



# MLN Connects™

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services**  
**CMS National Dry Run: Standardized Readmission Ratio (SRR) Measure**  
**MLN Connects National Provider Call**  
**Moderator: Charlie Eleftheriou**  
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**Operator:** At this time, I would like welcome everyone to the 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 objection, you may disconnect at this time.

I will now turn the call over to Charlie Eleftheriou. Thank you. You may begin

## **Announcements and Introduction**

Charlie Eleftheriou: This is Charlie Eleftheriou from the Provider Communications Group here at CMS and I'll be serving as your moderator today. I'd like to welcome all of you to the second of two MLN Connects National Provider Calls on Standardized Readmission Ratio for Dialysis Facilities National Dry Run. MLN Connects Calls are part of the Medicare Learning Network.

On March 31st, 2014, CMS began conducting a national dry run of the Standardized Readmission Ratio, or SRR, for Dialysis Facilities. CMS's contracted with the University of Michigan Kidney Epidemiology and Cost Center to develop and implement the dry run. CMS is using this dry run to test the implementation of SRR reporting and to educate dialysis facilities about the measure.

This MLN Connects Call is the second of two calls that provides stakeholders with the information about the measure and the dry report and provides answers to questions facilities may have about their results. The question-and-answer session will follow the presentation.

Our presenters for today are Dr. Joel Andress from the Quality Measurement and Health Assessment Group, Center of Clinical Standards and Quality here at CMS; Tempie Shearon, lead manager of Research and Analysis, and Jennifer Sardone, project assistant, both from the University of Michigan.

Before we get started I do have a couple of quick 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 presentation for today's call in an email today. If you have not already done so, please view or download the presentation found at the following web address: [www.cms.gov/npc](http://www.cms.gov/npc) as a National Provider Call. Again, that's [cms.gov/npc](http://cms.gov/npc). At the left side of that webpage, select National Provider Calls and Events, then select the date of today's call on the list. You'll find a link to the slide presentation in the Call Materials section.

Second, the call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Connects calls website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

I'll now turn the call over to Dr. Joel Address.

## **Presentation**

Joel Address: Good afternoon and thank you for joining us for our second call supporting the Standardized Readmission Ratio Dry Run. I am Joel Address, the CMS task lead for Dialysis Facility Quality Measure Development. Thank you for – all of you for your participation both in the dry run and on this call.

## **The Dry Run Website**

Your reports have been available online since the beginning of the month and you hopefully have had the opportunity to download and review your facility results. The primary purpose of this call is to discuss the interpretation of those results and to respond to your questions and concerns related to the reports.

And if you'll look on slide 2, we provide the agenda for today's call. I will begin with brief introductions to the presenters and then turn over control of the call to my colleagues at the University of Michigan Kidney Epidemiology and Cost Center, Tempie Shearon and Jennifer Sardone. They will discuss the resources available to you at the Dry Run website and how to access those resources. And afterward we will discuss the SRR measure specifications in detail and the presentation will then turn to the facility-specific reports that you will – received, including how measure results may be interpreted. Afterward, we'll discuss next steps, including how to request clarification for your report and how to provide feedback to us regarding both the measure and the dry run process.

I want to emphasize that last – since this is our first measure development dry run for dialysis facilities and it's intended to be helpful to your understanding how the measures are constructed and may be interpreted. Your feedback is, therefore, vital in ensuring that we are providing you with the information you need in a manner that you can understand and use. While we will not have time to address facility-specific data questions, we have provided you with multiple means to contact the Dry Run Help Desk for assistance, and we encourage you to do so.

## **SRR Measure Description**

If you will turn to slide 4. CMS is the measure steward for the Standardized Readmission Ratio, and in our role as measure developer, we maintain a blueprint for outlining the development process. The dry run is part of this blueprint that has not previously been used for ESRD quality measures. It's intended to enhance transparency and interpretability of the measures as well as identifying potential roadblocks to successfully reporting measure results to stakeholders.

While we do not anticipate using dry runs for all measures ahead of implementation, we believe that particularly complex measures such as the SRR, which incorporated advanced statistical modeling and risk adjustment, can benefit from these efforts. As the

measure development contractor, the University of Michigan Kidney Epidemiology and Cost Center has been tasked with developing new measures and carrying out dry runs when it is deemed to be appropriate. They are responsible for calculating the facility-specific results and providing the reports to facilities, as well as responding to questions from you, the providers.

With that in mind, I want to address a known issue regarding the accessing of reports by some facilities. Some facilities have been unable to download their reports because the University of Michigan has not been able to provide an account password. This has been a result of outdated contact information for the Master Account Holder – account holder list.

Normally, this is out – this out-of-date information would be resolved by contacting the networks and ensuring that data – that data are updated. However, in initiating the dry run, we discovered that support for this function for the purposes of the dry run was not included in their scope of work. As a result, the University of Michigan has faced limitations in providing reports where the Master Account Holder information is out-of-date as they cannot identify the appropriate point-of-contact who should receive the password.

This was an oversight on the part of CMS and we are working to address the issue. We do request that you provide your assistance in the manner by submitting written comments to us if your facility has not received a password so that we are aware of the scope of the issue as we're in – we're seeking to address it.

