MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Dialysis Facility Compare: Rollout of Five Star Rating
MLN Connects National Provider Call
Moderator: Amanda Barnes
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Contents

Operator: At this time I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the questions-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the conference over to Amanda Barnes. Thank you, you may begin.

Announcements and Introduction

Amanda Barnes: Thank you Crystal. I'm Amanda Barnes from the Provider Communications Group here at CMS, and I'm your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the Dialysis Facility Compare Rollout of Five Star Rating. MLN Connects Calls are part of the Medicare Learning Network®. CMS adopted star ratings across all medicare.gov compare websites to help consumers understand the websites' information and make more informed decisions about where to get health care.

The Dialysis Facility Compare star ratings launched on January 15th, 2015, and reflect the overall quality of each dialysis facility. During this call, we will learn about the first year of Dialysis Facility Compare star ratings and its future plans. Before I get started, I have a couple of announcements.

You should have received a link to today's slide presentation email. If you have not already done so, you my view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the page, select National Provider Calls and Events, and then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials are available. At this time, I would like to turn the call over to Elena.

Presentation

Elena Balovlenkov: Amanda, thank you. Hi, it's Elena Balovlenkov at CMS, and I am with Joel Andress. I am the public reporting lead for Dialysis Facility Compare, and Joel Andress is the lead for measure development for DFC Compare.

So what we're going to talk about today is the CMS update of the Dialysis Facility Compare refresh for the star ratings that is occurring October 2015. I want to point out that to help you out with the presentation, on slide 33 you will find a list of acronyms used throughout the presentation. Additionally, we've divided the presentation into two parts — part one will be on the star ratings and part two will be on the DFC measure selection process.

So let's move on to slide number 2, which basically is just a statement saying that the information is current, the websites that we gave you to use as resources for additional information are current. So let's move onto slide number 3 and talk about the agenda.

So we know that as part of natural attrition that occurs in the community that there is staff turnover. So we wanted to start today's presentation with a brief overview of the star ratings, basically a year in review. We're going to talk a little bit about the work that is currently being done by the star rating TEP, which is essentially a work in progress. And we're also going to talk about, within the part one of this presentation, the next steps for the star rating, some of the item that are being reviewed and discussed with the TEP panel, and talk about future updates. So let's move on to the next slide.

Overview of the Star Ratings

In terms of a brief overview for the first year of star ratings, there are really a bunch of activities that led up to the launch of the star ratings. In June of last year, Dr. Conway used the CMS Government blog to announce that the star ratings would be coming not just to DFC, but also to all five of the compare websites. And the reason for this was that part of the mandate for the Affordable Care Act is increased sharing of information and more effective public reporting.

So what happened was, last year in July we had a National Provider Call where CMS presented the background information as to why we were moving forward on to star ratings, a discussion about the star rating methodology that was being proposed and implemented at that time, the rating results, and future maintenance and updates of star ratings. We also at that time got a lot of feedback from the community based on what was discussed during that call. And so, based on the concerns that were raised by the community, CMS conducted some consumer testing in August of last year to ensure that website users would be able to understand not just the display that was being used for the star ratings but also the supporting content, the technical guides.

So we got some feedback, we had some additional concerns that were raised related to the methodology. And so what happened was that in meeting with our stakeholders — the providers, the patient community, the patient advocacy groups — a decision was made to delay the release of the star rating from October of 2014 to January 2015 of this year. And the reason that was done, that this delay would allow CMS an opportunity to meet with stakeholders, to meet with the community groups, to get some additional stakeholder feedback.

It was a way to engage stakeholders during this period so that we could get their comments and respond to them, which we did in an Open Door Forum that was held on October 6th of last year to answer questions. And in addition to that, CMS created a document, the consolidated question document, which was used to respond to questions that were mailed in, that were phoned in, and that were brought up during

discussions with the various provider groups and consumer groups, and that was posted for public review so that everyone could get the answers at the same time.

And based on the feedback for information raised during the special Open Door Forum, CMS conducted additional testing, because at that time we also got some concerns raised about the ability of patients to understand the difference between the CMS Quality Incentive Program and the Dialysis Facility Compare star rating program.

So let's move on to the next slide, the first year in review, continued. So now we're talking about that, on January of this year, the star ratings appeared for the first time on Dialysis Facility Compare. The one thing that we want to point out is, prior to the information being posted to the website, providers are given the opportunity to see their star rating during the time called the preview period. At this time, during this preview period, providers are able to ask questions about their scores, there's a process for requesting suppression, there's a process for requesting clarification for any of the information.

On February 2nd of this year, we held a Special Open Door Forum with a consumer focus. During this time, CMS provided additional information on Dialysis Facility Compare, including a description of current information, the introduction of the star ratings, and a summary of what star ratings means for consumers. At that time we also included consumer representatives, who provided their expertise and input into the importance of star ratings to help drive consumer knowledge.

And one of the things that came out during that call was that, while — though the site as it currently exists may not be sufficiently robust to meet all the needs for quality information that patients may want, that it was a starting point and would continue as a mechanism for dialogue within the patient community so that we could capture additional measures that patients would be interested in seeing on the site. Additionally, based on feedback from consumers, in April of this year we posted a video to educate website users about star ratings. Comments were received from the community that we're living in a very visual society, and that the use of a video would help patients understand the information being presented and the types of questions to ask related to quality measures in their facility or to help them formulate questions to ask when they were seeking facilities for care during travel or as newly diagnosed patients in ESRD.

Also in April of this year, we convened a Technical Expert Panel, which still continues to meet, that reviewed and evaluated the current star rating methodology and the website display of star ratings. During the TEP, we had basically two separate workgroups that worked side by side as well as together. The first group was the methodology group, and the second group was the public reporting patient and consumer understanding group.

What occurred at that time is that the group met together to basically discuss the agenda for the TEP, the goals for the TEP, and then broke into small workgroups to work on the different issues, which we will talk about further into the presentation. And also, that it — what has occurred is that we continue to meet, and just had a call this past August to continue discussing the findings and the recommendation of the TEP. And, as I said, we will continue to talk about what we can related to the TEP further on in the presentation.

I'll now hand the presentation over to Joel Andress, who is our measure development lead for Dialysis Facility Compare. And we are on the slide saying Quality Measures Used in the Calculation of Star Ratings. Joel?

