March 24, 2022 - Dialysis Facility Data on Medicare.gov National Provider Call Transcript

Moderator: Thank you for joining today's call. Our presenters are Golden Horton, Technical Lead for Dialysis Facility Care Compare on Medicare.gov at CMS, and Amy Couzens, ICH CAHPS Survey Sampling Task Leader at RTI International. Golden will begin the presentation with background and information on data releases. Amy will provide an update on the April 2022 refresh. And then Golden will share information on the summer and autumn 2022 releases.

We will then 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 CMS.gov ESRD general information page after the webinar. Next slide, please. Now I would like to introduce Golden Horton. Golden, you may begin.

Golden Horton: Thank you, Tim. Good afternoon. Thank you for joining us today. We hope the information shared will be useful in answering questions you may have had about data on Dialysis Facility Care Compare.

So let's jump right in. Just a little background. Typically, dialysis facility data on Dialysis Facility Care Compare is updated quarterly on Medicare.gov, with refreshes in January, April, July, and October. And as you may have noticed, public dialysis facility data has not been updated since October 2020. Initially due to the COVID-19 pandemic and subsequently due to the EQRS users' data reporting suspension outlined in the January 29, 2021, EQRS announcement. CMS will continue to monitor and evaluate the impact of the EQRS data availability issues 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. Next slide, please.

Delay of October 2021 Data Release. The April 2022 release will only include updated ICH CAHPS data. The preview period, as you know, for this release was held February 1st through the 15th of 2022. Calendar year 2019 data released in the October 2020 annual update will remain on Medicare.gov until the next annual update. Calendar year 2020 results reporting will be delayed until autumn 2022. Each of the measures will be calculated using calendar year 2020 data, excluding the Extraordinary Circumstances Exception (ECE) period. Updated version of Standardized Transfusion Ratio, Standardized Mortality Ratio, Standardized Hospitalization Ratio, and Standardized Readmission Ratio previewed by facilities last summer will be used for the calculations. Data from calendar year 2021 will be released in early 2023. The preview for this release will be held in autumn 2022. Public update of Star Ratings, which I know many stakeholders have inquired about, will not occur with any of these releases. Next slide, please.

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

And with that, I will turn it over to Amy to discuss the April 2022 Refresh of Dialysis Facility Data on Medicare.gov.

Amy Couzens: Thanks, Golden. Hi, I'm Amy Couzens and I serve as the ICH CAHPS Survey Sampling Task Leader at RTI International. Next slide, please.

Scores and Star Ratings from the ICH CAHPS survey will be refreshed on Medicare.gov's Care Compare in April. Reported data will be from the combined 2020 fall and the 2021 spring ICH CAHPS surveys. Next slide, please.

As a reminder, the ICH CAHPS survey is conducted each spring and fall with patients who receive in-center hemodialysis. The current survey has 62 questions, with 43 of those considered to be core CAHPS questions. The results are refreshed on Care Compare each April and October, combining two survey periods of data. A facility must have 30 or more completed surveys across two survey periods for their data to be publicly reported. Next slide, please.

We currently report survey data on three composite measures. The kidney doctors' communication and caring composite, the quality of dialysis center care and operations composite, and the providing information to patients composite. This slide shows how these composites are labeled on Care Compare and which questions comprise each composite. Next slide, please.

We also report on three global ratings. The rating of kidney doctors, the rating of dialysis center staff, and the rating of the dialysis center. Next slide, please.

On Medicare.gov's Care Compare, the Star Rating for the ICH CAHPS survey is called the patient survey rating. This is generated from the simple average of six individual stars; each of the three composite measures, and each of the three global ratings. Response rates and the number of completed surveys are also included as part of the publicly reported data. Next slide, please.

RTI is currently working with CMS to determine how best to reduce survey burden on in-center hemodialysis patients. This fall, we'll conduct a mode experiment with approximately 25,000 ICH patients to test a web mode for the ICH CAHPS survey and to test a revised survey instrument. The survey being tested takes the mail survey from 62 to 40 questions and the telephone survey from 59 to 38 questions. Once data is analyzed, a decision will be made whether to adopt the shortened survey in the national implementation, and also whether to allow ICH survey vendors to offer a web option for their ICH facility clients. Next slide, please.

That's all for me. Thank you for your time. I'm going to turn it back to Golden.

