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

Section-by-Section Summary

Title and Overview: S.xxxx, Medicare Value Purchasing (MVP) Act of 2005 would link a portion of Medicare payment to the quality of services delivered by hospitals, physicians, Medicare Advantage plans, facilities and providers of services in the End-Stage Renal Disease Program, home health care agencies and skilled nursing facilities.

Section 2: Findings

- The United States spends more per capita on health care than any other country, and most business leaders see rising health care costs as a serious problem.
- Yet we rank near the bottom in health care quality, and research has shown that our system results in high rates of medical errors and inappropriate care, and that more care does not necessarily result in better outcomes.
- Payment policies in the Medicare program do not include mechanisms designed to improve quality of care.
- The Medicare program, and the U.S. health care system as a whole, should foster the development of a national health information infrastructure, the adoption of clinical information systems, and the implementation of payment policies to reward health care of high quality and value.

TITLE I
Measuring Quality and Efficiency of Care
Creates an overall structure that would allow the Secretary of Health and Human Services (HHS) to reward providers first for reporting quality data, and later for both quality improvement and attaining certain quality thresholds.

- The Secretary shall:
  - Select measures of quality according to the following criteria, *to the extent feasible:*
    - Evidence-based, reliable, and valid, and feasible to collect and report,
    - Include measures of process, structure, outcomes, beneficiary experience, efficiency, and equity,
    - Include measures of overuse and underuse
    - Include measures of health information technology infrastructure,
    - Include measures relevant to rural areas,
    - Include measures relevant to frail elderly and those with complex chronic conditions.
  - Vary measures according to the size and scope of hospitals, ESRD facilities, and home health agencies, and according to physician specialty, type of practitioner, and practice size.
  - Assign weights to measures.
    - Measures of clinical effectiveness shall, where appropriate, be weighted more heavily than patient experience.
  - Risk-adjust measures.
    - Existing risk adjustment methodologies should be used where possible.
  - Use the most recent quality data, but may aggregate across years when there are too few cases in a given year.

    - Update measures, including adding new measures, retiring old measures, and refining weighting and risk adjustment methodologies.
        - A core set of measures must be available from one year to the next to evaluate improvement.

- In developing quality measurement systems, the Secretary shall:
    - Consult with and take into account recommendations of a multi-stakeholder body under contract with the Secretary for the purpose of building consensus around quality measures; and
        - Public nonprofit entity that does not charge a fee for membership or voting in the work under this contract, and that conducts business in an open and transparent membership.
        - $ 3,000,000/year authorized for 2006 and 2007 for this contract, and that amount adjusted for inflation in subsequent years.
    - Consult with provider-based groups and specialty societies.

- In implementing the quality measurement systems, the Secretary shall:
    - Consult with and consider the recommendations of public-private entities established to examine issues of data collection and reporting, involving representatives of health care providers and others interested in quality of care.

- MedPAC study on the impact on Medicare beneficiaries, providers, and the Medicare Trust Fund of the:
    - Data collection and reporting procedures associated with programs established under this Act; and
    - Value-based purchasing programs established under this Act.

TITLE II – Value-Based Purchasing for Hospitals

Incorporates and expands upon Section 501 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) by increasing Medicare payment to hospitals reporting certain measures of quality care, and by creating a payment pool that would be distributed to those hospitals meeting certain thresholds based on quality performance or performance improvement.

- Beginning in 2007, hospitals reporting quality data would receive a full market basket update (a measure of inflation) to their Medicare payments. Hospitals not reporting would receive a reduced update of market basket less 2.0 percentage points.
- Beginning in 2007, a "quality pool" will be created consisting of 1 percent of all Medicare hospital inpatient payments to hospitals reporting data on quality of care. These funds will be redistributed to those hospitals based on attaining a certain threshold of quality performance or quality improvement. These thresholds would be determined by the Secretary. The quality pool will increase by 0.25 percentage points annually, so that available funds total 2 percent in 2011.
- In each year, the total amount of value-based awards will equal the total pool available for such awards. A majority of the pool will fund awards based on achieving a specified performance threshold.
- The Secretary would be directed to select at least 5 quality measures that are specifically applicable to rural and low volume providers by 2008.
- The Secretary would establish a process to provide for the public reporting of data on quality of care in a manner that is understandable and usable to the public.

