October 25, 2017, Dialysis Facility Compare National Provider Call Questions and Answers

The questions below were received during the October 25 Dialysis Facility Compare National Provider Call. Questions were submitted to the Centers for Medicare & Medicaid Services (CMS) via the chat box and answered either over the phone during the webinar or subsequent to the webinar by CMS subject matter experts, as part of the question and answer commitment for the remaining submitted questions not answered during the webinar.

Section 1: responses to questions submitted through the chat box but not answered during the call due to time constraints.

In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)

Question: Is there any way we can get our survey results back in a timelier manner. From the time we get our results, we have about a month to try to make improvements before the next ones go out. This is very frustrating for the providers.

Response: As we understand your question, we think you may be able to obtain more timely data from your survey vendor. We suggest you contact your vendor about the reports you receive and get information on how often and how quickly they are created. If you are referring to preview reports for public reporting, our timelines for public reporting are not flexible. We report in April and October each year. In order to refresh ICH CAHPS on time, we cannot make adjustments to the public reporting timeline at this time.

Question: When you say a "sample of patients" receives the survey, what is the minimum and maximum number of patients getting surveyed per facility census?

Response: The goal of the ICH CAHPS Survey is to sample enough survey-eligible patients so that a total of 240 patients are sampled across two-semiannual survey periods. However, a census (all survey-eligible patients) is included in the sample in each survey period for many of the ICH facilities because the facilities do not serve 240 survey-eligible patients in a calendar year or across the two survey periods included in public reporting period.

Questions:

- Please explain what happens if a facility does not have 30 survey responses.
- Is the number 30 a total from both the spring and fall surveys?
- Is patient self-reporting the only source for patient adjustors for the ICH CAHPS? Nothing for CROWNWeb, claims or OSCAR?
- ICH CAHPS - what happens when a facility does not have 30 responses? Is 30 a total of both waves?

Responses:

The answers to each question follows.

1. *Please explain what happens if a facility does not have 30 survey responses*.
   Response: CMS publicly reports ICH CAHPS survey results for all facilities that have 30 or more completed surveys across the 2 semiannual survey periods included in the public reporting period. Results are not publicly reported on Dialysis Facility Compare (DFC) if a facility does not have 30 or more completed surveys (combined) for the 2 semiannual survey periods included in the public reporting period.

2. *Is the number 30 a total from both the spring and fall surveys?*
   Response: ICH CAHPS Survey results are updated or "refreshed" on Dialysis Facility Compare (DFC) twice each year (in April and October.) The results posted are based on data from the 2 most recent semiannual surveys. When analyzing data to produce results that will be publicly reported, CMS replaces data from the oldest semi-annual survey period with data from the most recent survey period. For example, the results that were posted on the DFC in October 2016 were based on combined data from the Spring and Fall Surveys administered in CY2016. The results that were posted on the DFC in April 2017 were based on combined data from the 2015 Fall Survey and the 2016 Spring Survey.

3. *Is patient self-reporting the only source for patient adjustors for the ICH CAHPS? Nothing for CROWNWeb, claims or OSCAR?*
   Response: ICH CAHPS Survey results are adjusted for mode effects and patient characteristics. There are 13 patient characteristics that are used to statistically adjust ICH CAHPS Survey results based on patient mix, as shown below. Ten are self-reported by the patients; three are from the CROWNWeb data base, including age, sex and total number of years on hemodialysis.
   - Overall health
   - Overall mental health
   - Heart disease
   - Deaf or serious difficulty hearing
   - Blind or serious difficulty seeing
   - Difficulty concentrating, remembering, or making decisions
   - Difficulty dressing or bathing
   - Age
   - Sex
   - Education
   - Does the patient speak a language other than English at home
   - Did someone help the patient complete this survey
   - Total number of years on dialysis

4. *What happens when a facility does not have 30 responses? Is 30 a total of both waves?*
   Response: CMS publicly reports ICH CAHPS survey results for all facilities that have 30 or more completed surveys combined across the 2 survey periods included in the public reporting period. Results are not publicly reported on Dialysis Facility Compare if a facility does not meet that requirement.