And now, I will turn the discussion over to Tempie Shearon from the University of Michigan.

## **Report Details**

Jennifer Sardone: Hi, Joel. This is – my name is Jennifer Sardone, and I'm actually going to go first. I am a project assistant at UM-KECC and I will briefly review the Dry Run website and the process for submitting comments and questions about your dry run report.

For those of you who are looking at the slides, I'm now on slide 6. As most of you already know, the website for the dry run is [www.dialysisdata.org](http://www.dialysisdata.org). This is where the facility-specific reports are available. During the dry run, you 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. We call this The Discharge-Level Data Report.

There are two ways to request this report. You can email the help desk at [dialysisdata@umich.edu](mailto:dialysisdata@umich.edu) or submit a request through the Dry Run website. Note that in order to receive a Discharge-Level Data Report, you will have to have permission to view PHI data granted to you by your Master Account Holder. If you are the Master Account

Holder and would like to request the data, you will need to grant this permission to your user account. Instructions on how to grant this permission can be found in the FAQs on the website.

During and after the dry run period, you will have several resources available to help you understand and interpret the readmission measure. First, as I just mentioned, dialysisdata.org has an FAQ section that provides information on logging in to the website along with some other general information about the measure and what facilities are included in the dry run.

In addition, we also provided a detailed methodological report outlining various aspects of the measure. Lastly, we are also operating a help desk, the phone number and email for which are on this slide. We are happy to answer any specific questions you have about your facility's report.

I'm now on slide 7. In case there's anyone listening today who has not yet downloaded their report, we wanted to briefly cover how to access it on the website. In order to access the dry run report, you will need a user account set up for you. If you do not have a user account, contact the Master Account Holder at your facility. If you don't know who this is, you can call the Dry Run Help Desk and we can provide you with that person's name.

If you are the Master Account Holder, please note that in order to download the report, you will need to create a user login for yourself. You will not be able to download the report when logged into the Master Account. When you have a user account and you log in, you will find a PDF of the report that details your facility's measured calculations under the SRR Navigation tab. If you have access to the reports for multiple facilities, you will see individual PDF documents for each of those facilities.

I'm going to move on to slide 8. On this slide we've included a screenshot of the comments and inquiry screen, which is available when you are logged into the website either as a Master Account Holder or as a user. We encourage anyone with specific questions about their dry run report or discharge-level data file to submit a question either through this form or through the help desk email at [dialysisdata@umich.edu](mailto:dialysisdata@umich.edu).

As I mentioned earlier, this screen is also one of the mechanisms that you can use to request that discharge-level data file. We do have a Q&A session scheduled at the end of this presentation. We wanted to note that if you have a specific question about a patient or a discharge that is included in your measured calculation, you should submit that questions via the website or the help desk to avoid – prevent providing sensitive information during this call.

My colleague Tempie Shearon is now going to review the details of the SRR measure and the dry run report.

Tempie Shearon: Thank you, Jennifer. Today, I will give a brief summary of the readmission measure in the dry run report available for each facility. As Jennifer mentioned earlier, a more detailed description of the measure calculation is available in the methodology report on [dialysisdata.org](http://dialysisdata.org).

I'm starting on slide number 10. To begin, I'll define a few terms that will be used in this presentation and which you will also see on your facility's readmission report. First, index discharge – this is a hospitalization that is eligible to be followed by a readmission. We call this a discharge rather than an admission because the discharge date is the starting point from which we identify readmission.

Next is readmission. In this measure a readmission is any unplanned hospitalization that occurs within 30 days of an index discharge. A readmission can also count as an index discharge. Last is readmission rate. This 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.

Moving on to slide 11. So, what is the readmission measure if not a simple readmission rate? The dry run readmission measure is an adjusted measure called the Standardized Readmission Ratio or SRR. It is the ratio of the number of readmissions at a facility to the number of readmissions one would expect to occur at the facility given the patient population. The expected value comes from a statistical model predicting whether an index discharge with particular characteristics will be followed by readmission. I'll review the model and the risk adjusters included in that model later in the presentation.

On slide 12, you'll see the sources of data used to calculate this measure. Most of the data come from Medicare claims. In addition, we get patient demographic information such as age and sex from the CMS database. The SRR is based on Medicare-covered hospitalizations for both hemodialysis and peritoneal dialysis patients.

Moving on to slide 13, you will see the list of exclusions for the components of the readmission measure. First, the index discharge exclusion. A hospital discharge is not considered an index discharge if the hospitalization is not covered by Medicare. In this case, we actually don't even have that in our data. If the patient died during the hospitalization or within 30 days of the discharge date for the hospitalization, if the patient was transferred to an acute unit, in other words, if a patient is discharged from one hospital and transferred on the same day to a second hospital, the discharge from the first hospital is not considered an index discharge. If the patient was discharged against medical advice, if the hospitalization was at a PPS-exempt cancer hospital – these are hospitals that provide care for a unique population of patient and are not comparable to patients admitted to other hospitals, if the hospital involved in the primary diagnosis of certain conditions related to cancer, psychiatric causes, or rehabilitation, and finally, if the hospitalization follows a patient's 12th hospital discharge during the year. We do this in an effort to limit the influence of high-risk patients on the number of index discharges at a facility.

