

THE FEDERATION OF AMERICAN HOSPITALS

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CMS UPDATE BREAKFAST

8:50 AM –

SPEAKER:

**LESLIE NORWALK,
CMS ACTING ADMINISTRATOR**

INTRODUCTION BY:

**KEITH PITTS,
2007 CHAIR,
FEDERATION OF AMERICAN HOSPITALS**

*Transcript by:
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KEITH PITTS: Welcome to our final function, the CMS breakfast. I'm Keith Pitts, your federation chair for 2007. I'd like to take this opportunity to thank all of our sponsors for this year's extremely successful meeting. I'd especially like to thank the Max (ph) and the Journal of Healthcare Contracting for sponsoring our chairman's reception and dinner last night. I hope everybody enjoyed the Capitol Steps. They certainly were current. I think there were within a day of the news in terms of their skits and they also left no one unscathed, except for the CMS administrator. Everybody else, they pretty much hit.

For this morning's breakfast, I'd like to thank River Rain Medical Group and Train. We're greatly indebted to all of our sponsors for their ongoing support of our industry's mission. I'd also like to thank kaisernetwork.org for being here today and producing an archive webcast of today's session. A webcast along with a transcript will be available in a few days on the kaisernetwork.org website. Also, we will have a link to this website and webcast on the homepage of the federation's website.

Now, I'd like to introduce our head table. To my far right is Chip Kahn, the president of the Federation of American Hospitals. To my near right, Vic Campbell, the very happy outgoing chair – (laughter) – our 2006 chair of the Federation of American Hospitals. To my far left, Leslie Norwalk, the acting administrator of Centers for Medicare and Medicaid Studies.

We want to make sure we get you out on time so we're going to just go ahead and move into this morning's program. If you haven't finished breakfast, go ahead and eat while we get under way.

First thing I want to do really is salute Vic Campbell, our outgoing chairman. Vic will be among the first to admit that 2006 was a very busy, but productive year. While the federation worked very hard on a number of fronts, without a doubt our most significant and lasting achievement was the creation of a comprehensive policy proposal to provide health care insurance coverage to virtually all Americans. Without a doubt, it was due to Vic's leadership on this issue that helped the federation accomplish this important public policy. As this year's chairman, I know I'll have my work cut out for me to match his standard. Vic, on behalf of the federation, I'm pleased to present you with the federation's traditional crystal obelisk as a token of our appreciation for your tenure as chairman. (Applause.)

On a more personal note, we'd also like to present you with a gift that Tony suggested you might appreciate. A look of nervousness on his face. (Laughter.) It's a print of the U.S. Capitol painted by a well-known local artist.

VIC CAMPBELL: Wow, wow. That's beautiful.

MR. PITTS: Tony thought you might want to – something to remind you of a place where you spent so much time. (Laughter.) So thank you again very much.

MR. CAMPBELL: Thank you.

MR. PITTS: Great. Let's give Vic a hand. (Applause.) Now comes the part of the program where I say a few words as the newly elected chair of the federation. I will try to keep my comments brief so we can get quickly to our guest speaker.

Typically, I'd like to – I intend to do this with the emphasis on the word few – (chuckles) – hopefully. Let me again say thanks to Vic. Vic did a tremendous job as chairman to help guide the federation to a new level of prestige and influence. I intend to build upon our accomplishments that we achieved under your stewardship. In particular, I intend to advance the federation's detailed and realistic proposal which we call Health Coverage Passport to solve the national health coverage crisis.

Vic, as you know so well, no one better understands the crisis of the uninsured than the hospital they turn to for care. The national conversation on the uninsured insurance crisis is fully engaged and now the federation's important voice is helping to lead the way toward coverage for all Americans. Meanwhile, this year our road ahead is a pathway paved with PAYGO perils, as Congress has pledged to adhere to rules that requires every policy calling for new spending to be paid for in full.

Our road began with President Bush's proposed budget for fiscal 2008. Compared to last year's budget, this year's budget proposal is double trouble. Last year, the president's budget contained about \$36 billion in proposed Medicare cuts. This year, it's contained \$76 billion in proposed Medicare cuts, not to mention another \$26 billion in proposed Medicaid cuts. Hospitals would have their market basket inflation update reduced not just in 2008, but permanently by .65 percentage points each year. I'd submit to you this public policy proposal is not responsible.

Just last week, MedPAC reported plummeting hospital Medicare margins and estimated 5.4 percent negative margin in 2007. This is the fifth year of declining negative Medicare margins for hospitals. And in short, payments are really not keeping pace with the rising costs of nursing care, paying specialists for on-call coverage, medical innovation, things that ultimately do save lives, information technology, and preparedness. This is just a short list of issues requiring substantial investment in human resources and capital infrastructure. It can't be done on the cheat.

To its credit, MedPAC could not and did not ignore the empirical data by recommending to Congress that hospitals receive a full market basket update in 2008. We will encourage Congress to follow the advice of its advisory commission. At the same time, we will also urge Congress to resist the expediency of meeting its PAYGO pressures by cutting hospital payments however well-intentioned.

As MedPAC's data demonstrates, hospitals are losing money treating seniors. Cutting Medicare hospital payments then is a backdoor way of really cutting Medicare benefits. Some lawmakers may see it as the path of least resistance, attempting targets simply because of the size particularly on the hospital payments side. I pledge to you that we'll do everything we can to change that dynamic.