Golden Horton: Thanks, Amy. So now we're going to discuss Autumn 2022 Dialysis Facility Data Release on Medicare.gov. Next slide.

As we mentioned earlier, the October 2021 release of dialysis facility data was delayed until autumn '22, 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 and that's also excluding the Extraordinary Circumstance Exception period. The updated versions of measures STrR, SMR, SHR, and SRR, previewed to facilities in a dry run in summer 2021, will be included. Star Ratings will not be

updated with this release. The preview period will be held prior to the public release of measures tentatively scheduled for July 15th through August 15th, 2022. Next slide, please.

So just a little background. From 2018 until 2020, measures reported on Medicare.gov that are NQF endorsed underwent comprehensive review. Measure specifications were reviewed, tested, and updated based on new information since the last review cycle. As a result of this review, several measures were improved, with the following measures receiving significant updates. And that would be the Standardized Hospitalization Ratio for Dialysis Facilities, Standardized Readmission Ratio for Dialysis Facilities, Standardized Mortality Ratio for Dialysis Facilities, and lastly, Standardized Transfusion Ratio for Dialysis Facilities. Next slide, please.

Prior measure inclusion criteria based on active Medicare coverage identified the presence of Medicare inpatient and outpatient claims did not account completely for Medicare Advantage patients. One of the key changes we made was how patients with Medicare Advantage are handled in several of our measures that rely on Medicare fee-for-service claims for determining time at risk, comorbidity information, and outpatient events. The changes were made because outpatient claims are not available for Medicare Advantage patients as a result of the different payment structure of the Medicare Advantage program. The absence of outpatient claims potentially introduces bias into the measures listed here, which are SHR, SRR, again, SMR, and STrR. As these measures have relied on all available outpatient and inpatient Medicare claims for defining time at risk, comorbidity adjustment, and advanced identification. The measure-specific changes are described on the next few slides. Next slide, please.

SHR was revised to better account for events and time at risk for Medicare Advantage patients in the measure. The changes were made because the SHR uses Medicare fee-for-service claims for determining eligibility, time at risk, and comorbidity information for SHR. Specifically, we now include all time at risk for MA patients. Another change we've made was to include variable measuring of proportion of time a patient had MA coverage. This allowed us to adjust for potential differences in admission rates for MA dialysis patients who tend to have an overall lower risk of hospitalizations, compared to other Medicare fee-for-service patients. Finally, we now only use inpatient claims for determining presence of prevalent comorbidity for both Medicare Advantage and fee-for-service patients. This avoids the bias introduced by the absence of outpatient claims for Medicare Advantage patients. Next slide, please.

The changes we made to SRR parallel those of SHR. First, we now only use inpatient claims for determining presence of prevalent comorbidities for both MA and fee-for-service patients. This lessens the bias associated with absence of outpatient claims for Medicare Advantage patients. We also include SRR which indicates whether the patient had MA coverage at the time of their Index discharge. We included this because our testing showed that, overall, Medicare Advantage dialysis patients tended to have an overall lower risk of hospitalizations compared to other Medicare patients in the measure. Next slide, please.

SMR includes revisions similar to those in SHR. Like SHR, SMR was revised to better account for events and time at risk. Specifically, we now include all time at risk for MA patients in SMR. As stated earlier, we used to determine the time at risk only by 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 Medicare Advantage patients, relying on those criteria alone by definition, did not include time at risk for all Medicare Advantage patients. Especially, those who did

not have inpatient visits. We have addressed this potential bias by now including all Medicare Advantage time at risk in SMR. As with SHR, we now only use inpatient claims for determining the presence of prevalent comorbidities for both MA and FFS patients. This avoids the bias introduced by the absence of outpatient claims for Medicare Advantage patients. Next slide, please.

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 an outpatient setting. Meaning the facility with a high percentage of MA patients may receive a very low or a high measure score, depending on whether the transfusion event happened in an 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 diagnoses. Most of the exclusion diagnoses are derived from outpatient claims. Therefore, we would not be able to ascertain eligible diagnoses 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.

