Health Care Reform:

FINDING YOUR WAY

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Quality Improvement in PPACA: Carrots, Sticks and Innovation

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EXECUTIVE SUMMARY

Title III of the Patient Protection and Affordable Care Act of 2010 (PPACA) is entitled "Improving the Quality and Efficiency of Health Care." The name summarizes the framework in which quality is considered as part of health care reform:

- quality is connected with payment;
- quality improvements are connected with cost reductions; and
- research and experimentation on new models of delivery that both improve quality and reduce cost are to be aggressively undertaken.

Hospitals and health systems already have begun to be accustomed to connections between payment and quality measures, but the new law takes the connection to a new level. Hospitals and health systems will need to watch the rulemaking process carefully to determine precisely what data collection and system and process changes will be required to obtain incentive dollars and avoid reductions. In addition, grant moneys are available for a wide variety of topics relating to quality improvement, and hospitals will want to pay attention to these areas, especially if they are already engaged in quality improvement projects that might align with the availability of government funding.

BACKGROUND

Over the past dozen years, questions about the quality of care and patient safety afforded in the American health care system have proliferated, along with ideas for improvement of quality and safety. No one single system has emerged, however, and innovations in health care quality and safety continue to take frustratingly long to reach all corners of the country. PPCA contains a section of provisions designed to make the federal Department of Health and Human Services (HHS) a hub of ideas about health care quality improvement and a center of dissemination of such ideas. Focusing on the development of new methods and processes that are effectively translatable into on-the-ground change, the law pulls health care providers along by connecting

quality to payment more directly and broadly than in the past, and cajoles providers to change with grants, demonstration projects and incentives.

This paper summarizes some of the key provisions of PPACs relating to quality improvement.

RELEVANT PROVISIONS OF PPACA

1. Links between Outcomes and Medicare Payments (Part III, Subtitle A, Part I)

Part I of PPACA Title III creates and enhances multiple links between the quality of outcomes in hospitals and Medicare payment. These links use a "carrot and stick" approach to improving quality. Key provisions include:

- **Value- Based Purchasing (Section 3001, 3006).** The Department of Health and Human Services ("HHS") is to establish a value based purchasing program under which most hospitals receive incentive payments for meeting performance standards related to discharges. HHS is to select performance measures for at least the following conditions: acute myocardial infarction, heart failure, pneumonia, surgeries and healthcare related infections and apply them to discharges after October 1, 2012. At the same time, HHS will develop efficiency standards, including a standard for "Medicare spending per beneficiary.

  HHS then develops a total performance score to each hospital. This "hospital performance score" is used to determine whether and how much value-based incentive payment hospital receives. If a hospital meets or exceeds performance standards, it receives an increase in its based operating DRG payment for applicable discharges that year. Further incentives are also included: starting in 2013, hospital DRG base operating payments are reduced annually – 1% in 2013, 1.25% in 2014, 1.5% in 2015, 1.75% in 2016, 2% thereafter. Thus, to maintain or improve the DRG base operating payment, hospitals must meet or exceed performance standards every year. Exceptions are to be made for small rural hospitals and sole community hospitals.

  HHS will publish aggregate information (not hospital-specific) on the Hospital Compare website.

  HHS also is to begin a 3-year value-based purchasing demonstration program in critical access hospitals starting in 2012. In addition, HHS will develop a plan for value-based purchasing programs for skilled nursing facilities, home health agencies and ambulatory surgery centers, and will implement pilot programs for value-based purchasing in psychiatric hospitals, long term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals and hospice programs.

- **Improvements to the Physician Quality Reporting System (Section 3002).** Currently, physicians receive incentive payments for submitting data on quality measures through the Physician Quality Reporting System (PQRS). Starting in 2015, physicians who do not satisfactorily submit quality data will have their Medicare fee schedule reduced.

- **Quality reporting to long-term care hospitals, inpatient rehabilitation hospitals, hospice programs and PPS-exempt cancer hospitals (Sections 3004, 3005); value based purchasing pilot projects (Section 3006).** Starting in 2014, long term care and rehabilitation hospitals that fail to submit quality data will suffer reductions in their annual increases. Data submitted will be made

public, with prior review by the hospital. PPS-exempt cancer hospitals will be required to submit quality data starting in 2014, but the law does not subject them to the same reductions.

