THE KIDNEY CARE COUNCIL
Providers of Quality Care the for Nation's Dialysis Patients

Via Electronic Submission: regulations.gov

August 12, 2016

William N. Parham, III
Director
Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Form Number: CMS–10105 (OMB control number: 0938–0926): Agency Information Collection Activities: Proposed Collection; Comment Request

Dear Director Parham:

The Kidney Care Council (KCC) is the nation's association of dialysis providers that collectively provide life sustaining dialysis treatment to 420,000 patients, representing more than 90 percent of individuals living with kidney failure in the United States. KCC members deliver care in more than 5200 facilities in every type of geography: urban, suburban, rural, and frontier. Our members – the 11 leading dialysis providers in the United States – are a diverse coalition of large, medium, and small dialysis organizations, operating with not for profit and for profit statuses, headquartered all over the country. We write today to provide detailed comments pursuant to the comment request on the National Implementation of the In-Center Hemodialysis CAHPS Survey (ICH CAHPS).

KCC members are committed to the delivery of quality dialysis care. As Medicare confers a unique eligibility for individuals with ESRD, the vast majority of our patients are Medicare beneficiaries and we aim to work in good partnership with the Centers for Medicare & Medicaid Services (CMS). KCC members stand ready to work with CMS to implement the policies supported here in our comments to achieve our shared goal of ensuring access to the highest quality dialysis care for Medicare beneficiaries at a significant value to the taxpayer.

KCC continues to support the inclusion of a measure to evaluate patient experience. However, we remain concerned that the ICH CAHPS survey, as currently administered,

inappropriately burdens patients and providers and is not optimized to provide the most accurate and useful data. Our recommendations to improve the ICH CAHPS survey administration for beneficiaries, providers, and Medicare are outlined below.

1. Survey beneficiaries once, not twice, per year.

CMS has required as part of the ESRD Quality Incentive Program (QIP) that the ICH CAHPS survey be administered twice yearly. There is no articulated rationale for the additional administration that exceeds the one per year survey contemplated in the ESRD Facility Conditions for Coverage. The cost associated with fielding the survey is significant. This requirement ignores the serious financial constraints the industry faces, especially in light of the proposal to cut the payment rate under the ESRD QIP. In addition to the ESRD QIP requirements, KCC members are being required by ESRD Networks to provide the survey or portions of it on a monthly basis. Further, KCC members report that the timing of multiple surveys is such that results may not be received from the first of the two surveys very far in advance, if at all, from the time they must prepare for the second survey, leaving facilities without time to make any changes that may be evidenced by survey results.

Rather than maintain this burdensome approach, we strongly encourage CMS to reduce the fielding requirement to once yearly and to coordinate with the ERSD Networks. Requiring that the survey be administered only once each year is also consistent with the findings of the American Institutes for Research/RAND et al.[1] While not eliminating the burden on beneficiaries and facilities entirely, this approach at least minimizes it, especially if coupled with the recommendations below.

2. Allow administration of ICH CAHPS survey in three component domains rather than in its entirety to each beneficiary.

Dialysis patients endeavor to survive despite vital organ failure and are frequently managing multiple, comorbid conditions. While we very much support the solicitation of their essential feedback, we do not find it productive to overburden our patients with surveys that seem insurmountable given their health condition. Based upon our day-to-day experience with

[1] *See,* American Institutes for Research, RAND, Harvard Medical School, Westat, Network 15. Using the CAHPS® In-center Hemodialysis Survey to Improve Quality: Lessons Learned from a Demonstration Project. Rockville, MD: Agency for Healthcare Research and Quality (Dec. 2006).

beneficiaries, we find that the full 58-question survey is too long for the vast majority of beneficiaries to complete. While we appreciate that CMS may view the requirement that beneficiaries answer only 29 of the questions to be considered complete, the survey continues to be presented to beneficiaries as something they must answer it its entirety. Also, we question the utility of incomplete surveys.

