KIDNEY CARE PARTNERS

July 31, 2018

Elisa Munthali, MPH (emunthali@qualityforum.org)
Senior Vice President, Performance Measures
National Quality Forum
1030 15th Street, NW
Suite 800
Washington, DC 20005

RE: Request for Ad Hoc Review of *NQF 2979: Standardized Transfusion Ratio [STrR] for Dialysis Facilities*

Dear Ms. Munthali:

Kidney Care Partners (KCP) is an alliance of members of the kidney care community that serves as a forum for patient advocates, dialysis care professionals, providers, and manufacturers to advance policies that support the provision of high quality care for individuals with both chronic kidney disease and End-Stage Renal Disease (ESRD). As an NQF member, we have been active participants in NQF's projects on ESRD quality and commend you for your work in this regard.

On the basis of a combination of two of the three criteria in NQF's Ad Hoc Review Policy, KCP requests that NQF undertake an ad hoc review of *NQF 2979: Standardized Transfusion Ratio [STrR] for Dialysis Facilities* (steward = Centers for Medicare & Medicaid Services [CMS]):

- material changes have been made to the measure (including changes to the measure's setting and data source); and
- implementation of the measure results in unintended consequences.

A table noting details of the measure is provided as Attachment A. In the following sections, we provide justification under the two criteria.

Material Changes to Data Source

NQF 2979 was endorsed on December 9, 2016. As part of the NQF submission process, CMS provided testing data from the period January 1, 2011 through December 31, 2014. CMS also provided a code table of the ICD-9 to ICD-10 crosswalk.

The ICD-9 to ICD-10 transition occurred on October 1, 2015. Accordingly, the testing and data provided for the measure were performed using ICD-9 data, but there is a new data source, i.e., ICD-10 data.

Implementation Results in Unintended Consequences

KCP has historically expressed concern to NQF and CMS about under-reporting of transfusions based on NQF 2979. KCP has maintained this posed a serious validity issue. Because there is no requirement that ICD codes be used by hospitals when billing for transfusions, many only use revenue codes. NQF 2979, however, requires ICD-9/ICD-10 codes to measure performance. Specifically, we noted:

> "All inpatient transfusion events must now include an appropriate ICD-9 Procedure Code or Value Code to be captured in the measure; inpatient transfusion events for claims that include only transfusion revenue codes without an accompanying procedure or value code are not included in the numerator.
>
> There is no existing coding requirement that procedure or value codes be used; valid transfusion claims that include only revenue codes will be missed, creating a significant threat to measure validity.
>
> Current transfusion coding practices vary by hospital,[i] and hospital coding practices are beyond dialysis facilities' sphere of control. For example, hospitals that exclusively use revenue codes for transfusions will appear to have no events assigned to a dialysis facility, while hospitals that do use procedure and/or value codes will have recorded events. Facilities within given catchment areas will thus be differentially affected by hospital coding variations, which will clearly impact STrR scoring.
>
> [i] Weinhandl ED, Gilbertson DT, Collins AJ. *Dialysis facility-level transfusion rates can be unreliable due to variability in hospital-level billing patterns for blood.* Chronic Disease Research Group poster, ASN. 2014."

As we describe in the following section, KCP's analysis demonstrates that implementation of NQF 2979, now with ICD-10 codes, results in unintended consequences that can adversely impact facilities when used in CMS' payment and public reporting programs.

Analysis of STrR Transfusion Capture and ICD-9/ICD-10 Conversion

Using the 2014-2016 Medicare Limited Data Sets (100% sample) for Medicare fee-for-service beneficiaries, we analyzed inpatient facility claims to identify transfusions during admissions to short-term and critical access hospitals.[1] Specifically, we identify hospitals with large changes in transfusion coding after implementation of ICD-10. The analysis separates non-critical access

[1] The results provided are for all beneficiaries, not specific to dialysis patients; there is no reason to suggest a hospital's coding practices differ between its general population and dialysis patients. An analysis limited to dialysis patients (which we can provide) leads to qualitatively similar conclusions, but there is more noise because there are fewer admissions to analyze. By volume, the largest hospital with a >80% apparent reduction in transfusion under ICD-10 was Christiana Hospital in Newark, Delaware. In the last year before ICD-10-PCS and the first year after ICD-10-PCS, a blood transfusion occurred during 10.0% and 0.1% of hospitalizations, respectively. Accordingly, a dialysis facility (or facilities) associated with this hospital will show a significant improvement in the StrR due to the ICD-10 implementation and change in the hospital's reporting practices.

hospitals and critical access hospitals, since the latter generally have smaller admission volumes, which influence the statistical model's detection of a change. We also provide maps that illustrate that the changes are widespread and not geographically driven.

