Consumer-Purchaser DISCLOSURE PROJECT Improving Health Care Quality through Public Reporting of Performance

# Changing Delivery & Changing Care: Summary of the Delivery and Payment Reform Elements of the Patient Protection and Affordable Care Act of 2010

April 5, 2010

The Patient Protection and Affordable Care Act (PPACA) has an array of provisions related to expanding coverage and changing the rules by which health insurers offer coverage. In addition, the newly enacted law includes a wide range of provisions intended to control health care costs and improve the health care delivery system. This summary provides a review of some of the major areas of reform that relate to fostering delivery system reform, including:

- Payment Reform
- Priority Setting, Performance Measurement, and Quality Improvement
- Public Reporting
- Promoting Population Health and Wellness
- Comparative Effectiveness Research
- Health Information Technology and Administrative Efficiency

(Note: for those interested in even more detail, the full bill as adopted can be found at: http://www.healthcaredisclosure.org/docs/files/PPACA_Text.pdf and you can search this PDF by section.)

The enactment of PPACA is historic, but in many ways this marks the starting line. How the reforms are shaped and then implemented in the months and years to come will define how they meet the need to deliver high quality and affordable care to all Americans. A number of factors will determine how this happens. The Consumer-Purchaser Disclosure Project will be developing a listing of the new decision-making bodies included in the legislation, as well as current bodies that play a role in delivery reform, and additional summaries and reviews of federal policies in these domains and descriptions of opportunities to shape these policies in the coming months and years. For more information, go to www.healthcaredisclosure.org.

## Executive Summary of Delivery Reform Elements

### Payment Reform to Improve Quality and Value

- *Value-based Purchasing and Piloting of New Programs:* Includes rapid testing and, as proven, expansion of programs that use payment redesign to encourage better quality while lowering costs.
- *CMS Innovation Center*: Establishes an Innovation Center with the capacity to implement innovations program-wide that require review and assessment by the Office of the Actuary.
- *Independent Payment Advisory Board:* Establishes a new Board which includes reporting on cost and quality trends in Medicare and the private sector as well as making recommendations regarding policies in the private sector.
- *Alignment between Public and Private Payers*: Includes multiple provisions that advance the goal of aligning payment between public and private payers.

C/O National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650
Washington, DC 20009
202.986.2600 • 202.986.2539 (fax) • healthcaredisclosure.org

**Priority Setting, Performance Measurement and Quality Improvement**

- *Priority Setting and Multi-Stakeholder Input:* Establishes a clear priority-setting process for federal health policy that ensures multi-stakeholder input.
- *Measure Development:* Supports the development and maintenance of measures to evaluate care (e.g., outcomes, patient experience, care coordination, resource use).
- *Measure Endorsement:* Fosters use of nationally standardized measures endorsed by a multi-stakeholder body.
- *Data Collection and Aggregation Processes:* Ensures CMS's ability to collect information and make it available for quality improvement by providers and for accountability and choice by consumers and purchasers.
- *Support Meaningful Quality Improvement Support:* Clinicians and other providers are provided the tools and support to use performance information to improve their care.

**Public Reporting to Promote Transparency**

- *Broad Plan for Public Reporting:* Requires a clear federal plan to make performance information widely available.
- *System-wide Reporting on Quality and Cost:* Periodic reporting on quality and costs that reflect both Medicare and the private sector performance to inform clinical and patient decisions and to assess the impact of reform.
- *Prescription Drug Risk/Benefit Information:* Standardized information on drug risks and benefits.
- *Release of Medicare Data:* Medicare data will be released to support better transparency of provider performance with full protections of patient privacy.

**Promoting Population Health and Wellness**

- *Implement a National Wellness Plan:* The Secretary shall develop and support a broad effort to promote population health and wellness.
- *Benefit Designs to Promote Wellness:* Coverage for preventive services and incentives for wellness are fostered in Medicare, Medicaid and for private coverage.
- *Encourage Employer Wellness Programs:* Employers' efforts to promote wellness are fostered through multiple vehicles.

**Comparative Effectiveness Research to Improve Care and Inform Clinical and Patient Decisions**

- *Independent Governance:* Establishes a new independent entity to support and oversee comparative effectiveness research.
- *No Restrictions on Use of Results:* The purpose of comparative effectiveness research is for findings to be used by clinicians, patients and others.
- *Effective Conflict of Interest Provisions:* Protections are in place and need to ensure that self-interested individuals and entities do not overly influence the CER research agenda and related processes.

***Health Information Technology and Administrative Efficiency***

- *Builds on the HITECH incentives:* The existing law provides incentives for the adoption of "meaningful use" of health information technologies is maintained.
- *Promotes Telehealth:* Acknowledgement of the potential of delivering care through telehealth is provided.
- *Supports Administrative Efficiency:* Important provisions support reducing burden on providers and saving resources by standardizing claims, utilization and credentialing processes.

# Patient Protection and Affordable Care Act of 2010
# Table of Contents – Delivery Reform Elements

# PAYMENT REFORMS

## Independent Payment Advisory Board
**(SEC. 3403)**

PPACA establishes the Independent Payment Advisory Board (IPAB). The IPAB is charged to submit proposals to Congress to reduce per capita growth rate in Medicare spending if it exceeds targeted growth rate, beginning in 2014. The Secretary must implement proposals unless Congress blocks them by enacting alternative legislation. The IPAB will also make advisory recommendations related to the private sector to reduce cost growth and promote quality. It will also produce a system wide report on cost and quality by 2014 and annually thereafter.

