

FEDERATION OF AMERICAN HOSPITALS

ANNUAL CONFERENCE

**REMARKS OF
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MEDICAID SERVICES**

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BREAKFAST SESSION

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VICTOR CAMPBELL (Chairman, Federation of American Hospitals):

It is a real pleasure to be able to introduce Mark. He is the administrator of the Centers for Medicare and Medicaid Services. He was sworn in March 2004. We all know he is in charge of one of the largest organizations in the world, clearly the largest healthcare entity in the world, the second largest budget outlay – good news, bad news – responsible for a whole lot of money, and insure 25 percent of the U.S. population.

Mark has a great history, great background; great experience. He was commissioner of the Food and Drug Administration. One time I was really worried they wouldn't let him out of there to come over here to do this important job, and fortunately they did.

He was a senior policy director for healthcare and related economic issues at the president's council of economic advisors. He is on leave from Stanford University. He was associate professor of economics and medicine there. He has published on all kinds of issues, and I encourage you to read them, although he is so much smarter than me I don't understand most of it. But still, read it. It's good stuff.

He has received lots of awards, a degree from Harvard, MIT, health science and technology, Ph.D. in economics at MIT – as I said, one smart man. And he is the proud father – most importantly in my mind – of twin daughters. I really want you to give him a warm welcome. Mark McClellan.

(Applause.)

DR. MARK B. MCCLELLAN: Vic, thank you for that introduction. Chip, all of you who are here this morning, it's good to be back with you. I look forward to these breakfasts because you do get some unique comments and unique perspectives on healthcare issues. And, Vic, just to let you know, I do have some pictures of those pictures of my daughters that I carry around. I don't have a copy of this classic – (chuckles) – brochure.

CHARLES N. (“CHIP”) KAHN: But you can carry it now.

DR. MCCLELLAN: Yeah, yeah. Thanks, Chip.

While we are on the topic of my daughters, it has been an interesting – you know, living in Washington is a great place to raise kids. They get exposed to a lot of very interesting perspectives, and this has been a particularly interesting year in the McClellan household.

As some of you may know, my mother is actually running for governor of Texas right now as an Independent. And yesterday it was a big day for her; it was the Texas

primary, which she was not in as an Independent, but that is when she can start collecting signatures to get on the ballot and they are already on their way to making that happen.

Well, we are on the mailing list for the campaigns, you know, one of those family things you do I guess when you have got politicians in the family. And a few weeks ago we got sort of the latest note from the campaign about how things are going, and of course this got attached to it. Since you all, many of you all are involved in these fundraising issues, you know how this works – a little tear-off sheet at the end where you put in your name and address and other information and how much you want to contribute.

Well, one of my seven-year-old daughters got a hold of that, read through the whole thing, thought this sounded pretty good and filled it out. You know, put in her name, her address, and everything else – got down to the checkbox, where, you know, how much you want to contribute. There was a checkbox for – she checked off the \$100 box and then put in parenthesis underneath, “Mom will pay.” (Laughter.) You know how to – I guess associations may work that way sometimes, too. (Laughter.)

Well, it is a pleasure to be here with all of you as I said. This is a – turn to a little bit more serious note, this is a very important time, and I’m please to see so many people here this morning – very important time for issues related to hospital care and quality. Vic mentioned some of the work that I had done in academics before coming into government, which seems a long time ago and very far away, but some of that work did involve for-profit hospitals.

And Dan Kessler, my co-author, who is still at Stanford University and still working on many of these issues in competitiveness, has done a lot of work since showing the impact that the entry and competition from a for-profit hospital can have on improving quality and lowering costs. It has a real disciplining effect on the market, and that is the kind of quality improvement and cost reduction that we want to promote in our policies in government.

You hear some about this from Al Hubbard yesterday. Al has a very clear way of making his views known. Transparency can only help with competition and competition has been one of the main ways in which for-profit hospitals have really made a contribution to improving quality of care, and that some of the things that I want to talk about this morning. You know, I will leave plenty of time for questions I hope about specific issues of bad debt and payment updates just to make sure I understand what your feelings are about specialty hospitals.

But I want to talk about some broader issues related to quality of care right now because this is such an important time, and thanks to your leadership, we can really make some important further progress in getting better care to patients at a lower cost. The federation’s members have been innovators in healthcare delivery, and we need to keep seeing that, and we need to keep supporting that now more than ever as we are facing the

need to find better ways to prevent complications, keep costs down while still giving patients access to the most innovative are possible.

So I want to talk a little bit about a basic concept which is what many of our policies in CMS are driving towards right now, and that concept is that we ought to be providing better support for care that prevents complications and keeps costs down. I know you all talk very often to Herb Kuhn, who is here with us this morning. He doesn't get much time off but he wanted to come see you all today. He is working on many of these issues, on of our key-point people in the agency on it.

So I hope you will not only come to talk to him about your complaints about the wage and acts and reclassifications and bad debt and so forth, but also he is a great point person on these quality improvement issues.

So we are working hard to focus on providing better financial support for treatments and services that make a difference instead of paying more for poor care that leads to more complications. Now, this kind of approach might sound like basic common sense and what you would expect somebody like me to come up and say something like that. But as you know, this is not the way things work often in the healthcare field; it's the way things work very often outside of healthcare, but today in healthcare we are not often paying for the care that we really value.

