AMERICA'S ESSENTIAL HOSPITALS

Board of Directors Meeting

October 1, 2013

Washington Marriot | Washington, D.C.

AMERICA'S ESSENTIAL HOSPITALS

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Agenda
Board of Directors Meeting
October 1, 2013
8:00 am – 1:00 pm

Washington Marriot
Meeting Room 30146-3017
1221 22nd Street NW
Washington, D.C. 20037

8:00 – 8:05 am	Call to Order and Disclose Conflicts of Interest (Mr. Traylor)	ACTION
8:05 – 8:10 am	Consent Agenda (Mr. Traylor) • Approve June 2013 Minutes • Approve New Members • Approve Finance Committee Appointments	ACTION
8:10 – 8:30 am	President and CEO's Report (Dr. Siegel)	
8:30 – 8:45 am	Treasurer's Report (Mr. Lopez)	ACTION
8:45 – 9:30 am	Legislative and Policy Update (Mr. Gremminger and Ms. Huang)	
9:30 – 9:45 am	Keys to E&M Advocacy Success (Mr. Gremminger)	
9:45 – 10:15 am	Policy Advisory Committee Report (Dr. Walker)	ACTION
10:15 – 10:30 am	Break	
10:30 – 11:00 am	Membership Committee Report (Mr. Lopez)	
11:00 – 11:15 am	Education Committee Report (Mr. Belzer)	
11:15 – 11:25 am	Sponsorship and Corporate Relations (Ms. Metter)	
11:25 am – 12:25 pm	Working Lunch with Updates from the Essential Hospitals Institute (Dr. Engler and Dr. Cummings)	
12:25 – 12:30 pm	New Business	
12:30 – 1:00 pm	Executive Session	

America's Essential Hospitals Board of Directors
2013-2014

CHAIR
Thomas P. Traylor, MBA
Vice President, Federal, State and Local Programs
Boston Medical Center

CHAIR-ELECT
William B. Walker, MD
Director and Health Officer
Contra Costa Health Services

SECRETARY
Johnese M. Spisso, MPA, RN
Chief Health System Officer, UW Medicine and VP for Medical Affairs, UW
UW Medicine

TREASURER
David S. Lopez
President and CEO
Harris Health System

PAST CHAIR
Stephen W. McKernan
CEO, UNM Hospitals
UNM Hospitals

AT-LARGE MEMBERS
Alan D. Aviles (2013-2015)
President and CEO
New York City Health and Hospitals Corporation

Betsey Bayless (2012-2014)
President and CEO
Maricopa Integrated Health System (MIHS)

Michael B. Belzer, MD (2012-2014)
Medical Director and Chief Medical Officer
Hennepin County Medical Center

Reginald W. Coopwood, MD (2012-2014)
President and CEO
Regional Medical Center at Memphis (The MED)

Steven G. Gabbe, MD (2013-2015)
Senior Vice President for Health Sciences, CEO
The Ohio State University Wexner Medical Center

Arthur A. Gianelli, MA, MBA, MPH (2013-2015)
President and CEO
NuHealth

Timothy M. Goldfarb (2012-2014)
CEO
University of Florida Health

George B. Hernandez, Jr., JD (2012-2014)
President and CEO
University Health System

Michael Karpf, MD (2013-2015)
Executive Vice President for Health Affairs
UK HealthCare

Santiago Muñoz (2013-2015)
Chief Strategy Officer
UCLA Health System

Jorge Ramon Orozco, MHA (2012-2014)
CEO
Rancho Los Amigos National Rehabilitation Center

Sheldon Retchin, MD (2012-2014)
Vice President, Health Sciences and CEO
Virginia Commonwealth University Health System

EX OFFICIO
Irene M. Thompson
President and CEO
UHC

AMERICA'S ESSENTIAL HOSPITALS

2014 Association Board of Directors Meeting Schedule

March 17, 2014
11:00 am – 5:00 pm
Washington, D.C.
In conjunction with spring legislative event

June 24, 2014
11:00 am – 5:00 pm
San Antonio, Texas
In conjunction with annual conference

Fall 2014
TBD
Washington, D.C.

Executive Committee Meeting Minutes

Tuesday, June 18, 2013

Westin Diplomat, Hollywood, Florida

Attendees: Alan D. Aviles; Betsey Bayless; Michael Belzer, MD; Kirk A. Calhoun, MD; Reginald W. Coopwood, MD; Arthur A. Gianelli, MA, MBA, MPH; Timothy M. Goldfarb George B. Hernández, Jr., JD; Stephen W. McKernan; Santiago Muñoz; Jorge Orozco; Sheldon Retchin, MD, MSPH; ; Johnese Spisso, RN, MPA; Thomas P. Traylor; William B. Walker, MD

Excused: Michael Karpf, MD; David S. Lopez

Staff: Sarah Callahan; Linda Cummings, PhD; David Engler, PhD; Beth Feldpush, DrPH; Rhonda Gold; Carl Graziano; Jane Hooker, RN; Xiaoyi Huang, Esq.; Kristine Metter; Bruce Siegel, MD, MPH; Jill Steinbruegge, MD, PhD

Guest: Tom Robertson, UHC

Executive committee Chair Stephen W. McKernan called the meeting to order and welcomed new members. McKernan recognized Calhoun, whose term has expired, for leading the association's leadership transition from Larry Gage to Siegel and thanked him for his service on the committee. Calhoun recognized Gage and Siegel for a smooth transition. McKernan recognized Robertson for attending the meeting. McKernan asked for a motion to approve the March 19 minutes; Aviles made a motion, which Bayless seconded.

