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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
Standardized Readmission Ratio for Dialysis Facilities: National Dry Run
MLN Connects National Provider Call
Moderator: Hazeline Roulac
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Contents

Operator: At this time, I'd like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-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 call over to Hazeline Roulac. Thank you. You may begin.

Announcements and Introduction

Hazeline Roulac: Thank you, Holly. I am Hazeline Roulac from the Provider Communications Group here at CMS, and I will be your moderator for today. I would like to welcome you to this MLN Connects National Provider Call on the Standardized Readmission Ratio for Dialysis Facilities: National Dry Run. MLN Connects Calls are part of the Medicare Learning Network.

In an ongoing effort to improve the quality of care provided by the nation's dialysis providers, CMS has developed a facility-specific hospital readmission measure, the Standardized Readmission Ratio, or SRR, for dialysis facilities. In conjunction with the University of Michigan Kidney Epidemiology and Cost Center, CMS is conducting a national dry run of this measure, and we'll use this dry run to test the implementation of SRR reporting and to educate dialysis facilities about the measure. This MLN Connects Call is intended to educate and to provide dialysis clinics, dialysis organizations, nephrologists, and other interested stakeholders with information about the SRR, the dry run report, and how the reports can be assessed.

After the presentation, there will be an opportunity to ask questions. Our presenters for today are Deanna Chyn, research analyst, and Jennifer Sardone, project assistant, both from the University of Michigan.

Before we get started, I have two announcements. A link to the slide presentation for today's call was provided on the registration site. You should have also received a link to the slide presentation for today's call via email. If you have not already done so, please view or download the presentation from the following URL: www.cms.gov/npc. Again, the URL is www.cms.gov/npc. At the left side of the webpage, select "National Provider Calls and Events," then select the date of today's call from the list. You will find a link to the slide presentation under the Call Materials heading. Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call webpage. An announcement will be placed in the MLN Connects Provider eNews when these are available.

Before we start with the presentation, I will now turn the call over to Elena Balovlenkov with the Center for Clinical Standards and Quality here at CMS. Elena?

Presentation

Elena Balovlenkov: Thank you, Hazeline. So, as you can see, today we're going to be talking about the Standardized Readmission Ratio measure, and you should be on slide number 1, and let's go ahead and get started. Next slide, please.

CMS is very committed to improving quality of care received by today's patients, and the facility-specific SRR measure developed in conjunction with UM-KECC is an important step in reaching this goal. We wanted to be sure that people were aware that CMS will be using the dry run initiative to test the implementation of SRR reporting and, more importantly, this is an opportunity to educate dialysis facility staff on this measure and its implication as a measure of quality.

Next slide, slide number 3, please. I'd like to introduce our speakers today, as well as our behind-the-scenes experts here at CMS for measure development.

Next slide, please. I'm Elena Balovlenkov, and I'm a nurse with 38 years of experience in ESRD and transplantation in roles as a clinical nurse specialist, patient care manager, and facility administrator. With me here in the room is also Dr. Joel Andress, and he is the lead for measurement development in the Center for Quality Measurement in the Health Assessment Group, affectionately known as QMHAG, in the Division of Chronic and Post-Acute Care. On the phone, we also have the University of Michigan Kidney Epidemiology and Cost Center, and they are the current CMS contractor for ESRD measure development, and they have developed this measure and are conducting the dry run for the SRR. Today's presenters are Deanna Chyn, research analyst, and Jennifer Sardone, project assistant.

I'd like to turn the presentation over to Deanna at this time. Deanna?

Hospitalization and Readmission Measures

Deanna Chyn: Thank you, Elena. So, today I'll go over what exactly the dry run is and what facilities can expect to see during the dry run, and hopefully to help you understand and interpret the measure of hospital readmissions that CMS is testing out during the dry run.

For those of you who might just have called in, I'm starting on slide number 5, which is titled "Measures of Hospitalization."

CMS recognizes the importance of hospitalization as an outcome for dialysis patients. A measure many of you are likely familiar with is the Standardized Hospitalization Ratio, or SHR, which is reported on both your Annual Dialysis Facility Report and your Quarterly Dialysis Facility Compare Report. This measure assesses overall hospitalization rates for patients at your facility. However, a readmission following a hospitalization is another important outcome. Considering the overall hospitalization rate with the readmission rate provides a more complete picture of how well a facility may be managing the patient's care.

On the next slide—slide 6 is where I am now—is the national distribution of readmission rates for dialysis facilities in 2012. As you can see from the national perspective, there's certainly room for improvement, with facilities having rates ranging from zero percent (that is, facilities with no readmissions in the 30 days following their patients' hospitalizations) to a rate of 85 percent.

Dry Run Overview

Now I'm going to go over some general details about the dry run, and I'm now on slide 8. All right, so what is the dry run? It's CMS's opportunity to introduce a newly developed readmission measure to dialysis facilities, demonstrated using 2012 hospitalizations. During the dry run, we'll be able to answer any questions you have about the development, definition, and interpretation of the readmission measure.

Facilities that were open and Medicare certified in 2012 will also receive a report that provides details of how their respective measure was calculated and facilitates comparison of their own performance on the readmission measure with facilities in their respective state and also across the U.S. Again, only those dialysis facilities who were open on December 31st, 2012, and Medicare certified will receive an actual report, but anyone is welcome to ask questions and provide feedback about the readmission measure.

