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Meeting Summary

Renal Standing Committee – Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the Renal Standing Committee for a web meeting on June 29 and 30, 2022, to evaluate six measures for the spring 2022 cycle.

Welcome, Review of Meeting Objectives, Introductions, and Overview of Evaluation and Voting Process

Paula Farrell, NQF director, welcomed the Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives. The Standing Committee members each introduced themselves and disclosed any conflicts of interest. No Standing Committee members disclosed a conflict of interest with any measures under review this cycle. Additionally, Oroma Igwe, NQF manager, reviewed the Consensus Development Process (CDP) and the measure evaluation criteria.

Some Standing Committee members were unable to attend the entire meeting due to early departures and late arrivals. The vote totals reflect members present and eligible to vote. A quorum of 16 was met and maintained for the entirety of both meetings. Voting results are provided below.

Measure Evaluation

During the meeting, the Renal Standing Committee evaluated six measures (one maintenance and five new) for endorsement consideration. A more detailed summary of the Standing Committee's deliberations will be compiled and provided in the draft technical report.

A measure is recommended for endorsement by the Standing Committee when greater than 60 percent of eligible voting members select a passing vote option (Pass, High and Moderate, Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40 percent of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement. If a measure does not pass a must-pass criterion, voting during the measure evaluation meeting will cease. The Standing Committee will not re-vote on the measures during the post-comment meeting unless the Standing Committee decides to reconsider the measure(s) based on submitted comments or a formal reconsideration request from the developer. The Standing Committee has not reached consensus on the measure if between 40 and 60 percent of eligible voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement. The Standing Committee will re-vote on criteria that did not reach consensus and potentially on overall suitability for endorsement during the post-comment web meeting. The Standing Committee was not able to discuss related and competing measures during the meeting and the discussion will occur during the post-comment meeting.

Voting Legend:

- *Evidence (Outcome Measures) and Use:* Pass/No Pass
- *Accepting Scientific Methods Panel (SMP) Rating and Overall Suitability for Endorsement*: Yes/No
- *All Other Criterion:* H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable

- *Maintenance Criteria for Which the Standing Committee Decided Additional Discussion/Vote Was Not Needed (Evidence, Reliability, Validity only):* Accepted Previous Evaluation

NQF #3659 Standardized Fistula Rate for Incident Patients (Centers for Medicare & Medicaid Services [CMS]/University of Michigan Kidney and Epidemiology Cost Center [UM-KECC])

Description: Adjusted percentage of adult incident hemodialysis patient-months using an autogenous arteriovenous fistula (AVF) as the sole means of vascular access. The Standardized Fistula Rate (SFR) for Incident Patients is based on the prior SFR (NQF #2977) that included both incident and prevalent patients. This measure was initially endorsed in 2016, but as part of measure maintenance review by the NQF Standing Committee in 2020, concerns were raised about the strength of evidence supporting the prior measure. Namely, recent updates to the KDOQI guidelines downgraded the evidence supporting fistula as the preferred access type and instead focus on catheter avoidance and developing an individualized ESKD Lifeplan. However, the guidelines do suggest that under favorable circumstances an AV fistula is preferred to an AV graft in incident patients due to fewer long-term vascular access events. Given that over 80% of incident dialysis patients begin treatment with a tunneled catheter, and that 12 months after dialysis initiation AV fistula rates exceed 60%, the incident SFR was developed to focus on the subset of dialysis patients that the evidence suggests may benefit the most during a time of intense vascular access creation. Specifically, blood stream infection rates are the lowest in incident patients with AV fistula compared to long-term catheters. Therefore the goal of this new measure is to evaluate facility performance in increasing fistula use in the incident population in order to reduce the heightened risks patients face due to bacteremia and infection related hospitalizations; **Measure Type**: Outcome: Intermediate Clinical Outcome; **Level of Analysis**: Facility; **Setting of Care**: Outpatient Services; **Data Source**: Registry Data, Claims

Measure Steward/Developer Representatives at the Meeting

- Jon Segal, MD

Standing Committee Votes

- **Evidence**: Total Votes-17; H-0; M-7; L-10; I-0 (7/17 – 41%, Consensus Not Reached)
- **Performance Gap**: Total Votes-16; H-0; M-6; L-10; I-0 (6/16 – 38%, No Pass)
- **Reliability**: Vote Not Taken
- **Validity**: Vote Not Taken
- **Feasibility**: Vote Not Taken
- **Use**: Vote Not Taken
- **Usability**: Vote Not Taken
- **Standing Committee Recommendation for Endorsement:** Vote Not Taken

