October 11, 2018, Dialysis Facility Compare National Provider Call Questions and Answers

The questions below were received during the October 11 Dialysis Facility Compare National Provider Call. Questions were submitted to the Centers for Medicare & Medicaid Services (CMS) via the chat box and answered either over the phone during the webinar or subsequent to the webinar by CMS subject matter experts, as part of the question and answer commitment for the remaining submitted questions not answered during the webinar.

Q. When will the new star rating reports be available for the 2017 outcomes?

A. The Quality of Patient Care Star Ratings for 2017 and the Patients' Experiences Star Ratings for the 2017 spring & fall surveys are available now on the DFC website. Note that the website is only showing the overall star rating for the survey of patients' experiences, which is a simple average of the 6 individual star ratings. The 6 individual star ratings are currently available via download (click on "About the Data" on the DFC website). However, the April 2019 refresh will show all 7 star ratings (6 individual and one overall) on the website.

Q. Hi, our patients tell us that the survey is too long, too many questions and sometimes confusing. They don't want to keep doing this twice a year. Also, in regards to transplant, our population is mostly elderly. We refer every patient who is eligible and/or wants to be referred but then it's up to the transplant center. So why would we be rated on this in the future?

A. This is an issue that Centers for Medicare & Medicaid Services (CMS) is constantly evaluating - CMS looks at the number of questions, length of the questionnaire, as well as the individual questions. We are currently going through an analysis to determine whether we can possibly drop questions and make the survey shorter. However, this is a complex process that requires much scientific testing to ensure that the integrity and validity of the survey are not compromised. Survey burden is a topic that arises often because CMS would like to receive get as many responses as possible. For 99% of the dialysis facilities, every eligible patient is included in the survey population instead of a sample, so we can meet the threshold of 30 completed responses across two survey periods. The results of survey burden studies in the past have been surprising. You might intuitively think that if somebody responds to the survey once, they would be less likely to respond to it again in the future. However, what CMS has found is that those who respond to the survey once are the most likely people to respond to it again. It's as if they've got a story to tell, and they want their data to be known. If there is a change at a facility and the conditions in the facility change, CMS will have the ability to keep track of those changes. CMS, aims to balance the burden of the survey with the need for up-to-date information.

To address the comment about the transplant measures, the rationale behind these measures is that the dialysis facilities and the transplant centers have a shared responsibility for ensuring that these patients have optimal access to transplantation. CMS agrees the transplant facilities do make the final decision on whether to waitlist a patient. During development of these measures,

transplant centers and transplant surgeons shared with us that the dialysis facilities were a large part of maintaining the health status to get a patient ready for transplantation and also providing the education necessary for patients to make informed decisions about transplantation. CMS believes that while the dialysis facility does not have full responsibility, the dialysis facility does have a shared responsibility with transplant centers for allowing their patients to have access to transplantation, which has been shown to have superior outcomes to being on dialysis.

Q. How many patients were included in the patient summit feedback session?

A. In the past, CMS has had as many as 9 patients in a session. CMS recently completed a feedback session that evaluated patient-health literacy in three states, and those groups varied from 4 to 9 participants each in each of the sessions.

Q. CMS requested feedback on the 2 transplant measures last year (from 10/25/17 - 12/31/17). There is a summary report available on dialysisdata.org. Are you seeking additional comments, or what is the purpose of another comment period?

A. CMS welcomes your comments. Specifically, CMS is soliciting comments on the inclusion of these measures on the DFC website beginning in October 2019. As part of our DFC communication process CMS will allow for a separate comment period regarding inclusion of new measures on DFC after facilities have had the opportunity to review the measures during the July - August preview period

Q. If a facility had 30 patients and should have administered the CAHPS survey but did not, would they receive a 1 star rating?

A. Patients' Experiences Star ratings are only assigned to facilities with 30 or more completed surveys. The facility would receive a footnote instead, indicating that they did not have results to report, and would not receive a star rating.

Q. Are you going to communicate about the biannual Patients' Experience Star Ratings to the public?

A. CMS has used results from the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey on Dialysis Facility Compare (https://www.medicare.gov/dialysisfacilitycompare/) since 2016, and refreshes the data twice a year. Additional information about the survey can be found at https://ichcahps.org/.

Q. When will the patient's compliance issues be calculated into the ratings? I have a large inner city clinic where patients refuse to follow recommendations despite continual education and redirection.

A. CMS understands the challenges that may be presented in the care of all patients. CMS quality measures have specific exclusion criteria that factor into the measure calculation. There are no exclusion criteria for "compliance issues."

