

Centers for Medicare & Medicaid Services (CMS)

2016 Dialysis Facility Compare – Star Ratings Refresh

Held on June 22, 2016

WEBINAR

MODERATOR: Good afternoon, everyone, and thank you for joining the 2016 Dialysis Facility Compare Star Ratings Refresh. We will be hearing from various CMS subject matter experts today on various topics related to Dialysis Facility Compare and the star ratings. So, with that, we will begin the presentation with Elena.

ELENA BALOVLENKOV: Thank you. This is Elena Balovlenkov from CMS, and we're very excited to have you all join us today. Thank you for making time out of your busy day. Today, what we will be doing is we have a panel of speakers. You can see the topic slide agenda which says that I will be talking about the Dialysis Facility Compare overview and some enhancements and changes that we've made.

Chris Harvey, a research analyst for the University of Michigan, Kidney Epidemiology and Cost Center, which we'll be referring to as UM-KECC will be presenting the methodology, and then I will also be talking about some of the next steps that we'll be taking based on some of the recommendations we've had from the technical expert panel and others, and then Joel Andress will be talking about the new measures that have been added to the Dialysis Facility Compare website for information for the consumers. Next slide, please.

So, let's chat a little bit about the Dialysis Facility Compare Star Ratings overview. Next slide, please.

As you know, making decisions on where to receive care can be incredibly challenging, and this is not limited to just the renal community. In light of what we believe that patients have expressed to us in terms of how complex it can be to decide where to get care, CMS has gone along to improve and develop Compare sites in accordance with Presidential and Congressional mandate. People always say, "So why DFC?" Basically, what we are doing is supporting mandates that have come through the Affordable Care Act, CMS' national quality strategy, and also directives from the Obama Administration's digital computer set strategy to increase transparency for healthcare information for



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the consumer. Next slide, please.

So, what we're going to talk about today is a brief overview of the history of the star ratings initiative and where we are today. We will focus on looking at the star ratings and the perspective of providing information to patients as well as to describe the new methodology to assist providers in educating patients on how star ratings are obtained. So, our audience for this presentation are those that are consumers and patients and family members, patient advocacy groups, dialysis facility providers, physicians, facility administrators, and others who are interested in understanding better the DFC star ratings and the DFC website. What's most important here is that in addition to providing star ratings and data and information on the measures, we are also pleased to be able to provide other information that patients can use; things such as distance modalities and other information that patients have asked for to help them in selecting a facility. Next slide, please.

So, let's talk about what we did over the past year. I'm not going to read this slide. Basically, we've been busy. The slide deck will be posted after this presentation, but the key point is that the changes to the star ratings and the DFC website are being driven by recommendations from the 2015 TEP that was held last year, the advocacy group comments we're getting, the message from different patient focus groups, letters that we've received from you all, feedback that we've gotten from meetings. So this is very much an iterative process and a process that will continue to mature over time. Next slide, please.

One of the big things that's important about the DFC star ratings timeline is that by now you all have seen the Technical Expert Panel report that has been posted, the public comment period that has been posted and responded to. We've had multiple calls, discussions with individuals, and what we're moving into now is the preview period is coming up and then in late fall you'll be seeing, or mid-October, the star ratings refresh. So, what I'm going to do now is we want to be sure that you all understand and have an opportunity at the end of the presentation to ask questions about the information presented. So, I'm going to turn the talk over now to Chris Harvey, a research analyst from UM-KECC, who will be presenting on the newest star ratings methodology. Chris.



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CHRIS HARVEY: Thank you, Elena. So, over the course of the next few slides, I'll be discussing the star ratings methodology. We will briefly go over the original methodology implemented in January 2015, some Technical Expert Panel recommendations, and discuss the changes that will be implemented for the refresh this October. Methodology discussion will focus on components of the rating where the methodology has changed. For the interest of time, we will not be able to go into complete detail during this presentation, so additional information can be found on Slide 28 of the slide deck where we link the original and the updated methodology technical notes, as well as the Technical Expert Panel reports and recommendations. Next slide, please.

Here on Slide 8 we list the measures used in the DFC star ratings. We note that these are the same measures used in the initial release of the star ratings. The first three measures listed are reported on a ratio scale measuring observed over expected events. These measure patient transfusions, mortalities, and the hospitalizations in a given facility. Additionally, there are four measures that are on a percentage scale. We have a combined measure of waste removed from blood during dialysis as measured by Kt/V from three separate modalities of patients. These are measures listed with an asterisk at the end on this slide. Finally, the star ratings utilizes hypercalcemia measures and catheter and fistula measure. Next slide, please.

