



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 1424

Corresponding Measures:

De.2. Measure Title: Monthly Hemoglobin Measurement for Pediatric Patients

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services

De.3. Brief Description of Measure: Percentage of patient months of pediatric (< 18 years old) in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients who have monthly measures for hemoglobin during the reporting period.

1b.1. Developer Rationale: Prior studies show a high prevalence of anemia in the pediatric ESRD population. Studies suggest that among Chronic Kidney Disease (CKD) pediatric patients, anemia is associated with adverse outcomes including increased mortality risk and hospitalizations. Therefore, routine measurement of hemoglobin levels and early management of anemia if present, are critical in this population.

S.4. Numerator Statement: Number of patient months of pediatric (< 18 years old) in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients with a measurement of hemoglobin during the reporting period.

S.6. Denominator Statement: All patient months for pediatric (< 18 years old) in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients under the care of the dialysis facility for the entire reporting month.

S.8. Denominator Exclusions: Exclusions that are implicit in the denominator definition include all patients ≥18 years and those who have not been in the facility the entire reporting month (transient patients). There are no additional exclusions for this measure.

De.1. Measure Type: Process

S.17. Data Source: Claims, Registry Data

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Aug 16, 2011 **Most Recent Endorsement Date:** Oct 24, 2019

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[1424_Evidence.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence.

Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Prior studies show a high prevalence of anemia in the pediatric ESRD population. Studies suggest that among Chronic Kidney Disease (CKD) pediatric patients, anemia is associated with adverse outcomes including increased mortality risk and hospitalizations. Therefore, routine measurement of hemoglobin levels and early management of anemia if present, are critical in this population.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Based on 2017 CROWNWeb clinical data (Jan-Dec), there were 62 facilities with at least 11 eligible pediatric patients. The mean and median performance scores were 90% and 92%, respectively. The 25th percentile was 89% and the 75th percentile was 97%.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Disparity analyses were performed among the entire eligible pediatric population (n=1445) to examine the difference in performance scores by sex, race, ethnicity and insurance status.

In particular, for each facility, the percent of patient-months by demographic group (sex, race, ethnicity, insurance status) was calculated. Then, the facilities were divided into tertiles (Q1-Q3) based on the percentage of patient-months in the particular demographic category (i.e., a facility with percentage of females similar to the national median will be included in tertiles 3). The top 33.3% of facilities in terms of rank, based on the percentages of females, were classified as Q3, while the bottom 33.3% of facilities were classified as Q1. Average (mean) performance for the measure was calculated for each tertile, and the means were examined for trend across tertiles (Q1-Q3).

The mean performance scores for percent of patient-months with a pediatric hemoglobin measurement in each tertile, by demographic group, are presented below. Males, non-Black, non-White, non-Hispanic, non-Dual eligibility, are the respective reference categories. Based on the small sample size, we do not believe that the following results suggest a meaningful trend.

Range of Facility Level Tertiles by Population Group (Tertile 1-3):

Females (Q1=91.4%, Q2=90.0%, Q3=89.2%)

Black (Q1=91.36, Q2=90.0%, Q3= 89.4%)

White (Q1=88.5%, Q2=90.1%, Q3=92.0%)

Hispanic (Q1=91.4%, Q2=86.7%, Q3=92.6%)

Dual eligibility (Q1=88.7%, Q2=90.4%, Q3=91.4%)

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

N/A

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Renal, Renal : End Stage Renal Disease (ESRD)

De.6. Non-Condition Specific(check all the areas that apply):

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Children, Populations at Risk

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

N/A

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

No

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

There have been no changes to the specifications since the last endorsement in 2015.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Number of patient months of pediatric (< 18 years old) in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients with a measurement of hemoglobin during the reporting period.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The numerator will be determined by counting all patient months in the denominator that include values for 'Hemoglobin' and 'Hemoglobin Collection Date.' A valid hemoglobin value is defined as between 5-20 g/dL. The hemoglobin value reported for the end of each reporting month (end-of-month hemoglobin) is used as evidence of measurement for the calculation.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All patient months for pediatric (< 18 years old) in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients under the care of the dialysis facility for the entire reporting month.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients are included in the facility calculation if "Admit Date" to the specified facility is prior or equal to the first day of the study period, AND the patient has not been discharged ("Discharge Date" is null or blank), OR "Discharge Date" from the facility is greater than or equal to the last day of the study period. The patient's age will be determined by subtracting the patient's date of birth from the first day of the reporting month. All patients under the facility's care for the entire calendar month and are < 18 years of age will be included in the denominator.