There were several other changes that were made in the aforementioned measures. First, we included a more granular adjustment for nursing home status that distinguishes between short-term nursing home stays, less than 90 days, and long-term stays, greater than or equal to 90 days, in the past 365 days. In our testing, we found that patients with long-term nursing home stays tended to have a higher risk for hospitalization or mortality. Next, we revised the categories for BMI to align with the World Health Organization's definition, corresponding with underweight, normal weight, overweight, and obese categories. Finally, we changed our definition of active Medicare status. Specifically, we now require $1200 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, early 2023 Dialysis Facility Data Release. I know a lot of stakeholders have had questions about this, so we wanted to share more information. Next slide, please.

We anticipate that the dialysis facility data for calendar year 2021 will be released in the early 2023 year. The measures reported will be the same as what will be released in autumn 2022, but with a new year of data. For measures that are calculated with multiple years of data, they will continue to exclude the Extraordinary Circumstance Exception period that we mentioned earlier. Star Ratings, again, will not be updated with this release. The preview period will be held prior to the public release of the measures. Next slide, please.

Early 2023 Data Release. During the preview period of this release, we will dry run two new measures. Those measures include Standardized Emergency Department Ratio (SEDR), Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge, known as ED30, for dialysis facilities. Calculation of clinical quality of care Star Ratings utilizing updated methodology will also be a part of this dry run. A technical expert panel was recently held to discuss changes to the Star Rating methodology. Methodology will be publicly released prior to the dry run. Next slide, please.

So, this is a brief description of SEDR. The Standardized Emergency Department Encounter Ratio is defined to be the ratio of the observed number of emergency department encounters that occur for adult Medicare ESRD dialysis patients treated at a particular facility. To the number of encounters that would be expected, given the characteristics of the dialysis facility's patients and the national norm for

dialysis facilities. So, we also have listed what the numerator and the denominator would be. Next slide, please.

And, again, a brief description of the ED30 measure that we're looking at including. The Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge for Dialysis Facilities is defined to be the ratio observed over expected events. And, again, we have explained what the numerator and the denominator would be for that measure as well. Next slide, please.

The University of Michigan Kidney Epidemiology and Cost Center, our colleagues here along with CMS, recently convened a technical expert panel to review and provide input on options and considerations for updating and publicly reporting of the Star Ratings. So, on the screen we have these considerations including a proposal to add two transplant waitlist quality measures currently reported on the Medicare.gov site to Star Rating. Also known as PPPW and SWR. And the next consideration includes because of COVID-19, determining a new baseline year for resetting the Star Rating and scoring facility performance. So, I've said a mouthful and shared a lot of information with you all. With that being said, this concludes my portion of presenting. I will now turn it back over to Tim to see if we have any questions.

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 in the webinar interface. Questions not answered during the webinar will be answered and posted with the other webinar materials on the CMS.gov ESRD general information page after the webinar.

You can go to the next slide. Thank you. Okay, our first question.

Patients often complain about the frequency of the ICH CAHPS survey. They don't like doing it twice a year and often don't complete one of them. Are there any plans to decrease the frequency of the survey?

Subject Matter Expert: So at this time, CMS has no plans to decrease the frequency of the survey. After many analyses, it was determined that an annual survey would lessen the number of facilities that meet the criteria for their data to be publicly reported and that the survey data would be dated by the time it was actually reported. However, our goal is that by reducing the length of the survey, the burden on patients is decreased.

Moderator: Thank you. That's our only question right now. So, folks, if you -- again, if you have any questions that you'd like to ask the panel, you can use the questions box in the webinar interface on the right side.

Okay, our next question. In the early 2023 release, will a calculation of Star Ratings be publicly available or just for preview period recipients?

Subject Matter Expert: So for the 2023 release, it will be publicly reported and not just privately reported.

Moderator: Okay. Thank you, Golden. Our next question, and I believe this is, again, referring to the ICH CAHPS survey. Are they reducing further questions, as noted in the slides were T63?

Subject Matter Expert: So for the ICH CAHPS survey, we are testing a reduced survey in our mode experiment this fall. The mail questionnaire will have 40 questions and the phone has 38. And as long as the analyses look good after the mode experiment, then that would be the survey that we'd adopt moving forward and the national implementation.

Moderator: Thank you, Amy. There's another question on the ICH CAHPS survey. Is there any plan to change the scoring for the ICH CAHPS survey? I've heard that any score below an eight or nine are considered a zero and that hurts good scores. Thanks.

