Dialysis Facility Compare (DFC) National Provider Call
July 10, 2019

Moderator: Hello and thank you for joining today's Dialysis Facility Compare National Provider Call. Our presenters are Golden Horton, Technical Lead for Dialysis Facility Compare at CMS, Joel Andress, End-Stage Rental Disease Subject Matter Expert at CMS, and Scott Scheffler, ICH CAHPS Survey Sampling Task Leader at RTI International. Golden will begin the presentation with background information on DFC. Joel will provide a measures, methodology, and Star Ratings update. Scott will give an update on the CAHPS Star Rating survey results. Joel will provide measure updates for the 2019 release. And then Golden will discuss how CMS lists its patients. We will have a question-and-answer portion at the end of the presentation. To ask a question, please use the "Questions" box in the webinar interface. Questions not answered during the webinar will be answered and posted with the other webinar materials on the ESRD general information page after the webinar. Now, I would like to introduce Golden Horton. Golden, you may begin.

Golden Horton: Thanks, Tim. Good afternoon. Thank you for joining us today. We hope that this webinar leaves you with a better understanding of the Dialysis Facility Compare website and the information that is displayed there. Next slide, please.

The Centers for Medicare & Medicaid Services, CMS, developed the Dialysis Facility Compare, the DFC, Star Ratings in response to a national call for greater transparency in how the agency measures the quality of kidney care and healthcare consumers' desire to use health care quality data to make informed decisions. Next slide, please.

So, what are Star Ratings? A key feature of the DFC website is the Quality of Patient Care Star Rating, which provide a simple summary of the quality of care a dialysis clinic provides. CMS developed the DFC Quality of Patient Care Star Ratings in response to a national call for greater transparency is how the agency measures the quality of care for patient with kidney disease and consumers' desire to use healthcare quality data to make informed decisions. The DFC Quality of Patient Care Star Ratings were implemented in 2015. So, with that being said, Star Ratings summarize performance on a 1 to 5 scale using stars to help consumers quickly and easily understand quality of care information. Star Ratings spotlight differences in health care quality and identify areas for improvement. Star Ratings are useful to consumers, consumer advocates, health care providers, and other stakeholders. Up next is my colleague, Dr. Joel Andress, who serves as the ESRD Subject Matter Expert here in the Division of Quality Measures. Joel?

Joel Andress: Thank you, Golden. Good afternoon. My name is Joel Andress, and I am the Lead for ESRD Quality Measure Development here at CMS. I'm going to begin with a review of the DFC 2018 measure and DFC Star Rating methodology updates. Next slide, please.

Thank you. In 2017, the University of Michigan Kidney Epidemiology and Cost Center convened a technical-expert panel comprised of clinical providers, statistical experts, patients, and caregivers to discuss the DFC Star Ratings and recommend changes to the Star Ratings measure set and methodology. The TEP produced several key recommendations, including the updating of the Standardized Mortality, Hospitalization, and Transfusion Ratio measures and the Hypercalcemia measure to reflect NQF-endorsed specifications, replacing the original Vascular Access measures with the newly endorsed Long-Term Catheter and Standardized Fistula Rate measures, including Pediatric Peritoneal Dialysis Kt/V in the Star Ratings, providing input on next steps for resetting the Star Rating baseline, and including the ICH CAHPS survey as a separate patient feedback base Star Rating on DFC. For a more complete summary of the TEP's deliberations and recommendations, we've provided a link here to the TEP summary report. Additional details about the Star Ratings methodology may be located at the link provided at the bottom of this slide. Next slide, please. Thank you.

The updated DFC Clinical Star Ratings were released in October 2018 using the updated methodology. Additional details about the updated Star Ratings methodology may be located at the link provided at the bottom of this slide. Next slide, please. Thank you.

In alignment with the TEP's recommendations, the October 2018 Star Rating release included updated versions of the Standardized Mortality Ratio, the Standardized Hospitalization Ratio, the Standardized Transfusion Ratio, and Hypercalcemia measures, while also replacing the original Vascular Access measures with the Long-Term Catheter Rate and the Standardized Fistula Rate measures. Also consistent with the TEP's recommendations, the Star Ratings included the Pediatric PD Kt/V measure. CMS also included the Standardized Readmission Ratio measure in the Star Ratings, although the TEP had not come to a consensus recommendation regarding that measure. the NHSN Standardized Infection Rate measure was also considered for inclusion, but while the measure will continue to be publicly reported on Dialysis Facility Compare, the decision was made by CMS not to include it in the Star Ratings. Finally, per the TEP's recommendations, the ICH CAHPS measure was added a separate Star Rating, reflecting patient feedback. The inclusion of the CAHPS measure was of particular importance to the patient members of the TEP. Next slide, please.

