

QUALITY (SECTION-BY-SECTION ANALYSIS)

(Information compiled from the Democratic Policy Committee (DPC) Report on The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. Available online at <http://dpc.senate.gov/healthreformbill/healthbill96.pdf>.)

Reporting requirements

Sec. 1001. Amendments to the Public Health Service Act.

Sec. 2717. Ensuring quality of care. Requires the Secretary to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health. As added by **Section 10101**, protects Second Amendment gun rights by precluding the collection and disclosure of information related to gun ownership or use for purposes of determining premium rates.

Sec. 10329. Developing methodology to assess health plan value. Requires the Secretary of HHS to develop a methodology to measure health plan value.

Affordable choices of health benefit plans – rating systems and rewarding of quality

Sec. 1311: Rating systems, rewarding quality through market incentives, quality improvement

Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. Requires the Secretary to:

- Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
- Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange's Internet portal.
- Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.

Allows States to require benefits in addition to essential health benefits, but States must defray the cost of such additional benefits. Section 10104 clarifies that States must make payments to cover the cost of additional benefits directly to individuals or plans, and not to Exchanges. Requires Exchanges to certify qualified health plans, operate a toll-free hotline and Internet website, rate qualified health plans, present plan options in a standard format, inform individuals of eligibility for Medicaid and CHIP, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual responsibility requirement. Beginning in 2015, requires Exchanges to be self-sustaining and allows them to charge assessments or user fees. Allows Exchanges to certify qualified health plans if they meet certification criteria and offering them is in the interests of individuals and employers, and, as amended by **Section 10104**, requires Exchanges to consider the reasonableness of premium rate increases when determining whether to certify and offer plans. Allows regional or interstate Exchanges if the States agree to, and the Secretary approves, such Exchanges. Requires Exchanges to award grants to Navigators, which may include resource partners of the Small Business Administration, to educate the public about qualified health plans, distribute information on

enrollment and tax credits, facilitate enrollment, and provide referrals on grievances, complaints, or questions.

As added by **Section 10104**, requires plans seeking certification by Exchanges to publicly disclose, in plain language, information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing, and enrollee rights. Requires such plans to provide information to enrollees on the amount of cost-sharing for a specific item or service. Requires the Secretary of Labor to update disclosure rules for group health plans to conform to these standards. Requires qualified health plans to implement activities to reduce health disparities, including the use of language services, community outreach, and cultural competency trainings.

State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.

Sec. 1331, Performance measures

Allows States to contract, through a competitive process that includes negotiation of premiums, cost-sharing, and benefits, with standard health plans for individuals who are not eligible for Medicaid or other affordable coverage and have income below 200 percent of the Federal Poverty Level (FPL). Requires the Secretary to certify that participating individuals do not have to pay more in premiums and cost-sharing than they would have paid under qualified health plans, and that the plans cover essential health benefits. 10

Requires the Secretary to transfer to participating States 95 percent of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard health plans if they were enrolled in qualified health plans. Section 10104 clarifies that legal immigrants whose income is less than 133 percent of the Federal Poverty Level (FPL), and who are not eligible for Medicaid by virtue of the five year waiting period, are eligible for the basic health program.

Medicaid quality measures

Sec. 2701. Adult health quality measures. Directs the Secretary of HHS to develop a set of quality measures for Medicaid eligible adults that is similar to the quality measurement program for children enacted in the Children's Health Insurance Program Reauthorization Act of 2009. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis.

Sec. 2702. Payment adjustment for health care-acquired conditions. Prohibits Medicaid payment for services related to a health care-acquired condition. The Secretary will develop a list of health care-acquired conditions for Medicaid based on those defined under Medicare as well as current State practices.

Hospital-based incentive payments under Medicare

Sec. 3001. Hospital value-based purchasing program. The proposal would establish a value-based purchasing program for hospitals starting in FY2013. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in the program (and in all other quality programs in this title) will be developed and chosen with input from external stakeholders. **Section 10335** clarifies that the hospital VBP program shall not include measures of hospital readmissions.

Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals and hospice programs. Establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers by requiring the Secretary to implement quality measure reporting programs for these providers in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update. **Section 10322** also establishes a quality measure reporting program for inpatient psychiatric hospitals beginning FY2014.

Sec. 3005. Quality reporting for PPS-exempt cancer hospitals. Establishes a quality measure reporting program for PPS-exempt cancer hospitals beginning in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update.

Sec. 3008. Payment adjustment for conditions acquired in hospitals. Starting in FY2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.

