COMMITTEE ON FINANCE
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Hearing Statement of Senator Max Baucus (D-Mont.)
On Turning Health Care Quality Measures into Real Results
As prepared for delivery

The American statistician W. Edwards Deming once said, “Quality is everyone's responsibility."

In 1999, the nation received a wakeup call about our health care system. The Institute of Medicine published a landmark report titled, “To Err is Human.”

It concluded that nearly 100,000 people die each year in hospitals due to preventable errors. That's more than die from motor vehicle accidents, breast cancer or AIDS. Americans were shocked.

High-quality care clearly needed to be more of a priority at every level: Medicare, Medicaid, insurance companies, doctors, hospitals and policymakers as well. Each group started focusing on quality.

The largest hospital accreditation group, the Joint Commission, required hospitals to report performance data.

Congress required Medicare providers to submit quality reports. Medicare created tools for beneficiaries to compare provider quality.

Hospital boards financially incentivized their leadership to improve quality.

We saw some early wins. Between 2001 and 2009, for example, central line IV infections dropped by more than half. This quality improvement saved $2 billion, and more importantly, 27,000 lives.

When we first started to focus on quality, we realized we had a long way to go. We began by requiring providers to simply report their data.

The Affordable Care Act moved Medicare to the next level – 2.0. Instead of paying just for reporting, Medicare now pays for results.

Under new programs, Medicare will pay hospitals and physicians providing high-quality care more than those providing low-quality care.

These health reform programs will move Medicare closer to a system built around the value and not the volume of care.

Let me provide a current example. From 2007 through 2011, nearly one in five Medicare patients admitted to the hospital returned within a month. For many of them, that readmission could have been avoided.

In the Affordable Care Act, we gave hospitals incentives to reduce avoidable readmissions. Hospitals responded. They made sure patients had follow-up visits. Doctors spent more time talking with patients about their discharge plans and answering questions. We are seeing results.

I'm proud to say that from 2007 to 2012, Montana's readmission rate fell by eleven percent – the largest reduction in the country.

And last year, Medicare saw 70,000 fewer beneficiaries readmitted to hospitals nationwide.

The Affordable Care Act also worked to increase quality in Medicare Advantage plans. The law gives bonuses to plans with high quality ratings. Seniors use these ratings to pick the best plan. And tying payments to performance has made plans focus more on quality.

Since the "To Err is Human" report, everyone has worked to improve quality. It is time for us to do a gut check. What has been most effective? What can we do better?

And what are the right measures of quality? It is astounding that we don't have agreement on how to calculate the risk of dying in a hospital.

Three different commonly-used measures of mortality produce different hospital rankings. So depending on the measure, a hospital could be at the top or bottom of the list.

Separately, Medicare uses 1,100 different measures in its quality reporting and payment programs. 1,100 measures. While we need to recognize the differences among providers, do we really need more than a thousand measures?

And that's just Medicare. Medicaid programs and dozens of commercial insurance companies all pay differently and run their own quality programs.

Providers are pulled in different directions by different payers. And they have a tough time finding the right way forward to higher quality.

So let us identify the key measures, develop them faster, and align these efforts across payers. Let us reduce the administrative burden on providers. We all have a stake in this. After all, quality is everyone's responsibility.

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