**National Quality Forum—Measure Testing (subcriteria 2a2, 2b1-2b6)**

**Measure Number** (*if previously endorsed*)**:** 0318

**Measure Title**: Delivered Dose of Peritoneal Dialysis Above Minimum

**Date of Submission**: 1/7/2019

**Type of Measure:**

|  |  |
| --- | --- |
| Outcome (*including PRO-PM*) | Composite – ***STOP – use composite testing form*** |
| Intermediate Clinical Outcome | Cost/resource |
| Process *(including Appropriate Use)* | Efficiency |
| Structure |  |

|  |
| --- |
| **Instructions**   * Measures must be tested for all the data sources and levels of analyses that are specified. ***If there is more than one set of data specifications or more than one level of analysis, contact NQF staff*** about how to present all the testing information in one form. * **For all measures, sections 1, 2a2, 2b1, 2b2, and 2b4 must be completed.** * **For outcome and resource use measures**, section **2b3** also must be completed. * If specified for **multiple data sources/sets of specificaitons** (e.g., claims and EHRs), section **2b5** also must be completed. * Respond to all questions as instructed with answers immediately following the question. All information on testing to demonstrate meeting the subcriteria for reliability (2a2) and validity (2b1-2b6) must be in this form. An appendix for *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Maximum of 25 pages (*incuding questions/instructions;* minimum font size 11 pt; do not change margins). ***Contact NQF staff if more pages are needed.*** * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). * For information on the most updated guidance on how to address social risk factors variables and testing in this form refer to the release notes for version 7.1 of the Measure Testing Attachment. |

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| **Note:** The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the testing results for this measure meet NQF’s evaluation criteria for testing.  **2a2.** **Reliability testing** [**10**](#Note10) demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise. For **instrument-based measures** (including PRO-PMs) **and composite performance measures**, reliability should be demonstrated for the computed performance score.  **2b1.** **Validity testing** [**11**](#Note11) demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality. For **instrument-based measures (including PRO-PMs) and composite performance measures**, validity should be demonstrated for the computed performance score.    **2b2.** **Exclusions** are supported by the clinical evidence and are of sufficient frequency to warrant inclusion in the specifications of the measure; [**12**](#Note12)  **AND**  If patient preference (e.g., informed decisionmaking) is a basis for exclusion, there must be evidence that the exclusion impacts performance on the measure; in such cases, the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately). [**13**](#Note13)  **2b3.** **For outcome measures and other measures when indicated** (e.g., resource use):   * **an evidence-based risk-adjustment strategy** (e.g., risk models, risk stratification) is specified; is based on patient factors (including clinical and social risk factors) that influence the measured outcome and are present at start of care; [**14**](#Note14)**,**[**15**](#Note15) and has demonstrated adequate discrimination and calibration   **OR**   * rationale/data support no risk adjustment/ stratification.   **2b4.** Data analysis of computed measure scores demonstrates that methods for scoring and analysis of the specified measure allow for **identification of statistically significant and practically/clinically meaningful** [**16**](#Note16) **differences in performance**;  **OR**  there is evidence of overall less-than-optimal performance.  **2b5.** **If multiple data sources/methods are specified, there is demonstration they produce comparable results**.  **2b6.** Analyses identify the extent and distribution of **missing data** (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias.  **Notes**  **10.** Reliability testing applies to both the data elements and computed measure score. Examples of reliability testing for data elements include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing of the measure score addresses precision of measurement (e.g., signal-to-noise).  **11.** Validity testing applies to both the data elements and computed measure score. Validity testing of data elements typically analyzes agreement with another authoritative source of the same information. Examples of validity testing of the measure score include, but are not limited to: testing hypotheses that the measures scores indicate quality of care, e.g., measure scores are different for groups known to have differences in quality assessed by another valid quality measure or method; correlation of measure scores with another valid indicator of quality for the specific topic; or relationship to conceptually related measures (e.g., scores on process measures to scores on outcome measures). Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.  **12.** Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, variability of exclusions across providers, and sensitivity analyses with and without the exclusion.  **13.** Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.  **14.** Risk factors that influence outcomes should not be specified as exclusions.  **15.** With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74 percent v. 75 percent) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 v. $5,025) is practically meaningful. Measures with overall less-than-optimal performance may not demonstrate much variability across providers. |

