



Dialysis Facility Data on Medicare.gov National Provider Call July 13, 2021

Moderator: Hello and thank you for joining today's Dialysis Facility Data on Medicare.gov national provider call. Our presenters are Golden Horton, Technical Lead for Dialysis Facility Data on Medicare.gov at CMS, and Andrea Curtis, Analyst, Clinical Standards Group, at CMS. Andrea will begin the presentation with information on addressing health equity in the conditions of participation. Then Golden will provide updates on data releases and measures updates. We will have a question-and-answer portion at the end of the presentation. To ask a question, please use the questions box in the webinar interface. Questions not answered during the webinar will be answered and posted with the other webinar materials on the ESRD General Information page after the webinar. Now I would like to introduce Andrea Curtis. Andrea, you may begin.

Andrea Curtis: Good afternoon and thank you for that introduction. Again, my name is Andrea Curtis, and I'm an Analyst in the Clinical Standards Group in CCSQ here at CMS. CMS periodically conducts a comprehensive review of the current health and safety standards, the Conditions of Participation, otherwise known as the CoP, and Conditions for Coverage, CfC, with the goal of evaluating the efficacy of the current standards and identifying opportunities for regulatory improvement. CoPs and CfCs are the health and safety standards that providers and suppliers must meet in order to receive Medicare and Medicaid payment. They apply to all individuals that receive care in a health care organization regardless of the payer type. These vary by provider, but generally cover issues such as care planning, governance, quality assessment and performance improvement, emergency preparedness, in patients', residents', and clients' lives.

In accordance with President Biden's three Executive Orders addressing issues of health equity, we are now evaluating how we can address health equity and improve health disparities through the CoPs and CfCs. We are committed to advancing equity for all including racial and ethnic minorities, members of the LGBTQ community, individuals with limited English proficiency, individuals with disabilities, rural populations, and individuals otherwise adversely affected by persistent poverty or inequality. In order to achieve these goals, we are asking for information, input, and ideas from the public for ways that we can address health equity within the CoPs and CfCs. We are asking for data, research, studies, and any other information that can help inform any potential changes to the CoPs and CfCs that we might make in the future.

In particular, we are looking for input on how we can ensure that individuals in underserved populations, particularly racial and ethnic minorities and those individuals with disabilities, know of their right to seek transplantation and how to pursue that option and receive appropriate support if they choose to do so. How we can increase awareness of known racial, ethnic, and economic disparity to care for chronic kidney disease and what other health equity concerns exist amongst these patient populations? How can organ procurement organizations, OPOs, encourage more individuals in underserved communities, including racial and ethnic minorities, to consent to organ donation? This would include ways that OPOs can improve their outreach and communications to those underrepresented communities. Are there any revisions that could be made to the transplant program CoP, or the ESRD facilities' CfC, or the OPO CfC to reduce disparities in organ transplantation? Further, are there ways that transplant programs, or OPOs, could consider social determinants of health in their policies relating to requesting consent, patient and living donor selection, or patient and living donor rights? How health equity can be improved during the care planning process and how providers can partner with community-based organizations to improve a person's care and outcomes after discharge. Ways to hold a facility's governing body and leadership responsible and accountable for reducing disparities within their facility and advancing health equity policies and efforts. How the CoPs can ensure that health equity is embedded into a provider's a strategic planning and quality improvement efforts. What types of staff training and other efforts are necessary to ensure that people receive culturally competent care? Ways to combat implicit and explicit bias in health care. How the CoPs could be improved to ensure that providers are not discriminating against individuals in underserved populations, particularly racial and ethnic minorities, those with disabilities, sexual and gender minorities, individuals with limited English proficiencies, and rural populations. Ways to reduce health disparities



amongst rural populations and increase access to care in rural areas. How the CoPs can ensure that providers offer fully-accessible services for their patients or residents in terms of physical, communication, and language aspects. And any other data or additional information or ways to ensure that a provider is addressing and reducing health disparities within their facility. We encourage you to submit any information you may have, and your valued input to the following mailbox: HE.Outreach@cms.hhs.gov. We will review the information that we receive and use it to inform a potential future policymaking. Again, our mailbox is: HE.Outreach@cms.hhs.gov. Thank you for your time. Now, Golden.