- **Payment adjustment for hospital-acquired conditions (Section 3008)**. In order to incentivize hospitals to reduce hospital-acquired conditions, starting in 2015 HHS will reduce Medicare payments to hospitals in reporting in the top 25% nationally for hospital-acquired conditions. HHS will report publicly on hospital-acquired conditions at each hospital.

  HHS will study and report to Congress on whether to expand this approach to other health care facilities including long term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, ambulatory surgery centers and health clinics.

2. National Strategy to Improve Health Care Quality (Title III, Subtitle A, Part II)

Central to the quality improvement strategy in the health care reform law is that the federal government takes on a leadership role in a centralized strategy. Key components of this leadership role include:

- **National Strategy (Section 3011)**: Using a "transparent collaborative process," HHS is to develop a national strategy for improving the delivery of health care services, patient health outcomes and population health. HHS is to create national priorities within these goals and develop a strategic plan for coordination among agencies, development of agency specific plans, the establishment of benchmarks, regular reporting, strategies to align public and private payors and incorporating health information technology. The deadline for initial submission of the National Strategy to Congress is January 1, 2011! HHS then must update Congress annually.

- **Interagency Working Group (Section 3012).** The President is to convene an "Interagency Working Group on Health Care Quality," with goals of achieving collaboration, cooperation and consultation across federal agencies for the purpose of implementing the National Strategy, avoiding duplication of efforts and resources and aligning quality efforts in the private and public sectors.

- **Quality Measures Development (section 3013).** HHS is to award grants, contracts and interagency agreements to develop and improve standards for measuring performance and improvement of population health and health plans, service providers and other clinicians in the delivery of services. Measures are to cover both physicians and hospitals for both acute and chronic diseases as well as primary and preventive care services. Between 2010 and 2014, HHS annually is to make $75 million available for this work.

- **Quality Measurement; Data Collection; Reporting (Sections 3014, 3015).** HHS is to convene multi-stakeholder groups to provide input on the selection of quality and efficiency measures and national priorities. HHS will collect and aggregate data on quality and resource use measures. HHS may align its collection and reporting efforts with health information technology expansion requirements.

3. Health Care Quality Improvements (Title III, Subtitle F)

As seen in several provisions already discussed above, the new law strongly promotes HHS's role as a change agent to improve health care quality. This section of the law contains several additional directives to HHS that forward this goal. For example:

- **Health Care Delivery System Research (Section 3501):** A Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality is created to conduct or support activities to identify, develop, evaluate, disseminate and provide training in innovative methodologies and strategies for quality improvement. The Center is to examine changes in processes and redesign of systems; identify providers with high quality outcomes; assess research, evidence and knowledge in the field; find ways to translate such information quickly into practice, develop tools, methodologies and interventions and fund other organizations doing such work. Perhaps most importantly, the Center is to provide for the development of best practices in health care delivery. The Center has a substantial obligation to disseminate its research findings.

- **Establishment of Community health Teams to Support Patient Centered Medical Homes (Section 3502).** HHS is to establish a program to fund the development of interdisciplinary, interprofessional community health teams to support the work of primary care providers in eligible areas.

- **Design and Implementation of Regionalized Systems for Emergency Care (Section 3504)**. HHS is to award at least four contracts to support pilot projects that design, implement and evaluate innovate models of regionalized, comprehensive and accountable emergency care and trauma systems. The models are to have specific characteristics including local coordination, tracking and a data management system.

- **Other Grant, Research and Education Programs**: Numerous additional programs are established, including for medication management services in the treatment of chronic disease (Section 3503); trauma care centers (Section 3505); the facilitation of shared decision making (Section 3506); presentation of prescription drug benefit and risk information (Section 3507); integration of quality improvement and patient safety training into clinical education (Section 3508); and improving women's health (Section 3509).

WHAT THIS MEANS FOR HEALTH CARE PROVIDERS

Quality improvement typically is not the first topic raised in any discussion of health care reform. Nevertheless, the new law pushes harder than before on hospitals and physicians to provide higher quality and more efficient care; on institutions and governments to embrace innovation; and on HHS to become the leader and center of research and grant making to promote new methodologies to improve care. Hospitals and health systems undoubtedly will feel the effects of these provisions in the new law.

FOR MORE INFORMATION

This Client Alert is the eighth in the "Finding Your Way" advisory series, designed to assist our clients and other health care providers as they prepare to respond to health care reform. Future articles will include discussions regarding the health care reform law's provisions regarding accountable health organizations, health reform pilot projects, and health reform quality initiatives.

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