**1. DATA/SAMPLE USED FOR ALL TESTING OF THIS MEASURE**

*Often the same data are used for all aspects of measure testing. In an effort to eliminate duplication, the first five questions apply to all measure testing. If there are differences by aspect of testing,(e.g., reliability vs. validity) be sure to indicate the specific differences in question 1.7.*

**1.1. What type of data was used for testing**? (*Check all the sources of data identified in the measure specifications and data used for testing the measure*. *Testing must be provided for all the sources of data specified and intended for measure implementation.* ***If different data sources are used for the numerator and denominator, indicate N [numerator] or D [denominator] after the checkbox.***)

|  |  |
| --- | --- |
| **Measure Specified to Use Data From:**  **(*must be consistent with data sources entered in S.17*)** | **Measure Tested with Data From:** |
| abstracted from paper record | abstracted from paper record |
| claims | claims |
| registry | registry |
| abstracted from electronic health record | abstracted from electronic health record |
| eMeasure (HQMF) implemented in EHRs | eMeasure (HQMF) implemented in EHRs |
| other: Click here to describe | other: Click here to describe |

**1.2. If an existing dataset was used, identify the specific dataset** (*the dataset used for testing must be consistent with the measure specifications for target population and healthcare entities being measured; e.g., Medicare Part A claims, Medicaid claims, other commercial insurance, nursing home MDS, home health OASIS, clinical registry*).

CROWNWeb and Medicare Claims Data from January 2013 to December 2013

For the Spring 2019 maintenance submission, 2017 CROWNWeb and Medicare claims data were used.

**1.3. What are the dates of the data used in testing**? January 2013 to December 2013

For the Spring 2019 maintenance submission, January – December 2017 data were used.

**1.4. What levels of analysis** **were tested**? (*testing must be provided for all the levels specified and intended for measure implementation, e.g., individual clinician, hospital, health plan*)

|  |  |
| --- | --- |
| **Measure Specified to Measure Performance of:**  **(*must be consistent with levels entered in item S.20*)** | **Measure Tested at Level of:** |
| individual clinician | individual clinician |
| group/practice | group/practice |
| hospital/facility/agency | hospital/facility/agency |
| health plan | health plan |
| other: Click here to describe | other: Click here to describe |

**1.5. How many and which measured entities were included in the testing and analysis (by level of analysis and data source)**? (*identify the number and descriptive characteristics of measured entities included in the analysis (e.g., size, location, type); if a sample was used, describe how entities were selected for inclusion in the sample*)

1,528 facilities with at least 11 PD patients. Public reporting of this measure on DFC or in the ESRD QIP would be restricted to facilities with at least 11 eligible patients for the measure. We have applied this restriction to all the reliability and validity testing reported here.

For the Spring 2019 maintenance submission, 1,984 facilities that had at least 11 eligible patients during January 2017 – December 2017 were included in the analyses. Public reporting of this measure on DFC or in the ESRD QIP would be restricted to facilities with at least 11 eligible patients for the measure to comply with restrictions on reporting of potentially patient identifiable information related to small sample size. We have applied this restriction to all the reliability and validity testing reported here.

**1.6. How many and which patients were included in the testing and analysis (by level of analysis and data source)**? (*identify the number and descriptive characteristics of patients included in the analysis (e.g., age, sex, race, diagnosis); if a sample was used, describe how patients were selected for inclusion in the sample*)

45,554 PD patients in facilities with at least 11 PD patients. 395,589 patient months are included in the analysis.

For the Spring 2019 maintenance submission, 57,969 patients who are from 1,984 facilities with at least 11 eligible patients were included in the analyses. 486,007 patient months are included in the analysis.

**1.7. If there are differences in the data or sample used for different aspects of testing (e.g., reliability, validity, exclusions, risk adjustment), identify how the data or sample are different for each aspect of testing reported below**.

N/A

**1.8** **What were the social risk factors that were available and analyzed**? For example, patient-reported data (e.g., income, education, language), proxy variables when social risk data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate) which do not have to be a proxy for patient-level data.