For your convenience, we present on slide 9 a list of the measures that were new or updated on Dialysis Facility Compare in October 2018. Next slide, please. Thank you.

And then on slide 10 here, we provide a list of the measures that were used to calculate the clinical Star Rating for October 2018. You'll note that this list includes many of the new or updated measures from the previous slide. Next slide, please.

In order to allow DFC users to follow annual trends in Star Ratings after changes to the measures, facility scores are being recalculated using the updated measure set and applied to the DFC Star Rating data. The score distribution from this calculation was then used to define a Star Rating cutoff that results in the same proportion of facilities in each rating level as there were using the prior measure set. This cutoff is then used to determine the October Star

Rating categories. This allows DFC users to compare results from the prior year to the current year, while also allowing us to make modifications to the measure sets as deemed appropriate. Next slide, please.

One of the issues that we've encountered in recent years is that there has been a steady increase in the Star Ratings of facilities. And so one of the issues that we've put forward methodologically to the Star Rating TEP has been the consideration of if the Star Rating distribution should be reset or re-baselined. The recommendations from the TEP were that the clinician Star Ratings distribution should be evaluated once three years have passed from the previous reset. And the goal here is to allow a time period for scores to improve and for us to track performance over time and to allow for a degree of stability within the clinical Star Ratings. After three years have passed, the clinical Star Rating distribution is evaluated for a reset when 15% or fewer facilities are receiving 1 or 2 stars in the distribution. This aligns with the TEP recommendations for CMS to evaluate a potential re-setting at predictable time intervals, the goal here being that it is something that industry can anticipate and prepare for. A resetting of the Star Rating distribution will also include the establishment of a new baseline. I will now turn the presentation over to Scott Scheffler, who will review ICH CAHPS Star Ratings.

Scott Scheffler: Thank you. Next slide, please.

The ICH CAHPS survey is currently being conducted twice a year, in the spring and fall. National implementation of ICH CAHPS began in the fall of 2014. We are currently in the spring 2019 cycle. Data collection for this period actually ends this Friday, and then we'll begin receiving the data and claiming it and processing it. The survey questionnaire contains 62 items. Of those, 43 are considered Core CAHPS. There are several processes that help ensure that quality of data meets a high standard. We use independent survey vendors. All survey vendors maintain ongoing training. There are in-person oversight meetings with the vendors. There is an ICH CAHPS website that provides announcements and updates. And there is a constant, ongoing QC review of the data that is collected. Next slide, please.

CMS began publicly reporting results from ICH CAHPS survey on the DFC in October of 2016. The results are updated twice a year as new data becomes available. The data that we used are from the two most recent survey periods combined. And for an ICH to be displayed, they need to have 30 or more completes for the two periods. Note that this is 30 total and not 30 in each period. The DFC is currently showing data from the combined fall 2017 and spring 2018 cycle. The DFC displays top-box scores, which are the most positive ratings for an item, as well as the overall Star Rating, which is somewhat new to ICH CAHPS and what we are talking about today. Also, if you click the "View more details" button, you can see the individual Star Ratings for each of the six items. Next slide, please.

The DFC reports on six measures of the survey. Three of those measures are based on a single item -- rating of the kidney doctor, the rating of the staff, and the rating of the center. And three of those measures are composites, meaning several questions are combined to create a

score. We have the kidney doctors' communication and caring, which has six survey items that go into it. We have staff care and operations that has 17 items. And the last composite is providing information to patients, which has nine items. Next slide, please.

As was explained earlier, Star Ratings are a visual tool. It's something that's immediately familiar to consumers and is quick and easy to understand. It summarizes numeric data on a five-point scale using stars, and they allow you to spotlight differences in healthcare quality relative to their peers. Next slide, please.

Star Ratings are somewhat new to ICH CAHPS. We began using them in October 2018, using the spring and fall data from 2017. However, Star Ratings are now new to CAHPS in general. They are currently being used on other CAHPS surveys, including Hospital CAHPS, Home Health CAHPS, and CMS Part C and D. We create a Star Rating for each of the six measures that we talked about on the previous slide, and we also create an overall Star Rating that combines or averages those six Star Ratings together. Next slide, please.

