

**Question and Answer Session
With the Honorable Mike Leavitt
Secretary of Health and Human Services
National Governor's Association
August 6, 2006**

Gov. Haley Barbour (Mississippi): Like you (Secretary Leavitt), I have run a company in the private sector. And I understand the point you make about cost.

Now, as governor, we have a large state employee health plan, and it covers about two hundred thousand lives and it costs too much, it goes up too much every year, and our employees don't have very good coverage. They don't have what we would like for them to have, or what they deserve.

Thank you for coming to Mississippi and meeting with our leadership about this, give me a little bit of a better explanation of time about whether, you talked today about the end of the year, do you think that the federal first step will be at the end of the year, or sometime soon?

Secretary Leavitt: I think it will be some time soon.

I think what you'll see over the next several months is you'll see the federal government make a clear declaration of our intention to make this a condition of doing business with us. I think you'll begin to see governors and major employers and groups of employers making the same, signing executive orders on their corporations or their organizations to do the same thing.

Now the reason that's important that it's happening now is because as we speak, most of your HR people are negotiating contracts for the '07 year. And what this amounts to is writing into those contracts conditions that say we're going to do business with people who can do business with us electronically, in a way we can understand. It's a condition that we will all adopt the same quality standards. And this just makes sense.

When sixty percent of the health care world all does it within a reasonably short period of time it's going to start a flow. And so I said by the end of the year, I think what you'll see is a large majority of health payers in this country will have provisions in their contracts that will essentially use the payer power they have to begin moving it.

Simultaneously, we have large groups of medical providers and organizations collaboratively working on the standards. We have a significant process going to develop the IT standards. And simultaneous to that, you have this debate happening in Congress, where the medical community wants to define pay for performance.

So you've got it all coming together at a time when I believe by the end of the year, we'll at least have the capacity to say, let's form this up in its most simple form, demonstrate

that it can work, and then we'll make it more elaborate as we go. That's the path forward.

Gov. Barbour: Governor Romney?

Gov. Mitt Romney (Massachusetts): Thank you Mr. Secretary. And like our Chairman (Gov. Barbour), I'm very happy that you made it to our state time and again to talk to our employers and members of government to help us catch the vision of what you're putting forward.

With regard to these standards, the approach you'd like us to pursue, just to make sure I understand, is that we work together to adopt what are developed on a national basis. Again, we don't all have different gauges of our railroad. So you're going to put the standards together first, and we adopt those. Is that right?

Secretary Leavitt: I'm very anxious that these standards emerge someplace other than government, but they do need to emerge as a single standard.

Now, on the healthcare standards, for example, there's a group called the Ambulatory Quality Care Alliance. It's made up of insurance companies, of major medical groups like the AMA and others, and subspecialty groups. And they have created what they refer to as a "starter kit". It's basically thirty-one conditions or procedures and what constitutes "quality".

We now have six different pilots. I was in Boston to visit one of them, I'll be in Minnesota and Phoenix and California and Indianapolis where they're beginning to try and figure out how to collect these.

Now the problem isn't just to set the standard, you also then have to figure out a way of collecting the information. Currently in all of these six pilots, they have teams that will go into physicians offices and look through the medical files and write down whether the quality was met or not.

You can't scale that up. Which means you ultimately have to have IT standards that will allow systems to collect it. Now we have the (group) — it's called the American Health Information Community — which is developing the standards for the IT so that once we have quality standards we'll have IT standards that will allow systems to ultimately gather that information and present it.

So, the answer to your question is, there are national standards being developed. They're being developed by collaborative processes that will ultimately be conducted outside of government. We're leading on this because someone needs to get it started.

Gov. Barbour: Dr. Fletcher?

Gov. Ernie Fletcher (Kentucky): Thanks. And Secretary Leavitt, again, thanks.

We visited with you in New Orleans recently, and you laid out a challenge to states at that time. Let me really commend you for pushing forward on these things and not waiting till we have the capability of building, as you said a racecar, but moving forward with what we have; because I think it's critically important that we move forward with the technology, the informatics and quality in order to get the best health care available.

Not only that, but get it at an affordable rate and technology really has not been implemented in medicine to the degree that it needs to be. We're looking at this writing this Executive Order, and I'm on board with you, and want to commend also for the help you all gave with DRA (the Deficit Reduction Act) and the Medicaid reform, because what you're talking about here is going to tie pretty closely into that, as well as our employee health care systems.