Question: Did they remove the question about pain with insertion of needles?

Response: No, the survey item that asks about inserting needles with as little pain as possible is still included in the ICH CAHPS Questionnaire (as Q21.)

Question: For the ICH CAHPS star rating, what do you show for facilities that had <30 patients respond?

Response: Although decisions about star ratings have not been finalized, at this time, CMS is planning to use the same rule for star ratings that are currently being used for publicly reporting ICH CAHPS Survey results. That is, a facility must have a total of 30 or more completed surveys combined across the 2 survey periods included in the public reporting period for ICH CAHPS Survey results to be publicly reported.

Questions:

- What is the average number of surveys returned per clinic per year?
- How does this compare to the number of surveys received by other providers (e.g., hospital, home health, etc.)?
- What is the average number of ICH CAHPS surveys returned per clinic per year? What is the average response rate?
- How does this compare to the number of surveys received by other providers (e.g., hospital, home health, etc.)? How does ICH CAHPS response rate compare to other providers' response rates?

Responses: See responses below.

1. *What is the average number of surveys returned per clinic per year?*
   Response: The number of completed surveys for any given ICH facility depends mainly on the number of survey-eligible patients the facility served during the two survey periods included in the public reporting period and the response rate of sampled patients. CMS does not track or maintain an average number of completed surveys. However, CMS does calculate and track response rates at the facility level and on a national level. The average response rate (among all participating ICH facilities) on the ICH CAHPS Survey varies during each semiannual survey period, but for the 2017 Spring Survey, the average response rate for all participating ICH facilities was 34.6%.

2. *How does this compare to the number of surveys received by other providers (e.g., hospital, home health, etc.)?*
   Response: CMS does not track the average number of completed surveys received on the ICH CAHPS Survey. However, most of the other types of providers that administer a CAHPS serve larger patient populations than dialysis facilities; therefore, we assume that the number of completed surveys obtained on those surveys is higher than on the ICH CAHPS Survey. With regard to the response rates obtained, it is our understanding that the response rates on some of the other CAHPS Surveys are about the same or similar to those on the ICH CAHPS Survey.

3. *What is the average number of ICH CAHPS surveys returned per clinic per year? What is the average response rate?*
   Response: CMS does not track the number of completed surveys varies based on the size of the facility.

4. *How does this compare to the number of surveys received by other providers (e.g., hospital, home health, etc.)? How does ICH CAHPS response rate compare to other providers' response rates?*
   Response: See the response to Question 1 and Question 2 above.

Question: With regards to ICH CAHPS not all patients are surveyed thus creating a "selection bias." How do we account for the home hemodialysis patients that are not considered in the scoring?

Response: The ICH CAHPS Survey is designed to collect data from patients who receive hemodialysis on an outpatient basis (in-center) from dialysis facilities. If a facility that primarily serves home dialysis patients provides in-center dialysis to hemodialysis patients, the patients who meet survey-eligibility criteria are eligible to be included in the ICH CAHPS sample. Note that CMS is currently investigating the feasibility of developing a CAHPS Survey for home dialysis and peritoneal patients.

Question: If patients did not respond to survey or did not mail, how it will affect the score?

Response: In order for ICH CAHPS Survey results to be publicly reported, each participating facility must have 30 or more completed surveys across the 2 survey periods included in the publicly reporting period. Facilities that do not receive at least 30 completed surveys during the performance period will not be scored on the ICH CAHPS measure, and the weight of the measure will be redistributed across all remaining measures within the clinical domain. For more information on this measure or any other measures included in the ESRD QIP program, please review the ESRD Measures Manual located on CMS.gov.
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/CMS-ESRD-Measures-Manual-2017.pdf

Question: When the preview report is sent to us for ICH CAHPS, how can we change it if we disagree?