On slide 9 you'll see that the dry run lasts from March 31st through May 2nd. What this means specifically is that this is the time that your facility-specific report for the readmission measure will be available on the site www.dialysisdata.org, and that website will be mentioned throughout the presentation.

As mentioned, you'll be provided with a report that details your facility's measure calculation. On March 31st, when you log in to the Dialysis Data website, you'll be able to download the report. And during this time period you'll also have the opportunity to request a more detailed report that provides certain information on each hospitalization used in the calculation of the readmission measure shown on your report. Toward the end of the presentation, Jennifer will talk a bit more on how to request this hospitalization-level data.

Now before, during, and after the dry run period, you'll have several resources to help you understand and interpret the readmission measure. First, dialysisdata.org has an FAQ section and a methodological report outlining various aspects of the measure. We're also providing a help desk, the phone number and email for which are on the slide you see here. (This is slide number 9.) And you can also contact us via the Dialysis Data website, which Jennifer, again, will review towards the end of the presentation.

Slide 10 provides a broad timeline for the dry run. Last week, each facility that's receiving a report should have received a Master Account Holder password. If you didn't receive a password and have questions about whether a report is available for your facility, you should contact the dry run help desk by calling the number that was on the previous screen—that's 855-764-2885—or by emailing dialysisdata@umich.edu. And,

again, Jennifer will go over this contact information at the end of the presentation. But when you contact us with any questions, just be prepared to provide your facility's name and the six-digit CMS certification number, the CCN number, for you facility.

All right. So going back to the timeline on the slide, CMS will host another National Provider Call on April 17th, which will be very similar to this call but will focus more on the sections I'm about to cover, which detail the readmission measure and provide guidance on interpreting your facility's measure. The April 17th call will also be an opportunity to ask questions about the report itself, since at that point you will have had time to review your facility's report. And then finally, on May 2nd, the dry run period ends and the readmission reports will be taken down from the website.

Measure Descriptions

Now I'll go into exactly what the readmission measure is. I'm now on slide 12. So first I want to couple – cover a couple of phrases that may not be familiar to you or sound specific enough, but that I'll use in the remaining portion of the presentation and which you will also see on the website and on your facility's readmission report.

The first of those is an *index discharge.* This is a hospitalization that is eligible to be followed by a readmission. I want to point out here that we call it a discharge on purpose instead of a hospital admission, because when we calculate the readmission measure, we look for any hospitalizations that follow the index hospitalization within 30 days, starting with the day on which the patient was discharged from the hospital.

The next phrase here is *readmission,* which in this measure is any unplanned hospitalization that occurs within 30 days of an index discharge. A readmission can also count as an index discharge.

And the third and final term on the slide is *readmission rate,* which is simply the percentage of index discharges that were followed by a readmission. The readmission rate is an unadjusted version of the readmission measure that is being put forth during the dry run.

So what is the readmission measure if it's not a simple readmission rate? The dry run readmission measure is an adjusted measure called the Standardized Readmission Ratio, or SRR. It's the ratio of the number of readmissions at your facility to the number of readmissions one would expect to occur at your facility given your particular patient population. This expected value comes from a statistical model predicting whether an index discharge with particular characteristics will be followed by a readmission, and I will review the model and the risk adjusters included in that model in a few slides.

On slide 14 you'll see that the data used to calculate this measure come mostly from Medicare claims, and additionally, we get patient demographic information such as sex and age from CMS's database. And I'd like to mention here, because we've already had a couple of questions about this, that the SRR measure includes both hemodialysis and peritoneal dialysis patients.

All right. I'm now on slide 15, which is a bit busy, so I apologize. I want to mention that this information, along with much of what I'm outlining briefly in today's presentation, is also available in greater detail in the methodology report on dialysisdata.org.

All right. So this slide covers some of the exclusions for the measure, and we exclude index discharges for the seven reasons you see here. Those are that the hospitalization is not covered by Medicare—that is, we don't even see it in our data; the patient died during the hospitalization or within 30 days of the discharge date for that hospitalization; the patient was transferred to an acute unit. And what that means is if a patient is discharged from hospital A, say, on June 1st, and transferred on the same day to hospital B, any readmissions following the patient's discharge from hospital B are attributed to hospital B and not hospital A.

All right. The fourth exclusion is for patients who are discharged against medical advice. We also exclude hospitalizations from PPS-exempt cancer hospitals which provide care for a unique population of patients that are not reasonably comparable to patients admitted to other hospitals, and this is just a set of 11 hospitals, total, in the U.S.

We also exclude hospitalizations involving a primary diagnosis of certain conditions related to cancer, psychiatric causes, or rehabilitation. And finally, we exclude hospitalizations following a patient's 12th hospital discharge in 2012. We do this in an effort not to have high-risk patients overly contribute to a facility's number of index discharges.

Finally, if a hospitalization does occur within 30 days of an index discharge but it's considered planned, we do not count this hospitalization as a readmission. There are two ways a hospitalization is characterized as planned. The first is if the hospitalization is for maintenance chemotherapy or a rehabilitation procedure. Now, this hospitalization, no matter any additional procedures or diagnoses that the patient undergoes or is diagnosed with, is always considered planned. The second way is if the hospitalization involves one of the several procedures characterized as planned (for example, hip replacement) and does not also involve a diagnosis for an acute event such as a heart attack.

All right. Moving on to slide 16. Here I'll talk pretty generally about the model and the risk adjustments included in this model. As I mentioned earlier, we use the model to determine the number of readmissions one would expect at a facility, given the facility's patient mix. We use a hierarchical logistic regression model which includes patient-level adjustments for age at index discharge, sex, a certain set of illnesses or conditions experienced in the year leading up to the hospitalization.

