

FEDERATION OF AMERICAN HOSPITALS (FAH)

**2008 FAH PUBLIC POLICY CONFERENCE
AND BUSINESS EXPOSITION**

CMS UPDATE

**WELCOME:
KEITH PITTS, VICE PRESIDENT,
VANGUARD HEALTH SYSTEMS;
CHAIRMAN, FEDERATION OF AMERICAN HOSPITALS**

**MODERATOR:
CHARLES N. KAHN III, PRESIDENT, FAH**

**SPEAKER:
KERRY WEEMS, ADMINISTRATOR,
CENTER FOR MEDICARE & MEDICAID SERVICES**

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KEITH PITTS: Good morning. Welcome to our final function, our CMS breakfast. I'm Keith Pitts, your federation chair for 2008, so if you think this is Groundhog Day, this is a Groundhog Day. Thanks all for coming tonight. Enjoy your breakfast. We're going to get started in about 15 minutes after you're through some of your breakfast. But after looking at the Washington CNN late at night last night, which was pretty interesting – some people were watching basketball; some people were watching political results.

I didn't know whether we would be singing a Hall and Oates song or seeing something out of a Stephen King movie, but I think she's back. So it should make it very interesting for the next three or four weeks for the Pennsylvania primary. So it should be a very, very interesting – I think the debate is going to heat up, and now with McCain solidly in there, unless anybody thought that Huckabee was going to overtake him in these two states. He has finally withdrawn, so it should be very interesting. So enjoy your breakfast and we'll see you in about 15 minutes.

(Break.)

CHARLES N. KAHN III: If I could get everyone's attention. One, I really appreciate everyone coming bright and early this morning. We have a great crowd here and I know it's a long meeting and we're getting to the end of it. And I greatly appreciate everyone sticking with us, particularly this morning because we always have the administrator of CMS, or in previous days, HCFA, at our closing breakfast. And it is really important to have a good audience, so I appreciate everyone being here.

The acting administrator is supposed to be here at 8:30 and needed to get started immediately. So Keith and I are going to go through our program now if it's acceptable to everyone since we have the crowd. And then we'll have the administrator, and then we will adjourn the meeting following that. Let me – before I hand the podium over to Keith, I'd like to ask him actually to come up here. And as many of you know, Keith is serving again as chairman. He was chairman last year and he is chairman this year of the federation, which is a rarity. Usually we have one-year chairmanships, so it is service beyond the call of duty. And even though he is not ending his tenure, we wanted to honor him. So Keith, we have made a contribution to the School of Journalism at the University of Florida because we understand that is special to you. And we want to give that –

MR. PITTS: Thank you very much

MR. KAHN: – contribution to you and thank you for you did.

MR. PITTS: I appreciate that. Great, thank you very much.

(Applause.)

MR. KAHN: And now I'll hand the podium over to Keith with great appreciation from the federation.

MR. PITTS: Thank you. Thanks, Chip. Well, hopefully we can get through this and it will be interesting to hear from Acting Administrator Weems. So I will try to be brief so we're done by the time he hopefully is here. Typically in Washington, nothing gets done in an election year. So fortunately though, there is a lot of interest in health policy issues, as you can see. In fact, frankly, you can't turn on the TV, at least on the Democratic side, and hear someone not talking about health care. But it's certainly a major topic.

This obviously presents us with an opportunity to press forward for important legislation, but we will face some challenges. The legislative calendar is short. There is little agreement between Congress and the Administration. And, you know, the need to find funds to pay for any proposed programs is pretty vexing and I think going to be pretty challenging for us. But we are going to continue to proceed full speed ahead. This year we will continue our hard work at further momentum for universal coverage. As part of this effort, on Monday, many of you heard this before, but we held a press conference, where we released updated information about our Health Coverage Passport proposal.

We believe our HCP proposal is the best one out there because it is a substantive, comprehensive plan to provide universal coverage while retaining current health coverage and choices and not disrupting existing coverage arrangements for most of Americans. I will say one of the sobering things is the prediction by Lewin in 2010 is that we will hit 50 million uninsured in the country.