McKernan asked committee members to disclose any current or potential conflicts of interest; no new conflicts were disclosed. McKernan asked members to complete and sign new 2013–2014 conflict of interest statements and return them to Gold.

President and Chief Executive Officer (CEO) Report (Siegel):

Siegel provided a brief report and stated that the main issue on Capitol Hill is immigration reform, noting that major immigrant health reform is a slim hope. He also noted that NAPH has been invited to testify on tax reform. Siegel reviewed the organization's new brand and thanked Gianelli for his critical service in the rebranding effort; he also noted that the vote for the name change had been lopsided with over 90% in favor. Belzer asked whether the name change could result in possible member losses; Siegel responded that he senses this will not be the case. Siegel introduced Engler as the association's new senior vice president for leadership and innovation. Engler was hired after a national search for Steinbruegge's replacement and recently served as vice president of the Ohio Hospital Association's Quality Institute. There, he oversaw a team of professionals in performance improvement and quality and worked on the Partnership for

Patients initiative. Siegel thanked Steinbruegge for her hard work and dedication in moving the Transformation Center forward.

Treasurer's Report (Spisso):

Spisso presented a summary of the organization's 2012 audited financial statements and 2013 projection. She stated that the audited financial reports were reviewed and accepted by the audit and compliance committee May 23; the committee was satisfied with the audited financial statements and had no significant management letter comments. Spisso stated that NAPH had $9.07 million in assets, $3.8 million in liabilities, and $5.17 million in unrestricted net assets, in addition to a $100,000 board-designated operating reserve to fund NAPH's future office relocation. NAPH ended the year with almost $7.92 million in revenue, $6.42 million in expenses, and a $1.5 million operating surplus that included $245,000 in unrealized gains.

Spisso referred the committee to the restated budget, which reflects budget changes within individual line items to accurately show programmatic, general, and administrative revenue and expenses without affecting the budgeted operating surplus. She noted the projected revenue of $8.11 million is almost $30,000 less than budgeted due to fewer Government Relations Academy participants, while the projected expenses of $7.70 million is $80,000 less than budget. The total projected net assets of $5.44 million is $50,000 higher than budgeted and includes $250,000 in restricted assets set aside for NAPH's future office relocation. However, since the brand rollout is a unique undertaking for NAPH, these funds may be needed to cover unanticipated, related costs.

Gianelli made a motion to accept the treasurer's report and 2012 audited financial statements; Calhoun seconded the motion; and the report and audited financial statements were unanimously accepted.

Spisso then presented the investment, audit, and compliance committee report. She stated that the auditors proposed four adjusting journal entries for the National Public Health and Hospital Institute (NPHHI), which decreased the net assets by approximately $3.4 million. The most significant of these was to defer income from the Partnership for Patients initiative into future periods. This adjustment was made because the number of participating hospitals is significantly lower than anticipated and budgeted for in the proposal submitted to the Centers for Medicare & Medicaid Services (CMS) (29 versus 66 hospitals). As of Dec. 31, 2012, only $3.8 million (out of the budgeted year 1 costs of $6.6 million) were spent on the contract, resulting in unspent funds of $3 million. The NPHHI board of directors is aware of the possibility that the federal government may ask NPHHI to return some funding or increase the scope of work, or both. The NPHHI staff intends to pursue a contract modification to add a new scope of work, positioning NPHHI as a national resource for the use of race, ethnicity, and language data to reduce health care disparities.

Spisso summarized the changes within the proposed revised investment policy statement that was approved by the investment, audit, and compliance committee. NAPH's investment portfolio as of March 31 totaled $3.11 million, in addition to $1.84 million in deposit and bond certificates. The investment, audit, and compliance committee also approved diversifying NAPH's investments by investing in the Janus Flexible Bond and Russell Strategic Bond fund within the intermediate portfolio. In addition, the committee agreed to diversify the Allianz Small Cap Value fund by selling 50 percent of the porfolio and investing in the Janus Triton I fund. Spisso stated that the investment, audit, and compliance committee has no concerns regarding these issues and

asked for a motion to accept this report. Walker moved the motion, and Bayless seconded. The report was unanimously accepted. Coopwood made a motion to approve NAPH's revised investment policy statement, which includes the new name America's Essential Hospitals. Bayless seconded, and the revised investment policy statement was unanimously accepted and approved.

Revised Bylaws and Articles of Incorporation (Traylor and Siegel):

Traylor reviewed the revisions to the NAPH bylaws and purposes proposed by the bylaws task force. He stated that implementation of the District of Columbia Nonprofit Corporation Act of 2010 and the need to make the association's governing documents more consistent with its daily operational practices necessitate revising these corporate documents. Traylor presented each proposed bylaw change (included in the memorandum in the executive committee's meeting materials). He also discussed the proposed changes to NPHHI's bylaws, the most significant of which is that NPHHI will no longer have members. A question was raised regarding the firm used to prepare the new bylaws. Siegel responded that Venable LLP, a Washington, D.C.–based law firm, was used because of its association expertise in this specialized area. Muñoz asked if the changes would have any practical impact on daily operations. Metter responded that the most significant change would be streamlining the budget approval process, since the full membership will no longer need to approve the budget.

