Report to the Board of the Partnership for Quality Care:

Care Improvement Provisions of the Patient Protection and Affordable Care Act

PQC PARTNERSHIP FOR QUALITY CARE
America's health providers and caregivers

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INTRODUCTION

A major goal of the Patient Protection and Affordable Care Act (PPACA)[1] is the extension of health insurance coverage to millions of Americans and small businesses who cannot afford to access it on their own. The Congressional Budget Office (CBO) projects that 54 million Americans would lack any form of health insurance by 2019 without the expansion of coverage under the new law.[2] Another major but often unnoticed goal of PPACA is improvement of the safety and quality of care obtained by patients within the United States. PPACA contains numerous initiatives aimed facilitating change in the health system so that care is safer, more coordinated and patient focused. Indeed, the full name of the health reform law – the *Patient Protection* and Affordable Care Act (PPACA) – speaks volumes about its primary intent.

The law targets several areas for improvement, such as lowering rates of preventable conditions that patients acquire during treatment, developing care transitions when patients change settings, expanding wellness benefits and creating the nation's first national strategy to improve quality. PPACA also makes new data on the safety and quality of care delivered to patients, such as hospital infection rates, publicly available. The law reduces Medicare and Medicaid payments to providers if they have high rates of preventable conditions (i.e., infections) or

The **purpose of this paper** is to spotlight the patient safety and quality improvement initiatives in PPACA. It is not an exhaustive account of all the health care reform provisions in the new law. Rather, it highlights initiatives that reflect the major goals of the bill.

A list of major PPACA patient protection and delivery system reform provisions can be found in the Appendix.

[1] Public Law 111-148, enacted March 23, 2010.
[2] Congressional Budget Office, *Letter to the Honorable Harry Reid,* December 19, 2009.

unnecessary readmissions. These provisions offer basic protection for patients and are also groundbreaking changes in Medicare and Medicaid policy because the health system has traditionally paid providers on a fee-for-service basis without regard for patient outcomes. The law also rewards providers that establish new arrangements, such as "health homes" and "accountable care organizations," that enable the delivery of care that is more coordinated, connected and informed. Finally, the law creates sustainability for improvement in health care by establishing new public and private organizations, such as the Center for Medicare and Medicaid Innovation, which can support and evolve reform over time without the need for further legislative action.

Health care reform provisions in PPACA are expected to be adopted by both public and private payers across the U.S. health system. They are as significant as the coverage provisions because they have the potential to improve the care obtained by all Americans, including individuals who have health insurance today and those who will be newly insured by the law.

HEALTH INFORMATION TECHNOLOGY: THE FOUNDATION OF A SAFE, HIGH-QUALITY HEALTH CARE DELIVERY SYSTEM

PPACA builds on existing legislation by aligning incentives to encourage care delivery systems that use electronic health records (EHRs) in a meaningful way. Health information technology is a fundamental building block of a safe, high quality health system.

EHRs can organize a patient's medical history and enhance coordination among providers, reduce duplication of services, and enable clinical knowledge to be communicated among providers at the time of service. However, with the exception of integrated health systems, major segments of the health sector lack the information networks that can connect providers with the medical data of their patients. The existence of multiple payers and the lack of integration among providers have diffused the financial incentives that would support the purchase of HIT systems by providers, even though such systems would improve care for patients.

Congress passed the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act to overcome these obstacles. It provides direct payments – a net total of $17 billion in federal funding – for eligible professionals and hospitals who participate in Medicare or Medicaid and who adopt and "meaningfully use" electronic health records beginning in 2011.[3] Another $2 billion in discretionary funds was included for grants to states and other entities to develop programs to promote the implementation of health IT more broadly.[4] Beginning in 2015, the financial incentives change: eligible professionals and hospitals will receive reduced Medicare payments if they fail to use EHRs in a meaningful way. The financial penalty is a one percent payment reduction in 2015, a two percent reduction in 2016, and a three percent reduction in 2017 and thereafter.

Congress adopted the HITECH Act because it foresaw that improving care in the United States requires widespread use of EHRs and other forms of health IT to support providers in delivering care. PPACA builds on HITECH by

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[3] Prior to HITECH and PPACA, the Department of Health and Human Services (HHS) made significant progress in removing technological barriers to building compatible IT products through the Office of the National Coordinator for Health IT (ONCHIT). Compatibility was necessary, but not sufficient to align incentives for providers to adopt IT in the health sector.