On Slide 9 we give a brief overview of the original methodology that was used in the DFC star ratings. The first step involves scoring the measures so that they were compatible to be combined. In the original star ratings methodology, all of the measures were given probit scores, or rank scores that follow a normal distribution. In this application, scores ranged from 0 to 100. After scoring, the weight of each measure was determined based on the correlation of the measures in the ratings. Groupings or domains of more correlated measures were constructed from the aid of correlation tables and factor analysis. Measures are equally weighted within a domain to give a domain score and domains are then equally weighted in creating a final facility score that has potential values ranging from 0 to 100. On the other hand, the updated methodology has the same domains as in the original methodology and those interested in more detail can see the original and updated technical guide.



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Finally, in the original methodology, star ratings were created directly from the domain scores, which were then, so the domain scores were combined to create a final score and then 10% facilities received five stars, 20% four stars, 40% three stars, 20% two stars, and 10% 1 star based on these final facility scores. Next slide, please.

So here in Slide 10, we discussed recommendations given by the Technical Expert Panel, abbreviated as TEP here. As shown in the timeline, the star ratings TEP met in April of 2015. TEP had two work groups: the Methodology Workgroup and the Public Reporting of Patient Consumer Understanding Workgroup that had separate and combined sessions. The technical expert panel discussed the validity of the current implementation of the star ratings system and provided discussions and recommendations on what could be implemented in the future. The panel also commented on the measures used in the rating and had discussions and recommendations regarding retirement of measures and future implementation of measures in the rating. Additionally, the panel commented and gave recommendations on the readability and presentation of the star ratings on the Dialysis Facility Compare website. Next slide.

So here on Slide 11, we described the TEP recommendations that are reflected in the updates of the methodology. The full TEP report can be accessed from the information on the resource Slide 28. In assessing how the original methodology handled the current measures available, the majority of the panel agreed that setting thresholds or setting a baseline to evaluate performance in the star ratings is preferred over relative rankings that update each year, where possible. In response to the updated methodology now defines all scoring and rating criteria based on the empirical analysis of a baseline year, which we will elaborate on in the coming slides.

Comparing the data in the current reporting year to the baseline standards allows us to directly track the study performance over time. That is, the new star ratings are constructed in such a way that a facility will receive the same rating that they would have received in other reporting years that calculate the star rating with the same baseline year.

The TEP also desired that the scoring of the measures accounted for the fact that some had skewed



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distributions. That is, some measures had mostly top performers and few facilities trailing in the tail. In response, the updated methodology accounts for highly skewed measures by scoring the four percentage-based measures with these scores. Scoring with these scores allowed the distribution of measured scores to better reflect the distribution of measure values. Therefore, with the skewed measures, performance differences between clustered top-scoring facilities would not be overstated. Additionally, we truncated these scores so that all measure scores are within the same range of values. This ensures that the star ratings are not completely determined by extreme outlier performance on a single measure.

And finally, the panel agreed that the accuracy of the ratings needs to be ensured throughout the update process. We addressed the accuracy of the ratings by reflecting the continuity of the measures in the measure scores. These scores and probit scores used in this rating differentiate facilities across the range of the measure preserving more information in the rating and scoring measures into a few categories. Next slide, please.

Slide 12 summarizes the three specific changes that were made to the star ratings methodology. We compared the original to updated methods side by side with changes in bold for clarity. For complete details, the updated DFC star ratings technical notes can be accessed on resource Slide 28. In the top row, we indicate the first change in the way we scored some of the measures. In the original method, probit scores were used for the four percentage-based measures. For example, the percentage of patients with hypercalcemia. Now, truncated Z-scores are used for the four percentage-based measures.

In the second row, we indicate the change in baseline that determines scores of measures. Before measure scoring criteria was changed relative to the current calendar year being reported. Now, we implement relative scores, both probit and Z-scores, in a baseline year and fix this criteria to calculate measure scores in current reporting years that use this baseline.

Finally, we indicate the change in baseline that determines the cutoffs that give a star rating to a final facility score. Before, cutoffs were determined based on criteria that put specific percentages of

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facilities in each category in the current reporting year. Now, the updated methodology uses the same criteria, but fixes these cutoffs in the same baseline year that was used to score the measures. Therefore, under the same baseline year, facility ratings across years are directly comparable and absolute improvement can now be observed. Next slide, please.

To illustrate how we might expect a distribution of ratings to change over time, Slide 13 shows an example with the original methodology in the updated methodology. The dark blue bars represent the fixed percentages of star ratings used in the original methodology; here implemented on data reported in 2014. The light blue bars represent what the distribution would have looked like if the updated methodology was applied in 2014 as the current reporting year with 2013 reporting year data set as the baseline. We can see here that the population improvement of facilities resulted in approximately 5% more four and five star rated facilities in the percentages in the originally defined categories. This gives an example of how population improvement affects the number of facilities in each star rating category over the course of a year.

