American Hospital Association

HIGHLIGHTS
GOVERNING COUNCIL MEETING
AHA Section for Small or Rural Hospitals
September 13-14, 2004 ★ Washington, DC

The governing council of the AHA Section for Small or Rural Hospitals met September 13-14, 2004 in Washington, DC in part with the AHA Sections for Psychiatric and Substance Abuse Services and Long-term Care and Rehab Services. Governing council members received reports on legislative, regulatory, and policy initiatives. They discussed several AHA policy priorities, including community benefit, tax-exempt status, and providing affordable coverage for all. Governing council members also visited with their members of Congress to talk about hospitals' priorities. A governing council roster is on the AHA Web site at http://www.aha.org/aha/member_relations/small_rural_hospitals/policy_boardmembers.html.

Washington Update: Council members from all three AHA Sections received a report on the framework for AHA's advocacy agenda, the Congressional agenda for the remainder of 2004, the current political environment, and AHA's response to litigation, tax exemption, and billing and charity care issues. They were briefed on the unfinished business of the 108th Congress, including Medicaid, appropriations, and several legislative proposals. Members were briefed on AHA's strategy regarding physician-owned limited service hospitals and reminded of the growing federal deficit and the prospects of a second Balanced Budget Act. They were apprised of AHA's significant progress with recruiting hospitals' confirmation of commitment to the AHA principles and guidelines on billings and collections that is intended to strengthen their relationship with patients and to reassure patients, regardless of their ability to pay, of hospitals' commitment to caring. Finally, members were briefed on the AHA's attempts to recruit members of Congress to pledge their support for the *Seven Steps to a Healthier America*. For information on the *Seven Steps*, visit http://www.aha.org/aha/campaign2004/index.html. For information on hospitals' commitment to caring, see http://www.caringforcommunities.org.

Federal Regulatory and Legislative Update: Members of the Section for Small or Rural governing council received a separate report on CMS's inpatient PPS final rule of August 11, 2004, which implements many of the hospital provisions of the MMA. Members were reminded that the rule implements a full market basket update, equalizes the standardized operating amount, reduces the labor-related share of the operating amount to 62 percent for certain hospitals, increases the Medicare disproportionate share cap to 12 percent, and adjusts the occupational mix for hospitals. Members were also briefed on the key provisions in the rule affecting Critical Access Hospitals (CAHs), including payment at 101 percent of cost for inpatient, outpatient, and skilled nursing services, use of up to 25 beds for all inpatient services, introduction of periodic interim payments, elimination of a state's authority to designate necessary providers, and options for distinct-part psych or rehab units of up to 10 beds each. Members expressed concern with CMS's new policy toward counting observation beds among the 25 used for inpatient care.

Members were briefed on CMS's proposed rule on outpatient PPS, which will extend the hold harmless through 2006 for rural hospitals with less than 100 beds and sole community hospitals. They also were reminded of the prohibition of non-compete agreements and income guarantees that went into effect with the final rule for Stark II physician self-referral. Members were apprehensive about implementation of the Stark II final rule and its impact on physician income guarantees and practice restrictions, which they found impractical and unreasonable. For information on AHA's regulatory advocacy, visit http://www.aha.org/aha/advocacy-grassroots/advocacy/index.html.

Governing council members were briefed on the status of several rural legislative priorities. Included among these were reimbursement of CAHs by Medicare Advantage at 101 percent of cost, reauthorization of the State 30/J1 Visa Waiver Program, a CAH lab service payment fix, the Rural Community Hospital Assistance Act, and 2005 appropriations. In addition, members were briefed on a variety of advocacy priorities in preparation for visits with their members of Congress. They were oriented to several legislative priorities, including the 75% Rule for inpatient rehab providers, Medicaid payment, patient safety, and niche providers. Governing council members were encouraged to share their story, advocate for the issues that would address their needs, and ask their members of Congress to respond to the *Seven Steps for a Healthier America*.

AHA Board of Trustees Update: Todd Linden, president and CEO, Grinnell Regional Medical Center, Grinnell, IA, and AHA Board liaison to the Section governing council, briefed governing council members on AHA Board actions for pay-for-performance, limited-service providers, and publication of JCAHO quality data. Mr. Linden reported that in the future JCAHO would work more closely with AHA, CMS, and others to coordinate release of quality data so that they are consistent with and support the efforts of the Hospital Quality Alliance. Members stated their support for AHA's intervention to stem the future unrestrained growth of limited-service providers and asked that the Board weigh provider size and resource capacity when developing policy on pay-for-performance.

Unified Health Care Policy: Mr. Linden briefed members on AHA's work with other stakeholders to create a vision of our future health care system and the options for providing affordable coverage-for-all that emerged from the July National Regional Policy Board meeting. The council was asked to make a recommendation based on three approaches (employer-based coverage; single comprehensive plan; and personal responsibility). Key points made during the discussion included:

- Many of the council members expressed urgency in addressing the immediate concerns of the uninsured/underinsured, and cautioned that pursuing comprehensive reform may detract from the crisis at hand.
- Some council members discouraged an employer-mandated approach because of the growing burdens being placed on small business for health care coverage and their fear of an employer backlash.
- Others discouraged any partnership with government because they were unreliable.
- Several council members identified a single comprehensive plan with a government program for basic and catastrophic coverage as the single best option of those presented.
- The group was evenly split between pursuing wholesale reform and incremental reforms of the current system.
- There was mounting frustration with the current system, but members showed continued trepidation around change and concerns regarding how much change could be tolerated.
- Members believe that the current system cannot be sustained and that changes are inevitable although unpredictable.

For additional information on creating a better health care system, visit the AHA Web site at http://www.aha.org/aha/nhcp/index.html.

Community Benefit and Tax-Exempt Status: Governing council members shared their views on demonstrating and communicating community benefit and discussed what the hospital field and health care in America might look like without tax exemption.

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.