: Average number of patients alive in facility, 2021	65.83	2021	pahy4m_s
NC	S: Calcium (Adult) - % of patient-months with uncorrected calcium < 8.4 mg/dL, 2021	19.67	2021	CWunCa1y4_s
NC	S: Calcium (Adult) - % of patient-months with uncorrected calcium 8.4-10.2 mg/dL, 2021	77.93	2021	CWunCa2y4_s
NC	S: Calcium (Adult) - % of patient-months with uncorrected calcium > 10.2 mg/dL, 2021	1.06	2021	CWunCa3y4_s
NC	S: Calcium (Adult) - % of patient-months with uncorrected calcium Missing or Out of Range, 2021	1.34	2021	CWunCa4y4_s
NC	S: Calcium (Adult) - Average uncorrected calcium in mg/dL, out of valid in range patient-months, 2021	8.88	2021	CWavgUnCay4_s
NC	S: Phosphorus (Adult) - Average serum phosphorus in mg/dL, out of valid in range patient-months, 2021	5.58	2021	CWavgPy4_s
NC	S: Phosphorus (Adult) - % of patient-months with serum phosphorus < 3.5 mg/dL, 2021	7.11	2021	CWP1y4_s
NC	S: Phosphorus (Adult) - % of patient-months with serum phosphorus 3.5-4.5 mg/dL, 2021	21.31	2021	CWP2y4_s
NC	S: Phosphorus (Adult) - % of patient-months with serum phosphorus 4.6-5.5 mg/dL, 2021	28.02	2021	CWP3y4_s
NC	S: Phosphorus (Adult) - % of patient-months with serum phosphorus 5.6-7.0 mg/dL, 2021	24.32	2021	CWP4y4_s
NC	S: Phosphorus (Adult) - % of patient-months with serum phosphorus > 7.0 mg/dL, 2021	17.63	2021	CWP5y4_s
NC	S: Phosphorus (Adult) - % of patient-months with serum phosphorus Missing or Out of Range, 2021	1.61	2021	CWP6y4_s
NC	S: Hypercalcemia (Adult) - Average uncorrected calcium > 10.2 mg/dL, out of valid in range patient-months, 2021	0.95	2021	CWunCagt102y4_s
NC	S: Calcium (Adult) - Average Number of Eligible Dialysis Patients, 2021	89.24	2021	CWptdenomy4m_s
NC	S: Calcium (Adult) - Average Number of Eligible Dialysis Patient-months, 2021	788.72	2021	CWptmthdenomy4m_s
NC	S: Phosphorus (Adult) - Average Number of Eligible Dialysis Patients, 2021	94.53	2021	serumphospatsy4m_s
NC	S: Phosphorus (Adult) - Average Number of Eligible Dialysis Patient-months, 2021	830.05	2021	serumphospmy4m_s
NC	S: Hypercalcemia (Adult) - Average Number of Eligible Dialysis Patients, 2021	89.24	2021	CWhcptdenomy4m_s
NC	S: Hypercalcemia (Adult) - Average Number of Eligible Dialysis Patient-months, 2021	788.67	2021	CWhcptmthdenomy4m_s
NC	S: Prevalent VA Type (Adult) - % of patients receiving treatment with fistulae, 2021	61.64	2021	ppavfy4_s
NC	S: Prevalent VA Type (Adult) - % of patients receiving treatment with grafts, 2021	18.57	2021	ppavgy4_s
NC	S: Prevalent VA Type (Adult) - % of patients receiving treatment with catheters, 2021	19.07	2021	ppcathy4_s
NC	S: Prevalent VA Type (Adult) - % of patients receiving treatment with other or unknown access type., 2021	0.72	2021	ppomy4_s
NC	S: Prevalent VA Type (Adult) - Long-Term Catheter Rate, 2021	13.55	2021	ltcy4_s
NC	S: Incident VA Type (Adult) - % of patients receiving treatment with fistulae, 2021	15.58	2021	piavfy4_s
NC	S: Incident VA Type (Adult) - % of patients receiving treatment with grafts, 2021	4	2021	piavgy4_s
NC	S: Incident VA Type (Adult) - % of patients receiving treatment with catheters, 2021	77.92	2021	picathy4_s
NC	S: Incident VA Type (Adult) - % of patients receiving treatment with other or unknown access type., 2021	2.5	2021	piomy4_s
NC	S: Incident VA Type (Adult) - % of patients with fistulae placed, 2021	16.07	2021	piesty4_s
NC	S: Prevalent VA Type (Adult) - Average number of HD patients, 2021	84.53	2021	phdvapty4m_s
NC	S: Prevalent VA Type (Adult) - Average number of HD patient-months, 2021	736.32	2021	phdy4m_s
NC	S: Incident VA Type (Adult) - Average number of HD patients, 2021	14.44	2021	ihdy4m_s
NC	S: Prevalent VA Type (Adult) - Standardized Fistula Rate (SFR), 2021	61.42	2021	sfry4_s
NC	S: VA infection - Average number of eligible PD patients, 2021	14.67	2021	pdpaty4m_s
NC	S: VA infection - Average number of eligible PD patient-months, 2021	106.6	2021	pdptmoy4m_s
NC	S: VA infection - PD catheter infection rate per 100 PD patient-months, 2021	2.6	2021	pd2inf100moy4_s
NC	S: Prevalent Comorbidities - Average Number of Medicare Dialysis Patients Alive on December 31, 2021	54.54	2021	ncmy4m_s
NC	S: Prevalent Comorbidities - Average % with Anemia, 2021	2.24	2021	clmanemy4_s
NC	S: Prevalent Comorbidities - Average % with AIDS, 2021	1.03	2021	clmhivaidmy4_s
NC	S: Prevalent Comorbidities - Average % with Alcohol Dependence, 2021	1.1	2021	clmalcomy4_s
NC	S: Prevalent Comorbidities - Average % with Cancer, 2021	3.21	2021	clmcanmy4_s
NC	S: Prevalent Comorbidities - Average % with Cardiac Arrest, 2021	0.99	2021	clmcamy4_s
NC	S: Prevalent Comorbidities - Average % with Cardiac Dysrhythmias, 2021	17.31	2021	clmcdmy4_s
NC	S: Prevalent Comorbidities - Average % with Cerebrovascular Disease, 2021	6.92	2021	clmcdvmy4_s
NC	S: Prevalent Comorbidities - Average % with Chronic Observeductive Pulmonary Disease, 2021	13.69	2021	clmcpdmy4_s
NC	S: Prevalent Comorbidities - Average % with Congestive Heart Failure, 2021	28.85	2021	clmchfmy4_s
NC	S: Prevalent Comorbidities - Average % with Diabetes, 2021	32.39	2021	clmdiabmy4_s
NC	S: Prevalent Comorbidities - Average % with Drug Dependence, 2021	1.1	2021	clmdrugmy4_s
NC	S: Prevalent Comorbidities - Average % with Gastro-Intestinal Tract Bleeding, 2021	3.06	2021	clmgtbmy4_s
NC	S: Prevalent Comorbidities - Average % with Hepatitis B, 2021	0.55	2021	clmhpbmy4_s
NC	S: Prevalent Comorbidities - Average % with Hepatitis Other, 2021	1.77	2021	clmhpthmy4_s
NC	S: Prevalent Comorbidities - Average % with Hyperparathyroidism, 2021	23.06	2021	clmhpythy4_s
NC	S: Prevalent Comorbidities - Average % with Non-Vascular Access-Related Infection, 2021	15.3	2021	clmhifmy4_s
NC	S: Prevalent Comorbidities - Average % with Ischemic Heart Disease, 2021	22.67	2021	clmihdmy4_s
NC	S: Prevalent Comorbidities - Average % with Myocardial Infarction, 2021	4.78	2021	clmimimy4_s
NC	S: Prevalent Comorbidities - Average % with Peripheral Vascular Disease, 2021	15.08	2021	clmpvdm4_s

NC	S: Prevalent Comorbidities - Average % with Pneumonia, 2021	2.8	2021 clmpnemy4_s
NC	S: Prevalent Comorbidities - Average Number of Comorbid Conditions, 2021	2.04	2021 clmcntcomy4_s
NC	S: Prevalent Comorbidities - Average % with Vascular Access-Related Infection, 2021	4.34	2021 clminfvamy4_s
NC	S: Prevalent Comorbidities - Average % with Metastatic Infection, 2021	1.39	2021 clmmstinfmy4_s
NC	S: Prevalent Comorbidities - Average % with Tuberculosis, 2021	0.06	2021 clmtbmy4_s
NC	S (AFS): Facility Information - Average number of patients, 2021	111.4	2021 allcnty4m_s