Now, for the readmission exclusions. A hospitalization that occurs within 30 days of an index discharge is only counted as a readmission if it's considered unplanned. There are two ways a hospitalization can be characterized as planned and, therefore, not considered as a readmission for this measure. First, a hospitalization for maintenance chemotherapy or rehabilitation procedure, no matter what other additional procedures or diagnoses occur on that hospital claim, is always considered planned. Second, a hospitalization involving one of several procedures is characterized as planned. For example, hip replacement, although there are many other procedures also, that does not also involve a diagnosis of an acute event, such a heart attack, is considered planned.

Moving to slide 14. As I said earlier, we use a model to determine the number of readmissions one would expect at a facility given the facility's patient mix. The readmission model is a hierarchical logistic regression model, which includes patient-level adjustments for age and index discharge, sex, a certain set of illnesses or conditions experienced in the year leading up to the hospitalization, the patient's BMI at incidence of ESRD, the number of years he or she has had ESRD as of the discharge date, and an indicator for whether diabetes was the primary cause of the patient's ESRD. We also include adjustments for whether the index hospitalization involved the high-risk diagnosis, the length of the index hospital stay, the discharging hospital, and the dialysis facility at which the patient was being treated as of the discharge date.

Slide 15. As I mentioned earlier, the SRR is the ratio of the number of readmissions that occurred at a facility to the number of readmissions that would be expected at the facility given its patient mix. It's important to note that we calculate a standardized readmission ratio only for facilities that had at least 11 index discharges in calendar year 2012. Those facilities that were open and certified at the end of 2012 but had fewer than 11 discharges do still have a report available, but the information included is limited and will not include a facility SRR.

Slide 16. The interpretation of the SRR is similar to that of the SMR and SHR that are reported on the Dialysis Facility Compare website and in the Dialysis Facility Report. The SRR for a facility is calculated relative to 1.0, which is the national value for the SRR. If your facility's SRR is larger than 1, your readmission rate is higher than would be expected given your patient population. If your facility's SRR is smaller than 1, your readmission rate is lower than would be expected given your patient population.

Slide 17. Your facility's report includes the Standardized Readmission Ratio along with a 95 percent interval estimate. This interval represents the range of reasonable values for your facility's SRR, given that the measure's estimated from a statistical model. CMS uses both the SRR measure and its 95 interval to categorize your facility's performance on readmission.

Slide 18 lists the three categories facilities fall into based on their SRR and 95 percent interval. A facility is in the "As Expected" category if the 95 percent interval contains 1. If the entire 95 percent interval is lower than 1, the facility is classified as "Better than

Expected,” and if the entire 95 percent interval is higher than 1, the facility is classified as “Worse than Expected.”

Next, I’ll review the tables and the figure included in the dry run readmission report.

I’m now on slide 20. The first table in your facility’s report provides your SRR measure and performance category. This table and the next table are organized in the same way. Values specific to your facility are shown in the first column and the average values per facilities in your state and in the U.S. are shown for comparison in columns two and three.

The first row of this table is the unadjusted readmission rate, that is the percentage of index discharges occurring in 2012 that were followed within 30 days by an unplanned readmission. The readmission rate for this sample facility is 36 percent. The two columns to the right provide the same measure for the state and for the nation. The second row is bolded and is the actual SRR, again, with the state and U.S. values presented directly to the right for comparison. The SRR for this facility is 1.10.

The remainder of this table has values only for the facility. State and U.S. values are not provided for these three rows. The third row is the 95 percent interval associated with the SRR. You’ll notice that on this report the interval includes 1. This means that the sample facility is categorized as “As Expected,” as shown in the last row of the table. Jumping back up to row four, you can see that the P-value is 0.639. This value is associated with the SRR and is related to the 95 percent interval. Specifically, if the interval in row three does not include 1, the P-value will be less than 0.05. If the P-value is less than 0.05 and your SRR is lower than 1, your facility is categorized as “Better than Expected.” And if on the other hand the P-value is less than 0.05 and the SRR is higher than 1, your facility will be categorized as “Worse than Expected.”

Slide 21 shows an example of the second table, which as the title indicates provides details of the SRR calculation. The first row of this table shows the number of patients in the facility on December 31st, 2012. The state and U.S. values 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 list of exclusion criteria I outlined previously.

Again, the average number of index discharges in the state and in the U.S. are provided in the two columns to the right for comparison. The sample facility shown here had 57 patients at the end of the year and 111 index discharges during the year. The number of readmissions is shown next separately, according to whether they are considered planned or unplanned. The number of unplanned readmissions is the number of readmissions considered in the calculation of the SRR. The number of planned readmissions is only shown here for your information. These are not included in the SRR calculation. So, you can see that this facility had 40 unplanned readmissions and six planned readmissions.

