

Day 2 Keynote Gail Wilensky

Samuel Chris Haffer:

I'd like to introduce Dr. Tom Valuck from CMS. Tom is the medical officer and senior advisor in the Center for Medicare Management. He also recently led the CMS special program office on value-based purchasing.

Tom Valuck:

Thank you, Chris. Good morning. My work in implementation of pay-for-performance for Medicare's fee-for-service payment systems, particularly positions in hospitals, is why Chris asked me to introduce the topic and the speaker this morning on Medicare pay-for-performance.

My motivation for attending this conference on Medicare Advantage quality measurement and performance assessment was to better understand not only what is being done to measure and improve quality and efficiency within Parts C and D, but also to connect and apply that learning to our work in Parts A and B. And I don't need to remind you of the importance and urgency of our work in health quality: it's really a matter of life and death. We see the headlines nearly every day. This morning, when I got up and turned on my computer and looked at the BNA daily news health policy report, the first headline was, "Medical errors cost Medicare 8.8 billion, resulting in 238,377 potentially preventable events." This was over a three-year time period using the AHRQ PSI indicators. And the headline went on to say, "Top-performing hospitals have 43 percent lower incidence rate compared with poorest performers." So clearly we have a lot of work to do. We've made progress, but much that we can do together.

So CMS is focusing on quality of care for Medicare beneficiaries, and one of our primary goals is to align the quality measurement efforts across all parts of the program -- A, B, C, and D -- and looking at various levels of accountability. We've been primarily talking about plan-level accountability here at this conference, but we also need to be thinking together about provider-level accountability and align measures across plans and providers for episodes of care that will generate the kind of information we need, not only for accountability, but also for transparency to provide information for better decision-making for consumers of health care and their caregivers.

Quality measurement data can also be used for performance-based payment, which is the topic of our next presentation. And there is no better speaker to address Medicare payment incentives than Dr. Gail Wilensky. When Chris called me to discuss speakers for this topic given my experience in Parts A and B, I immediately agreed with him that Dr. Wilensky would provide the ideal presentation if he could get her, and he got her, so kudos to Chris.

I've followed Dr. Wilensky's work since she was the HCFA administrator, but became personally acquainted with her when I was a Robert Wood Johnson health policy fellow in '98 and '99. I can't believe it's ten years ago now, but it is. Gail's a true friend of the fellowship. She devoted a whole day to our orientation and spent portions of other days

schooling us in Medicare payment policy, and actually is one of the reasons why I was motivated to join the Medicare program and public service. And we've also served on a couple of panels together since that time on Medicare performance-based payment over the last few years.

Gail has a stellar bio. She's an economist and a senior fellow at Project HOPE. She's a commissioner on the World Health Organization's Commission on the Social Determinants of Health. She's co-chair of the Department of Defense Taskforce on the Future of Military Health Care and vice-chair of the Maryland Health Care Commission. So a very product person, and again, we're very honored to have her here today. From 1990 to '92, she was administrator of HCFA, the Health Care Financing Administration, CMS's predecessor. She also served as a deputy assistant to the first President Bush for policy development, advising him on health and welfare issues from 1992 to '93. She's an elected member of the Institute of Medicine and has served two terms on its governing council, and she recently served as a member of the IoM's panel on rewarding provider performance, aligning incentives in Medicare, and was co-chair of the pay-for-performance subcommittee for that report.

Gail, it's a real privilege to have you here today. Please join me in welcoming Dr. Gail Wilensky.

[applause]

Gail Wilensky:

Thank you. It's a pleasure to be your closing speaker, almost. Penultimate closing speaker, I guess. You all have a few closing remarks. But I must say, it was a little daunting listening to the session previously, as I was being reminded how much we don't yet understand about both how to measure quality -- that's been the subject of your last two days -- but the most obvious and basic question, which is how improvements in quality actually would relate to improvements in clinical outcomes. It was for me one of the most interesting insights that I had on the IoM study that you just heard I served on.