Response: If you have concerns about your ICH CAHPS measure results, you can contact dialysisdata@umich.edu during the preview period to raise your concerns with CMS.

Dialysis Facility Compare (DFC)

Question: CMS mentioned the completeness of data used to calculate a subset of the measures previewed during July-August 2017 need to be reviewed. It appears that Kt/V and Calcium results are in question. Since these are shared measures between 5 Star & Quality Improvement Program (QIP), will these issues also affect QIP scores that were previewed?

Response: Upon identifying the concerns raised during the July-August 2017 preview period, we investigated whether the QIP was also affected. Upon review, we determined that the issues that led us to delay the DFC release in October were isolated and did not affect the end-stage renal disease (ESRD) QIP. The incomplete nursing home status data were a consequence of specific files transmitted to use in the DFC, and are not used by the QIP, which obtains data from the Minimum Data Set through other means. With regard to those data excluded from the numerator of the Kt/V and hypercalcemia measures due to patients with a 2728 form that is in saved status in CROWNWeb, those patients-months are systematically excluded from the QIP denominator as well due to ESRD QIP policy. Patients with 2728 forms in saved status have not been included in QIP measure calculations, and therefore, facilities were not penalized for missing lab values for these patients.

Question: Someone asked the question whether there will be patients excluded from the long-term catheter (LTC) rate numerator due to metastatic cancer, liver disease metastatic cancer and patients on hospice care. Is this in effect for Payment Year (PY) 2019 or is this just being considered?

Response: To clarify, this measure is not part of the ESRD QIP for PY2019.

The catheter measure that is currently reported on DFC and used in the Star Ratings does not have any diagnosis-based exclusions. As of October 2018, the Long-Term Catheter Rate that will be reported on DFC and used in the Star Ratings excludes patients with a catheter that have limited life expectancy. Limited life expectancy is defined as:

- Patients under hospice care in the current reporting month
- Patients with metastatic cancer in the past 12 months
- Patients with end stage liver disease in the past 12 months
- Patients with coma or anoxic brain injury in the past 12 months

Question: Can you confirm that the following measures will now be included in the Star-Rating System: adequacy, hypercalcemia, Standardized Mortality Ratio (SMR) for Dialysis Facilities, Standardized Hospitalization Ration (SHR), Standardized Transfusion Ratio (STrR) for Dialysis Facilities, Standardized Readmission Ratio (SRR), hypercalcemia, and adequacy (including all 4 subcategories?)

Response: Yes, the measures that will be used to calculate the star ratings for October 2018 include:

- Standardized Transfusion Ratio for Dialysis Facilities (STrR, NQF #2979)
- Standardized Mortality Ratio for Dialysis Facilities (SMR, NQF #0369)
- Standardized Hospitalization Ratio for Dialysis Facilities (SHR, NQF #1463)
- Standardized Readmission Ratio for Dialysis Facilities (SRR, NQF# 2496)
- Total Kt/V Measure
    - Delivered Dose of Hemodialysis Above Minimum (Adult Hemodialysis [HD] Kt/V, NQF #0249)
    - Minimum single-pool Kt/V for Pediatric Hemodialysis Patients (Pediatric HD Kt/V, NQF #1423)
    - Delivered Dose of Peritoneal Dialysis Above Minimum (Adult Peritoneal Dialysis [PD] Kt/V, NQF #0318)
    - Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V (Pediatric PD Kt/V, NQF# 2706)
- Hemodialysis Vascular Access: Standardized Fistula Rate (SFR, NQF #2977)
- Hemodialysis Vascular Access: Long-Term Catheter Rate (Catheter, NQF #2978)
- Proportion of Patients with Hypercalcemia (Hypercalcemia, NQF #1454)

The DFC Star Rating Methodology for the October 2018 Release document is available at the following link: https://dialysisdata.org/sites/default/files/content/Methodology/Updated_DFC_Star_Rating_Methodology_for_October_2018_Release.pdf.

