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Policy Initiatives Drive Quality of Care to Center Stage for Payers and Providers

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Improving health care quality has been a long-standing, often elusive goal of the health care delivery system. As highlighted by studies in the 1980s and 90s, quality problems were pervasive in health care delivery, resulting in avoidable errors, poor outcomes for patients, and additional cost to the health care delivery system.[1] Significant barriers impeded quality improvement: the absence of valid, objective public measures of quality that allowed meaningful comparison between providers; immature health information systems; and, most significantly, the lack of alignment of financial and quality incentives. Traditionally, providers have been paid based on the quantity of procedures and services they provide, not on the quality of care delivered.

Recent policy initiatives aim to reduce these barriers to quality improvement, with major implications for health care quality, payment for care, and the structure of the health care delivery system. The Patient Protection and Affordable Care Act, widely known as the health care reform law (the Health Care Reform Act or the Act) adopted in March 2010, included many provisions to promote quality of care, including requirements for transparency on quality, pay-for-performance, and incentives to redesign health care delivery to reduce cost and improve quality.[2] The Act follows on the heels of passage of the American Recovery and Reinvestment Act that provided federal funding and financial incentives for providers to adopt electronic medical records tied to quality objectives.[3] Taken together, these policies will accelerate the trends driving quality to the forefront of the agenda for public and private payers, regulators, and health care providers.

Transparency: Public Measures and Reporting

The Foundation for Public Reporting

Quality measurement is a relatively new field. Until the middle of the last decade, few measures of quality existed that could serve as a valid, objective, public assessment of the quality of care provided by health care professionals and facilities, including hospitals, nursing homes, and home care agencies. National organizations and state agencies conducted periodic surveys that either did not yield public scores or focused narrowly on specific process deficiencies that generally offered little insight about a provider's quality of care.[4] In general, payers and providers of health care alike lacked public quality measures to: (i) enable payers to purchase on quality; (ii) inform choice of provider; and (iii) generate comparative measures that providers could use to improve quality.[5]

Beginning in 2002 with publicly reported measures of nursing home quality, the federal government, through the Centers for Medicare and Medicaid

Services (CMS) as the largest national payer for health care, launched a series of initiatives to promote public reporting of quality measures. In 2003, CMS provided financial incentives to hospitals to report quality measures for processes of care for three conditions: heart attack, heart failure, and pneumonia. By 2005, CMS had established a website that reported the measures in an easily searchable format (www.hospitalcompare.hhs.gov). CMS also advanced public reporting in other sectors, adopting reporting on selected quality measures for home health care in 2003 and for physicians in 2007.

Mandates and Funding Established by the Health Care Reform Act

The Health Care Reform Act builds on these initiatives to advance transparency in the quality of care by expanding financial incentives for public reporting and by funding research to develop and enhance quality measurement. For physician reporting, the Health Care Reform Act maintains existing financial incentives to report on health care quality, requires the Secretary of Health and Human Services (HHS) to develop new measures for physicians, and imposes financial penalties for failure to report on quality measures beginning in 2015.[6] For hospices, long-term care hospitals, and inpatient rehabilitation hospitals, HHS must publish quality measures by October 2012.[7] Those entities that do not report on the measures as of 2014 will face financial penalties in the form of reduced Medicare reimbursement. The Health Care Reform Act also provides $75 million in funding each year from 2010 through 2014 for research and development of quality measures.[8] Specifically, the Act charges HHS, in consultation with other Federal agencies, to identify gaps in quality measurement and fund projects to develop and improve quality measures. The Act specifies priorities for funding, including measures of care management for high cost, chronically ill patients across the continuum of care, the meaningful use of health information technology, and patients' experience of care.

Public quality measures provide the foundation to advance quality in numerous ways, including pay for performance by public and private payers discussed below, choice of providers by health plans and employers as they build provider networks, regulatory enforcement, and oversight by provider leadership. With respect to regulatory oversight, poor quality measures may trigger or serve to target surveys and investigation by enforcement agencies. Quality measures that permit comparison with other providers are also a valuable oversight tool for Boards of Directors and executive leadership within hospitals and other providers to assess quality, set goals, and when necessary, require remediation to improve poor performance.

Pay-for-Performance: Aligning Quality and Financial Incentives

The Health Care Reform Act significantly expands existing federal and state initiatives to promote pay-for-performance in health care delivery. Since the first demonstration program in 2003 with hospital quality measures, CMS has gradually increased financial incentives tied to quality of care, offering both rewards for high performance and penalties for poor outcomes. For example, in 2008, CMS instituted a policy of non-payment for hospital-acquired conditions, such as serious infections, identified as preventable and that increase the cost of hospital care.