NC	S (AFS): Facility Information - Average number of all patients on 12/31/2021	75.47	2021 endcnty4m_s
NC	S (AFS): Facility Information - Average % of patients transferred in, 2021	15.64	2021 transiny4_s
NC	S (AFS): Facility Information - Average % of patients transferred out, 2021	15.49	2021 transouty4_s
NC	S (AFS): Facility Information - Average % Medicare patients on 12/31/2021	79.3	2021 medicarey4_s
NC	S (AFS): Facility Information - Average % Medicare pending on 12/31/2021	0.41	2021 medpendy4_s
NC	S (AFS): Facility Information - Average % Non-Medicare on 12/31/2021	20.3	2021 nonmedy4_s
NC	S (QIES): Facility Information - Average number of Condition-Level Citations/Survey	0.04	2021 cfc_S
NC	S (QIES): Facility Information - Average number of Standard-Level Citations/Survey	2.42	2021 std_S
NC	S: Prevalent Patients (Pediatric) - Age: % under 5 years, 12/31/2021	22.86	2021 p_age1y4_s
NC	S: Prevalent Patients (Pediatric) - Age: % between 5-9 years, 12/31/2021	14.29	2021 p_age2y4_s
NC	S: Prevalent Patients (Pediatric) - Age: % between 10-14 years, 12/31/2021	42.86	2021 p_age3y4_s
NC	S: Prevalent Patients (Pediatric) - Age: % between 15-17 years, 12/31/2021	20	2021 p_age4y4_s
NC	S: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Diabetes, 12/31/2021	0	2021 p_dis1y4_s
NC	S: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Hypertension, 12/31/2021	2.86	2021 p_dis2y4_s
NC	S: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Glomerulonephritis, 12/31/2021	34.29	2021 p_dis3y4_s
NC	S: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Cystic Kidney, 12/31/2021	37.14	2021 p_dis4y4_s
NC	S: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Congenital/Hereditary, 12/31/2021	8.57	2021 p_dis5y4_s
NC	S: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Hemolytic Uremic Syndrome, 12/31/2021	0	2021 p_dis6y4_s
NC	S: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Other Cause, 12/31/2021	17.14	2021 p_dis7y4_s
NC	S: Prevalent Patients (Pediatric) - Primary Cause of ESRD: % Missing/Unknown Cause, 12/31/2021	0	2021 p_dis8y4_s
NC	S: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy less than 1 year, 12/31/2021	37.14	2021 p_vin1y4_s
NC	S: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy for 1-2 years, 12/31/2021	14.29	2021 p_vin2y4_s
NC	S: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy for 2-3 years, 12/31/2021	17.14	2021 p_vin3y4_s
NC	S: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy for 3-6 years, 12/31/2021	17.14	2021 p_vin4y4_s
NC	S: Prevalent Patients (Pediatric) - Vintage: % on ESRD Therapy for over 6 years, 12/31/2021	14.29	2021 p_vin5y4_s
NC	S: Prevalent Patients (Pediatric) - Race: % Asian/Pacific Islander, 12/31/2021	5.71	2021 p_rac1y4_s
NC	S: Prevalent Patients (Pediatric) - Race: % African American, 12/31/2021	45.71	2021 p_rac2y4_s
NC	S: Prevalent Patients (Pediatric) - Race: % Native American, 12/31/2021	2.86	2021 p_rac3y4_s
NC	S: Prevalent Patients (Pediatric) - Race: % White, 12/31/2021	45.71	2021 p_rac4y4_s
NC	S: Prevalent Patients (Pediatric) - Race: % Other/Unk/Missing race, 12/31/2021	0	2021 p_rac5y4_s
NC	S: Prevalent Patients (Pediatric) - Ethnicity: % Hispanic, 12/31/2021	20	2021 p_eth1y4_s
NC	S: Prevalent Patients (Pediatric) - Ethnicity: % Non-Hispanic, 12/31/2021	80	2021 p_eth2y4_s
NC	S: Prevalent Patients (Pediatric) - Ethnicity: % Unknown Ethnicity, 12/31/2021	0	2021 p_eth3y4_s
NC	S: Prevalent Patients (Pediatric) - Sex: % Female, 12/31/2021	31.43	2021 p_sexy4_s
NC	S: Prevalent Patients (Pediatric) - Modality: % on Hemodialysis, 12/31/2021	31.43	2021 p_modhdy4_s
NC	S: Prevalent Patients (Pediatric) - Modality: % on Home Hemodialysis, 12/31/2021	2.86	2021 p_modhdy4_s
NC	S: Prevalent Patients (Pediatric) - Modality: % on Continuous Ambulatory Peritoneal Dialysis, 12/31/2021	0	2021 p_modcapy4_s
NC	S: Prevalent Patients (Pediatric) - Modality: % on Continuous Cycling Peritoneal Dialysis, 12/31/2021	65.71	2021 p_modccpy4_s
NC	S: Prevalent Patients (Pediatric) - Modality: % on Other Modality, 12/31/2021	0	2021 p_modothy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent with Medicare coverage, 2021	5.26	2021 p_allmdcrmy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent with Medicaid coverage only, 2021	47.37	2021 p_insmcdcm4_s
NC	S (2728): Incident Patients (Pediatric) - Percent with employer group coverage only, 2021	10.53	2021 p_insempmy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent with None, other or unknown coverage only, 2021	36.84	2021 p_insnonthmy4_s
NC	S (2728): Incident Patients (Pediatric) - No Pre-ESRD Nephrologist Care, 2021	15.79	2021 p_nephnomy4_s
NC	S (2728): Incident Patients (Pediatric) - Pre-ESRD Nephrologist Care Less Than 6 months, 2021	26.32	2021 p_nephy6my4_s
NC	S (2728): Incident Patients (Pediatric) - Pre-ESRD Nephrologist Care Between 6 and 12 months, 2021	15.79	2021 p_nephy612my4_s
NC	S (2728): Incident Patients (Pediatric) - Pre-ESRD Nephrologist Care Greater Than 12 months, 2021	42.11	2021 p_nephy12my4_s
NC	S (2728): Incident Patients (Pediatric) - Unknown Pre-ESRD Nephrologist Care, 2021	0	2021 p_nephunkmissmy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent of Patients Informed of Transplant Options, 2021	100	2021 p_ptinfmy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent of Incident HD Patients: AV Fistula, 2021	0	2021 p_mefavfmy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent of Incident HD Patients: AV Graft, 2021	0	2021 p_mefgrfmy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent of Incident HD Patients: Catheter, 2021	100	2021 p_mefcathmy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent of Incident HD Patients: Other/Unknown/Missing, 2021	0	2021 p_mefouaccessmy4_s
NC	S (2728): Incident Patients (Pediatric) - Percent of Incident Patients with Fistulae placed, 2021	9.09	2021 p_avfpresentmy4_s
NC	S: Prevalent VA Type (Pediatric) - % of patients receiving treatment with fistulae, 2021	22.97	2021 p_ppavfy4_s
NC	S: Prevalent VA Type (Pediatric) - Long-Term Catheter Rate, 2021	56.08	2021 p_ltcy4_s
NC	S: Prevalent Waitlist (Pediatric) - % of patient-months (<18 only) on waitlist, 2021	26.1	2021 p_WLy4_s
NC	S: Prevalent Waitlist (Pediatric) - % of patient-months <10 years on waitlist, 2021	26.35	2021 p_WLlt10y4_s
NC	S: Prevalent Waitlist (Pediatric) - % of patient-months aged 10-17 on waitlist, 2021	26.41	2021 p_WL1017y4_s
NC	S: HD HGB (Pediatric) - Average hemoglobin levels (g/dL), of valid in-range patient-months, 2021	10.61	2021 p_CWhdavgHGBy4_s