Quality Measures Used to Calculate DFC Star Ratings

Joel Andress: Thank you Elena. Just for all of you looking at the slides, we've provided here a list of the — of the current quality measures included in the star ratings. Those of you who, you know, met with us last year will be familiar with this list. We include three standardized ratio — outcome measures for transfusions, mortality, and hospitalization; a combined measure of dialysis adequacy that includes adult hemodialysis and peritoneal dialysis patients as well as pediatric hemodialysis patient. We include a measure of hypocalcemia in adult patients and two measures of vascular access, assessing the utilization of AV fistulas and the minimalization of catheter use in dialysis patients beyond 90 days.

Moving on to the next slide, the description of the current rating methodology. We're reviewing this, as Elena said, in part because some of you may not be familiar with it. This is the methodology that was in place for the — or that will be in place for the updating of Dialysis Facility Compare later this week. We are currently in discussions with the TEP on a number of points that are included in this methodology. We have not, however, arrived at final recommendations for implementation. And so Elena will be discussing what some of the discussion in the TEP has been. This is simply intended to reflect the current state of the star ratings methodology.

So first of all, we — as I mentioned, we combined the three existing dialysis adequacy measures into a single indicator that addresses — that addresses patients across modality and age — they're currently assessed on Dialysis Facility Compare. We then take a, as you see, a number of quality indicators with diverse scales and directionalities and transform them to make — to set them into a scale of zero to 100 so that we can make comparable assessments across these quality indicators. The intention of this is that if we left them to their individual — to their existing scales, then individual measures may have undue influence on the outcome of the star ratings. And so this transformation allows us to make an assessment without having one single measure dominate the outcome of the star ratings.

In this case, all measures have been arranged so that a higher score — toward the 100 end — indicates a higher level of performance. The median performance in the population for each measure is set at a value of 50. We'll also note that this tends — this also tends to control extreme values. So if a facility has a — has an extremely poor or extremely good value for a single measure but average values across other — in other measures, then this will tend to bring the assessment back to their overall performance rather than being influenced unduly by that outlier — by that outlier in performance.

On the next slide we continue the description of the methodology. We took these measures and identified through factor analysis three domains using statistical — using statistical association of the measures in order to – in order to group the measures as they — as they align — as they align in the data. The primary issue here is that we wanted to avoid having a set of measures have undue influence if they captured similar or alike aspects of quality. We wanted all aspects of quality to be assessed to the extent possible, and so we incorporated this domain methodology.

Each measure within a domain is weighted equally. The measure scores, remember, were ranked zero to 100, are averaged among those measures in the domain to arrive at a domain score. And then, finally, those domain scores are averaged equally — with an equal weighting to arrive at a final facility score, and it's that final facility score on which the star rating is ultimately determined.

So the factor analyses that we conducted identified three separate domains. The first is comprised of three standardized outcome measures — the hospitalization, mortality, and transfusion ratios. The other two categories were divided up into other outcomes — Category 1, which includes the AV fistula and tunneled catheter for greater than 90 days measures assessing that vascular access, and other outcomes 2, which includes the Kt/V dialysis adequacy measure and the hypocalcemia measure.

On the next slide, where we discuss our calculation of the scores. As we indicated, the domain score is an average of the transformed measure values for that domain. Again, we're referring to transformed measure values, we're talking about scores from zero to 100. If a facility is missing data on a single measure within a — within a given domain, we imputed the median value of 50 for use in that measure. And we did this because we reasoned that we had inadequate data to assume that the facility was substantially different from the average performance among all dialysis facilities one way or the other. And so for this reason, we imputed the value of 50.

If a facility is missing all of the values — missing values for all of the measures within a domain, our general course of action is to not provide a domain score for that facility in that domain. And as a consequence, we would not ultimately provide a final score, and there would be no star rating assigned to that facility.

The one exception that we made to this was in the case of facilities that only treat peritoneal dialysis patients. As was pointed out to us during comments last year, a facility that only treats peritoneal dialysis patients will have no patients within the denominator for the vascular access measures. And as such, for these facilities we developed — we calculated a final score that only incorporated the two remaining domains. In all other cases we included an average — the final score was assessed through an average — averaging of the three domain scores. And those facilities that lacked one of the domains simply did not receive a final score.

Arriving at the final score then on the next page, as you will be familiar, we assessed the distribution of final scores and assigned star ratings based upon that distribution. The distribution itself was normal and symmetrical. And because of that, we arrived at a — at an assignment for star ratings that reflected this. Facilities that fell within the top 10 percent of performers were assigned a score of 5 stars, facilities within the next 20 percent were assigned a score of 4 stars, facilities with the next 40 percent of final scores were assigned 3 stars, and facilities with the lowest 20 percent were assigned a score of 2 stars. And then, finally, facilities within the bottom 10 percent of performers were assigned a score of 1 star.

And with that, I will hand it back to Elena so she may begin to talk about where we've gone with the star ratings since the development of this methodology.

The Technical Expert Panel

Elena Balovlenkov: Thank you Joel. So we're on the slide that's labeled Technical Expert Panel. So we're really excited about the work being done by the Technical Expert Panel, which was held April 27th and 28th of this year. And, basically, how the TEP panel works is it's CMS contracted with the University of Michigan Kidney Epidemiology — wow that's a tongue twister – and Cost Center, affectionately referred to as UM-KECC, to convene a Technical Expert Panel, or TEP, because we needed to solicit input from health care consumers, patients, and experts with experience that was relevant to the care of dialysis patients and/or were academics involved in scientific research and knowledge development in the arena of nephrology to include them in the review and evaluation of the dialysis facility star rating methodology. And also to look at the online presentation to the public of the DFC star ratings.

Our TEP consisted of individuals from the following areas of expertise or experience. First, we consider our leading experts as our subject matter experts, our patients who are actually in the chair. We look very strongly to patients as being subject matter experts in the area of dialysis. So we had multiple patients on the TEP that were consumers of health care. Patients' family perspectives were able to be provided.

We also included biostatisticians and experts on statistical methodology. We included physicians and nurses who were involved in the clinical treatment of patients with End Stage Renal Disease. We included providers and suppliers of health care from the

dialysis organization operation, both the LBOs and the smaller chains, and also individuals with experience in performance measures and quality improvement.