- For non-critical access hospitals:
  - 473 of 3,259 hospitals (14.5%) had an estimated reduction in transfusion coding of >80% after the ICD-10 conversion was effected.
  - 733 of 3,259 hospitals (22.5%) had an estimated reduction in transfusion coding of >50% after the ICD-10 conversion was effected.

- For critical access hospitals:
  - 72 of 1,282 hospitals (5.6%) had an estimated reduction in transfusion coding of 80% after the ICD-10 conversion was effected.
  - 246 of 1,282 hospitals (19.2%) had an estimated reduction in transfusion coding of >50% after the ICD-10 conversion was effected.

Overall, 545 of 4,541 of hospitals (12.0%) had an estimated reduction in transfusion coding >80% after the ICD-10 conversion (Figure 1), and 979 of 4,541 hospitals (21.6%) had an estimated reduction in transfusion coding >50% (Figure 2).

Figure 1. Overall Distribution With Estimated Reduction in Transfusion Coding >80% after ICD-10 Conversion

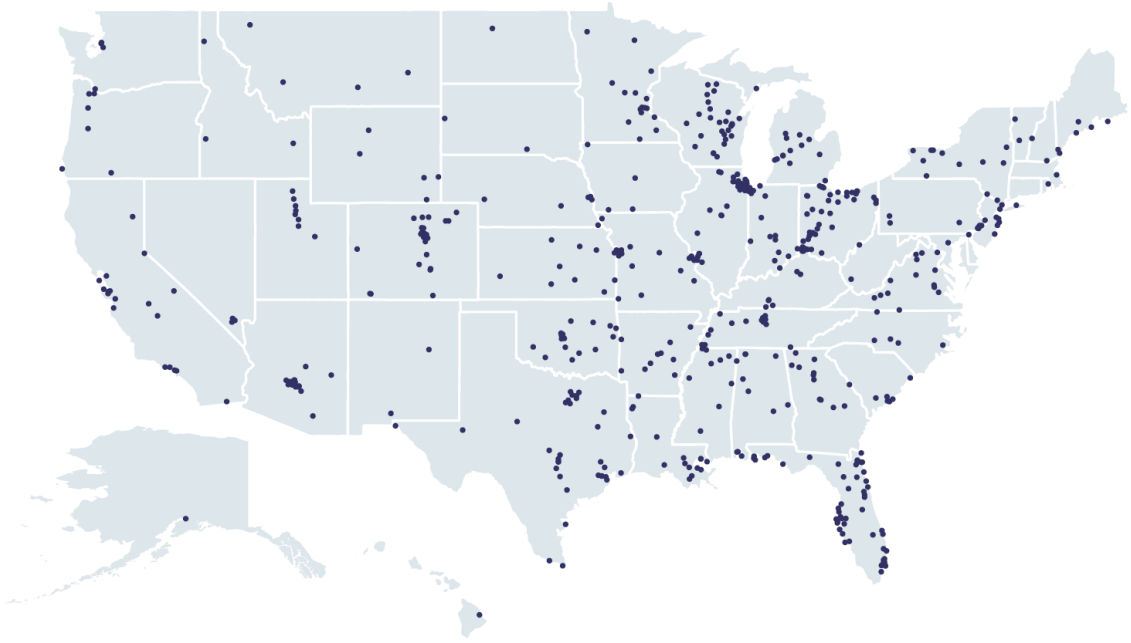
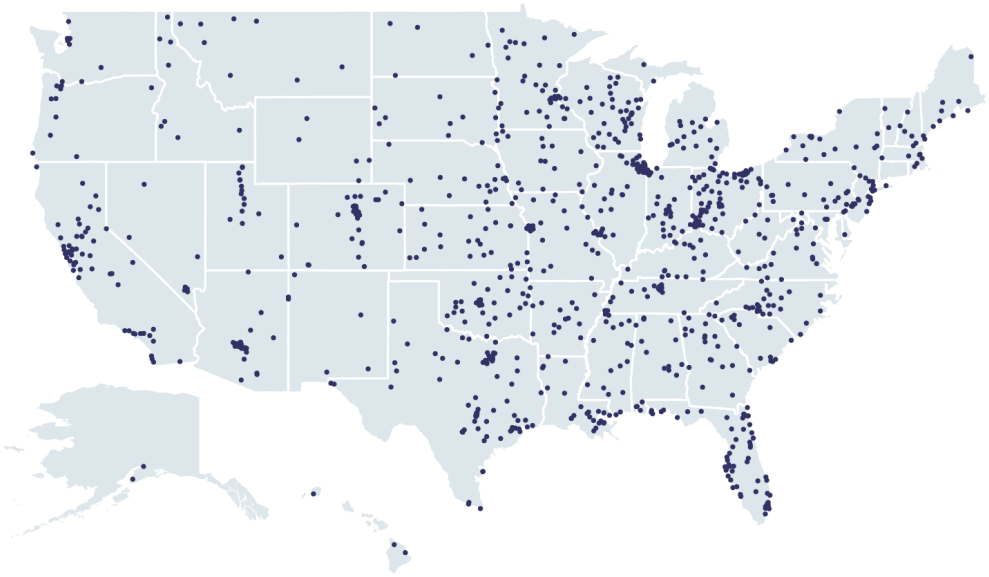