NC	S: HD HGB (Pediatric) - % of patient-months with hemoglobin < 10 g/dL, 2021	28.23	2021 p_CWhdhgb1y4_s
NC	S: HD HGB (Pediatric) - % of patient-months with hemoglobin 10 - <11 g/dL, 2021	24.19	2021 p_CWhdhgb2y4_s
NC	S: HD HGB (Pediatric) - % of patient-months with hemoglobin 11 - 12 g/dL, 2021	30.65	2021 p_CWhdhgb3y4_s
NC	S: HD HGB (Pediatric) - % of patient-months with hemoglobin > 12 g/dL, 2021	14.52	2021 p_CWhdhgb4y4_s
NC	S: HD HGB (Pediatric) - % of patient-months with hemoglobin Missing or Out of Range, 2021	2.42	2021 p_CWhdhgb5y4_s
NC	S: PD HGB (Pediatric) - Average hemoglobin levels (g/dL), of valid in-range patient-months, 2021	10.73	2021 p_CWpdavgHGBy4_s
NC	S: PD HGB (Pediatric) - % of patient-months with hemoglobin < 10 g/dL, 2021	32.95	2021 p_CWpdhgb1y4_s
NC	S: PD HGB (Pediatric) - % of patient-months with hemoglobin 10 - <11 g/dL, 2021	22.35	2021 p_CWpdhgb2y4_s
NC	S: PD HGB (Pediatric) - % of patient-months with hemoglobin 11 - 12 g/dL, 2021	16.29	2021 p_CWpdhgb3y4_s
NC	S: PD HGB (Pediatric) - % of patient-months with hemoglobin > 12 g/dL, 2021	19.32	2021 p_CWpdhgb4y4_s
NC	S: PD HGB (Pediatric) - % of patient-months with hemoglobin Missing or Out of Range, 2021	9.09	2021 p_CWpdhgb5y4_s
NC	S: Albumin (Pediatric) - Average serum albumin (g/dL), of valid in range HD patient-months, 2021	4.09	2021 p_CWhdalby4_s
NC	S: Albumin (Pediatric) - % of HD patient-months with Serum Albumin < 3 g/dL, 2021	0.81	2021 p_CWhdalb1y4_s

NC	S: Albumin (Pediatric) - % of HD patient-months with Serum Albumin 3 - < 3.5 g/dL, 2021	3.23	2021_p_CWhdalb2y4_s
NC	S: Albumin (Pediatric) - % of HD patient-months with Serum Albumin 3.5 - < 4 g/dL, 2021	22.58	2021_p_CWhdalb3y4_s
NC	S: Albumin (Pediatric) - % of HD patient-months with Serum Albumin >= 4 g/dL, 2021	70.97	2021_p_CWhdalb4y4_s
NC	S: Albumin (Pediatric) - % of HD patient-months with Serum Albumin Missing, 2021	2.42	2021_p_CWhdalb5y4_s
NC	S: Albumin (Pediatric) - Average Serum Albumin, of valid in range PD patient-months, 2021	3.91	2021_p_CWpdalb4y4_s
NC	S: Albumin (Pediatric) - % of PD patient-months with Serum Albumin < 3 g/dL, 2021	4.55	2021_p_CWpdalb1y4_s
NC	S: Albumin (Pediatric) - % of PD patient-months with Serum Albumin 3 - < 3.5 g/dL, 2021	17.05	2021_p_CWpdalb2y4_s
NC	S: Albumin (Pediatric) - % of PD patient-months with Serum Albumin 3.5 - < 4 g/dL, 2021	22.35	2021_p_CWpdalb3y4_s
NC	S: Albumin (Pediatric) - % of PD patient-months with Serum Albumin >= 4 g/dL, 2021	45.83	2021_p_CWpdalb4y4_s
NC	S: Albumin (Pediatric) - % of PD patient-months with Serum Albumin Missing, 2021	10.23	2021_p_CWpdalb5y4_s
NC	S: PD Kt/V (Pediatric) - % of patient-months with Kt/V >= 1.8, 2021	88.26	2021_p_CWpdktvge18y4_s
NC	S: HD Kt/V (Pediatric) - % of patient-months with Kt/V >= 1.2, 2021	98.91	2021_p_CWhdktvge12y4_s
NC	S: Patient Placement - % of incident patients, 2021	16.06	2021_ppidy4_s
NC	S: Patient Placement - % of patients continuing at facility, 2021	72.97	2021_ppcdy4_s
NC	S: Patient Placement - % of patients that transferred into facility, 2021	10.97	2021_pptdy4_s
NC	S: End of Year Status - % of patients death attributed to this facility, 2021	14.05	2021_pdhdy4_s
NC	S: End of Year Status - % of patients death attributed to another facility, 2021	1.63	2021_pdody4_s
NC	S: End of Year Status - % of patients that received a transplant, 2021	2.62	2021_ptxdy4_s
NC	S: End of Year Status - % of patients alive in this facility, 2021	69.74	2021_pahdy4_s
NC	S: End of Year Status - % of patients alive in another facility, 2021	7.49	2021_paody4_s
NC	S: End of Year Status - % of patients other, 2021	4.47	2021_potdy4_s
NC	S (AFS): Facility Information - Average number of in-center HD patients on 12/31/2021	64.26	2021_iuhemy4m_s
NC	S (AFS): Facility Information - Average number of in-center frequent HD patients on 12/31/2021	0.02	2021_iufreqy4m_s
NC	S (AFS): Facility Information - Average number of in-center non-frequent HD patients on 12/31/2021	64.24	2021_iunonfreqy4m_s
NC	S (AFS): Facility Information - Average number of in-center patients with other modality on 12/31/2021	0	2021_iuothy4m_s
NC	S (AFS): Facility Information - Average number of in-center Continuous Ambulatory Peritoneal Dialysis patients on 12/31/2021	0	2021_iucapdy4m_s
NC	S (AFS): Facility Information - Average number of in-center Continuous Cycling Peritoneal Dialysis patients on 12/31/2021	0	2021_iuccpdy4m_s
NC	S (AFS): Facility Information - Average number of home HD patients on 12/31/2021	2.59	2021_ihhemy4m_s
NC	S (AFS): Facility Information - Average number of home frequent HD patients on 12/31/2021	0.52	2021_ihfreqy4m_s
NC	S (AFS): Facility Information - Average number of home non-frequent HD patients on 12/31/2021	2.07	2021_ihnonfreqy4m_s
NC	S (AFS): Facility Information - Average number of home patients with other modality on 12/31/2021	0	2021_ihothy4m_s
NC	S (AFS): Facility Information - Average number of home Continuous Ambulatory Peritoneal Dialysis patients on 12/31/2021	0.64	2021_ihcapdy4m_s
NC	S (AFS): Facility Information - Average number of home Continuous Cycling Peritoneal Dialysis patients on 12/31/2021	7.98	2021_ihccpdy4m_s
NC	S (AFS): Facility Information - Average number of total staff positions on Dec 31 (full & part time), 2021	15.33	2021_staffy4m_s
NC	S (AFS): Facility Information - Average number of full time nurses on 12/31/2021	4.06	2021_nurseFTy4m_s
NC	S (AFS): Facility Information - Average number of full time patient care technicians on 12/31/2021	6.89	2021_ptcareFTy4m_s
NC	S (AFS): Facility Information - Average number of full time renal dieticians on 12/31/2021	0.33	2021_dietFTy4m_s
NC	S (AFS): Facility Information - Average number of full time social workers on 12/31/2021	0.33	2021_socwkFTy4m_s
NC	S (AFS): Facility Information - Average number of part time nurses on 12/31/2021	0.83	2021_nursePTY4m_s
NC	S (AFS): Facility Information - Average number of part time patient care technicians on 12/31/2021	0.91	2021_ptcarePTY4m_s
NC	S (AFS): Facility Information - Average number of part time renal dieticians on 12/31/2021	0.87	2021_dietPTY4m_s
NC	S (AFS): Facility Information - Average number of part time social workers on 12/31/2021	1.1	2021_socwkPTY4m_s
NC	F (AFS): Facility Information - Vocational Rehab number of Patients 18-54 on 12/31/2021	40.62	2021_vocrehabv4m_s
NC	S (AFS): Facility Information - Average % incident patients, 2021	14.88	2021_incpery4_s
NC	S (AFS): Facility Information - % Patients 18-54 who are employed on 12/31/2021	23.37	2021_employedy4_s
NC	S (AFS): Facility Information - % Patients 18-54 who are school on 12/31/2021	0.98	2021_schooly4_s