- Membership includes 15 members appointed by the President as well as the Secretary of HHS and the Administrators of CMS and HRSA.
- A ten-member Consumer Advisory Council will be established to advise the IPAB. The members are appointed by Comptroller General from each of 10 regions and must meet at least twice a year.
- Funding for the Commission is $15M for FY 2012 and then increased annually by CPI for All Urban Consumers.
- In order for the IPAB to be discontinued, Congress must introduce a joint resolution by February 1, 2017.

## Center for Medicare and Medicaid Payment Innovation
**(SEC. 3021)**

PPACA creates a new Center for Medicare and Medicaid Payment Innovation within CMS. This Center must be established by January 1, 2011 and is charged with testing innovative payment and service delivery models in Medicare and Medicaid. The Center will have broad authority to determine what models will be tested, in what populations, and for how long, with a preference for models that reduce program costs while preserving or enhancing quality. Among the important elements PPACA provides for the Center are:

- Allows the Secretary (in consultation with the Chief Actuary of CMS) to expand the duration and scope of a model that improves care and lowers costs and terminate or modify models that do not.
- Authorizes funds for the Center in the amounts of $5M for 2010, $10B for FY 2011-2019 and $10B for 10 year FY period beginning with 2010. Not less than $25M shall be made available each FY.
- Requires the Secretary, in 2012 and every year thereafter, to submit a report on the Center's activities to Congress.
- Includes the use of "patient-level outcomes measures".
- Makes demonstrating effective linkage to other public and private sector payers a factor for consideration.

## Alignment in Payment Incentives Across Payers

One of the priorities of consumers and purchasers has been to assure that public sector efforts are aligned with those of the private sector. There are multiple places in PPACA where the need to align payment incentives across public and private sectors is specifically called for, including:

- **The Center for Medicare and Medicaid Innovation** (**SEC. 3021)** The Center for Medicare and Medicaid Innovation is charged with considering programs that, for example, allow States to test all-payer payment reform and that provide an effective linkage to other public and private sector payers. The Center will also give preference to accountable care organizations (ACOs) that participate in similar arrangements with other payers.
- **Independent Payment Advisory Board (SEC. 3403)** The Independent Payment Advisory Board (IPAB) will, as early as in 2015 and every two years thereafter, provide non-binding recommendations on ways to slow the growth of expenditures in the private sector. The IPAB will coordinate its recommendations for the private sector along with its Medicare proposals. The IPAB will also produce a system wide report on cost and quality by 2014 and annually thereafter, which will address both Medicare and private sectors costs and quality.

- **Interagency Working Group on Health Care Quality (SEC. 3012)** The HHS Interagency Working Group is charged with assessing alignment of quality efforts in the public sector with private sector initiatives.
- **Health Plans** (**SEC. 2717)** Within two years of enactment, HHS, in consultation with health care quality experts and stakeholders, must develop reporting requirements for group health plans and health insurance issuers offering group or individual health insurance coverage, with respect to plan or coverage benefits and provider reimbursement structures that (1) improve outcomes through quality reporting, case management, care coordination, use of medical homes model; (2) implement activities to prevent hospital readmissions through a comprehensive discharge planning program; (3) improve patient safety and reduce errors; and (4) implement wellness and health promotion activities.

## Physician Payment – Value-based Purchasing

PPACA does not specifically address the need to do a review and "fix" of the Sustainable Growth Rate, but there are provisions related to addressing vehicles to bring value into payments made to physicians through the fee-for-service mechanism.

**Physician Quality Reporting Initiative (PQRI) Modifications** (**SEC. 3002)**

PQRI bonus payments for successful reporting are extended through 2014. However, if eligible health care professionals are not participating in PQRI by 2015, they will be penalized by a reduction of 1.5% in their Medicare FFS payments and by 2% thereafter. Additionally:

- Physicians would be eligible for an incentive payment if they participate in an American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) program and complete a MOC practice assessment. Physicians who report quality data through an MOC process will receive an additional 0.5% PQRI bonus for three years.
- By January 1, 2012, the Secretary will develop a plan for integrating reporting on clinical quality measures and meaningful use of EHRs into PQRI.
- An informal appeals process will be established for PQRI by 2011.

## Physician Payment – Reassessment of RBRVS
**(SEC. 3134)**

This section allows the Secretary to review and adjust codes and relative value units (RVUs) that are potentially misvalued. Adjustments could include the bundling of individual services. It also removes the authorization for the Practicing Physician Advisory Council (PPAC).

## Physician Payment – Primary Care Payments
**(SEC. 5501, 1202)**

The PPACA provides a five-year, 10% bonus payment for primary care practitioners, and general surgeons practicing in health professional shortage areas, beginning in January 1, 2011. It also provides federal funding to increase Medicaid primary care payments for family medicine, general internal medicine, and internal medicine to no less than 100% of adjusted Medicare rates in 2013 and 2014.

## Physician Payment – Other
**(SEC. 3003)**

The Secretary is directed to provide reports to physicians on resource use beginning in 2012. An episode grouper will be developed by January 1, 2012 to assist in analyzing utilization. The Secretary is to coordinate this program with other value-based purchasing reforms.

# PAYMENT REFORMS

## Hospital Payment – Value-based Purchasing

**(SEC. 3001)**

PPACA establishes a value-based purchasing (VBP) program for hospitals in which value-based incentive payments will be made to hospitals that meet a required set of performance standards.