The Standing Committee did not recommend the measure for initial endorsement. This facility-level measure was newly submitted for endorsement. This measure is not yet implemented in an accountability program. The Standing Committee expressed concerns about the evidence, noting that it did not demonstrate a significant difference between assessing incident and prevalent patients. Additionally, the Standing Committee discussed the absence of a definitive recommendation on the superiority of fistulas versus grafts, regarding infection rates, per the National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI). The Standing Committee also highlighted two pre-evaluation comments, which asserted that the proposed measure is inherently unchanged from the

previous measure and long-term catheter rate measurement is preferred over the currently proposed measure. The Standing Committee inquired about a correlation between low fistula rates and facility size. The developer stated that they did not parse the data out by facility size but explained that they cannot say for certain that the small facility size is a direct correlation to low fistula rates. The Standing Committee shared no additional concerns and did not reach consensus on the evidence criterion.

The Standing Committee noted that the developer cited an increase from 20 percent to greater than 60 percent in AVFs in the first year of dialysis and deemed this an indication of an opportunity for improvement. The Standing Committee questioned whether the data were a true reflection of a gap or indicative of other factors, such as the starting of dialysis in which a change in the use of AVFs and catheters is seen. The Standing Committee also questioned whether further improvement was feasible or appropriate, noting that it might not be appropriate for some subpopulations based on their stage of care. The Standing Committee did not pass the measure on performance gap, a must-pass criterion; therefore, the Standing Committee did not discuss or vote on any proceeding criteria.

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

Measure Steward/Developer Representatives at the Meeting

- Claudia Dahlerus, PhD
- Joe Messana, MD

Standing Committee Votes

- **Evidence**: Total Votes-17; Pass-7; No Pass-10 (7/17 – 41%, Consensus Not Reached)
- **Performance Gap**: Total Votes-17; H-1; M-14; L-2; I-0 (15/17 – 88%, Pass)
- **Reliability**: Total Votes-17; Yes-17; No-0 (17/17 – 100%, Pass)
    - The SMP evaluated this measure and deemed it complex.
    - The Standing Committee accepted the SMP's rating for Reliability: Moderate (Total Votes-8; H-0; M-6; L-2; I-0).

- **Validity**: Total Votes-19; Yes-9; No-10 (9/19 – 47%, did not accept the SMP's vote); Total Votes-19; H-0; M-7; L-12; I-0 (7/19 – 37%, No Pass)
    - The SMP evaluated this measure and deemed it complex.
    - The Standing Committee did not accept the SMP's rating for Validity: Moderate (Total

Votes-8; H-1; M-5; L-2; I-0) and voted on the measure.

- **Feasibility**: Vote Not Taken
- **Use**: Vote Not Taken
- **Usability**: Vote Not Taken
- **Standing Committee Recommendation for Endorsement:** Vote Not Taken

The Standing Committee did not recommend the measure for initial endorsement. This facility-level measure was newly submitted for endorsement. This measure is not yet implemented in an accountability program. The Standing Committee expressed concern with the evidence, noting that it is not clear that the evidence supporting modality switch as a marker of education is substantiated. The Standing Committee noted that a facility may provide education; however, if the patient chooses to stay on an in-center modality versus transitioning to home dialysis, that facility could be penalized, even though patient education was provided, due to patient choice. The Standing Committee discussed that dialysis modality education should occur prior to dialysis initiation and that this measure could encourage practitioners not to initiate home dialysis and recommend in-facility dialysis so that the dialysis facilities could then increase their switch rates. The developer advised that pre-dialysis education is outside of the scope of this measure but that the measure foci on incident patients and modality changes likely reflect robust education, effective presentation, and facilitation conducted by the dialysis unit. The Standing Committee did not reach consensus on evidence.

The Standing Committee agreed that a performance gap exists but asked the developer to clarify how the expected modality switch rates are determined. The developer stated the expected home modality switch rates are based on the national rate of home modality switches across facilities, which was adjusted for case mix. The Standing Committee accepted the developer's response and passed the measure on performance gap.