So too regulations too often are seen as an even easier, difficult-to-resist pathway to help balance the bottom line. We will always encourage and support thoughtful, reasonable regulations that stimulate more efficient and higher quality care. We stand ready, as we always have, to partner with CMS and other agencies along these lines. But we'll be vigilant when we need to be. Two areas come to mind. One is the excessive tightening of the 75 percent rule for inpatient rehab hospitals. The other is the use of payment policy instrument in substitute for appropriate classification criteria for long term care hospitals.

Congress will soon consider bipartisan legislation that would remedy these regulatory missteps and preserve patient access to the critical care that these important providers deliver. Of course, as is often the case, challenges come bundled with opportunities. So while our full service community hospitals fight funding cuts in Congress, we welcome Congress' renewed attention to the threat to community healthcare posed by physician-owned specialty hospitals.

Once again, leadership in the Senate Finance Committee are championing the cause of the community hospitals. Joined by Representative Pete Stark, chairman of the House Ways and Means Committee, along with Finance Committee Chairman Max Baucus and ranking member Chuck Grassley, they're all demanding that Congress regulators and enforcers take truly effective action to protect patients and the quality of care they receive. They know, as we know, how conflicts of interest arise when financial incentives compromise clinical care.

Federation staff have worked very hard to enhance our ability successfully, seize opportunities, and resist challenges while maintaining good working relationships with the new congressional leadership. This is a natural result of an association that cultivates bipartisan consensus based upon well reasoned and well respected policy positions. This will serve us well as we fight to preserve funding for healthy Medicare and Medicaid beneficiaries. It will also serve us well as we continue our well recognized leadership role with reporting hospital quality data. It will serve us well as we maintain our leadership and representation of the hospital industry regarding health information technology.

And I'd really like to end by saying that I deeply appreciate the honor bestowed upon me by the board and serve as your chairman, I will work hard with pride to advance our common goals and shared principles. I also want to complement Chip Kahn and his dedicated staff for all they've done and will continue to do on our behalf. Their hard work and consistent professionalism builds a platform for our success and accomplishment as an organization.

And now, on with the show. Leslie Norwalk has been acting – serving as acting CMS administrator since the departure of Mark McClellan. During her past five years at CMS, she has been a key member of the senior leadership team, having served as deputy administrator, chief operating officer, and then acting director of the Center for Beneficiary Choices. Ms. Norwalk played a central role in implementing the Medicare prescription drug benefit. She was the CMS lead on the secretary’s efforts in the wake of Hurricane Katrina.

Ms. Norwalk is in charge of one of the largest healthcare entities in the world. CMS has the second largest budget outlay of the federal government, directly responsible for one dollar out of every three dollars spent on healthcare in the United States. CMS insures about 25 percent of the U.S. population and processes over one billion claims each year. Prior to serving the Bush Administration, Ms. Norwalk practiced law in Washington, D.C. She attended George Mason University School of Law where she was a Dean’s Scholar and editor of the George Mason Law Review. Ms. Norwalk is a native of Dayton, Ohio.

Ladies and gentlemen, please give me a warm round of applause for this morning’s speaker, Leslie Norwalk.

(Applause.)

LESLIE NORWALK: Good morning. How’s that coffee? Keep drinking. (Laughter.) Make sure you’re still awake when I’m finished and we’ll try and get you out before the snow, but no worries, the taxicab line is so long that it will still be there when we finish. (Chuckles.)

Chip, congratulations, thank you very much for having me this morning and I gather this is something that you do every year. So I’d hate to have broken that tradition because of having to testify. All right, so let’s get to it. You raised a number of interesting points. I’m sure that if I don’t address them in my remarks, you will have an opportunity to ask me about them in terms of questions. I look forward to that. (Chuckles.) In the meantime, I’ll talk about a few other things as well.

Secretary Leavitt, when he was earlier this week, talked about the opportunity to create a new American healthcare system to deliver better healthcare for all Americans at a lower cost. As investor-owned hospitals, you can help us build a healthcare system where competition is really about value and, in fact, today we think sometimes the opposite is true.

That’s because up to now, Medicare in particular has been paying for the care – not paying for the care that we value, but instead just paying for whatever care is provided. Medicare spending today goes for paying complications for chronic care, disease that we know how to prevent – disease like diabetes, heart failure. And 23 percent of our beneficiaries have five or more chronic conditions that account for 68

percent of Medicare spending. They see an average of 13 physicians and fill 50 prescriptions annually.

Payment matters. As Keith noted, in 2005 we processed over one billion claims and if you add prescription drug claims, that's basically another billion that will be added this year. Last year we spent over \$600 billion on the health of approximately one in three Americans, about 90 million, and we have the largest healthcare budget in the world, which is not surprisingly larger than actually many budgets of countries.

But we have a strategic plan that is moving forward on a well-defined course to modernize the Medicare program. The plan is built around three simple but very important principles. They are providing up to date benefits, making healthcare programs sustainable for future generations, and paying for the kind of care we want. The principles take on more meaning when you look at the president's budget. I'm sure you've seen the numbers and Keith already mentioned them, \$76 billion in savings for Medicare over five years and approximately \$26 billion in Medicaid savings over the same five years.

Let me share with you some of the thinking behind those numbers. First, Medicare is projected to grow 6.5 percent per year over the next five years and the president's budget doesn't really do much. It simply reduces that growth rate to 5.6 percent, less than a one percent reduction in growth. The ten year growth rate for Medicaid is 7.4 percent per year. The budget brings that down to 6.7 percent, again far less than one percent per year in terms of reduction in growth rates. By taking measured steps now, the president's budget allows us to make our commitments to beneficiaries and providers while at the same time moving forward on the critical transformation agenda.