Medicare legislation is always a priority for us. Last year, we moved the ball down the field. This year, though, we'd like to push it over the goal line. Last year, lawmakers in the House agreed with many of our concerns about Medicare-related issues, and they included many favorable provisions in the CHAMP Act. Some of those included ending self-referral to physician-owned specialty hospitals, achieving DSH equity for rural hospitals, and establishing and funding the National Quality Forum as the nation's preeminent standards and priority-setting organization for quality measures.

This year, we will continue the fight to get those provisions through the House and Senate and to get them on the president's desk. We will continue to keep our eyes on the key discrete individual issues, but I view this year as a year of transition. I could list all of the individual issues we will tackle, but I would rather share with you why we should use 2008 as an opportunity to look ahead for setting the stage for what I believe will be a very tough 2009.

One way or another in 2009, there will be a new administration in power. There will be changes in personnel. That is throughout the cabinet, throughout a lot of the agencies and also at the congressional levels. We have a lot of seats open. We're going to anticipate a lot of changes because of this in program directions.

We are also facing a generational shift in Congress, and I think this is really important – and it's not only at this election, but looking forward at the next two-year cycle. Many long-

serving members of Congress are retiring at the end of this Congress. We think some of the major seats could retire in '010, certainly not later than '012, which is really not that far off from now. And it could change a lot of orientation, a lot of change in who the real key players are. We will be focusing time and attention, building relationships with the likely new and emerging leaders, and continuing our relationships with the existing leaders.

Hospitals are facing increased pressure from both the government and the private sector to control cost and to further improve quality of care and efficiency. And there is a lot of activity for those of you that don't have to, sort of, get involved in the regulatory side, day-to-day, particularly around quality. There is an enormous amount of activity from a regulatory standpoint around quality. And hopefully we will hear a little bit of that perspective this morning from Mr. Weems.

The other thing I think we're going to see are some emerging alliances, things that we haven't traditionally seen. We need to be prepared for the unexpected. We will have to be nimble. We will have to look at our traditional issues with fresh eyes and a new perspective. In summary, we are expecting a pretty exciting year leading into probably what will be one of the most critical years certainly in many decades in our business.

One of the things I would do is encourage everybody here to really get involved in the process of democracy because it is at its best right now. It is starting to crank up with the presidential primaries. We are going to have a lot of contested congressional seats and other seats, Senate and House around the country. The outcome of those could be very, very critical in the industry, so I would really encourage all of you where you have the opportunity to be very, very involved in the whole democratic process because it really is at its best this year. And I think we're going to see a crescendo into 2009 from what is going to be a very interesting next several months.

We are hopeful that you will all continue your excellent work and will help move the federation's agenda forward. And our success in the past is a large part is due to all of your hard work. And with that, I'm going to conclude, and we are going to wait, and I'll introduce Acting Administrator Weems when he gets here at hopefully around 8:30. So finish your breakfast, and thank you very much for coming.

(Applause.)

(Break.)

MR. PITTS: Now I'd like to introduce our traditional guest speaker for this morning's session. Kerry Weems is the acting administrator of CMS. Both Republican and Democratic administrations have recognized his leadership over the course of his 24 years in the Department of Health and Human Services. Mr. Weems served as deputy chief of staff for Secretary Leavitt and elevated health information technology as one of the cornerstones of the modern healthcare delivery system. He played a key role in the ongoing development of comprehensive health information technology standards while working under the Secretary Leavitt's American Health Information Community otherwise known as AHIC.

Also as deputy chief of staff, he played a major role in the department's effort to achieve domestic and international consensus for the global monitoring and early warning system for the pandemic flu threat. Mr. Weems has served in a number of other senior leadership positions at HHS, including acting assistant secretary for budget, technology, and finance and as chief financial officer. He is a native of New Mexico and received his MBA from the University of New Mexico. Please join me in welcoming the CMS acting administrator, Kerry Weems.

(Applause.)

KERRY WEEMS: Well, good morning. Thank you for inviting me here today. Keith, thank you very much, and also our thanks to Chip. As many of you may know, Chip Kahn serves on the AHIC, the American Health Information Community, with Secretary Leavitt, and has been, you know, a very valuable member of that team. And we would also like to recognize him for his many years of public and private service in this space.