NC	S: Prevalent VA Type (Nursing Home) - % of Patients Receiving Treatment with Fistulae, 2021	52.83	2021_nh_ppavfy4_s
NC	S: Prevalent VA Type (Nursing Home) - Long-Term Catheter Rate, 2021	18.49	2021_nh_ltcy4_s
NC	S: HD Kt/V (Nursing Home) - % of Patient-months with Kt/V < 1.2, 2021	2.05	2021_nh_CWhdktv1y4_s
NC	S: PD Kt/V (Nursing Home) - % of Patient-months with Kt/V < 1.7, 2021	7.08	2021_nh_CWpdktv1y4_s
NC	S: HD HGB (Nursing Home) - % of Patient-months with Hemoglobin < 10 g/dL, 2021	29.59	2021_nh_CWhdgb1y4_s
NC	S: HD HGB (Nursing Home) - % of Patient-months with ESA Prescribed, 2021	80.29	2021_nh_CWhdesarxy4_s
NC	S: PD HGB (Nursing Home) - % of Patient-months with Hemoglobin < 10 g/dL, 2021	28.02	2021_nh_CWpdhgb1y4_s
NC	S: PD HGB (Nursing Home) - % of Patient-months with ESA Prescribed, 2021	58.85	2021_nh_CWpdesarxy4_s
NC	S: All Patient Mortality (Nursing Home) - Observed death rate (per 100 patient-years), 2021	42.01	2021_nh_obdry4_s
NC	S: All Patient Mortality (Nursing Home) - Standardized Mortality Ratio (SMR), 2021	1.08	2021_nh_smry4_s
NC	S: All Patient Mortality (Nursing Home) - % of deaths from withdrawal, 2021	31.79	2021_nh_wity4_s
NC	S: SHR (Nursing Home Admissions) - Observed Admission Rate (per patient-year in average facility), 2021	242.17	2021_nh_obhtry4_s
NC	S: SHR (Nursing Home Admissions) - Standardized Hospitalization Ratio for Admissions, 2021	1.3	2021_nh_shrty4_s
NC	S: Hospitalization (Nursing Home) - Diagnosis: % with Septicemia, 2021	19.73	2021_nh_sepdy4_s
NC	S: Hospitalization (Nursing Home) - Diagnosis: % with Acute Myocardial Infarction, 2021	7.45	2021_nh_miy4_s
NC	S: Hospitalization (Nursing Home) - Diagnosis: % with Congestive Heart Failure, 2021	45.38	2021_nh_achfy4_s
NC	S: Hospitalization (Nursing Home) - Diagnosis: % with Cardiac Dysrhythmia, 2021	31.53	2021_nh_acdry4_s
NC	S: Hospitalization (Nursing Home) - Diagnosis: % with Cardiac Arrest, 2021	4.38	2021_nh_acary4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with AIDS, 2021	1.07	2021_nh_clmhivaidmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Vascular Access-Related Infection, 2021	6.4	2021_nh_clminfvamy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Hepatitis B, 2021	0.71	2021_nh_clmhhepbmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Hepatitis Other, 2021	3.16	2021_nh_clmhhepothmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Metastatic Infection, 2021	3.38	2021_nh_clmmstinfmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Pneumonia, 2021	6.98	2021_nh_clmpnemy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Tuberculosis, 2021	0.13	2021_nh_clmtbmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Non-Vascular Access-Related Infection, 2021	31.88	2021_nh_clminfmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Cardiac Arrest, 2021	2.62	2021_nh_clmcamy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Cardiac Dysrhythmias, 2021	34.06	2021_nh_clmcdmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Cerebrovascular Disease, 2021	17.3	2021_nh_clmcdvmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Congestive Heart Failure, 2021	48.69	2021_nh_clmchfmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Ischemic Heart Disease, 2021	38.28	2021_nh_clmihdmy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Myocardial Infarction, 2021	8.58	2021_nh_clmmimy4_s
NC	S: Prevalent Comorbidities (Nursing Home) - % with Peripheral Vascular Disease, 2021	31.39	2021_nh_clmpvmy4_s

NC	S: Prevalent Patients (Nursing Home) - Age: % Less than 18 years, 12/31/2021	0	2021_nh_age1y4_s
NC	S: Prevalent Patients (Nursing Home) - Age: % Between 18-64 years, 12/31/2021	33.51	2021_nh_age2y4_s
NC	S: Prevalent Patients (Nursing Home) - Age: % Greater than or equal to 65 years, 12/31/2021	66.49	2021_nh_age3y4_s
NC	S: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Diabetes, 12/31/2021	55.73	2021_nh_dis1y4_s
NC	S: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Hypertension, 12/31/2021	27.41	2021_nh_dis2y4_s
NC	S: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Glomerulonephritis, 12/31/2021	5.77	2021_nh_dis3y4_s
NC	S: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Other/Unknown Cause, 12/31/2021	10.63	2021_nh_dis4y4_s
NC	S: Prevalent Patients (Nursing Home) - Primary Cause of ESRD: % Missing Cause, 12/31/2021	0.45	2021_nh_dis5y4_s
NC	S: Prevalent Patients (Nursing Home) - Race: % Asian/Pacific Islander, 12/31/2021	0.87	2021_nh_rac1y4_s
NC	S: Prevalent Patients (Nursing Home) - Race: % African American, 12/31/2021	59.19	2021_nh_rac2y4_s
NC	S: Prevalent Patients (Nursing Home) - Race: % Native American, 12/31/2021	0.78	2021_nh_rac3y4_s
NC	S: Prevalent Patients (Nursing Home) - Race: % White, 12/31/2021	39.16	2021_nh_rac4y4_s
NC	S: Prevalent Patients (Nursing Home) - Race: % Other/Unknown/Missing race, 12/31/2021	0	2021_nh_rac5y4_s
NC	S: Prevalent Patients (Nursing Home) - Ethnicity: % Hispanic, 12/31/2021	2.18	2021_nh_eth1y4_s
NC	S: Prevalent Patients (Nursing Home) - Ethnicity: % Non-Hispanic, 12/31/2021	97.77	2021_nh_eth2y4_s
NC	S: Prevalent Patients (Nursing Home) - Ethnicity: % Unknown Ethnicity, 12/31/2021	0.04	2021_nh_eth3y4_s
NC	S: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy less than 1 year, 12/31/2021	17.56	2021_nh_vin1y4_s
NC	S: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy for 1-2 years, 12/31/2021	17.23	2021_nh_vin2y4_s
NC	S: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy for 2-3 years, 12/31/2021	11.79	2021_nh_vin3y4_s
NC	S: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy for 3-6 years, 12/31/2021	23.33	2021_nh_vin4y4_s
NC	S: Prevalent Patients (Nursing Home) - Vintage: % on ESRD Therapy for over 6 years, 12/31/2021	30.09	2021_nh_vin5y4_s
NC	S: Prevalent Patients (Nursing Home) - Sex: % Female, 12/31/2021	50.29	2021_nh_sexy4_s
NC	S: Prevalent Patients (Nursing Home) - Modality: % on Hemodialysis, 12/31/2021	96.74	2021_nh_modhdy4_s
NC	S: Prevalent Patients (Nursing Home) - Modality: % on Home Hemodialysis, 12/31/2021	0.58	2021_nh_modhdy4_s
NC	S: Prevalent Patients (Nursing Home) - % on Continuous Ambulatory Peritoneal Dialysis, 12/31/2021	0.04	2021_nh_modcapdy4_s
NC	S: Prevalent Patients (Nursing Home) - % on Continuous Cycling Peritoneal Dialysis, 12/31/2021	1.85	2021_nh_modccpy4_s
NC	S: Prevalent Patients (Nursing Home) - % on Other Modality, 12/31/2021	0.78	2021_nh_modothry4_s
NC	S: Incident Patients (Nursing Home) - Percent with Medicare alone or with other insurance, 2021	83.94	2021_nh_allmdcrmy4_s