If we're looking at going back and writing an Executive Order, we're writing on it that they must comply to these standards, when do we see that we're going to have a body of informatics standards here that we can actually have some kind of measure of compliance? And the same way with the quality standards too. I got a follow up later on the quality, but let me get that first.

Secretary Leavitt: Let me deal with that one first.

We're not just starting in the development of standards. And we've been working out for about fifteen months on the health information technology standards. It took us a few months to develop a collaborative vehicle that could do that.

But then we bit off a group of what appear to me to be the first obvious standards that needed to be developed. They were registration standards, so when you walk into the doctor's office you don't have to sit down and fill out the clipboard every time with your medical history.

The second one was lab results, being able to transfer lab results with the click of a mouse instead of having to walk around to you doctor's office and pick up a big brown envelope and take it to another doctors office, they can begin to send the lab results over the internet. The third is on prescription drugs. And the fourth is on secure messaging.

That's the first set of standards that we've developed. They have now been adopted. They've been put into place and we now have an accreditation process so that a piece of software or a vendor can say, here is my software, and this independent group -- like Underwriters Laboratory, or Good Housekeeping Seal -- or whoever does the certification, in this case it's called CCHIT (Certification Commission for Health Information Technology), can literally validate or certify that this system meets those standards. And we've already had eighteen software systems meet the standards on those four.

Now, the next batch is already being worked on. And the next batch will be quality standard measurement devices. So that once we have the quality standard, we'll have a health IT standard that will allow us to bring those in electronically, and be able to create the kind of data on a national basis that we're looking at here.

Gov. Fletcher: If we're going back to set these standards there's certain if you will, standards that you've mentioned before particularly that are available and you're asking us specifically to make that a requirement in our healthcare plan and it would be specifically on those four and then I assume that as they continue to develop you want the rest of them.

Secretary Leavitt: A little different than that.

We're hoping that we'll supply recommended language, you can chose your own language and negotiate your own contracts, but our contracts basically will say as a condition of doing business with us in the future we need to have providers and plans that will have systems that will have been certified "interoperable" to the point that we can do that now.

Interoperability is "this big." *[Secretary's arms stretched wide]* We've got standards that will do "this." *[Secretary's hands close together]* And so we're only expecting that people over time will get to "this" and then they'll get a little bigger and a little bigger. And over time, we'll begin to move our way to complete interoperability.

Right now, we just need to get a process going to where everybody begins to change their systems. Everyone upgrades their system periodically. When they do, they need to have the upgrades that will begin to move us toward that interoperability.

And can I just say, every other industry in the world has been through this? Banking went through this, cell phones went through this, the Internet went through this, health care is one of the final ones. But it's the same process.

Gov. Fletcher: Let me ask you a question on the quality.

Issues there on the quality and, we've passed legislation in Kentucky that gives transparency, it allows us to get information on costs and quality and we're working with the standards of how we'll establish that with, I think we're going down the road that you've advised to get down on the standards, or both of those.

It gets very difficult and it's a little different picking, and I just want your thoughts, and you did say it was going to be complicated, it's a little different than picking a hotel that's a five star or a one star hotel. You've got liability issues that will come up which will be tremendous. And we've been unable to get any kind of medical liability abuse reform that would help us deal with some of the issues because when you start talking about measuring quality, that's going to have a tremendous impact on our liability, particularly health care providers.

The thing is that when you start picking those things, unlike a hotel, none of us go into health care and want to pick anything less than a five star. How do we deal with that issue there? Because I know we're pushing toward consumer driven health care, but I see that we've got a lot of challenges there and I know you all have done a lot of thinking on that.

Secretary Leavitt: I'm persuaded we'll get to cost comparability fairly quickly.

The quality is a much more complex and difficult matter. And that's the reason that it ought not to be the Secretary of Health and Human Services that chooses these quality measures. It needs to be the medical community, for more reasons than just technical capability.

If you're comparing the confidence that a person has in a quality measure, that the Secretary of Health and Human Services set with the word of one's doctor, it's pretty clear that the doctor is the one that ultimately is going to be chosen. Doctors have to be confident of these.

Now the medical community, as I've met with them, I would characterize them as motivated but skeptical. And I understand their skepticism.

I met with a physician the other day who talked to me about a pay for performance standard that he is currently under for HIV tests and he's a solo practitioner, he got a report back from one of his providers saying that he had only twenty percent compliance on these tests, and he said I knew that was wrong because I don't even give people an option. I provide the HIV test for everyone who comes into my clinic for care – he's an OB.