Belzer asked who will be considered a voting member. Metter responded that NAPH staff will assume it is the CEO unless a member identifies a proxy for a specific vote. Each member will have one vote per each dues paid. Coopwood asked if the new bylaws will assist in gathering a one-third quorum at the annual meeting of members. Metter responded that it will help the process. Going forward, the annual meeting of the members will be an informational meeting as opposed to action items taken by the membership. Traylor asked if a CEO can appoint a designee to attend the annual meeting of members, to which Metter responded affirmatively. Metter stated that the full membership will vote on the changes to the bylaws in late summer. Belzer suggested executive committee members discuss the changes with their CEO peers to reduce pushback from the membership.

Traylor presented the revisions to NAPH purposes, which are listed on the articles of incorporation. He stated that the bylaws task force believes the current purposes are still appropriate and recommends only a minor change to reflect the reality that NAPH membership now includes both public and nonprofit hospitals and health systems. Metter stated the staff has already filed an amendment to the articles of incorporation reflecting the new name, and the District of Columbia has approved the change. If the executive committee approves the task force recommendations, the NAPH membership will vote on the proposed changes in late summer, at which point restated articles of incorporation will be filed.

Calhoun asked what is meant by "public" and "non-profit." Siegel responded that "public" is owned by a government agency or county. Because nonprofit also reflects the NAPH membership, staff added the designation "nonprofit." Siegel stated that hospitals with a public authority would still be considered public. Calhoun suggested clarifying the purposes and bylaws to read "public and/or nonprofit." Siegel and Metter agreed to makethe appropriate change. Metter added that the board has authority to approve a member for another membership category if the member does not qualify for a full membership.

Traylor asked for a motion to approve the recommended changes to the NAPH bylaws and purposes as listed in the articles of incorporation. Belzer made the motion, which was seconded by Bayless and unanimously approved.

Policy/Advocacy Update (Feldpush):

Feldpush presented an economic update that reflects an improved economy and budget outlook. While the country is seeing an improved financial situation, 62 percent of recent gains are due to the resurgence in the stock market, which primarily benefits the wealthy. And, real income in spring 2013 was actually $5,000 lower than at the start of the recession ($56,000 pre-recession versus $51,000 today). Feldpush stated the financial turnaround has led to an improved budget outlook for the federal government. At peak the economy was down 10 percent, but since then it has been trending upward due to several factors: (1) The budget cuts passed in 2012 were implemented; (2) 2013 tax increases are in effect; and (3) sequestration cuts occurred in early 2013. These changes mean the economic landscape does not imply the need for a grand bargain.

Retchin asked why workforce issues are not being considered more broadly during economic discussions given the changes in the labor market and market wage adjustments. Gianelli asked whether high deductible health plans or health reform under the Affordable Care Act (ACA) will have the most impact. Feldpush responded that both are likely to have an impact, but the ACA contains more provisions that could impact hospitals. Feldpush stated that Congress may be ending its drive to reduce the deficit and is currently focused on gun control, mental health, immigration reform, government scandals, and the sustainable growth rate (SGR) fix.

Feldpush stated that the executive committee recommended a set of policies in March that articulated NAPH's position on gun control and mental health issues. These position statements assisted NAPH staff with advocacy during the Senate's debate around gun control and mental health legislation. The Senate bill did not pass because there was no agreement on gun control and background checks. However, there was support behind the mental health provisions in the bill. It is still unclear what future action, if any, the Senate will take on those issues. Traylor represented NAPH at an Obama administration summit on mental health issues in early June, and he described the meeting at the White House. NAPH staff continues to focus on access to mental health services, which is dependent on funding and workforce capacity. It is clear that NAPH members often provide the most access to mental health services in their community.

Feldpush noted the Senate is currently discussing immigration reform. While NAPH supports immigration reform, we remain concerned that under the proposed legislation, it could take 15 years for undocumented immigrants to gain federal benefits, such as health coverage through Medicaid.

Feldpush stated that a fix to the SGR is estimated to cost $139 billion. The House and Senate have both floated ideas on how to reform the payment system, but they have not yet discussed how to pay for that reform. Feldpush noted that hospitals could be vulnerable as a potential "pay-for" for any legislation.

NAPH's current primary advocacy focus is to convince Congress to delay and reevaluate the Medicaid disproportionate share hospital (DSH) cuts. NAPH's current proposal would enact a 3-year delay in the start of the cuts, which would eliminate cuts in 2014–2016. Feldpush stated that staff is making progress on nailing down Democratic and Republication sponsors for this

proposal. Staff believes the best vehicle for moving the bill forward may be to attach the proposal to a continuing resolution bill, which is expected to come up in September to fund the government through at least part of fiscal year 2014. CMS has issued a proposed rule on the allocation methodology and distribution of the proposed cuts.

Muñoz stated that while California is aggressively working to expand its Medicaid program, the rates are essentially locked in at 50 percent of the cost. He noted that California hospitals are most concerned about the larger cuts beginning in 2017. Siegel responded that NAPH's argument in pushing for an initial delay focuses on the fact that coverage expansion is new, and it will take longer than CMS anticipates—for both Medicaid and the health insurance exchanges.

Coopwood referenced the recently released Medicaid and Medicare DSH reduction proposed rules, and asked if staff have modeled Medicare and Medicaid DSH cuts. Siegel responded affirmatively, and said there are winners and losers within the membership with regard to the Medicare cuts. Therefore, our comments to CMS will be tempered in this area. Feldpush stated that she was pleased to see the Medicaid DSH rule incorporate many of NAPH's recommendations, including incentives for states to target DSH cuts. This is a huge regulatory win for NAPH, even though DSH cut implementation will be extremely harmful to hospitals. NAPH will be distributing a report to each member system on the individual impact of the Medicare and Medicaid DSH rules on its hospital.