These next three to four slides give an overview of how the Star Ratings are created for ICH CAHPS. There are two main steps in this process. We create a linear mean on each rating and composite, and we do that at the facility level. Then we run a cluster analysis on those linear means to assign a Star Rating for each facility. Alright, so, what are the linear means? You can think of it as a true average for that question item. If you have a survey item that can be rated from zero to 10, the linear means uses all those levels. A 10 is 100%, a 9 is 90%, an 8 is 80%, and you go on down to a zero being 0%. And then you average all those scores. So, the percentage is actually an average of those scores. Now, this is different from top-box scores. Top-box is an all-or-nothing kind of variable. If you have a 10-point survey question, then you get 100% if you mark a 9 or a 10. Anything else gets a 0%. And when you see a percentage for top-box scores, that indicates the percentage of respondents who marked it a 9 or a 10. Is one score better than the other? No, not really. It kind of depends on the question you were asking. They both have their value. But this kind of thought process does start to show the need for a Star Rating. The numbers can quickly become overwhelming even for experienced analysts. And they can definitely become a data overload for the common layperson. Next slide, please.

Now, once we calculate the linearized means for our six ICH CAHPS measures, we patient-mix-adjust them. Patient-mix adjustment evens the playing field among providers that are known to have different mixes of patient characteristics. Patient-adjustment factors include age, gender, self-reported overall health status, education, years on dialysis, and selected diseases and conditions. And most of these items come from the survey itself. Next slide, please.

Now that we have the linear means at the provider level for each of the six ICH CAHPS measures, we can create the Star Ratings, and we do this using a cluster analysis. Once again, we only do this for facilities where we have 30 responses across the two survey periods. The clustering forms five groups, which correspond to our five stars. The difference between these five groups are maximized. So, 1-star groups are optimized to be different from 2-star groups,

but the difference within the groups are minimized so that the providers within a 5-star group are made to be as similar as possible. As a general comment, there are no quotas when creating these cluster groups, meaning they don't have to be a certain size. There can be as few or as many within a given Star Rating. Next slide, please.

Star Ratings are assigned based on cut points. So, the cluster analysis may determine that for a given rating that a score between 60 and 70 is one star and between 71 and 75 is two stars and maybe between 76 and 83 is three stars and on and on. Each rating in each composite gets their own set of cut points. Now, unlike what Joel was saying on the clinical side, the cut points on the survey side are re-estimated each reporting period. In other words, they are constantly changing. So, if a facility had a score that generated a five-star rating in one period, that same score may end up being a 4-star rating in the next cycle, particularly if the industry as a whole is improving. In fact, we had an example of a facility whose linear mean actually improved, but their Star Rating ended up going down. They'd e-mailed us asking what was the deal, and the answer is that they were originally at the lower end of the cutoff for their Star Rating originally. And although they did improve by a percentage point, they did not improve as much as their peers had. So, when it came to calculate the next set of cut points, they actually slipped down a notch to the next lower star. Now, admittedly, they were at the high end of that star, but they had still slipped. Now, this particular scenario doesn't happen a lot, but it certainly can. These cut points are available in a report on the ICH CAHPS website. And lastly, the overall Star Rating that's reported on the DFC -- that's calculated a little differently than these individual Star Ratings that we were talking about. The overall Star Rating is just simply an average of the six individual Star Ratings. We count up how many total stars they had and divide it by six and round up, and that's it. And that concludes my talk on the overview of how the Star Ratings are calculated. Next slide, please.

Joel Andress: Thank you, Scott. So, we've completed our review of the changes for DFC that occurred in 2018. What we're going to be discussing now includes the changes and process for the preview period that will be coming forward for the October 2019 release. Next slide, please.

Alright, as a broad overview, keep in mind that, as part of the October 2019 release, we are going to be refreshing the existing quality measures data, as per usual. So, no surprises there. However, we will be adding two new transplant wait listing measures, which will be publicly reported for the first time. The DFC Star Ratings will also be refreshed. However, there will be no changes to the Star Ratings methodology for 2019. That is, all of the rules that applied in the 2018 release are still in place for the 2019 release. Next slide, please. Thank you.