In Medicare for 40 years we focused on paying the bills without really taking into account whether what we are buying improves beneficiaries' health. And when we spend over \$300 billion a year – you heard we are the largest healthcare payer in the world, currently the largest payer in the United States, how we spend the money really matters. We ought to be spending the money in a way that enables and supports you in your – and your health professional staffs in finding better ways to get the best treatments to patients at the lowest costs, and getting the right care to the right patient every time. And we are very committed to doing more of that.

My background, as I mentioned earlier, as you heard earlier, I'm an economist as well as a physician, and one of the things you learn in economics is that you get what you pay for. Most Medicare spending today goes to paying for complications of common chronic diseases. It goes to paying for the additional costs associated when care is not well coordinated or when doctors, working with other professionals and hospitals and in the hand-offs to post-acute care and the like, don't do things right. We pay more in all of those cases.

In many of these cases, they are complications, duplication of services or use of services that we ought to be able to prevent. So it's no surprise that these kinds of costs are contributing to healthcare cost increases. By paying in many cases for volume and not value, we are endorsing duplicative services, we are endorsing missed opportunities to coordinate care, we are endorsing the use of treatments of often questionable value, we are endorsing delays in innovation to help patients stay well and help them get the care they need at the lowest costs.

And we see this around the country every day. We are seeing the impact in the substantial variations in treatment that persist around the United States that are not associated with better outcomes. We see it in the increasing number of employers who find it too expensive to continue to offer healthcare coverage. We are seeing this happen at a time when medical science has greater potential to improve health than ever before. It is a time that we need to be doing more than ever to support better care.

So that is why we have a real sense of urgency about transforming the way that we pay for care, and I think that is some of the – it's that urgency that is driving some of what you heard from Al Hubbard yesterday.

So how do you get better value at a lower cost? Well, we can keep tinkering with our current payment system, and I'm sure we will. We will have a lot of discussion, as we always do, about whether it should be a specific change in bad debt policy or post-acute care reimbursement and the like. But if we keep simply paying more for more volume, and that includes increased volume of more intensive inpatient and outpatient procedures. It includes more intensive post-acute care – if we keep moving just in that direction then clearly Medicare is not going to be financially sustainable.

On the other hand, if we just do the old approach of simply reducing payment rates, reducing them too much when costs go up, that has a real impact too; that is going to have a real impact on access to care. It is a no-win situation.

There is a better way. The way to get higher quality health at a lower – higher quality healthcare at a lower cost is to support providers better when they improve the quality of their care. That is what competition should be about. You know this can work because you're out there competing every day. It means paying more when we get better results.

You all have been involved in leading a lot of these efforts, and I particularly want to give some praise to the Hospital Quality Alliance that Chip has been instrumental and many of you have been instrumental in leading and supporting. It has been at the leading edge of this movement from the first 10 measure of quality that were incorporated into legislation and the Medicare modernization act, to the Hospital Compare Website that we now have up and running with information on just about every hospital in the country, to the further steps that are being taken to expand the quality measures available on hospitals.

We have come a long way in just a few years thanks to your leadership. The reason this has worked is leadership plus collaboration. This has been a model public-private partnership with people who are actually working, actually getting the job done, like you all, every day in the healthcare field. Hospitals, government agencies, quality experts, purchasers, consumer groups, many healthcare organizations have developed a shared national strategy for hospital quality measurement, and a shared commitment which they have demonstrated that the need for advancing the quality of care.

And we are seeing results. If the data are there, if the financial support is there, then better health outcomes will come. We have seen this in the improvements in performance on the quality measures that have been reported just in the – just over the past year. We have seen early very promising evidence from the premier hospital pay-for-performance-demonstration program where we are seeing real improvement in the five targeted clinical areas in that pay-for-performance-demonstration program where just limited additional financial incentives have been sufficient to drive across the board improvements in quality of care, both the high end and low end performing hospitals.

We have seen these improvements lead to better quality, fewer complications, and lower costs of care. That is what we want to support. That is the way out of this no-win situation of either rising volume of services of questionable value in some cases or excessive reductions in payment rates.

Now, healthcare professionals know that the gap between what we know and what we do in medicine remains large, even in the best healthcare system in the world, and that is why we are working hard to take the ideas, to take the approach that you all have helped lead and translate it into more substantial, more transforming improvements in quality of care, and in the efficiency of our healthcare system.

As we move forward, we need to keep focused on effectiveness and efficiency, working together to improve the measurement, improve our ability to support high quality efficient care and improve our ability to implement these changes. Groundbreaking work like this calls for commitments that are not business as usual. It is not easy; I want to acknowledge that but again I want to thank you for helping us lead the way. Each and every one of you deserves a tremendous amount of gratitude for your contributions to make our healthcare system work better.

In addition to the work that hospitals has done, I want to highlight that they are not alone in this. Throughout our agency, we are supporting efforts that are moving in the same kind of direction. Just to mention a few of these briefly, in our Medicare fee-for-service program, we are now supporting pilot programs and demonstrations that will be increasingly widely use that switch the way that we pay to support better quality and lower overall costs.

A couple of examples of this, and I'm sure some of you are familiar with, our Medicare health support pilot program, which Herb's group is leading, has made available additional benefits to our fee-for-service beneficiaries with chronic conditions like heart failure and diabetes. This program involves organizations that specialize in disease management, care management, and the support of better coordinated care for chronically ill individuals.