The next row is the unadjusted readmission rates for the facility, which is calculated as the number of unplanned readmissions divided by the number of index discharges. Next, you'll see the expected readmission rate, which is calculated based on the model described earlier. The last row shows the SRR, which is the ratio of the number of readmissions at the facility to the number expected. As indicated in parenthesis, an alternative way to calculate the SRR is to divide the readmission rate by the expected readmission rate. Both calculations will result in the same value.

Slide 22 shows a sample of the third table in the dry run readmission report. The first section of this table shows the number and percentage of facilities in the state and in the U.S. that fell into each of the performance categories. As you can see, most facilities fall into the "As Expected" category. The number and percentage of facilities that were not categorized because they had fewer than 11 index discharges in 2012 is also shown here. The last row of the table indicates the percentage of facilities in the state and in the U.S. whose SRR was better than this facility's SRR. These percentages will let you see how your facility ranks among other facilities in your state and in the U.S.

Moving on to slide 23, you will see a sample of the figure included in the report. This figure allows you to compare your facility's SRR with similarly sized facilities in your state. If your facility had fewer than 11 index discharges in the year, your report will not include this figure, however. The shapes on the figure represent SRRs and the horizontal lines represent those SRRs 95 percent intervals.

So, first, notice the vertical line, which shows the U.S. comparison value for the SRR. The U.S. SRR is equal to 1.0 by definition and is the standard to which we hold all facilities. The black square at the top of the figure is the state SRR. We do not calculate a 95 percent interval for the state SRRs, so, this square does not have an accompanying horizontal line.

The facility's SRR and 95 percent interval are shown next. The 95 percent interval for the facility is shown as a thick black line to distinguish it from the comparison facilities below, whose intervals are shown in gray. The marker indicates the performance category for the facility. In the sample figure, the facility SRR is shown with an orange diamond, meaning that the facility falls into the "As Expected" category. You can also see this by looking at the 95 percent intervals for the facility, which crosses the vertical U.S. reference line of 1.0.

Next, going down in the figure, there are SRR values in 95 percent intervals for 15 similarly sized facilities in the state for comparison. As indicated in the legend, facilities in the "As Expected" category are shown with an orange diamond. Those categorized as "Worse than Expected" are shown with a pink triangle and have 95 percent intervals entirely to the right of the U.S. reference line. Conversely, facilities categorized as "Better than Expected" are shown with a green triangle and have 95 percent intervals entirely to the left of the vertical line.

Thank you everyone for listening. I will now turn the presentation back over to Jennifer Sardone. Jennifer.

### **Next Steps**

Jennifer Sardone: Thank you, Tempie. I'm now going to cover the next steps for the dry run, including the outcomes we hope to achieve and the feedback we are requesting from the facilities. I'm now on slide 25, which is titled "Dry Run Outcome." By the end of this dry run, it is our aim that each facility is educated about the SRR measure, that each facility has been provided with accurate results and data, and that each user has reviewed their dry run report, has had ample opportunity to ask questions and receive feedback about the report.

As Joel mentioned at the beginning of this call, we want to ensure that we are providing you with information you need in a manner that you can understand it. To that end, we encourage all facilities to provide feedback on this process to ensure that we achieve those outcomes in future dry runs.

I'm now on slide 26. So, given that CMS plans to conduct future dry runs as part of the measure development process, we are looking for as much feedback as we can apply regarding the functionality of the Dry Run website, the process for conducting the dry run, and the usefulness of the dry run report. Any feedback that we receive through the help desk about the dry run will be passed on directly to CMS.

As a review, slide 27 details how you can contact us with feedback or to ask questions about the dry run. Again, the dry run lasts through May 2nd. Specifically, this is time that your facility report for the readmission measure will be available on the website. You also have until the 2nd to request that discharge level data file for your facility. We encourage anyone with questions or comments about the dry run to contact the help desk and any of the three methods that are listed on this slide.

And that is the end of our presentation. I'm going to turn things back over to Charlie for the Q&A session.

### **Keypad Polling**

Charlie Eleftheriou: Thank you. At this time, before we jump in to Q&A, we'll pause for a minute to complete keypad polling just so 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. We are now 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 were the only person in the room, enter 1. If you 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 I complete the polling. Please continue to hold while we complete the polling.

Thank you. I would now like to turn the call back over to Charlie Eleftheriou.

## Question-and-Answer Session

Charlie Eleftheriou: We will now take your questions. But before we begin, I'd like to remind everyone again that this call is being recorded and transcribed. So before asking your question, please state the name – I'm sorry, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to one at a time. If you would like to ask a followup question or have more than one question, you may press star 1 to get back in the queue and we'll address additional questions as time permits. We're now ready to take our first question.

**Operator:** 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 are asking your question so anything you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster. And again, it's star 1 to ask a question.

And there are currently no phone questions.

Charlie Eleftheriou: OK. If anyone on the line would like to ask a question of our subject matter experts here, please go ahead and enter the queue. And we'll pause for a few moments to see if anyone decides to ask a question.

**Operator:** Your first question comes from the line of Peter DeOreo.

Peter DeOreo: Hi. Thanks, for taking my call. The question is on Table 2. You have discharges and – I'm sorry, you have census on 31st of December, then you have index discharges. Is there any distribution of the discharges per patient census? In the example there, there's slightly fewer than two discharges per patient. The state and the U.S. have different ratios. Are there any confidence intervals or any predictions about what's normal for discharges per patient?