Again, for your convenience, slide 25 presents a comprehensive list of the quality measures that will be publicly reported on DFC as of the October 2019 release. I believe we had a question that came up in the chat about whether or not the slides will be made available for you. They will, of course, following the conclusion of this presentation. So you'll have the opportunity to peruse this list and other resources available on the slide deck at your leisure. Next slide, please. Thank you.

As noted previously, there are two new quality measures included in the October 2019 release -- the Percentage or Prevalent Patients Waitlisted, or PPPW, and the Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients, or SWR, both of which were previously available for facility preview only, but which will begin public reporting in October of 2019. Next slide, please. Thank you.

The first of these measures, the PPPW, measures the extent to which a facility maintains its dialysis patients on a transplant waitlist over time. The numerator is defined as the number of patient months in which the patient at the dialysis facility is on the kidney or kidney-pancreas transplant waitlist as of the last day of each month during the reporting year. The denominator is defined as all patient months for patients who are under the age of 75 in the reporting month and who are assigned to the dialysis facility according to each patient's treatment history as of the last day of each month during the reporting year. Next slide, please.

The measure excludes all patients age 75 or older, as well as patients who are admitted to a skilled nursing facility or hospice in a given month or who are admitted to a SNF at dialysis incidence. Full documentation for the quality measure can be accessed at the link found at the bottom of the slide. Next slide, please.

The SWR is a measure of wait listing among incident patients during the first year of dialysis. The numerator is defined as the number of patients at the dialysis facility listed on the kidney or kidney-pancreas transplant waitlist or who received living donor transplants within the first year following initiation of dialysis. The denominator is defined as the expected number of wait listing or living donor transplant events at the facility according to each patient's treatment history for patients within the first year following initiation of dialysis. The measure is adjusted for age and incident comorbidities. Next slide, please.

The SWR excludes patients age 75 or older at dialysis initiation, patients who had their first transplant prior to the start of the ESRD treatment, patients who are waitlisted prior to the start of dialysis, patients admitted to hospice at dialysis initiation, and patients admitted to a SNF at dialysis initiation. Again, full measure documentation can be found at the link provided at the bottom of the slide. Next slide, please. Thank you.

As previously noted, the DFC Star Ratings will be refreshed in October of 2019. There are no planned updates to the measure set or to the methodology intended for the October 2019 release. All documentation of the Star Rating methodology can be found at the link below. It remains, as has been noted, unchanged from what was made available with last year's release. Next slide, please.

Actually, just for a note, we received another question about whether or not the discussion of the reset methodology would be included in the October 2019 release. To clarify for that, the answer to that is no. There is no plan to reset associated with the October 2019 release. And

now to the slide. So, right here we show the list of measures being used in the DFC Quality of Care Patient Star Rating for the October 2019 release. As noted, they are unchanged from the prior year's list. Next slide, please. Thank you.

So, getting back to the question of when the clinical Star Rating distribution will be reset. As we've noted, we received some recommendations from the Star Rating TEP regarding how we should go about considering the possibility for resetting a baseline. We did not, however, settle all potential issues with regard to the resetting. So, we can go to the next slide, please. Thank you.

So, this year the University of Michigan Kidney Epidemiology and Cost Center convened another Star Rating TEP. This TEP was charged with providing recommendations on when and how to reset the DFC Star Ratings. The TEP recommendations will be used to inform the development of methodology and timeline for resetting the Star Ratings distribution. The purpose of the reset is intended to enhance the program's goal to inform the public of meaningful performance differences across U.S. dialysis facilities, while also allowing us to continue to promote continued quality improvement in those dialysis facilities. Next slide, please.

The TEP met for two conference calls in May of 2019, and an in-person meeting was convened on June 6, 2019. The TEP has already provided initial recommendations to the University of Michigan. However, we are still in the process of meeting with the TEP. We anticipate at least one more meeting following up later this summer. And as such, there are no final formal recommendations from the TEP. However, when the TEP's deliberations are complete and we have had an opportunity to review their recommendations, a TEP summary report will be made available on the CMS website in the coming months. We will also anticipate that any implications for the Star Rating methodology, including resets or reset timing, will be presented to you publicly in a forum such as this one well in advance of the implementation of those changes. So, based on the question we got earlier, I think it's reasonable to anticipate some people may be wondering if and when that's going to be implemented. The answer is that we're not sure yet. And we'll be making the decision and communicating it to you publicly once that decision had been made. But at the moment we're still discussing the issue with the technical experts that we've convened. Next slide, please. Thank you.