Again, we note that this data here on the slide is just an example. In the October 2016 release of the star ratings, 2014 will be used as the baseline year and the current reporting year will be the 2015 calendar year of data. Next slide, please.

The table on Slide 14 uses the same example as on the previous slide. In cross tabulation, a number of facilities in each star rating category with the original methodology in the rows, against the updated methodology in the columns. The percentages on the far right are the percentages in each star rating category for the old methods, the same as the dark blue bars on the previous slide. The percentages on the bottom are the percentages in each star rating category for the updated methodology example, the same as the light blue bars on the previous slide. This table gives a more in-depth look at how facilities are rated differently with the two methods. For example, in the top left we can see that the updated methodology rates 218 facilities as two stars that the original methodology rated as one star. This difference is due to both the shift in the star rating percentages and the difference in measure scoring. You will also notice that very few facilities were actually



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rated lower with the updated methodology even though there was population improvement from the baseline year. For instance, in the top left we can also see that six facilities were rated as two stars in the original methodology, but as one star in the updated methodology. This represents changes attributable to the new measure scoring used for the percentage base measures. These few numbers to the left of the diagonal is just one example that shows that the new measure scoring does not change the ratings all that much. Next slide, please.

On Slide 15, we again use the same example with 2013 as the baseline year and 2014 as the current year of data being reported. When the original methodology was implemented, we reported a table similar to this one and pointed out that the star ratings was able to capture consistent increases and average quality on each measure with higher star ratings. We also show that the updated star ratings also has this quality for the average facility in each star ratings category. To illustrate, we look at the SHR row. The average one-star facility has the SHR of 1.31. In this average, SHR decreases or improves with higher star ratings. We observed a similar increase in quality across star rating categories for all the measures in this rating. Additionally, you may notice that the new final score is now on a different scale than 0 to 100, reported previously. It actually ranges from -2.58 to 2.58, as described later in the presentation. The new final score, however, has a 0.9 correlation with the old final score which is pretty high further illustrating the small impact of the new measure scores on the star ratings. This new final score that facilities are rated on is shown near the top of the table, also has consistent average increases in each category by approximately 0.4. That was for a single year we move from the baseline, the star ratings seems to still possess these good qualities for the average facility in each star ratings category as we reported for the original methodology. Next slide, please.

Now that we have seen the overarching takeaways from the changes, we will talk a little bit more about the specifics. The description here will be quick out of necessity, but for those interested, the full details including why the specified ranges of values for measure scores were chosen can be obtained in the updated technical notes on resource Slide 28.

In the new methodology, we establish scores for the percentage-based measures. That is Kt/V ,



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hypercalcemia, catheter, and fistula measures by calculating Z-scores for these measures in the baseline year data. Calculating Z-scores, which involves subtracting the mean and dividing by the standard deviation, is often called standardization, and we'll make a note that this refers to standardizing variance and not adjusting for confounders such as the meaning of standardized mortality ratio.

The baseline year's Z-scores are then truncated and re-standardized. The final product results in the baseline year measure scores having all of the same range, -2.58 to 2.58, a mean of 0, and a standard deviation or variance of 1 in the baseline year. The values used to perform the scoring are then saved and used for application in the current reporting year. Next slide, please.

Here on Slide 17 is a visual of what the distribution of truncated Z-scores looks like. On the left, we have the original distribution of Kt/V. We see that many facilities have high scores and very few facilities are in the tail with low scores. On the right, we show the distribution of the truncated Kt/V scores. Remember that the original methodology score based on range that follow a normal distribution. We can see that the new scores better reflect the shape of the actual measure value than a normal distribution. That is, facilities that score highly on the measure get similar scores. Additionally, non-truncated Z-scores could give values as low as -10 which could possibly determine the rating from one measure. Truncation avoids this by allowing all measures to be scored within the same range and the values in the tail to be stacked on the left side of the measure as we can see on the figure on the right. Next slide, please.

Previously, we described how the truncated Z-scores were calculated. We standardized, truncated, and then re-standardized a measure so that the measure scores are within our specified bounds. The values that we use to standardize, truncate, and re-standardize effectively define the criteria that decides scores for measure values. Therefore, the criteria used in the baseline year is saved and applied to our current year for reporting. This allows facilities to be scored by exactly the same criteria in years where the same baseline is used. Next slide, please.

On Slide 19, we describe measure scoring for the standardized ratio measures. First, we note that

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there's a caveat when it comes to calculating scores for the standardized ratio measures. However, these standardized measures are relative measures from the start since the expected number of deaths or events is based relative to the population facilities in the current year. To score in a more absolute fashion, the current year facility ratios are multiplied by an adjustment factor to account for the differences in population event rate between the baseline year and the current year. This gives a better picture of the measure values as they would have been scored by baseline year standards.