Penalties for Poor Outcomes

Among other measures, the Health Care Reform Act obligates HHS to extend this policy to bar payments by State Medicaid programs, effective July 2011, for health care conditions developed in a hospital referred to in the Act as "health care-acquired conditions."[9] Proposed regulations issued on February 17, 2011, establish health care-acquired conditions identified by Medicare as a minimum standard for Medicaid non-payment, and grant states the flexibility to extend the non-payment policy to other conditions and care settings.[10] Many states and private payers have already followed

CMS's lead on non-payment for health care-acquired conditions as well as so-called never events, serious preventable medical errors such as severe medication errors that cause patient harm or operation on the wrong patient or wrong body part.[11]

Effective fiscal year 2015, the Health Care Reform Act imposes further penalties for health care-acquired conditions in hospitals. The Act requires a reduction in payment of one percent of Medicare reimbursement to hospitals that are in the top quarter nationally for the number of health care-acquired conditions.[12] Moreover, the Health Care Reform Act directs HHS to study expanding non-payment for health care-acquired conditions to other providers, including nursing homes, ambulatory surgical centers, and health clinics.[13]

Focusing on the high cost of frequent hospital admissions, the Health Care Reform Act also adopted provisions to penalize "excessive" hospital readmissions, starting with readmissions for three conditions in 2012.[14] Under the Act, HHS must compare actual readmissions with expected readmissions to arrive at a basis for identifying admissions as excessive for each hospital. Notably, the readmission rates must be risk-adjusted to take into account the patient characteristics, including socioeconomic status, that contribute to more frequent readmissions related to patient-self-care and other factors that cannot be attributed to the quality of care provided.

Pay for Performance on Public Quality Measures

Beyond these penalties, the Health Care Reform Act requires adoption of pay-for-performance based on quality measures for a broad array of health care providers, including hospitals, nursing homes, home care agencies, and surgical centers. Starting with the fiscal year 2013, a percentage of payments to hospitals will be tied to performance on quality measures for certain conditions under the Hospital Value-Based Purchasing Program established by the Health Care Reform Act.[15] Under that Program, each hospital's performance will be assessed against a baseline performance period for the hospital. Hospitals that have a high performance score on measures for specified conditions, or that achieve a specified level of improvement from the hospital's baseline score, will receive higher payments. Payments to hospitals that do not improve or meet goals for quality scores will be reduced. The Value-Based Purchasing Program is a zero-sum game; the total amount of payments available to higher performing hospitals will equal the total amount of reduced payments to lower performing facilities.

For physicians, pay-for-performance will be tied to measures of quality and cost identified by HHS, starting in 2015.[16] The Health Care Reform Act also charges HHS with developing a plan to move to value-based purchasing for long-term care, home care, and surgical centers by 2012.[17] That plan must identify the measures, structure of bonus payments, and the source of funding for the payments for each group of providers.

Redesigning Care Delivery to Attain Quality and Financial Goals

The most ambitious provisions of the Health Care Reform Act aimed at quality improvement seek to promote new models of care that enhance care management, especially for high cost, chronically ill patients. Specifically, the Act provides grants and financial incentives for state governments, health plans, and health care providers to participate in demonstration or long-term programs to achieve the twin goals of lower cost and improved quality. In general, the initiatives seek to prompt health care providers to coordinate the care provided across care settings, including the physician's office, hospitals, and nursing homes, to prevent frequent hospital readmission and improve patient outcomes. Significantly, the Act also establishes the Center for Medicare and Medicaid Innovation to fund and evaluate innovative methods of payment and care delivery, with $10 billion of funding for activities initiated from 2011 through 2019.[18]

Accountable Care Organizations

Among the most notable of the Act's programs to develop new delivery models are: (i) the Medicare Shared Savings Program, which encourages creation of Accountable Care Organizations; and (ii) a national pilot program for bundled payments for an episode of care. As defined by the Act, an Accountable Care Organization (ACO) is an organization of health care providers that share responsibility for the cost and quality of care for a specified group of patients in the Medicare Fee-for-Service program.[19] If the ACO meets the quality and cost benchmarks that will be set by CMS in forthcoming regulations, it will be eligible to share in the savings generated. In order to participate in the Shared Savings Program, an ACO must agree to be accountable for the quality, cost, and overall care of Medicare beneficiaries, and must define processes of care to promote evidence-based medicine and patients' engagement in their own care, among other requirements.

The Health Care Reform Act listed physician groups, hospitals, and networks of physician groups as eligible to participate in an ACO.[20] HHS may specify other providers in regulations, expected to be released shortly. The regulations are also expected to address whether HHS will exercise the authority granted by the Act to waive or modify enforcement of fraud and abuse laws to promote ACOs. In particular, Federal fraud and abuse laws, including the Civil Monetary Penalty Law which bars hospitals from paying physicians as an inducement to limit the services provided,[21] will otherwise be a substantial impediment to creating effective incentives to change physician practice patterns.

