CENTERS FOR MEDICARE & MEDICAID SERVICES
Special Open Door Forum:
Understanding Dialysis Facility Compare-Driving Informed Decision Making
Wednesday, February 4, 2015
2:00 p.m. – 3:00p.m. Eastern Time
Conference Call Only
Moderator: Jill Darling

Operator: Good afternoon. My name is (Sherri) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Understanding Dialysis Facility Compare Driving Informed Decision Making Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you (Sherri). Good morning and good afternoon everyone and thank you for joining us today on this Special Open Door Forum Understanding Dialysis Facility Compare Driving Informed Decision Making. This conference call will end at three so we will try and get as many questions as we can at the end.

If you did receive the announcement for the special open door forum, you'll notice halfway through the announcement there is a link for the PowerPoint slides so the speakers today will be going over the slides and announcing the page number per slide so if you did get that, please go to the middle of the announcement. So we'll begin and I will hand the call off to Elena Balovlenkov.

Elena Balovlenkov: Thank you Jill. I'd like to welcome everyone to the call today Understanding Dialysis Facility Compare Driving Informed Decision Making. I also would like to say that (Dr. Goodrich) would like me to extend our apology. She's not going to be able to join the call today, but I believe that we have an opportunity to share some good information and we're looking forward to the question and answer period.

We also, as you saw in the ODF announcement, requested that questions be submitted prior to the call and we did receive several and we'll be addressing some of those questions that were submitted at that time so we look forward to sharing that information with everyone as well.

So let's go to slide number two. The individuals presenting today will be myself, Elena Balovlenkov; I'm the DFC lead for public reporting; Joel Andress who is the DFC lead for measure development; Stephanie Glier, senior policy analyst for the Consumer-Purchaser Alliance and Celeste Lee, program manager for Patient and Family Centered Care.

Go to slide number three please. So let's talk a little bit about the overview of what we're going to talk about today. We will give some brief information about the background and talk about how the star ratings were developed in response to a national call for increased transparency and a wider use of publicly reported data on healthcare quality as outlined in the CMS National Quality Strategy, the Affordable Care Act and the Obama Administration's Digital Government Strategy.

We'll talk about the information that is currently available to the public on Dialysis Facility Compare, some of the information and features, the introduction of star ratings as part of the DFC refresh and what the star ratings mean for consumers. We'll also talk a little bit about some of the responses that we got from consumer representatives when we did our consumer focus groups.

Please go the slide 4. So what are some of the background information on the Compare site?

As you know, it is the official CMS source for information on healthcare provider quality. One of the things that we thought was very important is that for the DFC star ratings we use quality measures that are based on scientific standards of rigors and accuracy.

DFC is not the only site that is available to the dialysis community.

We do believe that it's important to look at the dialysis patient as a whole because we do have patients that look for nursing homes; we look for home health care so that there are five different sites. We've got Nursing Home Compare that's been active since 1999, Dialysis Facility Compare, Home Health Compare, Hospital Compare and Physician Compare.

Because as stated previously what we feel is really important is to try to offer as much transparency as possible on all the different services that are available to the ESRD community and the public at large.

One of the things that's important to note here is that the star ratings are in a direct response to calls from the consumer for increased sharing of publicly available information and that the need to have more open public reporting.

As previously stated, we do have other Compare sites that have publicly reported information, Nursing Home Compare, Medicare Plan Finder and Physician Compare for certain group practices.

When we talk about up-coming- the reason we left upcoming with Dialysis Facility Compare under it, we want to be sure that we have everyone understand that this is the first iteration of Dialysis Facility Compare.

As you know, we've been sharing and working with the community and with patient groups about the future plans that we have for Dialysis Facility Compare and the star ratings and that we'll also be talking today about the DFC TEP that will be upcoming so that the other thing that we also want to recognize publicly is we also know that the DFC star ratings do not take into consideration the patient experience of care. We do not look at patient satisfaction at this time as a measure of quality within the star rating.

So that when you look at Dialysis Facility Compare the information that is available is a database on greater than 6,000 dialysis facilities nationwide and we're on slide number six.

What we wanted to do is allow patients and their families to compare facilities based on the location because it's important for patients that they travel reasonable distances, the services that are provided because we have patients that are on PD as well as hemo and also measures of quality of care.

What we were looking to do was to try to give as much information as possible within the limited scope that we have at this time that gives information or guidance that can be used to understand quality data including why these measures are important, how to use the information as presented on the Web site not just for the stars, but also for what we considered demographic information on the facilities and where to find local resources for patients and also for their family members.

Slide 7 so what information is currently available on Dialysis Facility Compare and I wanted to point out that if we have individuals on the phone that have used Dialysis Facility Compare in the past, you will see that Dialysis Facility Compare has gone through a refresh and there is a difference in the use of white space and readability in terms of trying to make the information easier to read in terms of following it from top to bottom, left to right so we do believe that these changes as part of the refresh has enhanced the usability.

