U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
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Statement of Sen. Chuck Grassley
Upon Introduction of the *Medicare Value Purchasing Act* of 2005
Thursday, June 30, 2005

Mr. President, I am pleased to join Senator Baucus in introducing the *Medicare Value Purchasing (MVP) Act of 2005*. Senator Baucus shares my strong commitment to ensuring the vitality of the Medicare program for generations of beneficiaries to come. Two years ago, we worked in a bipartisan manner to establish the first ever Medicare prescription drug benefit, to create new coverage choices under the Medicare Advantage program, and to cover more preventive screening tests. The Medicare Modernization Act transformed Medicare benefits and choices.

Over the past 40 years, Medicare has made immeasurable differences in the lives of our nation's seniors and disabled citizens by providing beneficiaries with access to care. The bill that we are introducing today will ensure that they continue not only to have that access, but also have access to good care. Some folks might think I am saying that beneficiaries don't receive good care today. Nothing could be further from the truth. I know that physicians, hospitals, nurses and other providers across the country work every day to provide quality care. But just like all Medicare beneficiaries have the same benefits, all Medicare beneficiaries should get the highest quality care possible. And today, that's just not the case; there is tremendous room for improvement.

A May 2005 Commonwealth Fund review of more than four hundred studies and data sets painted a mixed picture on the quality of care received by Medicare beneficiaries. The analysis found that many improvements are occurring – breast cancer screening rates have tripled and many patients with diabetes get the tests they need to keep them healthy. At the same time, the review showed that in some parts of the country, beneficiaries get recommended treatments, such as immunizations, but in other parts they don't. They found that improvements in care for Medicare beneficiaries have not kept pace with improvements among other groups. For example, between 1988 and 1994, the percentage of forty-five year olds to sixty-four year olds whose blood pressure was controlled increased from 33 percent to 40 percent. Among Medicare beneficiaries, it stayed the same – just 24 percent. They also zeroed in on the need to strengthen programs to care for beneficiaries with a chronic illness. Research shows that twenty percent of Medicare beneficiaries have five or more chronic illnesses. Caring for these beneficiaries accounts for nearly 70 percent of Medicare spending.

One of the study's most disturbing findings was that states with higher spending per Medicare beneficiary tended to rank lower on twenty-two quality of care indicators. According to the researchers, this might reflect practice patterns that favor intensive, costly care rather than "effective" care. Simply stated, spending more does not necessarily translate into better quality care for beneficiaries. Of the 300 billion Medicare dollars spent last year, I think it's safe to say that in many cases we – beneficiaries and taxpayers – did not get the absolute best value. Not even close.

Why is that the case? In part, it's because of the way we pay for care. I am sure that everyone remembers "To Err is Human" in which the Institute of Medicine reported the startling fact that studies suggest that up to 98,000 Americans die in hospitals each year from medical errors. It was in headlines for months.

I would bet that not as many folks know about the IOM's follow up report, "Crossing the Quality Chasm." In my opinion, that report is equally, if not more, important because it sets forth a wide-ranging strategy to address the deficiencies in our health care system that undermine the delivery of high quality care. Among the IOM's chief recommendations was a call to both public and private purchasers to examine their current payment methods to remove barriers that currently impede quality improvement, and to build stronger incentives for quality enhancement.

The IOM specifically recommended that payment methods should provide "fair payment for good clinical management." Providers also need to be able to share in the benefits of quality improvement. Consumers and purchasers need opportunities to recognize quality differences and to use quality information when making health care decisions. In simplest terms, we need to better align financial incentives to help promote quality and to achieve better value. The Medicare Payment Advisory Commission (MedPAC) has issued similar recommendations.

Today, Medicare pays the same amount regardless of quality of care. Some people would argue that in fact, the current Medicare payment system rewards poor quality. For example, if a patient suffers a complication from subpar hospital care and ends up back in the same hospital to treat that complication, Medicare will pay the hospital for the patient's rehospitalization. On the other hand, if a hospital follows best practices of care and helps patients avoid complications that could require a rehospitalization, well, that hospital doesn't get anything. The hospital that provides lower quality care to the beneficiary gets another payment. The hospital that provides higher quality care to the beneficiary gets nothing.

