

## **Summary: CMS Quality Incentive Program Proposed Rule**

Alongside its recently-released final rule on ESRD bundled payments, the Centers for Medicare and Medicaid Services (CMS) detailed its vision for a Quality Improvement Program (QIP) in a proposed rule, released the same day as the ESRD Final Rule (July 26, 2010). Under the QIP, CMS will tie facilities' payments to care quality standards; those that fail to achieve specified performance scores for quality of dialysis care will see payment reductions of up to two percent. Going into effect on January 1, 2012, the QIP will be the first pay-for-performance program in a Medicare fee-for-service payment program.

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 mandated CMS to develop both new bundled payment system and the QIP, but the Agency is accepting public comments on its QIP Proposed Rule until September 24, 2010. ASN's QIP Task Force is drafting a comment letter to CMS based on a rigorous analysis of the proposed rule, along with the ASN Public Policy Board. This summary highlights the key components of the proposed rule.

### **Quality Measures (p. 17)**

Importantly, CMS finalized the three quality measures that facilities will be measured against during the first year of the QIP in the ESRD Final Rule:

- Hemodialysis Adequacy: Percentage of Medicare patients with an average urea reduction ratio (URR) of 65 percent or more
- Anemia Management: Controlled anemia, as shown in two measures:
  - The Medicare percentage of patients at a facility whose hemoglobin levels were less than 10 grams per deciliter (g/dL)
  - The percentage of Medicare patients at a facility whose hemoglobin levels were greater than 12 g/dL.

Facilities have already been reporting these measures on claims, and the results for each facility are now publicly available on the CMS Dialysis Facility Compare website.

### **Performance Standards (p. 19)**

CMS proposes two potential performance standards—baselines against which facilities will be judged—during the first year of the QIP. CMS would compare facilities data during the performance period to the lesser of the two following standards:

- a) The facilities' own performance on each measure during 2007, or
- b) The national performance rates of all dialysis providers (calculated from 2008 data)

This proposal would judge facilities against the most of the two lenient standards. For instance, a facility that performed worse than the national average in 2008 would be held to a lower performance standard (its own performance on each measure during 2007) than a facility whose performance in 2007 was better than or equal to the national average in 2008 (which would be held to the 2008 national average). The 2008 national performance rates (percentage of Medicare patients who had the following average values) for each measure are shown below:

- Hemodialysis Adequacy: 96 percent
- Hemoglobin Less Than 10g/dL: 2 percent
- Hemoglobin More Than 12g/dL: 26 percent

### Performance Period (p. 22)

MIPPA requires CMS to initiate payment reductions January 1, 2012. Consequently, CMS states, the performance period—the time period from which CMS will examine providers' data to establish payment reductions—must occur prior to that time so that it can collect, review, and calculate the performance scores that will determine the extent of each facility's reductions. CMS proposes to establish the performance period as the entire calendar year of 2010, reasoning that it needs a full year (all of 2011) to calculate applicable payment reductions—which will go into effect on January 1, 2012. Under this proposal, providers would see payment reductions in 2012 (the payment consequence year) for care provided during 2010 (the performance period).

### Performance Score (p. 23)

MIPPA requires CMS to calculate a total performance score for each facility, and to weight the performance score with respect to individual measures to reflect priorities for quality improvement, incenting providers to meet or exceed certain standards.

CMS proposes to assign 10 points to each of the three measures; if a facility meets or exceed a measure it would receive 10 points. Facilities that do not meet or exceed the measure would receive less than 10 points, with the exact number corresponding to how far beneath the standard its performance fell. CMS proposes to subtract 2 points for each percentage point a provider falls beneath its performance standard (again, based on the lesser of a) its own performance on each measure during 2007 or b) the 2008 national average).

The four tables below illustrate the proposed scoring methodology for each of the three measures under both performance standards options.

**Table 1. Proposed Scoring Methodology for Anemia Management Measures using National Average Performance Rates in 2008 as the Performance Standard for 2010 Facility-Specific Comparison**

	Anemia Management Measures	
	Percentage of Medicare patients whose average hemoglobin levels are less than 10 g/dL	Percentage of Medicare patients whose average hemoglobin levels are greater than 12 g/dL
<b>POINTS</b>	<b>Percentage</b>	<b>Percentage</b>
<b>10 points</b>	<b>2 percent or less</b>	<b>26 percent or less</b>
8 points	3 percent	27 percent
6 points	4 percent	28 percent
4 points	5 percent	29 percent
2 points	6 percent	30 percent
0 point	7 percent or more	31 percent or more

Note that the bolded rows show the performance standard for the applicable measure.