So that in addition to that, the quality information is available on best treatment practices including information on how facility has managed anemia, how they deliver adequate dialysis treatment based on kinetics, the use of different vascular access to deliver dialysis. Also, there's data available on hospitalization and death rate, the rate at which patients are admitted to the hospital and the rate of patient deaths that occur in the facilities.

Moving on to slide 8 so what other information is available? As we said, we believe that it's important, especially since this is life-sustaining treatment, that patients can look at dialysis facilities relative to location so we provide dialysis facility name and address, evening hours because we do know that

there are patients that are looking facility with hours after five to accommodate their work and school schedule, the number of hemodialysis treatment centers not everybody wants to be in a large center, the types of dialysis offered, home services, in-center services, facility ownership type whether or not a center is for-profit or non-profit, the name and address of the director and management and the date that the facility was certified or recertified by Medicare to provide dialysis.

So why did we decide as part of the facility information to include star rating? One of the things as I stated previously is that we want to make quality information more consumer friendly, more understandable for dialysis patients and I also want to know – want everyone to know that CMS recognizes that the quality measures that are included currently in the star ratings are not all encompassing.

We've been working with the consumer groups and collecting information on some of the additional attributes that patients would like to see on the site. So that we know that what we have is a good start; that we've added value to the site ,and that the information that we added we believe is understandable because what we're looking for is decreasing technical detail in the amount of information that someone using the site needs to read through and try to digest in order to understand facility performance, and I think it's important to reiterate again is that we want to decrease technical information and try to make the information as usable and as understandable as possible in the shortest amount of time possible and that's the reason we introduce what we believe are familiar icons to help the consumers more easily use and compare quality information as part of the information data that they gather in order to drive decision making.

Now what I would like to do is turn the presentation over to Joel Andress again. He is our DFC policy lead for measure development. Joel?

Joel Andress: Thank you Elena. I appreciate it. So to be clear when we started building the star ratings, we began essentially with what we – with what we had available to us in the way of quality measures.

We had the Web site for Dialysis Facility Compare and we began considering the measures that were reported on Dialysis Facility Compare for appropriateness, for a global indicator of quality for facilities, which is what the star rating is.

We evaluated the measures, determined that some of them were maxed out, which essentially means that everyone was performing well on those and we decided not to use those for the star ratings for the simple reason that they don't provide much information to patients if everyone performs well.

Having eliminated those, we found ourselves left with nine measures and we'll be going over those here. The first of these – of these nine measures were addressed the area of dialysis adequacy or dialysis clearance for patients. This started off as three measures.

For the purposes of the star rating, however, we will go into a single indicator and the reason for this is that not one of these measures is applicable to every patient and because (no one) measure may qualify for one measure, they may be an adult who received in-center hemodialysis or they may be a pediatric patient who receives hemodialysis, but they cannot receive both.

Combining the measures together, we're able to develop an assessment of all patients who were treated within a facility that allows us to determine how effective that facility is at providing adequate dialysis for all these patients and that's really what we're driving at for the star ratings. It also ensures that we include larger numbers of patients, larger numbers of pediatric patients and patients receiving nontraditional dialysis such as peritoneal dialysis.

If you'll join with me on slide 11, we also included three standardized outcome measures. Now these are measures that assess outcomes of care for patients, but that are risk adjusted to account for differences in how sick patients are when they begin treatment for dialysis and the reason for this is that it's – it's not fair to – we think to hold the facility accountable for the outcomes of care without giving them credit for taking care of the sickest patients that come through them.

In other words, we can't penalize the facility for caring for especially sick patients both because it would give them reason not to care for sick patients and because it would be unfair. These three measures assess or compare facilities performance to a national average for each individual outcome.

The newest of these measures is the Standardized Transfusion Ratio or STR and this looks at how often patients receive blood transfusion and the reason it does this is because blood transfusions can be a risk factor for disqualification of patients being able to receive kidney transplants, which is a significant outcome for the dialysis population. It also introduces risks – other risk factors associated with blood transfusions in general and this can typically be a consequence for anemia management so transfusions may not occur within the dialysis facility, but they will often be a consequence of the anemia management that a facility is responsible for providing.

The Standardized Mortality Ratio or SMR looks at patient death rates at facilities and compares them against one another. This has been reported on DFC since (inception). The lower your score on the Standardized Mortality Ratio the better the performance of facility because it indicates that patients, you know, are at lower risk for dying while under that facility's care.

And then finally the Standardized Hospitalization Ratio looks at how frequently patients are hospitalized. This has been reported since 2012 on Dialysis Facility Compare and the reason – and some of the reasons of this matter include the disruption to dialysis care that hospitalization represents. Patients require ongoing care for ESRD and this can be disrupted when a patient goes from treatment at a dialysis facility to a hospital, which then requires coordination of care between the facility and the hospital and so is a – is a significant risk factor for adverse events.

If you'll turn now to slide 12, we also have measures that assess – that assess the percentage of patients with high levels of calcium in their blood. This has recently been found to be associated with an increased risk for death in patients.

We also have two measures assessing vascular access. These are paired measures, which we use to create a tiered ranking of care for vascular access.