N/A

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**2a2. RELIABILITY TESTING**

***Note****: If accuracy/correctness (validity) of data elements was empirically tested*, *separate reliability testing of data elements is not required – in 2a2.1 check critical data elements; in 2a2.2 enter “see section 2b2 for validity testing of data elements”; and skip 2a2.3 and 2a2.4.*

**2a2.1. What level of reliability testing was conducted**? (*may be one or both levels*)  
 **Critical data elements used in the measure** (*e.g., inter-abstractor reliability; data element reliability must address ALL critical data elements*)  
 **Performance measure score** (e.g., *signal-to-noise analysis*)  
  
**2a2.2. For each level checked above, describe the method of reliability testing and what it tests** (*describe the steps―do not just name a method; what type of error does it test; what statistical analysis was used*)

We used January 2013 – December 2013 Claims data to calculate the inter-unit reliability (IUR) for the overall 12 months to assess the reliability of this measure. The NQF-recommended approach for determining measure reliability is a one-way analysis of variance (ANOVA), in which the between and within facility variation in the measure is determined. The inter-unit reliability (IUR) measures the proportion of the measure variability that is attributable to the between-facility variance. The yearly based IUR was estimated using a bootstrap approach, which uses a resampling scheme to estimate the within facility variation that cannot be directly estimated by ANOVA. We note that the method for calculating the IUR was developed for measures that are approximately normally distributed across facilities. Since this measure is not normally distributed, the IUR value should be interpreted with some caution.

For the Spring 2019 maintenance submission, we followed the same methodology as described above, using January 2017 – December 2017 CROWNWeb and Medicare Claims data.

**2a2.3. For each level of testing checked above, what were the statistical results from reliability testing**? (e*.g., percent agreement and kappa for the critical data elements; distribution of reliability statistics from a signal-to-noise analysis*)

For reliability we calculated the monthly and annual IUR across the 12 reporting months. As explained above, the method for calculating the IUR was developed for measures that are approximately normally distributed across facilities. IUR=0.910, which is high and suggests 91% of variation in the measure is attributed to between facility variation. The confidence interval is (0.904, 0.917).

For the Spring 2019 maintenance submission, the annual IUR was 0.858 across 12 reporting months, which is high and suggests 86% of variation in the measure is attributed to between facility variation and approximately 14% to within facility variation.

**2a2.4 What is your interpretation of the results in terms of demonstrating reliability**? (i*.e., what do the results mean and what are the norms for the test conducted?*)

The IUR suggests this measure is reliable. However, since the distribution of performance scores is skewed, the IUR value should be interpreted with some caution.

For the Spring 2019 maintenance submission, the IUR again suggests this measure is reliable. However, since the distribution of performance scores is skewed, the IUR value should be interpreted with some caution.

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**2b1. VALIDITY TESTING**

**2b1.1. What level of validity testing was conducted**? (*may be one or both levels*)  
 **Critical data elements** (*data element validity must address ALL critical data elements*)

**Performance measure score**

**Empirical validity testing** **Systematic assessment of face validity of performance measure score as an indicator** of quality or resource use (*i.e., is an accurate reflection of performance on quality or resource use and can distinguish good from poor performance*) **NOTE**: Empirical validity testing is expected at time of maintenance review; if not possible, justification is required.

**2b1.2. For each level of testing checked above, describe the method of validity testing and what it tests** (*describe the steps―do not just name a method; what was tested, e.g., accuracy of data elements compared to authoritative source, relationship to another measure as expected; what statistical analysis was used)*

Validity was assessed by calculating the Spearman correlation between this measure and the 2013 SMR and SHR.

This measure is also being maintained on the basis of face validity. Use of small solute clearance (urea reduction ratio and more recently Kt/V) as a dialysis quality measure was initially developed and approved by Clinical TEPs in 2006, 2010 (for pediatric HD and PD adequacy), and 2013 which all agreed that this quality measure domain will improve is important in the assessment of the quality of care for dialysis patients. Achieving target Kt/V was finalized for the ESRD QIP beginning with PY 2015, and has been reported on Dialysis Facility Compare since January 2013.

For the Spring 2019 maintenance submission, we followed the same methodology as the previous submission, using January 2017 – December 2017 CROWNWeb and Medicare Claims data and the 2017 versions of the SMR and SHR. Correlations were calculated to assess the association this measure with clinical outcome quality measures expected to be markers of quality care. The measures selected are fully developed and NQF endorsed, and represent an important subset of core clinical quality measures for this patient population.