Here we will also note that probit scoring, which gives rank scores that follow a normal distribution, was maintained for the ratio base measures. This is because Z-scores assume that the differences in measure values hold the same meaning across the entire range of the measure. This seems to be a strong assumption to make for ratios, so probit scoring was maintained. Probit scoring is performed in such a way that the range of scores is from -2.58 to 2.58, explaining the decision to truncate these scores at these values as well, and more information on these values is located in the technical guide.

Probit scoring is then performed in the baseline year data to determine the criteria that assigns scores to the measures. This criteria is then applied to the current year for reporting after implementation of the adjustment factor. In summary, this scoring allows all measures to have the same range of values with mean and variance stabilized in the baseline year. Next slide, please.

Now that we have described measure scoring, we'll describe how the star ratings are assigned. In the October 2016 release, 2014 reported data will be used as a baseline year and 2015 data will be reported as the current year. So, in the baseline year, baseline year facilities have their measures scored as described in the previous slides and measure scores are combined to give facilities final scores as in the original methodology. The star rating cutoffs are then taken so that the baseline year would have 10%, 20%, 40%, 20%, 10%, five through one star facilities respectively as we had in the old methodology.

Now we have established measure scoring criteria and final score cutoffs defined based on a baseline year. These baseline year cutoffs are retained for determining star ratings for current reporting years that use this baseline. Now, to assign star ratings in the current reporting year, the current year



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measures are scored with baseline criteria and combines so facilities have final scores. These final scores are then given star ratings based on the cutoffs defined in the baseline year. As shown previously, this resulted in 5% more four and five star ratings when the current year was one year removed from the baseline.

While the description may seem complicated in this presentation, defining measure scores in star rating cutoffs in this manner based on the baseline allows the dialysis community to observe the changes in facility performance over time and directly compares star ratings across years based on absolute rather than relative standards.

Finally, we note that measure scoring and star rating cutoff criteria is maintained in subsequent current reporting years until a new baseline year is established. So, this concludes the description of the star ratings updated methodology, and I now pass the presentation back over to Elena. Thank you.

ELENA BALOVLENKOV: Thank you very much. This is Elena Balovlenkov from CMS. So, let's move on to the next slide where we talk about the next steps. One of the things that's important to remember that we've emphasized since 2014 when we first talked to you all about the development of the star ratings and changes to the Compare site is that this work is ongoing and one of the things that we've talked about is the need to move forward, and some of these things will be such as evaluating when to re-baseline the star ratings, investigating empirical solutions, publishing new data on Dialysis Facility Compare in October 2016, and Joel will talking about that in a few minutes.

The most exciting thing that we believe is that as a result of our continued dialogue with the renal community, especially the patient advocacy groups and patient focus groups is our ability to report results from the In-center Hemodialysis Consumer Assessment of Healthcare Providers and Systems patient survey that will be posted semi-annually, and more importantly, were going to talk about introducing the new quality measure that you'll see on the website. Next slide, please.

But before I turn the presentation over to Joel, I do want you to know that we also listened to the



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focus groups and to patients on the discussion relative to making improvements to the DFC website. So, one of the things that we believe has been helpful is just as before we took recommendations from the patient community through focus groups, feedback from the TEP, feedback from the consumer advocacy, and some of the changes currently taking place is we continue to meet with the community for feedback, we're meeting with advocates, we are looking at reducing redundancy, improving static text, continuing to reach out to the different provider groups, meeting with advocates. As a result of that, we are looking at revising content, revising definitions, labels, reducing some of the re-work with people having to go back and forth between certain parts of the screen, updating the video and as we move forward and continue to move with the community and get feedback from you all we will continue to make changes as I stated. This is very much an iterative process, and we look forward to making changes moving forward. Next slide.

I will turn the presentation over to Joel Andress, our Lead Measure Developer from Dialysis Facility Compare, and he'll be talking about the new measures. Joel.

JOEL ANDRESS: Thank you Elena, and good afternoon to you all. As Elena said, I'm Joel Andress, and I am the ESRD Quality Measures Lead for CMS. In past years, we've added measures to DFC based upon an internal process, and it seemed adequate to us given the limited number of measures on the website, and the relatively low degree of attention to the site itself. However, as more measures have been developed and added and as the star ratings were introduced to the website, it became clear that we needed to introduce a more open process for including new measures that incorporated an opportunity for the public to provide input both into measures that we're proposing as well as measures that we are – that may be considered by the community appropriate that we have not yet presented to them.

In October of last year, we presented a set of four quality measures we were considering for inclusion on DFC in 2016 and requested that stakeholders provide us with comments on these over a period of 60 days, as well as any additional measures that they believe were appropriate for consideration.



