American Hospital Association

State Association Rural Hospital Liaison Call with the AHA Section for Small or Rural Hospitals

The AHA Section for Small or Rural Hospitals hosted a federal update conference call on April 4, 2011 for state association rural hospital liaisons featuring Lisa Kidder, vice president, AHA Legislative Affairs, and Joanna Kim, sr. associate director, AHA Policy.

AGENDA

Legislative Update – Lisa Kidder, vice president

- Political Environment
- AHA Advocacy Agenda for Rural Hospitals

Regulatory Policy Update – Joanna Kim, senior associate director

- Accountable Care Organizations
- March MedPAC meeting

Section Update – John Supplitt, senior director

- February Governing Council Meeting
- Hospital/FQHC Work Group
- AHA Annual Membership Meeting

In lieu of a recording of the April 4 call is a summary of its key points.

Legislative Update:

1. Physician Supervision - remains a priority and we continue to work with a sympathetic Congress to accommodate the needs of CAHs for flexibility in physician supervision of outpatient therapeutic services.
2. CAH Flexibility – remains a priority for members of Congress and sponsors have expressed interest; however the current CBO score makes introduction problematic. We continue to solicit new scoring from CBO with a hope of this being introduced soon
3. CAH Provider Taxes – remain a priority and Reps. Graves and Kind are prepared to reintroduce their bill from the 111th Congress once the language is finalized and with additional sponsors.
4. CAH CRNA Pass-through and Standby costs – remain a priority and we continue to discuss ways to reimburse CRNAs at cost for services at CAHs.
5. CBO Report on Cost Savings – identified CAHs, SCHs, and MDHs as potential sources of savings. However, this exercise was not a recommendation from CBO and received little to no attention from members of Congress.
6. 340B Expansion – is a priority with some potential for including inpatient CAH pharmacy services. Yet expansion has been met with considerable opposition from PhRMA (Pharmaceutical Research and Manufacturers of America).

Regulatory Policy:

1. MedPAC Report – is being tracked closely. The March version was somewhat improved. It is on the MedPAC agenda for April too.
2. Accountable Care Organizations – Staff reviewed the attached fact sheet from CMS On March 31, 2011, the Department of Health and Human Services (HHS) released proposed new rules to help doctors, hospitals, and other providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). Under the proposed rule, an ACO refers to a group of providers and suppliers of services. The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
- Hospitals employing ACO professionals, and
- Other Medicare providers and suppliers as determined by the Secretary

In the proposed rule, the Secretary has made clear that certain (Method 2) critical access hospitals are eligible to participate in the Shared Savings Program. The law requires each ACO to include health care providers, suppliers, and Medicare beneficiaries on its governing board. The ACO must take responsibility for at least 5,000 beneficiaries for a period of three years, also suggested in the law.

CMS is proposing to implement both a one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years), allowing the ACO to opt for either model.
CMS would develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or to be held accountable for losses. CMS is also proposing to establish a minimum sharing rate that would account for normal variations in health care spending, so that the ACO would be entitled to shared savings only when savings exceeded the minimum sharing rate. This minimum rate under a one-sided model ranges from 2.0 – 3.90% depending upon the number of beneficiaries and 2% across-the-board for two-sided risk. The amount of shared savings depends on whether on an ACO meets or exceeds quality performance standards. Beneficiary assignment for ACOs is retrospective, however providers must inform beneficiaries in advance that they are practicing as an ACO.

In addition, The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have worked together to facilitate the creation of ACOs by giving providers the clear and practical guidance they need to form innovative, integrated health care delivery systems without running afoul of antitrust laws.

Also attached is a summary of the February meeting of the Governing Council of the AHA Section for Small or Rural Hospitals.

Questions:

- CMS will propose the details on the physician supervision panel in the OPPS proposed rule in July.
- Concerns over SHIP Grant Funding exist over 1) cuts as proposed in the President's FY 2012 budget and 2) the absence of grant guidance form HRSA ORHP for FY 2011 funding.

I hope this helps. You are welcome to call if you wish to discuss further.

John T. Supplitt, Senior Director
AHA Section for Small or Rural Hospitals
Tel: 312-422-3306
E-mail: jsupplitt@aha.org