Question: When will CMS announce the weighting of the Five-Star measures, given the many changes that are being made to the system?

Response: The DFC Star Rating measures are categorized into three equally-weighted domains. For the October 2018 Release these domains are as follows: the first domain is named "Standardized Outcomes (SHR, SMR, STrR, and SRR)." The Standardized Fistula Rate and Long-Term Catheter Rate measures form the second domain, "Other Outcomes 1 (SFR, Catheter)." The Total Kt/V and Hypercalcemia measures form the third domain, "Other Outcomes 2 (Total Kt/V, Hypercalcemia)." The individual DFC measures for star rating are weighted equally within each of their respective domains. Please see the DFC Star Rating Methodology for the October 2018 Release document available at the following link: https://dialysisdata.org/sites/default/files/content/Methodology/Updated_DFC_Star_Rating_Methodology_for_October_2018_Release.pdf.

Question: Will Catheters greater than 90 days be categorized as to those with another access maturing and those who do not?

Response: The long-term catheter rate measure does not separate patients with a maturing access. If any of the following CROWNWeb "Access Type IDs" (16, 18, 19, 20, 21,"·") has been recorded, a catheter is considered in use. If a catheter has been observed for three consecutive months (i.e., in the reporting month and the immediate two preceding months) at the same facility, the reporting month is counted in

the numerator. Access Type ID “16” represents Arteriovenous (AV) Fistula combined with a Catheter, “18” represents AV Graft combined with a Catheter, “19” represents Catheter only, “20” represents Port access only, “21” represents other/unknown, and “·” represents missing. If a patient changes dialysis facilities, the counting of the three consecutive complete months restarts at the new facility.

Question: On Slide 21, the Kt/V measures indicated needing Kt/V results "above the minimum," not meeting or exceeding the minimum like we are used to seeing. Does this now mean that an HD Kt/V value of 1.20 is no longer considered "good" since it meets but does not exceed the minimum?

Response: All four Kt/V measures (Adult HD Kt/V, Adult PD Kt/V, Pediatric HD Kt/V, Pediatric PD Kt/V) are defined as the percentage of patients whose delivered dose of dialysis is ***greater than or equal to*** the recommended minimum. Specifically:

- Adult HD Kt/V: Percentage of all patient months for adult patients (18 years or older) whose delivered dose of hemodialysis (calculated from the last measurement of the month using the UKM or Daugirdas II formula) was spKt/V greater than or equal to 1.2.

- Pediatric HD Kt/V: Percentage of patient months for all pediatric (less than 18 years old) in-center hemodialysis patients in which the delivered dose of hemodialysis (calculated from the last measurement of the month using the UKM or Daugirdas II formula) was spKt/V greater than or equal to 1.2.

- Adult PD Kt/V: Percentage of all patient months for adult patients (18 years or older) whose delivered peritoneal dialysis dose was a weekly Kt/V greater than or equal to 1.7 (dialytic + residual).

- Pediatric PD Kt/V: Percent of pediatric (less than 18 years old) peritoneal dialysis patient-months whose delivered peritoneal dialysis dose was a weekly Kt/V greater than or equal to 1.8 (dialytic + residual)

Question: You mentioned earlier that SMR would only include Medicare patients, but later that all patients are included. What measures will be all patients and which Medicare only?

Response: The Standardized Mortality Ratio (SMR) that is currently reported on DFC includes all patients. Beginning with the October 2018 release an updated SMR will replace the current one. The updated SMR will adjust for prevalent comorbidities from Medicare claims and will be restricted to Medicare patients only. The following is a breakdown of the patients included in each of the current measures and the measures for the October 2018 release.