It was an extremely productive IoM study -- they are not always, but this one was -- it looked at issues of national measurement performances -- I'm going to touch on that in my talk this morning -- but I had the privilege of co-chairing the subcommittee on pay-for-performance with Bob Reischauer, and both of us I think were somewhat taken aback by the difficulties that will be encountered when you consider what it will actually take to change how we pay and the measurement issues that arise, both in terms of the actual measurement, but in terms of the presumed or actual causal relationships between what you're measuring and what you're going to pay on. And as I go through that part of my talk, I want to share with you how I have ultimately resolved these tensions.

But whenever I get back into the specifics -- and as some of you may know, I started as a policy researcher, and although I have spent the last now almost two decades of my life primarily either as a policy analyst or a policy maker, the researcher part of me isn't very far from the surface -- and so when I am forced to be reminded of the tenuous issues that

exist in terms of the actual measurement or the causal relationships, it does take me aback about the difficulties that we're going to encounter if we begin to use some of the measurements that you've been focusing on in these last two days to actually change how we pay for care delivered under the Medicare program. As you may or may not know, one of the things I have done since leaving HCFA, now CMS, is also to be the first chair of MedPAC, which I did for four years, and gave me an opportunity to sit on the other side -- that is, to think about directly advising Congress with regard to these payment issues -- and again, these are the kinds of challenges that you can't ignore.

I wanted to take the opportunity that I have to bring together, remind you why it is that what you've been talking about today is so fundamentally important to the future of the Medicare program. And again, what you're doing is very critical to the rest of us being able to make use and then move forward. But sometimes when you are focusing on the difficulties in terms of the measurement or the reporting and the reporting accuracy and the relationship between the self-reports and clinical outcomes. It's easy to forget the context that we need to put this in. And so I wanted to try to put this back into some context. Now it may have come up in your first day, but as I was quickly looking through the list, at least for the keynote speakers, I know that I'm the economist among them, so perhaps looking at some of these financial issues is something that I tend to think about more than some of my colleagues.

So the question that I'm going to try to pose to you and walk you through is, given all the difficulties that remain, the challenges, and they are very serious challenges -- all of you who are interested can plan to spend the rest of your lives, even those of you who are quite young, trying to resolve some of these measurements and causal relationships -- but having said that, this remains something that I think is important to think about as a here-and-now possibility. Now, when you talk about pay-for-performance, particularly if you ever happen to talk about pay-for-performance with the physician community, there is a lot of pushback. I'm not -- I mean, as an economist, I'm always a little surprised. You know, what's the deal here? Why would you think it so surprising that you would want to pay more for people or institutions or products or services that do more? I mean, that is what the market usually ends up producing. We're in an administered pricing system, and even for third-party payment in the private sector, it's administered pricing just different administrators doing it. So it's much harder to mimic that.

But most people, if you think about other services, if you want to go to some of the most skilled lawyers in Washington or elsewhere in the country, I would strongly suggest you assume you will pay a whole lot more in terms of the hourly rate, if you can get in to see them, than somebody who's a junior associate, recently out of a law school and not with a whole great history behind them. So it's not like we don't see this other places, or now that I've had longer time out of government and established myself in various credentials, when I'm not speaking to groups like this, I charge more for speaking than for people who are just starting their careers. People like this I do it for free. But the notion of paying more for more experience, for presumed higher quality -- sometimes we use proxies, can't really measure it -- is not really known in the rest of the world. But it does seem to be quite controversial in the health care area.

So rather than try to fight those fights that I don't need to, when I go out and speak to physicians, I usually put this in the context of what we're trying to do is to reward excellence, by which we mean both quality and efficiency, and to set up a reimbursement system that encourages and rewards continuing improvement. That's the idea. Somehow, that doesn't seem to ruffle quite so many feathers as saying "pay-for-performance," but it is a little touchy, so I'm just telling you this, so if you get into this situation, don't be surprised if you get the sense of pushback.

But what I really say to people, I don't get what the deal is. We're paying for performance now, that is, we pay for more and more complex. We just don't like the results we're getting. But it's not like we're not paying for performance now, we just haven't really focused as much as we might or should on what the performance is that we'd like to get and encourage. So for me, it's like I don't really get all of this problem. It's we pay for performance now. We seem to be surprised that we have so much of a problem with more and more complex -- that is what we're rewarding. We need to think about this in the context of what would we like to reward if we were thinking about it more explicitly.

