"MEDICARE VALUE PURCHASING ACT OF 2005"
JUNE 30, 2005

Frequently Asked Questions

What does this bill do?

The Medicare Value Purchasing (MVP) Act of 2005 requires the Secretary of Health and Human Services (HHS) to develop and implement value-based purchasing programs under Medicare, and by doing so, links a small portion of Medicare payment to the delivery of high quality health care.

What providers are affected?

The MVP Act applies to acute-care hospitals, physicians and practitioners, Medicare Advantage plans, End Stage Renal Disease (ESRD) providers, home health agencies, and to some extent skilled nursing facilities.

Is the MVP program mandatory? Does it cut payments to providers?

Participation in the program is voluntary, but providers that choose not to report quality data will receive a reduced payment update. Health plans already report quality data under current law. Providers and plans that do report data will be able to participate in a "quality pool," with these funds redistributed to providers and plans who achieve certain targets regarding quality improvement or quality performance.

Why is a value-based purchasing program necessary?

Medicare payment systems are currently neutral, and sometimes negative, towards quality. Health care costs are rising at an unsustainable rate, yet the quality of care we receive for these dollars is questionable. According to the World Health Organization, America pays more per capita for health care than any other developed nation yet we rank 37th in terms of health care quality. Medicare must attain better "value" for its money – higher quality for each Medicare dollar spent.

How does the bill affect problems with the SGR and the physician update?

The MVP Act is limited to provisions that directly relate to quality improvement, value-based purchasing, data coordination, and health information technology – for that reason, we chose not to address the SGR in this bill. However, the bill acknowledges, through "Sense of the Senate" language, that the negative physician payment update needs to be addressed. This language points out the unsustainable nature of the SGR formula and the need to develop a more sustainable model that is more appropriate in controlling the volume of physician services provided.

Why should Medicare lead improvements in health care quality?

Medicare is the largest single purchaser of health care, providing health care coverage to over 40 million Americans. Yet when the program was created back in the 1960's, it was structured so that providers received the same payment regardless of whether they provided excellent or sub-standard care to beneficiaries. It is time to make a dramatic, but necessary change to the payment system by aligning payment policies to encourage and support quality care.

What is quality health care?

The Institute of Medicine (IOM) defines quality health care as safe, effective, patient-centered, timely, equitable and efficient. This care would use scientific evidence as its foundation to ensure that the care provided is appropriate and necessary. And, studies have found that provider use of information technology (IT) has the potential to improve the quality and efficiency of patient care.

How much Medicare funding would be linked to quality?

The MVP Act sets aside 1.0 percent of Medicare payments from participating providers, and increases this amount to 2.0 percent over five years. We believe this modest payment adjustment will be sufficient to drive quality care. The Medicare Modernization Act (MMA) provided hospitals with a 0.4 percent higher payment if they reported on 10 measures of quality care, and the result was that over 98 percent of hospitals submitted the required data to receive the higher payment.

Will the public have access to the reported quality data?

Yes, the bill would require that the data reported be made available to the public and others. We believe this is critical to increasing transparency, and for providing beneficiaries with information to help them make choices about their health care. There would be an exception for small providers. The Secretary would determine which physicians and practitioners the exception will apply to.

How will providers and plans be measured on their quality?

The Secretary would select quality measures through an open and transparent, multi-stakeholder, consensus building process. This selection of measures would be done in consultation with providers and other stakeholders, and would take into account those quality measures already developed and accepted by the healthcare community. The measure set will likely start small, but our intent is that the sets would become more robust over time. These measures could focus on health care processes, structures, outcomes, beneficiary experience with their care, equity, efficiency, and the use of information technology.

What constitutes health information technology (IT)?

Health information technology means a computerized infrastructure, including hardware and software, which are involved in the delivery of health care (including telehealth). This would include items such as an electronic health record or decision support software to reduce medical errors and enhance health care quality. We support the adoption of health information technology that leads towards processes that have been demonstrated to improve the quality or efficiency of patient care.

Will all measures be weighted equally?

No. The bill indicates that certain measures, such as outcomes, can be weighted more than other measures, such as patient experience with their care. Additionally, the MVP Act states that the majority of funds in the quality pool must be used to reward attainment of certain quality thresholds rather than improvements in quality.

Will the same measures apply to all hospitals or to all physicians?

The bill gives the Secretary the ability to vary measures used within types of providers. For example, the Secretary could differentiate hospital measures depending on the hospital's size and scope of services. Or, the Secretary could vary physician measures based on physician specialty, type of practitioner, or the volume of services delivered.

Does the legislation take into account the circumstances of small, low volume hospitals?

Yes, in addition to allowing the Secretary to select different measures for different types of providers, the bill directs the Secretary to include measures that reflect the unique characteristics of small hospitals located in rural and frontier areas.

How does the legislation impact critical access hospitals?

While critical assess hospitals (CAH) are excluded from the value-based purchasing program, the MVP Act directs MedPAC and the Secretary to conduct various studies and demonstration programs to assess the feasibility of developing such a program for these small rural providers.

Is the implementation timeframe the same across providers and plans?

No. Currently, some providers are further along than others in developing, reporting and using quality measures. In general, all providers will begin with the reporting of certain quality measures. Over time, a value-based purchasing program will be implemented where providers would receive rewards for meeting certain targets or thresholds. The timeframes for providers are as follows:

Provider	Payment for Reporting	Value Based Purchasing System Initiated
Hospitals	Currently reporting	2007
Physicians	2007	2008
Plans	Currently reporting	2009
ESRD	Currently reporting	2007
Home Health	2007	2008
SNF	2009	N/A

What providers or plans are excluded from this program?

- Those hospitals not included are children's hospitals, cancer hospitals, long-term care hospitals and units (LTCH), inpatient rehabilitation hospitals and units (IRF), psychiatric hospitals.
- The only plans not included are MSAs.