Current DFC measures
Kt/V: All patients
Hypercalcemia: All patients
Standardized Infection Ratio (SIR): All patients
ICH CAHPS: All patients

Vascular Access Type (Catheter and Fistula): Medicare only
SMR: All patients
SHR: Medicare only
SRR: Medicare only
STrR: Medicare only

October 2018 DFC measures
Kt/V: All patients
Hypercalcemia: All patients
Vascular Access Type (Catheter and Fistula): All patients
SMR: Medicare patients only
SIR: All patients
ICH CAHPS: All patients
SHR: Medicare only
SRR: Medicare only
STrR: Medicare only

Question: Mr. Andress, you have mentioned that New Quality Measures will begin to be publicly reported in October 2018. In simpler terms, do you mean that the dialysis facilities are currently being measured on the new changes such as Standardized Fistula Rate? (In 2017)

Response: Yes. The measures reported on DFC in October 2018 will be calculated with data from calendar year 2017.

Question: What date will the new 5 Star Ratings be posted on Dialysis Facility Compare?

Response: CMS will not publish the data from the Quarterly Dialysis Facility Compare—Preview for October 2017 Report on Dialysis Facility Compare. Star Ratings and measure values available since July 2017 will remain on Dialysis Facility Compare until the next update. The date of the next site update is not yet available but CMS will keep the community informed.

Question: Can you tell us—in your opinion—did the Technical Expert Panel (TEP) process make a substantive impact on your deliberations and do you encourage more patient participation in TEPs moving forward as they are available?

Response: CMS is continuing to increase and encourage participation by patients as they are key stakeholders in this process. They serve as subject matter experts for patients who are receiving care in many different aspects of kidney care. Contributions by patients on the TEP provide valuable perspectives as part of the TEP deliberations.

Question: January 2018 DFC update will reflect the Star Rating received for the Facility in Preview October 2017?

Response: CMS will not publish the data from the Quarterly Dialysis Facility Compare—Preview for October 2017 Report on Dialysis Facility Compare. Star Ratings and measure values available since July 2017 will remain on Dialysis Facility Compare until the next update. The date of the next site update is not yet available but CMS will keep the community informed.

Question: Can you explain what is meant by Kt/V over and above minimum?

Response: All four Kt/V measures (Adult HD Kt/V, Adult PD Kt/V, Pediatric HD Kt/V, Pediatric PD Kt/V) are defined as the percentage of patients whose delivered dose of dialysis is ***greater than or equal to*** the recommended minimum. Specifically:

- Adult HD Kt/V: Percentage of all patient months for adult patients 18 years or older) whose delivered dose of hemodialysis (calculated from the last measurement of the month using the UKM or Daugirdas II formula) was spKt/V greater than or equal to 1.2.

- Pediatric HD Kt/V: Percentage of patient months for all pediatric (less than 18 years old) in-center hemodialysis patients in which the delivered dose of hemodialysis (calculated from the last measurement of the month using the UKM or Daugirdas II formula) was spKt/V greater than or equal to 1.2.

- Adult PD Kt/V: Percentage of all patient months for adult patients (18 years or older) whose delivered peritoneal dialysis dose was a weekly Kt/V greater than or equal to 1.7 (dialytic + residual).

- Pediatric PD Kt/V: Percent of pediatric (less than 18) peritoneal dialysis patient-months whose delivered peritoneal dialysis dose was a weekly Kt/V greater than or equal to 1.8 (dialytic + residual)

Question: How does the data quality issues effect the QIP?

Response: The data issues in CROWNWeb that effected Kt/V values reported in CROWNWeb did not impact how the QIP calculates Dialysis Adequacy. For PY2018, the ESRD QIP used lab values and occurrence dates reported on Medicare billing claims to calculate the four Dialysis Adequacy measures. The ESRD QIP will begin using CROWNWeb as the primary source starting in PY2019 to calculate the Comprehensive Dialysis Adequacy Measure.

If your question is in regards to Mineral Metabolism, please note that CMS has confirmed the Mineral Metabolism Reporting Measure calculation for PY2018 was calculated accurately and used all CROWNWeb clinical data available in the ESRD QIP production database. When the ESRD QIP extracts

clinical data from CROWN, there are several criteria that the data must meet in order to be included in the extract:

1. The record for the patient/provider/month must be in the "Submitted" state. Records that are in the "Saved" state will not be included.
2. The record for the patient/provider/month must not have the "No Clinical Data Available" flag set in order to retrieve any values.