But stepping back, let me put this in an even broader context. Now, as some of you know, I've been spending a lot of my own personal capital trying to encourage the development of comparative clinical effectiveness information. I'm going to mention that at the very end. And when people ask me -- which of course is a little unusual for an economist. This, I have to admit, is not the area that I actually bring specialized expertise to the table in comparative clinical effectiveness. But I am somewhat expert in this first issue, and I am overwhelmed with the problems that we are going to face as a country if we don't find a way to try to get from our present position, which has been our position for the last 45 years by the way, to another place. And that position is, we have an unsustainable growth rate in health care spending, in Medicare, which, not surprisingly, is a good mimic of what goes on in the rest of health care. And that's going to become an even better mimic of what goes on in the rest of health care as people like me and people who are five and 10 years younger than me start entering into the Medicare population and end up basically doubling the number of people who are using the service. But it's not really the numbers of people entering that's the problem.

The problem is what economists sometimes call as the "excess spend," that is the growth rate in health care spending that is two to two and a half percentage points faster than the rest of the economy in real terms -- that means adjusted for inflation -- on a per person basis. That's the real problem. And it's not a recent problem, and it's not a limited problem. It's basically how we can describe the United States since 1960, although the decade of the 1990s was a deviation. The first part, much slower spending in the private sector -- all those evil managed care companies were doing what people had asked them to do all of these years: purchase more aggressively, make the access to technology and specialists a function of whether or not primary care givers or nurses thought it appropriate, but clearly not what the American public thought they were getting when people said, "Oh, we need to slow down health care spending," followed by the Balanced

Budget Act in 1997, which dramatically slowed down spending in Medicare. Aside from that decade, this has described our experience for the last 45 years, and actually, when you fold in that decade, we're still within this ballpark of two to two and a half percentage points, faster growth than the rest of the economy. And I'm going to show you in a minute how serious that is for our future if we can't find a way to get off it.

But actually, we have an even worse whirl than just an unsustainable health care spin, because as you know, we just heard allusion to it this morning, we have a lot of problems with regard to patient safety -- sort of the negative or low end of quality, the 98 percentage people who died unnecessarily from medical errors that the IoM reported, and to err is human. I also saw the report that was just released or the description of it on the Internet, indicating I think 238,000 lives lost over a three-year period because of medical errors in the hospital, mainly to do with a failure to rescue is how it was described, so when people were in critical condition, which is a very serious number, compounding the fact that 8.8 billion dollars needlessly was spent on these medical errors. So no indication that the dirty little secret that those of us who work in health care actually knew far before the IoM study was released, that we have not found a way to get our arms around the problem.

And in addition to the actual patient safety area, just for the rest of us who use health care do not find ourselves into one of the patient safety bucket problems, the likelihood of having what is clinically appropriate done when you have an encounter with the health care system is not very good, basically, slightly better than a crapshoot. Fifty-three, 55 percent is the number that Beth McGlynn and her colleagues at RAND have estimated in terms of what is regarded now as clinically appropriate, which means only those things we actually know about, not the area that I've been focusing on in terms of all the areas that we actually don't yet understand because we haven't done enough proper research.

So we are finding ourselves in a very troubling position. We have an unsustainable spending growth rate. Not the absolute level. We do spend a lot relative to anybody else in the world, but we could tolerate that much better than that growth rate which is the rate of change every year. That's really what's going to get us. And at the same time, we have serious patient safety problems, and we have serious quality problems in terms of receiving what is clinically appropriate. When I tell people who are not involved with the health care this fact, they say, "Oh, but I'm going to go, when I have a problem, to an academic health center," and my response is, "Well, it's a little bit better, but a whole lot less better than you think." 53, I think goes up to the low 60s, on average. Now, if you're really careful where you pick, you might be able to do better, but it is much more of a serious problem, even in the places where we would presume that should not be an issue. My husband and brother and daughter-in-law are all physicians. I have made them swear to me if I ever find myself going into a hospital, particularly when I am not active and vocal, one of them will be by my side at all moments to make sure that there are not these kind of screw-ups occurring. You might want to think about the same things. It's the problem of knowing too much.