[4] According to CBO, spending for the bonuses and payment reductions from the penalties would increase net Medicare spending by $17.7 billion and increase net Medicaid spending by $12.4 billion over the 2011-2019 period. However, the net budgetary impact would be approximately $17 billion due to reduced federal direct spending on benefits in the Medicare, Medicaid, and Federal Employees Health Benefits (FEHB) Programs, and other effects.

establishing initiatives that encourage the delivery of care that is more coordinated, informed, and that reward better patient outcomes – that is, care providers can achieve with the support of health IT.

PROTECTING PATIENTS

PPACA includes provisions designed to accelerate momentum for targeted action on patient safety improvement through limiting hospital-acquired conditions and readmission rates, improving care transitions, increasing wellness benefits, and improving quality initiatives. In 1999, the Institute of Medicine (IOM) published a watershed report on patient safety, *To Err is Human: Building a Safer Health System,* which concluded as many as 98,000 Americans die each year from preventable medical errors that occur in hospitals alone.[5] Although some steps have been taken to protect patients since the release of the IOM report, many participants in the health system – including providers, patients, payers, policymakers and even authors of the IOM report – readily admit that progress on improving safety has been too slow.[6]

Hospital-Acquired Conditions and Readmission Rates

PPACA seeks to improve the safety of hospital care by tying reimbursement rates to rates of hospital-acquired conditions, adverse patient events, and readmission rates. Beginning in October 2014, Medicare will no longer give full payment to hospitals with high rates of hospital-acquired conditions (Sec. 3008). Specifically, hospitals with rates in the top quartile compared to the national average will have their Medicare payments reduced by one percent until their rates improve. This provision also requires HHS to make the information regarding the rates of acquired conditions of each hospital publicly available on the Centers for Medicare and Medicaid Services (CMS) Hospital Compare Website so that patients and other payers can access them.

In addition, PPACA prohibits state Medicaid programs from paying hospitals and outpatient providers for adverse patient events that can be reasonably prevented through the use of evidence-based guidelines (Sec. 2702). This provision creates more consistency between Medicare

[5] National Research Council. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press, 2000.
[6] "Five Years After To Err Is Human: What Have We Learned?" Lucian L. Leape, M.D., Donald M. Berwick, M.D., *Journal of the American Medical Association*, May 18, 2005, 293 (19): 2384–90.

and Medicaid payment and will leverage their effect within the delivery system.

The new law also aims to reduce unnecessary hospital readmissions. Recent studies have found that twenty percent of Medicare patients return to the hospital within thirty days of discharge and account for thirty-five percent of total payments for all admissions.[7] Beginning October 2012, hospitals with excessive readmission rates for certain conditions will have their Medicare payments reduced by one percent for those conditions (Sec. 3025). The reduction will increase to three percent by 2015 and will be in addition to any other payment adjustments the hospital might face from Medicare. As with acquired conditions, each hospital's track record on readmissions will be posted on the CMS Hospital Compare website so that patients and other payers can access them.

Together, these targeted incentives are intended to create sufficient pressure on providers to step up efforts to improve safety for all their patients. They do not prescribe specific actions that must be taken to improve safety. Rather they allow providers to analyze their own care processes and environment and implement what would work best in their communities and facilities. These Medicare and Medicaid provisions have spurred several major private insurers to adopt or consider similar payment practices.

Care Transitions

PPACA aims to improve the care of patients who are transferred between health care settings or providers by authorizing Medicare to test new models of improving care transitions under fee-for-service reimbursement. People living with serious and complex illness are especially at risk for medical errors when they are moved to a new setting (from hospital to home or nursing home, for example). These patients experience adverse events related to medications, including hospital readmissions, which can be avoided through medical management and better communication with patients before and after discharge. Transitional care is often lacking because fee-for-service payment systems, including Medicare's, do not reimburse providers for coordinating care for patients within or between settings. Medicare will provide payment for two years to community-based organizations that identify root causes of readmissions across providers and provide

[7] Jencks SF, Williams MV, Coleman EA. *Rehospitalizations among Patients in the Medicare Fee-for-Service Program*. N Engl J Med. 2009;360(14):1418–28.

care transition interventions to high-risk patients in their communities (Sec. 3026).[8]

Wellness Benefits

PPACA seeks to improve patient health status through expanded use of wellness benefits in Medicare and the private sector. For the first time in Medicare, beneficiaries are covered for an annual wellness visit with their doctors (Sec. 4103). Wellness visits enable physicians to identify health risk behaviors associated with the onset or progression of chronic conditions. With proper counseling, education and follow up care, wellness visits can be a first step in making care safer for patients who are at risk of chronic disease.

