Committee On Finance

Max Baucus, Ranking Member

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Contact: Diana Birkett/Wendy Carey
202-224-4515

Statement of U.S. Senator Max Baucus
Floor Speech on Introduction of the *Medicare Value Purchasing Act of 2005*

Mr. President, I rise today to introduce the *Medicare Value Purchasing Act of 2005*.

This bill will establish a new program to link a portion of Medicare's reimbursement for health care services to the quality of that care. This bill takes a crucial step towards improving the value of our health care dollar as well as the safety and quality of our nation's health care system.

Last week, I gave a statement in this chamber about America's place in the world. I am proud of our nation; I am proud of our enterprising spirit, our energy, our diversity, and the hope for a better future that is inherent to our roots. I am proud of this country, but I am disappointed in the state of our health care system and in the impact it is having on the lives of our fellow citizens, as well as on the economy and ultimately on our place in the world. As I look to the future, I see a stronger America, but I know we must work hard to make sure that vision is realized.

We hear about the problem of increasing health care costs nearly every day – in newspaper headlines and in casual conversations. Per capita spending on health care in America is nearly 2½ times the average in the industrialized world. We spend over $5,000 per person on health care, and premiums for employer-sponsored coverage are rising five times faster than inflation.

With all this money going into health care, one might assume we had the best health care in the world. But that assumption is wrong. Despite spending more per capita than any other developed nation, the World Health Organization ranks the United States 37th in health care quality. As many as 98,000 patients die each year as a result of medical errors, and research has shown that in some cases more care, more specialists, and more treatments, actually result in worse outcomes for the patient.

Costs are rising, we are not getting high-quality care for the dollars spent, and due to the nature of our health care system much of this burden is born by employers. For the first time, the Big Three automakers are beginning to charge premiums and scale back benefits for their workers and retirees, because they can't afford the cost of health care. All told, GM estimates that they will spend about $6 billion on 2005 on health care. This translates into $1,525 for every vehicle they sell. That is more than the company spends on steel.

By comparison, Toyota's health care costs are about $1,000 less per vehicle. It is not surprising, therefore, that a recent survey of business leaders found that 65 percent of top Chief Financial Officers in the United States feel that it is very important for Congress to address the cost of health care. Their European and Asian counterparts did not cite the costs of health care among their top concerns.

No other industry tolerates the level of disrepair that can be found in the U.S. health care system today. Many of my colleagues in the Senate agree that in order to improve the system, we need to do more to control health costs through efficient purchasing and the use of health information technology. In other words, we need to create a "culture of efficiency" in health care.

How do we do that? First, we need to begin building a health information infrastructure that can reach providers and patients nationwide, from Manhattan, New York to Manhattan, Montana. We must take aggressive steps to establish standards and policies around this infrastructure, and to make initial investments in hardware, software, and training. I applaud my colleagues Senator Enzi and Senator Kennedy for introducing important legislation on this topic today, the *Health Information Technology and Quality Improvement Act of 2005.*

Building a Health Information Infrastructure will facilitate the provision of high-quality care. But we also must begin rewarding quality in the way we pay for health care. Today, Medicare payment policies typically do not include mechanisms designed to encourage quality of care. Medicare does not distinguish between paying for care that is necessary and that which might be unnecessary or inappropriate.

As a result, I worked with Senator Grassley to design a program that will tie a portion of Medicare reimbursement for hospitals, physicians, health plans, renal dialysis facilities, and home health agencies to the quality of care provided in these settings. Payment for these providers, as well as for Skilled Nursing Facilities, would also be linked to reporting data on quality of care and, after the first year of the program, to making this data available to the public.

The Medicare Value-Based Purchasing program would begin paying for *value* in the health care system – good care, better patient outcomes, evidence-based medicine, and increased transparency. We have learned a lot from programs such as this that have begun on a smaller scale in the private sector, and we hope that taking this step forward in Medicare will drive the entire health care system toward a system of high-quality, high-value health care.

But designing a program like this one is not easy, and I want to be clear on this point: I don't believe Congress should determine how the quality of health care is measured. That is why my bill sets up a system of stakeholder involvement at every step in the development and implementation of a Quality Measurement System for Medicare – in determining what measures of health care quality are appropriate for each provider group, in implementing a system of data collection and analysis, and in updating the measurement system in accordance with changing science. Providers, payers, patients, and many other groups are the key experts who should be involved in the details of a health care quality system – not Congress.

But it is our job to lay out some of the parameters for the system, and to provide the Secretary of Health and Human Services with the authority to follow them and create this new program. It is

also our job to oversee such a program once it is enacted and implemented. Over the last year or so, we have met with provider groups, consumer organizations, researchers and policy experts, and many of the individuals who have built and participated in private-sector programs to drive quality improvement in health care.