The quarterly Dialysis Facility Compare review report for the October 2019 release will be available for preview and comments on the Dialysis Data secure website beginning on July 15th and through August 15th of 2019. The measures on the table "Dialysis Facility Compare Compare Preview" beginning on page 3 of the document are intended to be reported on the DFC website. So, if you look at that table, you'll see what information is intended for public report. We encourage you to review these data and contact us through our help desk, which is listed at the end of this presentation, with any questions or concerns that you may have during the preview period. The Preview Report, as noted, will now include the new PPPW and SWR measures of transplant wait listing. Next slide, please. Thank you.

During the quarterly DFC preview periods, users are able to request their facility patient lists using the following protocol. And we certainly encourage you to do so for the purpose of reviewing your performance. Facilities first will be encouraged to request patient lists in the first 5 days of a 15-day preview period and the first 10 days of a 30-day preview period. Because this is the preview period in advance of the October release, we would encourage you to use the first 10 days to request the lists in order to give us enough time to provide you with the lists and also to give you enough time to review them and then come back to us with any questions that you may have. Patient list requests in the first 5 to 10 days of a preview period will receive top priority in response time. After this period, DFC will continue to fulfill patient lists if requested, but the response time will likely be greater at that point in the preview period, as we'll be moving along in our conduct of the period. So, please be sure to request those patient lists as early as possible. We very much encourage their use on your end, not only for your own quality-improvement efforts, but to ensure that we have the most accurate data we possibly can on DFC. Thank you. I will now turn the presentation over to Golden Horton, who will discuss the patient voice.

Golden Horton: Alright. Thanks, Joel. Next slide, please.

The Dialysis Facility Compare website publishes data on thousands of Medicare-certified dialysis facility centers across the country. In an effort to meet the needs of individuals with kidney disease and their caregivers, we partnered with NORC at the University of Chicago in 2017. Support from the American Association of Kidney Patients conducted a five-hour discussion with ESRD patients and one caregiver. Patients were members of five national organizations representing the interests of ESRD patients. This feedback session was the first time DFC leveraged relationships with patient-advocacy organizations in the kidney community to dually receive broad patient input on the website and we engaged patients. CMS continues to engage with patients, ensuring their voices are heard, by soliciting their participation in past and future technical expert panels. Next slide, please.

Listening to the Patient Voice. In 2018, CMS conducted six focus groups in three cities with patients of all ages to hear about their experiences with dialysis. Conversations focused on how patients find and use information about dialysis facilities and treatments. Some of the feedback from patients also included -- participants frequently mentioned the need for basic information when starting dialysis. Dialysis facilities are generally the source for most or all care-related information for patients who crash into dialysis. Dialysis patients are often unaware or under-aware of the role Medicare plays in payment and regulations. And when introduced to the Dialysis Facility Compare website, participants found it helpful. Next slide, please.

Listening to the Patient Voice: The CMS Quality Conference. The CMS DFC team regularly attends the annual CMS Quality Conference to hear from patients, providers, ESRD Networks, and the larger healthcare community about dialysis. Some of this year's sessions that were featured include value-based care, promoting healthcare choice, and driving value-based care ESRDs, managing complex, chronic conditions, improving population health, rural health, and

health equity ESRD, improving access to kidney transplantations, and also healthy adjustment to dialysis. Next slide, please.

Including the Patient Voice. Feedback from the dialysis community included -- current depictions of ESRD and ESRD patients do not always represent the range of patient experiences, and many feel they are too negative. Information about treatment options and quality should be proactively provided directly into the hands of patients who might not otherwise seek it out. Patients want and seek resources specific to their current stage of disease and health status, but often don't know where to look. Medicare is a trusted source of information. Some of the feedback from patients also included that they were unaware of Dialysis Facility Compare and what it was utilized for. It is our hope that with continued stakeholder engagement that more patients will utilize the Dialysis Facility Compare website. Next slide.

CMS believes that DFC is intended to support patients and their caregivers seeking to inform them on kidney care. We continue to reach out to the community for ideas and suggestions on how to improve, work with the American Association of Kidney Patients and others to get feedback and perspectives from patients, continue to develop tools to help the community educate healthcare professionals, patients, and caregivers about DFC. We are also working on developing a DFC Handbook to help patients and the rest of the dialysis community understand and navigate the website. Again, we continue to develop informational resources to assist stakeholders and patients with understanding and utilizing all that the Dialysis Facility Compare website has to offer. Next slide, please.

