



March 20, 2014

Helen Burstin, MD, MPH
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National Quality Forum
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Via Email: readmissions@qualityforum.org

Dear Dr. Burstin:

Kidney Care Partners (KCP) greatly appreciates the opportunity to comment on the list of proposed measures for the *All Cause Admissions and Readmissions Project*, and commends NQF for instituting the continuous commenting policy, which facilitates greater stakeholder participation by permitting NQF Members and the public to provide input earlier and more thoughtfully.

As you know, KCP is a coalition of members of the kidney care community that serves as a forum for patient advocates, physicians, nurses, dialysis facilities, providers, and manufacturers to advance policies that support the provision of high quality care for individuals with chronic kidney disease and End-Stage Renal Disease (ESRD).

One of the measures submitted to NQF for endorsement consideration was developed for use in the ESRD population and consequently is of particular interest to KCP. In reviewing this measure, the Centers for Medicare and Medicaid Services' (CMS) *Standardized Unplanned 30-Day Readmission Ratio for Dialysis Facilities (SRR)* (NQF #2496), we have identified several significant concerns and offer the following comments. We note that these same concerns were detailed in KCP's May 2013 comment letter to Arbor Research and CMS when the measures were under development;¹ to our knowledge, none of these issues were addressed.

- I. KCP notes that, as specified, the SRR is inconsistent with CMS's *Dialysis Facility Risk-Adjusted Standardized Mortality Ratio (SMR)* and *Standardized Hospitalization Ratio for Admissions (SHR)* measures. Specifically, these measures only include patients who have had ESRD for 90 days or more, and the proposed SRR measure does not appear to be harmonized in this respect. In our May 2013 comment letter to CMS, KCP requested clarification on why this difference is present and asked CMS to provide the data analysis on the implications of the difference. To date, these details have not been provided for stakeholder review, and KCP urges the *All Cause Admissions and Readmissions Steering Committee* to seek this information so as to allow for an appropriate evaluation of the underlying rationale for and aptness of this disparity. We stress that harmonization is of particular importance with the SHR, given the SRR and SHR are likely to be used in conjunction to obtain a complete picture of a facility's hospitalization use.

¹ KCP comment letter.

- II. KCP notes that the SRR measure specifications submitted to NQF's Measure Applications Partnership (MAP) in November 2013 had an exclusion for index hospitalizations that occur after a patient's 6th readmission in the calendar year, which has now been revised to those that "occur after a patient's 12th readmission in the calendar year." KCP has requested that CMS explain the rationale behind this change. In particular, we are concerned about the impact of the revision on low-volume facilities, and believe it is imperative for CMS to report on the underlying distribution that led to the change in order to understand its implications as compared to the version submitted to the MAP.
- III. KCP notes that CMS's *Hospital-Wide All-Cause Unplanned 30-Day Readmission Ratio* (NQF #1789) excludes patients who have incomplete claims history from the past year, but the proposed dialysis facility SRR does not. KCP requested in its May 2013 letter to CMS that it provide the data on readmission rates for patients who have a full year of claims versus those who do not, as well as data on the impact of such an exclusion on the sample size and performance gap. While this information has not to date been provided, we believe such data and analyses are necessary in order to understand why the dialysis measure is not and/or should not be harmonized with the hospital measure.
- IV. CMS has incorporated numerous comorbidities into the SRR risk model, but KCP has recommended that in addition to sickle cell anemia, sickle cell trait also be included—as well as angiodysplasia, myelodysplasia, diverticular bleeding, and asthma. Likewise, we have suggested that the risk model also adjust for nursing home status, and have requested clarification on whether "poisoning by nonmedical substances" encompasses ongoing/chronic alcohol or drug abuse and not just acute events.
- V. KCP believes the measure's risk model fails to adequately account for hospital-specific patterns and fails to adjust at all for physician-level admitting patterns—a particular concern because the decision to admit or readmit a patient is a physician decision. We note that geographic variability in this regard is well documented in other areas, and there is no reason to believe the situation is different for ESRD patients. Specifically, merely adjusting for the hospital as a random effects variable is insufficient. Recent research indicates that beyond a simple hospital ranking, broader regional and geographic variability persists and must be accounted for.
- VI. KCP has recommended to CMS—and continues to strongly recommend—that the measure be limited to those readmissions that are related or actionable to ESRD, rather than the all-cause readmissions promulgated in the current specifications. Data from one KCP member revealed that approximately 45 percent of readmissions are not related or actionable to ESRD; moreover, only a subset of the 55 percent attributable ESRD admissions are same-cause-specific readmissions.
- VII. In our May 2013 comment letter to CMS, KCP recommended that patients who are readmitted in the first 1-3 days after discharge be excluded from the measure. Data from two KCP members find that among patients who were rehospitalized within 30 days of the initial hospitalization in 2011, 11-17 percent were readmitted during this period—often even before the first outpatient dialysis encounter. Specifically, for one KCP member, 17 percent of patients were readmitted within 3 days post discharge, among whom only 35 percent of patients had been seen by the dialysis unit prior to the readmission. In other words, by an

approximately 2:1 margin, rehospitalized dialysis patients had not been seen by the dialysis facility before readmission. Penalizing facilities for such situations is patently unreasonable. Further in this regard, during the first 8 days after discharge, up to 40 percent of patients were readmitted—again the dialysis center had had a limited number of encounters to intervene/affect quality of care.² Lastly, not all discharges are to home and a significant number of patients are readmitted before they receive care from a dialysis facility. The measure should account for this.

- VIII. Finally, CMS should provide data to demonstrate there is no bias of the SRR between rural and urban facilities; this is not simply adjusted for by the hospital as a random effect variable. We note that the distance of a patient's home relative to the outpatient facility and to the hospital likely influences their choices for care, and it likely further influences their utilization of care, particularly if there are symptoms that occur on non-dialysis days. The co-pay for transportation also may influence health utilization behavior. It is important for CMS to evaluate the impact of these factors on readmission rates for patients with ESRD and report why such factors should or should not be incorporated. We posit that billing data may shed light on how to evaluate these factors, yet they were not even considered.

Given the technical flaws and lack of validation elucidated above, KCP believes this measure should not be endorsed by NQF. We note that CMS has at its disposal the data to address a number of these issues—specifically the ability to understand the types of readmissions that dialysis patients experience, the length of time post-discharge when readmissions occur in relationship to when outpatient dialysis unit care resumes, the sites of service that patients are discharged to, and claims data related to physician admission/readmission for purposes of adjusting the model for this factor. Further, KCP is concerned with the approach and assumptions for the predictive model, which posits to reveal an actual versus predicted rate when the basis for the ratio comes from claims data and not EMR data. We strongly recommend a more evidence-based approach to this measure and reiterate our opposition to its advancement.

Thank you for your consideration of our comments and recommendations. Please do not hesitate to contact Lisa McGonigal, MD, MPH (203.298.0567 or lmcgon@msn.com) if you have any questions.

Sincerely,



Linda DeRuvo-Keegan
Executive Director

² See Chan KE, Lazarus JM, et al. Association between repeat hospitalization and early intervention in dialysis patients following hospital discharge. *Kidney Internat'l.* 2009;76:331-43.