NC	S: Incident Patients (Nursing Home) - Percent with Medicaid coverage only, 2021	6.01	2021_nh_insmcdmy4_s
NC	S: Incident Patients (Nursing Home) - Percent with employer group coverage only, 2021	2.09	2021_nh_insemprmy4_s
NC	S: Incident Patients (Nursing Home) - Percent with Other/Unknown/No insurance, 2021	7.96	2021_nh_insonothmy4_s
NC	S: Incident Patients (Nursing Home) - Percent of hemodialysis patients.: Arteriovenous Fistula, 2021	8.36	2021_nh_mefavfmy4_s
NC	S: Incident Patients (Nursing Home) - Percent of hemodialysis patients.: Arteriovenous Graft, 2021	2.74	2021_nh_mefgrftmy4_s
NC	S: Incident Patients (Nursing Home) - Percent of hemodialysis patients.: Catheter, 2021	86.03	2021_nh_mefcathmy4_s
NC	S: Incident Patients (Nursing Home) - Percent of hemodialysis patients.: Other/Unknown/Missing Access, 2021	2.87	2021_nh_mefouaccessmy4_s
NC	S: Incident Patients (Nursing Home) - Percent of patients with Arteriovenous fistulae placed, 2021	22.85	2021_nh_avfprentmy4_s
NC	S: Incident Patients (Nursing Home) - No Pre-ESRD Nephrologist Care, 2021	17.75	2021_nh_nephnoy4_s
NC	S: Incident Patients (Nursing Home) - Pre-ESRD Nephrologist Care Less Than 6 months, 2021	18.02	2021_nh_nephy6my4_s
NC	S: Incident Patients (Nursing Home) - Pre-ESRD Nephrologist Care Between 6 and 12 months, 2021	20.5	2021_nh_nephy612my4_s
NC	S: Incident Patients (Nursing Home) - Pre-ESRD Nephrologist Care Greater Than 12 months, 2021	28.85	2021_nh_nephy12my4_s
NC	S: Incident Patients (Nursing Home) - Unknown Pre-ESRD Nephrologist Care, 2021	14.88	2021_nh_nephunkmissmy4_s
NC	S: Incident Patients (Nursing Home) - Percent of Patients Informed of Transplant Options, 2021	90.08	2021_nh_ptinfmy4_s
NC	S (2728): Incident Patients - Percent alcohol dependent, 2021	1.88	2021_alcomy4_s
NC	S (2728): Incident Patients - Percent with atherosclerotic heart disease, 2021	11.78	2021_ashdmy4_s
NC	S (2728): Incident Patients - Percent with other cardiac disorder, 2021	22.54	2021_othcarmy4_s
NC	S (2728): Incident Patients - Percent with cancer, 2021	7.95	2021_canmy4_s
NC	S (2728): Incident Patients - Percent with congestive heart failure, 2021	28.5	2021_chfmy4_s
NC	S (2728): Incident Patients - Percent with cardiovascular disease, cerebral vascular incident, and transient ischemic attack, 2021	10.68	2021_cvamy4_s
NC	S (2728): Incident Patients - Percent with diabetes on insulin, 2021	44.27	2021_diabimy4_s
NC	S (2728): Incident Patients - Percent with diabetes, 2021	64.38	2021_diabmy4_s
NC	S (2728): Incident Patients - Percent drug dependent, 2021	2.76	2021_drugmy4_s
NC	S (2728): Incident Patients - Percent with history of hypertension, 2021	91.05	2021_hxhtmy4_s
NC	S (2728): Incident Patients - Percent inability to ambulate, 2021	7.07	2021_ambumy4_s
NC	S (2728): Incident Patients - Percent inability to transfer, 2021	3.06	2021_transmy4_s
NC	S (2728): Incident Patients - Percent with chronic obstructive pulmonary disease, 2021	10.03	2021_copdmy4_s
NC	S (2728): Incident Patients - Percent with PVD, 2021	8.92	2021_pvdmy4_s
NC	S (2728): Incident Patients - Percent smoker, 2021	10.53	2021_smokmy4_s
NC	S (2728): Incident Patients - Percent Hispanic, 2021	3.94	2021_ethmy4_s
NC	S (2728): Incident Patients - Percent White, 2021	47.05	2021_whitemy4_s
NC	S (2728): Incident Patients - Percent African American, 2021	48.96	2021_blackmy4_s
NC	S (2728): Incident Patients - Percent Native American, 2021	1.53	2021_nativmy4_s
NC	S (2728): Incident Patients - Percent Asian/Pacific Islander, 2021	2.33	2021_asianmy4_s
NC	S (2728): Incident Patients - Percent other/unknown/missing race, 2021	0.13	2021_racoumy4_s
NC	S (2728): Incident Patients - Percent currently employed FT/PT/student, 2021	21.44	2021_cempmy4_s
NC	S (2728): Incident Patients - Percent previously employed FT/PT/student, 2021	31.68	2021_pempmy4_s
NC	S (2728): Incident Patients - Percent diabetes as primary cause ESRD, 2021	47.18	2021_dbprimy4_s
NC	S (2728): Incident Patients - Percent glomerulonephritis as primary cause of ESRD, 2021	7.17	2021_gnprimy4_s
NC	S (2728): Incident Patients - Percent hypertension as primary cause ESRD, 2021	31.84	2021_hprimy4_s
NC	S (2728): Incident Patients - Percent other/missing primary cause of ESRD, 2021	13.81	2021_omprimy4_s
NC	S (2728): Incident Patients - Percent female, 2021	43.54	2021_femmy4_s
NC	S (2728): Incident Patients - Average age, 2021	63.08	2021_agemy4_s
NC	S (2728): Incident Patients - Average serum albumin, 2021	3.32	2021_salbmy4_s
NC	S (2728): Incident Patients - Average creatinine, 2021	7.02	2021_creamy4_s
NC	S (2728): Incident Patients - Average hemoglobin, 2021	9.3	2021_hgmy4_s
NC	S (2728): Incident Patients - GFR by MDRD formula, 2021	10.05	2021_gfrmy4_s
NC	S (2728): Incident Patients - Average count of comorbidities, 2021	3.25	2021_cntcomy4_s
NC	S (2728): Incident Patients - Primary Modality: Hemodialysis, 2021	86.41	2021_pdmodMEFHDmy4_s
NC	S (2728): Incident Patients - Primary Modality: Peritoneal Dialysis, 2021	13.59	2021_pdmodMEFPDmy4_s
NC	S (2728): Incident Patients -Primary Modality: Other/Unknown/Missing, 2021	0	2021_pdmodMEFOTHUNKmy4_s

NC	S (2728): Incident Patients - Percent with Medicare coverage only, 2021	45.55	2021	insmdcrmy4_s
NC	S (2728): Incident Patients - Percent with Medicaid coverage only, 2021	9.88	2021	insmcdcm4_s
NC	S (2728): Incident Patients - Percent with Medicare and Medicaid coverage only, 2021	7.62	2021	insmdcrdmy4_s
NC	S (2728): Incident Patients - Percent with employer group coverage only, 2021	10.98	2021	insempmy4_s
NC	S (2728): Incident Patients - Percent with no coverage, 2021	8.1	2021	insnonemy4_s
NC	S (2728): Incident Patients - Percent with Medicare and other coverage, 2021	10.38	2021	insmdcromy4_s
NC	S (2728): Incident Patients - Percent with other or unknown coverage, 2021	7.5	2021	insmedomy4_s
NC	S (2728): Incident Patients - Percent of Patients Received ESA prior to ESRD, 2021	16.02	2021	preepomy4_s
NC	S (2728): Incident Patients - No Pre-ESRD Nephrologist Care, 2021	13.56	2021	nephnomy4_s
NC	S (2728): Incident Patients - Pre-ESRD Nephrologist Care Less Than 6 months, 2021	15.84	2021	nephy6my4_s
NC	S (2728): Incident Patients - Pre-ESRD Nephrologist Care Between 6 and 12 months, 2021	20.26	2021	nephy612my4_s
NC	S (2728): Incident Patients - Pre-ESRD Nephrologist Care Greater Than 12 months, 2021	37.75	2021	nephy12my4_s
NC	S (2728): Incident Patients - Unknown Pre-ESRD Nephrologist Care, 2021	12.58	2021	nephunkmissmy4_s
NC	S (2728): Incident Patients - Percent of Patients Informed of Transplant Options, 2021	92.81	2021	ptinfmy4_s