We include a patient's BMI at start of ESRD, as well as how many years he or she has had ESRD as of the discharge date. We include an indicator for whether diabetes was the primary cause of the patient's ESRD, and we also include adjustments for whether the patient's index hospitalization involved a high-risk diagnosis. And finally, we adjust for the length of the index hospitalization stay.

I'm now on slide 17, where the general structure of the measure is presented. And, again, as I mentioned a few slides previously, the SRR is the ratio of the number of readmissions that occurred at the facility to the number of readmissions that would be expected at the facility, given its patient mix. It is important here to note that we calculated an SRR only for facilities that had at least 11 index discharges in 2012. So those of you who were open and certified on December 31st, 2012, but had fewer than 11 discharges will still receive a report, but you will not have an SRR presented on that report.

Slide 18 discusses how you interpret the SRR, which should look familiar to those of you used to looking at the SHR or Standardized Mortality Ratio measures, which, again, are on the DFRs and the quarterly Compare report. The SRR for a given facility is calculated relative to 1.0, which is the national level – the national value for SRR, rather. And for this slide, keep in mind that the SRR measure is a ratio of observed to expected readmissions. So if your facility's SRR is larger than 1, your readmission rate is higher than would be expected, given your patient population. But if your facility's SRR is smaller than 1, your readmission rate is lower than would be expected, again, given your patient population.

I'm now on slide 19. Your facility's report—again, which will be available to download from dialysisdata.org starting Monday, March 31st—will include this SRR value along with a 95-percent interval estimate. This interval represents the range of reasonable values for your facility's SRR, given that the numerator of the measure is estimated from a statistical model. CMS uses both the SRR measure and its 95-percent interval to categorize your facility's performance on readmission. And slide 20 shows these categories, which include As Expected, if the 95-percent interval contains 1; Better than Expected, if the entire 95-percent interval is lower than 1; and then Worse than Expected, if the entire 95-percent interval is higher than 1.

Report Details

Now, before I hand it over to Jennifer to discuss the dialysisdata.org website and the dry run help desk, I'll go over in detail the three tables and one figure that are going to be included in the dry run report.

All right. I'm now on slide 22. The first table in your facility's report will provide your SRR measure and performance category. This table and the next table are organized in the same way in that values specific to your facility are shown in the first column, and average values for facilities in your state and in the U.S. will be shown for comparison in columns 2 and 3 to the right.

So the first row on the sample Table 1 that you see here is the unadjusted readmission rate. That is the percentage of index hospitalizations occurring in 2012 that resulted in a readmission. The readmission rate for this sample facility you see here is 29 percent. The two columns to the right provide the same measure for the state and for the nation.

Moving on to the second row, which is bolded. This is your actual SRR, again with the state and U.S. values presented directly to the right for comparison. The SRR for this sample facility is 0.95.

Now, the remainder of this table will have values only for the facilities. So there is no missing information when you see a report; the state and U.S. values actually are not provided for these rows.

The third row here is the 95-percent interval associated with the SRR, and you'll notice that on this report, the interval includes 1. And thus, as we just reviewed a couple of slides earlier, this sample facility is categorized As Expected, which you can see on row 5.

Jumping back up to row 4, the P-value for this facility is 0.757, and this value is associated with the SRR and is related to the interval. Specifically, the interval presented on row 3 does not include 1. This P-value will be less than 0.05.

Now if the P-value is less than 0.05 and your SRR is lower than 1, your facility will be categorized as Better than Expected. And if a P-value is less than 0.05 and your SRR is higher than 1, your facility will be categorized as Worse than Expected.

Slide 23 shows Table 2 from the report which, as the title indicates, provides details of the SRR calculation. Similar to the previous table, I'm going to review each row just to give you some time to look over the table yourself while I'm talking.

The first row shows the number of patients in the facility on December 31st, 2012. The state and U.S. values that you see directly to the right are the average facility size for facilities in the state and in the U.S.

The second row is the number of index discharges included in the SRR measure calculation. These are all the index discharges that made it past the seven exclusion criteria I outlined previously. And again, the average number of index discharges in the state and U.S. are provided in the two columns to the right for comparison. So the sample facility you see here had 147 patients at the end of the year and 200 index discharges throughout the year.

The number of readmissions is shown next on the table. The fourth row is the number of unplanned readmissions in the facility—that is, this is the number of readmissions we considered in the calculation of the SRR. Also listed right below it on row 5 are the number of planned readmissions of the facility, but note that these are just here for your information and are not included in the SRR calculation. So this sample facility had 58 unplanned readmissions and 7 planned readmissions.

The sixth row is the readmission rate for the facility, which is just the number of unplanned readmissions from row 4 divided by the number of index discharges from row 2. The seventh row is the expected readmission rate, which, again, is derived from

the model described earlier. The last row shows the SRR, the ratio of the number of readmissions to the facility to the number of readmissions expected, and is indicated in parentheses here. An alternative way to calculate the SRR is to divide the readmission rate on row 6 by the expected readmission rate on row 7, and both calculations result in the same value.