Subject Matter Expert: We'll get back to you on this one.

Moderator: Okay, great. Next question. With the COVID-19 pandemic, the kidney community shared barriers to getting permanent vascular accesses placed. Will data related to vascular access at incidents of dialysis be considered as a metric and be made publicly available?

Subject Matter Expert: Yeah, hi. This is Joe Messana from the University of Michigan. So vascular access -- there are two vascular access measures currently comprising the second domain in the Star Ratings and in reflected in the Standardized Fistula Rate and the long-term catheter rate measures. Those measures are in star and we have captured or we're receiving ongoing data about current rates of long-term catheter use and fistula rates. And so at this point, I believe they will still be in the release.

Moderator: Thank you, Joe. Next question. If we do not receive 30 responses for the ICH CAHPS, what will happen to our score?

Subject Matter Expert: So the 30 completed surveys. We need 30 completed surveys over the two survey periods that are being publicly reported for that refresh. And if a facility does not have 30 total completed surveys across those two reported survey periods, then the data are not publicly reported. And, instead, there's a footnote saying that there were not enough data to meet the public reporting requirements.

Moderator: Thank you. As a reminder, if you'd like to submit a question, you can use the questions box in the webinar interface. We'll stand by for additional questions. Our next question is, if you don't have enough responses for an ICH CAHPS score and there are no EQRS data, what would be your score?

Subject Matter Expert: So no score would be publicly reported if you don't have enough surveys. You would get a footnote saying that there were too few surveys to report.

Moderator: Thank you. Our next question. There are two slides, I think 18 and 19, that seem to conflict. One says early 2023 release will not update Star Ratings. Then the next slide says early 2023 release will update Star Ratings. Could you please clarify the difference?

Subject Matter Expert: Yeah. Hi, Tim. This is Joe Messana from U of M KECC. I believe the intent was to point out that Star Rating calculations will be performed and will part of -- will be used as a dry run or a preview period for facilities only and not for public release. And then, assuming the preview goes well, that public release could be available for later in the year. And I think that that might be a clarification of an earlier response that we made to Patrick Bear.

Moderator: Thank you, Joe. As a reminder, you can submit your questions through the questions box in the webinar interface. Okay. Our next question is, will any bell curve methodology be applied to Star Ratings?

Subject Matter Expert: I would ask for clarification from the presenter. The Star Ratings fit a natural symmetric distribution that goes by many names. And the 2019 Star Rating TEP recommended actually resetting to the original 10-20-40-20-10 distribution. But that is based on the underlying distribution of the Star Ratings. And so I'd need some clarification about what the questioner is referring to when they talk about bell curve methodology.

Moderator: Thank you. As a follow-up question to that, will 10% of the industry receive a 1 Star Rating, for example?

Subject Matter Expert: That was the recommendations of the technical expert panel on Star Ratings, which included members of the patient community, industry, and other interested dialysis community members back in 2019. And I believe that that's -- that the plan is to implement those recommended resets, yes.

Moderator: Thank you. As a reminder, the slides will be posted to the ESRD general information page in the coming weeks. So if you have any questions about specific slides, you can view the slides on that website. Okay. We don't have any additional questions at this time. If anybody else has a question -- oh, here. Now there's one. How will no score for ICH CAHPS affect the overall score of the facility?

Subject Matter Expert: I think this may be related to the overall QIP score, which I'm not able to answer right now. So we will work on getting a response back to that question.

Subject Matter Expert: This is Alissa Kapke from Arbor Research. If that's related to QIP, I could address that question. So for QIP, if the facility is not eligible for ICH CAHPS, the weight of that measure, which I believe is 15%, would be equally distributed to the remaining domains. So it shouldn't have a negative impact to the score, the weight is just redistributed.

Moderator: Okay. We have reached the end of the question-and-answer portion of the webinar. Questions that have not been answered have been recorded and will be addressed in the Q & A document that will be posted to the ESRD general information page after the webinar. Golden, I will turn it back over to you to close the call.

Thanks, Tim. Thank you, guys, for joining us today. Taking time out of your busy schedule to join us as we share this information. I wanted to let you all know that we will have the FAQs that will go out that will clarify all dates with any upcoming releases and what information will be released. So we will be posting and that and sending that out via Listserv. Thank you again for joining us and enjoy your day.