



Committee On Finance

Max Baucus, Ranking Member

NEWS RELEASE

<http://finance.senate.gov>

For Immediate Release
Wednesday, June 23, 2004

Contact: Russ Sullivan
202-224-4515

Baucus Presses for Incentives to Improve Healthcare Quality within Medicare Programs *Senator Says New Legislation Will Help Curb Rising Costs and Improve Patient Care*

(WASHINGTON, D.C.) Today, U.S. Senator Max Baucus introduced, “The Medicare Quality Improvement Act of 2004”, which would build on the initiatives included in the Medicare bill to link payment with quality of care in the Medicare program.

Following the recommendations of MedPAC, the bill would establish a pay-for-performance system for Medicare Advantage and End Stage Renal Disease (ESRD) programs. Plans and providers delivering the highest quality care, as well as those who saw improved quality from one year to the next, would receive higher payments than those plans and providers that either were not high-quality and who did not improve.

“Giving healthcare providers a reason to make sure their service is top-notch will save taxpayer dollars in the long run,” Baucus said. “This legislation is a step towards raising the standard of care that Medicare beneficiaries receive.”

In addition to establishing new programs for Medicare Advantage and ESRD, the bill calls for a roadmap to creating pay-for-quality programs across all of Medicare.

The Medicare Quality Improvement Act will also allow more resources to be allocated to improve healthcare services in the Medicaid program. The legislation authorizes the hiring of five new personnel to work on quality improvement for Medicaid at the Centers for Medicare and Medicaid. It also looks at ways to improve quality of care and reduce costs for the dual-eligibles – those who are enrolled in both Medicare and Medicaid – many of whom represent the costliest beneficiaries in both programs.

“The United States has the most expensive health care system in the world, and our public programs should lead the way to providing high quality of health care,” said Baucus. “I believe this bill is a step in the right direction to ensure all receive good, affordable access to health care services.”

Full floor statement follows:

Statement of Senator Max Baucus
Introduction of the “Medicare Quality Improvement Act of 2004”
June 23, 2004

Mr. President, I rise today to introduce the “Medicare Quality Improvement Act of 2004.”

This bill will establish a new payment incentive structure for quality health care, starting with the Medicare Advantage and End Stage Renal Disease programs. Under this policy, Medicare would give a financial boost to plans and renal care providers demonstrating the highest quality care and a bonus to those that are working hard to improve.

Why focus on quality? I hear from all corners that the U.S. health care system is unsustainable in its current form. Costs are rising, and the care provided is not always appropriate or necessary. Not to mention that 43 million Americans lack health insurance.

As I travel around Montana, I hear so much from so many constituents about the rising cost of health care. Countless parents tell me they are struggling to pay for health care for their families, afraid that one more illness will force them into bankruptcy. Working people tell me they fear their employers will raise their premiums or drop coverage altogether due to rising health care costs. And employers, both large industries and small enterprises, tell me they face competition from companies in countries where healthcare is significantly less expensive. While these employers are trying to keep jobs at home, health care costs are pushing them abroad.

And most recently, my personal experience with the health care system has brought the issue of health costs and quality even closer to home.

A few weeks ago, I chose to have an elective procedure to keep my heart healthy. I have excellent health care coverage, and I was able to seek out excellent doctors and nurses at the Mayo Clinic. In short, I am fortunate that the care I received was high-quality care. The doctors and nurses who took care of me were on the ball – making sure I got the right medications with no dangerous interactions, using proper surgical safety so I wouldn’t get an infection, and providing good follow-up care so I could get back to my family and back to work.

My experience with the health system was a positive one. Unfortunately, not everyone is as lucky. Ninety-eight thousand people die every year in this country as a result of medical errors. That’s 270 people each day. An appalling statistic. Many of these deaths can be prevented, and we must work to make sure that they are.

In addition to the cases of medical error we know about, there are many that go unreported and even undetected. Studies have shown that patients in the U.S. receive recommended care and treatment when they visit the doctor or hospital only about half of the time. Failure to follow proper patterns of care or recommended guidelines can lead to poor outcomes, and it is also more expensive in the short and long run.

Errors can mean more trips to the hospital or to the doctor, more drugs, and sometimes even additional surgeries. Each preventable medication error costs about \$4,700 in added hospital costs alone, not to mention the personal costs of childcare and lost wages, and the societal costs of lost productivity.

While not as fatal as actual errors, missed health care opportunities also carry a cost. Each year, missed health care opportunities – inappropriate care and generally poor quality care – costs the U.S. health system more than \$1 billion dollars in avoidable hospital bills and 41 million lost work days, which costs American businesses about \$11.5 billion. Improving the quality of health care can reduce health care costs and stimulate our economy. In a time of slow economic growth and large deficits, health care is a compelling place to start.

Last year's Medicare Modernization Act got the ball rolling. The Medicare bill ties hospital reimbursement to reporting data on specific quality indicators. And hospitals are responding. Today, almost 2,000 hospitals are sharing data with the Centers for Medicare and Medicaid on at least one of the quality measures. Knowing more about the care that is delivered across the country should help us target incentives and resources to improve quality. It also provides employers and patients with new information about where to find the best deal for their health care dollar. And it also provides hospitals a way to compare their performance to other hospitals.

The bill I am introducing today builds on this strong start. It would establish a mechanism to pay for quality in the Medicare Advantage and End Stage Renal Disease Programs, through bonus payments for the best quality nationwide and bonuses for improving from one year to the next. Rewards for improvement are an important piece of my proposal – last year, the top ten percent of health plans in the country reported perfect scores on a set of quality indicators. There is no doubt that they deserve recognition. But we don't want to leave behind smaller or historically poorer-performing organizations that are making major strides to improve.