- The legislation does not apply to critical access hospitals (CAH), but calls for a MedPAC study and a CMS demonstration project on the development and implementation of a pay-for-performance system for CAHs.

TITLE III – Value-Based Purchasing for Physicians and Certain Practitioners

Establishes a program to reward quality care among physicians and practitioners by providing higher Medicare payment to physicians and practitioners reporting certain measures of quality care, and by creating a payment pool that would be distributed to those physicians and practitioners meeting certain thresholds based on quality performance or performance improvement.

- In 2007, physicians reporting quality data would receive the full update under current law to their Medicare payments. Physicians not reporting would receive an update reduced by 2.0 percentage points.
- Beginning in 2008, a "quality pool" will be created consisting of a 1.0 percent reduction from the conversion factor for physicians who are reporting quality of care measures. These funds will be redistributed to those physicians based on attaining a certain threshold of quality performance or quality improvement. These thresholds would be determined by the Secretary. The quality pool will increase by 0.25 percentage points annually, so that available funds total 2 percent in 2012.
- Beginning in 2006, a comparative utilization system to measure resource use will be established based on claims data. Physicians will receive this information in 2006 and 2007 on a confidential basis as an educational tool so they can compare their resource use to other physicians.
- In 2007, there will be a shadow year to educate physicians on how they will be paid from the "quality pool" based on measures of quality including information from the comparative utilization system.
- In each year, the total amount of value-based awards will equal the total pool available for such awards. A majority of the pool will fund awards based on achieving a specified performance threshold.
- Beginning in 2008, the Secretary would establish a process to provide for the public reporting of data on quality of care in a manner that is understandable and usable to the public.
- The Secretary will implement a demonstration project to determine the level of information technology connectivity to improve coordination of care for physicians and practitioners in rural and frontier areas. The demonstration project will be conducted in six sites over a three year period.
- Sense of the Senate language regarding the scheduled reduction in payment amounts to physicians and non-physicians under the physician fee schedule.

TITLE IV – Value-Based Purchasing for Health Plans

Establishes a program to reward quality care among Medicare Advantage plans (not including MSA plans) by creating a payment pool that is distributed to plans meeting certain thresholds based on quality performance or performance improvement.

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- Beginning in 2009, a "quality pool" will be created consisting of 1 percent of payments to Medicare Advantage plans (not including MSA plans). These funds will be redistributed to plans based on obtaining a certain threshold of quality performance or quality improvement. These thresholds would be determined by the Secretary. The quality pool will increase by 0.25 percentage points annually, so that available funds total 2 percent of payments to plans in 2013 and subsequent years.

- By March 2009, the Secretary will notify individual plans of how their payments would have been affected had the value-based payment system been in effect in 2008.
- In each year, the total amount of value-based awards will equal the total pool available for such awards. A majority of the pool will fund awards based on achieving a specified performance threshold.
- Plans must use funds from the quality pool to support quality improvement initiatives or to enhance benefits.
- The Secretary would establish a process to provide for the public reporting of data on quality of care in a manner that is understandable and usable to the public.
- MedPAC study on advisability and feasibility of implementing a value-based purchasing program for Part D plans.

TITLE V – Value-Based Purchasing for Providers and Facilities to provide services to Medicare Beneficiaries with End-Stage Renal Disease.

Establishes a program to reward quality care among facilities and providers of services under the End Stage Renal Disease (ESRD) program by creating a payment pool that is distributed to facilities and providers meeting certain thresholds based on quality performance or performance improvement.

- Beginning in 2007, a "quality pool" will be created consisting of 1 percent of payments to ESRD facilities and providers. These funds will be redistributed to facilities and providers based on obtaining a certain threshold of quality performance or quality improvement. These thresholds would be determined by the Secretary. The quality pool will increase by 0.25 percentage points annually, so that available funds total 2 percent in 2011.
- In each year, the total amount of value-based awards will equal the total pool available for such awards. A majority of the pool will fund awards based on achieving a specified performance threshold.
- The legislation does not apply to facilities participating in the bundled case-mix demonstration program. The Secretary is instructed to develop a similar program for facilities and providers participating in the demonstration that will start in 2007. The quality pool will consist of 1.0 percent of payments in 2008 and increase to 1.25 percent in 2009.
- The Secretary would establish a process to provide for the public reporting of data on quality of care in a manner that is understandable and usable to the public.
- The Secretary will implement a demonstration project to increase public awareness about the factors that lead to chronic kidney disease, how to prevent it and how to treat it. The demonstration will be in three states over a three year period.
- Sense of the Senate language regarding the renal dialysis composite rate update for renal dialysis services.
- MedPAC study on the advisability and feasibility of developing value-based purchasing program for pediatric renal dialysis facilities.
- MedPAC study on the implementation of the ESRD provider and facility value-based purchasing program including a consideration of both the traditional fee-for-service experience and what can be learned from the bundled case-mix adjusted demonstration program.