Tempie Shearon: We haven't looked – we haven't produced any distributions of that. I mean, we do know that in general patients have about two hospitalizations per year. But that's not – that's not applicable directly to this.

Peter DeOreo: Your reference data doesn't show that – 92 over 72 for the national data is way less than 2.

Tempie Shearon: Right.

Charlie Eleftheriou: I think we'll go on to our next caller.

**Operator:** Certainly. Your next question comes from the line of Avis Allen.

Avis Allen: Hi. Yes, I had a question about who gets – how do you know what dialysis unit the patient is discharged to? The reason I'm asking is I operate a facility that has both acute and chronic. We transfer a lot of patients, discharge out to the community, and frequently, we get – we get charged with their mortality rate. So, I'm curious about the readmission rate. So, how timely is the information about what facility they are currently at when they're hospitalized and readmitted?

Tempie Shearon: So, we use data from the CROWNWEB system, which has the census of where patients are being treated at all times. So, we look at the discharge date and we see where the database says the patient was being treated at that time.

Avis Allen: OK.

Tempie Shearon: For mortality, I think that's what you mentioned before. There are different rules. We don't – when a patient is transferred out of a facility, the mortality is still attributed to that original facility for 60 days. But there aren't such rules for the readmission measure.

Avis Allen: OK. That was really my concern. All right. Thank you very much.

**Operator:** And again, to ask a question, simply press star 1 on your telephone keypad. One moment for your next question. Your next question comes from the line of David Henner.

David Henner: Hi, yes. This is David Henner calling from Berkshire Medical Center in Massachusetts. My question is regarding discharge-level data. When we get reports on that, the patient ID instead of being in the form of patients' names as they were in reports in the past are now in CROWN-UPI numbers, which makes it a little more difficult to sort through and figure out who's who. You have to actually search each one, I think, unless there's an easier way of doing this. Why the change and is that something that could possibly be changed in the future back?

Tempie Shearon: This is Tempie. It was a CMS decision this time to make that change. I guess we can certainly consider going back to patient names.

Joel Andress: So, just to step in. This is Joel Andress. That –Tempie is correct, that was a decision made at CMS. It is something that we could – that is certainly something we can reconsider for a future dry run. It's not something that we could adjust for this current dry run, however.

David Henner: OK.

Charlie Eleftheriou: I think we'll take our next question please if we have one.

**Operator:** And there are currently no further phone questions.

Charlie Eleftheriou: Thank you. And again, if anyone that's on the line has a question to ask, please jump in to the queue and we'll be happy to answer any questions you may have.

**Operator:** Your next question comes from the line of Charlene Podach.

Charlene Podach: Hello. This is Charlene and I just had a question about the information. When we pull these reports, the information that is on the reports, does it come from the info that we – that we enter in CROWNWeb?

Tempie Shearon: This is Tempie. Different – different pieces of information do come from different sources. But the hospitalization data itself, which is the majority of what we're looking at here, comes from Medicare claims data.

Charlene Podach: OK. Thank you very much.

**Operator:** Again, to ask a question, simply press star 1 on your telephone keypad. Again, that's star 1 to ask a question. One moment for your next question. Your next question comes from the line of Eileen Walker.

Eileen Walker: Could you please on slide 14, "The Readmission Model," there is – you have listed risk – the risk adjustments. Can you explain to me the lengths of index hospital stay? What effect that has and the discharging hospital and the dialysis to which the patient was discharged?

Tempie Shearon: Sure. This is Tempie again. The length of index hospital stay is just the number of days that – that index admission or that index discharge lasted. And so, I think that – I think what I remember is that longer index discharges are more likely to have readmissions than shorter ones – for the discharging hospital and the dialysis facility, so we adjust for the discharging hospital in case there are things that the hospitals themselves are doing that have the patient beforehand. And then the dialysis facility is included in the model so that we get estimates for each dialysis facility. And I don't know if any of my colleagues here want to say more about that.

Kevin He: I think the reason why we (inaudible) dialysis facility and hospital share responsibility for the patient that's why they're accountable in fact.

Eileen Walker: So, I'd like to understand then. So, the length of the hospital stay – would the longer the hospital stay, the more you would expect them to be readmitted?

Tempie Shearon: I believe that's how it worked in the model. Yes.

Kevin He: What I remember is the 40 percent for data variable is very small. In fact, that's not very large for a data variable.

Tempie Shearon: Does that – I'm not sure if that helps. Does that answer your question?

Eileen Walker: Sort of. Kind of.

Tempie Shearon: So, there is – if you're interested in that in more detail about what the model looks like, there are some – there is more information included in this – in the detailed documentation on the website. I think that includes – I think that includes the coefficients in the model.

Eileen Walker: Thank you.

**Operator:** Again, to ask a question, press star 1. One moment for your next question. Your next question comes from the line of Delilah Walters.

Delilah Walters: Hi. I was calling – inquiring about the past year comorbidities in terms of the risk adjustment. Does that come from CROWNWeb or the Medicare claims as well as, can you give us examples of the presence of high-risk diagnoses?

