

## The List: ASN Kidney News “Top to Watch” in 2012

### States Wrestle with Health Reform Implementation

States this year will struggle to implement some of the provisions of the Accountable Care Act (ACA) while at the same time keeping an eye on efforts to repeal several of the provisions. Major reforms are set to roll out in 2014.

The Supreme Court announced in November 2011 that it would consider a lawsuit brought by 26 state governments challenging the constitutionality of both the individual mandate and Medicaid expansion. Although a decision could come as early as this summer, the court may have to defer a ruling on the individual mandate until it has run for a year. Based on a federal statute, consumers are barred from challenging a tax law until it has gone into effect and taxes have been paid.

In the meantime, all but seven states are somewhere in the process of creating a health insurance exchange, with 13 states having established an exchange either by state legislation or executive order. Twenty-three states have received federal funding but continue to study their options. Eight have so far been unable to pass legislation. State governments with strong opposition to exchanges may wait for a Supreme Court judgment before taking legislative action. But they risk cutting it close to the January 2013 deadline to determine whether they will run their own exchange or have the federal government take control.

The Institute of Medicine (IOM)

recently released a consensus statement, requested by the Secretary of Health and Human Services, outlining criteria and methods to be used in the process of determining an “essential health benefit” (EHB) package as required by the ACA for state health exchanges.

All plans offered through health insurance exchanges must include the EHB package at a minimum, which is based on 10 categories, including hospital services, prescription drugs, preventive services, and maternity care. The IOM emphasized that developing this benefits package will require a delicate balance between providing needed health services and maintaining plan affordability to avoid an explosion in consumer use of subsidized and public health care programs.

Armed with a set of criteria and a preferred methodology for determining benefits from the IOM committee, the Department of Health and Human Services is expected to release EHB rules in 2012, although there is no set deadline. Coverage for dialysis treatments and immunosuppressives for transplant recipients is unclear. Policy analysts must be ready to comb through the rules to be sure these populations are accounted for. Stay tuned.

States will be responsible for ensuring that plans maintain EHB, and may have to decide whether to impose coverage requirements on private plans that may



no longer provide services previously required under state law.

To see where your state stands with a health exchange, visit: <http://healthreform.kff.org/the-states.aspx>

Another ACA provision on the states' radar is the medical loss ratio (MLR) rule, which requires insurers to spend at least 80 percent of premium dollars on clinical services and quality improvement or provide rebates to consumers. Rebates for 2011 will roll out to consumers in 2012. Six states have been granted waivers by the Department of Health and Human Services owing to unstable and/or small state insurance markets. Five states have had their waiver requests denied, and seven states have waivers under consideration. The National Association of Insurance Commissioners recently passed, by a slim margin, a resolution expressing concerns with the ruling and urging Congress to increase protections for insurance brokers and agents, signaling that whether for or against, the MLR continues to be a top priority for state

insurance commissioners.

On the Medicaid front, the Centers for Medicare and Medicaid Services (CMS) continues to roll out funding opportunities, authorized by provisions in the ACA, to help states manage health care costs and improve health care delivery. Eight states have been awarded grants to participate in the Medicaid Incentives for Chronic Diseases Program, a three-year pilot measuring the effects of direct incentives on consumer participation in preventive care and healthy behaviors. The newly established Center for Medicare and Medicaid Innovation recently announced the Health Care Innovation Challenge as a means to provide funding for groups to design, implement, and test innovative models of health care delivery and payment for the Medicare, Medicaid, and Children's Health Insurance programs. Awards go up to \$30 million and states are welcome to apply as separate entities or as part of a collaborative effort with other payers/providers. ●

### Measuring Quality

Throughout 2012, the nephrology community will be focused on how Medicare's new Quality Incentive Program (QIP) affects patient outcomes and practice patterns.

Mandated by the Medicare Improvement for Patients and Providers Act of 2008, the QIP is the only mandatory “pay-for-performance” program in Medicare. The QIP was designed to establish performance standards for dialysis facilities and to adjust payments based on meeting (or not meeting) those standards.

Speaking at Kidney Week, Jeffrey Berns, MD, FASN, described QIP as a “pay for nonperformance” program or P4nP, since facilities will receive a payment deduction of up to 2 percent if certain performance measures are not met. Reductions in years 2012 and 2013 will be based on hemoglobin measures and urea reduction ratio (URR), with several

clinical and process measures being added in 2014. Reductions are made based on a complicated scoring system. Data used for reductions in 2012 and 2013 will come from claims filed in 2010 and 2011 respectively, leaving little room for actual quality improvement based on QIP.

Two of the QIP measures are already met by the majority of dialysis facilities: 96 percent have URR ratio of at least 65 percent and 84 percent keep hemoglobin less than 12 mg/dL. The fact that many facilities meet these standards begs the question of whether these measures really address a performance gap, Berns noted. The two measures also were not endorsed by the National Quality Forum, of which Berns holds a seat as the ASN representative. But they were included in the actual mandate for Congress, so by law they must be included.

Daniel Wiener, MD, assistant profes-

or at Tufts University and member of the ASN's Dialysis Advisory Group, noted that what is good for the majority of patients will still not benefit everyone and may even negatively affect a subpopulation of patients. As a case study, Weiner described how one of the 2014 QIP measures (use of AV fistula) may not be the best choice for everyone. For the elderly, physicians must choose carefully among arteriovenous (AV) fistula use versus catheter or AV, he said. Although targets are set at less than 100 percent to help physicians individualize therapies, Weiner said this may not be adequate to allow for adjustment.

The major components of a pay-for-performance program are operationalizing quality and designing incentives followed by communication, implementation, and evaluation, said Rajnish Mehrotra, MD, FASN, chair of the ASN Dialysis Advisory Group and associate

professor at UCLA. Mehrotra applied the dimensions of quality outlined in the Institute of Medicine's 2001 report, demonstrating that QIP is making an effort to provide higher quality care by addressing clinical effectiveness (Hgb, URR), patient safety (infection reporting), and patient centeredness (patient experience survey), but has not successfully addressed timeliness, efficiency, or equity.

The incentive structure for the QIP is also off kilter, Mehrotra said, using a payment withhold instead of bonuses, and using payment periods far removed from actual performance periods.

Ultimately, many in the kidney community remain optimistic about the use of quality measures in nephrology care, but will continue to advocate in 2012 for appropriate and effective measures that are better aligned with provider care and reimbursement. ●