American Hospital Association

HIGHLIGHTS
GOVERNING COUNCIL MEETING
AHA Section for Metropolitan Hospitals
September 8-9, 2008 ★ Washington, DC

The governing council of the AHA Section for Metropolitan Hospitals met September 8-9, 2008 in Washington, DC. Governing council members received updates on AHA's recent Board meeting, the political environment in Washington, DC, and AHA policy priorities. Members reviewed and discussed *Health for Life* and reducing hospital readmissions. A case example on hospital/physician relations was also presented. A roster of the Section's governing council is at http://www.aha.org/aha/membercenter/constituency-sections/Metropolitan/roster.html.

AHA Board Liaison Report: Gregory W. Lintjer, AHA board liaison and president, Elkhart General Healthcare System, Elkhart, IN, reviewed highlights of the July 23-24 Board meeting. He reported that Board members received an update on *Health for Life*, including discussions from the summer regional policy board and governing council meetings. Board members received information on community forums that have been held in Iowa, Colorado, and Pennsylvania. The forums were designed to solicit consumer feedback on how to improve health and health care in the United States. For more about the AHA Board visit http://www.aha.org/aha/about/Organization/index.html.

Health for Life, Coverage for All: At the May governing council meeting, members explored options for achieving coverage for all, paid for by all. These options ranged from increasing incentives for individuals to purchase coverage to the establishment of a single national health care program. At that time, members expressed strong interest in a combined individual/employer/and government mandate.

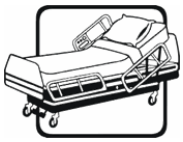
At the September meeting, members reviewed the Blue Cross Plan Federal Employees Health Benefit Program (FEHBP). They agreed that the FEHBP was rich in benefits, but did not suggest it as a starting point for negotiations on a basic benefit package because it is too generous and may prove unaffordable for providers and patients alike. Furthermore, members identified that there needs to be greater emphasis on coverage of health promotion and wellness benefits than what FEHBP currently offers. Members endorsed the use of incentives to encourage coverage because an individual mandate would be difficult to enforce and they advocated setting eligibility at 200% of the federal poverty level or higher.

Members examined several mandate options and discussed the merits of an employer mandate. They advised that employers should be required to offer only one plan if mandated and that the employee's premium should be consistent regardless of the size of the employer. Members believed that health plans should accept all applicants without pre-existing benefit exclusions up to the plan's stated capacity, use community rated premiums, and share premiums across plans on a risk-adjusted basis. Members recommended capping the current employer tax exclusion, and requested clarification of payments to disproportionate share hospitals. For more on AHA's health reform efforts visit http://www.aha.org/aha/issues/Health-for-life/index.html.

Washington Update: Members were briefed on the political environment including the 2008 presidential election, key advocacy developments such as the status of the federal budget resolution, a moratorium on six of seven provisions proposed by CMS to cut Medicaid, the Medicare Improvements for Patients and Providers Act (H.R. 6331), and action on physician self-referral. AHA supports proposed legislation to revise the Medicare Recovery Program (H.R. 4108) and has provided comments to CMS on its July 11 report on the RAC three-year demonstration program. For information on the RAC program visit http://www.cms.hhs.gov/rac.

Members were briefed on the inpatient PPS final rule, the outpatient PPS proposed rule, ICD-10 proposed rule, and a proposal by HHS to prohibit use of federal funds from coercing individuals in the health care field into participating in actions they find religiously or morally objectionable also called the "Provider Conscience Regulation" (PCR). The IPPS final rule was issued July 31 and changes will be effective October 1. Among the key provisions in the rule were payment updates, final transition of DRGs, wage index, and quality reporting.

The OPPS proposed rule was posted July 3. The final rule is due November 1, with changes effective January 1. Key OPPS issues include a payment update, quality reporting, imaging, emergency department services, drugs, and partial hospitalization. For the first time, this rule links Medicare payment for outpatient services to the reporting of certain quality measures and hospitals receive a market basket update of 3.0% if they submit data on seven measures. AHA will continue to monitor the proposed rules on adoption of ICD-10 code sets and the PCR.



Reducing Hospital Readmissions: According to 2005 MedPAC data approximately 18% of Medicare patients discharged from hospitals were readmitted within 30 days, costing the Medicare program approximately $15 billion. As MedPAC, CMS, and the National Quality Forum increase their focus on this issue, they may introduce incentives for hospitals to reduce readmissions, independent of other reform efforts. To assist the AHA in developing positions on and responses to policy makers' proposals for strategies and incentives to reduce readmissions, members shared their hospitals' readmission data. The data presented was on the percentage of readmissions based on 7, 15, and 30 days after discharge; 30-day readmit data for the five most frequent DRGs in the initial admissions; and the reasons that patients with frequently readmitted conditions come back to the hospital, using the top 5 DRGs for readmits. In addition to specific diagnoses such as heart failure, renal failure, psychoses, and sepsis that lead to readmissions, members said that discharge planning and patient understanding of and compliance with instructions also contribute to readmission rates. Members emphasized that the hospital is not always the cause of readmissions and that reducing readmission rates requires collaboration between hospitals and physicians.

Hospital/Physician Relations: Mark Gavens, senior vice president, Cedars Sinai, Los Angeles, CA, provided a case example on efforts to move toward better clinical integration. Cedars Sinai is pursuing a multiple strategy in creating clinical integration. A differentiation approach, mixed medical staff model, efforts to reduce variations in inpatient enterprise, leveraging its brand to bring more doctors to the table, and selectively growing faculty and the medical group are part of this multiple strategy. Cedars Sinai is rejuvenating its Independent Practitioners Association capitation model as a vehicle for doctors who do not want to join the faculty or the medical group. For more information visit http://www.csmc.edu/5.html.

For more information about the topics covered in these highlights or on the AHA Section for Metropolitan Hospitals, contact John T. Supplitt, senior director, at 312-422-3334 or jsupplitt@aha.org.