The SMP reviewed this measure prior to the Standing Committee's review and passed it on reliability and validity. The Standing Committee voted to accept the SMP's rating for reliability. In addition, the Standing Committee discussed several topics related to the validity of the measure. Specifically, the Standing Committee discussed the risk adjustment model and questioned whether the comorbidities included in the model influence the choice of dialysis modality. The Standing Committee also noted that capturing comorbidities from the Centers for Medicare & Medicaid Services (CMS) 2728 form is problematic because this form captures patients' health state at the beginning of care, not how their medical condition changes over time. The developer advised that the measure captures incident patients and adjusts for comorbidities when the patient initiates dialysis; thus, the comorbidities in the risk model should be those that are not the result of the dialysis facilities' care and should not reflect changes in the patient's medical condition over time. The Standing Committee emphasized that many factors are used to determine whether patients are appropriate for a home modality, many of which are not represented in the model, further calling into question the risk adjustment and exclusions. The developer noted that CMS is implementing screening for social determinants of health (SDOH), which will help in identifying patients for certain therapies. The Standing Committee questioned how dialysis facilities that do not offer home modalities will be perceived statistically. The developer noted that facilities that offer both modality types tend to do better in switches, as compared to those that only offer in-center dialysis, and that this may be due to less familiarity with home modalities. Lastly, the Standing Committee asked whether nursing home residents are included in the measure. The developer noted that patients currently residing in a nursing home are excluded from the measure. Due to the above concerns regarding validity, the Standing Committee did not accept the SMP's vote and did not

pass the measure on validity, a must-pass criterion; therefore, the Standing Committee did not discuss or vote on any proceeding criteria.

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

Description: The FYSWR measure tracks the number of incident patients in a practitioner (inclusive of physicians and advanced practice providers) group who are under the age of 75 and were listed on the kidney or kidney-pancreas transplant waitlist or received a living donor transplant within the first year of initiating dialysis. For each practitioner group, the First Year Standardized Waitlist Ratio (FYSWR) is calculated to compare the observed number of waitlist events in a practitioner group to its expected number of waitlist events. The FYSWR uses the expected waitlist events calculated from a Cox model, adjusted for age and patient comorbidities at incidence of dialysis. For this measure, patients are assigned to the practitioner group based on the National Provider Identifier (NPI)/Unique Physician Identifier Number (UPIN) information entered on the CMS Medical Evidence 2728 form; **Measure Type**: Outcome; **Level of Analysis**: Clinician: Group/Practice; **Setting of Care**: Outpatient Services; **Data Source**: Registry Data, Claims

Measure Steward/Developer Representatives at the Meeting

- Vahakn Shahinian, MD

Standing Committee Votes

- **Evidence**: Total Votes-18; Pass-10; No Pass-8 (10/18 – 56%, Consensus Not Reached)
- **Performance Gap**: Total Votes-19; H-4; M-14; L-1; I-0 (18/19 – 95%, Pass)
- **Reliability**: Total Votes-19; Yes-18; No-1 (18/19 – 95%, Pass)
    - The SMP evaluated this measure and deemed it complex.
    - The Standing Committee accepted the SMP's rating for Reliability: Moderate (Total Votes-10; H-0; M-10; L-0; I-0).
- **Validity**: Total Votes-18; Yes-7; No-11 (7/18 – 39%, did not accept the SMP's vote); Total Votes-18; H-0; M-6; L-10; I-2 (6/18 – 33%, No Pass)
    - The SMP evaluated this measure and deemed it complex.
    - The Standing Committee did not accept the SMP's rating for Validity: Moderate (Total Votes-10; H-0; M-8; L-2; I-0) and voted on the measure.
- **Feasibility**: Vote Not Taken
- **Use**: Vote Not Taken
- **Usability**: Vote Not Taken
- **Standing Committee Recommendation for Endorsement:** Vote Not Taken

The Standing Committee did not recommend the measure for initial endorsement. This clinician group/practice-level measure was newly submitted for endorsement. This measure is not yet implemented in an accountability program. The Standing Committee expressed concern that the evidence does not show a link between a nephrologist's care influencing a patient being waitlisted for a transplant because the decision to waitlist a patient is made by the transplant facility. However, other Standing Committee members supported attribution of the measure to the nephrologist, noting that if transplant centers are not responsive to a nephrologist's referrals, the nephrologist may change where they refer patients to. The developer stated that there is empirical evidence demonstrating the nephrologist's ability to impact the measure's outcome. The Standing Committee also questioned why the developer did not create a measure to track referral rates rather than waitlisting. The developer

noted that referral rates are data points that are not currently collected. Ultimately, the Standing Committee did not reach on consensus on evidence. The Standing Committee also agreed that a performance gap exists and that inequities exist regarding waitlisting. Therefore, it passed the measure on performance gap.

