

Q&A

A CONVERSATION WITH THOMAS SCULLY

In a candid, wide-ranging interview, the CMS administrator counsels patience in solving the myriad problems of health care. A fix could take 20 years.

'REAL CHANGE' IN SYSTEM WON'T COME OVERNIGHT

As administrator of the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services, Thomas Scully serves as CEO of the largest health insurance organization in the world, one that spends \$1 out of every \$3 expended for health care in the United States. As we went to press, Scully was preparing to testify before the House Small Business Committee on CMS compliance with the Regulatory Flexibility Act (RFA) relative to required industry cost assessments in the agency's development of the physician fee schedule. At a prior hearing on April 10, Scully had failed to comply with a congressional subpoena that he testify before the committee. His objection had been to his placement on a panel with nongovernmental witnesses.

In May 2001, Scully became head of the former Health Care Financing Administration. CMS insures approximately 25 percent of the U.S. population — more than 70 million beneficiaries — including the elderly, disabled, and some of the lowest income individuals in the country. The agency processes more than 1 billion claims each year, and it contracts with approximately 1 million providers.

The CMS appointment represents a return to public service in a Bush administration, after eight years in the private sector. Scully served as president and CEO of the Federation of American Hospitals, the trade association representing the nation's 1,700 privately owned and managed community hospitals and health systems, from 1995 to 2001. Before that, he was a partner in the Washington law firm of Patton Boggs. His practice focused on regulatory and legislative work in health care.

During the term of the man he calls "President Bush Number 1," Scully worked at the White House as deputy assistant to the president and as counselor to the director of the Office of Management and Budget from 1992–1993; as associate director of OMB for Human Resources, Veterans, and Labor from 1989–1992; and he advised then-President Bush on health care policy, Medicare, and Medicaid payment reform. He worked on the 1988 Bush-Quayle campaign and transition staffs. He relinquished seats on the boards of Oxford Health Plans and DaVita, a dialysis provider, when he joined CMS. Scully, who holds a law degree from Catholic University, spoke recently with Senior Contributing Editor Patrick Mullen.

MANAGED CARE: You once compared health care to the movie *Groundhog Day*. What were you thinking about?

THOMAS SCULLY: I said that because since I was last in the government, 10 years ago, nothing's changed. When you really look at the Medicare and Medicaid programs, they're the same as when I left in 1992. The Medicare program is structured the same; there's still no drug benefit. All the things that everybody complains about on a bipartisan basis are the same. Medicaid has exactly the same problems and pressures and tensions it had 10 years ago. States are still doing the same kind of financing that they were doing 10 years ago. We haven't been focusing on how to pay for long-term care more rationally, how we can fix Medicaid, how to cover more people, how to cover prescription drugs for the elderly, or how we can make sure that state Medicaid programs aren't paying too much for drugs. We just haven't been addressing any of the big structural issues.

MC: Why not?

SCULLY: Half the money in the health care system

comes from the federal government for these two programs, so they represent huge dollars. It might be easy for people, even on a bipartisan basis, to talk about fixing things, but because there are so many constituencies — physicians, hospitals, nursing homes, nurses, patient groups — affected by everything, real change is difficult. Also, people try to implement most changes overnight. Every major reform effort has blown up, because everybody tries to fix the system in a year. My view is that we've probably got a 20-year problem on our hands, and we ought to start looking at it as a 20-year-long fix.

MC: The GAO recently issued a report saying that Medicare has problems with how it communicates with physicians, that physicians have a hard time getting accurate, timely information.

SCULLY: Aw, that's nonsense. David Walker, who runs GAO, is a nice guy and a friend of mine, but I stick about half the GAO reports I get in the circular file.

MC: Would you concede that many physicians are not thrilled with how they get information from Medicare?

SCULLY: Physicians have legitimate complaints. I think I've doubled the number of physicians who work at CMS since I've been here. I've been trying hard to get real-world docs who actually practice medicine at the same time. I just placed Barbara Paul, who's been terrific as head of our physician outreach for the last two years, in charge of our quality efforts. That's the big focus for me. We got Bill Rogers, who is really a practicing emergency room physician, to be head of physician outreach. I'm determined to improve communications with physicians. It's been a little better, I hope. I mean, I know these people. The new incoming head of the AMA is from Tupelo, Miss. When I was there doing a town hall meeting — and I didn't know he was there — he came out of the crowd to congratulate me on improving communication with physicians. I've always had great relations with the AMA and most of the specialty groups, and I'm a lawyer. I'm determined to get more physicians in the agency and, in particular, physicians who will come in and work for two or three years and then go back to practicing, so that they truly bring a real-world experience to the place.

MC: You mentioned physician displeasure with Medicare payment rates. What might happen over the next few months in terms of any changes in that 5.4-percent cut in physician payments?

SCULLY: It's not really a 5.4-percent cut. It's a relative reduction in the conversion factor that was accidentally increased too fast. It's a 5.4-percent reduction in the conversion factor used to calculate the base payment. There was a significant error — worth a couple of billion dollars a year — in calculating what we should pay doctors. No one likes to hear this, but when you look back at the formula, we overpaid doctors for a couple of years. They got 11-percent increases in each of the last two years, when they should have received 5- and 6-percent increases. So the formula takes some of that back. Even though it's down 5.4 percent from last year, if you look at where it should have been all along, it's about right. So it makes sense that physician spending will still go up about 5 percent, even though the actual per-visit code goes down by 5.4 percent.

MC: Can anything be done this year to ease the hit on physicians?