On the next slide, slide 24, is a sample of the third table on the facility readmissions report. The first section of this table shows the number of facilities in the state and in the U.S. that fell into each of the performance categories. Row 2 is the number of – the number and percentage, rather – of dialysis facilities that CMS categorized as Better than Expected. Row 3 is the number and percentage of facilities categorized As Expected, and you'll see that most facilities will fall into this category. Row 4 is the number and percentage of facilities categorized as Worse than Expected. And row 5 produces – shows you some information specific to your facility. It's the number and percentage of facilities that were not – oh, I'm sorry, row 5 is actually the number and percentage of facilities that were not categorized because they had fewer than 11 index discharges in 2012.

So the last row is information specific to your facility. And it indicates the percentage of facilities in the state and also in the U.S. whose SRR was better than your facility's SRR. These percentages will let you see how your facility ranks among other facilities in the state and U.S.

I'm now on slide 26, which contains a sample of the figure you'll see in your report. This figure allows you to compare your facility's SRR with similarly sized facilities in your state. So, again, for those of you who've seen the SMR and SHR figures on the introductory pages of the annual DFR, this figure should look pretty familiar. The shapes on this figure, which I'll describe in just a minute, represent SRRs, and the horizontal lines you see represent those SRRs' 95-percent intervals.

Now, I want you to notice first the vertical line, which represents the U.S. value of SRR. By definition, this value will always be 1.0 because it is the standard to which we hold all facilities. The black square at the top of the figure is the state's SRR. We don't calculate a 95-percent interval for the states, so this square will not have an accompanying horizontal line on your facility report. The second shape on the figure will be your facility's SRR and 95-percent interval, which is bolded and shaded black to distinguish it from the comparison facilities below whose intervals are shaded gray. And then below your facility's value are 15 similarly sized facilities in your state.

So now I'm going to take a look at the legend on this slide in the top right corner, which explains how the facilities on this figure are categorized. So on the sample figure, all the facilities' shapes are orange triangles, so all facilities here performed As Expected. You also know this because all 95-percent intervals shown here cross the vertical line, which represents the value of 1.0. If any facility is categorized as Worse than Expected, its shape will be a pink upward-pointing triangle, and its 95-percent interval will be entirely to the right of the vertical line. Conversely, a facility categorized as Better than Expected

will have a green downward-pointing triangle, and its 95-percent interval will be entirely to the left of the vertical line. If your facility had fewer than 11 index discharges in the year, again, you will not see this figure on your report because you did not have an SRR calculated.

All right. So, thank you, everybody, for listening. I look forward to your questions, and I'll now turn it over to Jennifer Sardone, who works as a project assistant with me here at the University of Michigan.

The Dry Run Website and Resources

Jennifer Sardone: Thank you, Deanna. I'm going to review the dry run website and the process for logging in.

On slide 27 you will see the link to the website dialysisdata.org. By this time, each facility should have received a Master Account password via email. This password will allow the Master Account Holder for the facility to create user accounts, similar to the current process used for dialysisreports.org. While the process is similar, we want to note that the Master Account Holder passwords for the two websites are not the same, and the passwords provided for dialysisreports.org will not work on dialysisdata.org. The user accounts from that website also do not transfer to dialysisdata.org.

If your facility has not received a Master Account password, or if the Master Account Holder for your facility has changed, you can contact the dry run help desk at 855-764-2885. UM-KECC will be verifying the identity of the new Master Account Holders with the facility director or administrator of the facility for which the password is being requested. For security purposes, if the facility director or administrator cannot be reached or if he or she does not approve of the new Master Account Holder, the password will not be given out to that individual.

On slide 29 you will see the dialysisdata.org home page. This website contains information about the dry run and the SRR, including a list of FAQs, measure specifications, detailed methodology, and a sample dry run report. There's also a link to register for the next National Provider Call on April 17th. In the top navigation, you will see a link to log in to the site.

On slide 30, you will see a login screen. To log in to your master account, you enter your six-digit Medicare provider number into the email field. To log in to you user account, you will enter your email address. When you log in to the master account, you are taken to the Create and Edit User screen, which is displayed on slide 31. Here you can create user accounts for individuals at your facility. When you create an account for someone, they will receive an email notification with a link to set their password. To view the reports, Master Account Holders will need to create user accounts for themselves.

On slide 32, you can see the screen that will be displayed under your user account when the reports are posted. Starting on March 31st, you will see a navigation tab titled "SRR," and that is where the PDF of your dry run report will be posted and available for

download. If you have access to the reports from multiple facilities, you will see links to an individual PDF file for each of those facilities.

In the event that you have a comment or question about the website or your report, slide 33 shows the Comments & Inquiries page. It allows you to submit a web support question, a specific comment or question about your facility's report, or a request for the Discharge Level of Data file that will be available for your facility. You do need to log in to access this screen.

Slide 35 has a list of all of the ways that you can contact the dry run help desk, including by phone, email, or through the website.

I'm now going to turn things over to Hazeline for the Q&A session.

Keypad Polling

Hazeline Roulac: Thank you very much, Jennifer. At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line today. Please note there will be a few moments of silence while we tabulate the results. Holly, 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.

Again, 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.

And that concludes the polling portions of today's call. I'll turn the call back over to Ms. Roulac.

Hazeline Roulac: Thank you, Holly. We will now take your questions about Standardized Readmission Ratio Measure for Dialysis Facilities and the National Dry Run. But before we begin, I would like to remind you that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits. All right, Holly, we are ready to take our first question.

Question-and-Answer Session

Operator: All right. And once again, to ask a question, press star followed by the number 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…. And please hold while we compile the Q&A roster…. We apologize for the delay. Please stand by.

And your first question will come from the line of Sue Blankschaen.