The SMP reviewed this measure prior to the Standing Committee's review and passed it on reliability and validity. The Standing Committee voted to accept the SMP's rating for reliability. However, the Standing Committee raised several concerns with the validity of the measure, particularly regarding exclusions and attribution. The Standing Committee expressed concern that patients who are waitlisted, prior to starting dialysis, are excluded. The developer noted that most patients arrive to dialysis without being waitlisted, and this measure addresses those patients. The Standing Committee also expressed concern that patients who choose not to have a transplant are included in the measure and that this may incentivize providers to put patients on a waitlist to achieve a higher score. The developer noted that the measure should not reflect a waitlist rate of 100 percent but that the measure's objective is to compare practitioner groups and identify those who are outlying in their performance. The Standing Committee also raised a concern with attribution, specifically the developer's use of CMS form 2728, as the physician who fills out this form may not be the physician who cares for the patient in the facility. The developers stated that although the physicians may differ, the measure is at the group-practice level, and approximately 90 percent of the time, the physicians are part of the same practice. Due to the above concerns regarding validity, the Standing Committee did not accept the SMP's vote and did not pass the measure on validity, a must-pass criterion; therefore, the Standing Committee did not discuss or vote on any proceeding criteria.

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

Measure Steward/Developer Representatives at the Meeting

- Vahakn Shahinian, MD

Standing Committee Votes

- **Evidence**: Total Votes-17; Pass-9; No Pass-8 (9/17 – 53%, Consensus Not Reached)
- **Performance Gap**: Total Votes-19; H-2; M-17; L-0; I-0 (19/19 – 100%, Pass)
- **Reliability**: Total Votes-18; Yes-18; No-0 (18/18 – 100%, Pass)
    - The SMP evaluated this measure and deemed it complex.
    - The Standing Committee accepted the SMP's rating for Reliability: High (Total Votes-10; H-5; M-3; L-0; I-2).
- **Validity**: Total Votes-18; H-0; M-7; L-9; I-2 (7/18 – 39%, No Pass)
    - The SMP evaluated this measure and deemed it complex.
    - The SMP did not reach consensus on Validity: (Total Votes-10; H-0; M-6; L-4; I-0).
- **Feasibility**: Vote Not Taken
- **Use**: Vote Not Taken
- **Usability**: Vote Not Taken

- **Standing Committee Recommendation for Endorsement:** Vote Not Taken

The Standing Committee did not recommend the measure for initial endorsement. This group/practice-level measure was newly submitted for endorsement. This measure is not yet implemented in an accountability program. The Standing Committee questioned the evidence and whether the nephrologist is truly the driver for a patient to be added to the transplant list when the transplant center has control over this matter. Ultimately, the Standing Committee did not reach consensus on evidence. Conversely, the Standing Committee agreed that substantial gaps and disparities were present and passed the measure on performance gap.

The SMP reviewed this measure prior to the Standing Committee's review and passed the measure on reliability but did not reach consensus on validity. The Standing Committee voted to accept the SMP's rating for reliability. In addition, the Standing Committee discussed several topics related to the validity of the measure. Specifically, the Standing Committee discussed the potential of patients being removed from the transplant waitlist by the transplant team and thus reflecting poorly on the dialysis practitioner. Additionally, the Standing Committee questioned the use of SDOH in the measure's risk adjustment model, stating that adjusting for social risk can lead to reinforcing or sustaining disparities. The developer advised that area deprivation index (ADI) and dual eligibility are the two SDOH that are included in the risk model. The developer noted that the inclusion of SDOH in the risk model was informed by the measure's technical expert panel (TEP), considering that economic support needs to be accounted for regarding patients who are waitlisted. The Standing Committee questioned whether transplant center characteristics are accounted for in the risk model. In response, the developer confirmed that the transplant centers' waitlist mortality and transplant rates are accounted for in the model to account for variability among transplant centers. The Standing Committee continued to express discomfort with the use of SDOH in the risk model and did not pass the measure on validity, a must-pass criterion; therefore, the Standing Committee did not discuss or vote on any proceeding criteria.

