TESTIMONY BEFORE THE

SENATE COMMITTEE ON FINANCE

ON

IMPROVING QUALITY IN MEDICARE: THE ROLE OF VALUE-BASED PURCHASING

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Mr. Chairman and members of the committee my name is Byron Thames. I am a physician and a member of AARP's Board of Directors. Thank you for inviting us to testify on the need to link health care payments to quality performance.

Linking Medicare payment to the quality of care beneficiaries receive is a critical step for our nation's health care system. Towards that end, AARP strongly supports the Medicare Value Purchasing Act (S. 1356) sponsored by Chairman Grassley and Senator Baucus. We believe this legislation lays out an appropriate and reasonable framework for achieving vitally needed quality improvement in the U. S. health care system.

America spends more per capita on health care than any other nation in the world. Yet we have a health care system in which preventable hospital-based medical errors cause an estimated 98,000 deaths each year and patients receive recommended health care services only about half the time. Clearly, we are not getting our money's worth.

We can no longer simply pay the bills for health care without using those payments as an incentive to improve the quality of care. The time has come to improve our approach to paying doctors, hospitals, and other Medicare providers. Offering rewards for high quality, quality improvement, and use of health information technology (HIT) simply makes good sense.

Overview of the Quality Challenge

In its 2001 landmark study, *Crossing the Quality Chasm*, the Institute of Medicine found that, "Between the health care we have and the care we could have lies not just a gap, but a chasm." Although the Agency for Healthcare Research and Quality's 2004 annual assessment of the nation's quality of care found improvement in many areas, "the gap between the best possible care and actual care remains large."

There is abundant evidence of quality problems in the U.S. health care system. Experts at the Institute of Medicine (IOM) and elsewhere have described these problems as:

- *underuse of services*, where patients do not receive the care and services they require;
- *overuse*, where patients receive care for which the harm of receiving a particular treatment outweighs its benefits; and
- *misuse*, where medical mistakes, such as avoidable complications, put patients in jeopardy of injury or death.

According to the IOM, preventable adverse events are a leading cause of death in the U.S. On average, Americans only receive slightly over half of recommended care. In addition, researchers have found deficiencies in quality among persons over age 65 across several dimensions of geriatric care. Vulnerable individuals needlessly suffer from malnutrition, pressure ulcers, falls and mobility disorders, and urinary incontinence because they do not receive recommended care.

Moreover, findings from the National Healthcare Disparities Report indicate that disparities in health care are found among racial, ethnic, and socioeconomic groups in the U.S.

African Americans received poorer quality care than Caucasians for about two-thirds of the reported measures. Similarly, Hispanics had worse access to care than non-Hispanic whites for about 90 percent of access measures in the report.

Quality problems are found in all health care settings – such as hospitals, physician offices, and nursing homes – and they occur regardless of payer. Thus, quality problems are found in private plans, the Federal Employees Health Benefits Program, Medicare, and Medicaid. People across the entire life span are affected – young children, workers, boomers, and Medicare beneficiaries.

Clearly, there is a human cost to poor health care quality, but there is also an economic cost. In 2002, health spending in the U.S. was 14.6 percent of our gross domestic product. Switzerland and Germany are the only other nations that spent more than 10 percent of their GDP on health care and both of these countries have a national system of health care for their citizens.

The U.S. is a clear outlier and spends more per capita than any other country. Consumers are feeling the burden of escalating health care costs. Health insurance premiums continue to increase at rates considerably higher than general inflation. In 2004, premiums for employer-provided health insurance rose by 11.2 percent, exceeding the general inflation rate by almost 9 percent. In Medicare, the Part B premium grew 17.5 percent between 2004 and 2005 due in large part to reimbursement increases for providers.

However, spending more on health care does not necessarily yield better results. Medicare beneficiaries who live in higher-spending parts of the U.S. receive more care than those in lower-spending areas, but they do not have better health outcomes or greater satisfaction with care.

Finally, in addition to concerns about quality and cost, we must also recognize the failure of our system to establish access to coverage for all. The absence of universal coverage for individuals under age 65 requires immediate attention. The failure to ensure access to coverage for all Americans inevitably will hamper efforts to improve care and contain health care costs.

Overcoming the Challenges

The concerns enumerated above paint a bleak picture and help to underscore the compelling case for rapid improvement. Although it will be an enormous challenge, there is growing consensus on a course of action to encourage better quality. This multi-pronged approach combines:

- public reporting of standardized quality measures;
- promoting internal quality improvement;
- realigning payment policies; and
- promoting health information technology (HIT), which is an integral component in each of the above areas.

Meaningful progress toward the successful achievement of this strategy can only be made if all affected stakeholders, including providers, health plans, purchasers, researchers, and consumers, work together to accomplish shared objectives. The National Quality Forum (NQF) currently facilitates such collaboration and its diverse membership is becoming increasingly aware of the importance and value of participating on a consensus-driven body.

Standardized Measures

The NQF has articulated a standardized framework for identifying consensus standards to advance quality improvement. A guiding principle of the framework is that common performance measures should be useful in helping consumers make health care choices about their coverage options, providers, and treatments, *and also* helpful to providers in improving the delivery of care.

In order to minimize burden, the measure set selected should be as concise as possible while addressing the six quality issues or "domains" identified by the Institute of Medicine, including:

- patient safety;
- clinical effectiveness;
- patient-experience;
- equity;
- efficiency; and
- timeliness.

Although significant progress in the field of quality measurement is being made, much of the information needed to better assess the health care system is still lacking. There remains an inconsistent patchwork of information to assess quality and to support improvement efforts. A robust measurement effort that yields standardized, reliable, and objective data is essential.

