February 3, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Room 445–G
Hubert H. Humphrey Building,
200 Independence Avenue, SW
Washington, DC 20201

RE: Development of End-Stage Renal Disease Vascular Access and Access to Kidney Transplantation Measures

Dear Acting Administrator Slavitt:

The American Society of Diagnostic and Interventional Nephrology (ASDIN) is the professional organization of interventional nephrologists who focus on procedures that obtain and maintain patient’s optimal dialysis access. ASDIN also includes interventional physicians in other specialties who focus on providing dialysis access care. We are writing to provide comments on two of the End-Stage Renal Disease (ESRD) vascular access and access to kidney transplantation measures – the long term catheter rate and standardized fistula rate measures.

Hemodialysis Vascular Access - Long-term Cather Rate – ASDIN believes the addition of the exclusion for patients with limited life expectancy is appropriate; but is concerned about the limitation of these to the four specified categories listed (hospice care, metastatic cancer, end-stage liver disease and coma or anoxic brain injury). We recommend the addition of one more category of patients – Systolic congestive heart failure with NYHA class 4 or ejection fraction of <15%. Patients with severe systolic heart failure often have low blood pressure that precludes fistula or graft placement due to risk of exacerbation of heart failure and access thrombosis. The most appropriate access for patients with such severe systolic heart failure may be a catheter.

Hemodialysis Vascular Access - Standardized Fistula Rate – Again, ASDIN is concerned about the four specified categories listed under limited life expectancy and encourages CMS add severe systolic heart failure to the list. In addition, ASDIN has concerns related to the statistical methodology for the “standardization” – including the factors chosen and weakness of the model’s C-statistic. While it can be argued that this is better than the current unadjusted fistula rate, inadequate adjustment may adversely affect smaller units and introduces a degree of lack of transparency. The use of a standardized rate will preclude comparison to rates previously reported and potentially allow "gaming" of the system by aggressive reporting of comorbidities. We believe that continuing to use the unadjusted fistula rate is a better measure. Finally, ASDIN is concerned about the "pairing" of catheter and fistula rates described, and believe this needs additional clarification.
As always, ASDIN welcomes the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation’s kidney patients, and we stand ready as a resource to CMS in its future endeavors. Any questions or comments regarding this correspondence should be directed to ASDIN’s Executive Director, Mary Lea Nations, at 601-924-2220, or by email at mnations@asdin.org.

Sincerely,

Kenneth Abreo, M.D.
President, ASDIN