Golden Horton: Thank you, Andrea. All right. So, now we're going to discuss the Delay of October 2021 Dialysis Facility Data Release on Medicare.gov. Next slide, please. So, just a little background. Typically, dialysis facility data is updated quarterly on Medicare.gov with refreshes in January, April, July, and October. As many of you may have heard, though, due to data collection suspensions related to the COVID-19 pandemic, the January, April, and July of 2021 refreshes of data did not take place. CMS originally planned to update all measures during the October 2021 release. Next slide, please.

The ongoing EQRS users data suspension guidelines outlined via the January 29, 2021, EQRS announcement impacts available data for dialysis facilities. As a result, the October 2021 release of dialysis facility data will be delayed until Spring 2022. And data from the October 2020 release will remain on the Medicare.gov site until the next release. Additionally, star ratings will not be updated with this release. I wanted to notate we have an asterisk there and a website that you all can go to in reference to the EQRS announcement. Next slide, please.

So, Delay of October 2021 Data Release. CMS will continue to monitor and evaluate the impact of the EQRS data availability issue for the measures and will provide additional guidance on the specific timing of future releases of dialysis facility data on Medicare.gov at a later date. Later in this presentation we will review the measures that will be updated in the Spring 2022 release. Next slide, please.

So, we're going to discuss a little about the dry run of updated measures SHR, SRR, SMR, and STrR. Next slide, please.

So, just a little background. From 2018 to 2020, measures reported on Medicare.gov that are NQF-endorsed underwent comprehensive review. Measure specifications were reviewed, tested, and updated based on information since the last review cycle. So, as a result of this review, several measures were improved with the following measures receiving significant updates: Standardized Hospitalization Ratio for Dialysis Facilities, known as SHR; Standardized Readmission Ratio for Dialysis Facilities, SRR; Standardized Mortality Ratio for Dialysis Facilities, SMR; Standardized Transfusion Ratio for Dialysis Facilities, STrR; And we also have those in QF numbers. Next slide, please.

So, Dry Run July 15, through August 15, 2021. CMS plans to release facility-specific reports in order to allow dialysis facilities to preview updated calculations of the SHR, SRR, SMR, and STrR that we discussed on the previous slide. The measure specifications were updated to reflect the most recent version of the measure submitted to NQF. These results will not be reported on Medicare.gov until data for the end of the year is available and a regular preview period has been held. Facilities will be able to preview their report via the DialysisData.org website, similar to the typical quarterly preview process. Next slide, please.

So, we have a little table here in reference to the Dry Run. The CMS ECE policy restricts the use of claims data from March through June 2020. EQRS data incompleteness for the end of 2020 impacts data from the last three months of the year. A summary of data available for the measure in this report is provided in the table below. So, some of the things, just to give you a little information: The SRR has a shorter timeframe since it requires a follow-up period of at least 30 days in order to determine whether a readmission has occurred. A discharge in February would not have 30 days before the restricted period begins. Similarly, at the end of the year, two months are required in order to have the 30-day follow up and to allow for reporting delays in ascertaining readmissions. Next slide, please.



Summary of Changes. Medicare Advantage. Prior measure inclusion criteria based on active Medicare coverage identified through presence of Medicare inpatient and outpatient claims did not account completely for Medicare Advantage patients using dialysis and outpatient claims not available for MA patients resulting in unobserved events and comorbidities for these patients. Summary of Changes to Mitigate Bias added a variable for MA status, identified and added MA time at risk for risk adjustment, and MA patients are now excluded from STrR. One of the key changes we made was how patients with MA are handled in several of our measures that rely on Medicare FFS claims for determining time at risk, comorbidity information, and outpatient event. The changes were made because outpatient claims are not available for MA patients as a result of different payment structure of the MA program. The absence of outpatient claims potentially introduces bias into the measures listed here, which include SHR, SRR, SMR, and STrR as mentioned above, as those measures have relied on all available outpatient and inpatient Medicare claims for defining time at risk, comorbidity adjustment, and event identification. The measure's specific changes are described on the next few slides. Next slide, please.