National Quality Improvement Strategy

PPACA directs HHS to develop and maintain, for the first time in the United States, a national strategy for quality improvement in health care (Sec. 3011). The national strategy will focus federal, state and local efforts through common aims and priorities and serve as a roadmap that all stakeholders in the system can follow. The inaugural national strategy, released March 2011, makes improving the safety of patient care the first of three national goals and reducing harm caused by the delivery system the first of six national priorities.[9] HHS will measure the nation's progress annually and report to Congress and the general public on whether the health system has moved forward in achieving the goals outlined in the national strategy.

Quality Outcome Measures

PPACA seeks to improve care by through establishing safety and quality measures in both the public and private sectors. HHS must produce and update measures on the safety and quality of care, consistent with the national strategy, which can be used to assess the delivery of care, patient outcomes and population health in both the public and private sectors (Sec. 3013). HHS also must develop ten outcome measures for acute and chronic disease as well as ten outcomes measures for preventive and primary care. The goal is to update the current stock of quality measures that have been developed over decades in the United States and ensure that valid metrics for assessing and reporting patient outcomes are available across the health system. Only by measuring and reporting on the outcomes of care in the health system can appropriate actions be taken to improve its performance in the future.

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[8] Community-based partnerships were underway in seven states as of December 2011.

[9] "National Strategy for Quality Improvement in Health Care," Department of Health and Human Services, *March 21, 2011*.

HHS also must publish a core set health quality measures that are relevant for Medicaid eligible adults (Sec. 2701), a new segment of the population who will acquire health insurance coverage under PPACA. Compared to Medicare and the private sector, states have devoted fewer resources toward quality measure development. This provision will enable states to more adequately assess the care delivered to new populations covered under Medicaid.

IMPROVING CARE DELIVERY SYSTEMS TO ACHIEVE HIGHER QUALITY

PPACA contains an extensive set of initiatives designed to improve care delivery systems and achieve higher quality. These initiatives include value-based purchasing and the development of accountable care organizations and health homes. The United States provides some of the most advanced care in the world, yet quality problems abound; overall, adults receive only about half of the care that is recommended for them.[10]

Value-Based Purchasing (VBP)

PPACA created several programs that align health care payment with quality improvement, including: a Medicare quality incentive payment program for inpatient hospital care beginning in 2012 (Sec. 3001), reducing reimbursement for physicians who do not report quality measures, and expanding quality reporting requirements. The hospital value-based purchasing program (VBP) creates a direct financial incentive to improve quality because it ties a portion of Medicare payment to measures of care process, patient experience and outcomes of care. Under the hospital VBP, base payment rates will be reduced for all hospitals by up to two percentage points by 2017, but hospitals will be able to earn back this reimbursement – as well as additional bonus payments – for successfully meeting quality and care measures.

Efforts to align Medicare payment with quality for other fee-for-service providers are not as advanced as they are for inpatient hospitals and health plans. However, PPACA makes progress in expanding reporting requirements. Payment will be reduced for physicians who do not report quality measures by 2015 (Sec. 5501). Additionally, quality reporting by long-term care hospitals, inpatient rehabilitation hospitals, psychiatric hospitals and hospice programs will be required

[10] "The First National Report Card on Quality of Health Care in America" RAND Corporation, 2006.

over the next few years (Sec. 3004). These reporting requirements are a form of transparency that will begin to keep providers focused on the quality care delivered to their patients.

