FRESENIUS MEDICAL CARE

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National Quality Forum
1030 15th Street, NW – Suite 800
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Via Email: readmissions@qualityforum.org

Dear Dr. Burstin:

Fresenius Medical Care North America is the largest provider of outpatient dialysis services for individuals with end-stage renal disease (ESRD) in the United States, providing treatment to some 170,000 individuals in over 2000 facilities nationwide.

We write today to comment on the *Standardized Unplanned 30-Day Readmission Ratio for Dialysis Facilities (SRR)* (NQF #2496), one of the measures in the *All Cause Admissions and Readmissions Project.*
In reviewing this measure, we have identified several significant concerns and offer the following comments.

1. The experience provided by the developers and the recent CMS demonstration (2012) showed only annual data and did not show longitudinal trends. Therefore, the stability of this measure from year to year is not entirely clear, particularly for facilities with small numbers of eligible beneficiaries. We do not believe that a measure such as this one, that could lead to wide swings from year to year, with potential changes that do not necessarily relate to the actual quality of care provided, is not ready for NQF approval and CMS implementation.

2. The wide confidence limits from the current SRR methodology (that required increased event size, hence the move to allow for 12 vs. the original 6 readmissions or to remove a one-year Medicare history from eligibility) only identified 3% of all facilities in the US in 2012 as outliers for penalty (i.e. "worse than expected'). It is not entirely clear if facilities with small numbers are at higher risk to be identified, although it is expected, based on our experience with other standardized CPM like the SMR. Therefore, the point stated in #1 above could be magnified if the majority of the outliers are small facilities.

3. By definition, for the 95% of facilities that fall under the "as expected" category (i.e. within 95% confidence limits of the estimate), there is no valid construct to assign points (similar to other QIP measures) and will create no room to gauge improvement.

4. In reconciling our internal records from those provided by CMS for facilities that participated in the 2012 SRR Demo, we find that the median (IQR) percent of hospitalizations counted by CMS, that we had documented in each facility's dialysis information system records, was 85.5% (80%, 89%). Furthermore, among the hospitalizations where the facility documented an absence, >7% of admissions counted by CMS were not recorded as true admissions (e.g. <24 hours observation, day surgery, etc.) internally. Therefore, the lack of transparency and data from CMS to verify and act on readmissions/prevention of readmissions in a timely manner from a population management perspective, is very limited.

5. Public validation of definitions - to include the ICD-9 definition for "non-acute readmissions" and "planned procedures" - is necessary so that specialists from the different medical disciplines can weigh in before the measure is approved for use as a CPM.

We especially want to emphasize that the NQF Steering Committee should ask CMS, at minimum, to exclude patients/readmissions from the measure if they occur within 4 days of discharge because some patients will not have been seen by the dialysis facility staff within that timeframe. The facility cannot and should not be held accountable for a readmission under such circumstances. Typically, an individual returns to the dialysis facility post-hospitalization on their next regularly scheduled treatment day, which may be three days post discharge if the discharge occurred on a Friday and the patient's scheduled dialysis is for Monday. The patient is evaluated by facility staff. Such evaluation usually includes lab testing to determine the patient's status, and to inform the plan of care. By the time the results are received and interventions determined, it is not unusual that four days have elapsed. It is also important to note that the dialysis facility receives little to no substantive information about the patient's course of treatment while hospitalized.

Thank you for your consideration of our comments and recommendations. Thanks also for instituting the continuous commenting policy, which enables increased participation.

Please do not hesitate to contact me (frank.maddux@fmc-na.com) if you have any questions.

Sincerely,

FW Maddux MD

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