Q. Will pediatric facilities still have exemption for VA and ICH CAHPS? If so, how will this affect the star rating? Will it lower it?

A. Pediatric patients are still exempted from VA and ICH CAHPS measures. There would be less than 30 completed responses and no Star Rating reported.

Q. I was contracted to survey a clinic that had a 5 star rating of DFC. The facility had extreme safety issues that caused a risk to patient health/life. Have you considered tying the CMS survey to the DFC?

A. Surveys results are based on compliance with Federal Regulations, while DFC utilizes 11 measures. Additionally, a survey may tell us what's happening at the time of survey, while DFC's measures may have some delay, which may not capture a quick decline in performance noted by the survey.

Q. Although arteriovenous fistulas (AVF) are the best choice, often a graft is the only possible availability. Currently, CMS penalizes for this outcome when it may be the patient's only lifeline. We understand that catheters are not always a good thing. Access to this life saving care should not be a penalty. AVF and Graft percentages should be addressed together.

A. The two vascular access measures, when used together, consider arteriovenous fistula use as a positive outcome and prolonged use of a tunneled catheter as a negative outcome. With the growing recognition that some patients have exhausted options for an arteriovenous fistula, or have comorbidities that may limit the success of AVF creation, pairing the measures accounts for all three vascular access options. The standardized fistula rate measure includes risk adjustment for patient factors where fistula placement may be either more difficult or not appropriate and acknowledges that in certain circumstances an AV graft may be the best access option. This paired incentive structure that relies on both measures reflects consensus best practice, and supports maintenance of the gains in vascular access success achieved via the Fistula First/Catheter Last Project over the last decade. Additionally, the fistula and catheter measures apply exclusions for certain conditions recognizing that catheter placement may be the only means of vascular access for these patient sub-populations. Specifically, both measures exclude patients with a catheter that have limited life expectancy defined as being under hospice care in the current reporting month, or with metastatic cancer, end stage liver disease, coma or anoxic brain injury in the past 12 months. In this way, the combination of risk adjustment for the standardized fistula rate measure and the application of the exclusions to both measures does not result in doubly penalizing facilities and instead is intended to incentivize best practices for vascular access. Finally, the standardized fistula rate measure is a risk adjusted standardized rate, and contains exclusions, therefore the standardized fistula rate cannot be directly added/subtracted from a raw percentage of grafts and catheters.

Q. For the Patients' Experiences Star Rating, what would the outcome be if a facility was eligible and did not administer the survey? Do they receive a 1 Star or 0 Star Rating in ICH CAHPS?

A. Star Ratings are only assigned to facilities with 30 or more completed surveys. The facility would receive a footnote instead, indicating that they did not have results to report, and would not receive a star ratings.

Q. Did CMS develop any patient facing materials that explain the Patients' Experiences Star Ratings so the facility staff can be prepared to address patient and family questions? If so, can you please share with the community?

A. Please go to the ICH CAHPS (https://ichcahps.org/) website for materials that explain the technical details on the coefficients, as well as the Star Ratings (https://www.medicare.gov/dialysisfacilitycompare/#about/dialysisfacility-info) and how CMS calculates them. However, it is a very technical document. If there are questions, please feel free to submit them to the ICH CAHPS Coordination Team, and we'll see if we can give a more layman's explanation. CMS will also discuss if there's a way we can come with a resource that would help patient understanding, just like we're working on for all of the rest of the measures.

Q. In which Star domain are the transplant measures expected to land?

A. Transplant measures are not candidate measures for the Star Ratings yet. CMS will be to making a determination as to whether those would even be included in the Star Ratings at a later date.

Q. What happens if patients were ELIGIBLE and the facility did not administer the survey? Do they receive a 1 Star or 0 Star Rating in ICH CAHPS?

A. Star Ratings are only assigned to facilities with 30 or more completed surveys. The facility would receive a footnote instead, indicating that they did not have results to report, and would not receive a Star Ratings.

Q. Our facility is 100% nursing home residents. When will the Star Rating accurately reflect the disparity between our facility and a regular outpatient unit?

A. Most of the measures included in the Quality of Patient Care Star Ratings are risk-adjusted and endorsed by the National Quality Forum. As part of the NQF endorsement process, the need for risk-adjustment is explicitly reviewed, so NQF-endorsed measures that do not have risk-adjustment were not deemed to need it for endorsement. In addition, we're constantly working on enhancements to risk adjustments, including improving the nursing home risk adjuster variables included in several of our measures. If your facility has a significant number of nursing-home patients, that is accounted for in those respective measures. CMS will continue to evaluate whether a risk adjustment is adequate to account for the differences between facilities and improve the risk adjustment approach.