As I talked about earlier, the TEP was organized into two workgroups — the methodology workgroup and the public reporting patient and consumer understanding workgroup. The workgroup generally identified overall goals for the TEP prior to breaking out into separate workgroup sessions. And this is important. We felt that we all needed to be on the same page in the beginning and talk about what the goals of the TEP were, to raise awareness of what the responsibilities and expectations of TEP members were. And also to make clear that CMS does not run the TEPs, so we are very much looking forward to the information and recommendations that are brought forth from the TEP to CMS, and at that time that we will be involved in discussions with the TEP and come back to the TEP with what CMS approves as the final recommendations based on the hard work done by the TEP.

So also then, once we did our joint work in the beginning of the day, we also did it at the end of the day. During the middle of the day each group broke off into two sections. And this breakout allowed TEP members to then focus on issues that were specific to the patient and consumer understanding of star ratings, to look at issues that perhaps patients and consumer groups wanted addressed that CMS had not included in this first release of the star ratings. And that it also allowed the methodology group to discuss and explore those issues related to the technical details of the current methodology that was used for January 2015.

Some of the topics for the pubic reporting and the patient consumer understanding workgroup agenda topics included:

- The description of the measures that were included in the star ratings for January 2015.

- Discussions and an opportunity for questions and answers on the current methodology to make sure that what was presented was understood by the members of the TEP.

- Discussion on the use of symmetrical distribution and appropriateness of the current rating categories.

- Appropriateness and the utility of ranking based on relative and absolute performance.

- Consumers' demand for consistency in ranking across all Federal programs.

- Review of potential unintended consequences in the use of star ratings.

- Discussion of how the star ratings are conveyed and how to best educate the public in the use of star ratings and also to make an awareness that the star ratings exist on the Dialysis Facility Compare website.

- Also, looking at the interpretation of information on the DFC website — was it able to be understood without a lot of background information needing to be provided?

Some of the topics that were included in the methodology workgroup included:

- Measure scoring,
- Measure weighting,
- Categorizing facilities,
- Comparisons, and
- Alternatives.

The topics for both workgroups included consideration of possible quality measure topic areas for inclusion in the next iteration of star ratings and TEP recommendations for future iterations of star ratings, including request for measures, request for information in terms of readability and presentation, patient focus groups, outreach, and other items.

Let's move on to the slide, Recommendations by the Technical Expert Panel.

Technical Expert Panel Recommendations

So at the time when we had the TEP, it was held for 2 days. And why I think it's important to stress that is, while we had 2 full days that we worked really hard and we learned a lot from our two groups, the work is still continuing. And that is one of the things that I want to stress, that we did have a call in August, and we're also going to be having a call again before the end of the year, so that these — the information being presented today, I want to stress, is not final and, again, we do not have any final recommendations.

But let's go over some of the things that were brought up by the Technical Expert Panel. Let's look at the left-hand side, the methodology workgroup. Discussion focused on anchoring stars into clinical meaningful terms, both for patients and providers of health care, the average score for each measure and domain reported for each star rating category, whether or not it actually shows actual facility-level measures that are associated with percentiles, and questions of measures of uncertainty, that we needed to present information on the uncertainty in ratings. There needed to be a discussion on imputing missing values in a more informative way and the use of facility-level information to impute. I also wanted to be sure that everyone is aware that the final

report for the first part of the 2-day star ratings TEP can be found on the Star Rating TEP Expert Panel page.

Looking at the right-hand side of the slide, the public reporting and patient consumer understanding workgroup, some of the items were discussed and were the recommendation is the need for setting established standards to assess performance in star ratings, and that that would be preferred over relative rankings if that's possible; to include multiple levels of standards or the use of thresholds to indicate partial achievement of a standard. There was a request to allow facilities to provide comments and explanations for its star ratings on the DFC website. That there should also be greater consistency across ESRD programs, for example the DFC star ratings and the Quality Incentive Program.

And there was a lot of discussion, and we're still in discussion, about the addition of new recommendations — new measures, including information for patient safety outcomes, patient-reported outcomes, such as quality of life issues, patient-assessed quality of care, facility staff training, facility staff ratios, consumer testing of current measures in the star ratings to assess relevance to the community. One of the biggest messages that was driven home is that patients are interested in information that is not just based on clinical assessment and/or blood values. That they are also interested in being able to capture information on the patient's experience of care within the dialysis world.

Star Ratings Maintenance and Updates

Let's look at the next slide, Maintenance and Update to Star Ratings. As you know, we just went through the preview period. To reiterate again, the preview period is an opportunity for facilities to see their star ratings. CMS has a process that during this time, questions can be submitted so that we can clarify questions, respond to any confusion that exists relative to the rating, and, also, this provides an opportunity for requests for suppression.

The second release of the star ratings will be posted for public view on October 8th, which is the end of this week. The second release uses the current methodology with more recent data. And what's incredibly important, that I want to be sure that I emphasize, is the current methodology that was used in January 2015 was examined in depth during the 2 days by the TEP methodology workgroups. And at that time, that methodology was upheld for the release of the October refresh for the star ratings using the same methodology that currently exists with more recent data.

Now this does not mean that this methodology will continue going forward. As I said, we are continuing discussions with the TEP, and CMS will incorporate and consider TEP recommendations, as we talked about on the previous two slides. And also we will be allowing public comment as we move forward with TEP recommendations when they are finalized to get feedback from the public on future iterations and any changes for the release of the next star rating for 2016.

Let's move on to the next slide, Measures for Future Inclusion on Dialysis Facility Compare. And this, again, I want to drive home the fact that we really did hear from the patients in terms of what they felt was important. And some of the things that were requested for the TEP and for CMS to explore is more information on the patient experience of care, especially patient-reported outcomes, such as quality of life, quality of care, whether patients experience cramping on the machine, whether there were multiple infiltrates. There were also patient safety measures such as injury, falls, cleanliness.

We had discussions about grievances and failure to place — the issue of — some patients have a difficult time finding a dialysis facility that will accept them. We talked about grievances, we talked about assessment of staff performance and training, whether or not staff were promoting specific modalities of choice, whether patients understood their ability to choose whether they would go on PD or hemo, staff responsiveness to patient concerns, issues of adequate staffing, such as nurse-patient ratio, TEP-patient ratio. And again, these discussions are not final, they are still ongoing.