Without these measured steps, the options are less desirable. Benefit cuts, massive deficits, or huge tax increases. If you want to see an example of what happens if we don't act in time with measured payments adjustments, one only has to look at the problems we faced with physician payments. Right now, we're faced with cuts. Not reductions in the rate of growth like you're seeing, but an actual 10 percent cut next year on average per physician and five percent in the foreseeable future thereafter.

And if I haven't convinced you, let me tell you one more bit of information to add to the president's budget. Two weeks ago, the Office of the Actuary published their national health expenditures report. Their result is that healthcare costs are projected to double over the next decade. By 2016, the projection shows 20 percent of GDP being spent on healthcare. In other words, 20 cents on every dollar on healthcare services – \$4 trillion. How do we sleep at night?

The message is clear. We need to move to address healthcare costs. Small measured steps now will most certainly allow us to avoid larger problems down the road and that's what the president's budget is designed to do. Medicare must begin to pay for better health rather than more services to survive. The administration has made an

unprecedented commitment to healthcare quality and making healthcare more affordable and accessible to the individual patient.

The four cornerstones of the president's executive order, transparent quality information, transparent price information, interoperable health IT, and incentives for high quality efficient healthcare delivery – those have been CMS priorities for quite some time. We strongly believe in the importance of competition in healthcare. Consumer choice is important in Medicare and Medicaid programs as it is in the private sector. Improving consumers' understanding of the cost and quality healthcare, making healthcare more transparent for providers as well, should improve the healthcare system overall.

Paying for results is central to creating a value-based healthcare system in this country and it's the hospitals who are leading the charge. Let me give you a little background on the premiere hospital demonstration. We just extended the premiere hospital pay for performance demonstration project which has dramatically improved the quality of care delivered to patients for another three years. Launched in October of 2003 with approximately 260 hospitals in 38 states, the premiere demonstration is proving the hypothesis that financial incentives and public recognition will increase the quality of care provided. Second year results from the demonstration showed a substantial improvement in the quality of care leading to incentive payments totaling over \$8-½ million to 115 top-performing hospitals.

Participants reported significant improvement in quality of care across five clinical focus areas measured by more than 30 nationally standardized and widely accepted quality indicators. The average improvement in the project's second year were 6.7 percentage points for a total gain of 11.8 percent over the project's first two years. Though P for P is based on the assumption that any program would be budget neutral, for pneumonia alone, the premiere hospital costs dropped from \$11,000 to around \$7500 per patient when evidence-based clinical indicators were followed in a consistent way.

They saved a lot of money per patient. It resulted in shorter lengths of stay, fewer readmissions, and fewer complications. We had such success that we proposed to expand the demo on a voluntary basis outside premiere. But to pay for quality, it isn't enough to know it when you see it. You need to be able to measure it.

Over the past couple of years, we've made considerable progress for value-based purchasing, including quality improvement transparency, evidence development, and efficiency. All of this is based on the ability to use standard, clearly defined, and widely agreed upon measures of quality. And I want to thank Chip in particular for all of the work that he's done for the federation in terms of developing quality measures.

Hospitals are the vanguard on this front – (not the vanguard, you want that ?) – (Laughter.) Just thought I'd sneak that in there. This year, Medicare has started to pay for more when hospitals report on quality measures, providing the model for doctors and other providers on schedule in 2009. As part of the Deficit Reduction Act and the Tax

Relief in Healthcare Act, Congress directed CMS to explore ways to reward hospitals in both inpatient and outpatient settings for actual performance on quality measures in 2009. The administration is very serious about meeting this deadline, so much so that we've created a CMS special program office for value-based purchasing dedicated to developing a plan ready to implement by then.

Earlier this week, I believe you heard from Dr. Tom Valuck, the director of this new office, who spoke to the quality committee regarding the initial steps CMS is taking to develop a hospital P for P plan. It will build on the existing paper reporting measurement and reporting infrastructure and will include measures that address at least three performance domains: clinical quality, patient-centered care, and efficiency. We're going to build these measures through collaboration. You are the experts. Any movement we've made – and it's been substantial – has been the result of our partnership with people who are actually working in the healthcare field.

This process will be no exception. We will continue to work collaboratively with a broad range of stakeholders as well as through HQA, NQF, and JCO. We're going to monitor the new measures on an ongoing basis. We're going to make performance results transparent both to empower consumers to make value-based decisions about their healthcare and to encourage hospitals and clinicians to improve their quality of services.

We already held one listening session in January and received a host of excellent recommendations that we will incorporate into our draft plan. These recommendations suggest that we link process, measures, and outcomes and raise all boats. In other words, don't pick winners and losers. Instead, spread payments broadly to engage and motivate more hospitals. Disclose uncertainty and variability in scores based on small numbers. Adjust risk to recognize differences in case mix and socioeconomic status. Be sensitive to unintended consequences. For example, we don't want participants to assume that firing their complex patients is the fastest way to improve their score. Don't retire top dock measures. Hospitals need positive feedback about the things they are doing well as well as constructive feedback on areas needing improvement. Reward both improvement and attainment and partner with organizations to create composite measures as well as measure that can be used by other payors.

CMS will post on our website, which is the cms.gov website, the draft Medicare hospital value-based purchasing plan on March 22nd. I encourage you to take a look at that plan and sign up for the second listening session on April 12th.