It includes services like visiting nurses going to see high-risk patients for early intervention to keep them out of the hospital room with complications; it involves things like phone help lines for beneficiary education, use of electronic and personal health

records to help coordinate care between a physician's plan of care, a patient's understanding of that care and the actual execution with the other health professionals involved in that patient's care.

These are all kinds of services that until now made a lot of sense in healthcare but didn't make financial sense because under Medicare's volume-based payment systems, if a physician or group worked together to implement these kinds of innovations, we would end up paying them less. You know, if you keep your patient well, out of the doctors office, avoiding duplicative services, avoided complications, we would pay less. That is not the way it ought to work; it is not the way it is working in this program.

These organizations get paid and they only get paid as contingency basis if they improve quality of care, if they improve patient and physician satisfaction, and if they lower total cost of care. Within that framework they have a lot of flexibility in how they do it. It is promoting innovation; it is promoting steps to lead to better quality of care at a lower costs, and we are seeing services come into Medicare that achieve that we didn't have before.

We have a high-cost beneficiary demonstration where for some of our highest-risk beneficiaries, we are making available services a pilot basis like home visits from physicians or new electronic technologies that enable a patient at high risk to be monitored remotely so that there can be early and effective intervention if that patient's health status is deteriorating and you detect it early before they show up at the emergency room. Again, we are paying when these organizations get better quality results at a lower cost. We are paying in that case and only in that case. And we are seeing the way that Medicare beneficiaries are treated be transformed.

We are changing the way that we pay physicians. We started pilot programs for a physician reimbursement. For example, our physician group practice demonstration program where we are paying large groups. They get the usual Medicare fee schedule, but then they get additional payments if they improve quality of care and keep overall costs down for their patients. I hope you see a pattern here. And in these cases too we are seeing more investments by the physician groups and electronic records in building better coordination with the hospitals that they use frequently so that patients don't bounce back as much or don't have as many complications. We are seeing an impact.

The same thing is happening in our support for Medicare advantage plans, the health plans in the Medicare program that are more widely available than ever before. We now have HMOs, PPOs, fee-for-service programs, we have got probably HSA or MSA-type plans coming to Medicare as well. These plans are being reimbursed with what is called risk adjustment – you are probably familiar with this – which basically means that the new money that is going into the Medicare advantage program is going to the plans that attract and retain beneficiaries who are expected to have high costs. Why? Because that is where the opportunities are for the biggest savings and the biggest quality improvements.

And so we are seeing increasing the Medicare advantage plans take steps like including disease and care management programs or adding extra prescription drug benefits or adding other benefits that help attract these kinds of beneficiaries. We even have got Medicare advantage plans now that specialize in the most frail and high-cost beneficiaries, those with needs for nursing home level of care. There is even a plan that specializes in HIV/AIDS patients. It is a different model for the way that Medicare should work.

We are taking other steps and implementing competitive bidding programs in Medicare, something you are going to see more of. We're doing it now for prescription, for part-B covered drugs delivered in physician offices. It is going to be expanded soon to durable medical equipment. Here we get out of the business of setting prices and we rely on competition with good measures of quality and performance to assure that people are getting high level of service to help us deliver services more efficiently. Competitive bidding is going to be coming more broadly to Medicare programs as well. And we want to bring these same kinds of steps to other areas that are closer to some of the activities that you are directly involved.

In the Deficit Reduction Act, there is a provision for a post-acute payment reform demonstration. This is the demonstration program. I think it's very important. I hope you all work closely with us in implementing that will involve a single comprehensive assessment on the date of discharge to start that post-acute episode of care that the determination of the patient's needs when then be the primary determinant of how that beneficiary is going to get paid for their post-acute care, not which kind of facility they happen to go to after they are discharged, but what the patient's needs actually are.

Put more control in the hands of the patient and the physicians who are – and healthcare professionals and healthcare organizations that are taking care of them so they can then decide themselves the most efficient way, the most high-quality way for that patient to be treated. That is coming soon.

We also look forward to your input and participation in the Medicare gain-sharing demonstrations. This was another provision of the deficit-reduction act just implemented, which highlights something I think should be obvious that when physicians and hospitals work together, they can find ways to deliver higher quality care at a lower overall cost, and that is what we need to be promoting.

There is some concerns about physicians gaining from financial benefits of lowering overall costs. I am confident that we can work together to find a way to implement this program effectively to assure that we are getting what we want, which is higher quality and lower overall cost of care by recognizing that if we support financially doctors and hospitals working together well we are going to get better healthcare. So we need your input on that demonstration as well.

So these are just some examples of how we are trying to change the way that we pay, including areas like getting hospital and physician payments to work more effectively together.

The common goal of all of these projects is the fundamental change that will lead to substantial improvements in care without unnecessary healthcare costs and hopefully with avoiding a significant amount of the costs in our healthcare system now. We are looking for ways to bring these efforts even more closely together. I have given you a whole catalogue of areas, and I want to talk about a few areas where we would like to see some more collaborative work with you building on the successes so far.

One of these involves, as I just mentioned, making sure that our overall support for improved quality and lower costs doesn't silo hospitals and physicians and other types of care providers. You know you all have great approaches to working effectively together. We would like to find effective ways to reinforce that in our payment systems.