Additionally, please note that for CROWNWeb clinical data submission, when a user selects the "No Clinical Data Available" option in the CROWN Single User Interface (SUI), the system will remove any previous values for that patient/provider/month. When the clinical data arrives via batch and the "No Clinical Data Available" (i.e. Global N/A flag) is set, the system will remove any previous values for that patient/provider/month. However, if the batch data also arrives with the collection type flag set in addition to the Global N/A flag set, it will only delete the values that are associated with the collection type, leaving residual data on the other collection type. In this scenario, it was decided that for CROWNWeb extracts, the system will delete the residual data and keep the Global N/A.

CMS expects facilities to have processes in place to ensure data are entered accurately and in accordance with CMS requirements.

Question: Can you give us more details about the proposed transplant referral quality measures at this time, or are you waiting for community input?

Response: The specifications for the proposed transplant waitlist measures can be found here: https://dialysisdata.org/content/esrd-measures.

Question: Please could you help to share the Questions and Answers that were asked today apart from this Slide Deck?

Response: Yes, a transcript as well as a question and answer document will be made available to the public. CMS will send an eblast informing the community when they are posted.

Question: We are a hospital based offsite dialysis clinic. When we look at the DFC report and how we are compared to the other dialysis clinics in our area, it is like comparing apples to oranges. The report reflects that our clinic has seen over 800 patients during the reporting period. When you compare that to the other dialysis clinics in our area, those clinics have seen less than 200 patients during the reporting period. Our numbers are also well above the national average in terms of the number of patients seen. We see a much higher acuity of patients in our clinic that local for-profit clinics do not see. We received 2 stars versus other clinics receiving 4 stars. Will the reporting take these situations into consideration and compare clinics to similar clinics?

Response: The DFC star rating methodology does not directly compare similar clinics; however, several of the DFC quality measures included in the star rating are risk-adjusted to account for patient case-mix. In this way clinics with a similar patient-mix will be evaluated similarly on those individual quality measures. The quality measures included in the current star rating that adjust for patient risk factors are the following: SHR and SMR adjust for comorbidities at ESRD incidence; STrR adjusts for certain comorbidities in the prior year associated with higher transfusion risk. Please see the detailed measures specifications linked here: https://dialysisdata.org/content/methodology

In the updated DFC star rating for the October 2018 release, the following quality measures adjust for patient risk factors that can potentially impact the measure outcomes. The SHR and SMR will adjust for a set of comorbidities at ESRD incidence and each measure will also adjust for over 200 prevalent comorbidities. The STrR adjusts for certain comorbidities in the prior year associated with higher transfusion risk; the SFR adjusts for a set of prevalent and incident comorbidities associated with lower likelihood of fistula use; and the SRR adjusts for a set of high risk conditions associated with higher risk of readmission. Please see the detailed measures specifications for the October 2018 release linked here: https://dialysisdata.org/content/esrd-measures

Question: Is there a possibility that the recent preview result will change for next year's publish result? Is it safe for us to reveal our preview star rating to our patients?

Response: The star rating that was published in the Quarterly DFC Preview for October 2017 report will not be published on Dialysis Facility Compare. Star Ratings and measure values available since July 2017 will remain on Dialysis Facility Compare until the next update. The date of the next site update is not yet available but CMS will keep the community informed. It is possible that the star rating in the recent preview report will not match what is calculated for the next update.

Question: Our facility is a large staff-assisted home hemodialysis program that consistently receives low DFC scoring due to the severe co-morbid conditions of patients on this program. Not only do we service a sicker population, a significant amount of patients are not Medicare primary and thus not included in the scoring. We believe that the numbers are skewed as the total population is not represented. There are conditions that influence the possibility and advisability of surgical creation of permanent vascular accesses, morbidity/hospitalizations, infections and mortality. Should the factors in the difference in patient population not be considered in DFC scoring?