So one of the things — and we're at the slide that says The Future of DFC Star Ratings — is that CMS and UM-KECC are continuing to consider the TEP recommendations and are holding further discussions with both TEP workgroups on the use of thresholds, the cutpoints that are identified and used to determine star ratings, and also the method for imputing missing data. From the public relations and the consumer understanding and readability and traffic to the website, CMS is working actively with the Office of Communications, which is the center at CMS who's in charge of the website development, to help refine website display, content, technical guides, and other concerns that are raised by the TEP.

Now we have built in time for questions about the star ratings at the conclusion of the entire presentation. And part two of the presentation will be to discuss the broader DFC measure selection process. Please remember that this part of the presentation is not limited to the measures included in or under consideration for inclusion into the star ratings and that we welcome questions and comments relative to this part of the discussion.

Now, right now I will turn the call back over to Amanda Barnes for keypad polling. Amanda, thank you.

Keypad Polling

Amanda Barnes: Thank you so much Elena. At this time we will pause for a few moments to complete keypad polling. Crystal, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please

use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Thank you for your participation. I'd now like to turn the call back over to Amanda Barnes.

Presentation Continued

Amanda Barnes: Thank you Crystal. We'll now go ahead and resume our presentation with Joel.

DFC Measure Selection Process

Joel Andress: Thank you Amanda. So now we move to the DFC measure selection process. So first I want to start off by giving you a little bit of background, why we're — why we decided to present this here today.

DFC has spent most of its history with the same set of quality measures. These included the standardized mortality ratio, two hemoglobin process measures, and one dialysis adequacy measure. And there wasn't a great deal of change to it to the — or I should say, there wasn't any change to the measure set for some time. However, new measures began to be developed in around 2006, in part due to programmatic changes at CMS and later due to the requirements included in MIPA for the establishment of the Quality Incentive Program for ESRD.

And as that measure set expanded, we began to include some of these quality measures in DFC because of their — not only their clinical appropriateness for dialysis patients, but also because of their alignment with the National Quality Strategy and other quality priorities within CMS. However — well I should say, we expanded the set of measures from the purely — from purely assessing clinical performance, which the original measure set had done — had accomplished to some degree, to encompass issues such as care coordination through the readmission ratio and also patient safety with the hypercalcemia measure.

We've also replaced other measures. In the case of the URR, we replaced it with the Kt/V dialysis adequacy measure set because those measures allowed us to capture a broader of modality options. In the case of the hemoglobin measures, we removed them from the measure set on DFC, in large part, because they had fallen out of line with the changing guidance that had been provided by the FDA. And so the measure set has responded to a number of different requirements that we've had to address over the last decade or so.

However, as this has occurred, and with the expansion of the DFC to include the star ratings, which has garnered substantially greater attention to the website, and as new measure develop — or as new measure development has begun to occur outside of CMS, we came to the conclusion that we needed to present a more formalized process for the four measures being incorporated into DFC. Now, we've never been a part of rulemaking. This is in large part because we do not have an effect on payment determination, and we do not on DFC and in of itself have — DFC does not in of itself have additional reporting requirements. That is, none of the measures that go on DFC require additional reporting burden from dialysis providers, which means that we have not had a formal process for implementing new measures.

And so we've done some effort here over the course of the last several months to develop this process. We expect that there will probably be tweaks to it, and we certainly welcome comment from you on the process so that we can — we can improve it in future years. And that will – that will actually be part of — part of the discussion here at the end of the — toward the end of the presentation.

Moving on to the next slide for the DFC measure selection process. You know, the purpose of doing this is to increase the degree of transparency with which we're implementing measures. It is fair to say that measures have in the past been added to DFC without a tremendous amount of public fanfare. The notification of new measures has historically gone out with the preview period for which — for which dialysis providers could — to which dialysis providers could respond, and we provided notification with that.

This process is intended to expand upon the transparency that that provided, which was admittedly limited. We also want to enact a process that allows for increased input from the community on candidate measures and that also allows for the inclusion of measures that are developed outside of Dialysis Facility Compare. Historically, CMS has been the primary developer of dialysis facility quality measures, but we expect that that will not always remain so. In fact, it is not entirely true now. And so this process is intended to allow for external measures to also be considered for inclusion in Dialysis Facility Compare.

On the next page you can see the agenda that we have for this section of the presentation. We intend to discuss the selection criteria by which we assess internally what measures we want to include on Dialysis Facility Compare, as well as the criteria we apply when we are considering whether or not to retire a measure from Dialysis Facility Compare. We are also — we also want to discuss the process by which we intend to be selecting measures for this year and possibly — well, I should say, and into the future, pending feedback or improvement of the process on our end.

On the next slide we're starting — we'll start discussing the measure selection criteria. We begin, perhaps predictably, with the criteria applied at the National Quality Forum.

I won't go into too much detail on this as the —as — since the NQF has provided quite a bit of detail on their own website regarding these criteria. I'll only say that importance and scientific acceptability of measures are primary. However, with regard to implementation of measures on Dialysis Facility Compare, the feasibility of a measure and what — most importantly, the availability of data for us to be able to place those data on the website and probably post them is, of course, an area of primary concern. We'll talk a little bit more of how that fits into the process.

We also seek alignment with the National Quality Strategy, which highlights six domains of quality. This also governs, or I should say guides, our prioritization of measure development. And so these two processes have been closely weighted in the past, and we expect that they will remain so. But we'll also be looking at externally recommended measures for alignment with the National Quality Strategy as well.

Those domains, for those of you who are not familiar with them, include patient family engagement, patient safety, coordination of care between providers, population and public health, measures of clinical — that assess clinical process and effectiveness, and then finally, cost measures. And just a quick note for cost. This is generally addressed for ESRD quality programs through the PPS bundle, and so we have not targeted that specifically for new measures at this time, though, of course, that may be reconsidered by CMS in the future. We're not currently intending to do so now.

On the next slide, where we continue looking at the — at selection criteria, it is possible that for a measure that is otherwise appropriate for inclusion within Dialysis Facility Compare, we may not have access to the data that would allow us to present the measure. And this actually came up in the TEP, where it was recommended that we include measures like the NHSN bloodstream infection measure or the ICH CAHPS measure. These were not implemented in the initial round because we did not have access to data that would allow us to do so.