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In January, we announced three new quality measures that we intended to implement as of the October 2016 release for DFC and in the intervening time we've worked with our partners at the CDC and with the patient experience surveys to ensure that we have the data necessary to include these measures in your July facility preview reports and the public report facility performance beginning in October. I want to stress that these measures are new to DFC and are not included in the current star ratings that you will be previewing beginning in July. However, they may be considered for inclusion in the star ratings at some point in the future. You can go to the next slide, please.

We have received substantial interest from providers, patients, and patient advocates for the inclusion of the patient experience survey or ICH-CAHPS on DFC. Now for the first time, we have sufficient data to be able to implement ICH-CAHPS on DFC for the community. We're using NQF endorsed measures for the CAHPS, and we'll align our public reporting on DFC with that of the hospital CAHPS on Hospital Compare. The survey will include three items that summarize responses to questions about kidney doctor communication and caring, the quality of dialysis center care and operations, and the sharing of information with patients by the dialysis center. Three additional items will present patients' assessments of their experiences with kidney doctors, the dialysis center staff, and the dialysis facility. We can go to the next slide, please. Thank you.

The second measure we will be implementing in October is the NHSN standardized blood stream infection ratio, or SIR. This was developed and is calculated using data collected by our federal partners at the CDC and should be familiar to everyone from the ESRD QIP. The measure assesses a facility's performance in minimizing blood stream infections among its patients and will be reported in a similar fashion to our other standardized measures on DFC.

An SIR greater than a 1 indicates that a facility experienced more infections than predicted, while an SIR of 1 indicates that a facility experienced the same number of infections as would be predicted by their case mix. And an SIR of less than 1 indicates that a facility experienced fewer infections than predicted and reflects higher quality of care. Next slide, please.



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The final measure that we are implementing for 2016 is the Pediatric Peritoneal Dialysis Kt/V Dialysis Adequacy Measure. This expands our current set of dialysis adequacy quality measures to include pediatric patients receiving peritoneal dialysis, and the general design and approach to the measure and measure reporting will be identical to that seen in our existing Kt/V adequacy measures. Of note, is that this and our other Kt/V measures have been updated to meet current endorsed standards following the NQF maintenance endorsement project last year, and now, I'll hand over the discussion to Elena who will discuss some of the resources available to you.

ELENA BALOVLENKOV: So, as we said, in the interest of time and being able to allow you all to have an opportunity to ask questions, what we've done is given you a high level overview of what is occurring on the Dialysis Facility Compare website, to see that and recommendations that were implemented by CMS based on the recommendations from the TEP and from the community. There are two slides within the packet, and again, the slides will be posted, that give you an opportunity to go forward and do some more in-depth information searching. Notice the last bullet, which is very important: it says, for additional information about the star ratings methodology, measure specification, please email the University of Michigan UM-KECC and Cost Center at dialysisdata.umich.edu. We look forward to getting information and questions from you all because we know we won't get to everyone's questions today.

I'm also very excited that we have the following organizations represented who are available to answer questions for us. You have myself and Joel from CMS. We have representatives from the Center of Medicare and Division of Consumer Assessment and Plan Performance affectionately called the ICH-CAHPS measure, UM-KECC, and we also have the Center for Disease Control. I will turn the presentation back to our moderator, who will tell you how to submit questions at this time so that we can answer or accept comments on anything that you have to add. Thank you.



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QUESTION AND ANSWER SESSION

MODERATOR: Thank you so much, Elena. So yes we will now open the line for questions. If you have a question, you can either raise your hand or enter your question into the question box, and we can read it aloud. We have already received some questions, so we will go ahead with the first from Kim. She wants to know, “She opened her clinic in March 2015. What will mine be based on, and where will I receive the score?”

JOEL ANDRESS: Hello, Kim. This is Joel at CMS. It depends in large part on when your facility was opened. Because if we don't have enough data for our quality measures to be able to establish reliable scores, then we do not provide results for those measures and if we do not have enough results for the facilities' measures then we do not provide a star rating for that facility. So it would be dependent on when the facility was open and whether or not it met the criteria for the individual measures on the website.

MODERATOR: To clarify, Kim provided when the clinic was opened, and it was March 2015.

JOEL ANDRESS: So Kim, I think it would be difficult for me to say whether or not facility was included because it also depends on the size of the facility and the number of patients going through. If you want us to address the question specific to your facility, you can reach out to the Dialysis Data Help Desk, and they can talk with you about the specifics of your case and let you know whether or not you should anticipate an assessment. It will also be made clear on the Preview Report that goes out July 15 whether or not you will be receiving a star rating on the website.

MODERATOR: Okay. Great. Thank you, Joel. We will now move to the next question. Herschel Embry wants to know if you can explain the Z-scores method.