Policy Advisory Committee Report (Walker):

Walker stated that while the policy advisory committee has recently been focusing on gun control, mental health, and immigration reform issues, its primary focus has been on developing a federal definition for hospitals that serve as "essential hospital systems." Such a proposal would allow NAPH to take a proactive position during the continuous transformation of the health care delivery system and identify these hospitals as a group of providers whose continued viability and growth Congress should support during tough fiscal decisions. Once a designation is in law, it can serve multiple purposes and be adapted to various future proposals from Congress or the administration.

Walker then turned to Feldpush to explain the proposal in more detail. Feldpush stated that during the rebranding effort, it became clear the organization's work is centered on members' multiple missions, and this proposal would be as well. Walker stated the committee felt there should be at least one threshold criterion for the federal designation—a commitment to serve vulnerable populations. And hospitals receiving the designation likely should fulfill one or more additional criteria as well. Traylor stated that the commitment to serve the vulnerable should help drive membership criteria for joining the organization. Staff proposes to move forward with the development of the federal designation and then tackle specific benefits to designation as they arise.

Calhoun stated that while he likes the concept, it is important to be mindful of the word "essential" developing the same perception as the word "public." The organization's name was changed to get away from the concept of being supported by public funds, and it would be unfortunate to have the same perception 10 years down the road.

Walker made a motion for NAPH to pursue a federal designation for hospitals serving essential functions within their communities to support the long-term growth and viability of essential hospitals; the motion was seconded by Spisso and unanimously approved.

Education Committee Report (Belzer):

Belzer presented an update from the education committee that focused on the 2013 Annual Conference and 2013–2014 Fellows Program. The 2013 Annual Conference has 241 registrants and was expanded to include a full-day workshop and a set of concurrent breakout sessions on Wednesday, as well as a fourth set of concurrent breakout sessions on Thursday. In addition, a full-day leadership program that was previously offered to participants of the NAPH Safety Network (NSN) has been replicated for the Annual Conference. The 2014 Annual Conference will be in San Antonio at the Westin Riverwalk.

The 2013–2014 Fellows Program consists of 40 fellows from 19 institutions focusing on leading high-performing organizations. Belzer thanked Steinbruegge for her contributions the past 2 years and Metter for her work with the committee.

Transformation Center Update (Steinbruegge):

McKernan opened the discussion noting his appreciation to Steinbruegge for her Transformation Center leadership. Steinbruegge presented the Transformation Center's key activities over the past 2 years, which primarily focused on quality and leadership. Of NAPH members, 12 are appointed to 11 national quality groups, ranging from National Quality Forum committees to expert panels. Staff continues to seek opportunities to have members appointed to national quality groups.

Other activities include publishing several articles in peer reviewed journals, providing members with Institute for Healthcare Improvement (IHI) scholarships and discounted subscriptions to the IHI open school, and significantly improving the quality of submissions for Gage awards. Member engagement on quality improvement work includes spreading successful practices through CEO reports, the HCAHPS Learning Network, Massachusetts Collaborative, and NSN. To date, more than 60 percent of NAPH hospitals have reported their data for the NSN, and staff believe NAPH meets the criteria for a third year of CMS funding for this project. These results have not yet been verified by CMS' external contractor, Mathematica, CMS and the Office of Minority Health have also asked the NSN to take on a greater role in promoting health equity within the Partnership for Patients; staff are awaiting feedback on its proposal to do so from both agencies.

Steinbruegge stated that the 2013–2014 Fellows Program has grown from 25 to 42 participants and includes a broader group of people learning how to lead their organization to high performance. Coopwood and Walker thanked Steinbruegge for moving the Fellows Program forward; no questions were asked.

Understanding the UHC-NAPH Relationship (Siegel):

Siegel explained UHC's relationship with NAPH (which began in 1997), financial history, and the value proposition for both parties. Retchin suggested that leadership from UHC and NAPH present a session on the overlap of work between the organizations. He stated that leaders could

brainstorm on the benefits both organizations bring to government-sponsored programs. Robertson commented that UHC does not question the benefits NAPH brings to its organization and that UHC has purposefully avoided ramping up its own advocacy efforts because it views NAPH and the Association of American Medical Colleges as the experts in this area. UHC sees its role as helping to provide the support and data for NAPH's advocacy efforts. It does not make sense for UHC to enter the advocacy arena, but the organization is willing to support the advocacy wheel through data.

Spisso suggested that Transformation Center staff not duplicate UHC's work but rather leverage each organization's work. Robertson responded that UHC will be mindful of both organizations' respective areas of work. McKernan echoed Retchin and Spisso's comments that the organizations should have stronger and closer ties with greater information sharing. No further questions or comments were raised.

New Business (Siegel):

Siegel presented the new visual identity for America's Essential Hospitals and the Essential Hospitals Institute. He explained the meanings of the logo —a compass showing true direction, fluidity, resilience, diversity, and the four pillars of NAPH's strategic plan. Bayless asked what the reaction has been about the name change. Siegel responded that the majority are in favor, some are skeptical, and a few are against it. No single identifying theme or pattern for the skepticism has emerged.

Siegel presented a prototype of the new website, which will be unveiled on Thursday and operational in the fall. The articles of incorporation were filed after the member vote, and the new name will be unveiled on Thursday at the annual meeting of the members. Legally NAPH is now operating as America's Essential Hospitals.

McKernan recognized Coopwood for his service on the NPHHI board of directors, which he will be leaving, though he will remain on the executive committee. Siegel presented Coopwood with a token of appreciation.