The first measure is the percentage of adult patients who received dialysis through an AVF or arteriovenous fistula. The second measure is the percentage of adult patients who had a catheter left in a vein longer than 90 days for their regular hemodialysis treatments.

If a patient has received dialysis through an arteriovenous fistula then the facility succeeds at both measures. If on the other hand a graft is received and I know this is a question that we received regarding vascular access measures, if a graft is used then the facility will succeed in one measure because the patient will not be using a catheter at that point, but not for the second measure for the use of an arteriovenous fistula and then finally if a patient has used a catheter for more than 90 days for regular hemodialysis treatment, the facility will fail at both measures.

And what this means is that patients of that facilities are encouraged to use a fistula over a graft, but encouraged to use a graft over a catheter and so that those facilities, which tend – which tend to provide more treatments for arteriovenous fistula as well have higher ratings for the star ratings.

As you'll join me on slide 13, each of these measures were drawn from the suite currently reported on Dialysis Facility Compare describing either best treatment practices or patient outcomes of care. We provided a detailed guide through Dialysis Facility Compare that explains the complex methodological calculations that go into determining the final score. However, broadly, we take an average of the measure topics that we're assessing for the star ratings to create a single indicator or a global index of quality of care.

We account for missing data starting with the assumption that we require information to say that a facility is better or worse than average and where data are not available we (err) on the side of not assigning a rating at all.

On slide 14, you can see a graphic display of the – of how these scores are then assigned. Once we've calculated the final score, we found that scores fell within a bell curve. Now there's been some discussion on this point about

whether or not we force the bell curve or required everyone to fit within a specific curve and the truth – the truth of the matter is that the scores fell within a bell curve and we assign star rating cut points based upon that curve.

As you can see from the display, there's no obvious point at which to cut – at which to determine the boundary between a three or four star facility and so this was made as a policy decision.

CMS chose to assign the cut points to reflect broadly the distribution of facility's performance on the global – on the global score that we calculated and it's important to note that if this distribution had been significantly different from a bell's – from a bell curve then we would have assigned star ratings based on the shape of that curve and that if that distribution changes in the future then the assignment of star ratings will also take that into account.

On slide 15, we talked a little bit about the interpretation of star ratings and exactly what it is that they mean. The facility may receive a rating between one and five stars with three stars reflecting an average performance among all facilities. The vast majority of facilities fall within a range of two to four stars.

The stars allow us to compare facilities with one another rather than against an (arbitrary matter). This is an important thing to understand. Because the performance is – Because the facilities are compared against themselves what you are seeing in the star ratings is a point of comparison. So a facility that has a one-star rating is performing less well on the quality measures that we use than a facility that receives three stars and that facility is performing less well than a facility that receives five stars.

The star ratings should be understood within the context of patient needs and priorities. We're not presenting this as the final word of quality in a facility or where a patient should receive care. Rather, we want this to function as a single – as a single data point that patients are able to take into account when they are making decisions about their care.

We still encourage patients to speak with their physicians, to talk to the staff at their dialysis facilities. If they wish to consider other facilities, then we

certainly welcome them to use this information to do so, but we also encourage them to use this information simply to begin a conversation about the care they are receiving from their providers.

And then on slide 16, we talked a little bit about the facilities that don't receive a star rating. There are a couple of different reasons why a facility on the Web site may not receive a star rating. These include that a facility may simply be too small and not have enough patients for us to accurately calculate their performance using the underlying measures. In that case, we don't want to use unreliable data in order to – in order to assess – in order to assess the facility's performance.

It's also possible the facility is either new or has recently changed ownership and because of that data are either incomplete or had been delayed – or have been delayed and that shouldn't be considered as a mark against the facility, but you should expect that a facility in that situation will have data at a later date.

Facilities may also– may also treat highly specialized populations of patients. They are not included in most of the quality measures that we have developed. Now, it's true that we are working to make our measures be as comprehensive as we possibly can, but there are a number – but there is a fair amount of diversity in the treatment of dialysis in the United States.

As a consequence, we are not always able to include every patient population in our measures and that is reflected in the star ratings those measures are used to produce. We're always working to improve those measures and to enhance the degree to which they accept all patients and we certainly welcome suggestions on how we can continue to do this. And then finally its possible data are simply not complete for that facility and therefore we have not provided them with a star rating.

Now on the next slide, I'll turn it back to Elena so that she continues – can continue to discuss how consumers can use the star ratings.

Elena Balovlenkov: Thank you Joel. So one of the things that is important to understand is that the star ratings are a starting point. Again, we want to stress the fact that

when we developed the star rating program that the measures that we used were data that were reported over an extended period of time by the dialysis facilities.

We did not add at this time any new measures that were not ---- were known to the dialysis community and that as we move forward again we will be engaging with the dialysis community on future works as we'll be talking about with the TEPS and within the call today in looking at the types of measures that we believe are appropriate for the star ratings and also taking in to consideration what the consumers believe are important measures of quality so that when ,again I want to stress this ,that the star ratings currently only use quality information that are currently reported on the DFC Web site and had been reported over a significant number of years.