Well, first of all, let me start with a thank you. Thank you for all that you do for the Medicare beneficiaries of this country. Your work is important and even though we may differ on some things, we all agree that that is of paramount importance. And we thank you for your work in that area.

Last week, CMS released a national health expenditures report, and the outlook continues to be sobering to say the least. Between 2007 and 2017, our total healthcare bill will double, from 2.7 trillion to an estimated \$4.3 trillion. By 2017, we will be spending almost \$1 of every 5 of our gross domestic product on health care. Hospital spending will rise from about 700 billion to \$1.3 trillion. Good news for you. (Laughter.) But it is a trend that is troubling for Medicare. The Medicare trustees warn us every year that we are headed toward the insolvency of the Part A Trust Fund as soon as 2019, which is just 11 years from now.

So if you are 54 years old today, there will be no reserves by the time you are eligible for Medicare. And it is perfectly reasonable to predict that when the hospital insurance trust funds begin to run a deficit, expenditures will be limited to pay as you go. Initially, payments would not be made on time, and then payment lag would grow. And many payers would be unable to accommodate the delay. Under this scenario, it wouldn't be surprising if providers quit treating Medicare beneficiaries. Beneficiaries would also feel the impact in other ways. As the cost of health care increases, beneficiaries will see their Social Security checks shrink in direct proportion to the amount that is needed to pay for doctors' bills and outpatient services under Part D. But we don't have to wait very long for that either. In just two years, Medicare will eat up over one-third of the average monthly Social Security check.

Finally, every American would feel the impact as the cost of Medicare begins to consume greater shares of funds reserved for other priorities. Currently the CMS actuaries estimate that a couple retiring today would need \$244,000 to be able to pay for their cost sharing in the Medicare program over their expected lives. That doesn't include the cost of health care that the Medicare benefit doesn't cover like long-term care.

The president's 2009 budget represents a first step in bringing spending into line. Contrary to conventional wisdom, the budget doesn't cut spending. Annual Medicare spending would continue to grow at 5 percent over the five years rather than 7 percent as it does now. Let's all remind ourselves what a 7-percent growth rate means. Seven percent means that you are essentially doubling every 10 years.

Medicare spends \$391 billion this year. The president's budget would spend \$408 billion in 2009. However, this budget does address the problem we have in Part A – the problem we have no choice but to deal with sooner or later. Among the president's recommendations for hospitals, hold the inflationary update flat for three years, then update payments at full market basket minus .65 percent. Reduce disproportionate share payments by 30 percent to bring in line more of what it costs Medicare to cover low-income patients. Eliminate the double payments in post-acute care by paying skilled nursing facilities and inpatient rehab facilities at the same rate for conditions that they routinely treat.

Admittedly, the budget is a blunt instrument. But at this point, it is one of the only tools that government has to keep the costs of Medicare under control. What is important about this year's president's budget is that it's this budget this year, it's this budget next year, or it's this budget the year after that regardless of which administration is in charge. Year in and year out, we simply tinker with the payment system and say good enough. Reform will require discipline on all sides. And this isn't a partisan issue. Up to now, administrations and members of Congress, both parties, have been complicit in responding with short-term isolated fixes instead of collaborating on long-term reform.

You can point to as many examples as I can. The inpatient rehab facility, the so-called 75-percent rule, now the 60 percent rule. The post-acute transfer policy, where we decide when it's appropriate to transfer a patient, not the people who are really providing the care. Of course we are fine tuning payments to many more things than just hospitals. But the point is these small changes give the impression that we are just one physician fee fix or one oxygen cut away from true reform. Unless we stop tinkering with the payment system and take the necessary steps to reform it, as I said, you are going to see this same budget next year, the following year, and the year after that.

Instead we need to fix our payment system. One way to do that is to pay for outcomes and value rather than the volume of services and charge-based inputs. This isn't piecemeal; it involves every sector of the healthcare system from the physician's office to the hospital to hospice and everything in between. There is little disagreement that value-based purchasing is the right road to high-quality cost-effective care. The Institute of Medicine released the "Crossing the Quality Chasm" back in 2001. The president's budget has included elements of this in his '06, '07, and '08 budgets. The Congress enacted MMA, DRA, and TRHCA with important opportunities for paying for value. Even business is on board with initiatives like Leapfrog, Bridges to Excellence, and Five Million Lives.