McKernan solicited discussion of any new or other business; none was reported.

The committee went into executive session and the meeting was adjourned at 4:05 pm.

Submitted by:

William B. Walker, MD

Secretary

AMERICA'S ESSENTIAL HOSPITALS

DATE September 24, 2013
TO Board of Directors
FROM Kristine Metter, Vice President for Member Services
RE New Member Applications MEMORANDUM

Four hospitals have applied for membership with America's Essential Hospitals:

- Norwegian American Hospital, Chicago, Illinois
- Temple University Health System, Philadelphia, Pennsylvania
- University of Arkansas for Medical Sciences (UAMS), Little Rock, Arkansas
- University of Missouri, Columbia, Missouri

Norwegian American Hospital
José Sánchez, President and CEO

Norwegian American Hospital is the fourth leading provider out of 59 area hospitals. It has provided high quality, charitable health care to the residents of the near northwest side of Chicago for over 115 years.

This 200-bed, acute care facility offers a variety of health care programs and services, including inpatient and same-day surgery, an outpatient pharmacy, a radiology department, the All Kids health care program, a cardiology department, a corporate health program, an intensive care unit, a telemetry unit, a pediatrics unit, an emergency department, a physician specialty center, and a comprehensive array of women's health care with an incorporated midwife program.

Norwegian American Hospital Statistics

Beds	230
Employees	-
Discharges (Medicare)	44%
Discharges (Medicaid)	17%
Outpatient visits	85,021
Total Admissions	9,702
Births	1,449

*Source: American Hospital Association (AHA) 2011 utilization statistics

Temple University Health System
Robert Lux, Vice President, Chief Financial Officer, and Treasurer

This health system includes Temple University Hospital, Fox Chase Cancer Center-American Oncologic Hospital, and Jeanes Hospital. The primary points of contact will be from Temple University Hospital, a 728-bed teaching hospital with its main campus located on Temple University's Health Sciences Center in Philadelphia. The hospital provides patients with ready access to an exceptional group of physicians in every specialty and primary care field. These doctors include the nationally recognized faculty of the Temple University School of Medicine, who are supported by the advanced resources of its major teaching hospital.

Temple University Hospital Statistics

Beds	740
Employees	3,622
Discharges (Medicare)	32%
Discharges (Medicaid)	49%
Outpatient visits	161,857
Total Admissions	30,397
Births	2,726

*Source: AHA 2011 utilization statistics

University of Arkansas for Medical Sciences (UAMS)
Roxane Townsend, MD, Vice Chancellor for Clinical Programs

The University of Arkansas for Medical Sciences (UAMS) in Little Rock is the only academic health sciences university in the state of Arkansas. It is the state's largest public employer, with more than 10,000 employees in 73 of Arkansas' 75 counties. UAMS and its clinical affiliates, Arkansas Children's Hospital and the VA Medical Center, are an economic engine for the state with an annual economic impact of $3.92 billion.

UAMS offers 64 baccalaureate, master's, doctoral, professional, and specialist degree programs and certificates through its graduate school and its Colleges of Medicine, Nursing, Pharmacy, Health Professions, and Public Health.

UAMS Statistics

Beds	359
Employees	3,099
Discharges (Medicare)	29%
Discharges (Medicaid)	33%
Outpatient visits	379,557
Total Admissions	17,600
Births	2,448

*Source: AHA 2011 utilization statistics

University of Missouri
Mitch Wasden, EdD, MHSA, CEO

University of Missouri Health System serves patients from every county in the state of Missouri. University Hospital and Clinics, a 307-bed acute care hospital in Columbia, operates the region's only level I trauma center, the only burn and wound intensive care unit, the only kidney transplant program, and the chest pain center of excellence. The hospital annually receives more than 42,000 visits to its emergency center.

The system also includes the Ellis Fischel Cancer Center and Women's and Children's Hospital as well as three health sciences schools: the MU School of Health Professions, the MU Sinclair School of Nursing, and the University of Missouri School of Medicine.

University of Missouri Health System Statistics

Beds	307
Employees	3,392
Discharges (Medicare)	35%
Discharges (Medicaid)	22%
Outpatient visits	516,174
Total Admissions	14,148
Births	1,714

*Source: AHA 2011 utilization statistics

AMERICA'S ESSENTIAL HOSPITALS

DATE September 24, 2013
TO Board of Directors
FROM Rhonda Gold, Vice President and CFO
RE Proposed 2013-2014 Finance Committee Membership MEMORANDUM

2013-2014 Finance Committee

In accordance with the association's bylaws, the full board is asked to approve the following proposed composition of the finance committee for 2013-2014.

Person	Organization	Committee Position/Term
David S. Lopez	Harris Health System	Chair, 2013-2014 Ex officio as board treasurer
Johnese M. Spisso	UW Medicine	2013-2014 Ex officio as board secretary
Arthur A. Gianelli	NuHealth	2013-2015
Jorge R. Orozco	Rancho Los Amigos National Rehabilitation Center	2013-2014
Reginald W. Coopwood	The MED	2013-2014

AMERICA'S ESSENTIAL HOSPITALS

DATE September 24, 2013
TO Board of Directors
FROM Rhonda Gold, CFO
RE Financial Projection for 2013

MEMORANDUM

This memorandum summarizes the 2013 financial projection compared with the projection presented to you in June and with the approved budget. The attached materials have been reviewed by the association's treasurer, David Lopez.