**Table 2. Proposed Scoring Methodology for Anemia Management Measures using Facility-Specific Rates in 2007 as the Performance Standard and 2010 Facility-Specific Rate for Comparison**

	Anemia Management Measures	
	Percentage of Medicare patients whose average hemoglobin levels are less than 10 g/dL	Percentage of Medicare patients whose average hemoglobin levels are greater than 12 g/dL
<b>POINTS</b>	<b>Percentage</b>	<b>Percentage</b>
	4 percent (Example of a 2007 facility-specific score)	30 percent (Example of a 2007 facility-specific score)
10 points	4 percent or less	30 percent or less
8 points	5 percent	31 percent
6 points	6 percent	32 percent
4 points	7 percent	33 percent
2 points	8 percent	34 percent
0 points	9 percent or more	35 percent or more

**Table 3. Proposed Scoring Methodology for Hemodialysis Adequacy Measure using National Average Performance Rates in 2008 as the Performance Standard for 2010 Facility-Specific Comparison**

<b>POINTS</b>	Hemodialysis Adequacy Measure
	Percentage of Medicare patients whose average URR levels are greater than 65 percent
10 points	96 percent or more
8 points	95 percent
6 points	94 percent
4 points	93 percent
2 points	92 percent
0 points	91 percent or less

**Table 4. Proposed Scoring Methodology for Hemodialysis Adequacy Measure using Facility-Specific Rates in 2007 as the Performance Standard and 2010 Facility-Specific Rate for Comparison**

POINTS	Hemodialysis Adequacy Measure
	Percentage of Medicare patients whose URR levels are greater than 65 percent
	92 Percent (Example of a 2007 facility-specific score)
10 points	92 percent or more
8 points	91 percent
6 points	90 percent
4 points	89 percent
2 points	88 percent
0 points	87 percent or less

In calculating the total performance score, CMS proposes to give greater weight to the Hemoglobin Less Than 10g/dL measure; specifically, it proposes to weight that measure as 50 percent of the total score; the remaining 50 percent would be divided equally between the Hemoglobin More Than 12g/dL and Hemodialysis Adequacy measures. CMS details its proposed methodology for applying the weights and calculating the total performance score on page 31 – 36 of the proposed rule, and is specifically seeking public comments on this methodology.

**Payment Reductions (p. 26)**

Mandated by MIPPA to implement a sliding scale of payment reductions that reflects how close facilities were to meeting the performance standard, CMS proposes to use payment differentials of .05 percent across a performance score range of five levels, depicted in the chart below:

**Table 5. Proposed Payment Reduction Scale**

Total Performance Score	Percent of Payment Reduction
26 to 30 Points	0.0 Percent
21 to 25 Points	0.5 Percent
16 to 20 Points	1.0 Percent
11 to 15 Points	1.5 Percent
0 to 10 Points	2.0 Percent

CMS states that it seeks to avoid situations in which small deficiencies in a provider's performance would result in a large payment reduction—for instance, when performance falls just slightly below the performance standard—and seeks public comments on the proposed reduction scale. Importantly, the payment reduction would be applied after any other applicable adjustments to a facility's payment—such as case-mix, wage index, and outlier—were made. Similarly, CMS proposes to calculate beneficiaries' co-payments after applying the QIP payment reduction, thus lowering co-payment amounts.

### **Public Reporting (p. 40)**

MIPPA mandates that CMS make information regarding performance under the QIP available to the public, including individual facilities' performance scores. These scores must be posted in the facility in the form of a certificate, as well as on a CMS-maintained website. CMS proposes that each certificate would contain the following data elements:

- The total performance score achieved by the provider/facility under the QIP with respect to the year involved
- Comparative data that shows how well the provider/facility's total performance score compares to the national total performance score average
- The performance score that the provider/facility achieved on each individual measure with respect to the year involved
- Comparative data that shows how well the provider/facility's individual quality measure performance scores compare to the national performance score average for each quality measure.

CMS seeks comment on how to make this information user-friendly and as easy to understand as possible, including to patients with limited English proficiency. The agency also provides great detail on its proposals for notifying facilities of their scores, displaying certificates, and designing the website.

### **Future QIP Considerations (p. 53)**

CMS reiterates that it will be monitoring the effect of the new bundled payment system and the QIP in areas such as access to care, practice pattern changes, and drug utilization, and encourages comments on its approach to this effort. In addition, the agency anticipates that it will "strengthen the performance standard for each measure in future years of the QIP, including potentially moving away from the national performance rate and instead identifying absolute standards that reflect performance goals widely recognized by the ESRD medical community as demonstrating high quality care for ESRD patients." Specifically, CMS notes it is developing measures such as Kt/V, access infection rate, fluid weight management, and pediatric measures. Besides seeking public comment on new performance standards, CMS also requests input on how best to encourage improvement and achievement of standards under the QIP.

Additionally, CMS intends to establish the national performance rates of the three finalized measures as "floors" such that the performance standards will never be lower than those set for the previous year. As such, even if facility performance—and therefore, the national performance rate—fails to improve or declines, over time, the performance standard to which they will be held will not be reduced over time.

### **ASN Advocacy**

The society looks forward to submitting a detailed comment letter to CMS on the QIP, and will make this available on ASN's public policy website at that time. Moving forward, the society will continue to work closely with CMS, advocating on behalf of ASN members and the patients they treat as the agency finalizes and implements the QIP.