American Hospital Association

HIGHLIGHTS
GOVERNING COUNCIL MEETING
AHA Section for Small or Rural Hospitals
June 1-2, 2006 ★ Burlington, VT

The governing council of the AHA Section for Small or Rural Hospitals met June 1-2, 2006, in Burlington, VT. Governing council members and guest CEOs from rural hospitals in Vermont as well as representatives from the Vermont Association of Hospitals and Health Systems and the New Hampshire Hospital Association were present. Participants received reports on Congressional, CMS, and AHA advocacy initiatives; discussed AHA policy priorities including physician owned ambulatory settings and the Hospital Quality Alliance, and reviewed the emerging concerns of youth obesity and state health reform. 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.

Washington Update: Members were briefed on the current political environment in Washington including the Congressional legislative agenda and efforts on the 2007 federal budget. AHA opposes the President's proposed cuts to Medicare and Medicaid and is working with members of Congress and through the Coalition to Protect America's Healthcare of which AHA is a founding partner, to eliminate any budget cuts to Medicare and Medicaid. Members were informed of the recently passed tax legislation and the implications for hospitals. Member support was requested to reverse a requirement proposed by CMS for documented proof of citizenship prior to obtaining Medicaid coverage. Members reviewed AHA's legislative priorities carried over from the first session of the 109th Congress, which merit continued support. Among these are several bills to assist rural hospitals. Members were apprised of a bill (H.R. 5118) introduced in the House and for which a Senate companion (S. 3500) is expected, that would extend rural hospital provisions from the Medicare Modernization Act of 2003 including the outpatient hold harmless for sole community hospitals and rural hospitals with less than 100 beds; a five percent add-on for rural home health providers; and reasonable cost payments for outpatient lab services. Members also were apprised of a new bill (S. 2819) in the Senate to reimburse CAHs under Medicare Advantage.

Members discussed several key regulatory concerns affecting small or rural hospitals including a proposed rule on notice of hospital discharge, hospital payment under Medicare Advantage, CMS interpretive guidelines for CAH relocation, and implementation of changes to the occupational mix survey. Members also received an in-depth analysis of CMS's proposed rule for the 2007 inpatient prospective payment system (PPS), which contains the most significant changes to the PPS system since its inception. They offered observations on the impact of the rule to their hospitals for use in AHA's comment letter to CMS. To learn more about the AHA's advocacy activities visit http://www.aha.org/aha/advocacy-grassroots/advocacy/index.html.

Physician-Owned Ambulatory Services: Members were asked to advise the AHA's Task Force on Delivery System Fragmentation as to the nature and scope of issues associated with physician-owned ambulatory care settings. Recent years have been marked by intense debate on the issue of physician self-referral to limited-service hospitals and concerns have been raised that rapid growth in physician ownership of ambulatory care settings is affecting the ability of hospitals to maintain the availability of services to the entire community. The AHA's Task Force is currently examining alternative approaches to address concerns raised by these physician-owned ambulatory care settings.

Members reviewed a *TrendWatch* report highlighting the migration of care to non-hospital settings and the degree to which regulatory structures have kept pace with the resulting changes in care delivery. Members commented on the explosion in the growth of services offered by physicians and provided in ambulatory service centers (ASCs) or in their offices. They said that diagnostic and treatment services provided by physicians compete directly with the hospital. Quality and patient safety are major concerns of members due to a lack of regulation of the nature and type of services provided in a physician office or ASC. Also the lack of emergency services in either a physician's office or an ASC places the patient at an unnecessary risk. Member insights will be shared with the Task Force as they continue their work. Further information on limited-service providers is at http://www.aha.org/aha/key_issues/niche/index.html.

Hospital Quality Alliance: Members heard an update on the Hospital Quality Alliance (HQA), a broad coalition of hospitals, other healthcare providers, government, quality groups, employers and consumers, which is focused on providing meaningful information to the public on hospital quality, align quality measurement sets and support quality and safety improvement. AHA was instrumental in the creation of the HQA to address broad quality issues on behalf of the health care field. Efforts are underway to increase the involvement of business coalitions and insurer groups in the alliance.

Members heard plans for future measures, including the HCAHPS patient satisfaction survey, acute myocardial infarction, heart failure, pediatric asthma measures, Surgical Care Improvement Project measures and critical care measures. In addition, members were updated on the number of hospitals currently participating in HQA and plans underway to explore and develop a business plan and create a single data pathway to streamline data collection. For more on this initiative, visit http://www.aha.org/aha/key_issues/qualityalliance/index.html.

AHA Board Liaison Report: George N. Miller, Jr., AHA Board liaison and president and CEO, Provena St. Mary's Hospital, Kankakee, IL, updated members on the May 2006 AHA Board of Trustees meeting, held in conjunction with the AHA's Annual Meeting. He reviewed two policies approved by the Board on billing and collection practices and price transparency. To learn more about the AHA Board policy on hospital pricing transparency visit http://www.aha.org/aha/advocacy-grassroots/advocacy/content/5_1_06_sb_transparency.pdf. To learn more about the AHA Board policy on billing, collection, and tax-exempt status visit http://www.aha.org/aha/advocacy-grassroots/advocacy/content/5_1_06_sb_billingcoll.pdf. Mr. Miller also updated members on the Community Connections effort underway and the debut of the AHA's new Quality Center. Both can be found on the AHA Web site at http://www.aha.org/aha/index.jsp.

State Level Health Care Reform: Members discussed health care reform in Vermont and its Catamount Health program, which would offer health care coverage to about 30,000 uninsured state residents who do not qualify for other public health programs including Medicaid. Funding for Catamount Health will come primarily from premiums, but an employer assessment, savings from a federal Medicaid waiver called Global Commitment, and cigarette taxes would provide almost half the funding.

Youth Obesity in Rural Communities: Brian Shockney, CEO, Memorial Hospital, Logansport, IN and governing council chairman-elect led discussion on the emerging problem of childhood obesity. He described the growing public health concerns for adult obesity across Indiana and the direct and indirect costs to its residents. Mr. Shockney outlined the initiatives underway in Cass County, Indiana that address childhood obesity including both standardized and tailored programs used in his community. Members were very interested in the issue of youth obesity and volunteered several examples from their experiences and discussed funding and access to federal, state, and local grants to support their continued efforts.

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.