Sue Blankschaen: Hi. Sue Blankschaen, University Hospitals Case Medical Center. This is in regard to the risk adjustments. Will that, the – number one, is there a definition for a high-risk diagnosis? And does that come from hospital claims data or from the dialysis claims data?

Deanna Chyn: Hi. This is Deanna Chyn. So, there is a definition of that – of that adjuster on the detailed methodology report that's on the website. It's a little bit lengthy, so I won't go over it here, but it's currently linked on the website, and those are coming from hospital claims because those have to do with the current hospital discharge.

Sue Blankschaen: Thank you.

Hazeline Roulac: Thank you. Next question.

Operator: Your next question comes from the line of Adrienne Adkins.

Adrienne Adkins: Hi. My name is Adrienne Adkins. I'm calling from Fresenius Medical Care. I just had a question about the registration on dialysisdata.org with the Master Account Holders and creating the user accounts. Is this entire process voluntary? And as a large dialysis provider, are – is the expectation that all of our clinics participate in this dry run?

Elena Balovlenkov: I'd like to take this call. This is Elena Balovlenkov with CMS. The understanding from CMS is that we would like all facilities to participate even if they are under one provider, be it the – either of the three LDOs: Fresenius Medical Care, DaVita, or DCI. We are asking that each individual facility participate in the SRR dry run so that you can also receive the information that is facility-specific as well.

Adrienne Adkins: OK. Thank you very much.

Elena Balovlenkov: You're welcome. Thank you.

Operator: All right. And your next question will come from the line of Philip Calderone.

Philip Calderone: Yes. Hi, this is Dr. Calderone, CRRT at Water's Edge. We are a very small facility. Basically, we're based on a campus in a nursing home, and obviously our patients have an awful lot of comorbidities, and we have discussed this with Dr. Andress in the past. And we have an enormous amount of readmissions only because of the

condition of our patients. And because the 2728s cannot be updated after, I believe, 30 days from initiation, how are those comorbidities going to be recognized with our severely old patients that can require frequent hospitalizations?

Deanna Chyn: So, Mr. Calderone, this is Deanna Chyn again, from the University of Michigan. When we talk about comorbidities as adjusters, we're actually using prevalent comorbidities from a lot of Medicare claims. So these are going to be – we're looking at all the comorbidities that occurred for a patient in the year leading up to the hospitalization.

Philip Calderone: OK. But if there a lot of comorbidities, and I – you're taking this from the hospitalization data for Medicare-covered patients? How does that reflect over, then, into what your readmission ratio would be?

Tempie Shearon: So, those – the comorbidities that we – sorry, this is Tempie Shearon from University of Michigan. The comorbidities that we identify in the previous – in the year prior to the index discharge are adjusted for in the model.

Philip Calderone: OK. Then I guess we would have to do the dry run to see where we are and then take it from there?

Tempie Shearon: Yes. I think that – that's – one of the goals of the dry run is to – is so that you can see how things are falling out, and we can identify any problems that there might be with the calculation.

Philip Calderone: Will we be able to adjust that then prior to payment year 2016?

Tempie Shearon: So you should definitely submit any comments to the website, and we may or may not make changes based on the suggestions. I guess that is to be determined after we see what people suggest.

Philip Calderone: OK. Thank you.

Operator: And your next question – your next question will come from the line of Georgette Crawford.

Georgette Crawford: Hi. I just have a question about the index discharge. Can you give an example of what an index discharge is?

Deanna Chyn: So, I'll give a brief explanation and maybe we can work together to clarify. So it's just – if you go back to the Exclusions slide, that is – let me find it – the Exclusions slide, which is kind of long, is on slide 15.

So we start out with all Medicare-covered hospitalization claims. So we see all the hospitalizations for the patients in a year. We then make the exclusions on those hospitalizations that you see here. So we rule out any, for example, that – where a patient

transferred to another acute unit or a patient ended the hospitalization against medical advice. And then those sets – that set of hospitalizations is the index, the set of index discharges. So the word "index" just means it's the hospitalization that's eligible to have a readmission after it.

Georgette Crawford: OK.

Deanna Chyn: Does that answer your question?

Georgette Crawford: Yes.

Deanna Chyn: OK.

Georgette Crawford: Thank you.

Hazeline Roulac: Thank you. Next question?

Operator: And once again, if you'd like to ask a question, press star 1 on your telephone keypad. And your next question is a followup from Adrienne Adkins.

Hazeline Roulac: Adrienne?

Adrienne Adkins: Yes.

Hazeline Roulac: Adrienne?

Adrienne Adkins: Hi. It's Adrienne again. I'm sorry. I was listening; I wasn't expecting my question to come up that soon. I just was wondering, is there any way that corporate could have access to the Master Account Holders or to our individual reports to be able to run a corporate analysis of some of the data that's being presented in this dry run?

Joel Andress: Excuse me. This is Joel Andress. I'm the Quality Measure Development Lead for CMS. To answer your question succinctly, that's not something that we have planned for in this dry run. It's something that we have received questions on already. What I would suggest is that you submit your questions to the – to the website, and we can take that into account in future dry runs, but that will not be a functionality that we have available at – for this current dry run.

Adrienne Adkins: OK. Thank you very much.

Operator: And your next question comes from the line of Sumi Sun.

Sumi Sun: Hi. This is Sumi Sun from Satellite Healthcare. I just wanted to see if my assumption is correct. Would I expect the unadjusted rate that you're providing to equal the rate that I'm seeing in the DFR hospitalization table?