NQF #3695 Percentage of Prevalent Patients Waitlist (PPPW) (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. 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**: Registry Data, Claims

Measure Steward/Developer Representatives at the Meeting

- Vahakn Shahinian, MD

Standing Committee Votes

- **Evidence**: Total Votes-18; Pass-13; No Pass-5 (13/18 Total Votes – 72%, Pass)
- **Performance Gap**: Total Votes-18; H-1; M-14; L-3; I-0 (15/Total Votes – 83%, Pass)
- **Reliability**: Total Votes-18; Yes-18; No-0 (18/18 – 100%, Pass)
    - The SMP evaluated this measure and deemed it complex.
    - The Standing Committee accepted the SMP's rating for Reliability: High/Moderate (Total Votes-10; H-4; M-4; L-0; I-2).
- **Validity**: Total Votes-17; H-0; M-12; L-5; I-0 (12/17 – 71%, Pass)
    - The SMP evaluated this measure and deemed it complex.
    - The SMP did not reach consensus on Validity: (Total Votes-9; H-0; M-5; L-4; I-0).

- **Feasibility**: Total Votes-18; H-10; M-8; L-0; I-0 (18/18 – 100%, Pass)
- **Use**: Total Votes-18; Pass-17; No Pass-1 (Pass/Total Votes – 94%, Pass)
- **Usability**: Total Votes-18; H-3; M-10; L-5; I-0 (13/18 – 72%, Pass)
- **Standing Committee Recommendation for Endorsement:** Total Votes-18; Yes-13; No-5 (13/18 – 72%, Pass)

The Standing Committee recommended the measure for initial endorsement. This group/practice-level measure was newly submitted for endorsement. This measure is not yet implemented in an accountability program. The Standing Committee stated that evidence existed to support the measure and passed the measure on this criterion. Likewise, the Standing Committee agreed that disparities and variation are both present, the latter being meaningful across practices. The Standing Committee requested further details on the attribution of disparities, considering that transplant centers determine which patients are waitlisted but the measure is attributed to individual clinicians. The developer noted that the variation is derived from the risk model, which includes adjustment for transplant center effects. Variations persist after adjustment for patient characteristics and transplant center characteristics; thus, this indicates that the variation is attributed to the group/practice. The Standing Committee accepted this explanation and passed the measure on performance gap.

The SMP reviewed this measure prior to the Standing Committee's review and passed it on reliability but did not reach consensus on validity. The Standing Committee voted to accept the SMP's rating for reliability. In addition, the Standing Committee discussed several topics related to the validity of the measure, such as how a patient's comorbidities are established. A CMS 2728 form is completed when the patient first enrolls in dialysis; however, it is not updated as the patient's comorbidities change. Additionally, claims data are not an ideal way to obtain patient comorbidity data. The developer advised that the risk model utilizes transplant centers' rate of transplants and organ availability, along with waitlist mortality rates, which accounts for the variability across centers. The developer also advised that several models are based on Medicare claims data and a considerable amount of research utilizes comorbidities identified through claims. The developer also advised that their TEP believed strongly that SDOH were utilized in the measure's risk adjustment, considering that patient finances and social support are used by transplant centers to make waitlist decisions. Thus, the developer advised that as the measure is holding the dialysis practitioners accountable, SDOH need to be accounted for. The Standing Committee accepted this explanation and passed the measure on validity.

The Standing Committee agreed that the measure is feasible; it also acknowledged that the measure is new but is not currently publicly reported, nor is it utilized in an accountability or quality program. The Standing passed the measure on feasibility and use. In addition, the Standing Committee expressed concern regarding a potential unintended consequence: A practitioner may direct patients towards a center that is likely to waitlist them. This would potentially improve the practitioner's rate on the measure and could impact a patient's choice regarding which transplant center they choose to be waitlisted for their transplant. The developer advised that patient choice is accounted for in the modeling, as patients are tracked based on the ZIP code where they reside. Thus, if a patient goes to a transplant center outside of their ZIP code, this will be accounted for in the modeling. The Standing Committee accepted this explanation and passed the measure on usability and overall suitability for endorsement.