Accountable Care Organizations (ACOs)

PPACA provides substantial financial incentives for groups of providers that form accountable care organizations (ACOs) under Medicare (Sec. 3022) or Medicaid (Sec. 2706).[11] ACOs are voluntary groups of physicians and providers that are eligible to share savings with Medicare or Medicaid if they meet the two objectives in a given year: 1) exceed set quality of care standards and 2) reduce the total costs of care for their patient population compared to the expected total costs. ACOs share cost savings only if they meet the dual goal of improved care and lower costs. ACOs are free to design their own approaches to delivering and coordinating care, but they are likely to adopt capabilities of integrated delivery systems, such sharing patient information electronically across settings and time frames, improving communication with patients and providing care transitions between settings.

To more rapidly test the concept of shared savings, CMS established a demonstration for more advanced versions of ACOs. Referred to as "pioneer ACOs," these provider organizations can accept capitated payments from Medicare and share greater savings with the program if they meet the goals of improving quality and lowering costs. While pioneer ACOs take financial risk for delivering care, they remain provider organizations in the fee-for-service program and are not insurance entities.

Medicaid Health Homes

PPACA includes provisions to support better care delivery systems for people with chronic conditions. One example is a new option for states to pay for the delivery of care to Medicaid-eligible individuals with chronic illnesses through primary care practices that are organized into "health homes" (Sec. 2703). Medicaid health homes are organized teams of health professionals that provide the full array of primary care services, plus a specified set of coordinating services for their patients, including: care transitions when patients change settings (e.g., discharged from hospital to home) and communication and coordination with specialty care, acute care and long-term care providers. They also must provide linkages to behavioral health care, patient and family support and referrals to community services.

[11] PPACA authorized Medicaid ACOs only for pediatric populations.

Health homes are expected to improve the safety and quality of care for people with chronic illness because they can do more to keep up with varied needs of these patients than providers who treat patients independently.

Delivering Care at Home

PPACA created several new options to test innovative models of delivering long-term and primary care to the aged and disabled in their homes while maintaining or improving health outcomes. Below are two examples.

Medicare Independence at Home Demonstration. The "Independence At Home" demonstration under Medicare will test a model of care that utilizes physician and nurse practitioner directed primary care teams for patients with complex care needs (Sec. 3024). The model is similar to ACOs in that participating practices must form a legal entity that coordinates patient care and is eligible for shared savings, should specified quality measures and savings targets be met. In this program, participating organizations also must have experience in providing home-based primary care to patients with complex care needs. Unlike the ACO model, however, the Independence at Home Demonstration will only target individuals who are at risk of medical complications and morbidity – specifically those who have two or more chronic conditions, have two or more functional dependencies requiring the assistance of another person and had a non-elective inpatient stay within the past twelve months.

Care Giver Training. PPACA requires federally funded geriatric care education centers to publicize and offer at least two courses annually to family caregivers and direct care workers in their local areas (Sec. 5503). As many as 52 million Americans, or thirty-one percent of the adult population, are informal or family care givers, providing help with transportation and medications and assistance with daily living.[12] Improving education and training of caregivers can improve home-based care for many older and disabled Americans.[13]

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[12] National Alliance for Caregiving and AARP. Caregiving in the U.S. Washington, DC: 2004.
[13] For an overview of PPACA provisions related to family caregiving, see: L. Feinberg and A. Reamy, *Health Reform Law Creates New Opportunities to Better Recognize and Support Family Caregivers,* AARP Public Policy Institute Fact Sheet 239 Washington, DC: AARP, June 2011).

SUSTAINING IMPROVEMENT IN HEALTH CARE

PPACA includes several provisions to help bridge the divide between better evidence and better quality through the creation of the Patient Centered Outcomes Research Institute, the requirement of HHS to share Medicare claims data, and provisions to advance best practices in quality improvement.

PPACA includes several noteworthy provisions that will enable significant features of health care reform to be sustained over time without the need for further Congressional action in the near term. Most significantly, PPACA established the Center for Medicare and Medicaid Innovation (CMMI) to develop innovative payment and delivery system models that show potential for improving the quality of care in Medicare, Medicaid, and the Children's Health Insurance (CHIP) program, while slowing the rate of growth in program spending. CMMI is intended to incubate new ideas and rapidly test their effectiveness. Congress also authorized CMMI to spread successful innovations to all providers who chose to adopt them. To be successful, CMMI must move quickly, learn as it proceeds, and try multiple strategies rather than focus on a single model.[14] CMMI will coordinate with private sector activities when feasible in order to leverage effects of having consistent approaches across payers.