Deanna Chyn: So, it's a similar measure, but it will not equal what you see in the DFR because there are different exclusion criteria. It's – it's designed a bit differently on the DFR. So it will be similar but not exactly the same.

Sumi Sun: The readmission kind of measure in the DFR is different, is what you're saying?

Deanna Chyn: Yes.

Sumi Sun: OK. Thank you.

Deanna Chyn: You're welcome.

Operator: Your next question comes from the line of Barbara Tepper.

Barbara Tepper: Hi. I am – my question is, the data in the report is going to be generated by the claims that are submitted to Medicare from our hospitals and from our own hospitalization reports. Is that correct?

Deanna Chyn: So, the data do come from the hospitalization claims. I'm – I'm sorry, this is Deanna at Michigan. I'm not sure what the hospitalization reports are that you submit as a facility.

Barbara Tepper: Well, I'm basically saying, how is the information going to get into the report? How does it get – who feeds it into the report?

Deanna Chyn: So, we – we get all of the Medicare data and summarize it to calculate the facility measures and create the dry run report.

Barbara Tepper: And if we see some errors, we would have to email you or contact you through the help desk?

Deanna Chyn: Yes, that's right. And we encourage all facilities to do that because that's a big part of what the dry run is, is to identify any issues with the current measure calculation, and we rely on your feedback to identify those.

Barbara Tepper: Thank you.

Operator: All right. And your next question will come from the line of Zapora Burillo.

Zapora Burillo: Hi. Good afternoon. My name is Zapora from South Nassau Outpatient Dialysis Center. I just have a question on slide 25. I – I guess I got confused on this slide. So, you said that – that the vertical line is the standard—right?—the SRR equals 1. And does it mean that anything to the right of that are, like, Worse than Expected or – because I was just – I'm trying to figure out this, you know, this slide. Is everything all, you

know, to the right of it is worse, or anyway everything to the left of the vertical line is better?

Deanna Chyn: So, there's a lot of statistics behind this figure, so your confusion is definitely understandable.

Zapora Burillo: Yes.

Deanna Chyn: On this particular slide here, number 25, you'll see some shapes to the right of the line …

Zapora Burillo: Yes.

Deanna Chyn: … which means that their particular SRR is higher than 1.0.

Zapora Burillo: Yes.

Deanna Chyn: However, if you look at those horizontal lines, which are what's called the 95-percent interval, which is how confident we are in that SRR measure there in the shape, all those lines are touching the 1.0 line …

Zapora Burillo: OK.

Deanna Chyn: … which means that – those – all these facilities are categorized as As Expected. So, although they fluctuate around the 1.0 line, they're all touching the line and are As Expected. Now, on your report if your facility or some of the comparison facilities you see are, for example, completely to the left of …

Zapora Burillo: Yes.

Deanna Chyn: … the 1.0 line, the horizontal line won't touch the vertical line...

Zapora Burillo: OK. OK.

Deanna Chyn: …then those facilities are going to be categorized as Better than Expected.

Zapora Burillo: Ah, OK, OK.

Deanna Chyn: Yes. And then conversely, for the other side, if the measure and that horizontal are completely to the right …

Zapora Burillo: Yes.

Deanna Chyn: … and they're not touching the line, then those will be categorized as Worse than Expected.

Zapora Burillo: Oh, OK. All right. OK. Now I understand it better. OK. Thank you.

Deanna Chyn: You're welcome.

Operator: And your next question will come from the line of Ed Lacson.

Ed Lacson: Hi. Good afternoon. I was looking at the purpose of the result, and one – the second – and this is on slide 8. The second bullet is "Provide facilities with historical results and data." But in the example I only saw 1 year, 2012. Will you be providing multiple years of data? Like, how this looks, like 2010 or 2011, 2012, 2013? Or are you going to provide only 1 year? Because I believe that the comparisons, if you really want to do – it's better made longitudinally as well to see what the numbers look like for a particular facility over time.

Deanna Chyn: So, Mr. Lacson, this is Deanna. On slide 5, we do say "historical," but that just is representing the 2012 data. So it's just to say that it's not going to represent any current hospitalizations that you're undergoing. We, right now, during the dry run, are not looking longitudinally at this measure, but that's definitely a good suggestion that CMS has heard.

Ed Lacson: Thank you.

Operator: And your next question comes from the line of Kathleen Johnson.

Kathleen Johnson: Hello?

Hazeline Roulac: Yes. Hi, Kathleen.

Kathleen Johnson: Hi. We're calling from UF/DCI in Jacksonville. We want to know, how do you get the data from other hospitals to reflect on this facility? And say they're admitted to another hospital in Jacksonville, then they come back to this facility, and within 30 days they are admitted to UF Health. Is that still a 30-day admission – readmission?

Deanna Chyn: So, Ms. Johnson, I – I hope I understood your question correctly, but – this is Deanna – but please clarify if I don't answer it correctly.

Kathleen Johnson: OK.

Deanna Chyn: So, we attribute any readmissions within 30 days of discharge to the discharge – the facility to which the patient is discharged, and we have national hospitalization claims. So I – I'm not sure if that completely answers what you're looking for.

Kathleen Johnson: So if it's the same – if it's the same – if you get the reason for the admission and then they're discharged from another hospital, but they're readmitted to this hospital with the same diagnosis, that would be a 30-day readmission?

Deanna Chyn: So, this measure is for dialysis facilities …

Kathleen Johnson: Right.