Please remember the star ratings are a measure of quality of clinical indicators. They are not based on patient satisfaction. At this time, HCAHPS scores and patient experience of care are not included in the star ratings.

Star ratings provide a comparison of one facility to all other facilities. And that again, star ratings should be used in combination with other information.

What is the other information that patients can get? We know that patients talk to each other; that customer service is extremely important. We've heard from patients that, you know, and have stressed to patients the importance of physically visiting a facility.

Some patients feel better in a small facility. They like more intimate relationships, with the staff. Other patients want to be in a large facility. They should be talking with the physicians. They should be taking tours and all of this is it's like putting all the pieces of the puzzle together to come up with the most complete information that's possible for patients to use.

So the important thing is to remember and we're on slide 18 here is that one of the things that we've done at CMS is that we have worked with the public, with the dialysis community, with patients that are receiving treatment to do testing of the star site of the – not only just what we did with the star ratings, but also with the dialysis refresh and we have met with consumers, and we'll

talk about that in a minute ,because this testing of the star ratings , how it would be used, as a potential use, which is important to us so that we've shared it with patients, with their families and that again we stressed that there are other factors of quality that are important to people.

Some patients have said they want to look at staff turnover. They want to look at nurse-payers ratio. They want to find out if the director is board certified. They want to know if there are concerns about access to care, involuntary discharges.

So moving forward, there are a lot of measures that we could be talking about with patients --about what are important to them, but also what are the sources of data that are available to CMS in order to be able to evaluate any of the measures that are important to patients, but one of the things we want to be sure the patients understand is how CMS calculates the star ratings and the importance of public reporting in order to drive information.

In addition, we want to be sure that we are supporting the relationship between patients and physicians and that we also want to stress the relationship of talking to other patients because the consumer perspective is incredibly important and one of the things that are very important part of the CMS quality strategy is patient engagement and interacting with patients and making sure that we allow patients not just to talk to CMS, but to each other because there's nothing like getting another patient's perspective to help drive decision making as well.

And also to look at other data such as the Value-Based Purchasing Program, the QIP information, information that you see at articles that you read, questions that you can talk to your neighbors about so that we really do want you to use as much information as possible and it's one of the reasons that we have invited Stephanie to join us and Stephanie I like to introduce you and give you the opportunity to talk to us about the consumer perspective.

Stephanie Glier: Elena thanks very much. Good afternoon everyone. My name is Stephanie Glier and I'm with the Consumer-Purchaser Alliance.

The Consumer-Purchaser Alliance is a coalition of consumer groups, labor organizations and employers dedicated to improving the quality and affordability of healthcare. Our mission is to put the patient in the driver seat to share useful information about provider performance so patients can make informed choices and purchasers can reward the best performing provider.

The reason I'm on the call today as Elena mentioned is that our work focus is on how we can use performance measures to improve the transparency, accountability and quality of the healthcare system particularly in ways that amplify the voices of consumers and purchasers who were the other side in the healthcare system.

We know and evidence shows that public reporting quality information can drive quality improvement and with an extra public spotlight can help spur even faster improvement. Even more, patients need critical information about the variability of the quality of care that's delivered by providers so that patients can make informed choices about their own care.

So more specifically thinking about Dialysis Facility Compare, we know consumers with kidney disease are a really diverse group, but at the same time the vast majority of patients who are starting dialysis will have to choose the dialysis option or a facility during a pretty stressful time with a lot of new information coming at them.

Many patients are thinking about an ongoing need, not a one-time use and they're looking for an opportunity to develop an ongoing relationship with the dialysis provider so how can we make it easier for patients and their families and caregivers to choose a dialysis facility.

From consumer research, we know that there are some basic principles that help make decisions easier when you're looking at quality information. First and most important is to ensure the information that you're presenting is useful and relevant to consumers. So by that, I mean using a summary score like a star rating is a really great way to make it easy to understand the big picture and overall quality.

As Elena noted, the star ratings on Dialysis Facility Compare cut down on some of the cognitive (loads) that consumers are facing when they're trying to understand all of the information on the site and that makes it easier to use the information to make a decision. That summary score needs to be built on measures the patients care about like experience of care, health outcomes and safety problems and we heard from Joel about the measures that are included in the star ratings on Dialysis Facility Compare and those focused on some really key health outcomes and best practices and indicators for patient safety.

And beyond offering a summary score, consumers should be able to dig into that score and see what measures go into the rating. Some consumers are going to want to dig in there and understand the mechanics and see the nuts and bolts and some consumers are not going to want to do that. They're going to just want to look at that that top level; how's the big picture going.

One of the (second) factors that will make public report most useful is that consumers need to be able to make comparisons really easily; the information to highlight meaningful differences across facilities. We know the quality of care varies and that should be reflected so it's easy to understand which providers are better at what they are doing and what questions patients should ask when they're meeting with that facility.