When you think about the kinds of pressures this growth rate in spending is going to have, it depends where you're looking as to where the pressure is likely to be seen or felt. Now, a couple of weeks ago, we had our annual occurrence of the trustees releasing their report on the status of the Medicare trust funds and the Social Security trust funds. I actually had written this slide before that, but they were very kind. It didn't change the insolvency date. I was on a panel with Rick Foster at the American Enterprise Institute the morning after the report was released, and as he indicated, it did come a little earlier in the year now. They're projecting -- not that I would encourage you to put this much precision attached to their projections -- but it looks like right now it's early in 2019 as opposed to late in 2019. I would be quite satisfied to use the notion about a decade from now, if things don't change, that Part A trust fund, paying for hospital and patient first hundred day of home care and nursing home care, will be completely depleted of funds. But actually starting this year, 2008, less income is coming in than expenses is going out, so we're already on the path that will lead to insolvency.

But actually, the part that we're likely to experience earlier is the pressure on general revenue, the money in the treasury from the other parts of Medicare. As you know, Part B, the physician and outpatient hospital, and Part D now, the outpatient prescription drugs, are primarily financed out of general revenue, in addition to what the seniors themselves pay, and that is actually the place where we are going to feel the pressure first. These areas are growing faster than Part A, and their growth will impinge on what else the government can do in terms of providing money for health care reform, providing money for education for low income children, for all areas the government needs to spend money on, and that really is going to start being felt in the next four or five years.

And of course for the rest of health care, you also get a lot of pressure, and we've been hearing a lot about this, how people will say wages haven't even been rising as fast as health care premiums. Economists always way to say, but usually resist, "Duh." That's because the reciprocal of what you can spend on fringe benefits is determined by what goes on in wages and vice versa. And so when the fringe benefits like health care are growing faster, that means the other component, other fringe benefits but mainly wages, are going to be forced to grow slower, unless you think for some reason you can tolerate higher compensation to labor, either because of increased productivity or some other reason. So the fact that you get increasing health care spending in the private sector increases the amount of people without insurance coverage. Increasing health care spending is the single biggest predictor for the number of uninsured in the country and puts a lot of pressure on cash wages.

So the kinds of pressures that we are going to feel if we can't find some way to lower that spending growth rate -- we don't have to take it to zero. We don't have to reduce absolute spending, although there probably is no reason we couldn't for a year or two if we went after the right things. But we've just got to slow down that growth rate in spending, or there's going to be terrible amounts of pressure on general revenue in terms of what else government can do, and in terms of what happens to cash wages, particularly for lower-

wage employees, especially -- I mean, it's a problem for everybody -- but especially for lower-wage employees.

If we don't figure out how to do this -- and I'll leave this after that, but as you can see, I have now gone from an economist, who for the first 20 years or so of my career, mouth the usual orthodoxy of economists, which is, doesn't really matter what share of your GDP you spend on health care, as long as you're getting good value for what you're spending. And at a moment in time, I still buy into that notion. It's this growth rate and the dynamics that it is going to produce that has really gotten my attention. And if we were to continue doing for the next 25 years roughly, what we've done for the last 45, which is not an unreasonable way to make a projection, we will find ourselves in a very difficult strait. What we could find ourselves as a country doing is spending roughly 18.5 percent of our GDP on entitlements, most of which are accounted for by the medical entitlements, Medicare and Medicaid. So all the other things that are normally done by government would have to be on top of this 18.5 percent.

Now, people can say, "Yeah, okay. So what's the big problem?" Well, again, if you stand back and say, "Where have we been as a country?" Well, we've been is spending, depending on how you do interest on the debt and some of the off-budget items, roughly 18.5 to 20 percent of our GDP through the public sector, starting since post-World War, starting around the Korean War. So the notion is we will either have to find a way to slow down the pressure from the medical entitlements -- Social Security is really not the problem; it is really the medical entitlements -- or assume we are going to be willing to spend a lot more money. Now, people ask me, I now have it on my Web site, so I want to be sure everybody knows I do buy into this concept, "Will we have to spend more money in order to bring in all the people without insurance coverage," and the answer is, yes, of course.