Paying for results is central to creating a value-based healthcare system in this country, and it's hospitals that are going to be leading the charge. We appreciate Chip's testimony at the House Ways and Means Committee last May when he said, public reporting of quality and

performance metrics can lead to both improved care and better informed patient consumers. And there is strong evidence that the reporting of the Hospital Quality Alliance measures is making a difference. In fact, the Premier Hospital Quality Improvement Demonstration Project, now four years old, has been a very good model for value-based purchasing. In addition, it has shown that high performing health systems have some common elements.

They measure their effectiveness by objective standards. They make it easy for anyone who is interested to review providers' track records and what they charge for services. They keep records and communicate electronically, and they pay for performance. Of course what I have just paraphrased are the president's four cornerstones to value-driven health care. But it is not a matter of philosophy. Value-driven health care works.

Quality has improved across the board in Premier Hospitals for each of the five indicators: heart attack, heart failure, pneumonia, coronary bypass, and hip or knee replacement. Variation in Premier Hospitals' performance has decreased. Last November, CMS sent a value-based purchasing report to the Congress. The report lays out steps to move hospitals from pay-for-reporting to pay-for-performance. The blueprint builds on the current hospital pay-for-reporting program. Its performance measures are a subset of the quality indicators that hospitals are currently using: clinical process of care measures, patient perspectives of care, clinical outcomes, and the same heart attack and heart failure mortality rates we have begun posting on the Medicare website.

We fully expect legislation to implement this value-based purchasing roadmap in the not-so-distant future. But these are steps that can and need to be taken now. For example, we need to do more to prevent hospital-acquired conditions. Many hospitals have taken great strides, but I think you would all agree that there is more to be done. In a survey last September, the Leapfrog Group found that 87 percent of U.S. hospitals do not have all of the recommended policies in place to prevent many of the most common hospital-acquired infections according to findings released today. According to the CDC, an estimated 99,000 people died in 2002 from hospital-associated infections. A conservative estimate would put that at the eighth leading cause of death. Doing things right the first time prevents complications, saves lives, and lowers cost. And rather than reporting or not paying for selected complications, we need to go further and tie a portion of hospital payments to actual performance on measures including infection-related measures.

We need greater transparency to support consumers in making good decisions about their health. The CMS hospital-compare website posts information on how well hospitals provide recommended care for their patients for heart attack, heart failure, pneumonia, and those having surgery. Since last June, the site also includes mortality measures for heart attack and heart failure. In a few weeks, we'll post patient satisfaction rates with a new, user-friendly design that will bring together quality, reimbursement, and patient satisfaction information in one easy-to-navigate location that will encourage more healthcare consumers to take control of their health care. We know that the public is hungry for this kind of information. In 2006, we had nearly 36 million page views on the hospital-compare website. That's 100,000 page views per day.

We need to make secure, interoperable electronic health records a prerequisite for healthcare delivery. EHRs are central to low-cost, high-quality health care. At CMS, we're working very hard to eliminate many of the uncertainties providers have about adopting health-information technology. We're moving ahead with uniform health IT and e-prescribing standards to make sure that electronic systems can talk to each other. The best training, the best equipment, and the most up-to-date drugs and medical practices don't mean anything if providers and patients can't make the most effective decisions about using them due to limited available information.

Last fall, HHS awarded \$22 million in contracts to nine states and regional multi-stakeholder collaborations for trials with the National Health Information Network. These trials are already providing valuable lessons about connectivity and functionality and ultimately will provide a foundation for the network of networks for nationwide health-information exchange.

We're removing legal barriers to health information technology. For example, through exemptions to the Stark rules prohibiting self-referral so hospitals and others can support physicians, if they wish, to bring their offices online. We've also established a certifying body, the Certification Commission for Health Information Technology. It's an independent, voluntary, private-sector initiative to accelerate the adoption of health information technology through efficient, credible, and sustainable product certification.

