TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

Quality Provisions in the Affordable Care Act

Affordable Care Act Provisions Related to Provider Engagement

State goal	Related Affordable Care Act provision
Engage providers as partners in quality improvement initiatives and policymaking	Providers will be required to implement certain quality improvement strategies in order to contract with health plans in exchanges (Section 1311). The Independent Payment Advisory Board will include providers (Section 3403, as modified by 10320).
Support providers seeking to improve quality	Physicians will receive reports and data analysis on their reported quality data as part of the physician feedback program (Sections 3002(e) and 3003). HHS will award grants for developing health professional curricula on patient safety and quality improvement (Section 3508). The Institute of Medicine will conduct a study to determine best practices for developing clinical practice guidelines (Section 10303(c)). The new private, nonprofit Patient-Centered Outcomes Research Institute will conduct comparative clinical effectiveness research to be disseminated broadly by AHRQ (Section 6301, as modified by 10602). HHS will award grants to states to create interdisciplinary teams to support primary care physicians in creating medical homes (Section 3502, as modified by 10321). AHRQ will establish a Primary Care Extension Program to support, assist, and educate primary care providers on a variety of topics. HHS will award grants to states to establish state hubs under the program, to coordinate with quality improvement organizations and area health education centers (Section 5405, as modified by 10501). HHS will award grants to support community-based collaborative care networks, in which a safety-net hospital and all local FQHCs will coordinate and integrate health care services (Section 10333).

Affordable Care Act Provisions Related to Consumer Engagement

State goal	Related Affordable Care Act provision
Inclusion of consumers in quality improvement strategy development	A consumer advisory council will advise the Independent Payment Advisory Board on the impact of payment reforms on consumers (Section 3403, as modified by 10320). Exchanges will be required to engage consumers (Section 1311(d)(4), \(i)(3)).
New or improved tools to help consumers with informed decision-making	HHS will require health plans participating in exchanges to develop a quality improvement plan that includes patient-centered education (Section 1311(g)(1)(B)). The new Program to Facilitate Shared Decision-Making will award grants to develop standards for patient decision aids, and to disseminate best practices for shared decision-making (Section 3506). The Center for Medicare and Medicaid Innovation will be authorized to test payment models that support shared decision-making, according to the standards developed by the new shared decision-making program (Section 3021). The Patient Navigator grant program will continue, with a newly extended grant duration, and new minimum core proficiencies for patient navigators receiving grants (Section 3510).

Affordable Care Act Provisions Related to Public Reporting

State goal	Related Affordable Care Act provision
Publicly reported data to inform decision-making	The Department of Health and Human Services (HHS) will collect, aggregate, and publicly report data on quality and resource use, and publish summarized quality data (provider- and condition-specific) on public Web sites (Section 3015). HHS will develop Physician Compare, a Web site where Medicare beneficiaries will be able to view quality and patient experience measures for physicians (Section 10331). The Independent Payment and Advisory Board will issue annual reports on access, cost, and quality of health care for Medicare beneficiaries (Section 3403(a). Health plans participating in exchanges will be required to create a quality improvement strategy that includes quality reporting (Section 1311(g)(1)(A)). Financial relationships among providers, suppliers, and manufacturers will be publicly disclosed (Section 6002). Data from newly created quality reporting initiatives will be publicly available (Sections 2703, 3001(b)(1), 3004, 3005, 3006, as modified by 10301, and 3401(f), as modified by 10322(a)). The Centers for Medicare and Medicaid Services (CMS) will publicly report the hospital-acquired condition data it already collects (Sections 3013(b), as amended by 10303(b)).

Affordable Care Act Provisions Related to Data Collection and Standardization Goals

State goal	Related Affordable Care Act provision
Creation of standard measures	AHRQ will set priorities and fund the development of new provider-level quality measures for acute and chronic primary and preventive care. Emphasis will be placed on metrics for which data can be easily collected and freely and publicly available (Section 3013). Multiple stakeholders will convene to establish a quality measure development process and to select and review measures for reporting and payment in federal programs (Section 3013(a)(1), as modified by 10304). The new Medicaid Quality Measurement Program will develop and select a core set of quality measures for adult health care under Medicaid (Section 2701).
More complete data sets, to allow population-based approaches	Medicare claims data will be released, for the purpose of evaluating provider and supplier performance (Section 10332). Incentive payments for physicians to report under the Physician Quality Reporting Initiative will continue, and a new penalty will be imposed on physicians who fail to adequately report data (Section 3002(a)-(b)). Various entities will be required to report quality data for value-based purchasing. These include critical-access hospitals, ambulatory surgical centers, long-term care facilities, inpatient rehabilitation and psychiatric facilities, hospice providers, certain cancer hospitals, and participants in certain demonstration projects (Sections 2703, 3001(b)(1), 3004, 3005, 3006, as modified by 10301, and 3401(f), as modified by 10322(a)). Health plans participating in exchanges will be required to create a quality improvement strategy that includes quality reporting (Section 1311(g)(1)(A)). HHS and the Centers for Disease Control and Prevention will issue a national (and state) Diabetes Report Card, aggregating data on quality of care and outcomes for patients with diabetes, to be used to inform policy decisions (Section 10407(b)).
Streamlined data aggregation	Federal and state program data, including certain quality measures, will be integrated into a single “program integrity” database (Section 6402(a)). Quality reporting will be integrated with the use of electronic health records (Section 3002(d)).

Affordable Care Act Provisions Related to Payment Reform

State goal	Related Affordable Care Act provision
Innovative and tested payment reform models	The new Center for Medicare and Medicaid Innovation at CMS will test new payment models, focusing on quality improvement and cost (Section 3021). States will have an option to implement a health home program for individuals with chronic conditions, to include a team of health professionals providing coordinated care (Section 2703). HHS is permitted to develop guidelines for insurance plans to offer value-based benefit design (Section 1001). HHS will establish Medicaid demonstration projects to test bundled payments, global capitated payments, and pediatric ACOs (Sections 2705, 2706 and 3023, as modified by 10308).
Medicare participation in payment reform	Medicare payments to certain providers will be adjusted to account for productivity (Section 3401). A modifier based on value (quality in relation to cost) will be added to the Medicare fee-for-service physician payment formula (Section 3007). HHS will implement value-based purchasing programs for Medicare payments to acute-care hospitals (Section 3001(a)). HHS will develop plans or pilot programs to use value-based purchasing for Medicare payments to other facilities, including skilled nursing facilities, home health agencies, and ambulatory surgical centers. HHS will implement demonstration projects to test value-based purchasing at critical-access hospitals (Sections 3001(b), 3006, as modified by 10301, and 10326). The Independent Payment Advisory Board will develop proposals to improve the quality of care in Medicare (Section 3403(a)). The new Medicare Shared Savings Program will permit providers to organize into an ACO (Section 3022). HHS will establish a Medicare pilot for bundled payments (Section 3023, as modified by 10308).
Financial incentives to reduce hospital-acquired conditions	HHS will reduce Medicare payments for services related to preventable readmissions and hospital-acquired conditions at low-performing hospitals (Sections 3008 and 3025, as modified by 10309). Neither the federal government nor state governments will make Medicaid payments for hospital-acquired conditions (Section 2702).

Source: www.nashp.org,State Strategies to Improve Quality and Efficiency: Making the Most of Opportunities in National Health Reform