Deanna Chyn: … and not for hospitals.

Kathleen Johnson: Yes.

Deanna Chyn: So, there is no – we don't consider the different hospitals in terms of where we attribute the measure. If the patient is coming from one hospital to your facility, or they're at your facility and had a hospitalization in one hospital, then were readmitted to a different hospital, that's still counted as a readmission attributed to your facility.

Kathleen Johnson: OK.

Deanna Chyn: Does that make sense?

Kathleen Johnson: That makes sense.

Deanna Chyn: OK.

Kathleen Johnson: Thank you.

Operator: And your next question will come from the line of Kimberly Pettit.

Hazeline Roulac: Kimberly?

Kimberly Pettit: Hi. I'm calling from Tampa General Hospital, and I'm just trying find out if this measure also applies to pediatric units.

Deanna Chyn: Ms. Pettit, this is Deanna. Yes, this measure does apply to pediatric units.

Kimberly Pettit: OK. Thank you.

Operator: OK. And your next question will come from the line of Philip Calderone with a followup.

Philip Calderone: Yes. Again, on slide either 14 or 15, on the exclusions from readmissions, which includes chemotherapy and rehab. If a patient in a nursing home goes to the hospital and back in the nursing home for rehab, are they included or not included?

Deanna Chyn: So, I will refer again to the detailed methodology report that's currently linked on the website. And that report actually will show you all of the diagnosis codes that are included in the rehabilitation kind of catchall category. So it's just going to be diagnosis dependent.

Philip Calderone: Thank you.

Hazeline Roulac: Thank you. Next question?

Operator: Your next question will come from the line of Susan Massart.

Susan Massart: Hi. This is Sue, at a very independent small clinic in Hood River, Oregon. And my question: I noticed that you do talk about exclusions for patients who leave against medical advice. I'm not connected with a hospital—as I said, independent clinic. Then do you also take into consideration patients who choose to leave dialysis against medical advice? And how do you account for noncompliant patients that repeatedly do this?

Deanna Chyn: So, if – if you're referring to – maybe you're referring to patients who skip or shorten treatments. Is that what you're talking about?

Susan Massart: And then end up in hospitals, yes.

Deanna Chyn: Right. OK. That's not an adjustment in this measure. So, they're treated the same as everybody else.

Susan Massart: From my opinion, would that not be a reasonable adjustment?

Deanna Chyn: I guess it's a matter of opinion. I – I'm not sure. You should – you should submit that as a comment so that it can be considered by CMS.

Elena Balovlenkov: This is Elena from CMS. The reason why this is not an exclusionary criteria, while CMS is aware that there are patients that are more challenging than others in terms of getting them to work with the facility on their treatment plan and to adhere to their dialysis prescription, the idea being that the facility work with these challenging patients to assist them as much as possible in trying to get compliance with their prescription plan. That's one – and you can submit this as a question, and we will also take any comments during the comment period. When you see a report, if you have concerns as to how the data shakes out for you, please feel free to submit a comment.

Susan Massart: OK. Thank you.

Elena Balovlenkov: Thank you.

Operator: All right, and once again, if you'd like to ask a question, press star 1. And your next question is a followup from Ed Lacson.

Ed Lacson: Hello, again. One other issue that we've found is the hospitalization process. A lot of it varies regionally or locally. And part of it may include something like up-coding, where some hospital systems are very good at up-coding, and if you have a psychiatric or a rehab issue as the primary, and they find anything that they could put in there—congestive heart failure, even though that's not the primary cause—they put it in there. Are there any processes that CMS has done to be able to kind of look into this and see how they differ – the diagnosis types differ, and adjust for it regionally, locally?

Hazeline Roulac: One moment, sir…. Thank you for holding.

Joel Andress: Hi, Ed. This is Joel. The – my – my – my initial response is – is simply that we don't currently seek to adjust for regional variation in hospitalization practices. If you would like us to – to consider that, and you have some suggestions regarding how that might be considered in – in future maintenance of the measure, then we'd certainly be interested in – in hearing what suggestions you would have for that. And I would suggest submitting it in the form of a comment.

Ed Lacson: OK. Thank you. Well, one – one thing I could say right now is it might be helpful that all the people who volunteer to participate might get a report in terms of the national distribution of this, and maybe to look at regional differences, either by state, by area, and just see which – nationally, how does this pattern look like? And you may be able to get more suggestions that way. Thank you. Thanks, Joel.

Joel Andress: Thank you.

Operator: And your next comes from the line of Priscilla Hernandez.

Priscilla Hernandez: Hello. My question is, will the results be publicly reported, and will they be used as part of the ESRD Quality Incentive Program?

Joel Andress: So, as you may be aware, we are – I apologize. This is Joel Andress again. As you may be aware, we're – we're not allowed to discuss rulemaking one way or the other. I would stress that our efforts for the dry runs, here and in future measures, are part of our measure development process and not part of the measure *implementation* process that you're familiar with through rulemaking. So the decision to – to implement this – this measure in any program at CMS is independent of the dry run process itself.

Priscilla Hernandez: OK. Thank you.

Hazeline Roulac: Thank you. Next question.

Operator: Your next question – your next question will come from the line of Ed Curran.

Ed Curran: Yes. This is Ed Curran from University Dialysis in San Francisco – I mean, Sacramento. Is there any – going to be any difference between in-center and home program ratios?

Deanna Chyn: No, there will be no difference.

Ed Curran: OK.