We expected the following correlations with this measure:

* SMR: We anticipated a negative correlation with this measure
* SHR: We anticipated a negative correlation with this measure

Kt/V is a marker of dialysis adequacy; if targets are not being met, one would anticipate this being reflected in worse patient outcomes such as morbidity and mortality.

This measure is also being maintained on the basis of face validity. Use of small solute clearance (urea reduction ratio and more recently Kt/V) as a dialysis quality measure was initially developed and approved by Clinical TEPs in 2006, 2010 (for pediatric HD and PD adequacy), and 2013; the TEPs all agreed that this quality measure domain is important in the assessment of the quality of care for dialysis patients. Achieving target Kt/V was finalized for the ESRD QIP beginning with PY 2015, and has been reported on Dialysis Facility Compare since January 2013.

**2b1.3. What were the statistical results from validity testing**? (*e.g., correlation; t-test*)

The Spearman correlation between this measure and the 2013 standardized mortality ratio as measured by the NQF endorsed SMR (NQF 0369) for the same facility is -0.008 (p-value=0.7749). The Spearman correlation between this measure and the 2013 standardized hospitalization ratio as measured by the 2013 SHR (NQF 1463) is -0.139 (p-value <0.0001).

For the Spring 2019 maintenance submission, The Spearman correlation between the PD Kt/V measure and SMR is -0.058, and statistically significant (p=0.01). The Spearman correlation between PD Kt/V measure and SHR is -0.116, and statistically significant (p<.0001).

**2b1.4. What is your interpretation of the results in terms of demonstrating validity**? (i*.e., what do the results mean and what are the norms for the test conducted?*)

The Spearman correlation estimates indicate higher facility level percentages of patients at the facility that achieve the Kt/V target is associated lower standardized hospitalization, respectively, although the magnitude of the association is low. A very weak association between facility level percentages of patients achieving the Kt/V target and lower standardized mortality was observed and in the expected direction, however the correlation coefficient was not statistically significant.

For the Spring 2019 maintenance submission, The Spearman correlation coefficients indicate higher facility level percentages of patients that achieve the Kt/V target is associated with lower standardized mortality and hospitalization. The direction of the association was as expected and the association was statistically significant.

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**2b2. EXCLUSIONS ANALYSIS**

**NA**  **no exclusions — *skip to section*** [***2b3***](#section2b4)

**2b2.1. Describe the method of testing exclusions and what it tests** (*describe the steps―do not just name a method; what was tested, e.g., whether exclusions affect overall performance scores; what statistical analysis was used*)  
 N/A

**2b2.2. What were the statistical results from testing exclusions**? (*include overall number and percentage of individuals excluded, frequency distribution of exclusions across measured entities, and impact on performance measure scores*)  
N/A

**2b2.3. What is your interpretation of the results in terms of demonstrating that exclusions are needed to prevent unfair distortion of performance results?** (*i.e., the value outweighs the burden of increased data collection and analysis.*  *Note:* ***If patient preference is an exclusion****, the measure must be specified so that the effect on the performance score is transparent, e.g., scores with and without exclusion*)  
N/A

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**2b3. RISK ADJUSTMENT/STRATIFICATION FOR OUTCOME OR RESOURCE USE MEASURES**  
***If not an intermediate or health outcome, or PRO-PM, or resource use measure, skip to section*** [***2b4***](#section2b5)***.***

**2b3.1. What method of controlling for differences in case mix is used?**

**No risk adjustment or stratification**

**Statistical risk model with** Click here to enter number of factors **risk factors**

**Stratification by** Click here to enter number of categories **risk categories**

**Other,** Click here to enter description

**2b3.1.1 If using a statistical risk model, provide detailed risk model specifications, including the risk model method, risk factors, coefficients, equations, codes with descriptors, and definitions.**

N/A

**2b3.2. If an outcome or resource use component measure is not risk adjusted or stratified, provide rationale and analyses to demonstrate that controlling for differences in patient characteristics (case mix) is not needed to achieve fair comparisons across measured entities**.   
Risk adjustment is not necessary for this measure. Disparities were examined at the facility level in section 1b.4, and no disparities were found.