And in the event that a measure — that we think a measure is otherwise appropriate for implementation in DFC but we do not currently have access to the data through claims or from CROWNWeb or some other data source like NHSN, our intention is to meet with relevant parties to formulate a strategy for how to move forward in collecting the data in such a way that will allow us to report at a national level. If we — if we're able to identify a way forward that is feasible, then our intention would be to implement the measure in the future. We may not get at it the year that it is assigned, depending on what data — the year that it is recommended. But I think we would certainly intend to move it forward when we had access to the data that the measure required.

DFC Measure Retirement Criteria

Now for measures we're considering retirement, we sought to align these criteria with other quality reporting programs here at CMS, such as the Hospital Inpatient Quality Reporting Program. So one of the — one of the key criteria that comes up a lot, in this

case is also aligned with the ESRD QIP, is that we would consider retirement of measures that are statistically topped out. And the formal definition that CMS has applied in other programs and that we want to apply here is that we are — is that the 75th and 90th — 75th and 90th percentile of performers within the measure are statistically indistinguishable from one another with regard to the measure.

And the second criterion would be that we identify a truncated coefficient of variation of less than 0.1. And these are standards that we would apply to our measures. And we would continue to assess them on an ongoing basis if they — if they met this criterion, and then we would certainly begin considering whether or not we should retire those measures. We do not consider it to be an absolute requirement that we retire these measures, because there may be other circumstances in which we retain a measure, either because it is clinically significant, because it applies to an underserved population, such as pediatric patients — underserved in terms of clinical measures, I should say, or because of statutory requirements that we would need to meet.

We would also consider retirement of measures if we identify unintended consequences that lead to patient harm. This is consistent with other programs at CMS. We'd also consider retirement in the event that a measure has been rendered obsolete by an additional quality measure. And this has occurred before with the URR dialysis adequacy measure, which was subsumed by the Kt/V measures and, of course, which they themselves may be someday rendered obsolete by new quality measures supported by clinical data as they evolve.

We would also consider retiring a measure that no longer aligns with clinical guidelines or current standards of practice within the field. And this — a core example of this would be the hemoglobin measures, which did not themselves change, but the guidance provided by the FDA around the use of ESAs did change, and this resulted in CMS reconsidering our position on public reported — public reporting of those measures on DFC, and also, I should mention for context, within the QIP.

On the next slide, we'll continue with the retirement criteria. If implementation is not feasible, i.e., the data source that we've previously identified for a measure is no longer functional, or if there are other implementation issues with the measure that prevent us from reporting it, then we may retire it, either temporarily or permanently, in the event that we're unable to find an alternative data source. And then, finally, if improvement on the measure does not improve patient outcomes, then we will consider retirement of the measure because that is ultimately, of course, the entire point of these measures. We want them to reflect improvement that matters to the patients.

Selection and Implementation Process

So moving away from the criteria, on the next slide we move instead toward the selection and implementation process. Now first a note on the — on the schedule on which DFC operates. As you're aware, a couple of years ago we switched to a quarterly

reporting format. Our intention is to retain that quarterly reporting format. However, we are intending to consolidate a number of the releases that we include on DFC to the October — to the October release, and there are a couple of reasons for this.

It — and there are a couple of reasons for this. One, if we — we want first to take advantage of the 30-day preview period that we've been able to implement in our own infrastructure prior to the October release. And because of this, we've also aligned the release of the star ratings on an annual basis with the October release, and we think it would be appropriate to likewise align the release of new measures with the October release annually. And the result of this is that the new information, essentially the new information that will be posted on DFC on an annual basis will occur at the October release.

We would still conduct refreshes of most of our data on DFC during the other quarterly releases, but you would not expect to see new measures, an update to the star ratings, or the star ratings methodology during those — during those timeframes. And I should say that in the event that, you know, some other new modification comes to — comes to DFC, we would – we would also consider very heavily rolling it out during the October release as well. And our hope with this is that it gives some standardization to the process, it simplifies the process for providers to know when to look out for new information that goes into DFC, and it also allows us to anchor our selection process within this timeline. And I should say that our intention is that when we — when we do arrive at a — at a final set of recommendations for the star rating methodology, we intend that those updates would also roll out at the October release.

So the schedule for this year — and I'm going to the next slide for the selection implementation process. The schedule for this year is intended as a model for how we — how we plan for the selection process to operate. You should anticipate that the dates may change slightly, but that generally, the timeframes are going to remain — are going to remain consistent from year to year.

Our intention is to kick it off with a National Provider Call much like this one every October. At that time, CMS would intend to present to this meeting all of the quality measures that we are internally considering for implementation in the rollout of the — of Dialysis Facility Compare in the following year. So in this case, we plan — have a set of measures that we want to present to you today that we would plan for implementation in October 2016. The intention is that with the start of — is with this meeting we are kicking off what is essentially a 2-month window in which you will have the opportunity to comment on the measures that we are currently considering and also to make recommendations about alternative measures that we could — that we could consider for implementation.

Now a word on this quickly. We have some submission requirements for measures that we could consider directly. And so those would need to be met in order for us to be able

to consider actual implementation. But of course, we welcome any comments about areas for further developments or consideration in the future that may not be fully implemented quality measures at this time. So those are — so the idea is that you would have 2 months, essentially, until the first week of December, to either submit new measures to us or to comment on the measures that we're currently considering.

Following that, on the next slide, we would expect that we would do our own analyses of the comments we receive, of the measures that we're currently considering, and any new measures that we have had recommended to us by mid-January. And that we would make an announcement at this point what measures we intended to move forward with for implementation in October 2016. And I'm going to talk a little bit about that — about that a little bit more.

And I would just say at this point, this — part of the this timeline is based on our own internal processes for our systems to be able to build out displays for new measures, for us to ensure that we have all of the code in place to be able to calculate measures or to receive data files from other sources to incorporate them within the data file that feeds the display for Dialysis Facility Compare. And with that in mind, we investigated the possibility of setting a particular deadline for access to external measures — measure data. That is to say, we would need access to the data for those measures within a certain timeframe.

But what we found as we discussed this is that it really depends upon the — it really depends upon the measure that's being considered and the — and what kind of data would be available. For instance, where our own contractors need to calculate the data results, or would those data results be made available to us in a data file that we would need to incorporate into our larger file? And so we were concerned that setting a particular date would be difficult for us — it would be difficult for us to apply it to all circumstances. So instead, what we intend to do is, after the measure submission — the 2 months for measure submission close out, we would expect to reach out to relevant parties for measures that have been recommended to us to start a conversation about what data would be available and what data we could potentially pursue, and to try to strategize about how we could implement those measures.