NC	S (2728): Incident Patients - Reason Not Informed: Patient Medically Unfit, 2021	30.31	2021	ptxmedunfitmy4_s
NC	S (2728): Incident Patients - Reason Not Informed: Unsuitable Due to Age, 2021	0	2021	ptxagedmy4_s
NC	S (2728): Incident Patients - Reason Not Informed: Patient Psychologically Unfit, 2021	0	2021	ptxpsyunfitmy4_s
NC	S (2728): Incident Patients - Reason Not Informed: Patient Declined Information, 2021	9.76	2021	ptxdeclinemy4_s
NC	S (2728): Incident Patients - Reason Not Informed: Patient Has Not Been Assessed, 2021	59.93	2021	ptxnotassessmy4_s
NC	S (2728): Incident Patients - Percent of Incident HD Patients: Arteriovenous Fistula, 2021	16.57	2021	mefavfmy4_s
NC	S (2728): Incident Patients - Percent of Incident HD Patients: Arteriovenous Graft, 2021	3.71	2021	mefgraftmy4_s
NC	S (2728): Incident Patients - Percent of Incident HD Patients: Catheter, 2021	79.29	2021	mefcathmy4_s
NC	S (2728): Incident Patients - Percent of Incident HD Patients: Other/Unknown/Missing, 2021	0.44	2021	mefoumaccessmy4_s
NC	S (2728): Incident Patients - Percent of Incident Patients with Arteriovenous fistulae placed, 2021	31.33	2021	avfpresentmy4_s
NC	S (2728): Incident Patients - Median BMI for males >= 20 yrs, 2021	28.19	2021	bmimmy4_s
NC	S (2728): Incident Patients - Median BMI for females >= 20 yrs, 2021	30.44	2021	bmifmy4_s
NC	S (2728): Incident Patients - Average Patients Not Informed of Transplant Options, 2021	1.16	2021	ptinfmy4m_s
NC	S (2728): Incident Patients - Average Number of incident hemodialysis patients (n),2021	13.9	2021	hemomy4m_s
NC	S (2728): Incident Patients - Average Number of forms returned, 2021	16.08	2021	nmy4m_s
NC	S: All Patient Mortality - Average number of patients (per year in average facility), 2018-2021	91.18	2018-21	rdsmzm_s
NC	S: All Patient Mortality - Average years at risk for mortality (per year in average facility), 2018-2021	61.14	2018-21	dyzm_s
NC	S: All Patient Mortality - Average number of deaths (per year in average facility), 2018-2021	10.71	2018-21	deazm_s
NC	S: All Patient Mortality - Average expected deaths (per year in average facility), 2018-2021	11.03	2018-21	exdzm_s
NC	S: All Patient Mortality - Average number deaths from dialysis, unrelated deaths (per year in average facility), 2018-2021	0.07	2018-21	dudzm_s
NC	S: All Patient Mortality - Standardized Mortality Ratio (SMR), 2018-2021	0.97	2018-21	smrz_s
NC	S: All Patient Mortality - % of deaths from withdrawal, 2018-2021	28.55	2018-21	witz_s
NC	S: All Patient Mortality - % of deaths from infection, 2018-2021	12.02	2018-21	infz_s
NC	S: All Patient Mortality - % of deaths from cardiac causes, 2018-2021	45.08	2018-21	cardz_s
NC	S: All Patient Mortality - % of deaths from liver disease, 2018-2021	1.28	2018-21	livz_s
NC	S: First-Year Mortality - Average number of new patients, 2018 - 2020	16.14	2018-20	fynmzm_s
NC	S: First-Year Mortality - Average Years at risk , 2018 - 2020	11.73	2018-20	fydym_s
NC	S: First-Year Mortality - Average number of deaths, 2018 - 2020	2.34	2018-20	fydeazm_s
NC	S: First-Year Mortality - Average number of expected deaths, 2018 - 2020	2.49	2018-20	fyexdzm_s
NC	S: First-Year Mortality - Standardized First-Year Mortality Ratio, 2018 - 2020	0.94	2018-20	fysmrz_s
NC	S: First-Year Mortality - Percent of deaths from withdrawal, 2018 - 2020	30.91	2018-20	fywitz_s
NC	S: First-Year Mortality - Percent of deaths from infection, 2018 - 2020	10.78	2018-20	fyinfz_s
NC	S: First-Year Mortality - Percent of deaths from cardiac causes, 2018 - 2020	41.57	2018-20	fycardiacz_s
NC	S: First-Year Mortality - Percent of deaths from liver disease, 2018 - 2020	2.29	2018-20	fyliwz_s
NC	S: Hospitalization - Average Number of Patients (per year in average facility), 2018-2021	77.96	2018-21	rdshzm_s
NC	S: SHR (Admissions) - Average Number of Hospital Admissions (per year in average facility), 2018-2021	70.84	2018-21	htazm_s
NC	S: SHR (Admissions) - Average Expected Number of Hospital Admissions (per year in average facility), 2018-2021	77.11	2018-21	extzm_s
NC	S: SHR (Days) - Average Days Hospitalized (per year in average facility), 2018-2021	517.13	2018-21	hdzm_s
NC	S: SHR (Days) - Average Expected Days Hospitalized (per year in average facility), 2018-2021	583.73	2018-21	exhdzm_s
NC	S: Hospitalization - Average Years at Risk (per year in average facility), 2018-2021	51.53	2018-21	hdymz_s
NC	S: SHR (ED) -Average Number of ED Visits (per year in average facility), 2018-2021	122.16	2018-21	hedzm_s
NC	S: SHR (ED) -Average Expected Number of ED Visits (per year in average facility), 2018-2021	122.51	2018-21	exedzm_s
NC	S: SHR (ED) - Average Years at Risk (per year in average facility), 2018-2021	38.8	2018-21	hdyedzm_s
NC	S: SHR (Admissions) - Average Standardized Hospitalization Ratio for Admissions (per year in average facility), 2018-2021	0.92	2018-21	shrtz_s
NC	S: SHR (Days) - Average Standardized Hospitalization Ratio for Days (per year in average facility), 2018-2021	0.89	2018-21	shrdz_s
NC	S: SHR (Days) - Average Length of Stay (days per admission, per year in average facility), 2018-2021	7.3	2018-21	lenz_s
NC	S: SHR (Admissions) - Average % One Day Admissions (per year in average facility), 2018-2021	7.46	2018-21	onez_s
NC	S: Hospitalization - Diagnosis: Average % with Acute Myocardial Infarction (per year in average facility), 2018-2021	4.86	2018-21	miiiz_s
NC	S: Hospitalization - Diagnosis: Average % with Septicemia (per year in average facility), 2018-2021	10.19	2018-21	sepiz_s
NC	S: Hospitalization - Diagnosis: Average % with Congestive Heart Failure (per year in average facility), 2018-2021	28.79	2018-21	achfz_s
NC	S: Hospitalization - Diagnosis: Average % with Cardiac Dysrhythmia (per year in average facility), 2018-2021	17.78	2018-21	acdrz_s
NC	S: Hospitalization - Diagnosis: Average % with Cardiac Arrest (per year in average facility), 2018-2021	2.38	2018-21	acarz_s
NC	S: SHR (ED) -Average % Patients with at Least One ED Visit (per year in average facility), 2018-2021	63.26	2018-21	edptz_s
NC	S: SHR (ED) -Average % ED Visits Resulting in Hospitalization (per year in average facility), 2018-2021	38.1	2018-21	edipz_s
NC	S: SHR (ED) -Average % Inpatient Admissions Originating in ED (per year in average facility), 2018-2021	82.91	2018-21	ipedz_s
NC	S: SHR (ED) -Average Standardized Hospitalization Ratio for ED (per year in average facility), 2018-2021	1	2018-21	shredz_s
NC	S SRR - Standardized Readmission Ratio, 2021	0.97	2021	srry4_s
NC	S: SRR - Average index discharges, 2021	63.86	2021	indexmy4_s