Medicare physician reporting

Sec. 3002. Improvements to the physician quality reporting initiative. Extends through 2014 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates appeals and feedback processes for participating professionals in PQRI. Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine. Beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced. **Section 10327** provides an additional 0.5 percent Medicare payment bonus to physicians who successfully report quality measures to CMS via the new Maintenance of Certification program and eliminates the MA Regional Plan Stabilization Fund.

Sec. 3003. Improvements to the physician feedback program. Expands Medicare's physician resource use feedback program to provide for development of individualized reports by 2012. Reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs.

Sec. 3007. Value-based payment modifier under the physician fee schedule. Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The Secretary will phase-in the new payment system over a two-year period beginning in 2015.

Sec. 10331. Public reporting of performance information. Requires the Secretary of HHS to develop a "Physician Compare" website where Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures, provided that such information provides an accurate portrayal of physician performance.

Quality measures for skilled nursing facilities

Sec. 3006. Plans for a value-based purchasing program for skilled nursing facilities and home health agencies. Directs the Secretary to submit a plan to Congress by FY2012 outlining how to effectively move these providers into a value-based purchasing payment system. As amended by **Section 10301**, requires the Secretary of HHS to develop a plan to reimburse Ambulatory Surgery Centers (ASCs) based on the quality and efficiency of care delivered in ASCs.

Review responsibilities of Interagency Working Group on Health Quality

Sec. 3011. National strategy. Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a Federal health care quality internet website.

Section 10302 clarifies that the limitations on use of comparative effectiveness data apply to the development of the National Strategy for Quality Improvement.

Sec. 3012. Interagency Working Group on Health Care Quality. Requires the President to convene an Interagency Working Group on Health Care Quality comprised of Federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

Development of quality measures

Sec. 3013. Quality measure development. Authorizes \$75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services (CMS). Quality measures developed under this section will be consistent with the national strategy. As amended by **Section 10303**, requires the Secretary of HHS to develop and publicly report on patient outcomes measures.

Sec. 3014. 10304 Quality measurement. Provides \$20 million to support the endorsement and use of endorsed quality and efficiency measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.

Collection, reporting of quality data

Sec. 3015. Data Collection; Public Reporting. Requires the Secretary to collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. As amended by **Section 10305**, requires the Secretary of HHS to develop a plan for the collection and public reporting of quality measures.

Hospital readmission reduction program

Sec. 3025. Hospital readmissions reduction program. Beginning in FY2012, this provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. Also, provides the Secretary authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions. Section 10309 makes a technical correction to the hospital readmissions payment policy establishing in the underlying section.

AHRQ funding for patient safety

Sec. 3501. Health care delivery system research; Quality improvement technical assistance. Builds on the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (AHRQ) to support research, technical assistance and process implementation grants. Grants funded under this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services.

Healthcare Quality Improvements

Sec. 3508 Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.

Establishes a program at AHRQ to give grants to academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education.

Pain management

Sec. 4305. Advancing research and treatment for pain care management. Authorizes an Institute of Medicine Conference on Pain Care to evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations. Also authorizes the Pain Consortium at the National Institutes of Health to enhance and coordinate clinical research on pain causes and treatments.

Establishes a grant program to improve health professionals' understanding and ability to assess and appropriately treat pain.

Targeting Enforcement

Sec. 6112 National independent monitor demonstration project. Directs the Secretary to establish a demonstration project within one year of enactment for developing, testing and implementing a national independent monitor program to conduct oversight of interstate and large intrastate chains. The HHS OIG would evaluate the demonstration project after two years.

Patient-centered outcomes research

Sec. 6301. Patient-Centered Outcomes Research. Establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research. Requires the Institute to ensure that subpopulations are appropriately accounted for in research designs. Prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and contains patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference. Provides funding for the Institute and authorizes and provides funding for the Agency for Health Research and Quality to disseminate research findings of the Institute, as well as other government-funded research, to train researchers in comparative research methods and to build data capacity for comparative effectiveness research. **Section 10602** clarifies publication rights of researchers with respect to peer-reviewed journals and clarifies that findings published by the Institute do not include practice guidelines, coverage, payment, or policy recommendations. The provision also increases the number of physicians on the Board of Governors from three to four.

Pilot testing pay-for-performance programs for certain Medicare providers

Sec. 10326. Pilot testing pay-for-performance programs for certain Medicare providers.

Provides the Secretary of HHS the authority to test value-based purchasing programs for inpatient rehabilitation facilities, inpatient psychiatric hospitals, long-term care hospitals, certain cancer hospitals and hospice providers by no later than January 1, 2016.

Data availability for performance measurement under Medicare

Sec. 10332. Availability of Medicare data for performance measurement. Authorizes the release and use of standardized extracts of Medicare claims data to measure the performance of providers and suppliers in ways that protect patient privacy and in accordance with other requirements.