If we're able to arrive at a decision by January 15th on those and we can — we believe we can reasonably implement those measures, then we would intend to implement them for the October release that year. If, on the other hand, we found that we could not implement those measures in that year, we would instead turn toward developing a strategy for obtaining the data we needed, and we would intend to move that measure forward when we have the data available to us. And so that — and so in this fashion, we would hope to expand our measure rep beyond those that we've implemented or that we currently have available claims data or through CROWNWeb to include alternate data sources for DFC.

As you should be familiar by now, we would have a preview period from July 15th to August 15th of next year, which would present not only the preview period for all of the quality measures, but also for any new measures that we were implementing in October, and also for the new star ratings and also for the new data that would be displayed on DFC for the standardized outcome measures and for the various process measures that we include on the site. And then, finally, in mid-October, the new measures would be posted on DFC along with the rest of the DFC release.

Measures under Consideration for October 2016 Rollout

Now we talked about — or I talked about a moment ago, measures that we have been considering internally, and so a little bit about where we've gotten some of these measures for our own internal processes. Of course, we have considered very strongly measures that are already incorporated on the QIP because those have already gone through a level of vetting for appropriateness in a quality program and (inaudible) certainly. We've also listened to recommendations from the star rating TEP about the kinds of measures that they're very interested in. We've been on the lookout for measures that might fit some of those requirements that we would like to address. We also pay attention to some of the measure development work that's going on in the community and where the clinical evidence seems to be leading us toward advancements in quality assessment for dialysis patients.

And so that's led us to the — to the current set of four measures that we are currently considering for rolling out in October of 2016. On this slide, you can see we are considering the bloodstream infection measure in hemodialysis patients, which is endorsed at NQF Number 1460. We are also considering the ICH CAHPS measure based on the in-center hemodialysis survey endorsed under NQF 0258. We are considering the ultrafiltration rate great than 13 ml/kg/hr, and we are currently considering the pediatric peritoneal dialysis adequacy achievement of target Kt/V measure.

These measures are all currently being assessed by the National Quality Forum. The standing renal — the standing renal committee has made recommendations about these measures, and their specifications are available if you look on the next slide, through the link that we have provided. So this will provide details on the measures that are — that we are currently considering.

Submitting Comments

And that gets us now, I think, to the —to probably the most important part of this process. We have presented these four measures for your consideration. We want — I want you to take the opportunity to comment on the measures, their appropriateness for implementation, barriers that you might — that you might identify for us, but also — but we also want to hear if you think that these measures are appropriate and should be implemented on DFC.

So the next — the next 2 months are an opportunity for you to do that. We have provided a help desk email by which you my submit comments on these measures for the next 2 months until December 4th. You will, however, also have the opportunity to submit additional measures that you believe we have — may have missed. We certainly recognize that we are not the entire universe of development and quality issues where ESRD is concerned, and we are very interested in hearing about additional measures that are under development in the community, or that have been developed in the community and that have strong support for implementation.

So I want to be clear, and because there's some — there's some potential for confusion here, I do want to be clear. This is for implement — this is for implementation of measures on Dialysis Facility Compare. The fact that the measures are implemented on DFC does not automatically mean that they can — that they will or should be implemented in the star ratings.

Now we have not finalized a full — the full process for measure selection for the star ratings, although we anticipate that would involve feedback from the star rating TEP that we've convened. And so I just want to be clear that the measures we're considering now are not automatically going into the star ratings, although our expectation is that we're not going to consider measures for the star ratings until they've been reported publicly on DFC. So if you believe that a measure is appropriate for the star rating, that would be one reason to submit it for consideration here because we would use that as part of the pool of measures that we would take to the panel — take to the Technical Expert Panel.

One the next slide we talk a little bit about submission requirements. So the primary requirement for submitting these measures — for submitting the measure to us in order for us to consider it is that you have a fully specified measure. And the standard we're using for this is the NQF measure submission form, which has a number of data elements that address the NQF criteria and other factors that we've already said we want to consider within a measure. There needs to be measure testing data consistent with the requirements from NQF in the areas of data validity and acceptability. And, of course, we need — we would want to know what data sources are available for us to consider for implementation in DFC.

And I should note that we will be considering the measures based on the — based on the information that is submitted to us through the comment process. So if there's substantial testing on a measure but it is not submitted to us, we are not going to be in a position to consider it for implementation. So we'd certainly include — request that you include all that information, as appropriate.

And now I'm going to turn this over to Elena Balovlenkov so she can introduce the question-and-answer section of our presentation.

Question-and-Answer Session

Elena Balovlenkov: Thank you Joel. So we will now have questions for both parts of the presentation. Part one is the current DFC refresh and the star ratings for October 2015 and part two, DFC measure selection process as outlined by Joel. And again, remember we are limited in our ability to answer questions regarding the DFC star rating TEP as that work is continuing and CMS has not received any final recommendations from the TEP. Amanda?

Amanda Barnes: Thank you Elena. We will now take your questions about the dialysis star ratings. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please make sure you state you name and the name of your organization once your line is opened. In an effort to get to as many participants as possible, we ask that you limit your question to just one. All right Crystal, we're ready to take our first question.

Operator: To ask a question, press star followed by the 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you're asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Barry Rubin.

Barry Rubin: Yes, Barry Rubin from Maricopa Integrated Health System. I'd like to know which patients are included? Does it include just Medicare patients or is it all the patients that are in the facility? We have over 70 percent of our patients that are FES.

Joel Andress: To answer your question, it depends upon the measure. Some of the measures are Medicare only. Those are measures that are dependent upon claims-based data for calculation. So that includes Kt/V, it includes the vascular access measures, as well as the — on DFC, the standardized hospitalization ratio, the standardized transfusion ratio, and the standardized readmission ratio.

The hypocalcemia measure is based off of CROWNWeb data, and so it incorporates all patients. As well, the standardized mortality ratio is based on — based on all patients because the — we don't need claims data to calculate that measure.

Barry Rubin: Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Edward Pope.

