ASN recently provided comments on three Measures Under Consideration with the Partnership for Quality Measurement (PQM) administered by Battelle as a certified consensus-based entity for the Centers for Medicare and Medicare Services (CMS). The measures ASN commented upon were:

1. MUC2024-051: Prevalent Standardized Waitlist Ratio (PSWR)
2. MUC2024-060: In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey
3. MUC2024-028 - Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes

ASN expressed concern for measure one as nephrologists and nephrology practices have no control on the decision to waitlist a patient for a kidney transplant and yet the measure effectively assigned those results to them as opposed to transplant centers that actually control the decision to waitlist. ASN expressed concern for measure two as well due to the fact that the measure had not been reviewed by the measure consensus-based entity – the PQM. ASN urged CMS to submit the measure for full endorsement, including the submission of validity and reliability testing before adding the measure to the ESRD QIP program. ASN expressed support for measure three in alignment with its ongoing support of screening for diabetes and prediabetes.

Below are the actual comments ASN provided.

MUC2024-051: Prevalent Standardized Waitlist Ratio (PSWR)

The American Society of Nephrology (ASN) recognizes the importance of improving transplantation rates for patients with kidney failure but does not support the Prevalent Standardized Waitlist Ratio Measure. ASN believes that while referral to a transplant center and initiation or even completion of the waitlist evaluation process could be appropriate metrics for these levels of analysis in CMS quality programs, the proposed clinician/group-level Prevalent Standardized Waitlist Ratio (PSWR) measure is not. The waitlisting process is a decision made largely by each individual transplant center and is beyond the scope of control of the physicians/physician groups targeted in the measure. In reviewing the details of the measure, ASN offers the following comments:

ASN objects to the attribution of successful/unsuccessful placement on a transplant waitlist to individual physicians or group practices. As stated above, it is the transplant center that decides whether a patient is placed on a waitlist, not the physician or group practice. The waitlisting process involves multiple parties that are unrelated to the nephrologist or care team, which can lead to potential obstacles and delays in care. Several factors beyond the control of the physician or physician group can impact the transplant waitlisting process. For example, changes in a patient's private insurance can affect the locations where they can be evaluated for transplant eligibility, disrupting the process multiple times. Penalizing physicians or group practices for events like these, which are beyond their control, highlights that the measure is misaligned with the principle that attribution models should fairly and accurately assign accountability.

In addition, the criteria for determining a patient's eligibility for transplantation can vary by geographic location. For example, one transplant center may require evidence of the absence of chronic osteomyelitis infection, heart failure, or other conditions, while another may apply different or additional criteria. ASN believes that the significant variability in listing rates among transplant

centers undermines the validity of this measure. This measure, along with other waitlisting-related measures in their current proposed forms, highlights the need for metrics that align incentives across the entire continuum of care. ASN believes that the current proposed measure fails to achieve this alignment and urges CMS to implement measures that more accurately reflect the role of nephrologists in the transplantation process and promote high-quality care for patients.

MUC2024-060: In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey - Quality of Dialysis Center Care and Operations (QDCCO) measure

The American Society of Nephrology (ASN) believes it is critically important to measure patient experience related to their dialysis treatments and their interaction with nephrologists. While ASN supports shortening the survey tool to reduce the burden on patients, we are concerned that the measure has not been reviewed by the measure consensus-based entity. ASN urges CMS submit the measure for full endorsement, including the submission of validity and reliability testing before adding the measure to the ESRD QIP program.

We are pleased that CMS has refined the ICH CAHPS survey measure by shortening the tool to address the well-documented fact that the current tool is too long. Pre-pandemic response rates are currently approximately 35 percent, raising concern for possible underrepresentation of patient groups. For instance, in a cross-sectional analysis of survey administration to 11,055 eligible in-center hemodialysis patients across the U.S., Dad et al. reported in 2018 that non-responders (6,541 [59 percent]) significantly differed from responders, broadly spanning individuals with fewer socioeconomic advantages and greater illness burden, raising limitations in interpreting facility survey results. As CMS has recognized, these rates fell even more during the pandemic.

Fielding of the current measure has created such a high level of patient burn-out with completing the lengthy survey twice a year that the measure is no longer valid. In fact, the current tool marginalizes people of color. Non-responders were more likely to be men, non-white, younger, single, dual Medicare/Medicaid eligible, less educated, non-English speaking, and not active on the transplant list. This situation should not be perpetuated. In addition, the current tool excludes home dialysis patients, reducing the power of their voice in the process. There has been considerable success in adapting the tool for use with home dialysis patients by some dialysis providers, and ASN urges CMS to look at those efforts. ASN would be happy to join CMS and others in that dialogue. Specifically of concern:

- Continued exclusion of home dialysis patients. While ASN appreciates the revisions of this measure, ASN remains concerned that CMS has not revised the survey tool to include home dialysis patients.
- Reliability/Validity Studies. Given the historic problems with the ICH CAHPS measure's validity, we believe it is premature for CMS to adopt the measure until the reliability and validity of the revised survey tool.

MUC2024-028 - Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes

The American Society of Nephrology (ASN) believes that screening for prediabetes and undiagnosed type 2 diabetes is critical to improving both prevention and care of type 2 diabetes – one of the conditions most commonly associated with kidney diseases. The Centers for Disease Control and Prevention (CDC) estimates that approximately 97.6 million American adults have prediabetes. They note that more than 80% of adults with prediabetes are not aware that they have the condition. Additionally, the CDC estimates 38.4 million adults have diabetes with 8.7 million being undiagnosed. The prevalence of prediabetes and diabetes also increases with age.

ASN believes early identification of both prediabetes and type 2 diabetes is crucial so that patients can receive effective interventions to decrease the likelihood of disease progression or complications such as kidney diseases of which 37 million Americans have kidney diseases and the vast majority are unaware.

The Screening measure is based on the United States Preventive Services Task Force (USPSTF) 2021 Prediabetes and Type 2 Diabetes: Screening recommendation. “The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity.”

Furthermore, this measure would address a recommendation from the National Clinical Care Commission (NCCC) to Congress and the Secretary of Health and Human Services (HHS), which called for adopting the Screening measure developed by the American Medical Association as part of a strategy to prevent diabetes among high-risk individuals.

The 22,000 nephrologists who comprise the membership of ASN, most assuredly recognize this step as clinically appropriate and meaningful for improved patient care. The measure targets an appropriate patient population that would clearly benefit from glucose screening. We believe the measure specifications are feasible to implement by most health care organizations; most organizations routinely capture the data elements in their EHR. Additionally, this measure is both valid and reliable as demonstrated in the testing results.