So, Medicare Advantage changes. We have the STrR. The revised STrR excludes Medicare Advantage patients for three reasons. Marked regional geographic variation in Medicare Advantage dialysis patients were identified. Unable to identify outpatient transfusion events for these patients. Outpatient transfusions account for 15% of the transfusions in the chronic dialysis population. The source for the most claims-based diagnosis used for exclusion of patients from the STrR are derived from outpatient claims. Patients with Medicare Advantage are excluded from the STrR for several reasons. First, we found notable regional variation in the facility-level percentages of dialysis patients with Medicare Advantage. Second, and relatedly, we cannot identify transfusion events for MA patients if they occur in the outpatient setting, meaning that the facilities with a high percentage of MA patients may receive a very low or high measure score depending on whether the transfusion event happened in the outpatient or inpatient setting. And third, we rely on Medicare inpatient and outpatient claims to determine which patients should be excluded based on the presence of the exclusion diagnosis. Most of the exclusion diagnoses are derived from outpatient claims. Therefore, we would not be able to ascertain eligible diagnosis for MA patients due to the absence of their outpatient claims. By excluding MA patients altogether from STrR, we avoid introducing bias in facility scores. Next slide, please.

Okay. Medicare Advantage changes SHR. The SHR was revised in the following ways to mitigate bias. All time at risk for MA patients is excluded - included, excuse me, in the measure to mitigate bias related to definitions of Active Medicare Coverage based on inpatient and outpatient claims. MA coverage was associated with substantially lower hospitalization risk, we include an indicator in the model for the portion of patient months with MA coverage. And we also limit ascertainment of claims-based prevalent comorbidities for risk adjustment to inpatient claims using all available inpatient claims in the prior 365 days for both Medicare Primary FFS and MA patients. So, SHR was revise to better account for events and time at risk for MA patients in the measure. The changes were made because the SHR uses Medicare FFS claims for determining the eligible time at risk and comorbidity information for the SHR. Specifically, we now include all time at risk for MA patients. Prior time at risk was determined only on meeting the criteria of having active Medicare coverage based on the presence of paid outpatient claims or recent inpatient claims. However, because outpatient claims are not available for MA patients, relying on this criteria alone did not include time at risk for MA patients without an eligible inpatient event. This means that only a subset of MA patient time at risk was included, namely those with a recent inpatient event. Our inclusion of all MA time at risk addresses this bias. Another change we made was to include a variable measuring proportion of time a patient had MA coverage. This allowed us to adjust for potential differences for admission rates for MA dialysis patients who tend to have an overall lower risk of hospitalization compared to other Medicare FFS patients. Finally, we now only use inpatient claims for determining presence of prevalent comorbidities for both MA and FFS patients. This avoids the bias introduced by the absence of outpatient claims for MA patients. Next slide, please.

So, SMR. The SMR was revised in the following ways to mitigate bias. All time at risk for MA patients is included in the measures to mitigate bias related to definition of Active Medicare Coverage based on inpatient and outpatient claims. Limit ascertainment of claims-based prevalent comorbidities for risk adjustment to inpatient claims using all available inpatient claims in the prior 365 days for both Medicare Primary FFS and MA patients. Next slide, please.



The SSR was revised in the following ways. Limiting the identification of claims-based comorbidity adjusted inpatient claims both for FFS and MA patients. Added a model covariate that indicates whether or not the patient was Medicare Advantage at the time of index discharge. Next slide, please.

So, other changes. In addition to the revisions to account for MA patients, several other revisions were made including changes to the adjustment for nursing home status, changes to the adjustment for BMI requiring \$1,200.00 of paid Medicare claims for each patient month, up from \$900.00 to define Medicare Fee for Service Active Medicare Inclusion. So, several other changes were made to these measures. First, we included a more granular adjustment for nursing home status that distinguishes between the short-term nursing home stays-less than 90 days-and long-term stays-more than up to 90 days-in the past 365 days. In our testing, we found that patients with long-term nursing home stays tended to have higher risk for hospitalization and mortality. Next, we revised the categories for BMI to align with whose definition corresponds with underweight, normal weight overweight, and obese categories. Finally, we changed our definition of Active Medicare Status. Specifically we now require \$1,200.00 of paid Medicare claims for each month to define the patient month as Active FFS Medicare Patient and Eligible for Inclusion. Patients were also included if they had MA coverage. Next slide, please.

So, Spring 2022, Dialysis Facilities Data released on Medicare.gov. Next slide, please.