Edward Pope: Hello, I'm a SME and a patient at DaVita Center. My concern is that there are many of the things that are patient oriented, where diet and lifestyle makes a big difference vs. the outcomes of all of the expectations. And I apologize, because I'm at the center, for the noise in the background. But I'm trying to make sure that basically — that we are moving in the direction that doesn't just assess the patient from a basis as to how well they do because of their lifestyle, but rather how well the actual center is in helping the patients gain and improve their lifestyle over time. And my concern is we're not really doing enough of that with what I'm seeing now.

Elena Balovlenkov: Thank you very much, this is Elena. You're actually correct in that the subject matter experts from the community that were involved in the TEP and also that have been involved with CMS over the past year in bringing information to us regarding their concerns for the website have requested additional measures to be included on the Dialysis Facility Compare website and also to be included in the star rating system. As I said, the work with the TEP continues, and so that we do not have a final list of what will be included going forward.

One of the limitations that we will have regarding including additional measures, patient-focused measures and/or clinical measures is, as Joel talked about, the fact of making sure that we have access to data and looking at issues of being able to collect the data and verify the data in order to make sure that what we are representing for patients is information that we believe is as accurate as possible.

But you are absolutely correct in your concern that patients are asking for additional information to be included, not just clinical measures as a standard evaluating performance at a dialysis facility, and that is work that will continue.

Amanda Barnes: Thank you Elena.

Edward Pope: Thank you.

Operator: Your next question comes from the line of Tanya Saffer.

Tanya Saffer: Thank you, and thank you Elena and Joel. And I sit on the Technical Expert Panel, for those of you that don't know. I think you guys both represented the discussions that patients had and the desires that they had for improvements to the system very well. I did want to just ask Elena, if you could elaborate a little bit more on what you ranked, and this is a request as an aside about the TEP upholding the current methodology, given that the patient concerns about the methodology that were raised during the Technical Expert Panel?

Elena Balovlenkov: Tanya, this is a question Joel and I will answer together, and thank you very much for bringing it up. As you remember, when we had the 2-day TEP meeting, we had — and you're absolutely correct, there were concerns raised about

future iterations of the methodology, including the discussion about thresholds and the distributions for the assignment of star ratings. But if you also recall that within the methodology group, the statisticians, the physicians, the experts within that group who were charged with the process of what I call a deep dive into the validity and reliability, if I'm using the right terms, Joel, of the current methodology, that that methodology was deemed as being …

Joel Andress: So I think that …

Elena Balovlenkov: Go ahead Joel.

Joel Andress: Thanks Elena. So the issue, I think, is that the assessment was that the methodology was appropriate …

Elena Balovlenkov: Correct.

Joel Andress: … to the goal that CMS had laid out for itself in the star ratings. The question that was raised by the TEP, Tanya, I think this — this might be where some of the — some of the questions come into your mind is, whether or not what CMS was intending to do with star ratings was what it should be intending to do with the star ratings. And so I think some of the conversation that's been happening around how the cut values are…

Elena Balovlenkov: Right.

Joel Andress: … are assigned, whether or not we're using, you know, the absolute standards vs. relative assessments. You know, it's used in a part of that discussion. So our intention is to say that the methodology is in and of itself appropriate for what was originally intended. And now the conversation with the TEP …

Elena Balovlenkov: Moving forward.

Joel Andress: …moving forward is OK, but is that — have we accomplished everything that we needed to accomplish with the star ratings, or do we need modifications to change it? And that is what we're trying to say. We don't believe we're sending out faulty data with the star rating, but we believe that in working with the TEP we can make sure that the data that we're sending out are more useful to the patients — to patients and to the rest of the community moving forward.

Amanda Barnes: Thank you Joel.

Elena Balovlenkov: The other thing I wanted to add, Tanya, is one of the reasons that we went forward with the October refresh is, you know, there are facilities that — whose star ratings have improved or changed over time, and we wanted to be sure that we

were able to capture that improvement and also to be able to demonstrate that we were sensitive to changes that occur because people put a lot of investment in the work that was done and reflected in the star ratings.

Amanda Barnes: Thank you Elena.

Operator: You have a followup question from the line of Edward Pope.

Edward Pope: I apologize. I was looking also at the idea of ultrafiltration, and this is on DFC side, of being 13 millimeters by kilograms by hour. There has been several recent studies that have indicated that doing more than 10 can put your body into shock, that you're pulling too much off too quickly. Are you aware of these studies? And if so, why is the ultrafiltration at 13? Thanks.

Joel Andress: So, this is Joel. Thank you for asking the question. I don't want to get too much into measure specifications right now, although we would certainly appreciate you submitting a formal comment about the measure. The specific — the link that we provided to the National Quality Forum will provide the rationale behind the measure and why the measure is constructed the way that it is.

I think the — sort of the thumbnail sketch from the discussions we've had is that the — is that the evidence isn't entirely clear about — or I should say that the evidence was felt not to be entirely strong about where that cutoff should be. And so this was a matter of some debate within the TEP. I know that there's at least one other measure that was developed by KCQA that reflects the same threshold. But, yes, we are certainly aware of the — of the evidence that you're — that you're indicating. And if that, I would say if that's something that would cause you to pause at the implementation of the measure, then that is something that we would absolutely want for you to submit to us through the form of a comment and sort of discuss in more depth, you know, what your reservations would be.

Edward Pope: OK, and that's — I can follow the link to that and have a way to submit a comment?

Joel Andress: So the link — the link to NQF is simply the link to the specifications and …

Elena Balovlenkov: On slide 29.

Joel Andress: Yes, and so I just want to clarify this — I mentioned that we have the help desk email up, we do. However, we did not do a good job of highlighting that it's also where you would submit comments. If you look on slide 34, I believe, you will see a series of links for visiting dialysis facility — under the heading of Resources. You'll see a series of links for visiting Dialysis Facility Compare and for accessing DFC preview reports and technical documentation. At the bottom of that slide you'll see an email for

DialysisData@umich.edu. This is the help desk, and I just wanted to make clear that this is where comments should be submitted for the purpose of collecting comments or on the measures we're considering or for submitting new measures.

Amanda Barnes: Thank …

Edward Pope: Thank you very much.

Joel Andress: And we'll be sending out an email blast to that effect in the — in the near future.

Amanda Barnes: Thank you. Next question, please.

Operator: Your next question comes from the line of Stephanie Motter.

