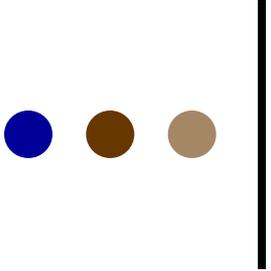


Quality Workgroup

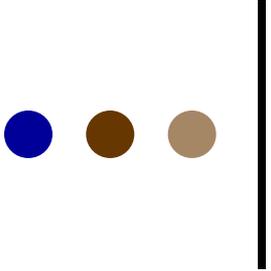
Additional Background Information and Future Work

Presentation by:
Sharon Schiro, PhD
NC Institute of Medicine
18 August 2010



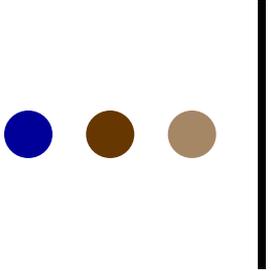
Agenda

- Overview of Quality Workgroup charge
- More detailed description of Affordable Care Act (ACA) provisions
- Next steps



Agenda

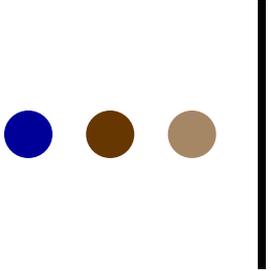
- Overview of Quality Workgroup charge
- More detailed description of Affordable Care Act (ACA) provisions
- Next steps



Quality Workgroup Charge

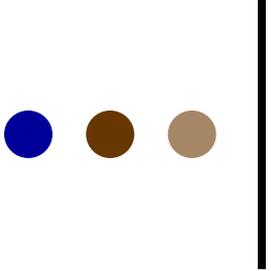
○ Charge

- Understand federal guidelines for patient outcome quality measures and reporting requirements
- Identify strategies to improve quality of care provided to meet the new quality requirements
- Build on existing state quality initiatives



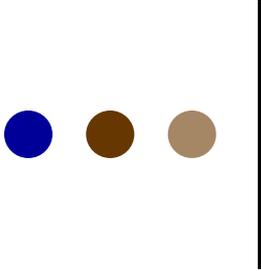
Agenda

- Overview of Quality Workgroup charge
- More detailed description of Affordable Care Act (ACA) provisions
- Next steps



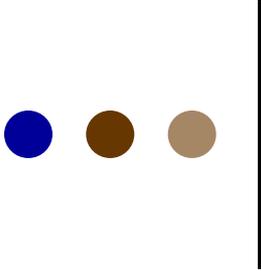
Quality Overview

- Federal bodies will promote research and coordinate care.
- Providers and payers will be required to report data to measure quality of care.
 - Data will be made available to the public.
 - These data will be compared to standards established by government entities, and value-based payments will be distributed accordingly.
- Government agencies will test new models of care to improve quality and efficiency.



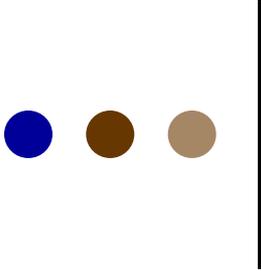
Quality: Coordinated Care Governance

- The Secretary will establish a national strategy to improve quality with an Interagency Working Group on Health Care Quality (Sec. 3011, 3012)
 - Secretary must develop health plan reporting standards within 2 years and develop methods to measure health plan value (Sec. 1001, 10329)
 - Plan for the collection and public reporting of quality data (Sec. 3015, 10303, 10305, 10331)
- Proposes Accountable Care Organizations of providers to manage and coordinate quality care for Medicare fee-for-service beneficiaries (Sec. 3022, Proposal for Medicare Shared Savings Program due Jan 2012)



Quality: Coordinated Care Governance

- Federal Coordination of Care Office, CMS (Sec. 2602)
 - Officers and Medicare/Medicaid employees will work to simplify access to benefits, improve quality of care, education efforts, continuity of care, and provision of drug coverage for all dual-eligibles beginning 2010.
- Community-based Collaborative Care Networks (Sec. 10333)
 - Secretary may award grants to provider networks (consortium of providers with joint governance structure) who offer collaborative and integrated community-based care for low-income populations.
 - Grant funding at the discretion of the Secretary from 2010-2014, but will favor those networks with the broadest range of providers serving the largest number of people
 - Grants also will favor county or municipal departments of health.