As I mentioned, our bill sets up a process by which a quality measurement system is developed in consultation with stakeholders and is uniquely tailored for the different groups of providers who participate in Medicare. This system should measure the quality of health care in a variety of ways, looking at processes of care, health information technology infrastructure, patient outcomes, patient experience of care, efficiency of resource use, and equity. For some groups of providers, only a very few measures of health care quality will be available when the program begins. These providers should not be penalized for that, but rather rewarded for reporting and improving the quality of the care they provide according to those measures. We may start small in some cases, but we can get the ball rolling.

The bill sets up a two-phase approach to quality improvement. In the first phase, the annual update to a provider's reimbursement is tied to reporting data on quality of care. This data would be on the measures included in the Medicare Quality Measurement System which has been developed by the Secretary with stakeholder involvement. Some providers – such as hospitals, Medicare Advantage Plans, and renal dialysis facilities, are already reporting data on quality of care to Medicare and might move more quickly to the second phase of the program.

In the second phase, those providers who report data on quality of care to the Secretary will be able to participate in value-based purchasing, where a portion of total payments to participants in each provider group is taken to form a quality pool. The funds in this pool are then reallocated to award providers who demonstrate high-quality care, or who show that they are improving. In theory, this sets up a system in which all providers could receive money back out of the pool – in essence it is a system that will "raise all boats." Following the recommendation of the Medicare Payment Advisory Commission, the portion of payments tied to quality in this second phase will be 1 percent in the first year of the program for each provider group, and will increase to 2 percent over five years.

In addition to setting up this program, the *Medicare Value Purchasing Act of 2005* includes additional measures to facilitate quality improvement in the health care system, such as a provision to reduce the legal barriers to health IT adoption that are present in the Federal anti-kickback and Stark laws.

It also includes several studies to look more closely at the true costs of health care, and the benefits – both human and financial – that can be gained from improving quality. The information generated by these studies will be critical in moving forward with value-based purchasing, allowing us to more accurately predict the program-wide savings from efforts to improve quality. Given that the Medicare Part A Trust Fund faces insolvency in 2020 – decades earlier than Social Security – identifying these savings will be critical to preserving access to care for Medicare beneficiaries and adequate reimbursement for providers.

Senator Grassley and I set out to write a bill that would address value-based purchasing, set up a system of measuring quality of care in Medicare, and encourage the adoption of health

information technology. We set out to write a bill that, in concert with the bill introduced by Senators Enzi and Kennedy would create a roadmap to a "culture of efficiency" in health care.

That means that our bill does not put new money on the table to reward health care quality, and it does not fix the problems that currently exist with the physician payment system or with reimbursement updates to renal dialysis facilities. But nor does it mean that we are blind to these issues. Indeed, I know that sustained cuts to the physician fee schedule, which will take effect if current law is not changed – are not sustainable.

I want to work with doctors to find a sustainable solution to the problems with the physician fee schedule and I want to work with the renal dialysis community to make sure that reimbursement is adequate so that facilities – especially those in underserved areas – can keep their doors open. But I also ask these providers to work with me to move Medicare in the right direction – ultimately, better quality and value means better health care, better coverage, and a stronger system for all.

Finally, I believe that quality improvement efforts should extend beyond Medicare, into the Medicaid and SCHIP programs, and into the private sector. Currently, programs at the state level have found ways to improve quality and find efficiencies through health information technology use in Medicaid. Our bill includes state government health program representatives in the process of developing the Quality Measurement System because we believe they have important perspective to share, and also because we believe that quality improvement policies are equally important for their programs. I look forward to working with Chairman Grassley on a bill to address quality of care in the Medicaid and SCHIP programs later this year.

I want to thank my colleagues Chairman Grassley, Chairman Enzi, and Senator Kennedy, as well as their able health care staff, for their tireless work on this legislation. We feel passionately about this issue because it matters to all of us. We all want to ensure that the best care possible is provided. We know how hard health care providers work for their patients, and we believe they should be rewarded for that work. And we believe this issue should be advanced in the Congress as soon as possible.

As I said, I have a vision of a stronger America. I envision a health care system in which quality and value are rewarded, in which innovative health information technology is accessible to all, in which data systems that can exchange crucial patient information to save lives and prevent mistakes, and in which American companies are not at a competitive disadvantage in the world because of health care costs. I call on my colleagues to support the important steps toward that vision that will be taken under the pieces of this legislation introduced today.

Mr. President, I request that the text of this bill be printed in the Record. Thank you. I yield the floor.

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