The movement to value-based purchasing is not limited to pay for performance. We are also investing in better information, including bringing breakthrough technologies to market, health information technology and pilot projects that will demonstrate the value of linking specialties in healthcare settings. They include coverage of evidence development. CMS provides coverage for breakthrough technologies such as ICVs and PETscans in the context of registries and other steps to help doctors and patients make more informed decisions about using these treatments.

The recently proposed new policy to use data from the Medicare part D program. We want to reach a new level of understanding about how prescription drugs are contributing to better health and identify opportunities to do more, or frankly to help spot adverse events – and if you read today's New York Times article, clearly people are not taking either the right prescriptions or enough of them, so there's a lot of work that we can do here.

In terms of coding, where we've implemented reforms in the code alignment process that's significantly reduced the time between the development of a new product and when a code becomes available. We're also looking to support the movement to ICD 10. Those codes – as soon as possible. ICD 9 is 27 years old, nearly out of space and has limited ability to accommodate new procedures and diagnoses. It lacks the precision needed for a number of current requirements such as the kinds of performance-based systems we need, more accurate billing, and public health monitoring for unusual patterns of complications in adverse events. The ICD code set will help address these shortcomings. We will seek public comment on how we can move to ICD 10 quickly and effectively and you should look for the rule to come out at some point so that you can provide us with comments.

Health information technology, which will replace paper with electronic health records, personal health records, and electronic prescribing. We know that health IT is the glue that ties together the different parts of the healthcare system. And our operability standards allow systems to communicate and their widespread adoption supports the development of innovative and effective new programs.

Coordination of care. We're developing evidence through a host of pilot programs to evaluate the impact of care coordination and improve service delivery. The secretary's value driven healthcare initiative is one of these. It will align hospital and ambulatory measures, include overall price and efficiency measures and promote local efforts to achieve improvements in quality. Another is the Physician Hospital Collaboration Demonstration which tests whether allowing hospitals to provide doctors with financial incentives to support better care can improve patient outcomes without increasing costs.

Pain (?) sharing with the appropriate quality metrics can support the best efforts of physicians in hospitals to improve quality and efficiency in the overall care for their patients over time. And we're considering how to test payments around entire episodes of care, including post-acute care settings.

In terms of new regulations – I think Pete also mentioned some of this. Our traditional regulatory rule toward meeting value driven health care is present there as well. And our hospital inpatient rule this year will take an important step towards accomplishing this. The DRA requires that Medicare not pay for preventable conditions, high cost, high volume, or – excuse me – I thought I'd memorized this last night, now I have to turn the page – (chuckles) – or both acquired in the hospitals. Their provisions will take effect in October of 2009.

We have consulted with hospitals as well as the CDC on this change because we're very concerned about getting it right. Please review the conditions that we've put in our proposed rule in April. And we'll need your feedback because you know about them at least as well we do.

In terms of the inpatient prospective payment system, I know many of you are very interested – I suspect each and every one of you – in our plans for continued reform of the inpatient PPS. We started major reforms of IPPS last year and promise to continue the efforts this year. You may remember that we began them because of the concern MedPAC expressed to their 2005 report to Congress that physician-owned specialty hospitals treat the healthiest, most profitable cases, leaving the sickest, and least profitable cases for community hospitals.

Ultimately, MedPAC included that physicians establish specialty hospitals in part because of “inaccuracies in the Medicare payment system and that improving payment accuracy will make competition more equitable.” MedPAC recommended at that time that we use hospital costs instead of charges to develop rates and adopt a DRG system that better recognizes patient severity of illness. Their recommendations were very significant and we began looking at them immediately.

When we began our efforts in the '07 inpatient rule with the adoption of cost weights, this is a change from charge-based payments to cost-based payments that we are implementing incrementally from 2007 to 2009. We began our efforts in the FY07 inpatient rule – sorry, although Medicare's hospital payments were based on charges for many years, they were a poor proxy for hospital costs and provided incentives for hospitals to treat surgical cases at the expense of medical cases. We also found that the charge system helped large urban hospitals at the expense of small and rural hospitals.

We believe these changes significantly improve payment accuracy by making Medicare's payment more closely reflect a hospital's costs and remove incentives and disincentives to treat or not treat any particular type of inpatient care. Although we proposed a DRG system that better recognizes severity for fiscal year '08, we did not adopt it because of concerns that were raised by you and others. However, we were able to make significant improvements to the DRG system to better recognize severity of illness while we pursue several long term solutions on the issue.

We created 20 new DRGs over 13 clinical areas, deleted eight, and modified 32, affecting more than 1.7 million cases. Again, we think these improvements better recognize severity of illness and will help ensure that hospitals receive equitable payment so they don't have the incentives to treat or not treat any particular type of patient.

We are not yet finished with this effort and are listening to what you have to say. Changes we are considering further are a direct result of the comments you made to the final rule last year. As we said, we are interested in making more improvements soon and have three initiatives under way. The first is a contract with the RAND Corporation

to evaluate five alternative DRG systems. Because we value the opinions that hospitals and other experts can provide, RAND assembled a technical expert panel that included a representative from the federation. RAND's evaluation is well under way and a preliminary report to the expert panel has since provided feedback to RAND. CMS will provide an update on the RAND project in the proposed rule. We plan to post a draft on the RAND study on the website soon.

Second, we are working – we are updating work done by CMS 10 years ago to develop our own severity DRG system and we will report on this work in the proposed rule at the same time. Many commenters express concern about basing payments on costs instead of charges. In particular, there was concern that the new payment system may underpay expensive but effective technologies. So we contracted with RTI to further study the very complex and detailed issues raised in the public comments. We don't want to discourage use in cycle (?) innovation by underpaying. The proposed rule will report on RTI contracts' progress and we'll also expect to post that on the website.