JOEL ANDRESS: I think we'll turn this over to the University of Michigan to provide additional explanation to the Z-score method, but before I do so I will point out that the in-depth description of the method is going to be found in the technical notes which we linked to in the resources.



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CHRIS HARVEY: So, a Z-score is the standard method of making sure that all of the measures have the same variance. So all it is, is it takes all the values of the measure and subtracts the mean and divides by the standard deviation. So, that gives a measure with the same distribution but now with the mean of 0 and the variance of 1. And then all we did additional to that was truncate so that the tail wasn't too long. But like Joel said, all additional information is also on the technical guide.

MODERATOR: Thank you, Chris. We will now take the next question from Ann Stone. Ann, your line is unmuted. Ann Stone, are you there? Okay, we'll move on to the next question. The next question is from Stephen Valderrama. Stephen, your line is unmuted.

STEPHEN VALDERRAMA: Hi. Thank you for this presentation. This has been really helpful. I've submitted some questions via the chat, so I'll wait for those, but one question I have with respect to the adjustment factor data used for the ratio metrics. Where and how can we get that specific information so we can try to replicate the 2013 to 2014 baseline calculation that UM-KECC has completed?

JOEL ANDRESS: I'll turn this over to the University of Michigan as well.

KAREN ANN WISNIEWSKI: That should be a part of the downloadable data that you will find during the preview period on dialysisdata.org.

STEPHEN VALDERRAMA: So, how about for the 2013 baseline adjustment national data that you used for your technical documentation because I'm assuming the preview data will be for 2014 baseline?

KAREN ANN WISNIEWSKI: Can we ask for a little more clarification? Are you asking for the model parameters?

STEPHEN VALDERRAMA: Well if you have the code in FAS or SPSS that would be ideal, and we'd love to see that specific code and deconstruct it. But if I'm having one question, my question is the adjustment factor data for the ratio metrics, the way the technical documentation states, national



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average I believe or national data for the rates for transfusions, mortality, and hospitalization. I'm asking specifically where we can get the 2013-2014 data so that we can replicate your findings in the technical documentation provided?

KAREN ANN WISNIEWSKI: Can you submit that to dialysisdata.org, and we can take that under review?

STEPHEN VALDERRAMA: Certainly.

KAREN ANN WISNIEWSKI: Thank you.

JOEL ANDRESS: Please do submit the question so we can address it in writing. I think the other piece to it is that there's a certain amount of information that we include within the downloadable data base, some of it we have not, we don't present everything at this point into the downloadable. If there is additional information that facilities or providers believe would be helpful to understanding the score than we would certainly be willing to take comments on what that information would be so that we can consider how it can be as transparent as possible.

STEPHEN VALDERRAMA: That would be great, we'll submit our questions. I think we've submitted some questions to UM-KECC but perhaps we weren't very crystal clear in some of our asks. So we'll send a set of questions regarding the new methodology.

MODERATOR: Great. Thank you. We will now move on to the next question. An attendee would like to know if someone can explain empirical solutions.

JOEL ANDRESS: I'm not sure we understanding what you're asking, but what I understand you to be asking is to clarify what empirical solutions are. I think that broadly speaking the answer to that is that we analyze the data and allow those to inform our decision making about different parameters within the scoring methodology. Is there anything in particular that you have a question about or was it just broadly what we mean by empirical solutions?



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MODERATOR: Thanks, Joel. The attendee didn't provide any additional context in the question box, so Herschel, if you can do that, we'll be happy to read that aloud, but in the meantime, we'll move on to the next question.

ELENA BALOVLENKOV: Or you can also – please also if you feel that you need more detail or need to provide more clarity, please send it to the helpdesk, and we'll make sure that we look into it and respond.

MODERATOR: Great. Thank you, Elena. So, we'll move on to the next question. It is, do you have a data dictionary and a file/table structure?

KAREN ANN WISNIEWSKI: We do have a data dictionary, I'm not quite clear what you mean in a file/table structure. But the data dictionary will be available on dialysisdata.org.

MODERATOR: Okay. Thank you, Karen. Moving on to the next question. It is what adjustment parameters will be included in the standardized BSI? I am specifically wondering about the use of CVCs for dialysis.

JOEL ANDRESS: We'll hand this over to our colleagues at the CDC for response.

PRITI PATEL: So vascular access type, including CVCs, is something that the measure is adjusted for.

MODERATOR: Thank you. We will now move on to the next question from Cathy Greenwood. Your line is unmuted.

CATHY GREENWOOD: Yes. Thank you for this call. I have a question about the metrics. I have a patient that is transfusion dependent. So, she can get up to 8 units or more a month and she's hospitalized frequently. So it's really killing our QIP score right now and absolutely going to feed into this as well. When you say I can put a comment, would that not be HIPAA? I'm not familiar with how to make the comment and how that process is handled.



