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Memo

October 6, 2022

To: Renal Standing Committee, Spring 2022

From: NQF staff

Re: Post-comment web meeting to discuss NQF member and public comments received and NQF member expression of support

Background

Without timely and effective treatment, chronic kidney disease (CKD) can progress to severe renal dysfunction and eventually end-stage renal disease (ESRD). The type of ESRD treatment and the education that accompanies the treatment are critical factors of overall quality of care and outcomes. For the spring cycle of the Renal project, the Standing Committee evaluated five newly submitted measures and one measure undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended two measures for endorsement but did not recommend four measures for endorsement.

The Standing Committee recommended the following measures:

- NQF ##2594 Optimal End Stage Renal Disease (ESRD) Starts (The Permanente Foundation/Kaiser Permanente Southern California)
- NQF #3695 Percentage of Prevalent Patients Waitlisted (PPPW) (Centers for Medicare & Medicaid Services [CMS]/University of Michigan Kidney and Epidemiology Cost Center [UM-KECC])

The Standing Committee did not recommend the following measures:

- NQF #3659 Standardized Fistula Rate for Incident Patients (CMS/UM-KECC)
- NQF #3689 First Year Standardized Waitlist Ratio (FYSWR) (CMS/UM-KECC)
- NQF #3694 Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) (CMS/UM-KECC)
- NQF #3696 Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR) (CMS/UM-KECC)

Standing Committee Actions in Advance of the Meeting

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Brief).
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses and the requests for reconsideration.

Comments Received

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 10, 2022, and closed on September 6, 2022. Comments received by June 7, 2022 were shared with the Standing Committee prior to the measure evaluation meetings. Following the Standing Committee's evaluation of the measures under review, NQF received 21 comments from four organizations (including two member organizations) and individuals pertaining to the draft report and the measures under review. This memo focuses on comments received after the Standing Committee's evaluation.

NQF members also had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration. One NQF member submitted an expression of support. More information on the submitted expressions of support can be found in Appendix A.

NQF staff have included all comments that were received (both pre- and post-evaluation) in the Comment Brief. The Comment Brief contains the commenter's name, comment, associated measure, and draft responses (including measure steward/developer responses if appropriate) for the Standing Committee's consideration. Please review this table in advance of the meeting and consider the individual comments received and the proposed responses for each comment.

In order to facilitate the discussion, the post-evaluation comments have been categorized into action items and major topic areas or themes. Although all comments are subject to discussion, the intent is not to discuss each individual comment during the post-comment call. Instead, NQF staff will spend the majority of the time considering the themes discussed below and the set of comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit the Standing Committee's discussion, and the Standing Committee can pull any comment for discussion. Measure stewards/developers were asked to respond to comments where appropriate. All developer responses along with the proposed draft Standing Committee responses have been provided in this memo and the Comment Brief.

Request for Reconsideration

NQF #3694 Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) (CMS/UM-KECC)
Description: This measure tracks the percentage of patients in each dialysis practitioner group practice who were on the kidney or kidney-pancreas transplant waitlist in active status. Results are averaged across patients prevalent on the last day of each month during the reporting year. The proposed measure is a directly standardized percentage, which is adjusted for covariates (e.g. age and risk factors); **Measure Type**: Outcome; **Level of Analysis**: Clinician: Group/Practice; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Registry Data

The developer submitted a request for reconsideration for NQF #3694 on the basis that NQF's measure evaluation criteria was not applied appropriately. The developer advises that identical evidence and validity testing was submitted for NQF #3694 and NQF #3695, but the Standing Committee's voting on these criteria was inconsistent. The Standing Committee voted consensus not reached on NQF #3694 and passed NQF #3695 on evidence. The Standing Committee did not pass NQF #3694 and passed NQF #3695 on validity. The developer notes inconsistencies in the Standing Committees application of the criteria and voting on the two measures. See the full request for reconsideration submitted by the developer in the Comment Brief.

During the measure evaluation meeting, the Standing Committee expressed concern that the evidence submitted for NQF #3694 did not demonstrate that nephrologists are the driver of a patient being waitlisted, noting that the decision to waitlist is made by the transplant facility. The Standing Committee also expressed concerns regarding validity. The Standing Committee noted that patients may be removed from the waitlist, by the transplant team, which would then reflect poorly on the dialysis practitioner. Additionally, the Standing Committee expressed concern with the use of social determinants of health (SDOH) in the risk model and questioned if transplant center characteristics are accounted for in the model.

There were six comments received on this measure including the reconsideration request. Five comments were in support of the Standing Committee's recommendation to not recommend the measure. These comments agreed with many of the concerns raised by the Standing Committee. Comments also cited concerns with attribution of the measure to the practitioner rather than transplant facility, variation in transplant center waitlist criteria not being appropriately accounted for in the risk model, and the absence of reliability results stratified by provider size.