There are important steps to making payments fairer to hospitals and to ensure beneficiary access to services in the most appropriate setting. The other piece of the hospital world, outpatient side – outpatient services are also critically important to the healthcare of our beneficiaries. So we need to ensure that our payment methods and the outpatient PPS are rewarding value. But outpatient PPS has been a typical example of the kind of value-based payment that has increased with the number and intensity of services provided, but yet hasn't reflected the impact on equality or patient health.

We've seen rapid growth and large variations in hospital outpatient services recently. Between 2005 and 2006, hospital outpatient expenditures increased by nearly 12 percent mainly due to the growth of value and intensity of services. This year, they'll be approximately 9.2 percent higher than the estimated '06 expenditures. It's an issue for taxpayers and it's an issue for beneficiaries whose monthly premiums pay 25 percent of the part B expenditures.

In addition to developing measures specific to hospital outpatient services, the rule we issued last November finalized a policy of tying payment rates, rate increases to the reporting of quality measures beginning in 2009. Hospitals would be required to report quality measures specific to hospital outpatient services and doing so would result in a full update on outpatient payments. Hospitals that fail to do so would receive the outpatient PPS update minus two percentage points.

Now, the decision to expand quality reporting and value-based purchasing to hospital outpatient setting in calendar year '09 was a deliberate decision to focus on service delivery that cuts across specialties in healthcare settings. Now, there's a reason we published a proposed rule and a final rule. It's because we wanted your expert input and we certainly appreciate Keith's comments to this regard and hope that in addition to the federation any of you who have comments – we encourage you to submit them. Without those, we can't get it right.

And that also goes for our new plan to pay for reporting by 2009. You have to stay out on front in this. Payment and performance must be linked. Transparency and competition can only make healthcare delivery stronger. It's not business as usual at CMS and it isn't easy. But there is no turning back. With your help, we can get more out of our healthcare dollars: more valuable innovation and medical products at a lower cost and more value for money. And we're using errors, complications, and unnecessary care.

Thanks for letting me speak with you this morning. I look forward to taking your questions.

(Applause.)

MR. PITTS: We have some microphones up here for anybody to come up and ask questions – (off mike) – if anybody has questions.

CHIP KAHN: Yeah.

MS. NORWALK: Chip does. He's not shy.

(Laughter.)

MR. KAHN: I'm not shy.

MR. PITTS: We have to repeat the question here for our webcast folks.

MR. KAHN: Okay, that'll give everybody else a chance to get your thoughts together. Embedded in the budget the president submitted was \$10 billion, I believe or so, that was going to come out of the regulatory process. And we've been – especially Steve Speil (ph) has been going through the papers trying to figure out where's that –

MS. NORWALK: To read our minds?

MR. KAHN: (Chuckles.) Where is that coming from? Because it tells us what the effect is over time but it doesn't tell us what the programmatic implications are. So I guess my first question out of the box is –

MS. NORWALK: I knew this question was coming.

MR. KAHN: What does that –

MS. NORWALK: What does that mean?

MR. KAHN: What does that mean?

MS. NORWALK: Well, we're looking at a number of different things. Let me give you a sense of what those are. Not surprisingly, program integrity is chief among

them and making sure that what we pay we're paying for appropriately, and so forth. And we anticipate getting a fairly significant amount of savings through program integrity.

You've already seen our LTAC proposed rule. That's another piece of that there. We're concerned about what we've been seeing in some parts of the country with regard to hospice; in particular, the average lengths of stay in hospice vary a tremendous amount in certain parts of the country. And the types of diagnosis we're seeing in hospice is changing from what used to traditionally be cancer treatment more to Alzheimer's. And hospice is not intended to be used as a nursing home, so it'll be interesting to see how exactly that plays out. But we're taking a close look at hospice.

We're looking at both home health agency and psych payments – those are both relatively new payment systems – and wanting to ensure that those, we adjust for any up-coding, etcetera. And we're taking a look at capital. So those are the – some of the – topics. I'm sure that if we see others as we continue to look at what MedPAC and others suggest to us, we may add others to the list, but those are just a few of some of our thoughts. So, all right.

And in terms of how they break out, I don't know yet, in terms of impact. Questions?

Q: Transparency for hospitals, I think, is a thing that's coming. We're all behind it; we're in favor of it, actually, even on the hospital side. But the triangle of providers being physicians, hospitals, and vendors, the vendors are left to hide their pricing behind such rulings as the Guidant/Aspen case, yet we don't get the same benefit that you get and particularly on the high position preference items – pacemakers, orthopedics, et cetera – how can we assist you to find that transparency for us?

MS. NORWALK: So just to repeat the question for the webcast. Basically, the – in short, the question is the hospital industry would like to have some more help in transparency around the pricing of equipment, basically, or other supplies.

Q: More for the high position preference items.

MS. NORWALK: Thank you – devices, high position preference devices, there you go. I think it's something that we'd like – I think it's something that we'll be taking a look at. I know that we've been discussing it internally. What makes the most sense to do? It's an interesting thing, transparency. And there are a number of ways that you can consider how transparency works.