NC	S: SRR - Average number of readmissions, 2021	15.8	2021	readmmy4_s
NC	S: SRR - Average expected readmissions, 2021	16.88	2021	srrexpmy4_s
NC	S: STR - Average number of eligible patients (age<75) with no previous transplant (per year in average facility), 2018-2021	69.6	2018-21	rdstzm_s
NC	S: STR - Average number of patients (per year in average facility), 2018-2021	74.65	2018-21	rdalltzm_s
NC	S: STR - Average number of 1st transplant (per year in average facility), 2018-2021	1.89	2018-21	txzm_s
NC	S: Transplantation - Average number of transplants (per year in average facility), 2018-2021	2.09	2018-21	txallzm_s
NC	S: STR - Average number of years at risk for eligible patients (age<75) with no previous transplant (per year in average facility), 2018-2021	46.81	2018-21	txyzm_s

NC	S: STR - Average number of deceased donor transplant (per year in average facility), 2018-2021	1.77	2018-21	cadalltzm_s
NC	S: STR - Average number of living donor transplant (per year in average facility), 2018-2021	0.35	2018-21	livealltzm_s
NC	S: STR - Average number of expected 1st transplant (per year in average facility), 2018-2021	2.16	2018-21	extxzm_s
NC	S: STR - Standardized 1st Transplant Ratio, 2018-2021	0.87	2018-21	strz_s
NC	S: Prevalent Waitlist - Average number of eligible dialysis patients (age<75), 2021	73.71	2021	pppwpty4m_s
NC	S: Prevalent Waitlist - % of patient-months (age<75) on waitlist, 2021	14.81	2021	WLy4_s
NC	S: Prevalent Waitlist - % of patient-months < 40 years on waitlist, 2021	25.02	2021	WLt40y4_s
NC	S: Prevalent Waitlist - % of patient-months aged 40-74 on waitlist, 2021	13.65	2021	WL4074y4_s
NC	S: Prevalent Waitlist - % of male patient-months (age<75) on waitlist, 2021	15.62	2021	WLMaley4_s
NC	S: Prevalent Waitlist - % of female patient-months (age<75) on waitlist, 2021	13.65	2021	WLFemy4_s
NC	S: Prevalent Waitlist - % Hispanic White patient-months (age<75) on waitlist, 2021	13.47	2021	WLwhhy4_s
NC	S: Prevalent Waitlist - % Non-Hispanic White patient-months (age<75) on waitlist, 2021	15.76	2021	WLwhny4_s
NC	S: Prevalent Waitlist - % of African American patient-months (age<75) on waitlist, 2021	14.24	2021	WLBly4_s
NC	S: Prevalent Waitlist - % of Asian patient-months (age<75) on waitlist, 2021	21.02	2021	WLas4_s
NC	S: Prevalent Waitlist - % of Native American patient-months (age<75) on waitlist, 2021	14.72	2021	WLnay4_s
NC	S: Prevalent Waitlist - % of other/unknown race patient-months (age<75) on waitlist, 2021	21.26	2021	WLthy4_s
NC	S: Prevalent Waitlist - % of diabetic patient-months (age<75) on waitlist, 2021	12.41	2021	WLDMy4_s
NC	S: Prevalent Waitlist - % of non-diabetic patient-months (age<75) on waitlist, 2021	16.62	2021	WLnody4_s
NC	S: Prevalent Waitlist - % of patient-months (age<75) without previous transplant on waitlist, 2021	13.68	2021	WLnthy4_s
NC	S: Prevalent Waitlist - % of patient-months (age<75) with prev KI transplant on waitlist, 2021	29.31	2021	WLtxy4_s
NC	S: Prevalent Waitlist - % of patient-months (age<75) with <2 years of prior ESRD therapy on waitlist, 2021	12.16	2021	WLVCat1y4_s
NC	S: Prevalent Waitlist - % of patient-months (age<75) with 2-4 years of prior ESRD therapy on waitlist, 2021	20.7	2021	WLVCat2y4_s
NC	S: Prevalent Waitlist - % of patient-months (age<75) with 5+ years of prior ESRD therapy on waitlist, 2021	12.38	2021	WLVCat3y4_s
NC	S: Prevalent Waitlist - Average number of patient-months (age<75) at risk, 2021	624.4	2021	pppwpm4m_s
NC	S: Prevalent Waitlist - Age-adjusted percentage of patient-months waitlisted (age<75), 2021	14.29	2021	pppw4_s
NC	S: Incident Waitlist - Average number of patients (per year in average facility), 2018-2020	11.07	2018-20	swrptzm_s
NC	S: Incident Waitlist - Average number of patient-years at risk (per year in average facility), 2018-2020	8.89	2018-20	swrpyzm_s
NC	S: Incident Waitlist - Average number of waitlisting or receipt of a living-donor transplant for SWR (per year in average facility), 2018-2020	0.86	2018-20	swrwlmz_s
NC	S: Incident Waitlist - Average number of expected transplant waitlisting or receipt of a living-donor transplant (per year in average facility)	0.9	2018-20	swrexwlmz_s
NC	S: Incident Waitlist - Standardized Waitlist Ratio, 2018 - 2020	0.96	2018-20	swrz_s
NC	S: Influenza - % of patients vaccinated, 8/1-3/31, 2021	86.78	2020	FVfy3_s
NC	S: Influenza - % of patients that declined vaccination, 8/1-3/31, 2020	7.39	2020	FVdeclinedfy3_s
NC	S: Influenza - % of patients without vaccination due to outside vaccination reported but no documentation, 8/1-3/31, 2020	0.12	2020	FVovndfy3_s
NC	S: Influenza - % of patients without vaccination due to other reason or vaccine data not available, 2020	1.57	2020	FVthrsnfy3_s
NC	S: Influenza - % of patients vaccinated, 8/1-12/31, 2021	82.12	2021	FVhy4_s
NC	S: Influenza - % of Medicare patients vaccinated, 8/1-12/31, 2021	83.5	2021	FVmcarehy4_s
NC	S: Influenza - % of Medicare Advantage patients vaccinated, 8/1-12/31, 2021	84.27	2021	FVmahy4_s
NC	F: Influenza - % of patients with Medicare as primary insurer vaccinated, 8/1-12/31, 2021	83.34	2021	FVmpphy4_s
NC	S: Influenza - % of dual Medicare/Medicaid eligible patients vaccinated, 8/1-12/31, 2021	81.32	2021	FVdualhy4_s
NC	S: Influenza - % of patients with Medicare as secondary insurer vaccinated, 8/1-12/31, 2021	80.96	2021	FVmsphy4_s
NC	S: Influenza - % of Non-Medicare patients vaccinated, 8/1-12/31, 2021	71.21	2021	FVnonmcarehy4_s
NC	S: Influenza - % of dialysis patients <18 vaccinated, 8/1-12/31, 2021	68.42	2021	FVlt18hy4_s
NC	S: Influenza - % of dialysis patients 18-39 vaccinated, 8/1-12/31, 2021	71.15	2021	FV1839hy4_s
NC	S: Influenza - % of dialysis patients 40-64 vaccinated, 8/1-12/31, 2021	79.47	2021	FV4064hy4_s
NC	S: Influenza - % of dialysis patients 65-74 vaccinated, 8/1-12/31, 2021	85.65	2021	FV6574hy4_s
NC	S: Influenza - % of dialysis patients 75+ vaccinated, 8/1-12/31, 2021	87.6	2021	FV75uphy4_s
NC	S: Influenza - % of male dialysis patients vaccinated, 8/1-12/31, 2021	81.38	2021	FVmalehy4_s
NC	S: Influenza - % of female dialysis patients vaccinated, 8/1-12/31, 2021	83.06	2021	FVfemhy4_s
NC	S: Influenza - % of Asian dialysis patients vaccinated, 8/1-12/31, 2021	84.57	2021	FVashy4_s
NC	S: Influenza - % of Native American dialysis patients vaccinated, 8/1-12/31, 2021	86	2021	FVnahy4_s
NC	S: Influenza - % of white dialysis patients vaccinated, 8/1-12/31, 2021	82.63	2021	FVwhhy4_s
NC	S: Influenza - % of Other race dialysis patients vaccinated, 8/1-12/31, 2021	61.9	2021	FVrothy4_s
