

How Health Reform Will Affect Health Care Quality and the Delivery of Services

The recently enacted Affordable Care Act contains provisions to improve health care quality, foster greater efficiency, and encourage changes in how health care services are delivered. This Fact Sheet looks at several of the major elements of these reforms.

The Affordable Care Act (ACA) contains provisions to improve the quality and efficiency of the health care system and test new ways to deliver and pay for health care services.

Integral to these strategies are performance measurement and assessment to evaluate how well care is provided. Results from these assessments will then be used in public reporting programs, payment reform, value-based purchasing, and quality improvement.

The law also includes other strategies, such as strengthening primary care, supporting clinical and patient decisions by making available evidence-based information, and accelerating adoption of health information technology.

The infrastructure for performance measurement will be strengthened to support quality improvement, efficiency, payment, and delivery reform.

- The secretary of the Department of Health and Human Services (HHS) will establish and implement a national strategy to improve the delivery and quality of services. The strategy will identify national priorities and align the efforts of public and private payers to improve health care quality and safety.
- HHS will identify gaps in quality measures and fund the development

of measures to fill these gaps, giving priority to health outcomes, functional status, care coordination, shared decision making, efficiency, and disparities.

- The Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality will conduct and support research and development of best practices for quality improvement and translate research findings so that they can be incorporated into clinical practice.
- HHS will oversee a process for collecting and aggregating data and develop a framework for publicly reporting performance information.
- The National Quality Forum (or another entity designated by HHS) will convene multistakeholder groups to provide input to HHS on the selection of quality measures and national priorities.

The ACA will encourage greater transparency to advance accountability. It will offer payment incentives to reward quality of care and greater efficiency in Medicare, Medicaid, and the private sector.

In Medicare
Hospitals that meet performance standards for clinical care and efficient use of resources will be eligible for

How Health Reform Will Affect Health Care Quality and the Delivery of Services

incentive payments to reward both improvement and achievement.

Starting in 2012, a Hospital Readmissions Reduction program will penalize hospitals for “excess” readmissions for three high-volume or high-cost conditions or procedures that HHS determines could have reasonably been prevented. Hospitals will be required to report on readmissions for all patients (not just Medicare beneficiaries). Readmission rates will be publicly reported on the Hospital Compare Web site. HHS will offer assistance through patient safety organizations to help hospitals with high rates of readmission improve their care.

To help improve care during transitions from one setting to another, a community-based, five-year Care Transitions program will be established to fund eligible entities that provide care transition services to high-risk Medicare beneficiaries. This program may be extended beyond five years if it demonstrates lower spending without reducing quality.

Hospitals will publish annual lists of standard charges for items and services. In 2014, hospital-specific health care acquired conditions (HACs) rates will be published on the Hospital Compare Web site. Starting in 2015, hospitals in the highest national quartile for HACs will see a 1 percent reduction in their Medicare payment.

Physicians caring for Medicare beneficiaries will continue to be rewarded for reporting on quality measures through 2014. Starting in 2015, physicians who do not report specified quality measures will see a 1.5 percent reduction in their Medicare payments; thereafter, the penalty for not reporting will increase to 2 percent.

- Physicians who participate in a Maintenance of Certification

program of one of the boards of the American Board of Medical Specialties will qualify for bonus payments.

- HHS will develop a Physician Compare Web site by 2011; starting in 2013, this site will include physician-level quality data as well as information on patient experience with clinicians.
- To foster greater efficiency in the delivery of care, starting in 2012, HHS will provide physicians with information on the amount of resources they use in delivering care.

Medicare Advantage (MA) plans will be subject to requirements to improve quality through new payment incentives and public reports on health plan performance. MA plans will be eligible for quality bonuses for high performance; the level of beneficiary rebates (i.e., the amount of money an MA plan has to provide “extra” benefits) will also be tied to quality. MA plans will continue to report clinical effectiveness and patient experience measures; performance results will be published on www.Medicare.gov.

MA plans will be required to spend at least 85 percent of their revenues on medical care or activities to improve quality; plans that spend less will be subject to enrollment freezes or contract termination.

In Medicaid

- Starting in January 2011, states will have the option to develop health homes that meet established criteria for Medicaid beneficiaries with chronic conditions.
- Starting in July 2011, states will not be allowed to reimburse hospitals for expenses related to HACs, although this prohibition will not result in loss of access to care for beneficiaries.

How Health Reform Will Affect Health Care Quality and the Delivery of Services

- Starting in January 2012, a demonstration will be launched in Medicaid to evaluate bundled payments for an episode of care that includes physician and hospital services provided in connection with the episode.
- By 2012, the secretary of HHS will establish a Medicaid Quality Measurement program to evaluate pediatric performance. By September 2014, the secretary will collect, analyze, and make available performance information reported by the states.

In the Private Sector

Health plans offered through state Health Insurance Exchanges established under ACA will be required to participate in public reporting and quality improvement activities. HHS will rate plans on quality and cost. Plans will also have to be accredited on the basis of local performance and report on clinical quality, patient experience, and quality improvement strategies.