On the one hand, if I'm a patient – my favorite story about myself – I – it's not, wasn't in a hospital setting, but I think it holds true elsewhere. I went to the doctor for a physical and after I had my blood work done a week in advance, I went to the desk to pay and I said, so what's the physical going to cost me next week? Yeah, I don't know. You don't know? Can I have a ballpark? Hundreds of dollars, a thousand – what's – Yeah,

we can't tell you. So to go to this – my doctor, of course, doesn't take insurance, I have to file myself, etcetera. So it's basically whatever the rate is and I get whatever the insurance company pays back, but she's fabulous, so fair enough. But conceptually, how can I – if I were – I know the quality side because I've been seeing here for a while, but I have no idea on the price side.

So the first thing from a transparency perspective is, can – does the patient have any idea what something costs? So I'm going to presume, say, in a hospital setting. Now, the Medicare program sets the prices. You don't like it – there's always this discussion about how Medicare negotiates. I'm sure that you don't think we negotiate. I know doctors don't think we negotiate. But – so there are some way that a patient, at least a Medicare patient, could have some idea of what he or she would be expected to pay and what the costs are, conceptually.

But what underlies those costs? Do you want to be transparent about devices, particularly those that physicians use often? That might be something that's important. But do you want to be transparent about salaries that you're paying to your workers? You are to us because of the wage index and so forth. But there are a lot of different pieces of what transparency is. And focusing on those that are critically important that impact both patient quality as well as the price, I think, are important to let patients know and understand because their – and physicians as well, frankly – because their actions make a very big difference on both the bottom line and their own health.

So I think it does make sense for us to work with you and figure out what makes sense and what – you know, you wonder, particularly on a Medicare side of the house, how much patients are going to really focus on that. But sometimes it's just letting the rest of the community appreciate their actions and the healthcare consequences that they bring. So that's a good question.

MR. PITTS: Well, there's another one. I could sort of do a follow up to that question. Thank you, first of all, for having a much tamer story about pricing transparency than the secretary was the other day. (Laughter.) But I think the point perhaps the gentleman was making really is that there's a lot of discussion about transparency and through providers' pricing and provider this and the costs to the purchaser of the provider. When you look at the healthcare dollar, there's a piece that goes from the provider to the ultimate purchaser in most of the country, and that's the insurance piece of the puzzle.

And on the other side, there's a huge amount that goes into the cost at all levels of quality of producing the services that we produce. And so I think the issue is transparency throughout the chain and also when will the discussion begin to assist us into actually being able to find ways to lower our costs, become more globally competitive, and the cost of us providing services to beneficiaries at all levels of quality – recognize that clearly quality improvement can have an impact on cost, but to an extent there's also the cost of actually producing even high quality services.

MS. NORWALK: Yeah, absolutely. I don't know if there's a question in that.

MR. PITTS: Well, that's kind of a question about how do we work together. I think that was a little bit the question, how do we work together to impact our costs –

MS. NORWALK: Well, I'm –

MR. PITTS: – in a positive way so that everybody benefits from the value.

MS. NORWALK: Absolutely. I'm hopeful. I know that – and you, in fact, mentioned in your opening remarks the discussion about how do we deal with the uninsured. And one of the problems that I have heard from hospitals since the day I walked into CMS five and a half years ago was things like the unfunded mandate that IMTALA provides and so forth. And so I've spent a great deal of time working on the changes to IMTALA that were proposed and finalized a number of years ago, including requiring transfer – that specialty hospitals take transfers and so forth.

So totally appreciating those sorts of things, that's a lot of what we're discussing with Affordable Choices and Chip and I have talked before if – in proposing something like this, wanting to ensure that we appreciate as we move to a system, hopefully, where more people are insured, what are hospitals most concerned about, now can we ensure that they are still there to provide the care that's needed, whether it be, frankly, in the emergency room or elsewhere. And that's part of this, I think, discussion.

In terms of being a partnership, I'm hopeful that you have found, whether it was Scully or Mark or me or frankly anyone at CMS, that we have been open and more than willing to work with you on whatever an issue happens to be. We may not agree on everything and, you know, we all have very different perspectives, so I wouldn't expect that we would, but that's not to say that we can't work together to find common ground on a whole host of issues and have as little space between us as possible.

So, any question?

Q: We hear a lot about consumer-driven healthcare decision making process. There's an area that seems buoyed in some of that discussion and I'd like to hear your comments on. Oftentimes it's thought that it revolves around the word pricing or choices about utilization, but one area that in spite of all the sophistication that we've put in prior years seems to be related to end of life care. Oftentimes, we're faced with conflict that in spite of all this, numerous – perhaps the majority of people we interact with have not made those decisions nor have they had those disclosures with their family.

Should Medicare, as a part of the CMS process, make such eligibility requirement that every person has to make that choice and their family has to have that disclosure and it be annually updated so that across the continuum of care, all providers, whether they're hospice, home health, long-term care, hospitals, we all know what the choices that have been made by the family? There's tremendous cost. There's tremendous resources

consumed. None of us wants to limit care. But there's a lot of confusion and a lot of activity in the physician world and the hospital world as to what to do with end of life care. If we really want to talk about running a better system and have consumer-driven healthcare, that's an important area that's missing at this point.

MS. NORWALK: And there's a lot in there. (Chuckles.) I'm thinking of how I can still have my job when I leave here. (Laughter.) The question for the webcast is how is it that we should take into consideration end of life care. And I think it's an important point and one that we should all be considering.

It comes to – the Terry Schiavo case comes to mind and thinking the number of people probably even sitting in this room in spite of the fact that we're all in the healthcare industry and may appreciate what happens when you don't have either an advanced directive or a will of some variety that includes healthcare decision making. Clearly, it has a gigantic impact. And I'm hopeful that Terry Schiavo's case and the public nature of that drove many people to sit down with their families and to write – put down in writing what their decision making is.