NQF #2594 Optimal End-Stage Renal Disease (ESRD) Starts (The Permanente Federation/Kaiser Permanente Southern California)

Description: Optimal End Stage Renal Disease (ESRD) Starts is the percentage of new adult ESRD patients during the measurement period who experience a planned start of renal replacement therapy by receiving a preemptive kidney transplant, by initiating home dialysis (peritoneal dialysis or home

hemodialysis), or by initiating outpatient in-center hemodialysis via arteriovenous fistula or arteriovenous graft; **Measure Type**: Process; **Level of Analysis**: Population: Regional and State, Clinician: Group/Practice, Facility, Health Plan, Integrated Delivery System; **Setting of Care**: Ambulatory Care, Inpatient/Hospital, Outpatient Services; **Data Source**: Registry Data, Claims, Other, Electronic Health Records

Measure Steward/Developer Representatives at the Meeting

- Dr. Leo Pravoverov

Standing Committee Votes

- **Evidence**: Total Votes-17; H-4; M-13; L-0; I-0 (17/17 – 100%, Pass)
- **Performance Gap**: Total Votes-18; H-0; M-18; L-0; I-0 (18/18 – 100%, Pass)
- **Reliability**: Accepted Previous Evaluation
- **Validity**: Accepted Previous Evaluation
- **Feasibility**: Total Votes-18; H-4; M-14; L-0; I-0 (18/18 – 100%, Pass)
- **Use**: Total Votes-19; Pass-17; No Pass-2 (17/19 – 89%, Pass)
- **Usability**: Total Votes-18; H-3; M-15; L-1; I-0 (17/18 – 95%, Pass)
- **Standing Committee Recommendation for Endorsement:** Total Votes-19; Yes-19; No-0 (19/19 –100%, Pass)

The Standing Committee recommended the measure for continued endorsement. This facility-level measure was originally endorsed in 2015. Although this measure is not yet implemented in a federal program, it is utilized internally by the Kaiser Permanente Federation and is reported on across eight regions within the Kaiser Permanente network. Components of the measure, such as rate of preemptive transplantation, rate of functioning vascular access, and incidence and prevalence of home dialysis modalities (peritoneal dialysis [PD] and home hemodialysis [HHD]), are publicly reported, and the developer team has applied for consideration in federal programming, specifically the CMS Merit-Based Incentive Payment System (MIPS) program.

The Standing Committee sought clarity from the developer on the measure's level of analysis (LOA) after observing what they identified as multiple LOAs in the submission. The developer confirmed that the LOA is best identified as an integrated delivery system. The Standing Committee then agreed that it would proceed with a review of the measure under the LOA designation of integrated delivery system. The Standing Committee agreed that the updated evidence further supports the measure and passed the measure on the evidence criterion. The Standing Committee also noted a clear performance gap, as well as variation in performance, as indicated by the disparities data, and passed the measure on the performance gap criterion.

The Standing Committee inquired about the rationale behind the requirement of a minimum of 50 new end-stage renal disease (ESRD) patients in the denominator. The developer explained that statistically, 50 optimal starts is necessary to deem the measurement statistically meaningful. The developer also attested that additional reliability testing was not conducted and that the measure specifications have not changed significantly. The Standing Committee agreed that further discussion and a formal vote were not needed and accepted the previous Standing Committee's vote on reliability with a unanimous verbal confirmation. The developer also attested that additional validity testing was not conducted. Likewise, the Standing Committee agreed that further discussion and a formal vote were not needed and accepted the prior Standing Committee's vote on validity with a unanimous verbal confirmation.

The Standing Committee agreed that the measure is feasible; it also acknowledged that the measure is not currently publicly reported but is used for internal and regional quality across the Kaiser Permanente network. The developer stated that the Kidney Care Choices model within the Center for Medicare & Medicaid Innovation (CMMI) Center started reporting optimal starts in 2022, and data will likely be seen in 2023. The developer also advised that they have applied for use in the CMS MIPS program. Ultimately, the Standing Committee passed the measure on feasibility and use. The Standing Committee also agreed that the measure data demonstrated continuous improvement and noted that there is continued opportunity for improvement; however, it expressed concerns with potential unintended consequences, including misrepresentation of an optimal start. The developer clarified the Standing Committee's concern with the misrepresentation of optimal starts by explaining that optimal starts capture the first day of outpatient dialysis treatment, not the first day of the designated modality of treatment, and that there is no penalty for failure on the initial modality. The developer also explained that patients who switch from one dialysis modality to another are not included in this measure. The Standing Committee accepted the developer's clarifications on optimal starts and passed the measure on usability and overall suitability for endorsement.

Public Comment

No public or NQF member comments were provided during the measure evaluation meeting.

Next Steps

NQF will post the draft technical report containing the Standing Committee's discussion and recommendations on August 8, 2022, for public comment for 30 calendar days. The continuous public commenting period with member support will close on September 6, 2022. NQF will reconvene the Standing Committee for the post-comment web meeting in the fall of 2022.