**2b3.3a. Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or social risk factors) used in the statistical risk model or for stratification by risk** (*e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of p<0.10; correlation of x or higher; patient factors should be present at the start of care*) **Also discuss any “ordering” of risk factor inclusion**; for example, are social risk factors added after all clinical factors?

N/A

**2b3.3b. How was the conceptual model of how social risk impacts this outcome developed? Please check all that apply:**

**Published literature**

**Internal data analysis**

**Other (please describe)**

N/A

**2b3.4a. What were the statistical results of the analyses used to select risk factors?**N/A

**2b3.4b. Describe the analyses and interpretation resulting in the decision to select social risk factors** *(e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects.)* **Also describe the impact of adjusting for social risk (or not) on providers at high or low extremes of risk.**

N/A

**2b3.5. Describe the method of testing/analysis used to develop and validate the adequacy of the statistical model or stratification approach** (*describe the steps―do not just name a method; what statistical analysis was used*)

*Provide the statistical results from testing the approach to controlling for differences in patient characteristics (case mix) below*.  
***If stratified, skip to*** [***2b3.9***](#question2b49)

N/A

**2b3.6. Statistical Risk Model Discrimination Statistics** (*e.g., c-statistic, R-squared*)**:**N/A

**2b3.7. Statistical Risk Model Calibration Statistics** (*e.g., Hosmer-Lemeshow statistic*):   
N/A

**2b3.8. Statistical Risk Model Calibration – Risk decile plots or calibration curves**:  
N/A

**2b3.9. Results of Risk Stratification Analysis**:

N/A

**2b3.10. What is your interpretation of the results in terms of demonstrating adequacy of controlling for differences in patient characteristics (case mix)?** (i*.e., what do the results mean and what are the norms for the test conducted*)  
N/A

**2b3.11.** **Optional Additional Testing for Risk Adjustment** (*not required, but would provide additional support of adequacy of risk model, e.g., testing of risk model in another data set; sensitivity analysis for missing data; other methods that were assessed*)

N/A

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**2b4. IDENTIFICATION OF STATISTICALLY SIGNIFICANT & MEANINGFUL DIFFERENCES IN PERFORMANCE**

**2b4.1. Describe the method for determining if statistically significant and clinically/practically meaningful differences in performance measure scores among the measured entities can be identified** (*describe the steps―do not just name a method; what statistical analysis was used? Do not just repeat the information provided related to performance gap in 1b)*

Differences in measure performance were evaluated separately for each facility using patient level analyses. The proportion of patients with monthly measurement of Adult PD Kt/V, calculated at the year-level, was compared between one facility and the overall national distribution, and repeated for each individual facility.

Note that the monthly based measure is a simple average of binary outcomes across individuals in the facility, for which the binary outcome equals to 0 (failure= not meeting the threshold) if the value is less than 1.7. The differences in proportions can be compared using Fisher’s Exact tests or its normal approximation. The yearly based measure, however, is not a simple average of binary outcomes and we instead used a re-sampling based exact test, with re-sampling generated from the population distribution of the patient level outcomes. Due to the non-symmetric structure of the measure distributions, a one-sided test with significance level 0.025 is used (corresponding to cutoff=0.05 in a two-sided test). To calculate the p-value, we assess the probability that the facility would experience a number of events (i.e., achievement of the Kt/V threshold) more extreme than that observed if the null hypothesis were true, the null hypothesis being that facility level proportions of patient months which achieve the threshold for Adult PD Kt/V will follow the overall national distribution.

For the Spring 2019 submission, we reproduced the significance analysis using data from January – December 2017. We have revised the description of the analysis to be clearer:

Testing was performed on the yearly based performance score. We used a re-sampling based exact test, with re-sampling generated from the population distribution of the patient level outcomes. Note that a one-sided test with significance level 0.025 is used (corresponding to cutoff=0.05 in a two-sided test) due to non-symmetric structure of the measure's distribution. To calculate the p-value, we compute the probability that the facility would experience a number of events (i.e., percentage with hypercalcemia) more extreme than that observed if the null hypothesis were true, with the null hypothesis being that the  facility's distribution of hypercalcemia will follow the overall national distribution.