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JOEL ANDRESS: So what you can do is submit, we have a help desk box at dialysisdata@umich.edu. Then you can submit questions or comments to that desk. So, in this case what I would suggest is that you describe the circumstances for your patient and your concern about how it is impacting your score and we can take a look at what your score has been in the past and what the potential impact has been. From there it's a question of going through the measure maintenance process which is an ongoing process for all of our measures. We can consider how that circumstance might either be addressed now or how it might be addressed in the future to measure modifications. Does that answer your question?

CATHY GREENWOOD: It does, it's just concerning because with the push to move our patients home, which we do a good job, the ones that we have in the center are usually not healthy enough to go home, and I just think that it's going to get more and more difficult. I just wanted to know how to submit through the help desk the best way when there's a concern like this.

JOEL ANDRESS: I think the general response to your concern is that we develop our measures and we're always trying to improve upon them. We certainly benefit from the kind of input that you're providing, so we would very much look forward to you contacting us in writing with the issue, and then we can touch base with you and start talking through what it may mean for the measure itself.

CATHY GREENWOOD: Thank you.

MODERATOR: Great. We will now move on to the next question which is, "Is there a place where we can see the actual ICH-CAHPS question numbers that are used to come up with the ICH-CAHPS score?"

ELENA BALOVLENKOV: Yes, so we have provided a link within the resources that takes you to the ICH-CAHPS website that describes the questions, the tools, that are being used, as well as methodological details for the overall survey. In terms of the questions that will be presented on the site, you will see those in the preview period on your preview port and you'll be able to review them at that time.



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MODERATOR: Yes. Thank you. We'll now move on to the next question which is from Shu-Fang Lin. The line is unmuted. You can ask your question.

SHU-FANG LIN: On Slide 25, what "data adjustment" was performed on ICH-CAHPS score so facility can be compared fairly?

ELENA BALOVLENKOV: 25?

SHU-FANG LIN: Yes.

ELENA BALOVLENKOV: Could you repeat the question, please?

SHU-FANG LIN: So, what data adjustment was performed on ICH-CAHP score so the facility can be compared fairly?

DEBRA DEAN-WHITTAKER: Yes, there are two. We are planning on doing what is considered a patient mix adjustment and a mode adjustment. The patient mix adjustment is intended to backup differences that we know exist between different groups of people regardless of the quality of the care. Example – in general young people seem to be more critical of their care than older people. So, one candidate for adjustment is age. And there are others. So we are going to do a patient mix adjustment. We are also going to do a mode adjustment. The survey is offered in three different modes. One is mail, second is telephone, and the third is mail with telephone follow up. It is known in the survey community that the mode of which the survey is given does sometimes have an impact on the responses; therefore, we will adjust for the mode. These adjustments will both be made for the publically reported data.

SHU-FANG LIN: So the July preview data that will included those adjustments?

JOEL ANDRESS: Yes, the preview data that are made available in July which will then be publically reported in October will include both forms of risk adjustment.

SHU-FANG LIN: For ICH-CAHPS, is that released semi-annually? So for the July review, will it



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be 2015 fall survey, or both spring and fall?

DEBRA DEAN-WHITTAKER: Yes. We have a spring survey and a fall survey and the release in October will cover the spring and fall 2015 data.

SHU-FANG LIN: Okay. Thank you.

MODERATOR: Okay. Thank you, and I'll take the next question from Stephen Valderrama. Your line is unmuted.

STEPHEN VALDERRAMA: Just a couple of follow up questions I think you guys might be able to answer very quickly over the phone. With respect to coming up with your final scores, the document sort of implies this, and I think you implied this earlier, but is it just taking the average of each metric score within the domain and then averaging all the domain scores together for a final score? Obviously excluding any imputation or PD-only facility call outs that you've mentioned in the technical notes.

JOEL ANDRESS: This is Joel, and we'll send this over to UM-KECC for response.

CHRIS HARVEY: It seems that you explained that correctly.

STEPHEN VALDERRAMA: Okay, great, and then for the CDC folks, on the reference rate to calculate SIR, my colleagues have told me that the latest rates are not available; I think we're using rates from a year or two ago. Do you have any idea when we might see the reference rates for the SIR calculations for vascular access, CVC, AVS, and so on?

JOEL ANDRESS: This is Joel, and we'll send this over to our colleagues in the CDC.

ALICIA SHUGART: So there are a few different places where data would be available. We are currently working on an update within the NHSN application where benchmarking can be done in the analysis section. We expect that will be done hopefully sometime later this summer. We also



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have those rates available currently just as a document on the website for reference. If you go to the dialysis event homepage, under CMS supporting resources, there's a document that's labeled 2014 BSI Rates by Vascular Access Type and it's a single page that just lists tables with the vascular accesses and BSI rates for each one for 2014.