Over time, this perverse situation could disadvantage the hospital that delivers higher quality care to beneficiaries because it will get less revenue, which could compromise its ability to compete against other hospitals. This situation just doesn't make sense to me, nor should it to beneficiaries. Providing lower quality care can lead to greater revenue, while providing higher quality care can penalize providers financially. It's the exact opposite of what we want and need for Medicare and beneficiaries. Of course, our nation is blessed with millions of dedicated and qualified health care providers who care deeply about the quality of care they provide to their patients. What we have is a systemic failure of Medicare payment systems to reward quality and provide the incentives to invest more in health care information technology and other efforts to improve health care quality. This bill creates the financial incentives that reward those providers who deliver that quality care today, and to those who make improvements where they are needed.

The MVP Act seeks to remedy this situation and to implement the IOM's and MedPAC's recommendations by creating quality payments under Medicare for physicians and other providers, hospitals, health plans, skilled nursing facilities, home health, and end stage renal disease facilities. Senator Baucus and I know that it's a pretty ambitious strategy. We also recognize that this substantial departure from current payment practices cannot and should not happen overnight. Careful consideration of which quality measures that the Centers for Medicare and Medicaid Services (CMS) should use in making quality-based payments will take some time. Providers will play a significant role in determining which measures to use. This is important – we need to make sure that the measures are valid and reliable. In addition, providers will need some time to become

more proficient in collecting and reporting quality data for payment purposes.

The MVP Act builds on the small step made in the MMA which established reporting incentives in its early years. Under the MMA, hospitals that report ten quality measures receive a full payment update; those that don't report receive a smaller update. This approach has been successful. In 2005, 99 percent of hospitals reported the data and CMS has seen improvements in quality among the participating hospitals. Under the MVP Act, using the data from these reporting years, CMS will give providers an idea of where they stand on quality before quality payments will begin. This will allow providers the chance to fine-tune their quality practices and data reporting capabilities before payments will be determined based on a specific provider's quality measures.

For each provider group and facility, as well as Medicare Advantage plans under our legislation, CMS will then begin to make quality payments from a pool that initially will equal one percent of their Medicare payments. Over five years, quality payments will increase to two percent of total payments. Payments will be awarded for meeting performance thresholds and to those that demonstrate a level of improvement specified by CMS. This approach recognizes that we need to offer incentives to a broad base of providers – providers who perform well today deserve recognition; those that might not be performing well, but have improved also should be recognized. Finally, CMS will report publicly on how various providers, facilities, and plans do with respect to quality. This information will help empower beneficiaries when making their health care decisions and when making informed choices.

Our bill recognizes that the private sector has made a lot of progress in developing and adopting quality measures. There are several value-based purchasing projects under way around the country. We don't want to reinvent the wheel – we want to build on these initiatives. These private projects, along with its own projects, can help inform the Centers for Medicare and Medicaid Services (CMS) as it works out technical details to implement quality-based payments using the framework established by the MVP Act.

This framework is consistent with the thinking of CMS on quality-based payments as expressed by Administrator Mark McClellan. It also is consistent with principles endorsed today by more than twenty of the nation's leading consumer, employer, and labor organizations. In announcing the principles, Peter Lee, president and CEO of the Pacific Business Group on Health and co-chair of the Consumer-Purchaser *Disclosure Project* stated, "We must move beyond a system that is performance-blind to one that rewards better quality and gives consumers tools to make informed choices."

Now some folks may think that Medicare shouldn't take on this issue – that it might be better for the private sector to do it alone. I respectfully disagree with that view. Medicare is the single largest purchaser of health care in the nation. The IOM in "Leadership by Example" expressed its opinion that federal government health care programs can significantly influence how care is provided by the private sector. The Commonwealth Fund researchers share this view – that adopting quality payments in Medicare can influence the level of quality in all health care, not just care for the elderly.

And there's a lot of health care to be influenced. Our nation spent $1.8 trillion on health care last year. Health care spending is expected to reach more than 15 percent of the gross domestic product. But just like in Medicare, we are not always getting the best value for those dollars. That $1.8 trillion in spending translated to a 37th place ranking for the United States compared to other countries

around the world in quality according to the World Health Organization (WHO). Spending more and more money without achieving commensurate improvements in quality is simply wasteful and unsustainable.

Mr. President, Medicare is just one month shy of its fortieth anniversary – a tremendous milestone. It has positively affected the lives of millions of seniors and disabled citizens. We set a goal for ourselves forty years ago – to improve access to care. Providers and policy makers came together to make that goal a reality. It's time for a new goal, a new challenge – to ensure that Medicare beneficiaries and all Americans get the best possible care and that as a nation, we get the highest value for our health care dollars. The MVP Act of 2005 provides us with a road map to live up to that challenge. I urge my colleagues to join me and Senator Baucus in advancing this important legislation.