Third to be most useful, the information display needs to be personalized or personalizable to fit the consumer's needs. This might mean that a consumer can dig in to a summary score and see what measures go into the rating or she can choose two measures that she cares about and compare the performance of the facilities in her area.

The display needs to be customized to the different audience needs for example (varying) levels of health literacy or a first-time dialysis patient who might have different questions and priorities than an experienced dialysis patient who is changing facility.

As Elena noted though, public reports like the Dialysis Facility Compare Web site and its star ratings are only one piece of the information that patients will use to make decisions. Patients are resourceful and they're going to consider

ratings alongside many other inputs like recommendations from their doctor, (extended) family, site visits, talking with other patients and how easily they can access the care they need at any given facility so hours, locations, convenience.

Overall, giving consumers important information about their healthcare provider's performance does help patients choose the care that's best for them and can help drive quality improvement that benefit all patients.

Thinking about how to make quality information accessible and meaningful to patients, Dialysis Facility Compare and the star ratings are a really great first step and I wanted to thank CMS for inviting me and other consumers to share our feedback on the site and with that, Elena, I will turn it back to you.

Elena Balovlenkov: Thank you Stephanie. I'd also like to stress as we've said one of the things that CMS is committed to is patient engagement and making sure that we hear the voice of the community in terms of all works that we do within CMS so I'm really honored that we have Celeste Lee with us today representing the patient's voice and talking about her perspective in terms of the star ratings and the Dialysis Facility Compare Web site and the work that CMS has done in this area. Celeste?

Celeste Lee: Thank you so much Elena for having me on the call and for CMS for actually doing this conversation I think it's really important. First, I want to say that I am really a patient, not so much a consumer because consumers sometimes indicate that you have choices that you're entering to go do something and a lot of patients don't have the choice to be a patient and so it puts them at a very different kind of mindset, but I just want to talk a little bit about, you know, my perspective as being a 33-year patient of ESRD.

I lost my kidneys at the age of 17 due to an autoimmune disease so have been on hemodialysis, had a transplant for 10 years, but have been back on dialysis since 1995. I'm been both on peritoneal dialysis and in-center hemodialysis.

As you also see here, I am also. my profession as a career, has been as a university administrator, but in 2007 switched over to the health system to actually lead Patient and Family Centered Care right and what that really is

about is how do we get patients engaged in their healthcare, right, their patients and families to get engage in the healthcare and really understand what is my illness and more importantly how can I care for myself and how can I own my health to be an active participant and not a passive receiver.

And I really do think that the Dialysis Facility Compare site is a good start. As Elena has mentioned, as Joel has mentioned like everybody else in the call has mentioned, this is a really good start to take some complicated clinical indicators and make them accessible to patients and families to be able to compare and look at some of the facilities based on the clinical indicators right.

We all know that end-stage renal disease is a very complicated population pool right. We have people from all different socioeconomic, diversity education, different disease types that cause the kidney failure and so we know that that's a challenge, but this gives us at least a beginning to get this information up there, to make this information accessible to the patient and family and then as we start testing the star ratings right, we start looking at this and then we do start engaging the patient voice in a way that it's very substantial and meaningful, which I wish we had much more time to talk about, but as much – as meaningful that we will be able to really bring in some other type of quality indicators that would help patients make even more informed decisions about not only their provider and I think all of us who are on dialysis and who are part of the dialysis community know that your real relationship is with your patient care techs within this dialysis facility right. That's really important and so those are some of the things.

As Elena had mentioned, there was a lot of indicators people would be looking to look for. This is a good start. We can actually start to engage the patients even more and I'm just so happy that this is now launching and that we can really start to determine how to best engage patients at, you know, because I would love to see which facilities have Patient Advisory Councils as a part of their group because that means they truly want to, you know, engage patients or have Peer Mentor Programs, et cetera, but again, I just want to thank CMS for actually bringing on the patient voice.

I know there is a lot of discussion that has been going on nationally about – especially from patient groups about this, but you know, we have to start somewhere and we have to figure out how to take these clinical indicators and get them accessible to patients and families and this is a great start so thanks so much.

Elena Balovlenkov: Thank you Celeste. So what I wanted to remind everyone is that we did have an opportunity to receive questions from the community prior to this call and while some of the questions were facility specific and we would not – we will not be answering those questions on this call, but we will be developing a consolidated question document, which again we will post online so that everyone gets the same answers to the questions.

What I like to do is one -point out on slide 23 that we are still accepting questions even though we had questions that we received prior to this call. Please feel free to continue submitting questions that you have related to the star ratings, the methodology or any forward work or suggestions that you have moving forward, but I do want to answer a couple of the questions that we receive.

One for example and some of these I am going to be paraphrasing is that in Charleston, West Virginia there is certainly one-star facilities within a 50-mile radius, what advice would you give to patients on how to act on this information.

CMS has gone on record. We continue to go on record that the star ratings are to initiate a dialogue between the provider and the community in which the patient is being treated.