One of the major initiatives launched by CMMI is the use of "bundled payment" as an alternative to Medicare fee-for-service. Specifically, CMMI seeks to improve care for patients while they are in the hospital and after they are discharged by aligning payments for services across an episode of care, such as heart bypass or hip replacement, rather than paying for services separately. Bundling payment across providers for multiple services will give physicians and hospitals new incentives to coordinate care, and improve quality.

Congress envisioned that CMMI would evolve PPACA reform provisions, such as ACOs, as well as launch new concepts for payment and delivery reform. Congress capitalized CMMI with $10 billion to cover the upfront or on-going costs of non-covered health care services that some reforms might incorporate.

[14] Guterman, S., Davis, K., Stremkis, K., and Drake. H., "Innovation in Medicare and Medicaid Will Be Central to Health Reform's Success," Health Affairs 29, No. 6 (2010): 1188-1193.

Sustaining Evidence Development and Disseminating Best Quality Practices

Despite unprecedented advances in medical knowledge and the highest per capita health care expenditures in the world, health care quality in the United States varies dramatically. Patterns of medical practice also vary widely for many conditions. Improved knowledge about what works in medicine and for which patients could lead to less variation in the quality of care, more consensus o

n how to apply medical knowledge to patient care, and potentially lower costs in the health system.[15] The success of many PPACA reforms to improve care depends on the ability of health system providers, payers and patients to make decisions based on the best medical evidence available.

Patient Centered-Outcome Research Institute. PPACA expands the capacity in the United States to conduct research comparing the effectiveness of different medical treatments by establishing a new institute, the Patient Centered Outcomes Research Institute (PCORI, Sec. 6301). The mission of PCORI is to generate and synthesize evidence comparing health effects of the treatments and procedures that are used in medical practice. The intent is to produce the best available medical answers that can be used by patients and their providers to make informed health care decisions. PCORI is authorized to study the effects that care processes and health care systems, in addition to individual treatments and procedures, have on clinical outcomes. For example, the Institute could compare the effect of different ways of teaching diabetic patients self-care techniques on A1C and cholesterol levels.

New Data Sources. PPACA also supports development of data sources to better monitor and conduct research on health care quality. For example, PPACA directs HHS to give standardized extracts of Medicare claims data for specified geographic areas to qualified public and private entities, including payers, to evaluate provider performance (Sec. 10332). In addition, the law collects new data on characteristics of the U.S. population so that health care programs and research can address disparities and differences among patients (Sec. 3101). Any federally conducted or supported program, activity or survey must collect to the extent practicable data on race, ethnicity, sex, primary language and disability status of applicants, recipients or

[15] National Research Council. *Knowing What Works in Health Care: A Road Map for the Nation*, Institute of Medicine of the National Academies, National Academy Press, 2008.

participants. Disparities data will enable better accountability and interventions.

National Programs Supporting Treatment Development and Best Practices. PPACA also includes a number of provisions that advance the dissemination of best practices for quality improvement and for the treatment of prevalent diseases. One provision directs the Agency for Health Care Quality and Research (AHRQ) to identify, develop, evaluate and disseminate innovative strategies for quality improvement practices in the delivery of health care services (Sec. 3501). AHRQ will conduct activities through its Center for Quality Improvement and Patient Safety, which existed prior to PPACA. The Center will assess research from a variety of disciplines to identify best practices for quality improvement. It will propose changes to processes of care and suggest ways to redesign systems to improve safety and reduce medical errors, and it will develop tools to facilitate the adoption of best practices that it identifies.

Preparing the Healthcare Workforce

PPACA extends the federal government's long-standing role in the education and training of the health workforce through loan and grant programs, establishing a graduate nurse education demonstration program, and modifying the Medicare graduate medical education (GME) program. Transforming the nation's health care delivery system will require significant changes in the education, training and composition of the health workforce. Policy makers are concerned about the size, specialty mix and geographic distribution of the healthcare workforce. The Health Resources and Services Administration (HRSA), which administers most federal health workforce programs, estimates that by 2020 there will be nearly 67,000 too few primary care physicians and a number of shortages in physician specialties, such as pediatric subspecialists.[16] Shortages of primary care practitioners, including nurses, are of particular concern because many delivery system reforms initiated by PPACA are centered on primary care. The current orientation of health education toward a fragmented delivery system is quickly becoming obsolete. Members of the workforce will have to learn how to relate to patients and each other differently when care is more integrated and coordinated.