Spring 2022 Data Release. As we mentioned earlier, the October 2021 release of Dialysis Facility Data will be delayed until Spring 2022. And data from the October 2020 release will remain on Medicare.gov until the next release. Each of the measures will be calculated using most of Calendar Year 2020 data excluding the exception period of March through June 2020. The updated versions of STeR, SMR, SHR, and SRR will be included. Star ratings will not be updated with this release. The preview period will be held prior to the public release of these measures.

So, I've said a mouthful, so at this time I will turn it over to Tim - next slide, please - to see if we have any questions for any of you that are on the line listening.

Moderator: Thank you, Golden. We will now begin the question-and-answer portion of the webinar. As a reminder, you can submit a question using the questions box. Questions not answered during the webinar will be answered and posted with the other webinar materials on the ESRD General Information page after the webinar.

Our first question is to clarify, a facility's star rating will not be updated in Spring 2022?

Golden Horton: I'm sorry, say that one more time, Tim.

Moderator: Sure. The question is asking to clarify if a facility's star rating will not be updated in Spring 2022.

Golden Horton: That is correct, Tim.

Moderator: Thank you. Our next question is: when will the facility star ratings be reset to the bell curve distribution?

Golden Horton: That's an awesome question, Tim. Give us just a moment. Tim, we're going to get that response and we're going to add that because I don't know if we have a specific timeframe in reference to that. So, we're going to say at the earliest right now October 2022. But we're still working on that decision, so more to come on that.

Moderator: Thank you. Our next question is: will the SHR revision include incident comorbidities from the CMS 2728?



Golden Horton: A great question. Give us just a moment.

Claudia Dahlerus: Yes, this is Claudia Dahlerus, the University of Michigan. And yes, the SHR will continue to include the incident comorbidities on the 2728.

Moderator: Thank you. Next question is: am I to understand that patients with MA are not to be entered into CROWNweb?

Golden Horton: A great question. Give us just a moment.

Jesse Roach: We're not giving any direction with the data submissions specifically for this. However, you should be inputting the data for all dialysis patients into CROWNweb.

Moderator: Thank you. As a reminder, if you have any questions, you can submit them using the question box. Our next question is: what are the three distinct groups of patients used in the SHR model based on time spent in a skilled nursing facility?

Golden Horton: Tim, repeat that question one more time, please.

Moderator: Sure. What are the three distinct groups of patients used in the SHR model based on time spent in a skilled nursing facility?

Joe Messana: Yeah, good afternoon. This is Joe Messana from the University of Michigan - KECC. The three groups that are evaluated by the nursing home metric, those that have no nursing home exposure in the prior 365 days before the beginning of the observation period for outcomes. Second category is those patients that have 30 days or less exposure--nursing home exposure--in the 365 days prior to the beginning of the observation period. And the third group are those - I'm sorry, the second group is less than 90 days. The third group is greater than 90 days exposure--nursing home exposure--in the 365 days prior to the observation period.

Moderator: Thank you. Our next question is, will patient experience star ratings from the CAHPS survey also not be released in April 2022 or does that only apply to clinical star ratings?

Golden Horton: Thanks, Tim. We're going to take that question back to the CAHPS team, and we'll make sure that this response is posted along with all other unanswered questions.

Moderator: Great. Thank you, Golden. As a reminder, if you have any questions, you can submit them using the questions box. And as Golden mentioned, questions not answered during the webinar will be answered and posted with the other webinar materials on the ESRD General Information page after the webinar.

Jesse Roach: This is Jesse Roach from CMS. I want to just clarify a previous question about the Medicare Advantage patients and putting them in CROWNweb. So, the successor to CROWNweb is EQRS, and all dialysis patients should have that data entered into it. The reason that Medicare Advantage patients don't show up in some of those measures is because it relies on claims and data that are outside of the EQRS/CROWNweb system, and that's why the measures can't be fully calculated. But all patients should be entered into EQRS regardless of their insurance coverage.

Moderator: Thank you for clarifying, Jesse. If anybody has any additional questions they'd like to submit, please do so through the questions box. At this time we don't have any new ones. We'll give everyone a couple more minutes in case you have any additional questions you'd like to submit. Otherwise we will wrap up the webinar.

Golden Horton: All right. So, we don't have any questions at this time. I would like to thank everyone again for taking time out of your schedules to join today's webinar. We hope that it's been informational. This transcript



and slides will be posted onto our page. We'll send that information out. And, again, thank you all for joining. Enjoy the rest of your day.