So, our next steps. We are looking to connect with patient and provider organizations to make sure they have the resources they need, create resources that help patients understand their dialysis options, look for opportunities to incorporate feedback into DFC where possible, and consider feedback in the bigger picture of DFC's future development. Please continue to look out for more ways to become involved as the Dialysis Facility Compare website continues to evolve. Next slide, please.

If you would like more information in reference to measure specifications and Star methodology, please see the link below. So, at this time, we will open the floor for any questions that you may have.

Moderator: Thank you, Golden. As a reminder, you can submit a question using the "Questions" box. Questions not answered during the webinar will be answered and posted with the other webinar materials on the ESRD general information page after the webinar.

Okay, our first question is, "Will CMS ever consider making a bell curve for those units who are not for profit to exclude those patients who are treated and have no way of paying or have been refused by all other units? These patients are typically the patients who have been shown to be not in compliance with medical care and therefore many times not meeting standard ratings. If the non-payment is a stressor for these units or they do not meet the

standards, it is a double whammy for not-for-profit units, as then the reductions of payments usually follow, as well."

Joel Andress: Alright, this is Joel Andress from CMS. First of all, thank you, Maggie, for your question. A couple of things to say. First of all, our program doesn't directly affect payments through reduction of reimbursement and the like. There is the ESRD QIP, which does this, but we're not in a position to answer for them one way or another. So, I just want to make sure that's clear. That said, your question is not irrelevant to what we do because of course the scoring can still have an impact, for instance, on the Star Rating that the facility is awarded. I would say this is not something that we have necessarily considered yet. It's also not something that's been suggested to us directly in terms of implementing a kind of a performance curve for this particular issue. I don't know that I can say clearly whether or not we would be willing to implement it. It would probably be something we'd have to sit down and think about. If you have a more formal or detailed suggestion that you'd like to submit to us, I would suggest submitting it to our help desk so that we can take a look. We would also be in a position to reach out to you just to seek out any clarification in terms of what you're looking for. Otherwise, I think the answer is that there needs to be more detail about what it is that you'd want to see before I could give you a clear answer. I hope that's addressed the question adequately. Please let us know if you need any other clarifications. Thank you.

Moderator: Okay. Our next question is, "Where are the transplant waitlist data coming from?"

Joel Andress: Thank you. Thank you again. This is Joel. I'm going to turn that question over to the measure developer who developed and produces the measures for DFC.

Jennifer Sardone: The data is obtained from the OPTN/SRTR data source.

Moderator: Okay. Thank you. Our next question is, "Many of the DFC measures are standardized, but many are not. Have you considered the risk that non-standardized metrics may skew results based on local demographic variation?"

Joel Andress: Thank you again for the question. This is Joel once again. So, it is true that we use non-standardized measures. Typically, when we incorporate a non-standardized measure, it is because it's considered to be a part of a process in which there should not be variation based on something along the lines of local demographics. This is the same reason that for certain measures, such as dialysis adequacy, we don't incorporate methodological functions like risk adjustment into them. So, typically when we've made the decision not to standardize a measure, it's because we're operating under the belief that performance on the measure shouldn't be contingent on those kinds of factors. If you have a question about a particular measure, then we'd certainly be willing to discuss those on a one-for-one basis.

Moderator: Our next question is, "Will consideration be made for patients who have transplanted?" I believe this is in reference to the new 2019 measures.

Joel Andress: Sure. Thank you. So, when patients have been transplanted, they are pulled out of the denominator. There were some concerns raised during development of the measures and following our initial development phase that, for instance, higher rates of transplantation in a given area might lead to an artificially poor performance among facilities because their patients who were transplanted might be leaving the denominator faster, and as a result they don't get the benefit in their score of having those patients present. Obviously, we don't want to discourage transplantation of those patients. So, we did some analyses in response to those concerns, and what we found is that variations in approaches -- variations in rates of transplantation regionally don't appear to have any negative consequences for facilities for which they're being rated. So, based on our analyses, we're confident that the measure is not going to unduly penalize facilities are that are, in fact, seeing their patients transplanted effectively. Thank you.

Moderator: Okay. Our next question is, "What if you have a patient who has been reviewed and denied by the transplant team? Will they be carved out of the statistics?"