For example, I know that the HQA leadership has been talking with a newer group, the Ambulatory Care Quality Alliance, which in many ways was modeled on the success, the initial success of the HQA to take the same kinds of ideas into the ambulatory and physician care setting. Well, what we have found in working with the AQA on support for improving physician care, for identifying and providing better support for high-quality physician care is that physician care doesn't often work well if it is not coordinated well with other aspects of hospital services. A lot of the most intensive, costly, and important physician services are delivered in your institutions.

So we really shouldn't be looking at the AQA activities in isolation from the HQA activities. I'm glad that the leadership of both organizations has recognized that and that they are going to start working even more effectively together. We fully support those efforts.

Another area where we want to see more involvement in working with you has to do with efficiency. I know you have heard about this and helping consumer price shop and think about the costs of your services. And you all are absolutely right that in good part there are some important things that insurers can do to help support price shopping and getting the best quality at the lowest cost and working with the insurers and healthcare payers and purchasers more generally on those kinds of issues.

There are a lot of interests from business payers as well in this area. But I do think you all need to stay very closely involved in the development of efficiency measures, and I hope that is going to be a more prominent and active and fast-moving part of HQA activities as it is with AQA. And the reason is that the kinds of things that you all can help us do in constructing ways of thinking about resource use and efficiency will shape how this effort progresses.

It is one thing for an insurer to publish a price list of what the physician fee is and what the hospital per diem is or the Medicare DRG is; it's another thing to help

consumers get a really good understanding of the overall costs of care that they are going to face.

What the consumer really cares about, what a patient cares about when they are getting – making a decision about where they should get their knee replacement done isn't just the specific bill for the physician or the specific daily charge for the hospital; it's the overall cost of that whole episode of care, and that involves not just the price list but the practices of your hospitals and the physicians who work with them: how many lab tests they are going to order, how long the person is going to stay in the hospital, what kind of rehab they are going to get and the costs associated with that, what the follow-up care is going to look like; how intensive it is, how likely the patient is to get readmitted with a complication.

All of those things influence the overall costs of care as well as the quality for that matter. So it really doesn't make sense for the HQA and all of you who are helping us lead this effort to shifting the focus to better quality and lower costs – it really doesn't make sense for you to sit on the sidelines as we talk about efficiency and resource use. I want your help in constructing the right level, or the right approach to these episode measures of care, which we need sooner rather than later. That is what I think patients really care about, and without your involvement, we are going to be less likely to capture accurately just what your organizations can do to help patients get care that is more efficient overall, and I know there is a lot they can do.

A third issue I want to talk about is some of our payments in areas for – in areas of medical complications and things that generally we don't think we should be paying for. I have talked about the problems that our payment systems create when we pay more for care that is less coordinated, when we pay more when patients have complications of care. There are some things, if you look closely, that we pay for now that shouldn't be happening at all. These are things like wrong-site surgery. It's rare but it happens and we pay for it.

And it also extends to more commonly occurring problems and care like nosocomial infections. If you listen to the hospital quality improvement efforts, the leaders of groups like Don Burwick at IHI and others, these events shouldn't be happening, yet we are paying more when they do. We need to take a close look at whether that is the right way to organize our payment systems or if there are better approaches to dealing with these so-called never events.

So these are some of the areas where I hope we can work closely together in the near future. Now, I want to pick up on one other approach to getting better quality at a lower cost, and that is something you have heard a lot from Al yesterday and Roy Ranthum about strengthening the role of the consumer working with healthcare providers to get better care at a lower cost.

Thanks in part to your support, health savings accounts and other features of consumer-directed healthcare are really taking off in this country. I think it makes a lot

of sense for many people in getting their health insurance – maybe not everyone and that is why we are taking some other – we are also improving our Medicaid programs and Medicare programs and other ways. But HSAs, and consumer-directed care more generally, are a very important and should be a very important part of the healthcare landscape.

As we are entering an era when the right treatments for the right patient are increasingly personalized, you can't depend on a Medicare payment schedule to match up the right treatment for the right patient each and every time. We have got to have more effective physician and patient involvement. With this in mind, the availability of measures of quality and the availability of measures of costs of care are very important to supporting the kinds of decisions that your institutions are designed to help promote, decisions that get the right care to the right patient each time.

We need empower patients and that is what is behind the urgency or what Al Hubbard and Roy Ranthum and others have been talking to you about. I think with the measure of development in quality of care, the measure of development in efficiency of care that I have already talked about that is progressing rapidly, we will be able to make tremendous progress here in a limited period of time.

Again, thanks to your leadership, we are not just looking at a limited number clinical measures of quality for hospitals any more; in the not-too-distant future we are going to have widespread information available and a broad number of key dimensions of patient satisfaction of care, complications related to care, like surgical complication rates, even outcome measures, as well as more clinical measures. It is going to be a much richer environment to support effective decision-making by individual patients and doctors.

Efficiency measures need to be a part of that as well. And I would encourage you again with the spirit of collaborating with the AQA, we recently announced with the Ambulatory Care Quality Alliance and the Agency for Healthcare Research and Quality, and a number of business purchaser groups, and a number of health professional groups led by the physician organizations six pilot sites around the country where we will be collaborating by combining Medicare data with business purchaser and other information to make available valid measures of quality of care and efficiency of care on the ambulatory – on key aspects of ambulatory care delivered in the six geographic regions.