The following action item is requested from the board:

- Acceptance of this treasurer's report

Column 3 of the attachment reflects the updated financial projection for the year. Projected revenue of $8.14 million is $30,000 better than last projected (in June) and on target with budget. We are also pleased to report that projected expenses of $7.13 million are 8 percent less than last projected and budgeted (by $577,000 and $657,000, respectively), resulting in a $990,000 operating surplus (after unrealized gains and one-time rebranding costs). After accounting for this surplus, we project total net assets of almost $6.26 million, of which $250,000 is restricted to cover the association's upcoming office relocation. At this point, the organization has close to one year of operating expenses in reserves.

This large surplus primarily results from unbudgeted unrealized investment gains (of $148,000); savings in the salary and fringe line from hiring delays in filling vacant positions; higher allocation of staff time to the institute; and lower-than-budgeted salary increases and health insurance premiums. Furthermore, there is a projected savings of $185,000 that is now not needed to support the Essential Hospitals Institute because of new external funding recently awarded. This new funding reduces the association's need to provide as much core support as budgeted to cover research and Transformation Center staff personnel costs and programmatic expenses.

Other significant variances (more than $30,000) are explained below:

Advocacy: Projected savings of $30,400 from the June projection (and $60,100 from budget) because of savings on speaker honoraria and lower food costs for the Spring Legislative Event and Government Relations Academy.

Conference expenses: Projected savings of $109,700 from the June projection and budget because of lower attendance at the spring executive committee governance meeting, resulting in less travel stipends and food costs; reduced annual conference hotel costs through complimentary rooms for staff; and annual conference food costs lower than budgeted.

Information technology: Projected savings of $39,000 from last projected and budget because of a reversal of a 2012 accrual for a budgeting tool that will not be spent this year.

Office expenses and equipment rental: Projected savings of $62,500 from last projected (and $44,800 from budget) because of lower printing costs for rebranded materials included as part of the association's design contract; savings in webinar fees from a flat-rate WebEx contract; lower staff recruitment advertising expenses; and savings in postage for membership material mailings.

Travel and professional development: Projected savings of $63,100 from last projected and budgeted because we did not convene an in-person strategic planning committee meeting; and travel, professional development, and in-house meetings were allocated to the Institute for staff working on Institute-related work.

Depreciation and amortization: Projected savings of $31,000 from last projected and budgeted because we anticipate spending less than budgeted for computers, software, and equipment.

Rebranding: Projected savings of $67,000 from last projected and budgeted due to lower design and implementation fees for the new website; and savings in the design of the new logo and rebranded printing costs.

In addition, there is $100,000 in budgeted funds set aside for project development costs that we do not anticipate spending by year's end. The costs are reflected in the year-end projection to cover unanticipated expenses related to rebranding and/or to architectural design fees for the office move.

If you have questions prior to the fall meeting, please contact Rhonda at 202-585-0109 or rgold@essentialhospitals.org.

Attachment I

2013 Projection vs. June Projection and Budget

	column 1	column 2	column 3	column 4	column 5	column 6
	2013 Restated Budget	2013 June Projection	2013 Fall Projection	Fall Proj. vs. June Proj.	Projection vs. Restated Budget	% Change from Budget
INCOME:						
Membership Dues	$4,630,500	$4,630,500	$4,630,700	$200	$200	0%
UHC Dues and Sponsorships	$3,079,500	$3,081,400	$3,081,400	$0	$1,900	0%
External Sponsorships	$200,000	$200,000	$209,500	$9,500	$9,500	5%
Conference Registration Fees	$103,500	$103,500	$110,000	$6,500	$6,500	6%
GR Academy Tuition	$80,000	$48,000	$44,000	($4,000)	($36,000)	-45%
Investment Interest and Dividends	$47,500	$47,500	$60,000	$12,500	$12,500	26%
Realized Gains (Losses)	$0	$0	$3,000	$3,000	$3,000	100%
Miscellaneous Income	$3,000	$3,100	$5,400	$2,300	$2,400	80%
TOTAL INCOME	**$8,144,000**	**$8,114,000**	**$8,144,000**	**$30,000**	**$0**	**0%**
EXPENSE:						
Retainer	$400,000	$400,000	$400,000	$0	$0	0%
Salaries and Fringes	$3,510,000	$3,415,000	$3,385,000	$30,000	$125,000	4%
Support to Institute	$885,000	$885,000	$700,000	$185,000	$185,000	21%
Policy	$202,000	$202,000	$189,000	$13,000	$13,000	6%
Advocacy	$518,700	$489,000	$458,600	$30,400	$60,100	12%
Member Services	$176,000	$176,000	$185,400	($9,400)	($9,400)	-5%
Communications	$237,000	$237,000	$241,200	($4,200)	($4,200)	-2%
Conference Expenses	$514,000	$514,000	$404,300	$109,700	$109,700	21%
Consulting and Professional Fees	$170,000	$197,000	$177,000	$20,000	($7,000)	-4%
Information Technology	$116,000	$116,000	$77,000	$39,000	$39,000	34%
Rent	$395,000	$395,000	$393,300	$1,700	$1,700	0%
Office Expenses & Equipment Rental	$235,000	$252,700	$190,200	$62,500	$44,800	19%
Travel and Meetings	$165,100	$165,100	$102,000	$63,100	$63,100	38%
Misc./Taxes and Insurance	$71,200	$71,200	$66,000	$5,200	$5,200	7%
Depreciation and Amortization	$89,000	$89,000	$58,000	$31,000	$31,000	35%
Project Development	$100,000	$100,000	$100,000	$0	$0	0%
TOTAL EXPENSES	**$ 7,784,000**	**$ 7,704,000**	**$ 7,127,000**	**$ 577,000**	**$ 657,000**	**8%**
Change in Net Assets before Unrealized Gains	**$ 360,000**	**$ 410,000**	**$ 1,017,000**	**$ 607,000**	**$ 657,000**	
Unrealized Gains/(Losses)	$ -	$ -	$ 148,000	$ 148,000	$ 148,000	
Change in Net Assets after Unrealized Gains	**$ 360,000**	**$ 410,000**	**$ 1,165,000**	**$ 755,000**	**$ 805,000**	
Items Funded from Reserves:						
Rebranding	($242,000)	$ (242,000)	$ (175,000)	$ 67,000	$ 67,000	
Changes in Net Assets after Funding from Reserves	**$ 118,000**	**$ 168,000**	**$ 990,000**	**$ 822,000**	**$ 872,000**	**$ -**
NET ASSETS:						
Prior Year Net Assets	$ 5,274,048	$ 5,274,048	$ 5,274,048	$ -	$ -	
Change in Net Assets	$ 118,000	$ 168,000	$ 990,000	$ 822,000	$ 872,000	$ -
Total Net Assets before Funding of Special Projects	$ 5,392,048	$ 5,442,048	$ 6,264,048	$ 822,000	$ 872,000	
Restricted Net Assets:						
Office Relocation (Restricted Net Assets)	$ (150,000)	$ (150,000)	$ (150,000)	$ -	$ -	
Total Restricted Net Assets	$ (150,000)	$ (150,000)	$ (150,000)	$ -	$ -	
Summary of Total Net Assets:						
Unrestricted Net Assets	$ 5,142,048	$ 5,192,048	$ 6,014,048	$ 822,000	$ 872,000	
Restricted Net Assets for Office Relocation	$ 250,000	$ 250,000	$ 250,000	$ -	$ -	
Total Net Assets	$ 5,392,048	$ 5,442,048	$ 6,264,048	$ 822,000	$ 872,000	