Pilot Program for Bundled Payments

The Pilot Program for bundled payments will establish a five-year program to integrate care by hospitals, physician groups, skilled nursing facilities, and home health agencies to reduce costs and improve quality through better care coordination before and after hospitalization.[22] The Health Care Reform Act defines the relevant period for the program as three days prior to admission to a hospital and 30 days post-discharge. The Act charges HHS with identifying ten medical conditions that will be the focus of the program and developing payment methodologies that do not increase the existing reimbursement to providers for Medicare beneficiaries who will be cared for in bundled payment arrangements.

The HITECH Act: Federal Investment in Information Systems Tied to Quality Objectives

Information systems with the capacity to record and aggregate clinical data and transmit medical information across care settings are a critical platform for the quality initiatives established by the Health Care Reform Act. To date, several major factors have impeded development of the health information infrastructure, including the lack of capital for investment by not-for-profit providers and physician practices, the fragmented nature of the delivery system, and physician resistance to integrating information technology, including the electronic medical record, into clinical practice.

In 2009, the Health Information Technology for Economic and Clinical Health Act (the HITECH Act), adopted as part of the American Recovery and Reinvestment Act, provided up to $27 billion in funds for financial incentives to providers to adopt health information technology tied to quality objectives and standardization of information systems.[23] Specifically, the HITECH Act promotes the adoption of electronic health record systems by physicians, hospitals, and other eligible providers through incentive payments and penalties. In order to qualify for financial incentives in 2011 through 2016, and to avoid the financial penalties that will begin in 2015, providers must adopt certified electronic health record systems in accordance with regulations that spell out "meaningful use" of the records. The meaningful use regulations, promulgated in July 2010, require providers to meet specified quality objectives; the objectives are divided into core objectives that providers must

meet and a set of options from which providers must choose and implement in the first two years to be eligible for incentive payments.[24] Core quality objectives include the capacity to report on quality measures indentified by CMS, electronic ordering for medications, and use of clinical decision support tools to reduce errors. Among other goals, the mandated technology standards are designed to promote the interoperability of information systems—the capacity of systems utilized by different providers to exchange information.[25]

Looking Forward: The Challenges Ahead

The Health Care Reform Act faces constitutional challenges as well as concerted efforts by some members of Congress to cut off the funding required for implementation. Beyond overcoming these challenges, the ambitious goals set for quality of care will require innovation and collaboration by health care providers. For initiatives that deliver care across settings, providers must reach agreement about strategic targets of opportunity for saving money and improving quality; implement steps to improve care supported by evidence of their efficacy; and generate the data needed by physicians and administrators to monitor and improve quality. Just as significant, effective collaboration among providers will depend on their ability to assign accountability for outcomes and develop financial incentives between and among physicians, hospitals, and other participating providers in a way that motivates change in existing patterns of care delivery.

Collaboration in the 1990s between hospitals and physicians to form integrated delivery systems largely failed to improve quality or reduce costs. Yet, the Health Care Reform Act takes significant strides to create transparency on quality and align financial and quality incentives. The impact of federal health reform will be amplified by adoption of quality incentives by private payers and state governments through the Medicaid program. In addition, the HITECH Act provides unprecedented financial incentives to advance and standardize health information systems. Together, these policy initiatives lay a much stronger foundation to overcome the barriers that impeded past efforts to improve care coordination and quality.

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[1] *See, e.g.*, The Institute of Medicine, *To Err is Human; Building a Safer Health System,* Academy of Medicine Press (2000).

[2] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119, *amended by* Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152 (2010).

[3] The American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (2009).

[4] Donald M. Berwick and Troyen A. Brennan, *New Rules: Regulation, Markets, and the Quality of American Health Care* (1995).

[5] Tracy E. Miller, *The National Quality Forum: A 'Me-too' Or A Breakthrough In Quality Measurement And Reporting?*, Health Affairs, November/December, 1999.

[6] PPACA §§ 3002, 3003, 3007.

[7] *Id.* § 3004.

[8] *Id.* § 3013.

[9] *Id.* § 2702.

[10] 76 FR 9283 (February 17, 2011).

[11] Proposed regulations on health care-acquired conditions note that 21 states have developed Medicaid policies denying payment for conditions identified as preventable acquired in a hospital or other settings. *Id.* at 9287.

[12] PPACA § 3008.

[13] *Id.* § 3008(b).

[14] *Id.* § 3025.

[15] *Id.* § 3001. *See*, proposed regulations, 76 FR 2454 (January 13, 2011).
[16] *Id.* § 3007.
[17] *Id.* § 3006.
[18] *Id.* § 3021.
[19] *Id.* § 3022.
[20] *Id.* § 3022(b)(1).
[21] 42 U.S.C. § 1320a-7a(b).
[22] PPACA § 3023.
[23] ARRA § 13001 *et seq*.
[24] 42 CFR Part 412 et seq. (July 28, 2010).
[25] 45 CFR Part 170 et seq. (July 28, 2010).