At the moment, over 40 percent of the ambulatory electronic health records, representing over 75 percent of the products used by doctors today, have been certified. We've just announced a nationwide demonstration project to show physicians and small and mid-sized practices where adoption has been slow the on-the-ground advantages of connecting to the information age. We're looking for communities across the country that can bring together a broad cross-section of leadership, especially hospitals, and leverage the resources to collaborate on one of these projects.

We hear from your representatives here in Washington that the hospitals are the hub of local healthcare systems. With that in mind, you need to take on the mantle of responsibility and drive change in your communities.

Finally, reform needs to be based on competition. Why? Well, it works. This administration is a strong believer in competition. From the dramatic success of market-based pricing in the new drug-benefit program to competitive bidding for durable medical equipment that goes live in July, we've proven that health care is not immune to the laws of supply and demand. For hospitals, we've leveled the playing field and believe that FAH members are well positioned to compete.

As you know, we've implemented changes that base payment rates on cost rather than charges and introduce severity-adjusted DRGs. This has reduced the incentives for specialty hospitals to cherry-pick profitable cases and profitable DRGs. I know that a portion of the FAH membership still has concerns with physician ownership of specialty hospitals. To further address these concerns, we've addressed standards to ensure adequate capacity, to provide

emergency care, and to require hospitals with physician owners to notify patients of that fact, to allow patients to make an informed decision as to where they receive their treatment.

The provider enrollment form, the 855-A, has now been updated and approved by OMB to capture whether an applicant hospital is a specialty hospital. Consider this: Specialty hospitals that play by Medicare rules could make your membership sharper. Competition can make you leaner and more efficient. This is good for your communities, your employees, patients, and, as investor-owned hospitals, for your shareholders.

The healthcare crystal ball will achieve further clarity with the Medicare trustees report in a few short weeks. The trustees will lay out our choices in the same stark terms as the health-expenditures report, the president's budget in last year's trustees report: tax increases, provider cuts, or reform. Sensible reform now will save painful reform later. You've led the way so far. So let's help us promote transparency and competition. Work with us to bring interoperable health IT to every provider. We've forged a strong partnership on value-based purchasing and together we can accelerate that pace.

Thank you for your time today. I do have time for a few questions and, let me tell you, this is really a good time to be subjected to questions because our draft IPSS rule isn't out yet and so my answer to many of your questions might be, oh, you know, it could be in the rule; can't talk about it. (Chuckles.)

MR. PITTS: We've set up a microphone over here so if anybody wants to ask a question, please the microphone over here so everybody can hear.

MR. WEEMS: Got you all stunned. You haven't had enough coffee yet. (Laughter.)

MR. KAHN: I'll ask a couple and then I know we have some in the audience. And I'm not going to ask something having to do with the rule, so I'll get around that. (Chuckles.)

MR. WEEMS: That's too bad. (Chuckles.)

MR. KAHN: We are really appreciative of the role that CMS has played at the Hospital Quality Alliance. And the work managing the measures that we're going to be asked to report on, working together on that has been gratifying. But there are some concerns with sort of how the website hospital-compare is going to progress into the future. And we understand from our work there that the administration plans to put DRG rates on the relevant DRGs that are listed on the website. And, per se, we don't necessarily object to that, but we are not so sure how meaningful it is going to be. First, in the case of beneficiaries, all they're responsible for is a uniform deductible so they are not going to make a decision based on it.

And in terms of the general public, we think this is, at best, meaningless and, at worst, could lead to general confusion unless the administration is sort of interested in benchmarking because the fact is that what is paid for – in this example – a gallbladder removal by a private payer or an individual has nothing to do with what Medicare pays. And they're going to see this rate. And I guess what we're concerned is, if you're going to go forward with this, which I guess

you are, is there going to be sufficient explanation on here that will tell people that, basically, for the average consumer, other than Medicare beneficiaries, this is, at best, meaningless and, at worst, irrelevant. I mean, you're not going to use those words. (Laughter.)