> **Action Item:**
> The Standing Committee will vote on whether it would like to reconsider the measure based on the comments received and the request received by the developer. If greater than 60 percent of the Standing Committee votes "yes," the Standing Committee will continue its review of the measure, starting with the criterion that the measure did not pass on. If 60 percent or less of the Standing Committee's vote is "yes," the Standing Committee will not reconsider the measure. There is no grey zone for reconsiderations.

NQF #3696 Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR) (CMS/UM-KECC)
Description: The standardized modality switch ratio (SMoSR) is defined to be the ratio of the number of observed modality switches (from in-center to home dialysis—peritoneal or home hemodialysis) that occur for adult incident ESRD dialysis patients treated at a particular facility, to the number of modality switches (from in-center to home dialysis—peritoneal or home hemodialysis) that would be expected given the characteristics of the dialysis facility's patients and the national norm for dialysis facilities. The measure includes only the first durable switch that is defined as lasting 30 continuous days or longer. The SMoSR estimates the relative switch rate (from in-center to home dialysis) for a facility, as compared to the national switch rate. Qualitatively, the degree to which the facility's SMoSR varies from 1.00 is the degree to which it exceeds (> 1.00) or is below (< 1.00) the national modality switch rates for patients with the same characteristics as those in the facility. Ratios greater than 1.00 indicate better than expected performance while ratios <1.00 indicate worse than expected performance. When used for public reporting, the measure calculation will be restricted to facilities with at least one expected modality switch in the reporting year. This restriction is required to ensure patients cannot be identified due to small cell size; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Registry Data

The developer submitted a request for reconsideration for NQF #3696 on the basis that NQF's measure evaluation criteria was not applied appropriately. The developer advises that the Standing Committee noted that clear evidence was not submitted to support modality switch as a marker of education and voted consensus not reached. The developer notes that the measure submission cited several studies that demonstrated how educational interventions facilitate shared decision making and greater home dialysis uptake, thus meeting NQF's evidence criteria. The developer also advises that the Standing Committee did not articulate why they overturned the Scientific Methods Panel's (SMP) decision to pass the measure on validity. In addition, the developer raised concerns with the Standing Committee's focus

on measuring patient choice and that the measure would encourage 100% performance. The Standing Committee ultimately did not pass the measure on validity. See the full request for reconsideration submitted by the developer in the Comment Brief.

During the measure evaluation meeting, the Standing Committee expressed concern that the evidence supports dialysis modality switch as a marker of patient education, and an unintended consequence could be to encourage practitioners to start patients on in-center dialysis and then switching them to home dialysis. The Standing Committee also expressed concerns regarding if the comorbidities in the risk model influence a patient's dialysis modality choice and if the measure exclusions were appropriate.

There were four comments received on this measure including two comments outlining the reconsideration request. The other two comments received supported the Standing Committee's recommendation to not endorse this measure. The comments cited concerns that the measure could lead to practitioners being encouraged to initiate patients on in-center dialysis in order to gain credit for changing to home therapy later, that the credit for a switch should be longer than 30 days, and that it is unclear how the developer is using modality switch rates as a proxy for education as there is no mechanism for the measure to discern whether a decision to switch is because of education.

Action Item:

The Standing Committee will vote on whether it would like to reconsider the measure based on the comments received and the request received by the developer. If greater than 60 percent of the Standing Committee votes "yes," the Standing Committee will continue its review of the measure, starting with the criterion that the measure did not pass on. If 60 percent or less of the Standing Committee's vote is "yes," the Standing Committee will not reconsider the measure. There is no grey zone for reconsiderations.

Comments and Their Disposition

Themed Comments

One major theme was identified in the post-evaluation comments, as follows:

1. Concern with recommended endorsement of NQF #3695

Theme 1 – Concern with recommended endorsement of NQF #3695

For NQF #3695 Percentage of Prevalent Patients Waitlisted (PPPW), two commenters disagreed with the Standing Committee's recommendation to endorse the measure. One commenter noted that they had several issues with the measure including: 1) the attribution of the measure to individual clinicians/practitioner groups; 2) the model not validly accounting for variation in transplant center eligibility criteria; and 3) the developer did not provide stratification of reliability scores by provider size for the measures, making it impossible to discern how widely reliability varies across practice sizes. The second commenter noted concern for how the PPPW could have a negative impact on smaller transplant centers.

