American Hospital Association

HIGHLIGHTS
2010 GOVERNING COUNCIL MEETINGS
AHA Section for Small or Rural Hospitals

The members of the governing council of the AHA Section for Small or Rural hospitals met three times in 2010. They received reports on AHA Board and AHA advocacy activities as well as discussed several policy priorities including health care reform, transforming health care, and health information technology. In addition, members petitioned their members of Congress during visits to Capitol Hill. A list of the Section's governing council members is available at http://www.aha.org/aha/member-center/constituency-sections/Small-or-Rural/roster.html

Washington Updates and 2010 Advocacy Agenda: Members received regular reports on the Washington political environment as well as legislative issues and the Association's 2010 advocacy agenda for small or rural hospitals. Members were briefed on the Congressional agenda, and the goals and strategies for the second session of the 111th Congress. Members reviewed election 2010, the seats needed to transfer party control of Congress for either the House of Representatives or the Senate, and the effect that would have for a lame duck session and the 112th Congress.

Members discussed policy issues emerging from the Patient Protection and Affordable Care Act (ACA) such as delivery system reforms, health insurance reforms, Medicare and Medicaid payment changes, workforce, quality and patient safety, and other provisions specifically effecting small or rural hospitals such as Medicare "extenders," payment adjustments for low-volume hospitals, and CAH payments. Immediate advocacy priorities were provisions for variation in cost and treatment, Federal Medical Assistance Percentage extension, a Medicare physician fee fix, reversing inpatient coding offsets, and HIT stimulus for CAHs and multi-campus providers.

Members were apprised of changes in regulatory policy introduced as proposed and final rules. AHA commented on a rule for inpatient PPS including payment, documentation and coding offsets, quality reporting, and specific provisions such as provider taxes as allowable costs and other rules effecting small or rural hospitals and CAHs. Members commented on a proposed rule for outpatient PPS including payment, supervision of therapeutic services, quality reporting, and expiration of the transitional outpatient hold-harmless provision among others. They also reviewed regulations in the physician fee schedule effecting small or rural hospitals as well as rules on 340B drug discount pricing, expanded broadband, and telehealth, and requirements for tax-exempt hospitals among others. Members were oriented to and commented on proposed rules for implementation of the HITECH ACT including meaningful use (MU) and standards for electronic health records (EHRs), a definition of hospital-based physicians, access to Medicare and Medicaid incentives as well as avoiding penalties under the ARRA.

AHAPAC

Members were reminded of the work of the AHA PAC and encouraged to contribute. To learn more about the AHA's advocacy activities, visit http://www.aha.org/aha/advocacy-grassroots/advocacy/index.html.

Board Liaison Reports: At each meeting members received updates on AHA Board activities from AHA's Board liaison to the small or rural governing council Ray Montgomery, II, CEO, White County Medical Center, Searcy, Arkansas and other AHA Board members. Among the many items discussed was a report with recommendations from the Task Force on Variation in Health Care Spending. Members discovered the factors influencing variation in per capita health care spending and that variation occurs at all levels with inefficient providers in low-cost as well as high-cost regions. Members support the role of the AHA to ensure that hospitals have the appropriate data, tools, and information to be successful in these efforts; to advocate for well-structured policies to ensure accountability and reward success; and to continue to advocate for the removal of existing barriers to clinical integration. The report concludes with a bold call to action on the portion of variation that legitimately belongs to hospital organizations while recognizing that other stakeholders must do the same.

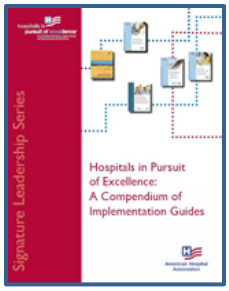
Health Care Reform – Moving Forward: The ACA makes a number of adjustments to current provider payment systems that will drive hospitals and other providers to improve continuity for patients across an entire episode of care, ensure patient care is more integrated across the continuum particularly for patients with chronic conditions, and consider collaboration with other caregivers including primary care physicians and specialists, home health agencies, public health agencies, and post-acute care providers. Members discussed key delivery system reforms designed to align provider incentives to improve care coordination, quality, and reduce cost such as

value-based purchasing, voluntary pilot projects to test bundled Medicare payments, voluntary pilot programs for accountable care organizations, financial penalties for excessive readmissions, and more.

The ACA incents health care leaders to concentrate efforts on multi-year strategies to assure long-term financial sustainability in an era of reform and a constrained economy. It tests existing business models and will include growing revenue pressures, greater emphasis on quality, an imperative to lower unit costs, and achieve greater efficiencies through economies of scale. Members shared examples of how they have begun to assess the impact of payment reductions and other policies contained in the ACA.

AHA Reform Tools and Resources: AHA remains committed to improving health and health care in America through its national framework for health care reform: *Health for Life: Better Health, Better Health Care.* Members encouraged efforts to promote collaboration and integration while reducing administrative burdens and sought assistance with exchange of electronic health information between hospitals and physicians. Members shared changes they have made to address integration, risk assumption, and greater accountability and shared examples on improving access to primary care services and ensuring better care coordination.

Members said that preparing for MU and EHR is doubling everyone's efforts including hospital boards and that the pace of change is coming too fast. Members proposed a dashboard that is aligned with a timeline for implementation of the various provisions of the ACA and a checklist of tasks to be implemented to assist them with meeting regulatory requirements. Members welcome on-line resources on health reform for use with their community and board as well as health promotion and wellness resources for patients.



Hospitals in Pursuit of Excellence (HPOE): HPOE *Hospitals in Pursuit of Excellence* (HPOE) is the American Hospital Association's strategic platform to accelerate performance improvement and support health reform implementation in the nation's hospitals and health systems. HPOE, develops evidence-based tools and guides, offers leadership development through fellowships and networks and engages hospitals in national improvement projects. HPOE synthesizes and disseminates knowledge, shares proven practices, and spreads improvement to support health reform implementation at the local level.

Members reviewed and discussed strategies for targeting avoidable readmissions, a health care reform implementation timeline, and achieving cultural competency and reducing disparities in access and treatment. Members identified several ways in which they have attempted to avoid readmissions such as telehealth, discharge planning, and community care coordinators. They also identified obstacles that had to be overcome to achieve success including cultural competency and policy on observation. To access tools or for more information on HPOE please visit http://www.hpoe.org.

Health Information Technology (HIT): American Recovery and Reinvestment Act (ARRA) of 2009 authorized incentive programs under Medicare and Medicaid, which would pay bonuses to meaningful users of certified electronic health records (EHRs) beginning in FY 2011, then phase-in penalties for those failing to meet MU beginning in FY 2015. The Centers for Medicare & Medicaid Services published a proposed rule on January 13, 2010, and final rule in July on Medicare and Medicaid payment incentives for "meaningful users" of electronic health records (EHR). At the same time, the Office of the National Coordinator for Health Information Technology issued a final rule that sets standards, specifications, and certification criteria for EHR technology. Taken together, these rules impede the ability of health care systems and hospitals, particularly CAHs to receive federal stimulus for HIT and puts many hospitals at risk for Medicare payment penalties beginning in 2015.

Members are moving forward with their IT plans, but remain concerned that they will not be ready in time due to the up-front capital costs and the inaccessibility of vendors that work with small hospitals. The group said that interoperability with other hospital, physicians, and clinics is essential for EHRs to be effective. In addition, members were concerned with vendor accreditation and EHR certification occurring after systems were installed. For more information on HIT regulations, please visit http://www.aha.org/aha_app/issues/HIT/index.jsp

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.