[16] Congressional Research Service. *Public Health, Workforce, Quality and Related Provisions in PPACA: Summary and Timeline.* September 2, 2010.

Congress anticipated that enactment of PPACA would likely exacerbate health workforce shortages and training issues as the newly insured seek health care services beginning in 2014. This section describes a handful of PPACA's workforce initiatives, highlighting areas especially relevant to the health care reforms described in this paper.

Grants and Loans. PPACA extends or expands dozens of workforce loan and grant programs authorized under the Public Health Service Act (PHSA). For example, nursing students can now receive up to $17,000 in federal loans, rather than $13,000, beginning in 2012. Another provision revamps HHS authority to award primary care grants or contracts to public and nonprofit hospitals, schools of medicine, physician assistant training programs or other public or nonprofit entities to build capacity for primary care and integrate various academic units into primary care fields (Sec. 5301). Congress authorized $125 million each year from 2011 through 2014, but amounts available will depend on annual appropriations by Congress.

Primary Care Workforce. PPACA seeks to increase capacity and competency of the primary care workforce. One provision establishes a graduate nurse education demonstration program in Medicare for advanced practice nurses (Sec. 5509). Advanced practice nurses will receive training in clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management and other nursing care appropriate for the Medicare population. Another PPACA provision modifies the GME program to redistribute unused residency slots to increase the number of positions available and to direct many of the new slots toward primary care and general surgery (Sec. 5503).

PPACA's workforce initiatives are an essential component of delivery system reform. They will help train more physicians, nurses and other practitioners so that more members of the workforce are available to treat newly insured Americans. Training is designed to help prepare the health care workforce to participate in new provider arrangements that are centered around primary care, such as Medicaid health homes, ACOs, community-based care transition teams and other integrated approaches to delivering care.

HEALTH INSURANCE REFORMS PROTECT PATIENTS

PPACA includes major reforms of the individual and small group health insurance markets. For example, PPACA prohibits health insurers from denying insurance coverage to individuals with pre-existing conditions. It also bars insurers from using a person's health status to set insurance premiums. While these reforms are essential to making health insurance markets function more equitably and efficient, they are a form of patient protection. Individuals with pre-existing medical conditions, such as diabetes or cancer, should not be shut out of the insurance market based on their conditions. In fact, these individuals often need coverage the most because health insurance is increases access to needed care.

In addition, the health insurance exchanges will offer a new marketplace for quality-based care. Health plans offered by the new exchanges must be accredited based on clinical quality and patient experience measures. Plans also must use strategies to improve patient safety, care coordination, hospital readmission rates and health disparities. HHS has proposed to align quality-reporting requirements of health plans in Medicare and Medicaid with the state insurance exchanges. These requirements will help reinforce the goals of safer, higher quality care.

CONCLUSION

Expanding health insurance coverage to almost all uninsured Americans is the well-known story of PPACA. However, significant reform of the health care delivery system to improve the safety and quality of care for all Americans is a primary goal and focus of the law, as well. PPACA contains a rich and robust set of provisions designed to encourage providers to change their care processes and systems to achieve higher quality and, in some cases, both quality and efficiency of care. Reform provisions represent a broad spectrum of approaches: from payment changes designed to reduce targeted medical errors to financial incentives designed to encourage voluntary groups of providers to take broader responsibility for total quality and cost outcomes of patients or for a larger package of care. Other approaches include the extension of resources to train and expand the health care work force to carry out reform's goals.

A unique feature of PPACA is that it establishes new organizations and activities to sustain reform over time and build new evidence for delivering better care. PPACA's payment and delivery reforms are intended to be a catalyst for improvement throughout the health system, both in the public and private sectors. Many of its goals will be echoed and built upon by state health insurance exchanges as new marketplaces for quality-based coverage for consumers and small employers. In the end, PPACA strives for a demonstrably improved health system in the U.S. that fulfills its potential to deliver safe, high quality care all Americans.