We cannot expect to bring in 47 million people without insurance coverage without spending some more money. How much more? That's a whole different issue. Are there lots of savings around that you could try to go after? You bet. Will it cost us more money? For sure. Will doubling the number of people on Medicare going from 44 million to roughly 78 million when all the baby boomers retire pretty much determined that we will spend more on Medicare? Hard to imagine another world. But having said all that, it's a question of how much more. How much more is this country going to be willing to tolerate in terms of increased taxes?

Now, I've already assumed -- which is not an unreasonably assumption given all of the campaign pledges that have been made -- that income tax rates on upper-income individuals are going up in 2009 and probably capital gains tax rates as well. But having said that, that doesn't begin to account for the kind of financial pressures that we are going to face if we don't find a way to reduce the growth rate and health care spending for the Medicare population, for the Medicaid population, and for the rest of the country. So this is to try to say to you, this is a really serious issue. We have ducked it for 45 years. It's not going to be easy to change. It means doing things differently on a lot of different fronts, and doing so in ways that that this country will tolerate. So it's like, don't

tell me that parts of Western Europe have tax rates of 35 or 37 percent, and they do their financing that way. It's unless somehow we have a total personality transplant -- which I don't see likely -- I don't see how we go from 18 and a half to 20 percent to 35 or 37, although I do agree that we will end up spending more through the public sector. So the end -- and, since there is so many indications that what we are spending is not really buying us what we would like, I don't see going for big money additions first as the first step. More than willing to concede, yes, at some point, that is what we should expect to do, but it ought to be last step, not first step. Because we know what'll happen if we just put more money in the system. We'll just spend it the same way we are.

Now, I feel, as somebody who regarded as a great honor to be the administrator of the Health Care Financing Administration -- some of you have heard me say this, probably the best job I will ever have experienced in my working life; since I'm still working, I don't want to make that an absolute statement, but it is my expectation -- and having chaired the physician payment review commission and the Medicare payment advisory commission, and continuing to work with members of Congress and the administration on these issues, I feel as entitled to say this as anyone else, which is incentives are a big problem, and Medicare has gotten it exactly wrong over the last 20 to 25 years with its prospective payment system. Wrong, if you are trying to change and reward what it is you want relative to what we've got now.

Now, we've made some improvements when we have been adopting over time prospective payment. When that happened in 1983 for the outpatient. When, as a result of the Balanced Budget Act, we began to change how outpatient hospital was reimbursed, nursing homes were reimbursed, home care was reimbursed, going to what I usually regard as a more bundled payment -- that is, paying out a less micro level for a bundle of services associated either with a nursing home stay or a hospital discharge or an outpatient encounter -- we at least provided financial incentives for those who are more efficient to be rewarded. No change in terms of quality. Best in class, worst in class, exactly the same amount. But some reward for efficiency.

For physicians, we have never done that. The physician reimbursement schedule, which I was responsible for seeing implemented when I was there in January of 1992, represents the worst possible incentives we could have possibly devised. It pays exactly the same amount -- best in class, worst in class, just barely above the indictable -- and because it is at such a micro level, using some 7,000 plus codes for reimbursement, there is no possibility to reward efficiency. So it is as perverse as you can get. Conservatively-practicing physicians who spend more time with their patients are involving less in the way of imaging or lab testing or other diagnostic testing have no way to be rewarded for that and have very low fee rates, that as again you know, have not been increased or increase in very small amounts over -- well, basically, almost all of this decade. One year, when they were actually reduced in 2002. We are again facing that chicken activity as to who's going to blink first when the current increase runs out in July, and what we're going to do to buy ourselves six months or 18 months -- that seems to be the choice that's on the table -- when we have to fundamentally redo how we pay physicians if we are going to change the incentives.

