Quality Standards & Measures - Relevant Provisions in Federal Reform
Based on OHPR understanding as of 4-22-10

Quality Strategy

- HHS is directed to develop a National Quality Strategy to improve care delivery, patient health outcomes, and population health. An initial strategy must be submitted by January 2011 with annual updates thereafter (Sec. 3011). As part of this effort, HHS will:
  - Assemble an interagency working group on Health Care Quality to help federal agencies coordinate and collaborate on the national strategy aims. Avoiding duplication of effort and streamlining processes for quality reporting and compliance are among the goals of the working group.
  - Establish a federal health care quality website no later than January 2011.

Quality Measures

- In support of the national quality strategy, HHS must publish initial national quality measures by December 2011 and is authorized to receive up to $75M over 5 years for quality measure development, improvement, updates or expansions. (Sec. 3013-14). Measurement priorities include:
  - health outcomes and functional status of patients;
  - the management and coordination across episodes of care and care transitions
  - the efficiency of care;
  - experience, quality, and use of information to inform decision making about treatment options,
  - the meaningful use of health information technology;
  - the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;
  - the equity of health services and health disparities across populations and geographic areas;
  - patient experience and satisfaction
- CMS is directed to develop adult quality measures for Medicaid, similar to the child health quality measures recently published for children's health insurance (CHIPRA). (Sec. 2701). A recommended set of measures must go out for comment by January 2011 and must be finalized in 2012. State reporting on the measures begins after that point but the effective date is not clear; the Secretary has a deadline of September 2014 to "collect, analyze, and make [the data] publicly available."
  - Grants to refine and test the measures (likely very similar to the CHIPRA grant that Oregon was recently awarded) should be announced by Jan 2012 and must be funded at the same level as the CHIPRA grants.
- An 8-member "Commission on Key National Indicators" is to be established by the National Academy of Sciences within 30 days of the law's enactment. It is not known to what extent health (care) quality measures would be part of the national indicators; the law just instructs the Academy to identify issue areas and measures. (Sec. 5605)
- By 2014, HHS must make plans for quality measurement and, ultimately, value-based purchasing in long-term care hospitals, ambulatory surgery centers, inpatient rehabilitation and inpatient psychiatric facilities, cancer hospitals, and hospices.

Quality Reporting

- HHS will begin a Medicare hospital quality reporting and value-based purchasing program in FY2013. Measures used must address heart attacks, heart failure, pneumonia, surgeries, and hospital-acquired infections and, starting in FY2014, efficiency measures such as adjusted Medicare spending per beneficiary.
    - The program will include demonstrations in critical access hospitals and hospitals too small to participate in the general program.
- On the physician side, the law starts to move Medicare from pay-for-reporting to value-based purchasing:
    - Extends incentives for reporting through 2014 and begins to penalize non-participation starting in 2015
    - 0.5% additional Medicare bonus to physicians who report via a qualified Maintenance of Certification Program 2011-14
    - Provides physicians with feedback on their resource use, as compared to peers, beginning in 2012
- HHS must develop a "Physician Compare" website (like the current Hospital Compare) by January 1, 2011 for consumers to compare Medicare physician quality and patient satisfaction, using data reported as part of the Physician Quality Reporting Initiative.
- Within 2 years of the law's enactment, private sector health plans and insurers will be required to report to the Secretary on how their benefit designs and/or payment structures: improve health outcomes (via strategies such as quality reporting, care coordination, medical homes, etc.); reduce hospital readmissions; increase patient safety; and support wellness and health promotion.

Other

- Within two years of enactment, all federally-supported programs must, to the extent practicable, collect and report data on race, language, ethnicity, and disability status as well as rural or under-served populations. The Secretary will establish uniform (4302) standards for the data.
- A Patient-Centered Outcomes Research Insititute will be established in 2010 to identify priorities for and support comparative effectiveness research. The Institutes's findings may not be construed as mandates for practice guidelines or coverage decisions. (6301)
- A Center for Medicare and Medicaid Innovation will be established by January 1, 2011 to test care delivery and payment models that reduce the cost of care while maintaining or enhancing quality. The Center is funded at $5M for 2010 and at $10B for 2011 – 2019.