Response: We recognize some facilities have a high proportion of very sick patients. To help address the interpretation of the measure scores the Dialysis Facility Compare website currently has language that notes, for example, "Patient deaths at a facility can be worse than expected due to a variety of reasons. For example, a facility may specialize in treating patients who are very ill and who may not live long; it doesn't always mean they're not providing good care. We encourage patients to discuss the information on the website with their health care team and with facility staff."

Several of the quality measures adjust for patient characteristics associated with higher risk of the respective outcomes. These are SMR, SHR, and STrR. New versions of the SHR and SMR, scheduled for release in October 2018, will also adjust for over 200 patient prevalent comorbidities. Additionally, the

new version of the measure that assesses fistula use will also adjust for patient characteristics. For more information on adjustments in the current and modified versions of the standardized measures and vascular access measures, please refer to the Guide to the Dialysis Facility Compare Report:
https://dialysisdata.org/sites/default/files/content/Methodology/DFCReportGuide.pdf
https://dialysisdata.org/sites/default/files/content/Methodology/New_and_Modified_Measures_Guide.pdf

The DFC website does include measures based on data sources other than Medicare claims.

Section 2: contains the transcript of questions answered during the live call

The following questions were answered over the phone during the October 25 webinar. Questions and answers are presented as they appear in the transcript of the webinar.

Question: When the DFC site is updated in January 2018, what is the time period? Will it be all of 2016 or is it 2Q16 - 1Q17?

Response: So, what will be happening is that, with regard to the Standardized Mortality Ratio, Standardized Hospitalization Ratio, all of the measures that are updated on an annual basis, what will be reported are the data that you would normally see released in October this year. Because these measures are not updated on a quarterly basis, you don't see rolling changes throughout the year, and what would be reported in January for those measures would be the calendar year 2016 data. For the vascular access measures, we would roll those data forward one quarter. So, what will be publicly reported in January would be from April 2016 through March 2017, which is what we would normally report in January. I do note that we are going to be taking steps to ensure that we have archived data reflecting the October data, particularly for those measures where we'll be rolling forward data. So, that will be available at a future date. We haven't yet determined when that will be. And then for the ICH CAHPS measure, which is updated twice annually, we'll be updating in January the data that would have been updated in October of this year. And so, I would actually have to go back and check to see what the time periods for those are, but I believe they're typically posted on the website. And it would be the two most recent survey periods.

Question: Is CMS concerned about using 2016 as the baseline for the Five-Star Rating system given the data concerns with adequacy and calcium in 2016? Will CMS wait until these measures have been fixed to recalculate the baseline? Will CMS release the new baselines - we believe this is important transparency.

Response: So, I think the answer to this is yes, we expect to have the data issues wrangled out. That's part of why we've taken so long to assess the issues and figure out what they were and come up with a solution for them. We don't like to delay reporting the measures, but I think the commitment to having accurate data available is certainly foremost in our mind when we do delay the presentation on DFC and elsewhere. So, I think the short answer to your question is yes, we plan to have the data figured out before we make use of the data for any purpose, such as public reporting or for creating a baseline of performance for the Star Ratings or really for any other public-reporting purpose. I don't know that we've discussed the question of presenting the baseline data except in the context that we present it, with regard to Star Rating performance, but that's something that we'll take back and talk about before I can give you a really solid answer on it. But it's good to know that that's something that you're interested in seeing. We appreciate that. Thank you.

Question: Is the nursing home data updated after the initial 2728? If so, what is the data source? Thank you

Response: The data that we use for nursing-home data is from the Minimum Data Sets (MDS). It's updated annually for us. We use it a risk-adjustment item for a handful of our measures. And so, it's updated annually, and it essentially consists of binary indicator of whether or not the patient received service in a nursing home during that time period. It's not based on the 2728 at all.

Question: My question is that in this day and age, more and more people, including patients, have smart phones and are on them almost 24/7. Have you thought about possibly developing an app in the near future?