That's a very serious issue. Medicare is a big leader in terms of how we pay. It has improved payments for efficiency in terms of moving to a bundled payment, except for the docs, which is definitely the most screwed up part of the reimbursement, and does nothing to reward a lot of what you have been talking about these last two days in terms of providing more to those clinicians' institutions who provide better quality as best we can measure it and, particularly if we can measure it, who improved clinical outcomes.

The study that was referenced, the IoM study, and if you haven't seen it, it is a quite a good series of reports, the first being on the measurement system, a second being on QIOs -- that was a request of Congress -- and the third volume, which was released in September of 2006 on pay-for-performance, and basically the points it makes is that in order to move ahead with pay-for-performance, we've got to have a coherent goal-oriented system that we can access and use to report on performance. It needs to be national. It ought to reflect national goals. The information needs to be transparent and easily available, and as desirable as it would be to start with a more comprehensive set, we are where we are. So ultimately, we would like to look at the physicians and other health care workers who provide health care to a person during an episode of illness, either individual hospital stay or more extended measure, but that's not where we are. So we need to recognize that we are going to have to start measuring, as CMS has been doing and reporting on their Web site, where we are in terms of how health care is provided, start with a starter set, and then go to some comprehensive measures.

Their caution, and it is one that I think is unfortunate but necessarily true, is start now, go slow, active learning. Start now where you can. Medicare Advantage is clearly one of the most obvious -- I'll remind you about why that is, but you know it as well as I do. Go slow in the sense that you can expect to completely change how it is that you pay in year one or two, but start it seriously. And then the active learning, which I had never heard the term used -- it probably is one that's been around, I just haven't personally heard it -- but is a very descriptive way to describe the process that we think needs to occur, which is monitor, assess what you're doing, make changes as a result of what is being experienced in year two and three, go back and refine your measures, and proceed forward, and assume this is going to be a very dynamic process. There's a lot we don't know about what to measure, how to measure it, how to measure it once you leave areas like health care plans. You can see how challenged the health care plans are, and the health care plans have been forced by Medicare to report, basically from the get-go, in terms of quality as best they could. Other areas, particularly anything that occurs outside the hospital relating to physicians, has almost no reporting to date. I mean, this has now started to change with the reporting that started last July in terms of the pay-for-reporting for physicians, but basically no history in terms of -- especially ambulatory care for physicians.

As I've indicated, fortunately, maybe you would use another descriptor if you're one of the plans that will be involved, the reporting system is not the same level of issue in Medicare Advantage as it is elsewhere, because at least three are ongoing, have been up and running, again trying to pull back, you have been focusing on all of the challenges

and problems and question that are raised, either in they have Outcome Survey or in HEDIS or in CAPS, but the fact is this provides measurement that the rest of us would love to have for the rest of the health care sector. There are, of course, some problems even for Medicare Advantage, which is -- unfortunately, I had not actually realized there had been quite the loopholes in the legislation that have occurred, but in one of the fastest-growing areas which are the private fee for service. This is not required reporting. I think leveling the playing field in terms of quality and other measurement recording is critical, inexcusable not to have in place, is not just a matter for either the MSAs or the private fee for service, but is for all of Medicare.

I mean, if we want to have people able to choose where they want to receive their care, traditional fee for service or Medicare Advantage, they need to have comparable measures available so they can see what it's likely to cost them given the kind of coverage, and at least as importantly, what they can expect to get in terms of process, consumer satisfaction, and available resources, and what kinds of quality, as best we can measure it, quality as the process or clinical outcomes, are they likely to experience given people in their area that are more or less like them. And to do anything else is really to do a great disservice to our senior population. How else can you expect people to make reasonable choices?