Q. Is there a way to denote a co-morbidity issue of gastro-intestinal bleeding for high incidence of transfusions and hospitalizations?

A. CMS recognizes that some transfusions are performed in response to acute events such as gastrointestinal bleeding or trauma. However, our own research (Hirth 2012) as well as that by Sibbel, et al. (Sibbel 2013) identifies a strong association between achieved hemoglobin and subsequent transfusion events. In both patient and facility level risk-adjusted models, achieved hemoglobin is the strongest predictor of subsequent transfusions. These observational analyses are consistent with the findings of an earlier randomized controlled trial (Foley, CJASN 2008)

that identified marked differences in rates of transfusion related to targeted hemoglobin. Since dialysis facilities do have a direct role in determining achieved hemoglobin as a result of their anemia management practices, there is a shared responsibility in subsequent transfusion events. That is, a patient who develops a gastrointestinal bleed is more likely to be transfused if the baseline hemoglobin is 8 g/dl compared to a baseline hemoglobin of 11 g/dl. The responsibility of the dialysis facility for achieved hemoglobin outcomes (and transfusion risk related to achieved hemoglobin) is strengthened by applying an extensive list of exclusions for comorbid conditions that are associated with decreased ESA responsiveness, increased transfusion risk, and increased risk of ESA complication.

Q. When will ICH CAHPS Star Ratings be public?

A. Patients' Experiences Star Ratings for the 2017 Spring & Fall surveys are available now on the DFC. Note that the website is only showing the Overall Star Rating, which is a simple average of the 6 individual star ratings. The 6 individual star ratings are currently available via download (click on "About the Data" on the DFC). However, the April 2019 refresh will show all 7 star ratings (6 individual and one overall) on the website.

Q. Are co-morbid diagnoses attached to Dialysis Facility claims taken into consideration for measure exclusions or risk adjustments? Or is this information solely dependent on the hospital or physician submitted claims?

A. Patient prevalent comorbidities for measure exclusions or risk adjustments were obtained from Medicare claims, including inpatient, outpatient (including the majority of dialysis facility claims), skilled nursing, hospice, home health, and physician and supplier claims.

Q. Are the new access measures pulling out grafts so that grafts don't count against a facility?

A. If a patient has an arteriovenous graft they would receive credit in the long-term catheter measure because they don't have a catheter currently in place, but they would not receive credit in the fistula measure because they don't have fistulas. This reflects the evidence that fistulas are superior to grafts, so while it would not be as bad for the facility as having just a catheter, it's not reflected as well as if the patient had had a fistula.

Q. How are small, non-profit facilities compared to large dialysis for profit organizations?

A. All measures are patient mix adjusted to make facilities comparable. Patient mix factors include age, gender, self-reported overall health status, education, years on dialysis, and selected diseases and conditions. CMS adjust for patient characteristics in the standardized measures (Standardized Mortality Ratio [SMR], Standardized Hospitalization Ratio [SHR], Standardized Readmission Ratio [SRR], Standardized Transfusion Ratio [STrR], and Standardized Fistula Ratio [SFR]), including select patient demographics, duration and cause of ESRD, nursing home status, comorbidities at incidence of ESRD, and patient prevalent and incident comorbidities (SMR, SHR, SFR). For SRR, certain comorbidities associated with a high risk of readmission are included as risk adjustors; STrR uses certain comorbidities as exclusion criteria. None of the clinical quality measures adjusts for facility type. In addition, there are minimum data

requirements in order for facilities to be eligible for the measures. For more information on adjustments in the standardized measures and information on the other clinical quality measures please refer to the Guide to the Dialysis Facility Compare Report (https://dialysisdata.org/sites/default/files/content/Methodology/DFCReportGuide.pdf).

Q. I'm the clinic manager of FMC Clinic which we agree with our insurance company to do the blood transfusion in our clinic instead of sending patients to the hospital or other clinics. But, in our DFC rating we got worse than expected. We feel we are doing this for patients' convenience and we shouldn't be penalized for that. Those patients are not on any ESA due to cancer diagnosis. We were discussing because of rating to start refusing Blood transfusion. Please advise.