I don't think that we have – I'd have to go back and check and think about this – whether or not we have the authority to require that of Medicare beneficiaries. I do think it's something critical and that we all have a personal responsibility to not just do this for ourselves but to let our families know, as well as let our healthcare providers know. The more we have health IT, the easier it will be for the entire spectrum of care, the whole continuum, to have the same information about someone's healthcare wishes.

And you can appreciate that often accidents happen and people don't know. And end of life care is something that you deal with whether or not, frankly, you're in the Medicare program. So how is it that we can help all providers appreciate what's there? I have heard – now, Medicare does have a requirement that advanced directives be adhered to and that physicians keep them.

But I'm not sure, frankly, that along the continuum that we yet have a good way to ensure that someone in a hospital, for example in an emergency department, would know what someone kept at their primary care physician's office, or whatever it is. And how is it that as we move to better electronic medical records that we can include that critical type of information in someone's file so if someone has gone to the trouble of having an advanced directive that the providers in the healthcare system appreciate what it says and then can abide by it.

So I think you raised a very good point because we spend a significant amount of money in our system of end of life care. It is a very personal issue and if it's – in the abstract, it's easy to discuss; but as soon as it's someone that you care about a great deal and want to live one more day, it is much harder from a political perspective to imagine how that works. And I think Terry Schiavo's case is emblematic of the issues that will arise as we really grapple with the costs of the Medicare program going forward. But at

the very least, we ought to ensure that people do have the personal responsibility and take that to let their providers know and that all the providers would know.

So, yeah, that's a good point. Yeah, sure?

MR. CAMPBELL: I'm awfully close up here, but I'll jump up anyhow. I've never missed this breakfast since Tom Scully started coming. Talking about my favorite subject – and everybody in here knows what it is. In fact, I handed this little brochure several years about a great loophole in the Medicare law: specialty hospitals, physician self-referral. Last year at this meeting, we talked to Mark and at that point in time we'd had an Oregon specialty hospital call 9-1-1, deliver a patient to one of our hospitals, dead on arrival.

Within the last few weeks, you're aware of the situation in Texas. It's happened again. That hospital called 9-1-1 14 times last year. It's a travesty. It is absolutely a loophole in the law that I know it was looked at last year by CMS. We were just playing with the final rule, the final report and we just once again want to put it back on the table.

Also, for what it's worth, a new study in JAMA today from University of Michigan, when cardiac specialty hospitals open with physician ownership, they double – in these markets – they double cardiac surgery. And the cost of healthcare is going up as a result of this.

So anyhow, I couldn't go home. I couldn't keep my job and go home without getting up here. So those of you from HCA can report back, I did my job again this year. (Laughter.)

MR. PITTS: It's on the webcast.

MR. CAMPBELL: However, it's actually – I'm the one that would feel bad if I didn't raise it one more time. So I'll leave you with that and ask you to keep looking.

MS. NORWALK: Sure. Well, I suspect that Mark – in fact, a number of people have probably commented on this, a number of other prior administrators who were standing before me. The statute under Stark does allow for physician ownership of the whole hospital. So the whole hospital exemption is something that's statutory, which we don't have any ability to change. So inasmuch as – as long as a specialty hospital is a hospital – and one of the things we've done is to ensure that those hospitals are not ambulatory surgical centers, for example. But if they are a hospital, they need to abide by all the conditions of participation that a hospital has.

I'm not going to comment a whole lot about what we've been seeing in west Texas. But I can say this much: that Texas generally requires hospitals to have emergency departments. And of course, we're going through the full immediate jeopardy issue and ensuring that they're surveyed and anticipate that being – my days are – (unintelligible) – but that's close to being done. There are many instances where

hospitals of any variety, whether it's a specialty hospital or a regular hospital, can call 9-1-1. There are times when it's appropriate and times when it causes us greater concern. I'm concerned about a death that is unnecessary in any hospital. I don't care if it's a specialty hospital or a general hospital.

And one of the things that we've done that I noted in my remarks around specialty hospitals is make sure that we're paying appropriately for a service, not to encourage cherry picking and so forth, but to actually focus on getting the payment right so that community hospitals are not disadvantaged by a specialty hospital on the market. And that's the other reason why we did, making sure that specialty hospitals had to take transfers under IMTALA. So that if they did not have a capability at a community hospital, that's not to say that the community lost that capability when someone went to an emergency department.

So we've been doing lots of things given the statutory requirement, or the statutory permission for a physician to have ownership in a whole hospital, and totally appreciating that that's there, what is it that we can do to ensure the healthcare system as a whole with that there, and make more sense of how a patient is treated within a community? So.

MR. CAMPBELL: I guess I go back to one thing. These are not whole hospitals. And I know we've wrestled with that term. But they aren't. They are not whole hospitals. They are departments in hospitals that have moved to a different building. And also the issue of – I've heard people say, oh it's common for a hospital to call 9-1-1 – I don't think that's true. It's common for a hospital to transfer or something – we'll transfer to Vanderbilt from time to time. We don't call 9-1-1 to do that.

MS. NORWALK: You know, I don't know that it's common, I just said that it's permissible in certain instances.

MR. CAMPBELL: No, you didn't happen to say it, but others on the other side of the industry have.

MS. NORWALK: Well, anyway. But just rest assured, we continue to take a close look and want to ensure that there's quality patient care regardless of the setting.

MR. PITTS: There's one more.