SCULLY: I don't expect physicians will be happy with the situation. But I also think that suggestions like that of the Medicare Payment Advisory Commission for a \$127 billion fix are a joke. MedPAC's recommended Medicare spending for this year was so outrageous that it was almost like they were on another planet. The physician formula has some problems. I think Congress will fix it, and we'll help them fix it. But I don't think it's going to be near what MedPAC thought. Physicians have a legitimate gripe about the way it's worked out this year. Some of it was accidental, and some of it was due to the inflexibility of the formula that's in place now. Some errors were made a couple of years ago, and the formula has an automatic recapture component. But physician spending has been going up pretty regularly in the last few years. Also, there are other facts that physicians don't see. We used to fix 100 codes;

now it's 7,000. Every year the AMA and others come in and say we need new codes for new procedures, and when we add them, it waters down the conversion factor. So there are a lot of factors that go into this. The bottom line is that physicians are very angry, and they should be angry. Some physicians are going to see a drop in income. We're going to do the best we can to come up with a fair and reasonable fix.

MC: When the National Governors' Association met recently, it named Medicaid costs as states' most urgent crisis. What are the principles by which Medicaid needs to change? I know you can't write the legislation yourself, but what needs to change to stabilize the program?

SCULLY: The program needs consistency. I don't think the federal government will ever get the financing back from the states, and maybe we shouldn't. The Number 1 concern is to come up with some consistent financing mechanism, where all the states get treated the same. Due to all the different financing loopholes in the last 15 years, the program's been thrown out of whack. The first thing I'd say is "Look, we're not going to get the money back from the states, but let's at least come up with a level playing field, so that everybody gets treated the same." Second, if you ask the states what their big issues are, it's the low-income seniors who are eligible for both Medicare and Medicaid. We probably need to come up with some consistent way of covering dual-eligibles. That may mean eventually phasing

them into a fully federalized program. I don't think we'd support having the federal government just assume the responsibility from the states. But I think if the states said "We'll take less money, continue to cover some populations, and hand the others to the feds," that option ought to be looked at. An awful lot of people have suggested that the federal government take long-term care and the disabled, and let the states take acute care, or vice versa. That's extremely difficult, because all 50 states have totally different programs, and there's no easy way to divide things like that.

Means testing for a drug benefit ought to be looked at. For a guy digging ditches in Cleveland to pay taxes to pay for health care for a wealthy retiree in Florida is crazy.

MC: Another huge issue is that most seniors spend down to get into nursing homes in the Medicaid program. How can that be fixed?

SCULLY: In the long run, we need to get people to start buying long-term-care insurance. In a rational world, 40-year-olds should be buying long-term-care insurance now. If you have a cafeteria plan, you should have a tax incentive to buy long-term-care insurance. In the long run, it's going to be good for you, because you'll be able to afford long-term care when you want home nursing or assisted living or a nursing home. You'll have a lot more flexibility in taking care of yourself when you're 90 years old.

MC: Given your own CMS estimates on the projections for health spending rising 7 percent a year through 2011, would it make sense to have means-testing as part of Medicare, so that benefits go only to those who need them?

SCULLY: This is not the administration's position. You don't want to undercut the social fabric of the program. I've spent years looking at means testing, and we pushed it a lot in the first Bush administration. Social Security is heavily means-tested. If you pay into Social Security at the maximum tax rate your whole working life, which I probably will for most of my life, I may pay in five times what somebody else pays in, and I may get back 20-percent more than they get back out. It's a very means-tested program. Say you want to means-test Medicare for people with income above \$70,000 a year. That's less than 1 percent of seniors. It sounds great, but there just aren't that many people up there.

MC: But there could be a lot of dollars up there.

SCULLY: Not really. You'd be shocked how few there are. It depends on what you want to do with means-testing. You want to start at \$30,000 of income, then you can do some serious means-testing, but most seniors don't think of themselves as rich at that level. If you want to really means-test upper income seniors, you'd be stunned at how few people are upper income. As a matter of principle though, for a new benefit like a drug benefit, for a guy that's digging ditches in Cleveland to pay taxes to pay for health care for a wealthy retiree in Naples, Fla., is crazy. For a new drug benefit, I think it's something that at least should be looked at.

MC: Some of the critics of the interim discount drug-card proposal in Medicare say that it leaves too much discretion to the manufacturers, and that the discounts that people will end up getting will be too small. How do you respond?

SCULLY: It's ridiculous. This is not a drug benefit; it's the beginning of a drug benefit. All the Democratic bills and all the Republican bills use pharmacy benefit managers. Every single human being in the country under age 65 who's insured is part of a PBM. When you go to a drugstore, that PBM has negotiated a lower price, so you pay 30-percent less than if you had walked in by yourself and ordered the drug. One reason our proposal is a good idea is that none of the bills in Congress creates a true drug benefit for three years. There's absolutely no reason we can't place the 40 million people in Medicare into group-purchasing pools to get discounts now.

MC: On the Medicaid side, some drugstore chains say they'll drop Medicaid if the states set the payment rate. Is that just an idle threat?

SCULLY: I was the person for President Bush Number 1 who negotiated that in the 1990 budget deal. I heard that in 1990, and I've been hearing it ever since.

MC: So you're not losing sleep over it?

SCULLY: I'm concerned about pharmacists. They're a critical part of the delivery mechanism. Pharmacists' real worries are about the Medicare prescription-drug card that we were talking about. They're concerned that PBMs will move people into mail order. We don't think that's going to happen, but there's absolutely no excuse for not trying to get the elderly some group purchasing power. I also know that when Congress actually puts a Medicare drug program into place, we're going to have to run it, and we have no experience running it. If we had a voluntary drug-discount program in place for three years, we would gain a lot of experience. So, there's absolutely no downside to it. The only people that have any legitimate concern are the pharmacists. We're doing everything we can to work with them to make them feel more comfortable with it. They're afraid they're going to get squeezed. They think it's going to do what Medicaid did to them, and I'm not sure that's necessarily right.

MC: Thank you. **MC**