As we have noted in previous letters, KCC recommends that when CMS administers the survey to dialysis beneficiaries it allow the vendors to divide the survey into the Agency for Healthcare Research and Quality's (AHRQ) three independently verified domains. We continue to hear from beneficiaries that it is difficult for them to complete such a lengthy survey. The survey could be administered so that the facility is assessed for all three domains, requiring beneficiaries to complete only one portion of the full survey. CMS could establish a schedule to ensure that the entire survey is provided to beneficiaries during a three-year period. The population would be divided into thirds. Each year, each group of beneficiaries would receive one-third of the survey and the full survey would be administered each year. In the experience of our members, who have administered a variety of patient experience surveys for years, we believe that reducing the patient burden would increase the completion rate and, in the end, be more useful.

3. Specific Recommendations Regarding Survey Specification, Administration, and Evaluation

(a) Homeless beneficiaries are not well served by the ICH CAHPS survey and should be removed from eligibility as per AHRQ specifications.

KCC remains concerned that CMS continues to include homeless persons as eligible for surveying when ICH CAHPS is administered as part of the ESRD QIP. This inclusion contradicts the specifications established by AHRQ. Given the multiple challenges the homeless face, it is simply inappropriate to include them in the ICH CAHPS survey. We recommend that, consistent with the AHRQ administrative specifications, individuals who are homeless be removed from the list of eligible beneficiaries. In addition, we ask that CMS provide a specific list of the exclusions that would exclude homeless beneficiaries as well.

(b) Facilitate verification and accuracy of beneficiary current contact information for survey administrators.

We urge CMS to establish a process and require third-party vendors who administer the survey to use it to ensure that beneficiary contact information is as accurate and up-to-date as possible. As we understand the process, CMS will identify beneficiaries who will complete the survey and a third-party vendor will administer the survey. Such a scenario is likely related to the time lag in drawing the sample, providing the information to vendors, and administering the survey. It is simply inappropriate to hold facilities accountable for low responses given that CMS's contact information may be out of date or inaccurate. Therefore, we ask that CMS provide an opportunity for facilities to ensure that the primary survey and/or any follow-up is delivered to the most current contact (phone or mail) given the penalty that applies for non-responsiveness.

(c) Independently verify lingual translations for cultural competence.

KCC have observed instances where the survey's lingual translations contain significant errors. One example of this is in the Chinese version of the survey. Therefore, we strongly encourage CMS to validate its translations of the ICH CAHPS survey to ensure that they are accurate.

(d) Ensure aggregate date is available for evaluation.

We wish to clarify that even though the specifications indicate that survey responses will not be shared with individual facilities, the aggregate responses should be provided. While we understand why individual survey results should be confidential, if the aggregate data are not shared, then survey is for naught.

(e) Expand and validate survey for beneficiaries receiving home dialysis.

Finally, we strongly recommend that CMS expand and validate the survey to include individuals who receive home dialysis and not focus solely on those whose treatments are in-center. Currently only a very small number of the total number of questions included on the ICH CAHPS applies to home dialysis patients, but these beneficiaries are nevertheless required to complete the survey as part of the ESRD QIP. As providers are interested in their experience of care, many conduct a separate home dialysis survey for their home beneficiaries, increasing the

survey burden on these patients. CMS should assess patient experience across all types of modalities through a thoughtful and streamlined process.

Conclusion

KCC understands the importance of measuring patient satisfaction and the vast majority of our members already measured patient satisfaction prior to the QIP. Yet, the continued use of the ICH CAHPS measure does not reflect an appreciation of the burden the measure places on beneficiaries and facilities, especially given that the QIP is a penalty-based rather than incentive-based program. In addition to our ongoing concerns about the burden and usefulness of this survey tool, we also have several concerns about the new administrative specifications that depart from AHRQ's tested approach.

KCC appreciates having the opportunity to comment on the ICH CAHPS. We would welcome the opportunity to provide you with more information. If you have any questions or would like to meet with representatives of the KCC, please do not hesitate to contact Kathy Lester at klester@lesterhealthlaw.com or (202) 534-1773.

Respectfully submitted,

Cherilyn T. Cepriano
President