KIDNEY CARE PARTNERS

January 12, 2015

Measure Applications Partnership
c/o National Quality Forum
1030 15th Street, NW - Suite 800
Washington, DC 20005

Subject: MAP 2014-2015 Preliminary Recommendations on Measures Under Consideration for Federal Programs and Programmatic Deliverable Report, Public Comment Draft

Thank you for the opportunity to comment on the Measure Applications Partnership (MAP)'s preliminary 2014-2015 recommendations on the Measures Under Consideration (MUCs) for Federal programs and the draft *Programmatic Deliverable Report.* Kidney Care Partners (KCP) is a coalition of members of the kidney care community that includes the full spectrum of stakeholders related to dialysis care—patient advocates, health care professionals, dialysis providers, researchers, and manufacturers and suppliers—organized to advance policies that improve the quality of care for individuals with chronic kidney disease and end-stage renal disease (ESRD). We greatly appreciate the MAP undertaking this important work.

Seven MUCs submitted by the Centers for Medicare and Medicaid (CMS) are proposed for use in the ESRD Quality Incentive Program (QIP), and consequently are of particular interest to KCP. These measures fall into three areas:

Adequacy MUCs
- X3717—Delivered Dose of Hemodialysis Above Minimum (CMS)
- X3718—Delivered Dose of Peritoneal Dialysis Above Minimum (CMS)
- X2051—Delivered Dose of Dialysis Above Minimum—Composite Score (CMS)

Medications Documentation MUCs
- E0419 (NQF #0419)—Documentation of Current Medications in Medical Record (CMS)
- X3721—Medications Documentation Reporting Measure (CMS; reporting measure of E0419)

Cultural Competency MUCs
- E1919 (NQF #1919)—Cultural Competency Implementation Measure (RAND)
- X3716—Cultural Competency Reporting Measure (RAND; reporting measures of E1919)

We offer the following comments by measurement area.

ADEQUACY MUCs

KCP supports the Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup's recommendation for conditional support for X3717, X3718, and X2051, pending NQF endorsement and also subject to the public availability of testing results. All three adequacy measures are composites. Combining measures into a composite format can materially alter the properties intrinsic to the component measures; even though the individual measures have been tested, this does not negate the need for the composite measures to be tested.

Additionally, although we offer conditional support for X2051, KCP urges that CMS continue to work with the community on assessing pediatric-specific quality. We acknowledge and

generally support the MAP's view on the importance of parsimony, but if CMS were to deploy only X2051 in the QIP as the measure for adequacy, pediatric-specific quality would effectively be masked by the overwhelming contribution of the numbers of adult patients.

Finally, based on the specifications CMS provided to MAP, we note apparent variations from the NQF-endorsed measures and believe the variations should be justified and tested:

- X3717 uses patient-months; NQF 0249 and 1423 (the components of X3717) use a straight patient count.
- X3717 and NQF 1423 exclude patients on dialysis for <90 days; NQF 0249 excludes patients on dialysis <6 months.
- X3717 and NQF 0249 only include patients dialyzing three times per week; NQF 1423 includes patients dialyzing three or four times weekly.
- X3718 and its component measure *Minimum Kt/V for Pediatric Peritoneal Dialysis Patients* (not endorsed) use patient-months; X3718's second component measure, NQF 0318 uses a straight patient count.

MEDICATIONS DOCUMENTATION MUCs

KCP recognizes that true medication reconciliation is an important and high priority, but neither E0419 nor X3721 adequately address this aspect of care. Both measures emerged from the PAC/LTC Workgroup with the designation "consensus not reached;" the Workgroup voted 56% to 44% against conditional support pending testing (E0419) and endorsement (X3721). ***KCP opposes both E0419 and X3721 and urges the MAP Coordinating Committee to do likewise. We believe the specifications are fundamentally flawed for the dialysis facility setting and hence should be opposed.***

We note that while E0419 has been endorsed for physician- and population-level use, there is a complete lack of testing in dialysis facilities. Unlike the adequacy measures, where there is both testing and experiential data on the components, CMS has not demonstrated that E0419 is reliable and valid for dialysis facilities. Accordingly, E0419 should not rise to the level of "conditional support," as has been recommended for the adequacy measures.