- FY 2013 measures will include five conditions and HCAHPS. FY 2014 will include measures of efficiency. Selected measures have to be reported on Hospital Compare at least one year prior to being used in the VBP. The Secretary may use non-NQF endorsed measures as long as consideration is given to measures adopted by a consensus organization (i.e., HQA).
- The Secretary can exempt hospitals that participate in a similar state program.
- Performance standards must be based on achievement and improvement; weights will be assigned for categories of measures.
- Payment for the program starts in FY 2013. To fund the program, the Secretary will reduce the base operating DRG payment amount from 2013 to 2017 from 1% to 2% (0.25% each year).
- The GAO will conduct a study on the hospital VBP program and provide the results to Congress in interim and final reports, on October 1, 2015 and July 1, 2017 respectively.
- The Secretary will conduct a study on the hospital VBP program and submit a report to Congress no later than January 1, 2016.
- The Secretary will establish demonstration programs in VBP for critical access and small hospitals to start within two years of enactment for duration of three years. These must be budget neutral.

## Hospital Payment – Readmissions

**(SEC. 3025)**

PPACA provides for greater transparency, accountability and assistance to address “excess” hospital readmissions, including:

- Hospitals will experience reduced payments for “excess” readmissions in three conditions selected by the Secretary beginning October 1, 2012. In October 1, 2015, the three conditions can be expanded to the four conditions in MedPAC’s June 2007 report to Congress and to other conditions and procedures as determined appropriate by the Secretary.
- Hospitals will be required to submit all-patient data, and readmission rates will be made public through Hospital Compare.
- The Secretary must also make available within two years of enactment a program for hospitals to reduce readmission rates through use of patient safety organizations.

## Hospital Payment – Health Care Acquired Conditions

**(SEC. 3008)**

PPACA provides for greater transparency and accountability for health care acquired conditions (HACs), including:

- Medicare will be required to calculate national and hospital-specific data on HAC rates, adjusted for a hospital’s relative risk, and starting in 2013 the Secretary must confidentially share the data with hospitals and allow hospitals the opportunity to correct errors. Beginning in Oct. 2014, HAC rates can be publicly reported on the HHS Hospital Compare website.
- Regarding payment, beginning in FY 2015, hospitals in the top quartile of national HAC rates (based on the prior year’s performance and risk adjusted) would receive only 99% of their otherwise applicable Medicare payment.
- HHS shall study and report by 2012 on expanding the HAC program to other providers such as IRF, LTCH, HOPDs, SNFs, ASCs, health clinics, and a wider range of small hospitals.

# PAYMENT REFORMS

## Health Plan – Medicare Advantage

**(SEC. 1102)**

Under PPACA, Medicare Advantage (MA) plans will receive bonuses based on their quality. MA plans with quality rankings of four or five stars or better will receive additional payments of 1.5% in 2012 and up to 5% after 2014; some plans in qualifying areas may receive double bonuses. Additionally, beneficiary rebates will be tied to plan quality; plans with 4.5 stars may offer rebates of up to 70% of the difference between the benchmark and their bid, those with 3.5-4.5 stars may offer 60% rebates, and those with less than 3.5 stars may offer 50% rebates.

## Payment Pilots – Medical Home

**(SEC. 3021, 2703, 5405)**

PPACA supports the expansion and testing of medical homes in a range of ways:

- Medical homes are specifically referenced programs that the Center for Medicare and Medicaid Innovation should consider (which means that, if proven, CMS could expand broadly without additional Congressional action);
- There will be a new Medicaid state plan option for a "health home" (i.e., medical home) for beneficiaries with chronic conditions. Beginning in January 1, 2011 states can implement the "health home" programs, and receive Federal medical assistance at 90% for the first two years. The Secretary will contract with an evaluator to determine effects on care and $25 million will be made available for "health home" planning grants.
- Under the Primary Care Extension Program, "hubs" are required to assist primary care physicians in implementing a patient-centered medical home, including "health homes".

## Payment Pilots – Accountable Care Organizations

**(SEC. 2706, 3022)**

PPACA establishes two accountable care pilots, one for Medicare (Sec. 3022) and the other for Medicaid (Sec. 2706).

- The Secretary will establish a Medicare "shared savings program" for accountable care organizations (ACOs). ACOs are defined as a group of providers that has the legal structure to receive and distribute incentive payments to participating providers. ACOs must coordinate services under Parts A and B, make investments in infrastructure, and redesign care processes for up to three years. For an ACO to participate, it will need to have at least 5,000 Medicare FFS patients. Participating ACOs will retain a percentage of savings and Medicare retains the rest.
- A state pediatric ACO program will be established for January 1, 2012 to December 31, 2016. Participating ACOs must be enrolled in the program for at least 3 years. Preference will be given to ACOs that participate in similar arrangements with other payers.

## Payment Pilots – Bundled Payments

**(SEC. 3023, 2704)**

PPACA directs the Secretary to establish a Medicare pilot program by January 1, 2013 on bundling to provide incentives to providers to coordinate patient care and be jointly accountable for the entire episode of care (Sec. 3023):

- Payments will be based on 10 conditions chosen by Secretary. The Secretary will develop payment methods (not rates), and the bundled payment will not include costs of readmissions.
- The Secretary, with AHRQ and a consensus-based organization, will develop quality measures for episodes of care and post-acute care.
- The pilot will be conducted for five years and Secretary may extend duration, IF quality has improved or remains the same AND spending is reduced. Secretary can expand the program after January 1, 2016 if it reduces spending without reducing quality.