A treatment history file is the data source for the denominator calculation used for the analyses supporting this submission. This file provides a complete history of the status, location, and dialysis treatment modality of an ESRD patient from the date of the first ESRD service until the patient dies or the data collection cutoff date is reached. For each patient, a new record is created each time he/she changes facility or treatment modality. Each record represents a time period associated with a specific modality and dialysis facility. CROWNWeb is the primary basis for placing patients at dialysis facilities and dialysis claims are used as an additional source of information in certain situations. Information regarding first ESRD service date, death, and transplant is obtained from CROWNWeb (including the CMS Medical Evidence Form (Form CMS-2728) and the Death Notification Form (Form CMS-2746)) and Medicare claims, as well as the Organ Procurement and Transplant Network (OPTN).

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Exclusions that are implicit in the denominator definition include all patients ≥ 18 years and those who have not been in the facility the entire reporting month (transient patients). There are no additional exclusions for this measure.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Exclusions that are implicit in the denominator definition include all patients ≥ 18 years and those who have not been in the facility the entire reporting month (transient patients). There are no additional exclusions for this measure.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that

exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

N/A

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Patients are included in the facility calculation if "Admit Date" to the specified facility is prior or equal to the first day of the study period, AND the patient has not been discharged ("Discharge Date" is null or blank), OR "Discharge Date" from the facility is greater than or equal to the last day of the study period. The patient's age will be determined by subtracting the patient's date of birth from the first day of the reporting month. All in-center HD, home HD, and PD patients under the facility's care for the entire calendar month and are < 18 years of age will be included in the denominator. The numerator will be determined by counting all patients in the denominator who have values for 'Hemoglobin' and 'Hemoglobin Collection Date.'

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Registry Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

CROWNWeb and Medicare claims.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Other:Dialysis Facility

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

2. Validity – See attached Measure Testing Submission Form

1424_testing__01072019-636909419331650432.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Data collection is accomplished via CROWNWeb, a web-based and electronic batch submission platform maintained and operated by CMS contractors. While this measure is not currently publically reported, measures reported on DFC that are based on CROWNWeb data are reviewed on a regular basis by dialysis facility providers and rare instances of inaccurate or missing data are present based on comments reported in the DFC ticketing system.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

N/A

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

N/A

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

The measure is not currently used in a CMS program at this time. CMS is currently evaluating whether this measure is appropriate for inclusion in a public reporting program

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for

implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

CMS is considering proposing the measure for DFC in 2019 or 2020 for implementation in 2021/2022 , The measure would be previewed to facilities via the Dialysis Facility Compare Preview reports prior to being finalized for inclusion on DFC.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

N/A

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

N/A

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

N/A

4a2.2.2. Summarize the feedback obtained from those being measured.

N/A

4a2.2.3. Summarize the feedback obtained from other users

N/A

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

N/A

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

The measure is not currently publically reported, so improvement data are not available. Public reporting of this measure would encourage facilities to comply with the Kidney Disease Outcomes Quality Initiative (KDOQI) Clinical Practice Recommendations, which recommends that pediatric patients have monthly measurement of hemoglobin if they are treated with erythropoiesis-stimulating agents (ESAs).

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

N/A

4b2.2. Please explain any unexpected benefits from implementation of this measure.

N/A

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)**5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.****5a. Harmonization of Related Measures**

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Centers for Medicare & Medicaid Services

Co.2 Point of Contact: Helen, Dollar-Maples, Helen.Dollar-Maples@cms.hhs.gov, 410-786-7214-
Co.3 Measure Developer if different from Measure Steward: University of Michigan Kidney Epidemiology and Cost Center
Co.4 Point of Contact: Casey, Parrotte, parrotte@med.umich.edu, 734-763-6611-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The TEP that provided face validity for this measure met originally in 2010, and was comprised of the following members:

Bradley Warady, MD - TEP CHAIR
 University of Missouri, Kansas City School of Medicine

Eileen Brewer, MD
 Baylor College of Medicine/Texas Children's Hospital

Carolyn Abitbol, MD
 University of Miami, Holtz Children's Hospital

Douglas Silverstein, MD
 Children's National Medical Center

Alicia Neu, MD
 Johns Hopkins Medicine

Stuart Goldstein, MD
 Baylor College of Medicine

Irene Restaino, MD
 Children's Hospital of The King Daughters

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released:

Ad.3 Month and Year of most recent revision: 04, 2019

Ad.4 What is your frequency for review/update of this measure? Annually

Ad.5 When is the next scheduled review/update for this measure? 04, 2020

Ad.6 Copyright statement: N/A

Ad.7 Disclaimers: N/A

Ad.8 Additional Information/Comments: After the submission of the testing attachment on January 7, we noticed a typo in 2b4.1 (Meaningful Differences). The description of the analysis mentions the wrong event (hypercalcemia), which was included in error. The description of the analysis performed is otherwise accurate.