That is why AARP is very pleased that the Medicare Value Purchasing Act charges the Secretary of Health and Human Services with selecting evidence-based measures of quality that will assess the processes and structures of health care delivery, and patient experience, as well. Selection of these measures should be informed by the deliberations and recommendations of a consensus body like the NQF.

Realigning Payment Policies

Current Medicare payment policies do not support better performance, and in fact reward poor performance with additional payment. Physicians, hospitals, and other institutional providers are now paid whether or not they provide good care. In fact, a hospital, for example, is paid more if it does not prevent a preventable, life-threatening infection because longer stays and more serious conditions automatically place patients in higher payment categories.

The Medicare Payment Advisory Commission has advised Congress that the Medicare program cannot afford for Medicare payments to remain neutral about quality. We agree.

Experience in the private sector as well as CMS' own hospital and physician demonstration projects are beginning to show that rewarding quality can improve results. Most of these reward programs target hospitals, physicians, and health plans and have been initiated by health plans, purchasing coalitions, and employers who purchase coverage for their employees.

In 2004, 35 health plans had some type of program to reward physician performance, and major Fortune 100 companies have participated in the *Bridges to Excellence* and other programs that pay bonuses to doctors for good performance in several dimensions of care. We expect these kinds of programs to proliferate, and we are pleased that this legislation will lay the groundwork for similar activities in Medicare across all health care settings.

It is appropriate and entirely consistent with its history as an innovator of payment methodologies for Medicare to also be a leader in the effort to improve care through redesigned payment policies. We believe that the approach taken in the Medicare Value Purchasing Act to reward both the attainment of good performance as well as quality improvement is the correct one.

Offering all players the opportunity to benefit from financial rewards for better care stands a better chance of success than other approaches.

We agree that the Medicare Value Purchasing Act provision to require data collection as a first step, without financial consequence, is sensible and will allow providers time to gain experience and confidence in the new payment system. However, financial consequences are crucial to changing provider behavior, and we support moving to pay for performance on an aggressive timetable.

Importance of Health Information Technology (HIT)

We agree that measurement should include assessing the capacity of providers to use health information technology (HIT) in providing care because the use of these systems can directly affect the quality of care. HIT can improve quality by:

- giving clinicians decision support that reminds them to conduct tests and treatments based on evidenced-based guidelines;
- helping providers monitor their patients' progress;
- providing timely reports of laboratory and x-ray results;
- reducing errors by improving the accuracy and legibility of patient records;
- enhancing coordination by facilitating shared use of records; and,
- expediting access to medical information and scientific advancements.

Patients also see benefits from HIT through:

- secure email communications with their clinicians;
- rapid access to test results;
- access to their own health records so they can be more engaged in their own care, which is particularly helpful for people with chronic conditions; and
- the convenience of on-line appointments.

Ultimately all of these changes will contribute to better health outcomes.

Finally, HIT can help promote quality improvement by easily and efficiently capturing information that will enable us to use medical encounter data to:

- measure and benchmark performance;
- design interventions for improvement;
- promote public accountability; and
- realign payment methods.

Ultimately, we expect that HIT will lead to greater efficiency and the elimination of wasteful services. Of course, we understand that there are major challenges to overcome, including:

- the cost of HIT acquisition and adoption;
- the lack of "interoperable" standards that allow different systems to communicate effectively;
- the absence of a common nomenclature or standards for data aggregation, storage, and communication; and
- provider and practitioner resistance to these changes.

But we believe that the Medicare Value Purchasing Act is a step towards addressing these and other challenges.

Privacy and Other Concerns

Patients must be assured that "consumer-centric" care standards will be implemented to permit a focus on patient outcomes. We must also recognize that many consumers may be suspicious of the "connectivity" that comes with HIT in the health care setting, and the threat to privacy this may pose.

Therefore, a standardized health information infrastructure that will ensure the protection and security of patient information is absolutely critical.

AARP also agrees that the new payment policies should be implemented without further burdening the Medicare Trust Funds. Medicare beneficiaries deserve the highest quality care from the current level of investment. Using existing funds will provide the necessary incentives to hasten improvement and to ensure that beneficiaries get the high quality care they deserve.

Learning As We Go Forward

There will be many lessons to learn as Medicare embarks in a new direction. It will be critically important to evaluate progress, measure, and publicly report on performance and make mid-course corrections as needed. We note that the Agency for Healthcare Research and Quality (AHRQ) has commissioned a review of the randomized controlled trials on the effectiveness of different "quality-based purchasing" initiatives. Based on the evidence reviewed, the study found that very little is known about the effects of pay-for-performance initiatives on clinical performance, because most of the existing initiatives were not designed as research projects.

Nevertheless, there is much to be learned from the many natural experiments that are underway in which results are very encouraging. It is clear that much more research is needed to better understand the conceptual and theoretical factors that affect performance and that will foster desired behaviors in clinicians and patients. We encourage Congress to ensure that AHRQ is adequately funded to pursue this research as well as continue its work in developing and testing new quality measures to ensure that there will be a robust, comprehensive set of tools suitable for assessing health care at all levels of the health care system.

In conclusion, we want to reiterate our strong support for the sensible and fair-minded approach you have identified in the Medicare Value Purchasing Act. AARP stresses the urgent need to improve quality. Medicare program resources must be used to obtain real value for the dollars spent for care. The measures selected to assess and reward performance should be well accepted measures that providers will find actionable and useful in their improvement efforts. These measures must also be clinically important and publicly available to consumers to inform decision making.

Measuring and reporting are part of a continuing process of improvement that should be part of the fabric of health services delivery and incorporated into the business model of every clinician and health institution and organization. AARP believes the enactment of the Medicare Value Purchasing Act will point us in the right direction to achieve this goal.