Q: Good morning. On Medicaid, just to switch gears here a little bit, I want to deliberately leave this as an open-ended question for you. Over the next two to three years, no doubt there are going to be changes in Medicaid. What would you anticipate to be some of the more spectacular things that you may be thinking of with respect to alterations to Medicaid in any form, administratively, regulatory, financially, etcetera? And just let you kind of talk about what you foresee.

MS. NORWALK: Well, there are a couple of things that may be less focused on the hospital community. But I think the biggest changes to the Medicaid program really focus on long-term care. And that – long-term care in this country, long-term costs are spiraling out of control. People don't appreciate that a typical month's stay in a nursing home was \$5,000. And they don't plan for their future. So I ask any of you, how many of you have long-term care insurance or in some way shape or form have prepared for a possible stay in a nursing home.

Moreover, in 1965 when Medicaid was created, that was the traditional place to receive care, so we subsidized institutions. When you subsidize an institution, it's the institution that gets taken care of as opposed to the patient, and we've often seen this in a Medicaid setting. So really changing the focus in the Deficit Reduction Act allows us to do this – changing the focus from treatment in a building as opposed to treatment in a home and a community, particularly when that's possible for a particular patient. It's not going to be possible for everyone, but when it is possible, most people would prefer to be in a home or in the community getting that sort of care. And the DRA allows us and allows states the flexibility to do that rather than coming to us every single time for permission.

So I think that is a pretty critical component in terms of changing the way that Medicaid works in the long term. And it also frees up significant resources for states because care in the home and the community not only is it often better for an individual, is often better for the state in terms of the resources that are required. Consequently, it allows states to cover more people in different eligibility ranges.

The other piece which I see changing in Medicaid – or we hope to see – probably somewhere in the neighborhood between a dozen to 20 states, maybe a little bit more than that now, have come to us talking about how it is that they can help with the uninsured. Now, Medicaid doesn't allow childless adults to be a part of the Medicaid program generally, but they certainly are uninsured and they certainly receive healthcare services and I suspect they receive lots of those services in hospitals. Given that, what is that we can do to help support, in particular, them getting insurance?

So it's more than just saying, hey let's make sure that you get the care that you need, that hospitals are there, that you can go to an emergency department. But instead, let's refocus that and ensure that those individuals, particularly those under income levels of 200 percent of the federal poverty limit, let's make sure that we can help support them getting insurance. At the same time, of the 47 million who are uninsured, many of them are over that level. Either they – they may make money, but they are uninsurable because of certain healthcare conditions. How can we help the states with high risk pools or reinsurance so that they can – so that those individuals can have access to insurance, but have it in a way that's affordable, instead of paying premiums that cost at least as much, often as much, as any treatment might cost?

And then finally, of course, the tax proposals that President Bush made in his budget in terms of the standard deduction. Between the HHS side and the standard tax

deduction side, those two were intended to work together to provide an insurance market for those who don't have access to health insurance through an employer. Not everyone is so fortunate. And of the 47 million people who – many of the 47 million who are uninsured actually work and just don't have access to insurance either because they can't afford it or – it's typically because they can't afford it – or if they think they're sort of 20 and they think they're invincible and they're never going to die or get sick. In any event, I think there are lots of different ways that the states are coming together to help support insurance and make the individual market look more like the employer market.

So those are the things that I see in the future. Whether it's the federation, Congress, governors, the administration, we're all talking about how do you deal with the uninsured. And between those two things, moving from an institutional-based long-term care treatment to – that's the first thing and dealing with the uninsured. Those are the two things that I really see over the next two to three years in Medicaid and changes that will be important.

So, anyway, thanks for having me this morning. Did you have a comment, I'm sorry, Chip.

MR. KAHN: One more question, and I know we're –

MS. NORWALK: He is taking that prerogative.

MR. KAHN: I am taking that prerogative. (Laughter.) And actually, it's sort of a plea as well as a question. There's been a lot of analysis done on the Premier Demonstration and I think it has a good track record. I'm not debating that. But I think if you look at just the production and the improvement by hospitals on the reporting side, where you have a sample of all hospitals, it actually, one, is quite dramatic overall and, two, it is not as high as the Premier Demo, but then it's not been in the field as long and, two, it actually is almost comparable.

So I hope – and this is more of a hope as well as question – that in the future as the analysis is done, particularly in preparation for any kind of pay for performance proposals that have to be sent to Congress, that there's some look at reporting alone in comparison and some noting that progress is being made just from that, because the problems that we see with pay for performance is not a concept, but how it will actually be done. You could take a Premier Demo methodology and it might look great for a couple of years, but after a while, it could become quite arbitrary. Whereas reporting is something that, you know, is done one day, done the next, and can be done into the future. So I just hope that you'll look at both in your analysis and that some comparisons – albeit Premier is a little bit ahead, but not that much when you look at the numbers.

MS. NORWALK: Interesting. Well, I'm quite sure that we'll be spending lots of time together discussing just that, Chip, and I look forward to it. (Chuckles.) Anyway, thanks everybody.

MR. KAHN: Thank you.

(Cross talk.)

MR. PITTS: Thanks again, Leslie. This will mark the conclusion of the 2007 annual Public Policy Conference and Business Exposition of the Federation of American Hospitals. Once again, I want to thank our many sponsors, buyers, and suppliers, who play such a vital part in this meeting. We owe the continued success of the meeting to you and are grateful to each and every one of you who are taking part.

I hope to see everybody next year at our annual conference scheduled for March 2nd through the 5th, right here at the Marriott Wardman Park in Washington, D.C. The meeting is now adjourned. Thank you very much.

(Applause.)

(END)