KCP also opposes X3721. This structural/reporting measure has reportedly been tested in dialysis facilities (though that information has not been made available), but is based on E0419, for which validity and reliability have not been established in that setting. We must therefore question both the process of testing a reporting measure in a setting for which its foundation measure was neither intended nor tested, as well as the soundness of the resultant findings.

Additionally, KCP believes E0419 and X3721 are essentially "checkbox measures" that are unlikely to improve medication reconciliation. We also note that E0419 looks at the percentage of visits in which a review of the medications occurs; we believe this is an inappropriate specification when dialysis facilities are the care setting with, typically, three or more treatments per week. Testing a measure would shed light on the feasibility and validity/reliability of the current E0419 specifications as presented, but has not been performed in dialysis facilities. Reliability and validity demonstrated in other care settings should not be assumed to transfer.

We cannot overemphasize the importance of testing medications documentation and reconciliation measures specifically at the dialysis facility level. Again, we are acutely sensitive to the potential utility of a valid medication reconciliation measure for patients with ESRD on dialysis, because they take an average of 8 to 10 medications, prescribed by 4 to 6 different

doctors. Further, all non-prescription medications and medications prescribed by other providers must be included in the review. ***We believe that, as currently specified, E0419 is not feasible and would yield inaccurate data (as would X3721) because it is based on faulty specifications. Accordingly, MAP should not conditionally support either measure.***

CULTURAL COMPETENCY MUCs

KCP acknowledges that cultural competency is an important health care priority and that the cultural competency MUCs would serve to expand the ESRD measure set to include nonclinical aspects of care such as patient engagement. However, KCP believes that as these measures have neither been adequately tested in the dialysis facility setting nor demonstrated as having any impact on patient care or outcomes, they are not appropriate for use in the QIP, which should be limited to care delivery in the dialysis facility setting. As with the medications reconciliation MUCs, the PAC/LTC Workgroup voted 56% to 44% against support (E1919) and conditional support pending NQF endorsement (X3716). ***KCP concurs and opposes both E1919 and X3716, and urges the MAP Coordinating Committee to do likewise.***

KCP notes that while E1919 is NQF-endorsed and is in use for internal and external QI purposes, it has not been used for public reporting or payment. Moreover, while E1919 was specified for use in and has been tested in dialysis facilities (among other settings), testing was limited to seven dialysis facilities within a single organization in Texas. Given the uniqueness of the setting and the complexity of the patients receiving care therein, KCP does not believe that this level of testing is sufficient to deem the measure appropriate for use in dialysis facilities.

KCP also stresses that, given the intrinsic burden associated with health care surveys, whatever cultural competency measure is ultimately adopted for use in the QIP should be empirically linked to at least some improvement in care and/or outcomes stemming from the assessment. This has not yet been demonstrated for this measure. We additionally note that there is some overlap with the ICH-CAHPS domains. As research is currently abundant in this area, we urge the MAP Coordinating Committee to wait for the development of a more appropriate cultural competency tool, with no redundancy with existing surveys and a demonstrative efficacy in the dialysis setting.

KCP reiterates that the issue of burden is complex and must be approached with caution. Each survey required places a heavier load on physicians, staff, and patients. We stress that it is critically important before adopting the cultural competency measures that additional testing be performed and that use of the measures in the dialysis facility setting be better understood. ***We believe that as currently specified, E1919 and its reporting measure X3716 would be burdensome and have not been demonstrated to yield accurate data or to improve care, outcomes, or patient experience in the dialysis facility setting. Accordingly, the measures should not be supported/conditionally supported (respectively) by the MAP.***

KCP again thanks you for the opportunity to comment on this important work. If you have any questions, please do not hesitate to contact Lisa McGonigal, MD, MPH (lmcgon@msn.com or 203.298.0567).

Sincerely,

AbbVie

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American Kidney Fund
American Nephrology Nurses' Association
American Renal Associates
American Society of Nephrology
American Society of Pediatric Nephrology
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