We would like – I think it would make great sense to include more hospital care in those efforts as well. People are really going to role up their sleeves – business purchasers, government representatives, and especially healthcare industry leaders are going to role up their sleeves and find the right way to do this on the ambulatory side. Let's do it on the hospital side as well and show how we really can together support effective decision-making by individual patients working with their physicians.

So these are some key areas where I think we can and should build on the tremendous progress that you all have already made. In the short term 2006 is going to

be a year for substantial progress in the development of quality and cost measures in all settings and across all settings of care.

We will be continuing to seek your input and your partnership in making these programs work. And I hope in the months ahead we will be able to put a lot of effort into these programs that can lead to better quality of care, lower costs of care, and get us out of this no-win box of trying to pay adequately for a higher and higher volume of services rather than trying to support the innovation, the insight, the more effective ways of delivering healthcare to patients who really need it, that your organizations and your association has been so instrumental in making happen. Thank you all very much for this opportunity to talk with you.

(Applause.)

I would be happy to take some questions.

MR. KAHN: Yeah, you always do. Let me take the first one and then other people can take over. But one of the privileges of sitting here is I'm close to the microphone and I will grab it.

Over the last few years, and particularly with the Hospital Quality Alliance and the federation and the other hospital groups, have been working collaboratively, and I think we have made progress, and you have outlined an ambitious agenda, and we are more than happy to cooperate with that.

The problem that I think we need to cope with, though, as we proceed is that we want Medicare to pay for the right thing and pay for it the right way. But the problem is that when you do things by regulation, it tends to be a blunt-edged sword.

DR. MCCLELLAN: Mm-hmm. Right.

MR. KAHN: And there are two areas that I guess I would like to point to and get your thoughts about. First, you are going to consider from all of the sort of talk in April a significant change in the DRGs, and we understand the importance of more fine-tuned payment, more appropriate payment. But what we are concerned about is this kind of change is sort of a blunt-edged sword when it's done overall, when it affects everything. We are talking about basically going from 500 DRGs to really a different system if we go to APR DRGs.

So rather than simply talk about the health policy of whether or not they should be more finely tuned, the question is, is this change going to materially make things better for the payer, the provider, and the patient. And I think we need to really collaborate as you think through this.

And let me give you another example of something that is already outstanding that I think is a good example of this blunt-edged side. In the LTAC proposed regulation,

which I guess comments are due March 20th, you basically, to sort of carry the analogy, are using a blunt-edged sword to eviscerate a whole modality as it now stands.

And we can argue back and forth about at what stage it is appropriate for LTACs to come into play. But I think to use regulatory power in the way that it's implicit in this proposed reg sets a terrible precedent. Obviously it has an effect on LTACs but it sets a precedent for everyone to think, gee, are they going to come in and say you literally can't do things without sort of going through a collaborative effort to determine what is good and what is bad and what ought to be changed.

So with that sort of in light – and also I think with the recognition that over the next couple of years we are going to see a lot of tumult on the other side of Pennsylvania Avenue and probably not much action. And you're where the action is going to be down at the Humphrey Building. And we want to be collaborative in these changes, but we're just real concerned and there is just – you know, we can sort of at the edges have a discussion about transparency but this is where the rubber hits the road in terms of the literal survivor of the ability of providers to offer the services Medicare beneficiaries expect and want from us.

And we really need to work together on these as whether – as these broader efforts where we have already been collaborating. So I just thought I'd laid that all out.

DR. MCCLELLAN: All right. Thanks, Chip. And obviously we do – just because my remarks focused on these big-picture and a very urgent and real efforts to get to better systems for understanding what we are paying for and helping patients and doctors and all of you deliver more effective care at a lower costs, these other issues related to our DRG payments and other payment systems are extremely important and a major area of focus as well.

And a lot of Herb's staff is spending just as much if not more time thinking through how we get the DRG system to work as effectively as possible, how we deal with LTAC payment issues. But I do want to emphasize that it's part of this larger context. So let me tie both of these issues that Chip mentioned back to the bigger context of our wanting to pay for the right care for each payment in these areas as well.

With respect to the DRG refinements that you have been hearing about and that we are going to be talking about publicly a lot more, especially after the proposed in-patient rule comes out very soon, what is driving a lot of that is concerns about the accuracy of our payments leading to some of the issues that you all have rightly raised about specialty hospitals.

And if I can just spend a side minute on specialty hospitals, we have been watching very carefully to make sure that the moratorium that is in place now is a real and effective moratorium. That is what led to some very strong action in that Oregon case. And I want to be very clear in public about if there are any other violations,

especially if there any violations that may have some safety concerns attached to them, we are going to act promptly and effectively.

This moratorium is in place though while we refine our policies. We have gotten a lot of guidance on that from Congress as a result of the Deficit Reduction Act. So we will be issuing in weeks ahead a proposed report as we are directed to do by Congress and then a file report on how we are going to make further changes in how we deal with the specialty hospitals to make sure that they are working effectively to help improve care and lower costs and give patients more options for high-quality care rather than what I think some of the real and legitimates concerns are that they are skimming patients, they are contributing to problems in access to care.