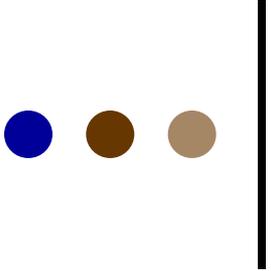


Quality: Hospitals

- Medicare value-based incentive payments based on achievement or improvement for general hospitals (beginning 2013) (Sec. 3001, 3004, 3008, 10335)
 - Funded through 1% (FY 2013) to 2% (FY 2017) reductions to DRG payments for most hospitals.
 - Reduction to hospital payments for hospital acquired infections (2015)
 - Data available to the public
- For long-term care hospitals, inpatient rehab hospitals, PPS-exempt cancer hospitals, hospice, inpatient psychiatric hospitals: (Sec. 3002, 3004, 3005, 10322, 10326)
 - Development of a quality standards and reporting requirements
 - Testing of value-based purchasing

Quality: Skilled Nursing Facilities, Home Care, Hospice

- Development of a value-based purchasing program for skilled nursing facilities and home health agencies (Sec. 3006)
 - Plan to be submitted by HHS Secretary to Congress by FY2012
- Quality measure reporting programs for hospice providers to be implemented by FY2014 (Sec. 3004)



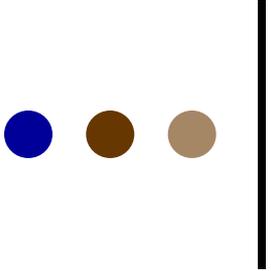
Quality: Physicians

○ Medicare reporting requirements (Sec. 3002, 3003, 3007, 10327)

- Extends incentive payment system for reporting quality measures to CMS through 2014
- Beginning 2014, Medicare payments reduced if providers do not report quality measures
- In 2015, payments reduced by 1.5%, 2016 by 2%
- Value-based payments result from risk-adjusted performance data (cost neutral)
- Some quality information made available to the public
- Public reporting of physician performance data for those enrolled in Medicare or participating in the Physician Quality Reporting Initiative (Sec. 10331)

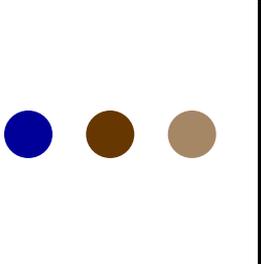
○ Medicaid reporting requirements (Sec. 2701)

- Appropriates \$60M for each FY 2010-2014 to develop initial adult health quality measures in Medicaid by Jan. 2012, with annual state reporting requirement



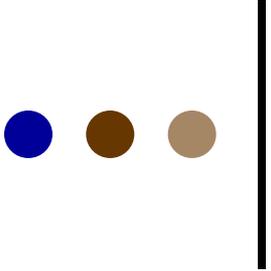
Quality: Other Providers

- Secretary must develop a plan to reimburse Ambulatory Surgery Centers based on quality and efficiency of care (by Oct 2011) (Sec. 3006, 10301)
- Architectural and Transportation Barriers Compliance Board and FDA must establish standards for accessibility of medical diagnostic equipment for people with disabilities (Sec. 4203)



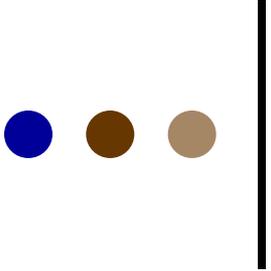
Quality: Insurers

- Will be required to report information on initiatives and programs that (Sec 1001) :
 - Improve health outcomes through the use of care coordination and chronic disease management
 - Prevent hospital readmissions and improve patient safety
 - Promote wellness and health.
- As part of Health Benefit Exchange, criteria will be established for qualified health plans on quality improvement and quality measure data requirements (Sec 1311, 1331).
- HHS Secretary will develop a methodology to assess health plan value (Sec 10329)