But the problem is – and the problem is and the reason I'm sort of confrontational about it is the problem is it's people in the room who are going to get called by people who look at this and say, well, why is my bill different? And they're going to give an explanation and, you know, what credibility are we going to have against the government? So I'm sort of assertive on it because this is something that was never considered by the Hospital Quality Alliance and we never really discussed it. And we made suggestions at the last meeting, but it was already a fait accompli so I sort of have strong feelings about it.

MR. WEEMS: Yes. (Laughter.) Well, as always, Chip, thanks for your question and – (laughter) –

MR. KAHN: Strong letter to follow. (Laughter.)

MR. WEEMS: And thanks for your passion. (Laughter.) We do hope we'll have an adequate explanation and, you know, would be happy to work with you to make sure that that explanation does inform consumers. But what you've just said is also an important part of the dialogue that needs to start happening with consumers, is, why is this charge different? What does this really cost? What should I pay? Why is this different from Medicare – all with good explanations, but we are looking to provoke that conversation, not provoke you, but provoke that conversation, to have people start understanding the real cost of their care. And, you know, yes, Medicare prices much differently than others, but it's a great conversation to have. That we're having it here and now is good and we'll work with you to make sure we get the right explanation. But meaningless probably won't be in there. (Laughter.)

MR. KAHN: Are we going to get some questions from the audience?

Q: I don't think I need a microphone. (Laughter.) When you address the issue of specialty hospitals and said that they might make us “leaner and more efficient,” I don't think we could be any leaner. And you talked about providing information, making sure we have informed patients. You talked about addressing emergency services concerning – (off mike) – you talked about universal. But the one element you kind of left out of the formula to me seems to be physician motivation. And I love my physicians, but, as a human being, I have to say, I don't think of them as any more honorable than I am. And if I were a physician and I could send my patient to hospital A and be paid once or hospital B where you pay twice, I think I know what I'd be doing. So what about physician motivation?

MR. WEEMS: Well, you know, it's a great question. And I think that by making the ownership transparent to patients and to others, they can sort of perform that calculus inside their own mind as to, you know, how have I been referred here? How, you know, what is the motive? You know, we still understand that there is that potential for conflict and I think we've made, you know, some progressive steps to at least revealing that conflict and making, you know,

making it more open to consumers who might, you know, in their own mind perform that calculus and it, you know, becomes an element of choice.

Q: What about the – (off mike) – who don't know – (off mike). I think the average consumer – I think you're putting a lot of burden on the average consumer.

MR. WEEMS: Well, you know, consumers do accept responsibility for many other things that we do in life. And health care shouldn't be any different. And, yes, we do expect people to make informed choices. And, you know, even the Medicare beneficiaries who, you know, might not be in a position to do that personally, we understand that they get a lot of help from, you know, people who are involved in their care, from, you know, their adult children and from others.

Q: Hi. My name is Tony Fay. I'm with a company that represents rural hospitals. Actually, we own 14 and we've been kind of concerned about the MS-DRG system having redistributed some of the Medicare funding from the rural setting to the urban setting. We're also concerned about the outlier payment system, which seems to be having the same effect on rural hospitals. Is CMS actively considering outlier reform in the context of overall payment reform?

MR. WEEMS: Yes, we are. And the things that you've mentioned there, we're concerned about two. Let's get some experience under our belt with MS-DRGs and see what, you know, see what distortions may be there. And then we're going to come back to it once we have some data.

Q: Thank you.

MR. PITTS: I do have a quick one here. I think all of the hospitals represented here and I think all of the providers in the country realize that if you look at the trajectory out 15 years and you start with sort of the horror story of the cost of health care that it's unsustainable. But it seems to me that 100 percent of the dialogue in Washington out of CMS and the Administration is about what you pay us. And there's no dialogue about what it costs us to provide the care. And there's really no dialogue that we see or any attempt to help us with that. What we see is more complexity and regulation and unfunded mandates every year.

So when do you think we'll switch over to a collaborative approach to deal with the cost of care versus a one-side, kind of non-market based approach to it?

MR. WEEMS: You know, it's a great question and I would always be in favor of collaboration and a dialogue. But you've really just sort of put your finger on the problem. The way that the law now requires us to do pricing and, you know, I've talked about this in other for a on this, it's input, cost-based pricing. Literally, you know, what does it cost and, you know, that goes into our formula on what we pay. And then when we look for areas to economize, it's exactly antithetical to what you would consider a market signal. You know, we look at a particular care setting or institutional type of care and say, wow, look at that. They've got a 12-percent Medicare margin. We need to cut them.

