The Patient Protection and Affordable Care Act (PPACA)\(^1\) and the Health Care and Education Reconciliation Act\(^2\) of 2010 may be the first steps in the process of federal healthcare reform, but many of the provisions of the PPACA represent further movement on a path that has been laid out over the past decade by policymakers in the public and the private sectors—the historical aim of increasing value in healthcare. As healthcare reform changes the shape of the US healthcare system, the PPACA sends a strong signal that quality will be a central driver of this change.

In an environment that rewards value and quality, attention to outcomes measurement and improvement will be essential to the success of organizations across the healthcare system. This includes health plans and the physicians and institutions with which they interact. The volume and complexity of healthcare quality data will increase quickly. Investment in the infrastructure and programs needed to support quality measurement, reporting, and improvement will likely be driven by the simultaneous increase in demands for transparency and accountability at all levels of the healthcare system.

The PPACA, as well as the regulations and legislation that will follow, are driven by forces that rely profoundly on the measurement of health system performance in 2 core areas—the expansion of insurance to more Americans, and an effort to ensure consumer protection and affordability. But PPACA signals that these forces will drive the next stages of change—payment reform and delivery system reform.

Payment reform is, and increasingly will be, driven by the trend toward value-based rather than service-based purchasing. As quality becomes part of the foundation for economic success at all levels of the healthcare system, increased coordination of care and more sophisticated population management will be necessary. The link between demonstrated performance and economic success, which began more than a decade ago, will move from the periphery to the center of healthcare. Healthcare organizations, and individual physicians, will have to respond. Now is the time for them to prepare.

**Opportunities for Quality Outcomes Measurement and Reporting**

With the expansion of insurance and consumer protection forming the backbone of healthcare reform, the language of the acts themselves speaks not only to affordability but also to value. Value-based purchasing strategies, beginning with health plans and ending with the consumer, will create pressure on institutions to perform. Performance must become quantifiable, so the development of metrics to measure all facets of healthcare performance will be a key element of the reform process and is explicitly funded by the reform legislation, as discussed below.

Much of the language in the PPACA speaks to a greater awareness of coordination of care and how improved coordination at each level of the system increases value for the patient and decreases cost through enabling better clinical outcomes and the elimination of wasteful and redundant medical spending. One bonus that creates a powerful incentive for care management programs is the Care Coordination and Management Performance Bonus for Medicare Advantage (MA) plans.

The following excerpt from the PPACA explains this particular bonus and points to health reform priorities in terms of clinical and quality outcomes:

“For years beginning with 2014…in the case of an MA plan that conducts 1 or more programs described [as]…

(i) Care management programs that—

(I) target individuals with 1 or more chronic conditions;

(II) identify gaps in care; and

(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—
(I) help manage chronic conditions;
(II) reduce declines in health status; and
(III) foster patient and provider collaboration.

[The bonus would be] equal to the product of—
(i) 0.5% of the national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year; and
(ii) The total number of programs.”

Older systems of quality measurement will be expanded. For example, the Physician Quality Reporting Initiative (PQRI) introduced by the Centers for Medicare & Medicaid Services (CMS), which once offered Medicare reimbursement for providers who reported a limited set of metrics, will likely become a requirement, and quality reporting will no longer be an option. Investment in systems to support the measurement and reporting of metrics related to PQRI should increase as physicians face stronger incentives to participate.

Starting in 2010, CMS’s Five-Star Quality Rating system—a performance rating system for MA plans—will be used to create bonuses for plans that achieve 4 or 5 quality stars. Increased reimbursement will be determined by a plan’s ability to effectively demonstrate performance.

The PPACA defines these quality performance bonuses on an incremental scale, with plans eligible for a 1.5% bonus in 2012 and up to a 5% bonus in 2014.

These new financial incentives are bound to significantly shape health plan priorities in the future.

Implications for Quality Outcomes Measurement and Reporting

The most notable implication of healthcare reform on quality outcomes measurement and reporting is that quality, explicitly measured, will be more tightly linked to overall economic success through the emergence of achievement-based bonuses, value-based purchasing, and exchange-enabled competition among health insurers. The demand for transparency and enhanced public reporting create a significant challenge to institutions, which will have to be able to use data for the quantitative measurement of performance and to understand how to use that information to guide efforts to improve performance.