Response: Actually, we don't have an app, but we would welcome community input on creation of an app. Right now our focus has been on doing usability testing for the presentation of Dialysis Facility Compare and the Star Ratings on tablets and on smartphones, but that is an excellent suggestion, and we will continue to move that forward. But, again, we also would welcome applications that are created by the community. There actually are some versions that have been adopted by some of the Large Dialysis Organizations (LDOs) that will point you to Star Ratings and quality results.

Question: Regarding the Long Term Catheter Rate Measure, will exclusions be considered for patients that are not a candidate for permanent access or patients that refuse permanent access?

Response: Thank you for the question. So, this is probably more, could be more directly addressed by the links that we had on one of those slides with the measure specifications, and I'm looking through to see what slide that is. The answer to that is yes and no. Okay, it's on slide 35. So, if you look there, you can see the measure specifications for this and the other quality measures. We do incorporate some exclusions that address patients with a limited life expectancy, where we would anticipate that it may be inappropriate to seek placement of a fistula, for instance. For patient refusal, this was a matter of discussion by the TEPs at some length. They did not come to a consensus regarding an appropriate way to do this that would not also be resilient to issues like gaming, and so that is not currently an exclusion with the catheter measure. Thank you.

Question: The hypercalcemia measure is a 3-month rolling period. How does missing one month of data for a patient determine that the patient has hypercalcemia?

Response: Thank you. So, the way this works is if you have no months of data, then you're considered to have hypercalcemia. If you have one month of data, then your value is the value for that month. If you have two or three months of data within that rolling period, then it's an average of those data elements, and that's defined as the patient's value for the measure for that time period.

Question: How are grafts viewed under the Vascular Access Type (VAT) measure?

Response: The grafts -- okay, thank you. So, part of the driving force in developing these two new measures was a series of concerns that have been raised within the community that we had essentially laid out a circumstance in which there were no circumstances when it would be appropriate for a provider to give a patient a graft or a catheter and that in our review of the available evidence that didn't pan out, frankly, and so we decided to pursue development of these measures to address those issues. So, what we came out with was first and foremost within the fistula measure, we developed a risk-adjustment approach that risk-adjusted for factors that might result in difficulty in placing or continuing to maturity a fistula. And the purpose of this is to reflect the fact that when patients experience these, that it may be more reasonable for them to have a graft. And the result is that if you have patients who exhibit these circumstances within the data, then them not having a fistula is less impactful to the quality measures and to their assessment. So, the risk adjustment for the fistula measure is designed to take those circumstances into account, and that was one of the primary keystones we were looking at with the TEPs when we developed these measures. In further considerations, we added additional excluding criteria. For example, limited life expectancy, to simply exclude these kinds of patients from the measures entirely, as we believe that was the more appropriate approach for patients who were diagnosed with terminal illness or suffered under some other similar circumstance. Thank you.

Question: Will the Kt/V value include all patients or Medicare-only patients?

Response: Thank you for asking. The measures that we've incorporated on Dialysis Facility Compare include all patients. So, it comes from the CROWNWeb data source. So, it includes non-Medicare patients, as well as Medicare patients.

Question: If my memory serves me correctly, you need a specific number of patients per year to qualify for the DFC site, is this correct? Our information always shows as "Not Available" and I believe this is because we did not qualify due to our low census?

Response: Yes, thank you. The qualifications for being reported on a measure are specific to the individual quality measures. It depends on the type of measure and the methodology used for it. I think probably we shouldn't go over it here, but we can get you access to the information on the website, which can point out what the minimum thresholds are for our reporting of the measures. The reason we've implemented those are twofold. One, we want to ensure that we have sufficient data to provide a minimum degree of reliability in the assessment of facilities that we're publicly reporting. And the second issue is one of preservation of patient confidentiality. We don't want to report a number so small that it might be possible to unmask who a particular patient is and what may have happened to them, those captured within the measure.

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