He said I was fascinated to find out where this twenty percent came from. So he began working back through, first he went to billing and said there must be a billing mistake. Turned out they had billed all of them. He then found out that there was a, after several weeks of inquiry, found out there was one case they were doing it on a revenue code, and on another case they were doing it on a procedure code. That's more technical than need be, other than to say, he said, I don't mind being measured, but I want to make certain that the standard is such that it can literally be accurate.

This is where we get back to the go-kart. You don't start assuming we're going to do this for every medical procedure. We're inventing a new way of doing business, and we've got to keep it very simple, on a highly limited number of procedures. We need to have the medical community help define what the standard is, and then we've got to have a means of implementing that will allow confidence to grow in it. But we do need to change.

Gov. Barbour: Governor Lynch?

Gov. John Lynch (New Hampshire): Good morning, Mr. Secretary, and thank you also for coming to New Hampshire, and we hope to have you back sometime to do some skiing up there.

Secretary Leavitt: Thank-you, I've never skied on ice before!

Gov. Barbour: Obviously, the Secretary's not running for President!

Gov. Lynch: Very good comment! This follows up in terms of a point that Governor Romney was making.

About a year ago, I created Citizen's Health Initiative in New Hampshire, where we brought together people from business and industry, health care and the educational communities and so forth, to begin to make progress on the same initiatives which you've just described. Electronic medical records, e-prescribing, as well as making information available in terms of cost, quality, developing standards, that would be consistent and endorsed by the medical community. And, as I said, I think we're making real progress.

Is what we're doing going to conflict with what would be done on the national level? In an effort to make everything consistent beyond just the state borders, and how do we engage in a process to all end up in the same place in terms of compatibility?

Secretary Leavitt: Governor, this is a great question, because the fact that this needs to be done is obvious. And it's happening all over the country. It's happening in Seattle, it's happening in Detroit, it's happening in Boston, it's happening in Phoenix.

I have visited, I think, twenty three different communities now and met with the groups that are organizing to develop the means of creating quality measures and IT standards. Now the great thing about standards is there's so many of them to choose from. That's the problem.

Now, there are lots of ways in which government can provide leadership. Congress can pass a law. And it provides leadership.

But we can also lead as payers. And we're a major part of this market. That's the reason that we are initiating this. But I want to be clear that what your community is doing is exactly the right thing. And it's exactly the right thing that Governor Romney's community is doing, and Governor Fletcher's.

What we now need to do is use the government's capacity as a payer to begin an effort harmonizing with our market power. And we don't need to do it alone.

The private sector desperately wants this to happen. And that's the reason I believe we're beginning to enter a period of unique change. With a combination of the medical community feeling the pressure of reimbursement rates and the need to change that system, they'll be at the table.

So the reason I'm here today is to invite you to begin doing three things. The first is, sign an Executive Order moving as a payer toward the goal of standards. The second thing is, to work with the groups that you've talked about and encourage them to become part of this rather significant national harmonization process.

Now, I haven't gone into any details today, but there are a lot of them. We're literally forming a network, if you will, of organizations like the one you described, for three purposes. One is to "cross pollinate"; the second is to harmonize; and the third is to create more them.

So what you'll see between now and the end of the year is not just the employers coming together, but you'll see the formation of a network of the effort in Boston, the effort in New Hampshire, the effort in Mississippi, Kentucky, Vermont, and we'll begin to harmonize those. Everybody wants to use the same system. They don't care if the rail gauge is 4.8, or 5.3 or 5. They just want to know what it is, and they'll begin to move to it and we will use our collective payer power to begin to organize that market.

Gov. Barbour: Governor Douglas?

Gov. Jim Douglas (Vermont): Well, Mr. Secretary, thank you for being with us, you're certainly on the right track.

In all of our states we're wrestling with these challenges, trying to find ways to improve the quality of care, reduce the cost, I'm sure it's the best possible outcome for all the people of our state and I'm pleased to hear you say that the experience that you've had in various states will be a part of this process because there are a lot of creative approaches that are underway.

You made some allusion to your conversations with physicians and others, and I guess that's what I was trying to drill down on, as to what the level of receptivity is among the provider community, the insurance community, advocacy groups, is it possible we're going to achieve some consensus as to these standards?

Secretary Leavitt: Here's what I hear from physicians, and I've talked to a lot of them. First of all they make clear, look, I want these standards, because I want to know how I'm doing in comparison with the larger universe.