Tempie Shearon: So, the past year comorbidity information comes from looking at all of the – all of the Medicare claims we have for the patient over the previous year and looking to see – looking for any indication of the list of comorbidities that I don't remember off the top of my head but I think are included in the documentation. And your second question – oh, about – your second question was about high-risk diagnoses?

Delilah Walters: Yes.

Tempie Shearon: Do you remember what the high-risk diagnoses are, Kevin? I can't remember.

Kevin He : HIV and sickle cell anemia were two.

Tempie Shearon: So, two of them were HIV and sickle cell anemia. I think that, again the detailed documentation showed – include the complete list if there were others.

Delilah Walters: Thank you.

**Operator:** Your next question comes from the line of Deborah Werner.

Deborah Werner: Yes, I just wondered – I think I missed – how do you get into the website with the username and password?

Jennifer Sardone: Hi. This is Jennifer – Jennifer Sardone. So, with your – so the Master Account – if you were the Master Account Holder for your facility – you should have received a password via email. If you didn't receive that, you can go ahead and give the help desk a call. There's somebody at the help desk right now.

Deborah Werner: OK.

Jennifer Sardone: And if you're talking about – were you talking about your Master Account?

Deborah Werner: Yes. I'm the Master Account Holder.

Jennifer Sardone: OK. Yes. Sure. So, you can go ahead and either give them a call or email us...

Deborah Werner: OK.

Jennifer Sardone: ... and we can get it. We can take care of it.

Deborah Werner: All right. Thank you.

**Operator:** Again, if you would like to ask a question, press star 1 on your telephone keypad. One moment for your next question. Your next question comes from the line of Michelle Walker.

Michelle Walker: Yes. I was just trying to clarify the patients that are included in the calculations, so obviously it's Medicare-only patients. We have a home program. So, does this include just in-center patients or are we including home hemo, peritoneal dialysis? Who is that, who as all are the patients that are being included?

Tempie Shearon: So, it will include – this is Tempie. It will include all of those patients – peritoneal dialysis patients, hemodialysis patients, whether they're being treated in-center or at home as long as they're – as long as the hospitalization was a Medicare-covered hospitalization.

Michelle Walker: OK, thank you.

**Operator:** You have a followup question from the line of Charlene Podach.

Charlene Podach: Yes, I just had a question about the report itself, when it would be available to print to – for us to review?

Jennifer Sardone: Hi, this is Jennifer again. So, were you able to open your report?

Charlene Podach: I have not tried yet. I'm just listening in on the WebEx today here, so I just wanted to find out when they would – are they available to print now?

Jennifer Sardone: Yes, yes.

Charlene Podach: OK, OK, thank you.

**Operator:** Again, if you would like to ask an audio question, press star 1 on your telephone keypad. One moment for your next question. Twyla Norquist, your line is open.

Twyla Norquist: Hi, I'm looking at my report and it only lists three of my five facilities on there, but I did the same thing for all five of them. Should they all be listed together?

Tempie Shearon: So are you – are you looking at – on the website and you're only seeing three PDFs, is that what you mean?

Twyla Norquist: I can get into the – I got into dialysisdata.org and sign in and I got – yes, I got three of my facilities listed and I could see their report, but I can't – my other two.

Jennifer Sardone: This is Jennifer again, Twyla, that's something I'll probably have to go look at after this call just to make sure that it's not like a technical error, but I think I have your email address, so I will contact you after this call.

Twyla Norquist: OK.

Jennifer Sardone: Thanks.

Twyla Norquist: Thank you.

**Operator:** Again, if you would like to ask an audio question, simply press star 1 on your telephone keypad. One moment for your next question. Your next question comes from the line of Pauline Terry.

Pauline Terry: Yes, this is Pauline Terry. I would like to know what – how often will these reports be coming out? I know this is a dry run. What should we expect as far as the frequency? I see this for 2012.

Joel Andress: Excuse me, this is Joel Andress from CMS. So, the dry run itself is a – is a one-time deal for this measure. We don't have any plans to do another dry run for the SRR. The future dry runs will be – will be done on a case-by-case basis for the measures. Typically, we're – we're going to look at doing dry runs for measures that include complex statistical modeling or are – or are – especially complex for some other reason. If you – does that answer your question?

Pauline Terry: No my question is like – OK, so this is how we did for 2012, how do I know if I’m getting better with 2013 data?

Joel Andress: OK, all right, for the – for the report, so that’s going to be dependent upon measure implementation, which for the – for the SRR has not yet been decided. So, it would depend upon where and how the measure was implemented in a CMS quality program. But that’s – this dry run is part of the development process. It’s not part of this measure beginning a life cycle on a – on a given program, so ...

Pauline Terry: OK, so it’s not yet known if they’re even going to continue or – OK.

Joel Andress: Right, so if it’s implemented on another program, then it’s – then future reports would – would – I would – I would assume follow along the anticipated life cycle for reports from that program.

Pauline Terry: Thank you.

**Operator:** Your next question comes from the line of Patricia Applestein.

Patricia Applestein: Hi. I was looking at the Figure 1, “Your Facility’s SRR.” Now should there be a more specific, like patient name or something, I just have a number that we’re supposed to be looking at?