Operator: And your next question will come from the line of Raymond Cavazos.

Raymond Cavazos: Yes. Hi. This is Raymond Cavazos with the Children's Hospital of San Antonio. I'm just curious—how will that statistic be affected by centers that have a large proportion of their census that are not Medicare eligible?

Deanna Chyn: So, since the – since the measure is only going to be including Medicare-covered hospitalizations, those patients if they're not being – if their treatment isn't being covered by Medicare – if their hospitalizations, I mean, aren't being covered by Medicare, they won't be included in the statistics.

Raymond Cavazos: So will that give me a better statistic or a worse statistic?

Deanna Chyn: It could go either way.

Hazeline Roulac: Did that answer your question?

Raymond Cavazos: Yes, yes.

Hazeline Roulac: OK. Thank you. Next question?

Operator: Once again, if you'd like to ask a question, star 1. And your next question is another followup from Adrienne Adkins.

Adrienne Adkins: Hi, yes. This is Adrienne Adkins again. On the slide that talks about the Table 2 with the details of the SRR calculation, they have for that facility the 50 30-day unplanned readmissions, the 58. Is there some sort of maybe dropdown or patient-level report that is accompanying the dry run so that facilities could look at those patients and see if there were any discrepancies with the data?

Deanna Chyn: Yes, absolutely. This is Deanna again. These reports that you – that we talked about here today will be automatically up on the website when you log in on March 31st through May 2nd, but you can also request hospitalization-level reports that provide more detail on each of the hospitalizations that went into the calculation of the measure. And then we would like for you to provide feedback if you see any discrepancies on that report.

Adrienne Adkins: So the facility would have to note or request the hospital-level data reports? Or is that somewhere, you know, in the, you know, the instructions when you're looking at the reports?

Deanna Chyn: So, it's mentioned on the website when you – when you go to the website, that you can request the reports, and it's also in the slides here, but you would just contact the – the help desk in any of the three methods we – we talked about.

Adrienne Adkins: OK. Thank you.

Deanna Chyn: You're welcome.

Operator: Once again, to ask a question, press star 1. And your next question comes from the line of Christopher Simon.

Christopher Simon: Hi. Can you tell me what constitutes hospitalization? And does hospitalization include emergency room visits or observation stays in the hospital?

Deanna Chyn: Hi, Mr. Simon. This is Deanna. The hospitalizations will not include ED visits that don't result in the patient being formally admitted. And the calculation does also not include observation stays.

Christopher Simon: OK. Thank you.

Deanna Chyn: Welcome.

Operator: And your next question is another followup from Ed Lacson.

Ed Lacson: Hello, again. One thing, I'm looking also at the risk adjustments. In – some of the unplanned admissions may not be totally under control of anyone except potentially fate or the patient. So if there's trauma or gunshot or IV drug use outside – illicit drug use outside of the setting, are these considered as part of these? Or are these excluded from your hospitalizations?

Deanna Chyn: Hi, Mr. Lacson. This is Deanna again. We include those hospitalizations in the measure.

Ed Lacson: So, there is no concern that they may, especially in the smaller facilities, tip things in terms of – of additional readmissions when they are totally out of control for the particular facility or hospital?

Deanna Chyn: So, I can't speak to the concern level about that, but I think that this sounds like a really good suggestion that you could provide during the comment period. I think that's a very valid suggestion.

Ed Lacson: Thank you.

Operator: And your next question will come from the line of Peter DeOreo.

Peter DeOreo: Hi. This is Peter DeOreo from the Centers of Dialysis Care in Cleveland. Question I have is on observation. There –there's an evolving definition of what an observation is, and there's also the issue about a patient who was admitted, who was brought into the hospital with the full understanding from the hospital that this is observation status, but then Medicare denies it as an observation status. So we have this two – 2-midnight rules, and we have the difference between the hospital's expectation and the fiscal intermediaries' response to it. How will that be identified?

Hello?

Deanna Chyn: So, we have looked to see whether – we have looked to see how many observation stays we think there are, and there aren't that many, and they aren't included in our statistic. I'm not exactly sure how – I guess if Medicare denies the observation status, I don't really – I don't really know how that works. But basically, if the patient – if the patient is admitted to the hospital and Medicare pays for it, we're including it.

Peter DeOreo: So what definition of observation status is used for the 2012 cohort?

Deanna Chyn: So, this is Deanna, again. I'm not sure if this answers your question, but the way – it's a little bit technical. The way that we get the data, we are looking in institutional Medicare claims, and observation stays as defined by the CPT codes don't make it into the institutional claims that we're looking in. So we don't include observation stays at all. The patient has to be admitted to the hospital as a non-observation stay for us to even see the record and the data.

Peter DeOreo: OK.

Deanna Chyn: Does that answer …

Peter DeOreo: That answers the question. Thank you, yes.

Operator: And at this time, we have no further questions.

Additional Information

Hazeline Roulac: Well, thank you, Holly. If you have questions or comments about your report, the dry run website, or the dry run process, please refer to slide number 35, which provides you with information on how you can submit your questions or comments through the dry run website, or by calling the dry run help desk. An audio recording and written transcript of today's call will be posted to the MLN Connects website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide number 37, you will find information and a URL that provide you with an opportunity to evaluate your experience with today's call. Evaluations are anonymous,

confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Hazeline Roulac. I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on the Standardized Readmission Ratio for Dialysis Facilities: National Dry Run. We thank you for your time and have a great day, everyone.

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

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