A. For your specific concerns, CMS recommends sending a query to the help desk. In general, however, all transfusion events are captured by this measure. As long as the transfusion patients were assigned to your facility during the period, the location wouldn't matter, whether it happens in a dialysis facility or in a hospital. In either case, the transfusion would count towards the measure. First, the Standardized Transfusion Ratio (STrR) excludes patients with active and recent cancer diagnoses from both the measure numerator and denominator. Second, our methodology captures transfusion events regardless of transfusion venue, so transfusions provided during inpatient hospitalization, those provided by outpatient infusion centers, and those provided in your facility are all captured. The identification of transfusion events for your facility should not be influenced by your described practice to provide the blood transfusions in the dialysis center.

Q. I frequently get comments from my patients that ICH CAHPS questions are too long and are too vague. Is it possible, instead of sending the same long questionnaire twice a year, to make them shorter and divide them in 4 sections and every quarter send 1 section?

A. CMS is in constant communication regarding the length of the surveys and the questions within it. CMS is considering making changes to the survey, and we welcome suggestions. However, changing the survey is a complex process and takes much testing to ensure that the integrity and validity are not compromised. If you have other suggestions, please feel free to email the ICH CAHPS Coordination Team at ichcahps@rti.org.

Q. Frequently, the network is asking our clinic to include patients in our quality assurance meeting. How much does CMS include patients when they choose ICH CAHPS questions?

A. The ICH CAHPS Survey was developed by the Agency for Healthcare Research and Quality (AHRQ) in conjunction with CMS. In the process of creating the instrument, interviews and focus groups were completed of patients and their families, as well as nephrologists and other health care professionals, and ESRD Networks executives and facility staff to ensure the survey captured patients' experience of care at dialysis facilities.

Q. If a patient does not complete some or all of the self-reporting portion on the ICH-CAHPS, how is this reflected in the patient mix?

A. The response depends on which question(s) are missing. The process of calculating the patient mix adjusted scores can be broken down into the following 4 steps:

Step 1. To be included as a respondent, the patient must answer at least 50% of the core survey questions. Once a patient is considered a respondent they are included in their facility's patient mix adjusted score.

Step 2. When estimating the facility-level patient mix adjusters, respondents with any missing values in the patient mix adjusters (and this includes some of the self-reporting questions) are removed from the regression models.

Step 3. For any respondents with missing values for the patient mix adjusters, we impute their values using a hot deck imputation procedure.

Step 4. The patient mix adjusters determined in step 2 and the mode effect adjusters are applied to all respondents (those with no missing values, and those with missing values that were imputed in step 3).

Q. Will CMS ever consider the barriers ESRD service providers encounter, specifically rural dialysis facilities, in managing the vascular access of patients? For example, CMS have no vascular access surgeons at present in our county. Our patients have to travel out of county to find providers. This is often difficult to accomplish for patients who do not drive, have no public transportation providers that cross county lines, or no family available to accompany during outpatient procedures. Will CMS ever consider circumstances that are beyond a facility's control?

A. CMS understands the challenges that may be presented in the care of all patients. CMS quality measures have specific exclusion criteria that factor into the measure calculation.

Q. Many of the elderly have poor vessels and we are finding poor maturation for arteriovenous fistula. Why shouldn't we get equal credit for arteriovenous graft? An arteriovenous graft is better than a catheter.

A. The two vascular access measures, when used together, consider arterial venous fistula (AVF) use as a positive outcome and prolonged use of a tunneled catheter as a negative outcome. With the growing recognition that some patients have exhausted options for an arteriovenous fistula, or have comorbidities that may limit the success of AVF creation, pairing the measures accounts for all three vascular access options. The standardized fistula rate measure includes risk adjustment for patient factors where fistula placement may be either more difficult or not appropriate and acknowledges that in certain circumstances an AV graft may be the best access option. This paired incentive structure that relies on both measures reflects consensus best practice, and supports maintenance of the gains in vascular access success achieved via the Fistula First/Catheter Last Project over the last decade. Additionally, the fistula and catheter measures apply exclusions for certain conditions recognizing that catheter placement may be the only means of vascular access for these patient sub-populations. Specifically, both measures exclude patients with a catheter that have limited life expectancy defined as being under hospice care in the current reporting month, or with metastatic cancer, end stage liver disease, coma or

anoxic brain injury in the past 12 months. In this way, the combination of risk adjustment for the standardized fistula rate measure and the application of the exclusions to both measures does not result in doubly penalizing facilities and instead is intended to incentivize best practices for vascular access. Finally, the standardized fistula rate measure is a risk adjusted standardized rate, and contains exclusions, therefore the standardized fistula rate cannot be directly added/subtracted from a raw percentage of grafts and catheters.

Q. Why are clinics being dinged for transfusions when a patient has, for example, cancer or sickle cell and are in hospital for any reason, but are given a transfusion? This should be based on diagnosis not always being ESRD.