Pilot programs, such as accountable care organizations (ACOs) and the Medicare bundled payment program, are evidence that clinical outcomes will be implicated in the determination of the monetary value of healthcare. Subsequent quality-based competition between managed care plans and delivery system–based entities (eg, ACOs) could also emerge as consumers are offered new options and have more information to guide choice.

Health insurers will not be the only level of the system affected by these changes; providers contracted with health plans will be under additional pressure to measure and improve care. Measured and reported quality in the clinic setting may enhance opportunities for health plans to value-purchase and may create opportunities for health plans to support their networks with programs to further enable improvement.

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Driven by the $75 million annually appropriated by the PPACA for quality measure development between 2010 and 2014, quality metrics will advance across a broader surface. More robust measures of clinical quality and outcomes will emerge, including measures to assess:
• Health outcomes and functional status of patients
• Management and coordination of care across episodes of care
• Care transitions for patients across the continuum of providers, healthcare settings, and health plans.

With CMS’s triennial assessment of gaps in quality measures, the expectation is that there will be more specific metrics for the assessment of coordination of care and metrics to accurately address safety, efficiency, and patient experience. This broader set of metrics—many much more complex than those available today—will require more complex calculations to measure quality. At the same time, healthcare organizations—from health plans to individual physicians—will find further challenges, managing and improving the more complex care processes on which these broader and more robust metrics will shine a light.

How Health Plans Can Prepare for Increasing Demands for Quality Data Management

Strategic investment will not only lead to positive and significant return on investments (ROIs); it will also enable health plans to create more value for their covered members.

Invest in Measurement

The HEDIS (Healthcare Effectiveness Data and Information Set) measures developed by the National
Committee for Quality Assurance are an important starting point, but a starting point nonetheless. First, health plans must assess themselves comparatively against the competition. They will need to define the internal processes that influence the accepted measures of quality to understand why they rank the way they do. Beyond comparative assessment, health plans will need an infrastructure for compiling information about the providers with whom they contract; quality measures will include data related to clinical outcomes for which the providers are responsible. As healthcare reform drives accountability, it will be the responsibility of the health plan to determine and constantly improve the value of the providers who comprise their network.

With the rise of value-based purchasing, health plans will have to be more transparent regarding their performance and will have to demonstrate that they are delivering and improving value across their entire network.

**Invest in Improvement**

Health plans should be aware that the 2012 MA reimbursements will be based on the 2011 CMS Five-Star Quality Rating system. Improvement in those areas will increase reimbursement almost immediately. The key is knowing where you are starting, understanding what measures represent the best opportunity for improvement in the Five-Star Quality Rating system, and then focusing resources on making the changes that will lead to the largest improvement in the plan’s overall star rating.

**Buy on Value and Partner with Providers to Improve Value**

Just as purchasers are beginning to buy based on value, so should health plans. Provider evaluation and assessment form the basis for contract decision-making and allow plans to work with providers to improve performance and quality metrics. Pay-for-performance and other value-based purchasing strategies reinforce accountability at all levels of the system. Risk-sharing between health plans and providers will be combined with information-sharing and investment in other programs to support provider performance improvement for the benefit of the purchaser, provider, and payer—and, of course, the patient.

**Conclusion**

With pressure to create a more value-driven, transparent, and accountable marketplace, and with appropriated funding for quality measure development, the PPACA is going to drive significant increases in the extent and complexity of reporting requirements at all levels of the healthcare system. The PPACA’s commitment to patient protection, expansion of insurance coverage, and affordability demands investment on the part of CMS, health plans, and providers. With the rise of value-based purchasing, health plans will have to be more transparent regarding their performance and will have to demonstrate that they are delivering and improving value across their entire network. The potential ROI is significant for quality measurement and reporting, and for systems that enable documentable improvements. The PPACA has established bonus incentives in the language of reform to begin rewarding health plans and providers almost immediately for achievement, and appears to guarantee that investment today will lead to economic success and better quality healthcare for patients in the very near future.

**References**