We want patients to openly be able to say can we talk about any information that a patient finds whether it is a star rating, whether it is a QIP score, certificate that they see hanging in the lobby, whether it's an article that they see in the newspaper, we want them to sit down with their provider and their healthcare team. They have care conferences and that they can ask questions relative to these scores.

The star ratings were not intended to be a bus pass to get people to move out of facilities, but they were intended to initiate dialogue between the healthcare team and the patient.

The second question that I would like to answer is what step CMS is taking to ensure that star ratings do not deter physicians from serving the sickest patients. The first thing I would like to address is the issue some people calls' it cherry-picking, other people call it lemon-dropping, is the issue of ethics.

One of the things we know is that patients have learned that physicians take an oath that says "do no harm" and while we know that there are instances anecdotally that have been reported to us of cherry-picking where people are picking "the healthiest patients to have in their facilities," when those situations occur, we refer them to state agencies.

We also have developed the patient contact utility at CMS, which is a grievance tool that patients can use to come directly to the network or to CMS to talk about concerns that they have whether it's relative to access to care because they feel they're being denied entry into a dialysis facility based on comorbid conditions or behavior contract or any other conditions that exist.

We also have the opportunity to track involuntary discharges or at risk for discharge because of the fact that patients feel that they are getting a different level of care based on their illness or how their illness presents and then we also feel very comfortable that with an investigation we can involve State Survey Agencies to also respond to these concerns of cherry-picking and lemon-dropping but the biggest thing is that CMS would like to believe that the healthcare community is interested in providing the best care to patients- no matter what level of health that patient is in relative to their disease.

I would like to turn it over to Joel. You have a couple of questions that also come up that we would like to respond to.

Joel Andress: Certainly. So, the first was actually fairly specific with regards to methodology, that said, very few of our and again I'm paraphrasing here,. so if you recognize the content but not the language, I apologize, very few of our

home dialysis centers received a star rating possibly because each center may have a handful of home hemo dialysis patients.

We feel it is important to include these home programs in the current public star rating system and by just doing so under the same rules as the PD (only) centers. This is referring to rules that were like- we provide ratings to peritoneal dialysis only centers, even though they do not provide – they don't include data for the vascular access measures.

So first of all I'll say in response to this that we agreed that including the special Dialysis Program is important. Typically this involves, you know, modifying our existing measures or developing new measures that allow us to do so. I think the suggestion here is actually one that speaks directly to the (sustaining) the methodology itself.

As Elena has pointed out, we are going to be convening a TEP this spring. We actually – we just posted the call for nominations to be involved in that. I would certainly recommend that anyone interested in participating or knows someone who might be interested in participating, fill out a nomination form but it will the purpose of that TEP to review issues like this.

And I'll say this maybe one of the issues that we bring before the TEP, so that they can discuss. The – during the course of that TEP, the calls (will) themselves be opened, so members of the public will have the opportunity to listen in and we will – we'll have the opportunity to comment at the end of that (the TEP)t as well.

The second question I want to touch on is a – is more specifically addresses the interpretation of the star ratings. How can we reconcile saying that the star rating show quality – show quality of care with the statement that CMS for a (government Web site that just because a facility receives a 1, 2-star rating does not mean the facility will provide poor quality of care.

And that's an entirely reasonable question. I think it gets to – directly to the purpose of the star rating as we constructed them. The star ratings are intended to provide a mean of comparing facilities to one another. It doesn't

compare to an absolute value of quality, that was an intentional decision on our part and we made it for two reasons.

The first is that by setting an absolute value, we allow – we can allow potentially for a phenomenon referred to a number of different ways but for our purposes we'll call it scoring (degree) and that situation which facilities scores against that particular – against a particular threshold increased over time to the point where everyone is scoring highly against that threshold.

Now on the one hand, that's good because it means that their performance has improved in absolute terms but it has two consequences that I think are problematic for the star ratings as we can see with them for this program. The first is that when everyone is scoring highly, it gives very little information to patient consumers.

If everyone has a 5 on the star ratings, then all facilities appear equally good and I think that's potentially problematic. It also doesn't recognize facilities that have improved – continued to improve beyond that threshold that was originally set.

The second issue is that as facility crossed that arbitrary boundary, they then lose that incentive to continue improving care, to continue engaging patients and discussing – and discussing quality improvement. And we think that is potentially problematic as well. We want facilities to have a continuous drive for quality improvement through the star ratings.

So, I would say it is – one is appropriate to say that a star – a 1-star facility provides lower quality of care than most of its peers and has worse health outcome but it's also appropriate to say that this does not mean they cannot provide the life sustaining treatment for ESRD based solely on the information provided by the star ratings.

I would – I would suggest however that it is a good reason for patients to talk to their facility staff, to their physician and find out more about the – about the outcomes of care, that their – that their facilities engaged in and to see what they're doing for their own quality improvement purposes and efforts.

Elena Balovlenkov: Thank you Joel. We like to take and open the line now for questions and answer session; Operator.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one followup to allow other participants time for question. If you require any further followup, you may press star one again to rejoin the queue.

Our first question comes from the line of Lana Montgomery from Fresenius Medical, your line is open.