A. One of the strongest clinical predictors of transfusion during hospitalization is admission hemoglobin (or Hematocrit). This has been reported in the medical literature for a wide variety of clinical conditions and settings, including for chronic dialysis patients. The need for transfusion associated with inpatient hospitalizations is driven by both the acute condition requiring hospitalization and the effectiveness of anemia management by the dialysis facility prior to admission. In addition, the Standardized Transfusion Ratio incorporates multiple exclusions that account for many conditions that are associated with contraindication to the use of erythropoiesis-stimulating agents (ESAs) or have been associated with reduced clinical responsiveness to exogenous ESA administration. Furthermore, all transfusions associated with transplant hospitalization are excluded. Patients are also excluded if they have a Medicare claim for: hemolytic and aplastic anemia (including sickle cell anemia), solid organ cancer (breast, prostate, lung, digestive tract and others), lymphoma, carcinoma in situ, coagulation disorders, multiple myeloma, myelodysplastic syndrome and myelofibrosis, leukemia, head and neck cancer, other cancers (connective tissue, skin, and others), metastatic cancer, and sickle cell anemia within one year of their patient time at risk. Since these comorbidities are associated with higher risk of transfusion and require different anemia management practices that the measure is not intended to address, every patient's risk window is modified to have at least 1 year free of claims that contain these exclusion eligible diagnoses.

Q. While it is extremely important to have patient input, are there any plans to hold the patient accountable for their choices in the ESRD process?

A. As providers of health care it is CMS responsibility to improve outcomes for patients regardless of the choices that they make. Whether this is done by education, or mitigating social pressures, it is the job of health providers to provide optimal care to patients without regard to the choices they make.

Q. There are patients that cannot tolerate arteriovenous fistula (AVF). Why would a facility be held accountable for that?

A. The vascular access measures are paired, with presence of a functional fistula seen as a positive outcome and use of a catheter as dialysis vascular access as a negative outcome. AV grafts are by definition an intermediate (neutral) outcome. This valuation system reflects the majority opinions published in consensus clinical guidelines, clinical technical expert panel input and the endorsement of the National Quality Forum's Renal Standing Committee. With the

growing recognition that some patients have exhausted options for an arteriovenous fistula, or have comorbidities that may limit the success of AVF creation, pairing the measures accounts for all three vascular access options. In addition, the new standardized fistula rate measure includes risk adjustment for patient factors where fistula placement may be either more difficult or not appropriate and acknowledges that in certain circumstances an AV graft may be the best access option. This paired incentive structure that relies on both measures reflects consensus best practice, and supports maintenance of the gains in vascular access success achieved via the Fistula First/Catheter Last Project over the last decade. Additionally, the fistula and catheter measures apply exclusions for certain conditions recognizing that catheter placement may be the only means of vascular access for these patient sub-populations. Specifically, both measures exclude patients with a catheter that have limited life expectancy defined as being under hospice care in the current reporting month, or with metastatic cancer, end stage liver disease, coma or anoxic brain injury in the past 12 months.

Q. Where can we find CAHPS result? Have the spring results for CAHPS sent already?

A. CAHPS results can be found on DFC (https://www.medicare.gov/dialysisfacilitycompare/). The October refresh includes the 2017 spring and 2017 fall surveys. 2018 spring results, combined with 2017 fall results, will be available in the April 2019 refresh.

Q. In regards to facilities that have a majority of patients who are elderly and speak mostly Russian: They simply don't have enough vocabulary to answer the many complicated questions and their families often don't want to be burdened with that. What would your suggestion be? And also what happens when there are less than 30 answers for both period combined? How does that affect not only the star rating but the QIP part?

A. CMS encourage ICH CAHPS vendors and facilities to reach out to the ICH CAHPS Coordination Team if a new language might be needed. If you feel that a Russian language survey might be beneficial, please email ichcahps@rti.org with the recommendation and if possible, the approximate number of Russian speakers. If there are less than 30 survey responses between the two survey periods that are being reported, the data, including Star Ratings, are suppressed on the DFC website. QIP makes a determination based on whether the facility participated in the calendar year surveys (if required); it does not matter the number of response for QIP.

Q. The reimbursement rate for providing care to dialysis patients have not changed in quite some time despite the rate of inflation. As the result of the new quality of care metrics, will the reimbursement rate for providing dialysis care increase?

A. Thank you for your question. The focus of this call was to discuss the Dialysis Facility Compare measures and the Star Ratings. We are not in the position to respond to questions related to payment.

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