Many physicians have said to me, I go to work every day and I do the very best I can for what I was trained to do which is to help and heal people. I have no idea what I'm compares with the larger universe of physicians and I would love to know how my results compare – I can learn from that.

Now, what they are properly skeptical about is whether or not we can create a system that will accurately reflect their work. The OB I told you about, he's in one of these groups. He's been helping to define it, so when he got the report that said he'd only provided HIV

tests for twenty percent of his patients, he knew it was wrong and also knew he needed to fix the system, and began to work through it.

So, they're motivated, on one hand, because they know they need to get there both for quality of care, and to keep their economic equation moving forward, but they also want it because they're very conscientious people who trained because they wanted to help people.

Gov. Barbour: Governor Turnbull?

Gov. Charles Turnbull (Virgin Islands): Mr. Secretary, it's nice to see you again!

Secretary Leavitt: Good to see you!

Gov. Turnbull: Do visit the Virgin Islands also, and the other territories. You don't have to ski, you could just swim. But, my question is this; in this matter of reform, the governors should take the lead? Or the private sector together?

Secretary Leavitt: Together.

And I'm making contact, as I said, I've been in touch with twenty one of the top one hundred and had conversations and twenty one for twenty one there is a desperate desire for us collectively to move this forward right now. And what you can do to be helpful is first of all, sign the Executive Order on your own, and second of all, find the quality initiative that's going on in your state and do everything you can to give it a boost. And the thing you can do most to give it a boost is to encourage the larger employers in your state to participate in that quality initiative.

The quality initiatives will begin to harmonize. The fact that they're all doing it is a very positive thing.

Gov. Barbour: Governor Romney we're going to give you the last bite at the apple.

Gov. Romney: Thank you Mr. Chairman.

Mr. Secretary, going back to the chart that you showed at the beginning here, as you looked at information that, in the ideal world might be available to a consumer looking for health care, I guess hip replacement in California, excuse me, in Florida there.

Admittedly, as you see those columns, that's what exists if you're thinking about buying a car or a sport coat. We don't have it in health care. If we do have that kind of information in health care, you're going to begin seeing the kind of magic that the market exerts on everything else in our society, which will tend to increase quality, productivity, and cost will be contained.

The one column there that is not achieved through information is the one in the far right. Meaning, the patient pays. We can, through standards and information technology, for the first time allow consumers to understand quality differences, to understand cost differences, between different hospitals, but right now under most insurance plans the patient pays the same amount whether they go to the hospital one star but costs a fortune or one that has in your model, four stars and costs less than that.

It's all the same to the patient. Their cost is a deductible amount, once they hit that number, they pay nothing. Is there some way we can move, and what's your thinking about actually having the patient have an economic interest in looking at, for instance two hospitals that both have excellent records, but one is going to cost them twice as much as the other?

And that's the kind of market force I think we're going to need to see the kind of productivity enhancement and quality enhancement that our society needs. How do we get the patient to have a stake, financially in making a wise economic and quality decision?

Secretary Leavitt: I said earlier, we live in a world right now that is a, where it's impolite to ask about quality and nobody really has a reason to ask "how much." I personally believe that is going to be best accomplished in an interaction between the person who's actually paying for it, in most cases an employer or government, and the person who is the employee or beneficiary.

In other words, I believe, once we have this information, we will begin to see employers say to that health plan, "I want you to construct this plan in a way that it rewards people who provide high quality and moderately priced care." And frankly, in other words, they say to the employee, "You go to somebody that's a high quality provider that provides it at a competitive rate, I'll pay one hundred percent. But if you decide to go to one down the street, to someone who's got low quality and high cost, you need to bear part of the burden of that and I'm only going to pay part of it."

Now, I hope the nursing homes will talk a little bit about this because this has been there's been a wonderful thing happening in the nursing home industry. They started posting their quality measures, and their prices, and a combination of three things. Price comparisons, quality comparisons, and public disclosure of them. They immediately began to improve. And the price got lower and the care got better, because the providers themselves said, we don't want to be in a place where we're compared negatively, because it will affect our market.

And health care competition does work. It's happened in (Medicare) Part D, it's happened in many other settings. Once people have information, they make good choices.

Gov. Barbour: Mr. Secretary, thank you very much. This is exciting, it's bold, my hats off to you for having the courage to take the bull by the horns.

Secretary Leavitt: Thank-you.

Gov. Barbour: Thank you, Mr. Secretary.