NC	S: Influenza - % of black dialysis patients vaccinated, 8/1-12/31, 2021	81.64	2021	FVblky4_s
NC	S: Influenza - % of Hispanic dialysis patients vaccinated, 8/1-12/31, 2021	82.24	2021	FVhishy4_s
NC	S: Influenza - % of dialysis patients with <1 year of prior ESRD therapy vaccinated, 8/1-12/31, 2021	72.28	2021	FVVCat1hy4_s
NC	S: Influenza - % of dialysis patients with 1-2 years of prior ESRD therapy vaccinated, 8/1-12/31, 2021	81.88	2021	FVVCat2hy4_s
NC	S: Influenza - % of dialysis patients with 3+ years of prior ESRD therapy vaccinated, 8/1-12/31, 2021	85.91	2021	FVVCat3hy4_s
NC	S: Influenza - Total number of patients treated on 12/31, 2021	69.43	2021	eFVy4m_s
NC	S: Influenza - Average number of patients not vaccinated due to medical contraindication, 8/1-3/31, 2021	0.47	2021	medrsnfy4m_s
NC	S: HD HGB (Adult) - Average hemoglobin levels (g/dL), of valid in-range patient-months, 2021	10.73	2021	CWhdavghGBy4_s
NC	S: HD HGB (Adult) - % of patient-months with hemoglobin < 10 g/dL, 2021	24.16	2021	CWhdhgb1y4_s
NC	S: HD HGB (Adult) - % of patient-months with hemoglobin 10 - <11 g/dL, 2021	33.21	2021	CWhdhgb2y4_s
NC	S: HD HGB (Adult) - % of patient-months with hemoglobin 11 - 12 g/dL, 2021	28.94	2021	CWhdhgb3y4_s
NC	S: HD HGB (Adult) - % of patient-months with hemoglobin > 12 g/dL, 2021	12.76	2021	CWhdhgb4y4_s
NC	S: HD HGB (Adult) - % of patient-months with hemoglobin Missing or Out of Range, 2021	0.93	2021	CWhdhgb5y4_s
NC	S: HD HGB (Adult) - % of patient-months with ESA prescribed, 2021	75.07	2021	CWhdesarxy4_s
NC	S: PD HGB (Adult) - Average hemoglobin levels (g/dL), of valid in-range patient-months, 2021	10.95	2021	CWpdavghGBy4_s
NC	S: PD HGB (Adult) - % of patient-months with hemoglobin < 10 g/dL, 2021	22.94	2021	CWpdhgb1y4_s
NC	S: PD HGB (Adult) - % of patient-months with hemoglobin 10 - <11 g/dL, 2021	27.36	2021	CWpdhgb2y4_s
NC	S: PD HGB (Adult) - % of patient-months with hemoglobin 11 - 12 g/dL, 2021	27.82	2021	CWpdhgb3y4_s
NC	S: PD HGB (Adult) - % of patient-months with hemoglobin > 12 g/dL, 2021	20.11	2021	CWpdhgb4y4_s
NC	S: PD HGB (Adult) - % of patient-months with hemoglobin Missing or Out of Range, 2021	1.77	2021	CWpdhgb5y4_s
NC	S: PD HGB (Adult) - % of patient-months with ESA prescribed, 2021	55.22	2021	CWpdesarxy4_s
NC	S: HD HGB (Adult) - Average number of eligible patients, 2021	80.48	2021	CWhdptdenomy4m_s
NC	S: HD HGB (Adult) - Average number of eligible patient-months, 2021	710.9	2021	CWhdptmthdenomy4m_s
NC	S: PD HGB (Adult) - Average number of eligible patients, 2021	27.44	2021	CWpdptdenomy4m_s
NC	S: PD HGB (Adult) - Average number of eligible patient-months, 2021	207.37	2021	CWpdptmthdenomy4m_s
NC	S: STR (Adult) - Average Number of Medicare Patients, 2021	42.85	2021	rdstfy4m_s
NC	S: STR (Adult) - Average Patient Years at Risk, 2021	26.61	2021	tfyy4m_s

NC	S: STR (Adult) - Average Number of Transfusions, 2021	8.91	2021 tfy4m_s
NC	S: STR (Adult) - Average Expected Total Number of Transfusions, 2021	9.3	2021 extfy4m_s
NC	S: STR (Adult) - Standardized Transfusion Ratio, 2021	0.96	2021 strry4_s
NC	S: Albumin (Adult) - Average Serum Albumin, of valid in range HD patient-months, 2021	3.89	2021 CWhdalb4_s
NC	S: Albumin (Adult) - % of HD patient-months with serum albumin < 3 g/dL, 2021	2.17	2021 CWhdalb1y4_s
NC	S: Albumin (Adult) - % of HD patient-months with serum albumin 3 - < 3.5 g/dL, 2021	9.26	2021 CWhdalb2y4_s
NC	S: Albumin (Adult) - % of HD patient-months with serum albumin 3.5 - < 4 g/dL, 2021	40.91	2021 CWhdalb3y4_s
NC	S: Albumin (Adult) - % of HD patient-months with serum albumin >= 4 g/dL, 2021	45.83	2021 CWhdalb4y4_s
NC	S: Albumin (Adult) - % of HD patient-months with serum albumin Missing, 2021	1.83	2021 CWhdalb5y4_s
NC	S: Albumin (Adult) - % of HD patient-months with Serum Albumin < 4.0 g/dL, 2021	52.34	2021 CWhdalblt4y4_s
NC	S: UFR (Adult) - Average UFR, of valid in range HD patient-months, 2021	7.44	2021 CWhdavgufry4_s
NC	S: UFR (Adult) - % of HD patient-months with UFR <= 13, 2021	89.44	2021 CWhdufr1y4_s
NC	S: UFR (Adult) - % of HD patient-months with UFR > 13, 2021	6.75	2021 CWhdufr2y4_s
NC	S: UFR (Adult) - % of HD patient-months with UFR Missing or Out of Range, 2021	3.81	2021 CWhdufr3y4_s
NC	S: Albumin (Adult) - Average Serum Albumin, of valid in range PD patient-months, 2021	3.66	2021 CWpdalb4_s
NC	S: Albumin (Adult) - % of PD patient-months with serum albumin < 3 g/dL, 2021	6.75	2021 CWpdalb1y4_s
NC	S: Albumin (Adult) - % of PD patient-months with serum albumin 3 - < 3.5 g/dL, 2021	22.69	2021 CWpdalb2y4_s
NC	S: Albumin (Adult) - % of PD patient-months with serum albumin 3.5 - < 4 g/dL, 2021	43.36	2021 CWpdalb3y4_s
NC	S: Albumin (Adult) - % of PD patient-months with serum albumin >= 4 g/dL, 2021	25.39	2021 CWpdalb4y4_s
NC	S: Albumin (Adult) - % of PD patient-months with serum albumin Missing, 2021	1.82	2021 CWpdalb5y4_s
NC	S: Albumin (Adult) - % of PD patient-months with Serum Albumin < 4.0 g/dL, 2021	72.8	2021 CWpdalblt4y4_s
NC	S: HD Dialysis Adequacy (Adult) - Average number of eligible patients, 2021	80.48	2021 CWhdndenomy4m_s
NC	S: HD Dialysis Adequacy (Adult) - Average number of Eligible Dialysis Patient-months, 2021	710.9	2021 CWhdmthdenomy4m_s
NC	S: PD Dialysis Adequacy (Adult) - Average number of eligible patients, 2021	27.44	2021 CWpddenomy4m_s
NC	S: PD Dialysis Adequacy (Adult) - Average number of Eligible Dialysis Patient-months, 2021	207.37	2021 CWpdmthdenomy4m_s
NC	S: PD Kt/V (Adult) - Average Kt/V, of valid in-range values, 2021	2.22	2021 CWpdavgktvy4_s
NC	S: PD Kt/V (Adult) - % of patient-months with Kt/V < 1.7, 2021	3.88	2021 CWpdktv1y4_s
NC	S: PD Kt/V (Adult) - % of patient-months with Kt/V 1.7-<2.5, 2021	72.45	2021 CWpdktv2y4_s
NC	S: PD Kt/V (Adult) - % of patient-months with Kt/V >= 2.5, 2021	22.19	2021 CWpdktv3y4_s
NC	S: PD Kt/V (Adult) - % of patient-months with Kt/V missing or out of range, 2021	1.48	2021 CWpdktv4y4_s
NC	S: HD Kt/V (Adult) - Average Kt/V, of valid in-range values, 2021	1.65	2021 CWhdavgktvy4_s
NC	S: HD Kt/V (Adult) - % of patient-months with Kt/V < 1.2, 2021	1.84	2021 CWhdktv1y4_s
NC	S: HD Kt/V (Adult) - % of patient-months with Kt/V 1.2-<1.8, 2021	68.52	2021 CWhdktv2y4_s
NC	S: HD Kt/V (Adult) - % of patient-months with Kt/V >= 1.8, 2021	28.85	2021 CWhdktv3y4_s
NC	S: HD Kt/V (Adult) - % of patient-months with Kt/V missing or out of range, 2021	0.79	2021 CWhdktv4y4_s
NC	S: HD Kt/V (Adult) - Average number of eligible patients, 2021	66.76	2021 CWhdktvptsy4m_S
NC	S: HD Kt/V (Adult) - Average number of eligible patient-months, 2021	621.48	2021 CWhdktvptmthy4m_S