So the question of how to proceed, well, as I said, I really did buy into what was a quite long and extensive process of the IoM: start now, go slowly, active learning. That really does make sense for me. And the "slowly" part here is going to mean recognizing that while you would like to put a lot of the money on the table at risk, you can't really start that way. You can't start that way because we're not sure enough of how good these measures are, and how responsive plans and clinicians will be to the measurement and to the change in payment. But, you can start. And that's really what we will need to do and the threat or promise -- you can decide which way you want to phrase it -- of moving reimbursement in the direction and the clear signal that we're going to start with Medicare Advantage and hospitals, and bring in and probably renal dialysis centers, and bring in other groups quickly on a phased-in schedule, really would change a dynamic that would be much more than simply the individuals and institutions that are impacted. For me, there's no question, sooner rather than later. Next year's just fine.

Now I have asked a few people, including one of my successors who also happens to be a lawyer, Nancy Ann, whether or not she thought we needed new legislation to do this. She opined, as she thought not. So I'm going with this. I don't think we need new legislation to do this. Obviously, before CMS actually could do this, it would have to be clarified that they don't need new legislation. I haven't seen any reference in my conversations with Mark Miller and others at MedPAC that this is necessary, but that is a fair question. If you do, you will have to get it. That will make it a little harder. If it can be done administratively, it should be done, and it should be done in the next year.

Right now, budget-neutral in the sense of using whatever the scheduled increases are already on the books. So what you can do is some of the portion that is above the bid amount you could use some of the 25 percent that's supposed to go revert back to CMS

or the treasury, I'm not sure which, and use that to distribute some of the pay-for-performance, or you could just use -- which is what was considered in the pay-for-performance report in the IoM -- use the update as a way to have the increase for pay-for-performance starting out using HEDIS measures and either the hospital outcome or the CAPS measures or some kind of combination, and make sure that you continue with the public reporting as well. You're going to want to monitor and make it as clear and transparent as possible what you're doing, why you're doing it, open to change as that becomes appropriate.

Going forward, we clearly need to bring in those other MA plans. As I said, I was a little embarrassed to realize they had escaped. Somebody did good lobbying. That needs to end. They need to be part of this. But we really need to make sure the quality information is available for fee-for-service in the market area. I sound like broken record. I have been on record as saying this at least since 1997, when changes were put in place in terms of the Medicare plus choice that this is really critical to have a level playing field here. And also to recognize that it's important to start rolling this out elsewhere. Hospitals had pay-for-reporting starting in 2003. It was very effective. They went from about a third of them voluntarily reporting. Last I heard 98 or 99 percent of the hospitals report because of the payment. I have to admit, I was initially appalled at the concept that we were going to pay hospitals for reporting these quality measures. It was like, "What do you mean? You want to get Medicare money? This is what you have to do." But I have mellowed some since. We have had payment that ignored quality for the last 25 years taking a couple years to do a transition by paying for reporting is probably not unreasonable. We've done that. It's time to go.

I think it was very important that in July, payment for the agreed-upon measures for physicians started and a pay-for-reporting -- not a whole lot of payment, but a little bit of a bump up in the fee schedule for physicians who report the quality measures. We do need to give them a little time to see particularly the impact for the small practices whether or not they are able to do this. But it's really critical to put a timeline in place. Two or three years, they ought to go forward as well. They need to be part of this process at least as much as everybody else. That is where so much of the decision-making goes on.

Lots of things. Again, you've spent the last day and a half focusing on. Some of the things that we need to make better if we're going to do this. There's been -- and it was very interesting listening to some of this discussion on the quality measures -- not nearly as much in terms of how to define efficiency, so that really needs to go forward if you want to do a blend of the two. Need to figure out how to do lots of blends. Efficiency and quality, but also improvement versus attainment. And it's going to be a very big issue. You don't want to take the guys at the bottom and wipe them out if they're showing quality improvement. If you've got people that are not showing any quality improvement and have low attainment, you need to at least think about whether you'll be prepared three to five years out to pull the plug, and if not, to try to explain why it is, when they're high-spending, risk-adjusted, and they're having bad quality outcomes, you think it's an okay thing to keep these institutions going in the program.

A lot of debate still about how big a change do you really need to change physician behavior. Hospitals have shown, just a little seems to do the trick. It's actually quite surprising, the relatively small amounts that seem to be able to drive change in the hospitals. It's not clear, and it becomes more complicated anyway, because physicians face a whole multitude of payers, how big it has to be. And we clearly need not only to do risk-adjustment in the health status sense, but we need to recognize that some populations are socially much more difficult to deal with, and we need to have some kind of an adjustment so the institutions are not unduly penalized, including considering whether we want to have rewarding better behavior on the socially difficult populations, which has also some, although not a huge history behind it.