There isn't a dialogue about what a real market-based approach would look like where incentives are properly aligned. And that really is the discussion that needs to come out of Washington, but also out of the rest of America.

Q: There seems to be some movement in the physician specialist community for certain segments of those physicians to opt out of Medicare and some to even opt out of commercial-payer insurance and got to cash-only practices. And I'm wondering to what extent that's appearing on your radar screen and what impact do you think that may have moving forward.

MR. WEEMS: It's certainly something that we're concerned about. And, you know, given the now almost seasonal uncertainty over physician payment rates in Medicare, you know, with the sustainable growth rate where we used to fix it for a couple of years and then we got to where we fixed it annually and that looks like we're on a six-month cycle. Maybe we can get that down to two weeks if we really try. It produces a lot of uncertainty in the physician community about reimbursement. And we are very concerned about that because we believe that physicians should be able to have a predictable trajectory for their income, have realistic expectations for the business that they run. And if we can't produce that kind of predictability, then we are going to have physicians leaving the program. That's going to reduce access and that's of real concern to us.

Q: Thank you for being here today. You mentioned earlier a question or statement regarding specialty hospitals and the emergency-room responsibilities that you're imposing there. It strikes to another question is that I think all of us as community hospitals fulfill those responsibilities in our community and fill a deep need to take care of our communities. But there doesn't seem to be a corresponding requirement coming out of CMS regarding the physician component of that. For us to fulfill our EMTALA obligations, certainly we're dependent upon a voluntary medical staff. Do you have the authority in your office to deal with provisions, to enforce within physician communities their service to the community, their requirement to serve the community through an EMTALA panel? And if you have the authority, is that on your radar screen for action?

MR. WEEMS: Let me just tell you and this is one that I'll have to be somewhat elliptical on: That is something we're looking at so I'll have to stop there.

Q: Good morning. I know the agency has been actively involved in self-referral regulations and updating in the past year through the phase-three rule as well as the Medicare physician-fees schedule proposals. And there's many wonderful and meaningful changes in there that help clarify the rules for the whole area. In particular, the sand-in-the-shoes policy has gotten a lot of attention recently. It was a policy that I think was well explained, but may have had unintended consequences as it was implemented. We supported the agency taking a time out to look at that. However, the tax-paying integrated healthcare systems were not included in that interim relief. And I was just wondering if you can comment on why that was.

MR. WEEMS: Well, let me comment more on where we're headed. As you note, this is an issue that can be – (inaudible) – complex as you look at it. We're going to take another shot

at this this year and we're going to want to make sure that we get – now that we've got everybody's attention, we're going to want to make sure we get our actions right this year. So we're going to make sure that, you know, we take and consider as many comments as we can. So this is an important issue, but we're committed to getting it right this year.

MR. KAHN: I just want to – this equity issue is something, Kerry, that we're extremely sensitive about. And we really appreciate movement on policy. But, you know, we're talking about eight months that our institutions are exposed to a change in the rule and having to make accommodations which are not inexpensive. And we would argue not even necessary or appropriate in terms of general policy, particularly if your policy moves in a more reasonable way at the end of the day. So what are we to do between December 4th, which was, as far as I can check, a few weeks ago, and August 1, which is, if you just do it in a normal reg (?), the first time you would actually have the rule going into effect? So we appreciate what you're done, but we're really in jeopardy here and we're just concerned about it. So I just want to put an exclamation point on what the questioner asked.

MR. WEEMS: And, you know, we certainly understand that. I think that, you know, in that intervening time, we need to work closely together. And if there's some sort of administrative clarification or something that we can do in that time that will relieve some of those burdens, I think that's something that we can do and talk about.

MR. KAHN: That would be much appreciated.

MR. PITTS: Great. Kerry, thank you very much for coming. Please join me in giving him a round of applause.

(Applause.)

We are officially adjourned. Thank you very much for coming this year and we'll look forward to seeing you next year.

(END)