In Medicaid, the Secretary is directed to develop a demonstration program in up to eight states for bundled payments, with a duration of January 1, 2012 to December 31, 2016 (Sec. 2704):

- Programs that reduce costs and improve quality of care will be considered.
- Hospitals would receive bundled payments for a hospitalization and physician services provided during the hospitalization.
- As part of the program, hospitals will need to have/establish robust discharge planning programs.

## Payment Pilots – Gainsharing

**(SEC. 3027)**

The current Medicare Gainsharing Demonstration will be extended until September 30, 2011, with an additional $1.6 million for FY 2010. The final report on the Gainsharing Demonstration deadline is extended by three years to March 31, 2013.

## Payment Pilots – Global Capitation

**(SEC. 2705)**

The Secretary, in coordination with Center for Medicare and Medicaid Innovation will select no more than five states to participate in a global capitation demonstration project that will adjust payment for safety-net hospitals from FFS to global capitation for FY 2010-2012. Budget neutrality is not required during the testing period.

## Payment Pilots – Shared Decision-Making

**(SEC. 3021, 3506)**

PPACA seeks to promote shared decision-making through multiple programs:

- The Center for Medicare and Medicaid Innovation is charged with testing how best to pay providers and suppliers for using patient-decision tools.
- PPACA directs the Secretary to facilitate the development and use of patient decision aids. This program will be funded through appropriations beginning in FY 2010. The various program components are:
  - The Secretary will contract to: (1) develop and identify standards for patient decision aids; and (2) endorse patient decision aids and develop certification process.
  - Grants will be awarded to (1) develop, update, and produce patient decision aids for preference sensitive conditions; (2) test materials; and (3) educate providers on use. These patient decision aids will be available to the public.
  - The Secretary will fund Shared Decision-making Resource Centers to provide technical assistance to providers.
  - The Secretary will provide grants to health care providers for the development and implementation of shared decision-making techniques.

## Payment Pilots – Care Transitions & Independence at Home

**(SEC. 3026 & 3024)**

PPACA establishes a demonstration project to improve care transition services to high-risk Medicare beneficiaries (Sec. 3026).

Beginning no later than January 1, 2012, Secretary will conduct a demonstration to test payment incentives for home-based primary care teams (Sec. 3024). The demonstration will last no more than three years. It will require reporting on quality measures, as specified by the Secretary. Home-based care teams will qualify for incentive payments if spending targets are reached, subject to performance quality measures. Incentive payments can be no more than 5% less than spending target. Funding for this demonstration is $5 million for each fiscal year from 2010 through 2015.

## Expanded Value Purchasing Pilots
(**SEC. 10326)**

Value-based purchasing pilots will be implemented by 2016 for long-term care; rehabilitation facilities, PPS-exempt cancer hospitals, and hospice.

## Market Basket Update and Productivity Adjustment
**(SEC. 3401)**

PPACA makes adjustments to Medicare payments through a market basket update and accounting for economy-wide productivity gains.

- It implements a market basket reduction of 0.25% in 2010 and 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016, and 0.75% in 2017 through 2019 for inpatient and outpatient hospitals, inpatient rehabilitation facilities, and psychiatric hospitals.
- For long-term care hospitals (LTCHs), it implements a market basket reduction of 0.25% in 2010, 0.5% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016, and 0.75% in 2017 through 2019.
- It implements a 0.1% market basket reduction for home health agencies in 2011, 2012, and 2013.
- It implements a 0.3% market basket reduction for hospice providers from 2013 through 2019, except no reduction would occur from 2014 through 2019 if the total percentage of the insured population for the applicable year is more than five percentage points below CBO projections.
- To account for economy-wide productivity gains, it adjusts downward the annual market basket increase for inpatient and outpatient hospital services, SNFs, LTCHs, IRFs, home health, psychiatric hospitals, hospice, ASCs, and other services (e.g., ambulance, laboratory, DME, dialysis, and prosthetics). Most reductions would begin in FY 2012. Productivity adjustments could result in negative market basket changes and a reduction in payment rates from the preceding fiscal year.

## Geographic Adjustment
**(SEC. 3102)**

PPACA extends the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.

## Priorities and Strategies for Quality Improvement
**(SEC. 3011)**

The Secretary, through a transparent collaborative process, will establish and implement a national strategy to improve the delivery of health care services, patient health outcomes, and population health. By January 1, 2011 the Secretary will submit to Congress the national strategy and update the strategy annually thereafter. There are various requirements for the strategy:

- In identifying priorities, the Secretary will take into consideration the recommendations submitted by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders.
- The Secretary shall collaborate, coordinate, and consult with State agencies administering Medicaid and CHIP with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities.
- The strategic plan will include provisions for addressing, at a minimum:
  - Coordination among agencies within the Department.
  - Agency-specific strategic plans to achieve national priorities.
  - Establishment of annual benchmarks for each relevant agency to achieve national priorities.
  - A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.
  - Strategies to align public and private payers with regard to quality and patient safety efforts.
  - Incorporate quality improvement and measurement in the strategic plan for health information technology required by the ARRA of 2009.

## Measure Development
**(SEC. 3013)**

PPACA provides for the identification of gaps of quality measures and funding to fill those gaps.