Lana Montgomery, your line is open.

Our next question comes from the line of Bruce Upton from Ozarks Dialysis, your line is open.

Bruce Upton: Yes, I had a question about your adequacy of dialysis treatment. CMS uses the Kt/V on the QIP program but you also use it in the Dialysis Facility Compare. However, you actually do the calculation differently in those two programs; can you just tell me why that decision was made to calculate those differently in those two programs?

Joel Andress: Sure, thank you for your question, this is Joel Andress. So, the differences in the calculations are relatively small. I would say they stemmed from two considerations. The first is that the Dialysis Facility Compare calculation makes use of the measure specification (because) they were endorsed by the National Quality Forum when the measures were developed and then submitted for endorsement.

However, when the measures were proposed for use in the Quality Incentive Program, part of what came out of the rulemaking across – out of the rulemaking process led to decision – led to decisions that limited its application to patients who had been seen for a – who had been seen a certain amount of – certain number of – for certain number of treatments in the course

of a given month and the reason for that is the Quality Incentive Program applies a payment penalty.

And so that was a consideration I believe to address the presence of transient patients for that program. In general when we have a program that I measures quality– and then when we have a value-based purchasing program, we tend to err on the side of caution when applying payment penalties precisely because they can be so consequential for the facilities in place.

But let's say for Dialysis Facility Compare and for the star rating themselves, you know, the purpose is not to penalize facilities rather the purpose is to inform patients and so we want to provide as much quality information for patients as we possibly can.

Elena Balovlenkov: Thank you.

Operator: Our next question comes from the line of Tonya Saffer from National Kidney Foundation, your line is open.

Tonya Saffer: My question is really around – I first want to say that I think it's great that you guys are incorporating patients' thoughts and looking to incorporate patients experience down the road. So my question is today, if we were to refer a patient to Dialysis Facility Compare to look up the ratings for their facility or a new patient trying to choose a dialysis facility and today there's no sort of experience of care reflected in there.

They choose a facility that maybe a 4 or 5-star facility and then, you know, next year new measures were incorporated and that facility rating changes dramatically. I see that as a potential scenario, so I'm wondering today in the absence of any patient experience of care or other quality measures incorporated into this, how helpful it is to refer patient there and how indicative the rating system is on the actual quality of care delivered versus the population health issues?

Elena Balovlenkov: Hi, this is Elena Balovlenkov. Thank you for your question. It's a good question and while I really do believe that ratings can change over time, there's staff turnover, centers expand, centers cut (chairs). There's a lot of

changes that occur based on financial constraint, based on mergers, buyout, closing of facilities, so there really is a realistic perspective that a facility can change based on the physical dynamics that are occurring within that facility.

I have experienced it as a dialysis practitioner, so that we know that reality exists and it's also important as we spoken to by, you know, myself, Joel and everybody on this call, you know, Celeste and Stephanie is that, that information is important to consumers because just as we expect that quality can improve, we also know that quality can go down based on the different dynamics that occurred and we believe that information is valuable to patients.

Because again, the intent of the star rating are to initiate dialogue in the facility, so that they can sit down and talk with their healthcare team when they're having their care plan and say, hey, I just saw that, you know, last year we were, you know, a 4-star and this year we're 3-star. Can we talk about what happened because as a patient being treated in this facility I have some questions.

Celeste Lee: Right. Can I respond to that?

Elena Balovlenkov: Certainly.

Celeste Lee: OK, this is Celeste and you know I absolutely – this is something that I'd been grappling with myself, right? I know for a fact that choosing a facility and sometimes people don't even have a choice but let's say choosing a facility is something that is really important and I think a first step to have patients that at least be able to understand what these measures mean not only to look at the entire unit as a whole but then personally because I have to tell you there's a number, 75 percent of the patient in unit do not have an understanding of what this quality indicators (mean) for them personally.

So, I think this is the way to start to initiate the conversation of if your unit is being evaluated on these measures, what do they actually mean for you? And that's where I think it does – if you're going to refer patients to this, it also, you know, the conversation should be here is a site that you can look at to get an understanding of what these clinical indicators are, but more importantly, let's talk about what they mean to you and how you can have a partnership

with your facility, with your care team, with your patient care technicians on how to actually make sure that these are good for you, right?

That's my goal. So, that's where I think this allows the conversation to happen because you're absolutely correct. Indicators are going to change; facilities are going to change, just like patients changed, right? And I mean, just this month, I've lost three of my fellow patients who passed away. And so this is a constant changing group but it's a way of trying to allow people to take this larger indicator and bring it back down to themselves.

Elena Balovlenkov: Next question?

Operator: Your next question comes from the line of Julie Williams from Branson Dialysis. Your line is open.

Julie Williams: Yes, I have a whole bunch of questions but I'll just stick to the one that concerns me the most. The – when the five-star rating, were you guys put all these together and you had facilities that hit like two or less stars? Was there any testing done to verify the integrity of the data that if you're going to put something out there on the public site, that those facilities won't basically penalize because I agree with Celest that patients don't understand what that means. And I'm just curious as to whether or not CMS did any just, you know, contact those units and so let's go through your data before they do – put this information out there on the public.

