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Emergency Department Visits Measures Team
University of Michigan Kidney Epidemiology and Cost Center (UM-KECC)
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Joel Andress, PhD
Centers for Medicare and Medicaid Services
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RE: HHSM-500-2013-13017I: End Stage Renal Disease (ESRD) Quality Measure Development, Maintenance, and Support

Dear UM-KECC team and Dr. Andress:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with kidney disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease.

We appreciate the opportunity to provide comments on the two proposed "End-Stage Renal Disease Emergency Department (ED) Visits" measures put forth by the Centers for Medicare and Medicaid Services (CMS)/University of Michigan Kidney Epidemiology and Cost Center (UM-KECC). RPA commends CMS' attention to improving dialysis patient safety. However, RPA believes that there are significant limitations and concerns with the measures as developed in their present form. These concerns are detailed below:

- **All-Cause Readmission:** As proposed, the Standardized Ratio for ED Encounters Occurring within 30 Days of Hospital Discharge (ED30) and Standardized ED Encounter Ratio for Dialysis Facilities (SEDR) capture all ED visits by ESRD patients, regardless of cause. RPA objects to this construction, believing that it is too expansive in scope and will unfairly penalize dialysis facilities for ED visits that are beyond their control and unrelated to quality of dialysis care. ESRD patients seek ED care for reasons unaffected, separate and independent from their life as a dialysis patient. Hence, attributing

performance on these measures to dialysis facilities does not represent quality of care at such facilities. To hold facilities accountable for these visits to the emergency room is both risky from a quality perspective and both inequitable and daunting for dialysis facilities.

- **Unintended Disparities in Care/Access to Care:** There are also concerns that need to be considered related to how an ED is defined in context of the increased use of urgent care centers. CMS should consider whether there will be a disparity between communities with multiple walk-in clinics/urgent care centers (e.g., more affluent communities with greater healthcare access) versus resource-poor communities where the ED is the only immediate facility for acute health matters. Since walk-in clinics/urgent care centers are not included in the numerator, there will be under capture of emergent/urgent care in communities where such centers are more widely available.

  This issue is compounded in areas where there are few physicians and/or patients have no primary care physician, as utilization of the ED may also be increased.

- **Lack of Evidence:** RPA is unaware of any data that demonstrates that a measure of ED use provides any different information regarding quality of care than hospitalization/rehospitalization data. Furthermore, the included NQF evidence forms do not provide such information. RPA suggests that if such evidence exists, that it be clearly articulated in the measure evidence forms; otherwise it appears that there is both a lack of performance gap and lack of supporting evidence in this area.

- **Reliability Concerns:** In ED30, testing found that inter-unit reliability (IUR) = 0.35, indicating that only 35% of the variation in a score can be attributed to between-facility differences and 65% to within-facility differences—by statistical convention, this is a poor degree of measure reliability. As such, it is difficult to ascertain whether this data can be consistently captured across facilities.

- **Exclusions:** RPA believes that the measures should include an exclusion for ESRD patients who reside in or are discharged to a Long-Term Care (LTC) or Skilled Nursing Facility (SNF), as medical decisions made at LTCs and SNFs are beyond the control of the dialysis facility and its providers.

- **Policy and Payment Issues:** While RPA appreciates that the evidence cites that the increased use of telehealth may reduce use of EDs by high-risk ESRD patients, we note that dialysis facilities are not currently approved as an originating site for telehealth services under Medicare. At this time, Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:
  - A county outside of a Metropolitan Statistical Area (MSA); or
  - A rural Health Professional Shortage Area (HPSA) located in a rural census tract.

  These legislatively-mandated limitations restrict the potential real-world impact of the use of telehealth in this patient population.

As always, RPA welcomes the opportunity to work collaboratively 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 work on improving dialysis patient safety. Any questions or comments regarding this correspondence should be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Sincerely,

Michael D. Shapiro, MD, MBA, FACP, CPE

RPA President