The biggest worry in all of this, it's the thing you want always to worry about when you're changing public policy; it's the unintended consequences. What it'll mean in terms of patient selection. What it'll mean in terms of potentially widening performance gaps or increasing disparities and of teaching to the test, although that appears to be a smaller issue, at least according to some of the research that I've seen, that when there's been some assessment as who is doing well on the measured variables and analysis is done as to some of the other variables, they appear to correlate pretty well. But it is something to continue worrying about.

So what does this mean going forward? Well, the notion that we can fundamentally change the excess spending gap I commented on extensively at the beginning without realigning financial incentives makes no sense to me. It's not the only thing that needs to be done, but without rewarding the institutions and clinicians who do it right the first time, pay attention to their patients' preferences, and have good clinical outcomes, it's just not going to happen. We also of course need to involve consumers more. I like value-based insurance. The notion of having the lowest co-payments for the therapeutics and pharmaceuticals and procedures that seem to make the most sense for people that have particular symptom classes, and it would be nice if we could encourage healthier lifestyles.

We all know the impact of chronic disease on spending. The impacting of the rise in obesity in the country in terms of the impact on chronic disease, not just for the current Medicare population. What is most worrisome is the increase in obesity that is being observed in children, and the likelihood that that would have a negative effect all through their lifetime. It is not a good way to try to make adjustments for increasing longevity for anybody. And it is something that we are going to have to take in a much more serious way. And of course I can't resist the plug of saying it would really help if we actually knew more than we do about what works when, for whom, under what circumstances.

We've had an explosion in terms of medical procedures and technologies, devices and pharmaceuticals, and they're usually just compared only for drugs and devices, and only in a very narrow sense, and since I'm with a CMS group, I will say that one of my favorite examples was reported now in *The New York Times* about six months ago, Sunday, half above the fold -- that's how you know if it's important in the front page --

and it was a story about atrial fibrillation, and that the newest trick in the back of cardiologists for atrial fibrillation population was ablation therapy. You're reading through about all the numbers of people doing ablation therapy, and then about two thirds of the way through, the article you get to me, the big ah-ha moment, and actually it's we don't know whether or not patients with atrial fibrillation who are treated with ablation therapy are going to be any better off two or three or three or five years down the road than medical treatment with Warfarin or Coumadin or other medical treatments, and this was again the light bulb going off: maybe we should find out. It might actually be well worthwhile for CMS to make that investment. I don't know exactly what ablation therapy costs, and I don't know exactly what share of the atrial fibrillation population is Medicare, but I am willing to wager some serious money: both of those are big numbers. And this is precisely the kind of information we are going to need to go in addition to paying for performance.

Now, if we get the kind of information that I think we need, if we actually start adopting information systems so we could make use of this information, most importantly for purposes of my talk with you here, if we fundamentally change financial incentives, realign the financial incentives, will this actually bend the curve as people have liked to describe going from two or two and a half percentage points faster than the economy, to something close to the economy, one percentage point faster, give or take a quarter of a point. The answer is I don't know. It is the only thing I can imagine a country like the United States being seriously willing to consider, because it is information-based and motivationally based. It's hard for me to imagine us, for any extended period, using the meat cleaver strategies of global budgets and price controls without basically relying on better information and better financial incentives.

So I don't honestly know whether this will work, because we've never tried anything like it. It's the only thing I can imagine being adopted, and as I have tried to just indicate to you, one, we can't tolerate doing what we've been doing for the last 45 years for the next 25, and two, the alternatives start to get really ugly, really fast, so that makes me much more positive and optimistic about the potential for pay-for-performance as one of many strategies to begin to realign financial incentives along with a lot better information so that clinicians, institutions and patients can get rewarded for doing the right thing the first time around.

Thank you very much.

[applause]

[end of transcription]