AMERICA'S ESSENTIAL HOSPITALS

DATE September 24, 2013
TO Board of Directors
FROM Shawn Gremminger, Assistant Vice President for Legislative Affairs and Xiaoyi Huang, Assistant Vice President for Policy
RE Advocacy and Policy Update MEMORANDUM

This memo outlines advocacy and policy activities of America's Essential Hospitals since the last in-person meeting of the executive committee, in June, and details what we expect for the remainder of the year.

Year-End Political Context

Partisan Gridlock Amid Health Reform Implementation

The 113th Congress, now in its ninth month, has been, to date, the least productive Congress in modern history, based on the number of bills enacted. As of September 19, 2013, only 31 laws have been enacted this year, seven of which are non-substantive legislation that either name a federal facility after a person or award a Congressional Gold Medal to a person. With 2014 being a mid-term election year, prospects for bipartisan compromise and the movement of meaningful legislation seem dim.

Of particular partisan disagreement are virtually all issues related to health care and any provision included in the Affordable Care Act (ACA), also known as "Obamacare." Republicans have steadfastly opposed the law since winning back the House of Representatives in the 2010 midterm elections and have voted on dozens of bills to repeal or defund all or part of the law. With open enrollment in health insurance marketplaces beginning October 1, 2013, and Medicaid expansion becoming a reality in expansion states on January 1, 2014, Republican staff privately concede that their last window of opportunity for stopping the law is quickly closing. Despite being unable to stop the law, congressional Republicans have successfully hindered it by refusing to appropriate federal spending requested by the administration. Working on a shoestring budget, the U.S. Department of Health and Human Services (HHS) has worked hard to implement the law on time, but has missed some deadlines. With major provisions of the law coming online over the next several months, administration officials have been working to lower expectations, noting that they expect some glitches and lower immediate enrollment than previously projected.

Federal Discretionary Budget

On March 1, the Budget Control Act's (BCA's) budget sequestration began, despite broad recognition that the across-the-board budget cuts are poorly targeted and would harm the economy. The BCA stipulates between 7.8 percent and 10 percent cuts to discretionary spending, depending on the budget category. Medicare is limited to a 2 percent cut in payments to providers and Medicaid and other low-income programs are exempted. Democrats, in particular, pushed for sequestration to be repealed, in some cases arguing that the cuts could send the economy back into recession. While many economists believe sequestration has reduced economic growth, the slow and steady recovery from the recession has continued unabated throughout the year, and calls to stop or renegotiate sequestration have softened. Polls released in September find that sequestration is becoming less unpopular within the general public. Both parties appear to be resigned to the fact that sequestration-level cuts will continue into 2014.

As has become commonplace in the past decade, none of the 12 annual appropriations bills to fund the federal government has been completed, despite the fact that the federal fiscal year ended September 30. Instead, Congress is working on a short-term continuing resolution (CR) to fund the government until mid-December. As of September 19, the House was preparing to pass a CR that would both fund the government and defund the ACA. The Senate is expected to strip the defunding language before sending the measure back to the House. A path to compromise on this legislation is not clear.

Debt Ceiling Debate

The federal government is expected to hit its statutory debt ceiling by the middle of October. Before that time, Congress must pass legislation to raise the debt ceiling or risk defaulting on its debt obligations. As of September 19, a path forward has not become clear, however House Republicans are demanding significant budgetary concessions from Democrats in exchange for passage of the legislation. The White House has asked for a "clean" vote on the debt ceiling, without concessions.

