KIDNEY CARE PARTNERS

June 30, 2016

Kate Goodrich, M.D.
Acting Director
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Goodrich,

On behalf of Kidney Care Partners (KCP) and its members, I am writing to share comments on the recently announced methodology for Star Ratings of dialysis facilities. We appreciate the Agency's efforts to work with the kidney care community to revise the Star Rating methodology. As you know, addressing methodology concerns with the ESRD Star Rating program is a top priority for the members of KCP. We strongly support the modifications to recognize improvement, the adoption of the Z-score methodology for the rate measures, and the removal of the proposed triggers for rebasing.

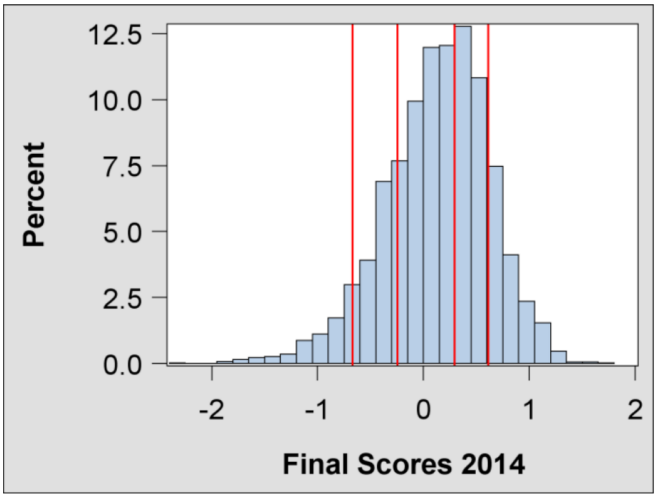
The updated methodology represents important progress, but we continue to have concerns about unresolved issue of using a forced distribution of Star Ratings in the baseline year and for periodic rebasing. In addition, the current language about when rebasing will occur is unfortunately too vague to provide a clear standard as to when rebasing will occur.

I. CMS Should Select Consistent Cut Points Using Appropriate Performance Ranges, Rather than Using the Forced Distribution for Cut Points

KCP continues to urge CMS to consider an alternative to the forced 10-20-40-20-10 distribution of Star Ratings for dialysis facilities. We believe that using a forced distribution is antithetical to the purpose of the Star Rating program, which is to provide consumers with meaningful information upon which to base their care decisions. To achieve this purpose, CMS should seek to align the Star Ratings as closely as possible with actual facility performance. Any transformation of the underlying data can potentially distort the results so that the Star Ratings misrepresent actual facility performance, and consumers may be misinformed when making their choices. For example, the forced distribution can mean that a relatively small difference in actual performance results in a two-star difference in rating. Consumers will then make decisions based on this inaccurate representation.

The updated Star Rating methodology partially addresses this concern by moving to a z-score model to score most of the individual measures (as KCP had suggested previously). Z-scores work better than the prior percentile model because z-scores preserve the underlying distribution of facility performance. However, the value of improving the methodology for individual measure scoring is undermined by using a forced 10-20-40-20-10 distribution for the baseline Star Ratings.[1] The forced distribution distorts the actual distribution of performance, which is skewed toward higher performance. If CMS's goal is to portray accurately the actual performance of dialysis facilities, the distribution of Star Ratings should track the actual distribution of performance.

This graph, from the "Technical Notes on the Updated Dialysis Facility Compare Star Rating Methodology"[2] illustrates our point. The distribution of Final Scores is obviously asymmetrical (reflecting the underlying asymmetry of measure results), with more facilities bunched toward the high end of the performance spectrum. Achieving a symmetrical distribution of Star Ratings requires that CMS set Star Rating cut points that are not based on actual performance, but are merely chosen to achieve pre-determined results. Therefore, the actual performance ranges included in each Star Rating vary, making the result less useful to consumers.



Instead, we recommend that CMS choose consistent cut points using appropriate performance ranges, and then the Star Rating distribution flow from that. For example, 3 Stars could be defined a final score between -.25 and .25, 4 Stars between .25 and .75, 5 Stars above .75, etc. This would result in an asymmetrical distribution of Star Ratings <u>because that is what the actual facility performance looks like</u>.

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[1] Keeping the Star Rating cut-points consistent year to year is an improvement, since it will accurately portray year-to-year quality among dialysis facilities. However, see our comments on rebasing, below.

[2] https://dialysisdata.org/sites/default/files/content/Methodology/UpdatedDFCStarRatingMethodology.pdf

II. CMS Should Establish a Clear Standard for Rebasing

We support the change to the methodology to use fixed performance benchmarks for the Star Rating cut points. This will allow facilities to demonstrate performance changes over time, and eventually would allow the distribution of Star Ratings to shift based on overall improvement trends. Both of these results are aligned to the overall program goals on conveying accurate information to consumers.

However, the final methodology is still unclear on how frequently the program is likely to rebased to the forced distribution. If the program is frequently rebased, then in effect the program will retain the forced distribution. For this reason, we support the decision to remove the automatic trigger to rebase the program if the distribution shifts by a specified amount.

There are other aspects of the rebasing process that are still a concern to us, and which are unclear in the final methodology. The proposal released earlier this year combined the rebasing triggers for the individual measures and the overall Star Ratings. While the proposal was ambiguous, it seemed to imply that the whole Star Rating program would be rebased back to the 10-20-40-20-10 distribution if even just one component measure needed to be rebased. Our comment letter raised concern about "using rebasing triggers that seem likely to result in the rebasing the star ratings every year." The final methodology released by CMS makes a clear distinction between rebasing individual measures and rebasing the overall Star Rating distribution. Therefore, we interpret that the final methodology permits rebasing of one and not the other. We support this interpretation. The less frequently the program is rebased, the more it will display for consumers the ongoing improvements in quality among dialysis facilities.

The final methodology also provides for rebasing when the program "becomes ineffective at communicating differences in outcomes between facilities due to shifting to the extreme." We request that CMS clarify this criterion so that the ESRD community can better anticipate potential changes and updates to the program. Who will make this decision? What criteria will be considered? How will the community be included in the decision-making process? We recommend that CMS work with KCP to more clearly articulate the rebasing process.

III. Conclusion

Once again, we want to thank you and your team for addressing some of the concerns we have raised in previous letters. We reiterate our commitment to working with you to resolve the outstanding issues that will allow the Star Rating program to achieve the Agency's goal and be a useful tool for patients, caregivers, and consumers. Please do not hesitate to contact Kathy Lester at klester@lesterhealthlaw.com or (202) 534-1773 if you have questions or would like to discuss these recommendations.

Sincerely,

Frank Maddux, M.D.
Chairman
Kidney Care Partners

cc: Pierre Yong, Acting Director, Quality Measurement and Value-Based Incentives Group
Elena Balovlenkov, R.N., Technical Lead for Dialysis Facility Compare
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