

The governing council of the AHA Section for Small or Rural Hospitals met September 14-15, 2009 in Scottsdale, AZ. Members received updates on AHA's recent Board meeting, AHA's commitment to health care reform, and the political and regulatory environment in Washington, DC. Members discussed health reform proposals and policy options for an analytic framework for payment reform and quality and patient safety. A governing council roster is at [http://www.aha.org/aha/member-center/constituency-sections/Small or Rural/roster.html](http://www.aha.org/aha/member-center/constituency-sections/Small%20or%20Rural/roster.html).



AHA Board Liaison Report - Raymond Hino, CEO, Mendocino Coast District Hospital, Fort Bragg, CA and AHA Board liaison to the Section governing council reviewed with members the agenda from the July 22-23 meeting of the AHA Board of Trustees, which was held in San Francisco. Topics on the agenda included advocacy and public policy, Association affairs and informational reports. Mr. Hino said the Board discussed *Health for Life* and health care reform which featured a report from the AHA Board Task Force on Payment Reform. The Board referred the work of the task force to the governing councils and others for their review and

comment. Mr. Hino said that the Board reviewed information on geographic variation in payment and its relevance to the health reform debate. He explained that AHA is developing a *TrendWatch* to explain the reasons for regional variations in costs and payments. In addition, the AHA will convene a task force this fall to look at the reasons for geographic variation and potential payment models. AHA Board members agreed that staff should continue to work on the principles for comparative effectiveness research. Mr. Hino reported that Board members also reviewed bundling and health information technology (HIT). For more information on the AHA Board visit the AHA's Web site at www.aha.org/aha/about/Organization/index.html.



AHA's Payment Reform Task Force - In April the AHA Board of Trustees established a Task Force on Payment Reform. The Task Force was charged with evaluating the range of proposals being debated within public policy circles. They developed an analytic framework laying out the criteria that should be used to evaluate any given approach in the hope of developing an approach that could be supported by the hospital field. Members discussed the framework and the Task Force recommendations on adoption of a Medicare payment reform approach that advances the goals and meets criteria described in the framework. They reviewed the three evolutionary stages of the framework, with intermediate changes within those stages. Each stage involves three types of changes: payment, performance metrics, and barrier removal. The Task Force also established side paths for certain types of organizations that may not be able to make bundled payments work appropriately due to their operating environments.

Members suggested modest changes to the goals and criteria of the analytic framework. They commented that the stages were reasonable and noted that the framework allows integrated organizations to move through the stages more quickly than is possible for other provider organizations. Members agreed that side paths for certain hospitals such as low-volume rural hospitals are necessary.



Washington Update - Members were briefed on the political environment, proposals and politics of health reform, AHA's advocacy message, and "Card-Check." Staff outlined the basics of H.R. 3200, the *America's Affordable Health Choices Act of 2009*. The bill represents a combination of proposals from the House Committees on Education & Labor, Ways & Means, and Energy & Commerce. The bill includes cuts to disproportionate share hospitals (DSH) for both Medicare and Medicaid, but does not include cuts for indirect medical education (IME). Key hospital concerns remain among the three reported bills including a public program for the uninsured, policy on readmissions, and the structure of accountable care organizations.

Members heard that the Senate Health, Education, Labor and Pensions (HELP) Committee submitted its proposal for health reform called the *Affordable Health Choices Act* (S. 1679). The Senate Finance Committee had not released its health reform proposal at the time of this meeting. Staff emphasized the areas of

consensus among the health care reform proposals and AHA's advocacy message of a deep commitment to achieve comprehensive health care reform that expands coverage to all Americans. Key challenges for hospitals remain making grass-roots advocacy by member hospitals a priority. In addition, staff reported that the *Employee Free Choice Act* otherwise known as the "Card-Check" bill is still under consideration. The AHA strongly opposes this legislation because we support employees' rights to free and fair elections.

Members were supportive of AHA's strategies, but were concerned about card-check and cuts to hospitals to fund health care reform. For information on AHA's health reform strategy visit www.aha.org/aha/advocacy/health-reform.html.



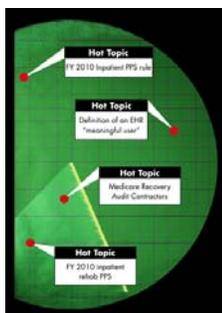
Health Reform: The Details – Members were oriented to the details of the various health reform proposals being debated in Congress and at home during the August district work session. The *America's Affordable Health Choices Act of 2009* (H.R. 3200) is the product of three committees: Ways & Means, Energy & Commerce and Education & Labor. The result is that three slightly different versions of H.R. 3200 now exist and that the different versions must be merged before bringing a final bill to the House floor. In the Senate, two committees have jurisdiction over health care. The HELP Committee introduced its health reform bill *Affordable Health Choices Act of 2009* (S. 1679) which addresses costs, quality, disease prevention, and the health care workforce. It includes a public option as well as employer and individual mandates. The Senate Finance Committee, which has jurisdiction over Medicare, Medicaid, and tax policy, had not released its health reform proposal at the time of this meeting. Nevertheless staff assured members that the AHA participated in extensive discussions with the Finance Committee staff and that AHA has a good sense of the main elements of their reform plan.

Members discussed the details of the House and Senate health reform proposals in three areas: coverage, delivery system reform, and Medicare/Medicaid payment. There were many questions about the public plan, payment rates, and mandates as well as expanding Medicaid and the ability of states to absorb additional beneficiaries. A *Snapshot Comparison of Key Issues* that lists some of the major differences in the House and Senate health care reform packages is available at www.aha.org/aha/content/2009/pdf/090805-aa-attach-health-reform-snapshot.pdf.



Quality and Patient Safety: Ten Years after the IOM Report - Rick Wade, senior vice president, AHA Strategic Communications and AHA's senior executive liaison to the governing council reminded members that a decade ago, the Institute of Medicine's (IOM) report *To Err is Human* jolted the public with its estimates of the number of people who are injured or killed through medical errors. It provided a call to action for all involved in the health care field including providers, regulators, payers, patients and others. He explained that AHA is compiling information on how the hospital field has improved patient safety. The AHA wants members' input on how it can use that learning to broaden and expedite progress in quality and patient safety over the next few years.

Members agree that significant and measurable changes have taken place in quality and patient safety since the advent of the IOM report. Members quickly identified a culture of safety as the biggest and most enduring change as a result of the IOM report and offered many examples from their organizations that will be forwarded to the AHA Quality Center for use as case examples for Hospitals in Pursuit Of Excellence. To assist this effort, visit the AHA Web site at www.hpoe.org.



Regulatory Update - Members were briefed on the current regulatory environment including the CMS final rule for the inpatient prospective payment system (PPS) and a proposed rule for outpatient PPS, as well as updates on the meaningful use of health information technology (HIT) and the Recovery Audit Contractor (RAC) program. Regarding inpatient PPS, members reviewed the market basket update and heard details on quality reporting, DSH, rebasing of Medicare dependent hospitals, and provisions specific to critical access hospitals (CAHs). Members reviewed the proposed outpatient PPS rule including payment updates, quality reporting, and coverage criteria. They discussed a restatement and clarification of policy from CMS on physician supervision incident to therapeutic services furnished in a hospital or on campus provider-based department. Members see the change in policy on physician supervision as an obstacle to delivering care in rural communities and appreciate AHA's response. Members remain anxious about the RAC program and timelines for adoption of HIT.

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.