Appendix: Major PPACA Patient Protection and Delivery System Reform Provisions

Section Number	Section Name	Title	Title Name	Effective Date
1001	Amendments to the Public Health Service Act -- No lifetime or annual limits, coverage of preventive health, ensuring quality of care, patient protections	Title I	Quality, Affordable Health Care for All Americans	September 23, 2010
1101	Immediate access to insurance for uninsured individuals with a pre-existing condition	Title I	Quality, Affordable Health Care for All Americans	June 23, 2010
1103	Immediate information that allows consumers to identify affordable coverage options	Title I	Quality, Affordable Health Care for All Americans	July 1, 2010
1201	Guaranteed availability of coverage	Title I	Quality, Affordable Health Care for All Americans	January 1, 2014
1201	Guaranteed renewability of coverage	Title I	Quality, Affordable Health Care for All Americans	January 1, 2014
1201	Prohibiting discrimination against individual participants and beneficiaries based on health status	Title I	Quality, Affordable Health Care for All Americans	January 1, 2014
2401	Community First Choice Option	Title II	Role of Public Programs	October 1, 2011
2405	Funding to expand State Aging and Disability Resource Centers	Title II	Role of Public Programs	FY 2010
2602	Providing Federal coverage and payment coordination for dual eligible beneficiaries	Title II	Role of Public Programs	March 1, 2010
2701	Adult health quality measures	Title II	Role of Public Programs	January 1, 2012
2702	Payment adjustment for health care-acquired conditions	Title II	Role of Public Programs	2011

2703	State option to provide health homes for enrollees with chronic conditions	Title III	Role of Public Programs	2011
2706	Pediatric accountable care organization demonstration project	Title II	Role of Public Programs	January 1, 2012
2707	Medicaid emergency psychiatric demonstration project	Title II	Role of Public Programs	FY 2011
3001	Hospital value-based purchasing program	Title III	Improving Quality and Efficiency of Health Care	FY 2013
3002	Improvement to the physician quality reporting system	Title III	Improving Quality and Efficiency of Health Care	2014
3004	Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs	Title III	Improving Quality and Efficiency of Health Care	FY 2014
3007	Value-based payment modifier under the physician fee schedule	Title III	Improving Quality and Efficiency of Health Care	2015
3008	Payment adjustment for conditions acquired in hospitals	Title III	Improving Quality and Efficiency of Health Care	FY 2015
3011	National strategy	Title III	Improving Quality and Efficiency of Health Care	January 1, 2011
3012	Interagency Working Group on Health Care Quality	Title III	Improving Quality and Efficiency of Health Care	December 31, 2010
3013	Quality measure development	Title III	Improving Quality and Efficiency of Health Care	Various
3021	Establishment of Center for Medicare and Medicaid Innovation within CMS	Title III	Improving Quality and Efficiency of Health Care	January 1, 2011
3022	Medicare shared savings program	Title III	Improving Quality and Efficiency of Health Care	January 1, 2012
3023	National pilot program on payment bundling	Title III	Improving Quality and Efficiency of Health Care	January 1, 2013
3024	Independence at home demonstration program	Title III	Improving Quality and Efficiency of Health Care	January 1, 2012
3025	Hospital readmissions reduction program	Title III	Improving Quality and Efficiency of Health Care	FY 2012

3026	Community-Based Care Transitions Program	Title III	Improving Quality and Efficiency of Health Care	January 1, 2011
3027	Extension of gainsharing demonstration	Title III	Improving Quality and Efficiency of Health Care	2010
3501	Health care delivery system research; Quality improvement technical assistance	Title III	Improving Quality and Efficiency of Health Care	2010
3502	Establishing community health teams to support the patient-centered medical home	Title III	Improving Quality and Efficiency of Health Care	Not Specified
3503	Medication management services in treatment of chronic diseases	Title III	Improving Quality and Efficiency of Health Care	May 1, 2010
3504	Design and implementation of regionalized systems for emergency care	Title III	Improving Quality and Efficiency of Health Care	FY 2010
3509	Improving women's health	Title IV	Prevention of Chronic Disease and Improving Public Health	FY 2010
4001	National Prevention, Health Promotion and Public Health Systems	Title IV	Prevention of Chronic Disease and Improving Public Health	July 1, 2010
4002	Prevention and Public Health Fund	Title IV	Prevention of Chronic Disease and Improving Public Health	FY 2010
4101	School-based health centers	Title IV	Prevention of Chronic Disease and Improving Public Health	FY 2010
4103	Medicare coverage of annual wellness visit providing a personalized prevention plan	Title IV	Prevention of Chronic Disease and Improving Public Health	January 1, 2011
4104	Removal of barriers to preventive services in Medicare	Title IV	Prevention of Chronic Disease and Improving Public Health	January 1, 2011
4201	Community transformation grant	Title IV	Prevention of Chronic Disease and Improving Public Health	2010
4302	Understanding health disparities: data collection and analysis	Title IV	Prevention of Chronic Disease and Improving Public Health	March 23, 2012
4303	CDC and employer-based wellness programs	Title IV	Prevention of Chronic Disease and Improving Public Health	March 23, 2012