Medicare Advantage plans, which tend to utilize a coordinated model of care, have a unique opportunity to impact a patient's health outcomes – plans have access to information about a patient's medical history, and can follow patients more closely to ensure that they are receiving appropriate preventive, acute, and follow-up care. Medicare Advantage plans can translate their own payments into quality incentives downstream. They can reward providers for performing certain procedures known to be effective, or for prescribing drugs known to have equal or greater effectiveness at a reduced cost. And they can improve a beneficiary's preventive and wellness benefits.

Dialysis clinics that participate in Medicare through the program for patients with End Stage Renal Disease have a momentous mission, helping these patients enjoy life for years longer than we might have thought possible just a few decades ago. Because dialysis is such a complex operation, quality of care is extremely important.

Plans and providers in the Medicare Advantage and ESRD programs have already started measuring and reporting on quality, which makes them an excellent place to start. But I want to be clear – these programs should not be singled out simply because they are ahead of the game. Working with ESRD providers and Medicare Advantage plans heralds the beginning of a longer journey, and we need to stay the course.

First, we need to monitor this quality incentive program and ensure that the methods used to measure health care quality and evaluate performance are evidence-based and valid.

Second, we should evaluate the impact of a pay-for-performance program on health plans and providers – particularly small organizations and those that are just entering the market. Additionally, because last year's Medicare legislation made payment and policy changes to these providers – for example, a short-term payment increase for ESRD and a new payment policy and the addition of regional plans for Medicare Advantage – we would need to keep a close eye on the consequences of these changes and the interaction with the pay-for-performance quality initiative – and take action where necessary.

Third, we should look with a wide lens and move forward with quality initiatives in all government health care programs. It is our responsibility to set an example for the industry through quality improvement programs in Medicare and Medicaid, including traditional fee-for-service Medicare.

As I mentioned, the National Voluntary Hospital Reporting Initiative is a groundbreaking program, but we need to do more in traditional Medicare to encourage high quality care. My bill sketches out a roadmap that will lead us toward expanding the quality measures currently collected for fee-for-service providers, and ultimately toward additional Medicare payment systems that promote quality improvement.

We can also do more to focus on quality care in Medicaid. Today, there are a number of people at the Centers for Medicare and Medicaid Services whose responsibility it is to improve the quality of care in Medicare. On the Medicaid side, there is one person – one person who, while given the responsibility for quality, has no resources or authority to develop program innovations.

You might say that quality is already addressed in Medicaid. I applaud my colleague and Chairman of the Finance Committee, Senator Grassley, for encouraging CMS to increase its quality improvement activities for home and community-based services in Medicaid. We should build on this foundation and broaden the effort. We need to identify barriers to quality improvement throughout the Medicaid program, and take steps toward removing those barriers.

The bill I introduce today would target a few of those barriers, and it would require further studies to identify others. It authorizes money to hire new staff – experienced health professionals – to improve the quality and coordination of care delivered to Medicaid beneficiaries. It explores ways to integrate data on Medicaid beneficiaries who are also enrolled in Medicare – the dual-eligibles – and coordinate the care they receive from both programs. Many dual-eligibles are among the sickest and costliest beneficiaries. By better coordinating their care we can improve health outcomes and save money in both programs at once.

Mr. President, as you can tell, I have a lot of ideas. But I have only scratched the surface of this issue and am deeply committed to working with my colleagues in the Senate to move forward. This bill is a good start, but it is just that – a start. We must do more.

Many of my colleagues in the Senate also care deeply about improving the health care system, and I commend their efforts to develop courageous proposals that will spark change. Senator Clinton introduced a bill last year, the Health Information for Quality Improvement Act. More recently, Senator Kennedy Introduced the Health Care Modernization, Cost Reduction, and Quality Improvement Act.

These bills lay out a comprehensive array of policies to improve health care quality and reduce costs, and my bill focuses on one piece of that picture – paying for quality. They represent the gold standard toward which we should all be working. But we share a common goal – to make the most of the American health care dollar, so that we can provide better care to more people.

As I mentioned, health care in this country is more expensive than it is elsewhere. But we don't necessarily get more for our money. The United States spends twice as much on health care than any other country, but studies have shown that quality is about the same. Better in some areas, worse in others, but all in all about the same. No matter how you cut it, that means that the *value* of our health care – what we are getting for each dollar – is less in the United States than in other developed countries.

I've always believed that Americans were all about value. We are the country of start-up companies and the home of Wal-Mart. We know about good business, and we know about hard work. We should know more – and do more – about health care.

We are an amazing country, but today our health care system is sick. Why? It is not the fault of hard-working doctors and nurses who put in long hours to make their patients healthy. It is our fault. We need to support the work of health care professionals by providing the right resources and designing payment systems to promote quality. Today, it takes an average 17 years for a new discovery in medical care to move from the lab bench into regular clinical practice. And for providers working in settings without regular Internet access or without the luxury of time to peruse medical journals, it may take even longer. As Members of Congress, we have the opportunity to change the system, to provide incentives for good care, funding for research into best medical practices, and to require the development and reporting of quality measures.

The road to this goal is long and difficult. I call on my colleagues for their energy and support, and I call on health care professionals and the health insurance industry to work with us. This is challenging work, and involves many difficult decisions. But I've never been one to shirk a challenge, and I hope you will join me. This bill is the beginning of what must be a strong bipartisan push to improve our health care system – to increase quality of care, to reduce costs, and to strengthen the American spirit.

Thank you, Mr. President. I yield the floor.

###