As part of that, one of the areas where MedPAC and others have strongly recommended changes is in the way that the DRGs work. And this gets to Chip's point that there is clear evidence that our current DRG payment system does not pay accurately for many types of admissions and that is because we aren't taking account of the acuity of severity of disease for patients as well as we could in ways that could lead to reducing or eliminating the improper incentives that often face specialty hospitals today. And it also has to do with the way that we base DRGs on charges rather than costs.

So certain DRGs end up being more profitable because they happen to involve a high level of the ancillary cost centers that have high cost-to-charge markups. So both in terms of the DRG refinements, in terms of the patient severity and in terms of looking at ways to better account for the actual cost variations across DRGs or areas where we are going to be asking for a lot of public comment in the proposed rule. And while we do need to move promptly on these payment refinements to get them done right, we don't want to move so promptly that we don't get effective input from all of you on implementing them effectively.

So I would encourage you – I know you will – to take a quick look at that regulation when it comes out and then get in to see us. And there are – we're open for comment. We will be open for comment on all of these issues – you know, how we can best take account of the complexity of patients, how we can best take account of the fact that costs may not be accurate – cost variation may not be accurately captured across DRGs, how we can – how fast we should be moving on these kinds of refinements on our payment system.

All of that will be subject to comment beginning with the proposed regulation coming out and continuing as we discuss our report to Congress on some other changes that we want to make and Congress asked us to look at transparency about specialty hospitals, about a whole host of other issues involving specialty hospitals as well, and we want your comments on all of those.

With respect to the LTAC we are proposing some significant changes in the proposed LTAC rule, and here while we definitely want your comments on the specific changes, I would ask you to take a step back and take this broader focus. What we now

in Medicare is post-acute payments that are growing very rapidly, double-digit rates, and that includes not just LTACs but a number of other post-acute settings of care: inpatient rehab facilities on down the line.

Post-acute care is an extremely important part of healthcare today. It is going to be even more important in the future as more patients are undergoing procedures including elected procedures as more patients have more opportunities because of changes in the way that care is delivered to get out of the hospital faster and to get their follow up care in a more appropriate setting. That is all to the good and that is something that we want to fully support.

What concerns me is the fact that we have now a multiplicity of payment systems that are more tied to where you happen to be than what the clinical needs of an individual patient is. And that is why I mentioned that post-acute payment demonstration earlier. So what I think is the best way forward on this for us is we will be looking at your specific comments on the LTAC rule and definitely taking those into account before any final action, but let's really work as hard and as quickly as we can on getting to more patient-focused post-acute payment systems.

In the Deficit Reduction Act in Medicaid we're getting there. The deficit reduction act included a change in the way that Medicaid pays for long-term care needs for patients with a disability. Instead of having an entitlement is the case for 40 years in Medicaid to getting care in a nursing home, now there is much more flexibility in the Medicaid program and much more federal support for giving patients with a disability the financial support they need regardless of the setting they choose.

What that is going to lead to I predict is many more people getting care in settings other than nursing homes. Nursing homes are great for people that need it but there are a lot of people with a disability who would like to live in the community or who could modify their home or get home care services at a lower cost than what institutional care would cost them, and we now have a change in the payment system that is going to make that possible.

We need to be making the same kind of progress as quickly as possible in our post-acute payment systems and Medicare otherwise we are going to be in that box I was talking about earlier: when the spending on post-acute care, including LTAC is going up at rapid double-digit rates that is not sustainable for the program. There has got to be a better way for us to support the needed enhancements in post-acute care for our beneficiaries and we look forward to working with you on that.

MR. KAHN: I have never seen this group so quiet.

Charlie.

Q: Charlie Alan (sp) president of Triumph an, LTAC company. And Chip started the question so I will continue to finish it. In order to be together with you in the future

to discuss the post-acute evaluation and all of those types of things, we have to survive until then, the LTAC companies.

And I think our evaluation of the reg that has been proposed is that it doesn't give us the chance to survive to get there, especially on the short-stay patients. And so that is our real concern. It seems to be counter to our own analysis of the data and what we think really happens in our hospitals: We don't want to take them early; we don't want to take patients that aren't sick; we want to have the high-acuity patients.

But it doesn't seem like we have been in a conversation about dealing with that issue, so just a few more comments on how to we get together to talk about that issue before the new system comes into place?

DR. MCCLELLAN: Well, definitely send in your comments. We want to see the economic analysis and make sure that we got the impact right. When we did our preliminary impact analysis in the proposed rule, no questioning that there is a financial impact, but underlying some of the work that we did was what we thought was a recognition that some of the patients now being treated in LTACs have been, and in many parts of the country are today being treated overwhelming in other settings of care at a much lower cost, and so that factored into our analysis as well.

Where we got it wrong we want to hear about it and we'll definitely take that into account before the final rule. Again, I would encourage keeping the focus on the patient. You know, how do we get our payment systems lined up to provide the right level of financial support for a patient's needs. So as you know, in the LTAC rule, some of the payment reforms that we proposed, we are looking specifically at patients who did not have other complicating conditions, were getting single-joint replacement, which has been a big part of the growth in LTACs in certain specific geographic areas – not in other parts of the country, but in certain specific geographic areas where there seem to be pretty clear evidence that appropriate payments were at a lower level – were working well in getting those patients the post-acute care that they needed.