Figure 2. Overall Distribution With Estimated Reduction in Transfusion Coding >50% after ICD-10 Conversion



While there is currently a downward trend in transfusion utilization in the United States, it defies logic that such a significant proportion of hospitals would reduce their transfusions by 80%, or even 50% after the conversion to ICD-10. Rather, KCP submits that our original concern regarding under-reporting has been exacerbated. With the switch to ICD-10 codes, we hypothesize that even more hospitals are using only revenue codes, and no accompanying ICD-10 procedure or value codes, which are required for NQF 2979. Dialysis facility performance that may appear to have drastically improved on the STrR (fewer transfusions), may in fact solely be due to hospitals not including the ICD-10 codes specified by the measure.

Again, because there is no requirement that the ICD-10 procedure or value codes be used for a facility to be paid, valid transfusion claims that include only revenue codes will be missed by the measure. Facilities associated with hospitals that use the codes will appear to have more transfusions and hence perform more poorly on the STrR and be inappropriately penalized financially under CMS' Quality Improvement Program (QIP) or be inappropriately scored under CMS' Five Star Program because their score on the STrR relative to a significant number of other facilities is likely an artifact of coding practices by hospitals associated with the seemingly "good" facilities.

<u>Summary and Requested Action</u>

KCP posits these findings call into question the scientific acceptability (Validity criterion) of the STrR with the change to ICD-10 coding, and we therefore request that the Renal Standing Committee conduct an ad hoc review of *NQF 2979: Standardized Transfusion Ratio [STrR] for Dialysis Facilities*. We appreciate that NQF cannot compel CMS to discontinue using the STrR in either the QIP or Five Star Program, but removing endorsement because it no longer meets the validity criterion would send a strong signal that its use should be discouraged.

We look forward to working with you on this important matter. Please do not hesitate to contact Lisa McGonigal, MD, MPH (lmcgon@msn.com, 203.530.9524) with any questions or concerns regarding this request.

Sincerely,

Allen R. Nissenson, MD, FACP
KCP Chair

cc: NQF Renal Project (renal@qualityforum.org)
Jesse Roach, MD (jesse.roach@cms.hhs.gov)

ATTACHMENT A

ID/Title/Steward	Description	Numerator	Denominator	Exclusions
NQF 2979 Standardized Transfusion Ratio for Dialysis Facilities Steward: CMS Level: Facility Risk Adjustment: Yes	The risk adjusted facility level transfusion ratio "STrR" is specified for all adult dialysis patients. It is a ratio of the number of eligible red blood cell transfusion events observed in patients dialyzing at a facility, to the number of eligible transfusion events that would be expected under a national norm, after accounting for the patient characteristics within each facility. Eligible transfusions are those that do not have any claims pertaining to the comorbidities identified for exclusion, in the one year look back period prior to each observation window. This measure is calculated as a ratio, but can also be expressed as a rate..	Number of eligible observed red blood cell transfusion events: An event is defined as the transfer of one or more units of blood or blood products into a recipient's blood stream (code set is provided in the numerator details) among patients dialyzing at the facility during the inclusion episodes of the reporting period. Inclusion episodes are those that do not have any claims pertaining to the comorbidities identified for exclusion, in the one year look back period prior to each observation window.	Number of eligible red blood cell transfusion events (as defined in the numerator statement) that would be expected among patients at a facility during the reporting period, given the patient mix at the facility. Inclusion episodes are those that do not have any claims pertaining to the comorbidities identified for exclusion, in the one year look back period prior to each observation window.	All transfusions associated with transplant hospitalization are excluded. Patients are also excluded if they have a Medicare claim for: hemolytic and aplastic anemia, solid organ cancer (breast, prostate, lung, digestive tract and others), lymphoma, carcinoma in situ, coagulation disorders, multiple myeloma, myelodysplastic syndrome and myelofibrosis, leukemia, head and neck cancer, other cancers (connective tissue, skin, and others), metastatic cancer, and sickle cell anemia within one year of their patient time at risk. Since these comorbidities are associated with higher risk of transfusion and require different anemia management practices that the measure is not intended to address, every patient's risk window is modified to have at least 1 year free of claims that contain these exclusion eligible diagnoses.