

H.R. 3590 *The Patient Protection and Affordable Care Act*

Health IT or Health Information Policy-related Provisions

Provision	Relevant Issue Areas
<p>Section 1001/PHSA Sec. 2717. Ensuring quality of care. Requires the Secretary to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health. Guidelines to be developed 2 years after enactment.</p>	<p>Reporting</p>
<p>Sec. 1003. Ensuring value and lower premiums Amends the Public Health Service Act to require health insurance issuers in the small and large group market to meet a medical loss ratio of not less than 85%, effective for plan years beginning January 1, 2010. Directs the Secretary to require that plans in the individual market also meet a medical loss ratio of not less than 85% so long as it does not destabilize the existing individual market. If plans exceed that limit, rebates to enrollees are required. In determining the methodology for the medical loss ratio, the Secretary is to design it to ensure adequate participation by issuers, competition in the market, and value for consumers.</p>	<p>Payment policy</p> <p><i>Need to make sure payments for health information technology or quality reporting is considered in the medical expense category of the medical loss ratio</i></p>
<p>Sec. 1104. Administrative simplification. Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act (such as benefit eligibility verification, prior authorization and electronic funds transfer payments). Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. The goal of this section is to make the health system more efficient by reducing the clerical burden on providers, patients, and health plans.</p>	<p>Standards</p>
<p>Sec. 1561. Health information technology enrollment standards and protocols. Requires the development of</p>	<p>Standards</p>

<p>standards and protocols to promote the interoperability of systems for enrollment of individuals in Federal and State health and human services programs. These standards shall allow for electronic data matching, and electronic documentation. The Secretary may require State or other entities to incorporate such standards as a condition of receiving Federal health information technology funds.</p>	
<p>Title II Sec. 2701. Adult health quality measures. Directs the Secretary of HHS to develop a set of quality measures for Medicaid eligible adults that is similar to the quality measurement program for children enacted in the Children’s Health Insurance Program Reauthorization Act of 2009. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis.</p>	<p>Secondary Uses Quality Measures</p>
<p>Sec. 3002. Improvements to the physician quality reporting initiative. Extends payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates appeals and feedback processes for participating professionals in PQRI. Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine. Includes integration of quality reporting and EHRs</p>	<p>Secondary Uses Quality Reporting</p>
<p>Sec. 3003. Improvements to the physician feedback program. Expands Medicare’s physician resource use feedback program to provide for development of individualized reports by 2012. Reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs.</p>	<p>Secondary Uses Reporting</p>
<p>Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals and hospice programs. Establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers by requiring the Secretary to implement quality measure reporting programs for these providers in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update. Section</p>	<p>Quality Reporting</p>

<p>10322 also establishes a quality measure reporting program for inpatient psychiatric hospitals beginning FY2014.</p>	
<p>Sec. 3005. Quality reporting for PPS-exempt cancer hospitals. Establishes a quality measure reporting program for PPS-exempt cancer hospitals beginning in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update.</p>	<p>Quality Reporting</p>
<p>Section 3011-- National Strategy to Improve Health Care Quality.</p> <p>Direct the Secretary to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process. In developing these priorities, and among other items, the Secretary would consider how the priorities would: enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.</p>	<p>Secondary Uses</p> <p>Quality Measures</p>
<p>Sec. 3012. Interagency Working Group on Health Care Quality. Requires the President to convene an Interagency Working Group on Health Care Quality comprised of Federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.</p>	<p>Secondary Uses</p> <p>Quality Improvement</p>
<p>Section 3013-- Quality Measure Development. The Secretary would identify, not less than triennially, gaps where no quality measures exist, or where existing quality measures need improvement, updating or expansion consistent with the national strategy and priorities.</p>	<p>Secondary Uses</p> <p>Quality Measures</p>
<p>Sec. 3014. Quality measurement. Provides \$20 million to support the endorsement and use of endorsed measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.</p>	<p>Secondary Uses</p> <p>Quality Measures</p>
<p>Sec. 3015. Data Collection; Public Reporting. Requires the Secretary to collect and aggregate consistent data on quality and resource use measures from information systems used to</p>	<p>Data Collection and Reporting</p>

<p>support health care delivery to implement the public reporting of performance information.</p>	
<p>Sec. 3021—Center for Medicare and Medicaid Innovation</p> <p>Requires the Secretary to create an Innovation Center within the Centers for Medicaid and Medicare Services (CMS). The Innovation Center will be a new office established within CMS that is authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. Objectives include:</p> <ul style="list-style-type: none"> • Supporting care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization through a health IT-enabled network that includes a chronic disease registry, home tele-health technology, and care oversight by the beneficiary’s treating physician • Utilizing technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time. • Assisting individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools that improve individual and caregiver understanding of medical treatment options. 	<p>Demonstrations Incentives; Special care delivery; Payment policy; Coordination of care</p>
<p>Sec. 3501. Health care delivery system research; Quality improvement technical assistance. Builds on the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (AHRQ) to support research, technical assistance and process implementation grants. Grants funded under this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services.</p>	<p>Secondary Uses Research</p>
<p>Sec. 4301. Research on optimizing the delivery of public health services. The Secretary, acting through the Director of CDC, shall provide funding for research in the area of public health services and systems. This research shall include examining best practices relating to prevention, analyzing the</p>	<p>Secondary Uses Research</p>

translation of interventions from academic institutions to clinics and communities, and identifying effective strategies for delivering public health services in real world settings. CDC shall annually report research findings to Congress.	
Sec. 4302. Understanding health disparities; data collection and analysis. Ensures that any ongoing or new Federal health program achieve the collection and reporting of data by race, ethnicity, primary language and any other indicator of disparity. The Secretary shall analyze data collected to detect and monitor trends in health disparities and disseminate this information to the relevant Federal agencies.	Secondary Uses Collection and Reporting
Sec. 5605. Key national indicators. Establishes a Commission on Key National Indicators to conduct a comprehensive oversight of a newly established key national indicators system, with a required annual report to Congress.	Measures
Sec. 6301--Patient-Centered Outcomes Research Institute. Authorizes a private, non-profit corporation -- the Patient-Centered Outcomes Research Institute --to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis.	Secondary Uses Comparative Effectiveness Research
Sec. 6302. Federal coordinating council for comparative effectiveness research. Upon date of enactment, this provision would sunset the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2010 (P.L. 111-5).	Secondary Uses Comparative Effectiveness
Sec. 10330. Modernizing computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery. Requires the Secretary of HHS to develop a plan (and a detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery.	Federal Infrastructure
Sec. 10331. Public reporting of performance information. Requires the Secretary of HHS to develop a "Physician Compare" website where Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures, provided that such information provides	Reporting

an accurate portrayal of physician performance.	
Sec. 10332. Availability of Medicare data for performance measurement. Authorizes the release and use of standardized extracts of Medicare claims data to measure the performance of providers and suppliers in ways that protect patient privacy and in accordance with other requirements.	Secondary Uses Database
Sec. 10333. Community-based collaborative care networks. Provides grants to develop networks of providers to deliver coordinated care to low-income populations.	Coordination of Care