STEPHEN VALDERRAMA: And so then are you saying that your analysis that you'll be completing by the end of this summer will result in those tables being updated and those documentation being updated with 2015 rates?

ALICIA SHUGART: No. It's 2014.

STEPHEN VALDERRAMA: So, it will stay 2014 – like when do you think you'll have the 2015 data, I guess, is the question.

ALICIA SHUGART: So just to clarify, the 2014 rates will still be the baseline that's used for SIR calculation. So, the information that CMS reports will still be the 2014 rates. What will get updated in application is that you'll see new 2015 data that you can compare to, but that's not so much relevant for CMS' purposes. Does that make sense?

STEPHEN VALDERRAMA: Got it. Got it. Okay. Thank you. Joel, just one last question. You made a specific point to call out that ICH-CAHPS will not be a part of the 2016 DFC refresh or 5 star refresh, I should say the 5 star results. But that call out was not made with SIR or the Pediatric PD metrics. Should we assume that for the star ratings that will be published in October 2016 that will preview here in about a month will not include those the SIR and pediatric PD metric as well?

JOEL ANDRESS: The NHSN and blood stream infection measure and the pediatric PD Kt/V review measures will not be in the 2016 star ratings calculations. That is correct. Actually I saw that as I was going over the slides this morning and I wondered if anyone was going to pick up on that. But no, none of these three measures will be included in the star ratings at this time. Which is not to say that they cannot be available for inclusion later.



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ELENA BALOVLENKOV: And if you look at the presentation slides that Chris Harvey gave, he actually noted the measures that are included in the star rating and they are the same measures that were included, reported on, before.

STEPHEN VALDERRAMA: Yep, just wanted to clarify that the other callout was made and I just wanted to make sure we're all on the same page. Great thank you, Joel.

MODERATOR: Great. Thank you. Moving on to the next question. I'll read it aloud. It says, "Can you please explain the difference between DFC Compare Total Performance Score and QIP Score? Is Total Performance Score related to star ratings?"

JOEL ANDRESS: To clarify, the TPS is a formal part of the calculation that goes into the payment determination for the ESRD QIP. The TPS is not something that is associated directly with the DFC star ratings and nothing that gets calculated specifically for the QIP determination gets factored into the star ratings. Nothing about the calculation for the star ratings gets factored directly into the payment determination for the QIP. There is overlap in quality measures that are incorporated, but the actual calculations for the two programs use different methodologies and are intended to accomplish different policy objectives for each of the programs.

MODERATOR: Thank you and moving on to the next question. Actually, before we do that, we just want to let everyone on the line know that we only have about three minutes left. We will try to take as many questions as we can in that time. We will be sending a note following the call with more information on where the slides will be posted and where you can submit questions if we weren't able to get to you today. So, the next question is, "Are the five stars still distributed in the 10% bottom and top and 20% four stars and 20% two stars and the 40% in the middle with three stars?"

JOEL ANDRESS: So we have used this distribution to calculate the cut offs in the baseline year. And those specific cut offs are what we compare facility performance in the performance year against. So as we noted in our example, we actually moved out of the 10-20-40-20-10 distribution



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when we compared facilities performance to the cutoff determined in the baseline year. So as a consequence of that, our example here using 2013 as the baseline year and 2014 as the performance year, we can see that we have 15% 5 star facilities, 25% 4 star facilities, 38% 3 star facilities, 15% 2 stars, and 6% of the facilities received 1 star. So we use the original 10-20-40-20-10 split to assign the cutoffs from the baseline year. Those cutoffs will remain static until we re-baseline. But, the facility performance can vary from year to year and overall performance will be compared against those cut offs. So, the facilities are not restricted to the specific split as they were in the original methodology.

MODERATOR: Yes. Thank you very much, Joel, and that was actually all the time we have for questions. We will now turn it back over to Elena.

ELENA BALOVLENKOV: Hi. This is Elena, and I want to thank you all for the opportunity to present the new methodology information about the new measures, and again, to clarify the new measures. They're not part of the star ratings, but they're to help provide information, one, for patients and also, two, to providers to help in educating your patients in terms of what this means or what is occurring in your clinic. Additionally, please do not hesitate to use the helpdesk information that we gave you to reach to us for any questions that were still left in the queue. Or if you didn't have an opportunity to actually enter your question, and we look forward to that and then also please remember we have the preview period coming up which will also allow you the opportunity to ask questions relative to the data that you see during that preview period. I want to thank you all very much and let you know that we will also be planning a call again later this year where we will be talking again about the star ratings with the different community groups and also providing an opportunity to respond to different questions that you've asked for clarification.

I'd also like to thank our partners, UM-KECC, CDC, and our representatives from CMS for ICH-CAHPS for their participation. Thank you all very much.

(END)

