American Hospital Association

HIGHLIGHTS
GOVERNING COUNCIL MEETING
AHA Section for Small or Rural Hospitals
February 24-25, 2005 – Portland, OR

The governing council of the AHA Section for Small or Rural Hospitals met February 24-25, 2005 in Portland, OR. Governing council members and 12 guest executives from rural hospitals in Oregon and Washington received reports on legislative, regulatory, and policy initiatives. They discussed several AHA policy priorities including limited-service providers, coverage for all, and community accountability. The Section's governing council roster may be found on the AHA Web site at www.aha.org/aha/key_issues/rural/section/council.html.

Federal Legislative and Regulatory Update: Governing council members and guests were briefed by staff on the new political environment, what it means for health care, and AHA's 2005 advocacy agenda. With respect to the political environment, staff reviewed the outcome of the November 2004 elections, shared general observations, and reviewed key changes in committee chairmanships in both the House and Senate, as well as the President's health agenda for the 109th Congress. Members heard that the President's budget proposes to cut the federal deficit in half by 2009 and includes $60 billion in reductions and savings from Medicaid. Staff also noted that the President's budget significantly reduces discretionary spending for several health programs including rural programs; however, the proposed cuts may not muster Congressional support.

With respect to AHA's advocacy agenda, governing council members and guests were oriented to the immediate priorities of the AHA, which include Medicaid and Medicare payment, public accountability specifically quality and patient safety and tax-exempt status, medical liability reform, physician owned limited service hospitals, and coverage. Staff emphasized the importance of telling the hospital story and the strategic approach toward communication through the Coalition to Protect America's Health Care. AHA's 2005 advocacy agenda is at http://www.aha.org/aha/advocacy-grassroots/advocacy/content/2005agenda.pdf

Governing council members and guests were briefed by staff on AHA's rural health agenda, which includes advocacy efforts to improve payments to CAHs for referral lab services and payment at 101 percent of cost under Medicare Advantage. Additional efforts exist to reintroduce the Rural Community Hospital Assistance Act and to improve payments for sole community hospitals, expand the 340 B drug discount pricing program to include CAHs, extend the home health bonus for rural providers, and fight for continued discretionary funding of rural health programs. The AHA's agenda for small or rural and critical access hospitals is at www.aha.org/aha/key_issues/rural/advocacy/advocacy.html

Governing council members and guests listened to a review of MedPAC's recommendations from its January meeting. AHA offered appreciation for the commission's vote to extend the moratorium on self-referral to physician-owned, limited-service hospitals, but criticized its recommendation to reduce hospital payment as misguided and disappointing. AHA's January 13 statement on MedPAC recommendations may be found at http://www.aha.org/aha/press_room-info/index.jsp.

Limited-Service Providers: Governing council members and guests reviewed background information on physician-owned, limited-service hospitals, including recommendations from two AHA Task Forces, GAO findings, MedPAC recommendations, and a moratorium on new limited-service hospitals established by the Medicare Modernization Act (MMA) of 2003.

Governing council members and guests stated that what they wanted from better alignment with their physicians was to improve the overall work environment, enhance communication, and improve patient care. They listed gainsharing, incentives for performance, and stipends for participation on hospital and medical staff committees as alignment strategies that would be useful and that do not involve physician ownership or self-referral.

When asked what barriers impede their success, members and guests quickly identified the need to change the regulatory paradigm, which imposes hospital surveillance of the clinical, economic, and financial behavior of physicians while severely limiting any form of constructive partnering. Greater regulatory flexibility regarding scope of practice and supervision of physician extenders and professional nurses would assist in this regard, as well as a level playing field on which all providers including niche hospitals and ambulatory surgical centers must meet equal standards of care and access. Members and guests also commented that alignment with physicians would improve markedly if Medicare reimbursed hospitals at cost in markets with limited-service specialty hospitals or adjusted payments as suggested by MedPAC to eliminate loss leaders and cash cows. Members and guests commented on the critical importance of engaging payers in this discussion since they have a key role in facilitating alignment of hospitals and physicians. For more on AHA's position on limited-service providers, visit the Web site at www.aha.org/aha/key_issues/niche/index.html.

Unified Health Care Policy Coverage for All: Governing council members and guests reviewed background information, including the 10 principles for a vision of America's future health care system. They were oriented to the preferred approach to achieving coverage for all, which was validated by the AHA Regional Policy Boards during their fall 2004 meetings. Regarding the relative size of the coverage benefit, almost all of the governing council members and guests believed the majority of federal resources should support basic and catastrophic coverage, but the bulk of the services should be covered under the private "in-between" plan. All members and guests agreed that basic coverage should require some cash contribution on the part of consumers. Regarding the options for private "in-between" coverage a sizable majority identified unlimited private coverage options and the balance identified standardized private coverage options. The vast majority of members and guests agreed that government catastrophic coverage should begin after a dollar limit that would be subject to a means test. They also agreed that government subsidies for private "in-between" coverage be available only to those with incomes under 200 percent of the federal poverty level. Finally, there was unanimous consent that basic and catastrophic benefits be government financed, but privately administered.

AHA Board Liaison Report: George Miller, CEO, Provena St. Mary's Hospital, Kankakee, IL, and liaison to the governing council of the AHA Section for Small or Rural Hospitals, reported on the AHA Board of Trustees February 2005 retreat. He explained that the theme of the retreat was accountability and that each Board member conducted an organizational self-assessment and met with community groups and leaders to better understand the perceptions that our communities have of our hospitals, to explore how effectively we connect with our communities, and to learn how hospitals can strengthen relationships with our communities. Basically the public perception of hospitals is still problematic. Consumers perceive divisions between physicians and hospitals; they reject competition and embrace a utility model for health care regulation. Consequently, Mr. Miller said hospitals need to tell their story better, and the Coalition to Protect America's Health Care is an effective way to do this. Visit the Web site at www.protecthealthcare.org/protecthealthcare/index.jsp for more information on the Coalition.

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