Measure Steward/Developer Response:

Response to first commenter: Being waitlisted for kidney transplantation is the culmination of a variety of preceding preparatory activities. These include, but are not limited to, education of patients about the option of transplantation, referral of patients to a transplant center for evaluation, completion of the evaluation process, and optimizing the health of the patient while on dialysis. These efforts depend heavily and, in many cases, primarily, on dialysis practitioner groups. Although some aspects of the waitlisting process may not entirely depend on dialysis practitioner groups, such as the actual waitlisting decision by transplant centers, or a patient's choice about the transplantation option, these can also be nevertheless influenced by the dialysis practitioner groups. For example, through coordination of care,

strong communication with transplant centers, and advocacy for patients by dialysis practitioner groups, as well as comprehensive education, encouragement, and support of patients during their decision-making about the transplantation option. The practitioner level access to transplant waitlisting measures were therefore proposed in the spirit of shared accountability, with the recognition that success requires substantial effort by dialysis practitioner groups. In this respect, the measures represent an explicit acknowledgment of the tremendous contribution dialysis practitioner groups can be, and are already, making towards access to transplantation, to the benefit of the patients under their care. Although waitlisting measures directed at the transplant center may also be potentially appropriate, the scope of this particular measure development effort was focused on performance of dialysis practitioner groups. The developer agrees that measures directed at referral and transplant education would be potentially valuable, but limitations in national data availability on referral and appropriate tools to capture quality of transplant education pose practical hurdles to development of such measures. We agree with KCQA th at referral is an important metric to report at the dialysis facility level, and we have done a lot of work over the years (including holding two TEPs) in support of development of a measure/collection of referral data. Although we agree that information on referral can be valuable for incorporation into access to transplantation measures, there is currently no mechanism to capture data on referral on a national scale. Further, in light of known ongoing disparities in access to transplantation, and in the spirit of ensuring fair access to kidney transplantation, we believe a denominator including all dialysis patients is still appropriate, rather than only those the dialysis facilities chooses to refer. We agree that there is variation across transplant centers in eligibility criteria and that underlying patient comorbidities may affect their candidacy. All three waitlisting measures accordingly include adjustment for a wide range of comorbidities, and furthermore include adjustment for transplant center characteristics. An example is waitlist mortality, which can be viewed as a proxy for stringency of center waitlisting criteria. Further, the prevalent waitlisting measures include adjustment for transplant center random effects, capturing broad aspects of each transplant center's tendency to waitlist patients. Given the established effect of sample size on IUR calculations, it is expected that large facilities will have higher IUR values and small facilities will have lower IUR values for any given measure. Using the empirical null method, facilities are flagged if they have outcomes that are extreme when compared to the variation in outcomes for other facilities of a similar size. That is, smaller facilities have to have more extreme outcomes compared to other smaller facilities to be flagged.

Response to second commenter: We agree that there is variation across transplant centers in eligibility criteria for waitlisting and that implementation of waitlist mortality measures directed at transplant centers may further affect this. To adjust for this, we have included transplant center effects (both a random effect, and adjustment for transplant center waitlist mortality) in the model for this measure.

Proposed Standing Committee Response:

Thank you for your comment. The Standing Committee considers measures independently of others that have been recently implemented. The Standing Committee determined that this measure met all NQF criteria for endorsement and therefore, recommended the measure for endorsement.

Action Item:

Discuss and finalize Standing Committee response.

Appendix A: NQF Member Expression of Support Results

One NQF member provided their expressions of support/nonsupport for five of the six measures under consideration. The NQF member did not support the measures. Results for each measure are provided below.

NQF #3659 Standardized Fistula Rate for Incident Patients (CMS/UM-KECC)

Member Council	Commenter Names, Organizations	Support	Do Not Support	Total
Quality Measurement, Research, and Improvement	Lisa McGonigal, Kidney Care Partners	0	1	1

NQF #3689 First Year Standardized Waitlist Ratio (FYSWR) (CMS/UM-KECC)

Member Council	Commenter Names, Organizations	Support	Do Not Support	Total
Quality Measurement, Research, and Improvement	Lisa McGonigal, Kidney Care Partners	0	1	1

NQF #3694 Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) (CMS/UM-KECC)

Member Council	Commenter Names, Organizations	Support	Do Not Support	Total
Quality Measurement, Research, and Improvement	Lisa McGonigal, Kidney Care Partners	0	1	1

NQF #3695 Percentage of Prevalent Patients Waitlisted (PPPW) (CMS/UM-KECC)

Member Council	Commenter Names, Organizations	Support	Do Not Support	Total
Quality Measurement, Research, and Improvement	Lisa McGonigal, Kidney Care Partners	0	1	1

NQF #3696 Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR) (CMS/UM-KECC)

Member Council	Commenter Names, Organizations	Support	Do Not Support	Total
Quality Measurement, Research, and Improvement	Lisa McGonigal, Kidney Care Partners	0	1	1