- Triennially the Secretary, in conjunction with AHRQ and CMS, will identify gaps where no quality measures exist as well as improvement to current measures. The Secretary will consider gaps identified by NQF, quality measures in the pediatric program, and quality measures in the Medicaid Quality Measurement Program. The Secretary will also give priority to areas on health outcomes, functional status, coordination of care, shared decision-making, meaningful use of HIT, safety, patient experience, efficiency, disparities and other areas.
- The Secretary will fund the development and improvement of the quality measures identified. Funding is $75 million for each FY 2010-2014. A set of criteria is laid out for measure development entities. Additionally, the Act provides a timetable and direction for the development and updating of provider-level outcome measures. (SEC 10303)

## Fostering Quality Improvement
**(SEC. 3501, 3508)**

Providers will receive assistance to improve their quality of care.

- The Center for Quality Improvement and Patient Safety at AHRQ:
  - Will conduct or support research and development of best practices for quality improvement, and find ways to translate those into practice.
  - Is encouraged to support a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating interventions to improve quality and efficiency in health care.
  - Will create a grant program for technical assistance to health care providers with limited infrastructure and financial resources to support quality improvement activities.
- A demonstration program will also be established for the development and implementation of academic curricula that integrates quality improvement and patient safety in education of health professionals.

## Promoting Standardization & Multi-Stakeholder Input

**(SEC. 3014)**

The PPACA directs the Secretary of HHS to get input from a formal multi-stakeholder process before deciding on using measures for public reporting or payment purposes. Among the provisions in the Act which promote the multi-stakeholder engagement and the use of standard and nationally endorsed measures are:

- Beginning in 2011, by December 1 the Secretary shall make public the list of quality measures being considered for use in public reporting or payment;
- Beginning in 2012, by February 1, there shall be a facilitated process by which multi-stakeholder feedback is provided to the Secretary. To develop this feedback, an independent entity will convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures and national priorities for quality improvement for use in public reporting and public health care programs. The Secretary will take into consideration the input from these multi-stakeholder groups. Where the Secretary proposes to use measures that have not received national endorsement, the Secretary shall publish in the Federal Register the rationale for such use.
- By March 1, 2012 and at least every three years thereafter, the Secretary will make public an assessment of the impact of the use of the endorsed measures.
- Not less than every three years, the Secretary will review measures to determine which ones to continue and phase out.
- To promote support for the national measure endorsement and maintenance process, and the facilitation of multi-stakeholder input, funding of $20M is authorized for each FY 2010-2014, of which the Secretary will determine amount appropriate for CMS.
- Quality and efficiency be considered in tandem.

## Data Collection and Aggregation

**(SEC. 3015)**

The Secretary will collect and aggregate data on quality and resource use measures for public reporting. As a part of this work:

- The Secretary will award grants and contracts to eligible entities for data-collection. Eligible entities must meet the following criteria: be multi-stakeholder and experienced, support the provision of timely quality and resource use information to providers with the opportunity for providers to correct inaccuracies, and agree to publicly report measures on quality and resource use.
- The Secretary will develop a strategic framework for public reporting of performance information.
- The Secretary will collect/aggregate data from IT systems supporting health care delivery and align efforts with the expansion of HIT.
- The Act reflects a recognition of the need to support modernization of CMS' capacity to collect data.

## Medicaid Quality Measurement
**(SEC. 2701)**

The Secretary will be required to develop/facilitate implementation of a core set of adult quality measures for Medicaid. The PPACA details that:

- By January 1, 2011, the Secretary shall publish a recommended core set of adult quality measures for Medicaid.
- By January 1, 2012, the Secretary shall publish the initial core set of adult quality measures for Medicaid.
- By January 1, 2013 the Secretary, in consultation with States, will develop a standardized format to report on the core set of quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.
- Not later than 12 months after the release of the recommended core set of adult health quality measures, the Secretary will establish a Medicaid Quality Measurement Program. Under this program, grants and contracts will be awarded for the development, testing, and validation of emerging and innovative evidence-based measures
- States must report annually to the Secretary adult health quality measures and State-specific information on the quality of health care furnished to Medicaid eligible adults. The Secretary, beginning September 30, 2014, must publicly report the information annually.

## General Reporting

PPACA charts an aggressive path for ensuring that the federal government supports consumers and others through making publicly available performance information at all levels. Provisions with regard to public reporting are detailed specifically for different types of providers (described in the sections that follow) and in terms of the overarching need to establish a reporting framework, which includes:

- **Broad Public Reporting Strategy for Quality and Resource Use Measures (SEC. 3015)** The Secretary is directed to collect quality and resource use data and to implement public reporting of performance information. Specifically, the Secretary is charged to:
  - Make the quality measure data publicly available on websites and assure that the information is presented to meet needs of providers, patients, consumers, researchers, policymakers, States, and others.
  - Where appropriate, Secretary will consult with multi-stakeholder groups for website design and format.
  - Where appropriate, quality information on the websites is to be "provider-specific and sufficiently disaggregated."

- **Independent Payment Advisory Board (SEC. 3403)** The Board is charged with issuing periodic reports on costs and quality that discretely report on public and private sector trends by sources of costs and regions.

- **Data Collection and Analysis (SEC. 3015)** The Secretary is required to collect and aggregate data on quality and resource use measures to support public reporting of performance. The Secretary may award grants and contracts to eligible entities for data aggregation. Eligible entities must be multi-stakeholder.