Value-based Purchasing

- Payments to providers will be impacted by performance on quality measures
 - Incentive payments tied to performance on quality measures (Sec 2012, 3001, 3004)
 - Payment penalty under Medicare for hospital-acquired conditions (Sec 2702, 3008)
 - Adjustment to Medicare physician payments under the physician fee schedule based on quality and cost of care beginning in 2015 (Sec 3007)
 - Reduction in payments based on potentially preventable Medicare readmission rate beginning in FY2012 (Sec 3025)

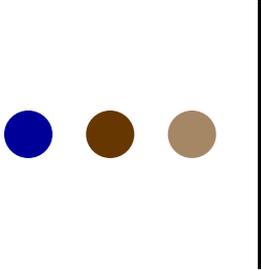


Funding Opportunities

- Medicaid Quality Measurement Program (Sec 2701)
 - Research on evidence-based adult health quality measures to use for reporting
 - Appropriates \$60M for each FY 2010-2014
- Quality measure development (Sec 3013)
 - Grants through AHRQ and CMS to develop, improve, update, expand quality measures
 - Quality measure topic areas include health outcomes, functional status, transitions, consumer decision making, meaningful use of HIT, safety, efficiency, patient experience, and equity and health disparities.
 - Authorizes \$75M for each FY 2010-2014

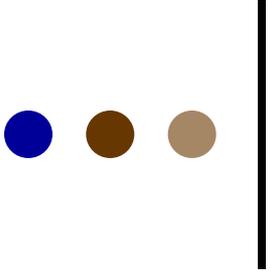
Funding Opportunities

- Data collection and aggregation research (Sec 3015)
 - Grants awarded to research organizations that coordinate and develop methods for consistent reporting of summary quality and cost information
 - Research organization must match \$1 for each \$5 of federal funds
 - Federal government has authorized appropriations for “such sums as necessary” for this provision



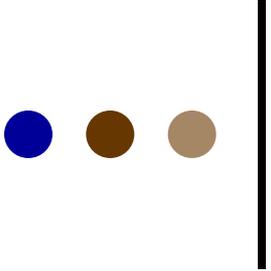
Funding, continued

- Center for Quality Improvement and Public Safety
(Authorizes \$20M for FY 2010-2014; Sec. 3501)
 - AHRQ-based center will distribute money to eligible organizations for technical assistance and implementation awards.
 - Grants will assist providers with implementing and managing technical models to improve efficiency and quality of care.
 - Identification and dissemination of evidence-based strategies for quality improvement, safety, efficiency



Funding, continued

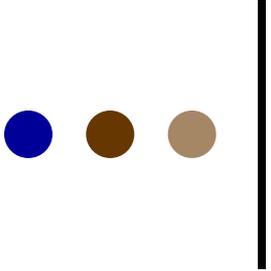
- Pain management research (Sec 4305)
 - Grant program to improve health professionals' ability to assess and treat pain
 - Directs the Institute of Medicine and National Institutes of Health to conduct research on pain causes and treatments



Funding, continued

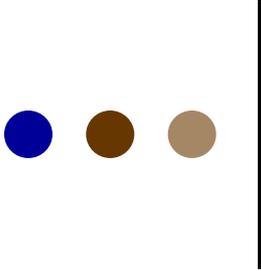
○ Patient-Centered Outcomes Research Institute

- To establish research priorities and fund comparative effectiveness research (Sec 6301)
- Appropriates: \$10M (FY 2010)-\$150M (FY 2012); thereafter, money from insurers and self-insured plans shall help support funding along with appropriations of \$150M in each fiscal year (FY 2014-2019)
- Transfers from Medicare Trust Fund: \$1/Medicare beneficiary (FY 2013), \$2/Medicare beneficiary (FY 2014)
- Findings will be distributed by the AHRQ Office of Communication and Knowledge Transfer



Agenda

- Overview of Quality Workgroup charge
- More detailed description of Affordable Care Act (ACA) provisions
- **Next steps**



Next steps: Questions for Discussion

- How do we build on North Carolina's existing quality efforts to prepare for the new requirements? What are the gaps?
 - Examples: Community Care of North Carolina, North Carolina Healthcare Quality Alliance, Regional Extension Centers, Hospital Center for Hospital Quality and Patient Safety
- How can we ensure that providers/payers are aware of the new requirements and opportunities?
- What are the challenges we face in implementing these health reform provisions?
- How should we move forward from here?
- What information do we need for the next meeting?