**2b4.2. What were the statistical results from testing the ability to identify statistically significant and/or clinically/practically meaningful differences in performance measure scores across measured entities?** (e.g., *number and percentage of entities with scores that were statistically significantly different from mean or some benchmark, different from expected; how was meaningful difference defined*)

Proportion of facilities with significant p-values (0-as expected; 1-worse than expected; significance level <0.025) is shown as follows:

Category Number of facilities Percent of facilities

0 1272       83.25%

1 256       16.75%

For the Spring 2019 maintenance submission, the proportion of facilities with significant p-values (0-as expected; 1-worse than expected; significance level <0.025) is shown as follows:

Category Number of facilities Percent of facilities

0 1,763 88.86%

1 221 11.14%

**2b4.3. What is your interpretation of the results in terms of demonstrating the ability to identify statistically significant and/or clinically/practically meaningful differences in performance across measured entities?** (i*.e., what do the results mean in terms of statistical and meaningful differences?*)

Using patient month values for achieving versus not achieving the threshold for Kt/V in adult PD patients, calculated at the year-level, as the performance measure, 1272 (83.25%) facilities have achieved expected performance, and 256 facilities (16.75%) have performed worse than expected when compared to the overall national proportion of facilities.

In general, higher Kt/V values represent better quality of care. This analysis demonstrates both practical and statistically significant differences in performance across facilities based on their proportion of patient months with a Kt/V that meets the target.

For the Spring 2019 Maintenance submission, 1,763 (88.86%) facilities have achieved expected performance, and 221 facilities (11.14%) have performed worse than expected when compared to the overall national proportion of facilities.

In general, higher Kt/V values represent better quality of care. This analysis demonstrates both practical and statistically significant differences in performance across facilities based on their proportion of patient months with a Kt/V that meets the target.

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**2b5. COMPARABILITY OF PERFORMANCE SCORES WHEN MORE THAN ONE SET OF SPECIFICATIONS**

***If only one set of specifications, this section can be skipped.***

**Note***: This item is directed to measures that are risk-adjusted (with or without social risk factors)* ***OR*** *to measures with more than one set of specifications/instructions (e.g., one set of specifications for how to identify and compute the measure from medical record abstraction and a different set of specifications for claims or eMeasures). It does not apply to measures that use more than one source of data in one set of specifications/instructions (e.g., claims data to identify the denominator and medical record abstraction for the numerator).* ***Comparability is not required when comparing performance scores with and without social risk factors in the risk adjustment model. However, if comparability is not demonstrated for measures with more than one set of specifications/instructions, the different specifications (e.g., for medical records vs. claims) should be submitted as separate measures.***

**2b5.1. Describe the method of testing conducted to compare performance scores for the same entities across the different data sources/specifications** (*describe the steps―do not just name a method; what statistical analysis was used*)

N/A

**2b5.2. What were the statistical results from testing comparability of performance scores for the same entities when using different data sources/specifications?** (*e.g., correlation, rank order*)  
N/A

**2b5.3. What is your interpretation of the results in terms of the differences in performance measure scores for the same entities across the different data sources/specifications?** (i*.e., what do the results mean and what are the norms for the test conducted*)  
N/A

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**2b6. MISSING DATA ANALYSIS AND MINIMIZING BIAS**

**2b6.1. Describe the method of testing conducted to identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased** due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias (*describe the steps―do not just name a method; what statistical analysis was used*)

Reporting months with missing values are not excluded from this measure. Missing months are used to help define the measure numerator (missing is counted as not meeting the minimum threshold), so introduction of bias from exclusion of missing values is not a consideration for the measure as specified.

**2b6.2. What is the overall frequency of missing data, the distribution of missing data across providers, and the results from testing related to missing data?** (*e.g.,**results of sensitivity analysis of the effect of various rules for missing data/nonresponse; if no empirical sensitivity analysis, identify the approaches for handling missing data that were considered and pros and cons of each*)

N/A

**2b6.3. What is your interpretation of the results in terms of demonstrating that performance results are not biased** due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias**?** (i*.e., what do the results mean in terms of supporting the selected approach for missing data and what are the norms for the test conducted; if no empirical analysis, provide rationale for the selected approach for missing data*)

N/A