

NEWS RELATED TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

PPACA COST CONTAINMENT CONCEPTS: QUALITY, TRANSPARENCY, WELLNESS, PREVENTION AND PROVIDER PAYMENT REFORMS

The Patient Protection and Affordable Care Act includes a number of provisions that are intended to change consumer, purchaser and provider behavior in order to improve efficiency and align incentives within our health system. Among other things, these provisions aim to promote health literacy, empower purchasers with better data, promote wellness and prevention, and provide a basis of knowledge for moving away from the fee-for-service payment model.

Transparency

- » Each hospital is required to make public standard charges for items and services, including DRGs (9/23/10).
- » Physician-owned hospitals will need to report the identity of physician owners and must report if patients are referred to these providers. Medical device manufacturers must disclose payments to physicians or teaching hospitals. Pharmaceuticals Research and Manufacturers Association (PhRMA) must disclose ownership or investment interest by physicians (2013).
- » Employers and insurers will be required to help participants understand their coverage through standardized forms (2012). Similar efforts to be studied for pharmaceuticals.
- » Ombudsmen and navigators will be employed to help consumers understand choices (2010 and beyond).
- » Exchange plans will be rated on cost and quality.
- » Medicare data will be made available for performance measurement, possibly for a fee (2012).
- » HHS to publicly report Medicare hospital acquired conditions data (when practicable) and readmissions data.

Quality and Efficiency

- » HHS will establish and annually update a National Quality Strategy to improve the delivery of health services patient outcomes and overall health. This will include creating or modernizing quality measures for provider and health plan performance. This information will be made publicly available to all users via the Web (2011).
- » Interagency Working Group on Health Care Quality formed to work on aligning quality efforts in the public sector with private sector initiatives.
- » Health plans are required to provide annual reports describing how their benefit design and reimbursement structure improve outcomes, prevent readmissions, improve patient safety and reduce medical errors. Wellness and health promotion activities must also be part of the report (2012).
- » Incentive payments will continue for physicians that report quality data, and Medicare payment penalties will begin in 2015 for providers that do not report. HHS will develop and update provider-level outcome measures (at least ten measures for acute and chronic conditions by 2012).
- » HHS will develop a Medicare “Physician Compare” website (work begins in 2011, report made to Congress by 2015).
- » Clinical Effectiveness Research will be supported by the Patient Centered Outcomes Institute funded via an assessment on employers. There is also funding to support evidence-based research and implementation through AHRQ.
- » Insured plans will be required to spend 80 - 85 percent of premium dollars on clinical care or on efforts to improve quality or issue rebates (2011).
- » Tax-exempt hospitals will be required to conduct community needs assessments every three years and then report, on form 990s, how it is addressing the needs identified. If needs are not addressed, the hospital must explain why those needs are not being addressed (taxable years after 2012).
- » Funding is available within AHRQ to foster best practices through training and mentoring by identified high quality providers.
- » A hospital value-based purchasing program will be established where hospitals receive Medicare value-based incentive payments for meeting quality and efficiency standards. Scores will be publicly reported (2013).
- » Fraud and abuse prevention efforts augmented.

Wellness and Prevention

- » National Prevention, Health Promotion and Public Health Council and Fund established. Work aimed at public health strategies begins in 2010.
- » Several grants available for general wellness and disease-specific research and program implementation.
- » AHRQ and CDC to work on clinical preventive services.
- » Grants provided for research and development of products to treat or prevent disease.
- » Grants to small employers for workplace wellness.
- » CDC to provide employers with technical assistance in evaluating workplace wellness programs and to survey and study employer-based wellness strategies.
- » Employer will be able to increase wellness rewards.

Payment Reforms

- » Independent Medicare Advisory Board will recommend ways to control Medicare costs plus make recommendations for private purchasers that can be implemented without Congressional approval (recommendations in 2014).
- » The Center for Medicare and Medicaid Innovation created with broad authority to test and expand innovative payment models including medical homes and accountable-care organizations (ACOs).
- » Medicaid payment rates for certain services provided by primary care providers increased to Medicare rates.
- » Medicare will penalize providers if they have a high number of hospital-acquired conditions or readmissions (2015).

If you have questions about your plan's compliance with these requirements or how to implement them, please contact your attorney.

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