Stephanie Motter: Hi there, this is Stephanie Motter, Vice President with DaVita Healthcare Partners. Elena and Joel, thank you so much for this call. It's just such a wonderful way to exchange information and stay in the loop. So my question is twofold.

Number one, if any of the four measures were approved and did appear kind of as a preview on the DFC in October of 2016, would that be based on performance from calendar year 2015? And then my second question is, is there a way for providers, patients, and the community to respond to any of the other measures that may be submitted that are not among the four?

Joel Andress: So I would say that the community has never given us any evidence that it is hesitant to comment on the measures that are on DFC, whether they're being considered for something or not. So, yes, certainly you can — you can comment on other measures as well. It was our intent initially, I think, to include them as part of this process, but we are certainly willing to hear comments regardless.

I think in terms of what timeframe would be used for the measures, it would depend, frankly, on the measure and the data available for it. So we would have to consider that as part of the implementation discussion. That information would be available with the preview reports; however, as we make it available now for the current measures.

And then the measures themselves would be — would be made available on the preview reports that you receive from July to August on an annual basis. And you would have an opportunity to comment then on reporting of the measures, the data, and so forth. So you would — you would have that opportunity still. Does that answer your question?

Stephanie Motter: Yes, thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Derek Forfang.

Derek Forfang: Hi, this is Derek Forfang — hi Elena and Joel — with the ESRD Forum of Networks, the patient group Kidney Patient Advisory Council. My question is — well, first of all, my comment is thank you very much for bringing the patient voice so strongly into this process. And my question is, with this tool becoming very valuable to patients, especially new patients, is there a marketing plan beyond ESRD patients to Stage 3 or Stage 4 CKD patients when they're starting to think about dialysis to make sure this tool gets into their hand?

Elena Balovlenkov: You know, that's an absolutely excellent question, and it's one that we've discussed, actually not necessarily as part of the TEP but offline between our two contractors that are working with us and also with part of — as part of the framework that was presented during the TEP. You're absolutely correct in the consideration that we need to capture the chronic kidney disease patients, CKD 3 and 4, if we're going to help provide information to drive discussions between them and a nephrologist and when they go to visit different facilities to help them ask questions and go through a mental checklist of things that they need to look at and talk about in terms of selecting a dialysis facility.

So that is something that we've considered. Whether or not that will be part of the initial rollout, part of that will come from discussions with our community resource group, but that absolutely is something that we've started talking about.

Amanda Barnes: Thank you Elena.

Derek Forfang: Thank you very much.

Elena Balovlenkov: Thank you.

Amanda Barnes: Next question please.

Operator: Your next question comes from the line of Harry Waters.

Elena Balovlenkov: You may be on mute.

Amanda Barnes: Crystal, we'll take our next question, please.

Operator: Your next question comes from the line of David White.

David White: Hi, I'm David White. I'm a patient consumer in Maryland and I was also a TEP participant in the patient group. My question is from part one, calculating domain

scores. As I understand it, and I'm sorry if I missed anything, if a facility is missing values for all measures, its domain score isn't calculated, and if it's missing a domain score, the final score is not calculated, and the facility does not receive a star rating. I was just curious as to what CMS or some other organization does to address that issue.

Joel Andress: Well, so it depends. I guess it depends in part on why there isn't a measure value. In most cases, there is not a measure value because the facility is small enough that there aren't enough patients to meet a minimal requirement that we've set for data reporting. And we've chosen not to report those data because we consider the measure to be too imprecise for use in that purpose.

And so there's not much to be done in that case, unfortunately, for the — for the facility, and that's an issue that's faced by dialysis facilities, I think, in some cases more than — more than other settings because they tend to be relatively small. So there's not a whole lot to do. I guess, are you asking, David, in the case where a facility is simply refusing to report data?

David White: Well, that had crossed my mind as well, Joel. Has that — has that been an issue?

Joel Andress: That does not seem to be a particular issue right now. So some of the measures they — it would be difficult for a facility to do that because they are dependent upon submitted claims files. So if they didn't submit claims files for those patients, they wouldn't get paid. And it's our experience that providers appreciate being paid for the care they provide, and so that hasn't been an issue for claims.

There is — I mean, so there is separate issue potentially for CROWNWeb, although our experience with CROWNWeb has been such that the completeness of data reporting has ramped up substantially in the last year or so, so that it's not nearly as much of an issue as it may have been a couple of years ago. So, I think, for the purposes of the star ratings, we would consider that to not be a terribly large difficulty, but of course it's something that we keep an eye on.

Generally, if we don't have data for a facility, we will identify why that is and if it — if it seems odd, for instance, a facility has lots of patients in other measures but they simply have no data for another measure where we think they would, that would be something that might raise our alarm bells. But I don't believe that's been something that we've encountered to date.

Amanda Barnes: Thank you Joel. Crystal, we have time for one final question please.

Operator: Your final question comes from the line of John Sadler.

John Sadler: Hello, I am a nephrologist who leads a small dialysis organization called Independent Dialysis Foundation in Maryland. We have two facilities that are small, and yet they do get rated. And when you only have 20 patients, one patient makes a huge difference. And I think since this is so statistically based, it really does make it impossible for them to be fairly rated.

Joel Andress: So I — I'm not sure I understood the question. I think you're right in that there are some difficulties with addressing the assessment of small facilities. We have put into place specific thresholds for which we're willing to report on measures and there are a subset of facilities that come in at just above those thresholds, so they're still relatively small. I guess, are you — are you asking for a particular action or are …

John Sadler: What I'm saying is that facilities, for instance a facility that gets classified as a low-volume facility, probably shouldn't be evaluated for star rating because it requires statistical validation, which is unlikely to be available for that facility.

Joel Andress: OK. I — so the current methodology does not recognize that. I think that is — that is certainly something that we can take a look at as we're evaluating the methodology in general, and we can take it into account. I'm not in position right now to be able to address it directly, but I do assure you that we'll take it back to the University of Michigan and ask them to conduct some analyses on that particular point. So thank you.

John Sadler: Thank you.

Additional Information

Amanda Barnes: Thank you so much. Unfortunately, that's all the time we have for questions today. On slide 35 of the presentation you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Amanda Barnes, and I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on Dialysis Facility Compare Rollout of 5 Star Ratings. Have a great day everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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