## Public Reporting on Health Plans

PPACA has an array of provisions directed at fostering improved public reporting related to health plans, including:

- **Health Plans in the Exchange – Quality and Price Rating System (SEC. 1311)** PPACA requires States to establish American Health Benefit Exchanges by 2014 for individuals and Small Business Health Option Program (SHOP) Exchange for small employers. There are many requirements related to the establishment and operation of Exchanges, those related to assuring consumers and employers have the information and the ability to make value-based choices are:
  - OPM is to contract with insurers to offer at least two multi-state plans in each Exchange.
  - Exchange plans must meet a number of requirements related to engaging in quality improvement strategies with market-based incentives, and being accredited using clinical quality measures such as HEDIS and CAHPS, consumer access, utilization management and quality assurance.
  - Plans in the Exchange are supposed to be rated based on quality and price.

- **Develop Methodology for Cost to Consumers through the W-2 Form (SEC. 9002)** The cost of employer-sponsored health coverage will be added to required reporting on W-2 forms to promote transparency of health care costs.

- **Health Plans in the Exchange – Accreditation (SEC. 1311)** The Secretary will establish criteria for certification of qualified health plans. Minimum certification requirements include being accredited on local performance on clinical quality measures (e.g., HEDIS), patient experience (e.g., CAHPS), consumer access, utilization management, quality assurance, etc.

- **Health Plan Reports on Quality (SEC. 1001).** Health plans will report to the Secretary and enrollees on how health plan benefits and provider reimbursement structures improve outcomes, patient safety, readmissions, etc.

## Public Reporting on Hospitals and Ambulatory Surgical Centers

PPACA has an array of provisions directed at fostering improved reporting related to hospitals and ambulatory surgery centers, including:

- **Expand Hospital Compare and Inclusion of Value-Based Purchasing Data (SEC. 3001)** The Secretary will make public hospital performance data from the Hospital Value-Based Purchasing (VBP) program on Hospital Compare. This will include reporting of individual hospital performance by individual measures, by condition or procedure, and total performance. The Secretary will periodically post on Hospital Compare aggregate information of how many hospitals received value-based payments, range and total amount of value-based payments, and the number of hospitals receiving less than the maximum value-based payment available. The Secretary will develop website reports to meet needs of different stakeholders (e.g., hospitals, patients, researchers, policy makers). The Secretary will seek input from stakeholders on format and what information to include.

- **Health Care Acquired Conditions (SEC. 3001)** Health Care Acquired Conditions information will be publicly reported. (See Health Care Acquired Conditions under Hospital Payment for complete description of program).

- **Hospital Readmission Data (SEC. 3025)** As part of the Hospital Readmission Reduction Program, the Secretary will publicly post readmission rates on the Hospital Compare website. (See Hospital Readmissions under Hospital Payment for complete description of program.)

- **Hospital Charge Data (SEC. 1001).** Hospitals will annually make public a list of hospital standard charges for items and service provided by the hospital.

## Public Reporting on Physician Performance

PPACA has an array of provisions directed at fostering improved reporting related to physician performance, including:

- **Physician Compare (SEC. 10331)** The PPACA directs the Secretary to implement a "Physician Compare" website. It details elements of reporting on physician performance, which over time will include outcomes, patient experience and other important indicators.

- **Physician Resource Use Feedback Program (SEC. 3003).** This provision sets out a timeline for developing reporting on physicians' resources use. While the section does not refer to the public reporting of these results – but only to the feedback to physicians – the provisions for establishing a "Physician Compare" website would allow for the Secretary to consider these data elements as part of the public reporting for physicians.

- **Physician Ownership Public Reporting and Self-Referral Provisions (SEC. 6001)** The Secretary will annually publish on the CMS website information on physician ownership or investment in hospitals. Hospitals would submit this information to the Secretary as a precondition of being exempt from the prohibition on self-referral. A hospital would also disclose this information on any of its public websites and public advertising for the hospital. Additionally there will be limits on Stark law's "whole hospital exception" to existing specialty hospitals as of December 31, 2010. This exception permits a physician to refer patients for the provision of 11 designated health services to a hospital if ownership is for the entire hospital and physician can perform services at the hospital.

- **Physician Ownership and Relationships (SEC. 6002)** The Secretary will make publicly available information about payments or other transfers of value by manufacturers, and physician ownership or investment interest in a manufacturer. The Secretary will make the information publicly available no later than September 2013 and on June 30th of each calendar year beginning thereafter. The information will be presented by manufacturer to applicable group purchasing organization, etc. It will not include the NPI.

## Medicare Data Release
**(SEC. 10332)**

PPACA provides directs the Secretary to establish processes to release of Medicare data for the purpose of performance measurement and public reporting and takes effect January 2012.

## Nursing Home, Skilled Nursing, LTC Facilities

The PPACA has an array of provisions directed at fostering improved reporting related to nursing home, skilled nursing and long-term care facilities, including:

- **Nursing Home Quality (SEC. 6103).** The Secretary will add five types of new information to Nursing Home Compare website (i.e. staffing data, complaints, criminal violations, etc.). This information is to be on the website within one year of enactment. In revamping the website, the Secretary will consult with state long-term care ombudsman programs, consumer advocacy groups, providers, and others.

- **Skilled Nursing Facility (SNF) survey, certification, and complaint investigation reports (SEC. 6103)** SNFs' survey, certification, and complaint investigation reports from the three preceding years must be made available upon request. These reports must be posted prominently and be accessible to the public. SNFs must comply within one year of enactment.