Plans will need to be eligible for market-based incentives for efforts to improve health outcomes through quality reporting, care coordination, chronic disease management, medication, and care compliance initiatives. Incentives should also reward activities that prevent hospital readmissions, improve patient safety, reduce medical errors, and support health promotion.

The ACA calls for testing payment and delivery models designed to enhance patient-centered care and shared accountability without raising costs.

By January 2011, a new Center for Medicare and Medicaid Innovation will be established to test payment and service delivery models that reduce program expenditures while enhancing the quality of care in Medicare and Medicaid. In determining which

innovations to test, HHS will give preference to programs that improve coordination, quality, and efficiency of patient-centered health care services, and promote broad payment and practice reform in primary care.

By January 2012, a Shared Savings program will be established in Medicare that promotes accountability for a patient population, coordinates services under parts A and B of Medicare, and encourages investment in infrastructure and redesigned care processes to achieve high-quality, efficient care delivery. HHS will identify payment models, which may include global payments, partial capitation, or other methods.

Accountable Care Organizations (ACOs), consisting of groups of providers and suppliers (e.g., physicians and hospitals), will work together to manage and coordinate care for beneficiaries enrolled in the traditional Medicare program.

- ACOs will be eligible for an annual incentive bonus if they meet a savings target established by HHS. Measures to determine if an ACO qualifies for bonus payments will assess clinical processes and outcomes, patient and caregiver experience (when possible), and rates for ambulatory sensitive hospital admissions (i.e., admissions that might have been prevented had appropriate ambulatory care been provided.)
- ACOs must have defined processes to promote evidence-based medicine and patient engagement, and report on quality and cost measures.
- ACOs must have a sufficient number of primary care professionals to serve the patients assigned to them.

Medical homes will be piloted by the Center for Medicare and Medicaid

How Health Reform Will Affect Health Care Quality and the Delivery of Services

Innovation. As noted above, a new Medicaid state option is created for “health homes” (similar to medical homes) to serve beneficiaries with chronic conditions.

Bundled payments will be piloted by January 2013 to encourage providers to coordinate care and share accountability for an episode (i.e., a hospital stay plus 30 days postdischarge) that occurs around a hospitalization.

- The quality of care across the episode (to include acute and postacute care) will be measured.
- If the pilot results in improved care *and* reduced Medicare spending, HHS may expand the scope and duration of the program.
- To be eligible, beneficiaries must be enrolled in parts A and B of the traditional Medicare program and have one or more of 10 conditions specified by HHS.

The law also calls for development of a Shared Decision Making program designed to support partnerships between patients and providers that incorporate patient preferences and values into treatment decisions and support patient decisions with information about treatment options. The new program will—

- Have a process through the National Quality Forum to establish standards and certify decision aids;
- Fund the development and maintenance of decision aids;
- Create Shared Decision Making Resource Centers to provide technical assistance to providers, disseminate best practices on the use of decision aids, and promote adoption of these tools;
- Offer grants to providers for the development, use, and assessment of

certified shared decision making aids; and

- Fund the development of measures to assess shared decision making tools.

Primary care will be strengthened.

Primary care supports patient-centered care by ensuring care coordination, continuity, patient self-management, disease prevention and health promotion, and bridging personal, family, and community health. ACA provides resources to develop, train, and organize the health care workforce.

In Medicare, a new 10 percent bonus for certain evaluation and management activities will apply to primary care practitioners, including physicians practicing family medicine, internal medicine, geriatrics, or pediatrics; and nurse practitioners, clinical nurse specialists, and physician assistants. In addition:

- Funding will be available to accredited public or nonprofit hospitals or schools of medicine to support training for primary care physicians to provide care through medical homes.
- Funding to primary care extension programs will support primary care extension agents who assist primary care practices to implement quality improvement or system redesign.
- Community, interdisciplinary health teams will be established to support primary care practices in medical homes.

Health information technology (HIT) and comparative effectiveness research will facilitate care based on best evidence and help inform clinical and patient decisions.

The Patient-Centered Outcomes Research Institute, a private, not-for-profit entity, will be established to help patients, clinicians, purchasers, and

How Health Reform Will Affect Health Care Quality and the Delivery of Services

policy makers make informed health decisions based on evidence. Among its duties, the Institute will—

- Identify research priorities and establish a research agenda;
- Conduct research, giving priority to the Agency for Healthcare Research and Quality and National Institutes of Health in awarding research contracts; and
- Release and disseminate research findings.

Restrictions apply to how HHS may use the evidence and research findings in determining Medicare coverage, reimbursement, or incentive programs.

The new law builds on the Health Information Technology Act of 2009 (HITECH), which was part of the American Recovery and Reinvestment Act of 2009. ACA and HITECH are

mutually supportive; each promotes and advances HIT. For example, ACA requires ACOs to use technology, including telehealth and remote patient monitoring. It establishes HIT protocols and standards for certain administrative functions. It also creates a time frame for public and private health plans to collaborate to simplify health insurance administration by developing common methods for claims processing, credentialing, and utilization review.

Fact Sheet 197, July, 2010

Written by Joyce Dubow
AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3890, ppi@aarp.org
© 2010, AARP.
Reprinting with permission only.