But we definitely want your input on that, and I do want to highlight that we are going to be paying a lot of attention to these post-acute care reform issues in the year ahead. So do work with Chip to – and directly with us and Herb's group to make sure you get those comments in.

MR. KHAN: Maybe I'll ask another question. Yesterday obviously at our meeting, Al Hubbard spoke and there was a lot of discussion about transparency. And on the quality side, we really do have a field of play. The Hospital Quality Alliance, which plays out in hospital compare –

DR. MCCLELLAN: Yeah, there has been tremendous leadership?

MR. KHAN: And we are really moving down the road.

DR. MCCLELLAN: Exactly.

MR. KAHN: In a sense there we helped develop it but we know where the football field is. Barring legislation, which even though they may be discussion about, I really don't expect soon this voluntary notion that comes out of what Al is talking about. Where is the football field? Who are we supposed to deal with and what do you see as the role HHS or the secretary or CMS is likely to play because obviously in terms of getting together to talk about some kind of transparency we actually have constraints about that because you get into antitrust issues almost immediately. So where is the football field for this discussion?

DR. MCCLELLAN: Well, just to start this, we are – we have been directed by Congress to build that football field in the Deficit Reduction Act. There was a lot of discussion about expansion of the quality measures that will be a basis for our update payments to include efficiency measures – very explicitly included there. Just to go back to my remarks earlier, we want your help in building the way that these measures are constructed.

I see this as having several main components. And, you know, Al highlighted the fact that we need to get price information out, including information on out-of-pocket costs. That is something that can be led in good part by insurers and by healthcare purchasers. The business groups around the country – and I highlighted these six pilot areas where we really are lining up together to make that information available hopefully in a very consistent way. We are doing it on a pilot basis because we want to make sure we build the football field the right way and one that can be replicated and is going to be very useful for consumers.

Much of that information can come from the insurers, the business payers and public payers like us. However, I do think there needs to be leadership from the hospital industry in the concept of efficiency measures just as there has been in quality measures. And I talked some in my remarks about where I think you all can particularly help us get this right, and add some thinking about the overall bottom line that patients care about, this overall episode-of-care notion.

I don't know if he mentioned it in his remarks yesterday, but in some of our discussions, Al has talked about the example of LASIK surgery, where instead of having to look up the specific lab tests and pre-op evaluations that are done, and the payment rates for each of those services, and then the payment rates for the post-op visit and the anesthesia charge and the lab charges and the ASC charge that will all be associated with that procedure, patients get one price – you know one bottom-line cost estimate for what they are going to pay for this overall package of services.

We need to be providing more help in getting people to the point where they can think about how a specific fee for a hospital or a specific fee for a doctor or a lab test or an anesthesiologist really add up to the overall costs that they are going to be paying for

the care that they get and that is an area where I think that you all can really help us conceptualize this the right way.

You did this for many of the quality measures. We have constructed now a broad set of measures that go beyond just whether or not a specific treatment is provided to thinking more about the overall care that a patient is receiving, whether it's in satisfaction or complication rates, or any of these other areas where we have made tremendous progress.

So that is part of the field that I think you all need to help us build specifically even as we are working very closely with insurers and business group purchasers in the private sector on the payment kinds of measures. Herb Kuhn and his group for the important work you've done on the access to IVIG therapy for Medicare beneficiaries. We have a long ways to go but thank you very much. We appreciate it.

DR. MCCLELLAN: Well, thanks. That's a good example of where the dialogue works. When you all identify problems, the sooner you bring it to us, the better. Herb and his team are – they're very busy but they try to be very responsive on all these specific issues as well.

Q: Dr. Bob Hendler, regional chief medical officer with Tenet. You mentioned developing – or working on physician practices being an integral part of being able to tell people what the price is for a given procedure, et cetera. It's really clear that – and you've expressed publicly that – I'm going to misquote you here, but that you really feel the physician should be held accountable for best practice, and yet, for example, we're seeing right now, as an example, to clarify this, some private insurers are saying if you don't stage cancer properly by doing 12 nodes for colon cancer, you're not going to be in our preferred provider network, so you're out.

What I'm seeing, working with a large number of physicians in Texas, is that there is a real strong sense of accountability coming from the private sector but no sense of responsibility or accountability coming from CMS. Now, we know it's coming but I can't seem to convince them what is coming. And I do believe – and I think everybody in the room knows it – that if physicians were really interested in their profiles and how to be efficient and have high quality to be in some special group, you'd move things along a lot quicker. So my question to you is – I know you want to do this, but I'm really curious how you're going to put CMS accountability at the physician level in place.

DR. MCCLELLAN: Good question, and by accountability I think you mean the ability to document and understand what we're getting for the money that we're putting into physician services. Another way of putting this is that doctors have – on a more positive side, many doctors have a lot of good ideas about how they could deliver better care at a lower cost but we don't support that right now in our current fee-based payment systems. Instead we're hitting – we're facing the usual problem of increased volume and lower payment rates. So we're trying to reform that as a basis for accountability. You need measurement. Unless you know what it is that we're getting – what is it we're

trying to improve, it's hard for physicians to do it, it's hard for us to support it. And so that's a key of accountability as well.