Joel Andress: Thank you for the question. This is Joel again. So, the way the measures currently work, these patients would not be carved out of the measure. I'm assuming you mean would they be excluded or would the facility be given credit for that review? And the answer to your question is that, as they're currently constituted, the measures do not. The goal and reasoning behind this is that the facility will work with the patients to attempt to return for a review to be considered by the transplant team. And our hope is that the measure specifications will encourage this. I think we recognize that there is not going to be a state in which all patients are being waitlisted for these measures. And in fact, the performance distribution for the measures reflects that. So, I think we recognize that there are going to be some patients who aren't going to end up being transplanted. You're not expected to top out these measures at 100% -- well, ideally 100%. So, I think with regard to that, there is not -- The short answer is, no, they're not carved out of the measures. And the reason for that is that we want to encourage the facilities to continue to work with patients to seek wait listing where it is appropriate and possible. Thank you.

Moderator: Alright, next question -- "Given the new emphasis on home modalities, will you offer measures that will be sensitive to ESRD outcomes and quality for patients choosing home modality?"

Joel Andress: Thank you for the question. This is Joel. The answer to that is, of course -- Well, I shouldn't say "of course." The answer to that is that we've given a lot of thought to how to measure populations such as patients receiving dialysis at home. And there are some inherent difficulties to this. One of them is that the population is still relatively small, and that makes it difficult to develop quality measures that can meaningfully differentiate performance on them. On the other hand, we've undertaken a number of efforts that look into developing measures such as patient-reported outcomes that can reflect meeting patients' needs and expectations with dialysis that we think may have an opportunity to reflect this kind of concern. I think it's important to recognize, though, that this is a -- there are some inherent

difficulties to developing measures that target this particular space directly. We are always interested in hearing ideas for what kinds of measures we could potentially develop in this area, and so we certainly welcome suggestions either through the help desk or reaching out to us directly. So, we certainly encourage you to do so. Thank you.

Moderator: Okay. I believe our next question is in reference to the new measures. How does this affect a facility of less than 15 or less than 20 patients?"

Joel Andress: Thank you for the question. So, I'm assuming that you're referring to the Star Ratings in this case. The answer actually relates back to the quality measures themselves. In order to receive a Star Rating, a facility has to have at least one measure in each of the three measure domains that we developed for the Star Ratings. And so the answer is that it depends upon whether or not the facility is meeting the case minimum thresholds for these individual quality measures. Those are themselves specific to the measures. That information can actually be found on DFC. If you follow up with the help desk, we can actually point you to that specific information with regard to the individual measures. The answer, though, is that if a facility doesn't meet those criteria for the measures, then they simply are not given a Star Rating. They come up with N/A, and we indicate that the facility doesn't have enough power for us to be able to provide a meaningful assessment within the Star Ratings. Thank you.

Moderator: Next question -- "Are AKI non-ESRD patients included in DFC measures?"

Joel Andress: Thank you for your question. The answer to that is that, no, we are not currently including those patients within the denominators for our measures on DFC. Thank you.

Moderator: Next question -- "Do the ineligible patients for transplant be excluded from the denominator? How do you identify the ineligible patients for your data?"

Joel Andress: Thank you. This is Joel. So, if you go back and look at slides -- Let me see where these slides are. Go back and take a look at slides 27 through 30 in the presentation. I don't know -- If we can take the slide deck back to 27, please. Okay. So, the slides actually list out here the exclusions for these measures, which you can find for the PPPW on slide 28 and for the SWR on slide 30. The answer is that we've applied fairly broad exclusion criteria for these measures. The first and probably the most prominent is that we've excluded all patients who are age 75 or older. And then we've excluded patients who are, depending on the measure, admitted to a SNF or hospice within a given month for the PPPW or who had been admitted to a SNF at dialysis incidence. And this is intended to reflect either that clinically the patient is unlikely to be a likely candidate for a transplant, as indicated by the fact that they've been admitted to a SNF or hospice. We've also incorporated within the SWR risk adjustments for age and incident co-morbidities to not exclude patients from the measure based on these, but to account for variation due to patient condition and comorbidity load. If you have any other questions with regard to how the measures are formulated, as we've noted, we've provided links to the measure documentation for these measures in the slide deck. I would certainly encourage you to review those. If you have additional questions about the precise

specifications of the measures, then we'd certainly encourage you to reach out to us through the help desk and share your questions or concerns, and we can discuss them with you. Thank you.

