American Hospital Association

HIGHLIGHTS
GOVERNING COUNCIL MEETING
AHA Section for Metropolitan Hospitals
March 3-4, 2005 – Atlanta, GA

The governing council of the AHA Section for Metropolitan Hospitals met March 3-4, 2005 in Atlanta. Governing council members and 5 guest executives from hospitals in Georgia received reports on legislative, regulatory, and policy initiatives. They discussed several AHA policy priorities including limited-service providers, coverage for all, and health information technology. The Section's governing council roster is on the AHA Web site at www.aha.org/aha/member_relations/metropolitan_hospitals/council_regional_policy_members.html.

Federal Legislative and Regulatory and Legislative: 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 and 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 or savings from Medicaid. Staff also noted that the President's budget significantly reduces discretionary spending for several health programs, however the proposed cuts may not muster Congressional support.

With respect to AHA's advocacy agenda, 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. AHA's 2005 advocacy agenda is at http://www.aha.org/aha/advocacy-grassroots/advocacy/content/2005agenda.pdf. Staff emphasized the importance of telling the hospital story and the strategic approach toward communication through the Coalition to Protect America's Health Care. Visit the Web site at www.protecthealthcare.org/protecthealthcare/index.jsp for more information on the Coalition.

Governing council members and guests listened to a review of MedPAC's recommendations from its January meeting. In a letter to MedPAC AHA thanked Commissioners for proposing to extend the moratorium on self-referral to physician owned limited service hospitals, but criticized their recommendation to reduce hospital payments as misguided and disappointing. Members and guests expressed support for AHA's position and concern regarding their ability to plan future budgets given the recommended cuts to hospital payments. AHA's January 13 letter to MedPAC 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.

When asked what they wanted from better alignment with their physicians, members and guests commented that they sought improved efficiency and productivity. They commented that the ultimate value proposition for hospital and physician alignment is better 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. They explained that sustaining incentives without creating an environment of entitlement is difficult and performance incentives were complicated where outcomes are subjective. They also commented that physician employment where legal, made incentive programs more effective.

When asked what barriers impede their success members and guests identified the need to change the regulatory and legal environment. The Stark Law and its limits on physician recruitment specifically income guarantees and practice restrictions as well as limits on incentives for nonprocedural activities were identified as barriers to alignment, but were not considered insurmountable. In addition, members requested clarification of gainsharing specifically regarding what hospitals may not do. 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 design features for a proposal to provide affordable coverage governing council members and guests leaned toward means testing particularly for premium/branded benefits, but not for preventative or wellness benefits. They expressed anxiety regarding any government administered program and preferred government funded, but privately administered benefit plans. There also was a belief that employer responsibility should be reduced, but not eliminated in its entirety.

Hospital Investment in Information Technology: When funding the development of health information systems, hospitals must consider how to structure the arrangement so that it complies with the Stark Law. CMS may be open to exploring ways to address the Stark Law's barriers to hospitals' more general efforts to provide physicians with health information technology (HIT). Governing council members and guests agreed that finding ways to provide physicians with HIT resources was imperative and offered numerous examples of the kinds of resources and arrangements hospitals might offer physicians. They commented that the initial capital cost while considerable was not as big a concern as the ongoing training and maintenance needs, which seem to migrate back to hospitals even when systems are located in physician offices. They commented that easy access and use of HIT is becoming the standard for care. They stressed the cost effectiveness of shared HIT and its relevance not only to care delivery, but as a way to improve hospital, physician, and patient relations.

Governing council members and guests described Stark as an issue over who pays for HIT, but one that could be managed. To them, HIPAA represents a bigger barrier because of privacy issues in exchanging information over numerous sites with varying degrees of security. Challenges are levels of aggregation and electronic permission by levels of need. Resolving these challenges requires broad involvement in developing national communication protocols and standards. Members identified a tailored change of Stark as a short-term fix and recommended a national policy that lays out shared responsibility for financing, standards, and maintenance of HIT from which future legislation and regulation could be drafted.

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