5101	National health care workforce commission	Title V	Health Care Workforce	September 30, 2010
5202	Nursing student loan program	Title V	Health Care Workforce	FY 2010
5208	Nurse-managed health clinics	Title V	Health Care Workforce	FY 2010
5210	Establishing a Ready Reserve Corps	Title V	Health Care Workforce	FY 2010
5301	Training in family medicine, general internal medicine, general pediatrics, and physician assistantship	Title V	Health Care Workforce	FY 2010
5304	Alternative dental health care providers demonstration project	Title V	Health Care Workforce	Not Specified
5306	Mental and behavioral education and training grants	Title V	Health Care Workforce	FY 2010
5307	Cultural competency, prevention, and public health and individuals with disabilities training	Title V	Health Care Workforce	FY 2010
5308	Advanced nurse education grants	Title V	Health Care Workforce	FY 2010
5309	Nurse education, practice, and retention grants	Title V	Health Care Workforce	FY 2010
5310	Loan repayment and scholarship program	Title V	Health Care Workforce	FY 2010
5311	Nurse faculty loan program	Title V	Health Care Workforce	FY 2010
5312	Authorization of appropriations for parts B through D of title VIII	Title V	Health Care Workforce	FY 2010
5403	Interdisciplinary community-based linkages	Title V	Health Care Workforce	FY 2010
5403	Interdisciplinary community-based linkages	Title V	Health Care Workforce	FY 2010
5501	Expanding access to primary care services and general surgery services	Title V	Health Care Workforce	January 1, 2011
5503	Distribution of additional residency positions	Title V	Health Care Workforce	July 1, 2011

6101	Required disclosure of ownership and additional disclosable parties information	Title VI	Transparency and Program Integrity	March 23, 2012
6301	Patient-Centered Outcomes Research	Title VI	Transparency and Program Integrity	FY 2010
6401	Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP	Title VI	Transparency and Program Integrity	March 23, 2011
7002	Approval pathway for biosimilar biological products	Title VII	Improving Access to Innovative Medical Therapies	Requires rule making, not specified
9007	Additional requirements of charitable hospitals	Title IX	Revenue Provisions	March 23, 2012
9023	Qualifying therapeutic discovery project credit	Title IX	Revenue Provisions	Taxable years beginning December 31, 2008
10331	Public reporting of performance information	Title X	Strengthening Quality, Affordable Health Care for All Americans	January 1, 2011
10332	Availability of Medicare data for performance measurement	Title X	Strengthening Quality, Affordable Health Care for All Americans	January 1, 2012
10333	Community-based collaborative care networks	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2011
10334	Minority health	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2011
10407	Better diabetes care	Title X	Strengthening Quality, Affordable Health Care for All Americans	March 23, 2012
10408	Grants for small businesses to provide comprehensive workplace wellness programs	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2011
10409	Cures Acceleration Network	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2010
10410	Centers of Excellence for Depression	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2011
10411	Programs relating to congenital heart disease	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2011

10413	Young women's breast health awareness and support of young women diagnosed with breast cancer	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2010
10501	Amendments to the Public Health Service Act, the Social Security Act, and title V of this Act	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2011
10503	Community Health Centers and the National Health Service Corps Fund	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2011
10607	State demonstration programs to evaluate alternatives to current medical tort litigation	Title X	Strengthening Quality, Affordable Health Care for All Americans	FY 2011