- **Nursing Home Ownership and Relationships (SEC. 6101)** Nursing homes are required disclose ownership and additional disclosable parties' information. The Secretary must make this information publicly available one year after the date on which the final regulations are promulgated for this section. Secretary must have these regulations in place within two years of enactment.

- **Skilled Nursing Facility Expenditure Disclosure (SEC. 6104)** SNF expenditures in this section will be made accessible to interested parties with preconditions to be determined by the Secretary.

- **GAO Review of Nursing Home Five-Star Quality Rating System (SEC. 6107)** The GAO will study the Five-Star Quality Rating System for CMS nursing homes and submit a report to Congress on this study within two years of enactment of the Act.

## Prescription Drug Risk and Benefit Information
**(SEC. 3507)**

The Secretary is directed to submit a report to Congress, within a year of enactment of the Act, on whether adding "quantitative summaries of the of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decision-making by clinicians and patients and consumers." Within 3 years after submission of the report, the Secretary is to promulgate the regulations if the Secretary determines that the information is beneficial.

## National Strategy, Funding and Information Dissemination
**(SEC. 4001, 4002, 4003, 4206)**

PPACA includes many provisions to promote population health and wellness, including the creation of:

- A National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. The Council is to develop national strategy to improve the nation's health (due one year after enactment).
- A Prevention and Public Health Fund, supported with annual funding, to expand and sustain funding for prevention and public health programs ($500M in FY 2010, $750M for FY 2011, $1B for FY 2012, $1.25B for FY 2013, $1.5B for FY 2014, $2B for FY 2015 and each FY thereafter).
- Task Forces on Preventive Services and Community Preventive Services are charged with developing, updating, and disseminating evidence-based recommendations on the use of clinical and community preventive services (effective on enactment).
- A 10-State Wellness Demonstration Project will apply health promotion and disease prevention wellness programs to programs of health promotion offered by health insurers in individual market

## Medicare and Medicaid Benefits and Incentives
**(SEC 4103, 4103, 4108, 1406)**

PPACA includes changes in Medicare and Medicaid coverage intended to promote prevention and reduce risk factors among beneficiaries, including:

- Medicare Beneficiaries will have access to an annual wellness visit, including comprehensive health risk assessment and creation of personalized prevention plan, with no copayment or deductible. (Effective January 1, 2011)
- Medicare will eliminate cost-sharing for evidence-based preventive services.
- The reconciliation bill closes the donut hole by lowering the beneficiary coinsurance from 100% to 25% over ten years. For generic drugs, the coinsurance will drop to 93% in 2011, and will continue to be reduced annually until reaching 25% in 2020. For brand-name drugs, manufacturers will provide a 50% discount starting in 2011, in addition to federal subsidies that will phase in beginning in 2013. There will be a one-time rebate of $250 for Part D beneficiaries who reach the donut hole in 2010.
- A $100 million program will be created to provide incentives to Medicaid beneficiaries who successfully complete programs to lower risk factors.
- States that expand Medicaid coverage to include preventive services approved by USPSTF and immunizations recommended by ACIP with no-cost sharing will receive increased federal FMAP contribution for these services.

## Preventive Service Coverage
**(SEC 1302)**

The definition of the core "essential benefits package" includes provisions that plans may not apply deductibles to the benefits under the new 2713 of the Public Health Service Act *(*preventive care)

## Employer Wellness Programs

**(SEC. 10408, 4303, 4303, 1201)**

PPACA promotes employer-based wellness programs through an array of provisions, including:

- Grants will be offered for up to five years to small employers that establish wellness programs.
- Technical assistance and other resources will be provided to evaluate employer-based wellness programs.
- A national worksite health policies and programs survey will be conducted to assess employer-based health policies and program.
- Employers will be permitted to offer employees rewards of up to 30% of cost of coverage for participating in a wellness program and meeting certain health-related standards and Secretary has the authority to issue regulations that allow financial incentives up to 50 percent.

## Reporting of Nutritional Content in Restaurants and Vending Machines

**(SEC. 4205)**

Chain restaurants and food sold from vending machines will be required to disclose the nutritional content of each item.

## Entity Created
**(SEC. 6301)**

The Patient-Centered Outcomes Research Institute will be created to carry out/facilitate comparative effectiveness research (CER). This Institute is an external entity that is "neither an agency nor establishment of the U.S. government."

## Scope of CER and Research Priorities
**(SEC. 6301)**

The Patient-Centered Outcomes Research Institute's scope of research is potentially limited to "clinical effectiveness", as there are no references to appropriateness. PPACA provides specifications and transparency in the development of the Institute's research priorities.

## Governance and Oversight

- **Governance (SEC. 6301) A** "Board of Governors" will be established to govern the Patient-Centered Outcomes Research Institute. The Board will include:
    - The Director of Agency for Healthcare Research and Quality (AHRQ)
    - The Director of the National Institutes of Health (NIH)
    - 17 members including 3 patients/consumers, 3 industry reps, and 3 private payer reps (they will serve six-year terms and be appointed by the Comptroller General)
- **Advisory Panels (SEC. 6301) Advisory** panels will be established to guide the work of the Institute. All panels made up of clinical and science experts must also have patients. Specifically, the Institute:
    - **May** appoint "permanent or ad hoc advisory panels"…to assist in identifying research priorities.
    - **Shall** appoint expert panels in carrying out clinical trials.
    - **Shall** appoint panel for any research into "rare diseases."
- **Methodology Committee (SEC. 6301) The** Institute will establish a separate "methodology committee" of not more than 15 members appointed by Comptroller. The Directors of AHRQ and NIH directors (or their designees) will also be members of this committee.
- **Consumer/Patient Participation (SEC. 6301)** Consumer and patient participation is embedded in the advisory bodies and review process. Financial support is also provided to foster consumer participation.
- **Transparency (SEC. 6301)** To facilitate transparency, the Institute will be required to submit various annual reports to Congress. The Comptroller General will also be required to submit an annual report regarding the Institute. Additionally, there will be: public comment periods of 45-60 days for research priorities list and all findings; forums will be conducted to increase public awareness; and information will be posted on the Web.