Moderator: The next question, I believe, is related. "Will DFC consider patients that have multiple comorbidity conditions and are on a staff-assisted home program?"

Joel Andress: Alright, so, I'll do my best. I'm not entirely certain whether or not this is intended to be a comment directly to the transplant measures. I think the answer is that where we have risk-adjusted for our various measures, we've attempted to adjust for patients' comorbidities. So, we don't necessarily risk-adjust for the fact that they have multiple comorbidity conditions, but if patients do have multiple comorbidity conditions, then these are typically captured in the risk-adjustment models that we have applied to our outcome measures. If this isn't quite what you're getting at with the question, then I would encourage you to submit clarification so that we can try to address that. Thank you.

Moderator: Our next question is, "Why do you see a high number of home-therapy standalone facilities with no Star Ratings?"

Joel Andress: Thank you for your question. So, the reasons that we might see something like that is that we have certain criteria in the Star Rating methodology, which, again, you can link to in the slide deck and review and certainly get back to us with any questions you have -- But the main one here I think that is likely to apply is that you have to qualify for at least one measure in each domain. And so if you have a small number of patients or if you don't have enough patients to fit within the denominators of specific categories, then a facility may not receive a rating for that reason. Another reason may be simply that the facility is new, then the facility may not yet have adequate data in the performance period to receive a star rating even though it's already open and therefore reflected on DFC. So, those are two potential reasons which might explain why you see that. If you have a chance to take a look at the methodology and you think that doesn't explain why you're seeing that, then we'd certainly be interested in talking with you further about any concerns you would have.

Scott Scheffler: And this is Scott Scheffler with RTI. If the question happens to be directed on the survey end, I'll just say that, for a patient to be eligible, we require that the dialysis treatments be at the in-center. And so on our end, we exclude home-dialysis patients. Now, we don't exclude the whole facility because there's some facilities out there that serve a mix of home and in-center. And so that type of facility, we don't want to be surveying patients on the in-center side. And so that particular facility would need at least 30 of those type of patients to be able to report it. And so if that facility primarily served the home-based crowd, then they would most likely be excluded.

Moderator: Okay. Our next question is, "Are QIP composites of quality consistent with Star Ratings?"

Joel Andress: Scott, I think that may be a question for you regarding the composite measures.

Scott Scheffler: Yeah, and I'm not entirely sure I understand the question. If you could submit it again and explain a little bit more, I might be able to answer that for you.

Moderator: Okay. We only have time for a couple more questions, but next one is, "When calculating transplant waitlist data, is there any account for patients less than 65 years old that have had transplants in the past but rejected and declined to go back on the list?"

Joel Andress: Thank you for the question. I think the short answer is no. However, I think what we don't have within the measure is a capacity to capture if a patient has declined to go onto the list in the first place. So, no, we can't track whether or not they've simply declined to go back on a list. That's not something we currently have access to for the measures.

Moderator: Okay. Next question, "When patients have been determined not a candidate for transplant after evaluation due to medical comorbidities or removed from transplant lists due to medical issues, are they not removed from the denominator of the percentage for number of patients listed?"

Joel Andress: Thank you. I think the question there is actually, "Why are they not removed from the denominator percentage for number of patients listed?" Okay. Thank you for the question. I think the answer to that is simply that we're intending the measures to encourage continued effort to seek wait listing where possible. I think it's certainly reasonable to expect that there would be circumstances where it's highly unlikely that an individual patient is going to be waitlisted due to the presence of medical comorbidities. That's one of the reasons, for instance, that we risk-adjust for these in the risk model for the SWR. But it's also one of the reasons why we've incorporated the exclusions that we have for these measures, including placement in hospice of SNFs or for patients age 75 and older, where you're more likely to see the presence of those kinds of medical comorbidities. And so what we've done is we don't have exclusion criteria that fits specifically with a reason for rejection from the transplant, which we don't have access to, but rather what we've done is we've excluded populations of patients from the measures that are more likely to encounter those kinds of circumstances. Thank you.

Moderator: Thank you, Joel. We've come to the end of the time for our presentation. 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'll turn it back over to you to close the call.

Golden Horton: Thanks, Tim. We hope this webinar today has been informative. If you have any further questions, please utilize the links below on the previous page. There you go. Thanks. Thank you for joining us today, and, again, have a good day. Thank you.