Joel Andress: So, I – this is Joel Andress. So, part of our process on dialysis and so compare in general, and then to be clear, we've been – we've been doing this first annually and now quarterly since 2001 is that when we released data of any kind, we conduct a preview period prior to – prior to posting anything publicly on DFC.

The preview period is – is a period time where we provide a report and make it available to the individual dialysis facility. So, the facility staff can look at it and review the data and raise any concerns that they may have about the – about the correctness of the data and then contact us. They then have the opportunity to request suppression in the event that they think that the data are flawed in some fashion.

Now, typically, one of three things happened. Either we clarify a misunderstanding in terms of how the measures are calculated. We are able to identify a flaw or data issue and then we suppress the data because we certainly don't want to post data that are incorrect. That we know – I certainly agree with you there or we are able to identify that there is some other issue and I, you know, there are really too many to count or go over here that led to facility believing that it should have a different score than it does. And we viewed the preview periods to allow this.

Now, for the star ratings, we actually rolled this out in a preview period in July and August of last year initially. When we delayed the release of the star ratings until January, we, again, presented this in a preview period during November. So, yes, we do have that mechanism in place to allow for checking of the data. More than that, I think that the data that we – the underlined data that we used to calculate the measures come from – come from the same data sources that we used to provide for facility payment of claims. Most of these measures are claims based with this time frame.

So, I drove the same validation checks that the files that provide you with payment also go through. So, I think with any large data system, you know, expect that there are problems there are going to be errors present, but I think that to the extent that any large data system can provide for valid and reliable data we have – we have made an effort to do so for the star ratings.

Elena Balovlenkov: Thank you, Joel. We have time for one more question.

Operator: Your next question comes from the line of Seema Jose with Concerto Dialysis. Please go ahead.

(Richard Delvo): Oh, yes. Thank you for allowing this question. My name is (Richard Delvo). Seema had stepped out. Our question is in regard to our facility having both an outpatient chronic unit and inpatient, a home dialysis unit and a nursing home. Eighteen of our patients are on our outpatient chronic unit. The rest are from our home dialysis centers. Having such a large volume of nursing home patients combined with our outpatient centers, gives us a rating very low of 1 – number 1 in rating.

Our patient centers' is – should be divided because if we compared our outpatient mortality rate compared to our – inpatient or home patient mortality rate, our outpatient is zero, but our home patient is 35 for the past year. We accept where we have many patients who are hospice patients that come to us and have many comorbidities. It's very difficult – we're in a difficult position having that we only have one provider number for our subacute, as well as our chronic unit.

Would it be possible to look at how we're being rated in our outpatient unit because those patients that's in the 1 or they aren't fully aware of understanding, that it's not regarding the outpatient unit?

Joel Andress: So, that's all. There's a lot. This is Joel Andress. So, I'll say first of all, it would probably be better for us to respond to this directly than over the phone. I would ask, OK, first of all on slide I believe 23, we have a mailbox at the www.dialysisdata.org. I would ask you to submit your question in writing. I don't sort of (like) to want to attempt to embarrass myself by unpacking the entire – the entire (thing) there. I think, you know, it's certainly something that we can – we can listen to your concern in depth and get details from you and take a look at it. But I – it's not something that I could – I could hope to respond to. (I'd like to weigh) in this format.

Elena Balovlenkov: Yes, I think really is important that you send us the details and also so that we can look back and see any information that was submitted during the preview period so that we can give you a complete answer. Is that OK? Hello?

(Shiny Chacko): This is (Shiny Chacko) from Concerto and actually we have contacted Renal (with) regarding this and even they didn't have an answer because the 18 patients that we have, (it seems) – somehow that's correct because we have no deaths among those patients, but if you consider us, you know, I mean, we have – we have sent – I think we're almost 30 employees, more than 18 (of patients) commented in this Web site, this www.dialysisdata.org. As matter of fact, we even sent you comments today as well.

So, we'll definitely hope for an answer and we really appreciate that you're listening to us.

Elena Balovlenkov: No, absolutely. And I give you my word that we will get back to you on this either myself or Joel and it may even be both of us. We will definitely look into this. So, again, I want to encourage everyone, if you have additional questions, to please submit them to the web address that is on slide 23 and also I just wanted to remind everyone that while we are moving forward in the development of the TEP for the star ratings, I want you to know that we continue to work with the dialysis community, with the advocacy groups and with the professional groups.

We are collecting information and considerations and recommendations in the formation of the TEP and in the work going forward and we'll continue to respond to the comments and questions received and, again, I want to thank our speakers Celest and Stephanie. Thank you so much for sharing your time and your expertise especially Celest, I think it was wonderful getting a patient perspective on this. So, thank you, again.

Celeste Lee: Thank you very much.

Jill Darling: All right. Well, thank you everyone for joining today's call and have a wonderful day.

Operator: This concludes today's conference call. You may now disconnect.

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