## Conflict of Interest
**(SEC. 6301)**

To address problems of conflict of interest:

- There will be two levels of conflict of interest (COI) for the Institute's Board and panels:
    - A "potential" to bias or appearance of bias.
    - A "real" COI where a direct financial interest is apparent, with a peg of $10,000 as cut off criteria.
- The Comptroller General must disclose COIs when appointing Board and staff.
- The Institute must disclose COIs when appointing advisory panel members.
- There must be full disclosure of COIs to public on internet.
- There is a non-gift clause for Board and staff

However, if a person recuses himself or herself from vote b/c of COI, the nature of that COI need not be disclosed.

## Research Contracts
**(SEC. 6301)**

The Institute will distribute contracts for comparative effectiveness research (CER) to existing government agencies and with private sector as appropriate. Preference is given to AHRQ and NIH if appropriate to those agencies' charters. Contracted external entities must consult with the Institute's advisory panels and comply with the Institute's methodological standards, etc.

## Use of Research
**(SEC. 6301)**

All findings must be made public and broadly available, including Web posting. PPACA requires release within 90 days of finalized research. Additionally any research published…"shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute…." – the penalty for lack of adherence is no future awarded funds.

The existing Office of Communication and Knowledge Transfer at AHRQ, in consultation with NIH, will be required to broadly disseminate the Institute's research findings. PPACA also requires the creation of "informational tools that organize and disseminate…findings" for doctors, patients, payers, and policy makers", and mandates a "publicly available resource database." The Institute will also assist users of health information technology focused on clinical decision support to promote the timely incorporation of research findings.

While the language is clear that the CER effort may not define how the results are used, PPACA also allows the Secretary to engage in follow-on processes to determine potential use of results. Among the key provisions relating to these areas:

- No part of the CER program or Institute "shall be construed…to permit the Institute to mandate coverage, reimbursement or other policies for any public or private payer" or to "prevent the Secretary from covering the routine costs of clinical care…"
- Secretary **can't use** CER findings to make coverage decisions or create incentive programs based on comparisons of treatments…based on age, disability or terminal illness….or prevent or discourage individuals from making their own tradeoff clinical decisions based on their own values.
- The Secretary "may **only** use evidence and findings from [CER] research…to make a determination regarding coverage if such use is through an iterative and transparent process which includes public comments and considers effects on subpopulations.
- CER is barred from including quality-adjusted life year (QALY) evaluations.

## Special Populations/Health Disparities
**(SEC. 6301)**

"Differences" among diverse populations must be taken into account.

## Data Collection
**(SEC. 6301)**

The Institute had broad authority to tap into existing government databases that could inform and support CER. It is also encourages the use of disease registries data. Additionally, the Secretary will provide for the coordination of relevant Federal health programs to build capacity for CER.

## Funding
**(SEC. 6301 – "SEC 9511")**

The Institute funds will be kept in the Patient-Centered Outcomes Research Trust Fund, which will be created in the Federal Treasury. Funding will come from a variety of sources:

- For 2013 the Institute will receive $1 for each Medicare beneficiary from the Medicare Hospital Trust Fund (about a total of $50M); for 2014-2019, there figure will increase to $2 (about $100M).
- There will be appropriation from the general treasury of $10 million in 2010, $50 million in 2011, and $150 million in 2012, and ongoing.
- A fee will be imposed on insurance companies and self-insured plans, beginning in 2012, of $2 per enrollee, or employee.

## HEALTH INFORMATION TECHNOLOGY & ADMINISTRATIVE EFFICIENCY

PPACA leaves much of health information technology issues to the already enacted Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), a part of the American Recovery and Reinvestment Act of 2009 (ARRA – which included $34 billion in financial incentives for Medicare and Medicaid providers (e.g., hospitals and health care professionals) to "meaningfully use" electronic heath records (see http://www.healthcaredisclosure.org/docs/files/Meaningful_Use_IssueBrief.pdf for background description).

### Telehealth

**(SEC. 3022, 6407)**

The PPACA encourages the use of telehealth by the following provisions:

- Accountable care organizations are required to define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care; telehealth, remote patient monitoring, and other enabling technologies are specifically referenced as vehicles ACOs can use to meet these requirements.
- In determining whether a patient is eligible for home health services or durable equipment, physicians are required to engage in a "face-to-face" which is specifically defined to include telehealth encounters.

### Program Enrollment Protocols and Standards

**(SEC. 1561)**

The PPACA provides for the establishment of health information technology protocols and standards for enrollment in federal and state health and human service programs that are supposed to be implemented within 180 days of enactment.

### Administrative Efficiency

**(SEC. 1104)**

The PPACA establishes a timeline for public and private sector health plans to work together to simplify health insurance administration by implementing common processes for claims processing, credentialing and utilization review.