Tempie Shearon: So, you’re looking at your discharge report?

Patricia Applestein: I’m looking at that report that’s on last page of the slide, where it has the state and our facility in a little diamonds and ...

Tempie Shearon: Oh, I see, I’m sorry, sorry this is Tempie, I keep forgetting to say my name. So, that’s the year it will appear on your facility’s report and it’s showing you the state – the state SRR; your facility’s SRR that’s the second one.

Patricia Applestein: Correct.

Tempie Shearon: And then the SRRs for a few other facilities that are similar to your facility?

Patricia Applestein: Right.

Tempie Shearon: Some information on there and we also we don’t identify which facilities those comparison facilities are.

Patricia Applestein: Right. But will there be something that we can look at to see who is included in this or ...

Tempie Shearon: Oh, I'm sorry, yes, so you can request your discharge-level data and that includes the list of all the patients, of all the hospitalizations.

Patricia Applestein: OK, so that would be that special request that we have to make?

Tempie Shearon: Yes.

Patricia Applestein: OK, thank you.

Tempie Shearon: You're welcome.

**Operator:** And there are no further questions at this time.

Charlie Eleftheriou: If anyone has any questions, please feel free to press star 1 and ask – ask away.

**Operator:** And again, star 1 to ask an audio question. You do have a followup question from the line of Charlene Podach.

Charlie Eleftheriou: Hello?

Charlene Podach: Yes, my next question is basically, all in all, its purpose is, is this going to be part of like a repayment or what – what is the ultimate factor that this is going to – what's its main purpose?

Joel Andress: This is Joel Andress of CMS. Are you asking where we're planning to implement the measure?

Charlene Podach: Right. I mean is this – is this going to be compiled for – what are you going to do with this information? Does it go towards like a repayment?

Joel Andress: You – are you asking if it's being included in the QIP?

Charlene Podach: Right or – I mean is it just for information or is it going to be, you know, like our – our reimbursement down the road?

Joel Andress: Right, so there – there's a number of ...

Charlene Podach: Would that be included in that?

Joel Andress: ... so there are a number of possible destinations for the – for measure implementation on this and we haven't made any final decisions about where the – the measure ultimately will be implemented.

Charlene Podach: OK.

Joel Address: So, I can't tell you where it will or won't be. Those decisions are typically made by other processes that aren't related to the – to the measure development, which is – which is what we're conducting as – well, we're conducting the dry run as part of the measure development.

Charlene Podach: Right.

Joel Address: Some – some examples of where quality measures could be implemented at CMS, you know, would include, the QIP is one possible destination, reporting on dialysis facility compare, or from the dialysis facility reports that we receive.

Charlene Podach: OK, OK, thank you.

**Operator:** Your next question comes from the line of Twyla Norquist.

Twyla Norquist: Hi, so in looking at my report, I just want to try to make sure that I can understand it. So if my – if my SRR number is 1.33 and it says, "As Expected," but I go into the, I think it's the third page or the third graph and it says percent of facilities with SRR is lower than yours is 89 percent. That means – that means I'm in the lower percentile, so I'm not doing as good as 89 percent of other facilities, is that correct?

Tempie Shearon: Yes, although that percentile ranked just your SRR itself and doesn't take into consideration the uncertainty in that estimate. So for instance, if you're a very small facility, that estimate might be very wide and I don't know how many patients you have or how many discharges there are. So the fact that your facility is classified as "As Expected" means that 1.3 isn't significantly bigger than 1.

Twyla Norquist: OK.

Tempie Shearon: OK, but yes, you're right, that – you're right in your interpretation of that percentile.

Twyla Norquist: And my interval went from 0.5 to 2.26, so my number ...

Tempie Shearon: Yes.

Twyla Norquist: ... falls right in the middle of that. It's a small unit, 20-some patients.

Tempie Shearon: Right, so right, so that's why it says "As Expected," it's because that – the fact that your interval is so wide means that we don't have very good confidence that we've got the right – we've got the right estimate for your facility. So, we don't – it's somewhere in that interval but that's a very wide interval, as you said. So, the estimate we have is our best guess at that value but it could be anywhere in that range.

Twyla Norquist: So, hearing that makes me a little bit nervous not knowing what the intent of using this number is, of what that's going to do to these smaller units.

Joel Andress: So, this is Joel at CMS again. So, again I can't – I mean I can't speak to how the measure will or won't be implemented in the future, I simply don't know at this point, but I can say that the – that the information that's provided on the dry run and the – that we receive as feedback for the dry run will certainly be considered in any implementation process as we're – as we're discussing it with the – with the associated program.

Twyla Norquist: OK, thank you.

**Operator:** Again, to ask a question, press star 1. And there are currently no further phone questions. I'm sorry, you do have one in queue, one moment for your next question. Your next question comes from the line of Susan Senich.

Susan Senich: Susan Senich, North Central PA Dialysis. This is giving us an opportunity to comment on our individual facility reports. Is the dialysis facility – is the dialysis community as a whole going to be allowed to comment on the methodology?