TITLE VI – Value-Based Purchasing for Home Health Agencies

Establishes a program to reward quality care among home health agencies by providing higher Medicare payment to agencies reporting certain measures of quality care, and by creating a

payment pool that is distributed to agencies meeting certain thresholds based on quality performance or performance improvement.

- Beginning in 2007, home health agencies reporting quality data would receive the full update to their Medicare payments. Home health agencies not reporting would receive an update of 2.0 percentage points lower. Measures shall include process measures.
- Beginning in 2008, a "quality pool" will be created consisting of 1 percent of home health payments to facilities reporting data on quality of care. These funds will be redistributed to those facilities based on obtaining a certain threshold of quality performance or quality improvement. These thresholds would be determined by the Secretary. The quality pool will increase by 0.25 percentage points annually, so that available funds total 2 percent in 2012.
- In each year, the total amount of value-based awards will equal the total pool available for such awards. A majority of the pool will fund awards based on achieving a specified performance threshold.
- The Secretary would establish a process to provide for the public reporting of data on quality of care in a manner that is understandable and usable to the public.

TITLE VII – Value-Based Purchasing for Skilled Nursing Facilities (SNFs)
Establishes initial steps toward building a value-based purchasing program for skilled nursing facilities.

- Beginning in 2007, SNFs will be required to report data on functional status of residents at admission and discharge.
- The Secretary shall report by July 1, 2008 on quality measures for SNFs, including process and staffing measures.
- Beginning in 2009, skilled nursing facilities reporting quality data would receive the full update to their Medicare payments. Skilled Nursing Facilities not reporting would receive an update of 2.0 percentage points lower.
- MedPAC study on advisability and feasibility of developing value-based purchasing for SNFs.

TITLE VIII – Additional Provisions

Exception to Federal anti-kickback and Stark laws for Health Information Technology
Establishes exceptions to the Federal anti-kickback and Stark laws for entities that provide support for allowable health information technology products, systems, and services to providers for the purposes of improving health care quality.

National Health Information Network Pilot Program
Establishes a pilot project to facilitate the exchange of clinical, claims and outcomes data with respect to beneficiaries in the Medicare and Medicaid programs, particularly those individuals who are dually-eligible for these two programs, as well as clinical research findings and practice guidelines, for the purposes of improving health care quality. This program shall serve as the foundation for a nationwide health information exchange network dedicated to improving the quality and safety of care, reducing medical errors, increasing the appropriateness and efficiency of medical care, and reducing health care costs.

Health Care Value Project
Establishes a one year project to document, track, and quantify the value created, both in terms of patient outcomes and reduced expenditures under the Medicare Trust Funds, by delivering high-quality health care to individuals under the Medicare program.

- Sites shall include six sites that involve providers of services receiving reimbursement under the Medicare program.
- At each site, process engineers, health care providers, and activity-based cost accountants shall be involved in identifying and correcting system flaws and attaching real costs to health care outcomes.
- There are authorized to be appropriated such sums as are necessary to fund the implementation of this demonstration program. In addition, the Secretary could provide bonus payments to providers for achievement of savings to the Medicare program.

Demonstration Project on Data Aggregation Across Payors of Health Care Services
Directs the Secretary to establish a demonstration project to evaluate the process, costs, and benefits of aggregating data on quality of care across all payors of health care costs within health care delivery markets.

Study on the use of Telemedicine
Directs the Secretary to conduct a study to examine variation among state laws that relate to the licensure of physicians and practitioners, and to evaluate the costs and benefits of cooperation amongst state medical licensure boards to develop mechanisms where providers from out of state can deliver care via telemedicine devices in underserved and frontier areas.

GAO Studies and Reports on the Accuracy and Completeness of Data
Directs the GAO to study the accuracy and completeness of data submitted by participants in the value-based purchasing program.