Following on the model with HQA there is now a broad effort to develop consensus measures of physician quality for a broad range of physician specialties for most of the kinds of services provided to Medicare beneficiaries. The AMA is now working closely with us on that. Many other medical specialty groups have been involved with this even longer – the American College of Physicians, American Academy of Family Physicians, many of the specialty groups, many of the surgical groups. You know, they were writing me last year saying, look, higher volume services for us generally means lower quality. We need to get out of this payment system. And when we do care right, the patients are coming to see us less. They're staying in the hospital a shorter period of time, and that's exactly what you don't pay for in Medicare right now.

So there is a lot of support, just as there has been for the HQA, in developing the measures that can be a basis for accountability. You may announce they've got something like 90 measures – the HQA has already endorsed a broad set of measures and there is now broad specialty participation to expand that. For cancer care, we have a demonstration program running right now where we are – as a step towards accountability – paying more when physicians report on whether or not they followed evidence-based practice guidelines in their treatment of Medicare beneficiaries with cancer. That program is getting off the ground right now. It's a 2006 program and seems to be working, at least in getting us better information on what exactly we're paying for when, you know, all this money is going out the door for cancer care and a foundation for providing better support for getting more patients the best evidence-based treatments.

So this is a process but it's one where I think – just as I talked today about a lot of the rapid progress on the hospital side, you're also going to see a lot of rapid progress in 2006 on the physician's side. And this is something that Congress strongly supports as well. In the discussion about physician updates there is a lot of input from leading members of Congress about the need for this kind of accountability and real progress on quality measurement so we can better support higher quality care for physicians.

And finally, this intersects very closely with the efforts that we're undertaking on hospital quality improvement because, as I've said, you can't get real improvement in hospital quality unless – you can't get as much unless physicians and health professionals are really being supported and moved in the same kind of direction. It doesn't make sense for us to silo one set of hospital-quality measures over here and be doing something completely different in our efforts to support better quality from the physicians who are practicing in the hospitals. So we need to work with you on bringing these HQA and AQA and hospital and physician efforts more closely together.

Q: And I will tell you, I'm a big fan of what you're doing because I think the outside is going to make this happen, not within the hospital or the medical staff.

DR. MCCLELLAN: Yeah.

Q: My last comment, though, is that while this is all going on, the level of awareness in American physicians is very low, and I really do think it's important that somehow you project that out of this is coming; it is in your best interest; what's in it for you to get onboard and to control length of stay, multiple procedures, over-consultation – all the things that we seen endemic in care that really doesn't provide you any benefit.

DR. MCCLELLAN: I agree with you completely on that, and we're trying to do a lot more local outreach efforts to support that, and hopefully that's another area where we can work with all of you.

Q: Time for one more? I'm Susan van Gelder with the federation. I hope this question doesn't sound too much in the weeds, but as we talk about the Hospital Quality Alliance expanding, we know more and more measures will come out, and we're working hard to do that, and you're talking about what makes a lot of sense: integrating the AQA measures so that we don't have them siloed; they're integrated. And all of this takes a huge number of processes and systems for the data to be housed and collected and validated and processed, and I just

wondered what sort of resources CMS is thinking about in terms of building that structure, or how is that all going to come about to make this work?

DR. MCCLELLAN: Well, it's a very good question. For one thing, we're very glad you're paying Chip so much money – (laughter) – so he can support these efforts.

On the CMS side, we have – (cross talk) -- on the CMS side we have expanded our efforts to support quality measure development. In the agency, initially a lot of these quality efforts were done in a kind of a smaller group in our Office of Clinical Standards and Quality. And Trent Haywood and Barry Straube and the leadership of our OCSQ was still very much involved in this effort. It is really the main thing that they're working on, along with better evidence development. But that's not the only place this is all happening. I gave you a laundry list of demonstration programs that we're implementing in a coordinated way as the main focus of our research and demonstration program efforts today, and – and think is something I think is really fairly new – this is built into our Center for Medicare Management now.

So on Herb's staff there are people who are spending a lot of their time because it's a key part of their job description to work on supporting the development and the implementation of quality measures and financial systems that help support better quality and greater efficiencies. Some of you may know Dr. Tom Valek (sp), for example, who has been working on a lot of these efforts primarily on the physicians' side as well as others. Herb's staff on the hospital side have been working on implementing the Hospital Compare website and the appropriate methods for updating the payments. And we're also building in programs like Medicare Health Support, where we move entirely to paying for quality – in Medicare Health Support we're paying for what we want for really the first time ever. We're paying for better quality and lower overall costs of care, and that's what we ought to be aiming for, and is increasingly getting built in to CMM (ph) as well.

And as you heard yesterday from Al, these efforts to promote better measurement and better ability to support quality care and decisions by patients – to get to better quality of care at a lower cost – is a top priority for the White House as well. So there will be more efforts in this area. You know, dollars are always scarce. It's a tight budget time, but this is one of our top priorities and I'm very pleased with how much Herb's staff and the rest of the agency staff have stepped up to move it forward.

And I want to thank you all for the time today. You know, these breakfasts are always entertaining and stimulating – I think probably the high point of my day. I hope you've enjoyed the discussion too. Thank you all very much. Thank you.

(Applause.)

MR. CAMPBELL: Ladies and gentlemen, we are now adjourned. See you at the next meeting. Thank you.

(END)