Tempie Shearon: So, during this – this is Tempie, during the dry run, we welcome any feedback on the methodology or specifically, you know, questions about your report or questions or comments about the methodology. So, that is – that is one of the purposes of this dry run.

**Operator:** One moment for your next question. Your next question comes from the line of Sara Holsen.

Sara Holsen: Yes, my question, I'm just trying to understand the ranking and scoring and the – one of the previous callers had mentioned that her score was 1.3, but her report stated that she was doing "As Expected," and earlier in the presentation somebody had mentioned that if your score was above – was above 1 and then you probably weren't doing so well. So, I guess I'm kind of confused on the relevance of that score if, you know, whether or not you're doing is, you know, as you should be and is dependent on your facility size and how many other factors is that going to be dependent on? Is it – is it possible that maybe there's a better way to do this rather than the score that may or may not be relevant?

Charlie Eleftheriou: Give us one quick second please.

Sara Holsen: Sure.

Jack Kalbfleisch: So, this is Jack Kalbfleisch, I'm a statistician at the University of Michigan. So, I guess when – whenever one is looking at a measure like this of anything, there's going to be variability in it and so that if you repeated things, trying to keep conditions exactly the same one year to the next, you wouldn't get exactly the same SRR. So even if you were operating exactly as the – as the overall national average all the time, your SRR would vary about 1 – sometimes it would be higher, sometimes it would be

lower. And so what we're getting here is an estimate basically of what your true performance is – and that's subject to error.

And that's what the interval is about, it's really trying to quantify how uncertain we are about the estimate, how much variability there is in that estimate. And – so the – so if an SRR happens to be above 1, that could just be random variation and that's – that's what we try to indicate in the interval or it could be – if it's large enough, it suggests there is something different about this – about this facility compared to the – to the – over national norm. Does that help?

Sara Holsen: It does and I think I am also – if this is a measure that CMS intends to implement as part of QIP or some other, you know, standardized program, I think public comment from the ESRD community would be a fantastic thing.

Jack Kalbfleisch: So...

Joel Address: This is ...

Jack Kalbfleisch: ... sorry, go ahead Joel, yes.

Joel Address: Yes, this is Joel from CMS. So of course, with regard to the QIP specifically, of course any measure that gets implemented there does go through public comment process as part of the standard rulemaking process. I think – I think another pertinent point to provide here is that if you look at the measures we're currently reporting on dialysis facility compare, you will see the standardized hospitalization ratio and the standardized mortality ratio, which are currently reported in the same fashion as you see on this report, which is that you have a table which labels them as – labels a particular facility as performing “As Expected,” “Better than Expected,” or “Worse than Expected” and then a table view that allow – I'm sorry a graph view that allows you to look at the point estimates, which is what the – which is what the ratio is, as well as the confidence interval.

So, what you're – so what you're actually looking at, and I think this is what Jack was describing, the point estimate is our best capacity to estimate your quality performance with regard to readmissions or – or in the case of the other – the other measures, hospitalization or mortality. And the confidence interval defines the degree of confidence that we – that we have or the extent – the extent of the precision of the measure. And so when we say that someone is “Better than Expected” or “Worse than Expected” as a facility, what we're saying is that the confidence interval demonstrates to us a high degree of confidence that their performance is better than or worse than their expected performance as its gauged by the overall performance of the – of the nation.

Sara Holsen: So, OK, thank you.

**Operator:** As a reminder, if you would like to ask an audio question, press star 1 on your telephone keypad. You have a followup question from the line of Twyla Norquist.

This document has been edited for spelling and punctuation errors.

Twyla Norquist: Hi, this is Twyla from Sanford in South Dakota. I just have one more question about, if this was – this report is to become a permanent part of – not this one but eventually if it's going to become permanent, would it be included in the existing Dialysis Facility Report that we're getting to – so that it will be kind of easier to find out the data that we look for?

Joel Andress: So, this is Joel at CMS. I'm not responsible for the Dialysis Facility Report or their production, so I couldn't tell you. I can say that certainly – certainly that's one possible place where these data could be reported.

Twyla Norquist: OK, thank you.

**Operator:** Again, star 1 to ask a question. And there are no questions at this time.

Charlie Eleftheriou: I guess we'll give folks another couple of minutes to – or a minute or so to ask a question if – if they have one or if they can think of one, press star 1 and we'll hold the line for a short while just to make sure no one else can think of any questions. And we'll give it another a few seconds or so and if we don't have any questions, we might wrap it up a little bit early today.

**Operator:** And there are currently no phone questions.

## Additional Information

Charlie Eleftheriou: OK, well I guess if anyone on the line can think of any questions or comments about your report, the website, or the national dry run process, go ahead and refer to slide 27, which provides you with information of how you can submit your questions or comments through the Dry Run website or by calling the help desk. Remember that the dry run comment period will end May 2nd. Facilities will not be able to access reports after May 2nd.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We'll also release announcements in the MLN Connects Provider eNews when they are available. On slide 29, you will find information and a link 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 Charlie Eleftheriou and I would like to thank the presenters and participants of today's call. Have a great day everyone. Thank you.

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