Medicare Sustainable Growth Rate

In a rare victory for bipartisanship, on July 31, the House Energy and Commerce Committee unanimously passed legislation to permanently repeal Medicare's flawed sustainable growth rate (SGR) formula for physicians and replace it with a more stable payment system. The Energy and Commerce bill would:

> "[P]rovide an annual statutory update of 0.5% per year for 2014 through 2018. During this time, the current law payment incentives, such as the Physician Quality Reporting Program (PQRS) and the Electronic Health Record (EHR) Incentive Program will continue. Quality measure development also will continue to ensure robust availability of measures for rewarding provider performance. Providers will also have the option of using current delivery system reform avenues as well as a new Alternative Payment Models (APM) process to put forward and test new models of care delivery and improvement.

> "Beginning in 2019, providers will receive an annual update of 0.5%. However, physicians practicing in fee-for-service will receive an additional update adjustment based on quality performance under a new Update Incentive Program (UIP). Performance under the UIP will be assessed based on quality measures and clinical practice improvement activities…"

The Energy and Commerce bill does not include offsets to cover the $175 billion cost of repealing the current SGR. As of September 19, the House Ways and Means Committee, which has partial oversight of Medicare and nearly full jurisdiction over potential offsets for the cost of repealing the SGR, has not yet taken action. Ways and Means may choose to amend the Energy and Commerce legislation, draft its own legislation, or do nothing, allowing the current bill to move to the House floor. While Energy and Commerce succeeded at crafting a bipartisan replacement policy, offsetting the cost of repealing the SGR is likely to be more contentious. The Senate Finance Committee, which oversees all of Medicare, has not yet taken action.

America's Essential Hospitals continues to monitor this legislation, with a particular eye toward protecting Medicaid and essential hospital funding from being used to offset the cost.

Top Association Advocacy Issues

At America's Essential Hospitals' legislative event, beginning on the afternoon of October 1, the association is asking member hospitals to focus on two top-priority issues:

1. a delay in Medicaid disproportionate share hospital (DSH) cuts
2. inclusion of essential hospitals in qualified health plan networks offered through newly-established health insurance marketplaces (exchanges)

Medicaid DSH Delay

The ACA makes significant cuts to both Medicaid and Medicare DSH payments. The ACA explicitly sets the Medicaid DSH cuts and has no provision for adjustments to reflect the actual level of uncompensated care hospitals provide. Each year, beginning in fiscal year (FY) 2014, the HHS secretary must reduce aggregate state DSH allotments by these amounts:

- FY 2014: $500 million
- FY 2015: $600 million
- FY 2016: $600 million
- FY 2017: $1.8 billion
- FY 2018: $5 billion
- FY 2019: $5.6 billion
- FY 2020: $4 billion

The law was silent about what happens to DSH allotments in FY 2021 and beyond. The Congressional Budget Office (CBO) interpreted the law to mean that DSH allotments would return to pre-ACA levels. Recognizing a potential offset for other spending, Congress has twice rebased DSH (for FY 2021 and 2022) by extending the FY 2020 reduced baseline, using the savings to pay for an extension of the Medicare SGR and other policy extenders.

In his FY 2014 budget, President Obama recommended a one-year delay in the Medicaid DSH cuts, postponing the decrease in funding to FY 2015. The White House said the delay would "better align Medicaid [DSH] payments with the expected levels of uncompensated care...." To pay for the delay, the administration would incorporate the FY 2014 cuts into cuts in future years.

The Supreme Court's July 2012 ruling on the ACA effectively makes the law's Medicaid expansion voluntary for states. To date, only about half of states have opted to expand Medicaid. The Kaiser Family Foundation estimates that up to 6.4 million people could remain uninsured as a result. America's Essential Hospitals has calculated that this decision will increase nationwide hospital uncompensated care costs by more than $53 billion over the next 10 years.

America's Essential Hospitals is focused on making the case that the DSH cuts must be delayed and ultimately reconsidered in total. As of September 19, the association was working with Sen. Jay Rockefeller (D-WV) on legislation, to be introduced before October 1, that would delay the Medicaid DSH cuts for three years. Further, the legislation would require HHS to provide information necessary to help Congress make well-informed decisions on the future of Medicaid DSH payments.

Immigration and Gun Control

Earlier this year, the association focused attention on two policy areas normally outside its scope of work: immigration reform and gun control.

Following the 2012 election, in which Latino voters were a key constituency that propelled President Obama to reelection, both parties became more interested in considering comprehensive immigration reform. Following months of bipartisan negotiations, the Senate overwhelmingly passed a comprehensive immigration reform bill in June by a 68-32 vote. The bill includes a path to citizenship for the estimated 11 million undocumented immigrants living in the United States. But despite advocacy by America's Essential Hospitals and many allied organizations, it includes no provisions to help these immigrants access health care during the next 10 to 15 years. The bill stipulates a 10-year provisional status for this population. Current law requires permanent legal residents to wait five years before they may access many federal programs, including Medicaid. The House has yet to act on immigration reform this year. House leadership appears to prefer a piecemeal approach of passing smaller laws, rather than the comprehensive approach preferred by the Senate. Prospects for enactment of a comprehensive bill during this Congress appear slim.

Following the tragic shooting in Newtown, Connecticut, last fall, Congress focused its attention on gun violence for the first time in nearly two decades. While significant gun control legislation was on the table for a brief period, the bill that came to the floor of the Senate only sought to institute universal background checks for prospective gun buyers. After furious advocacy by gun rights advocates – and despite public approval ratings for the legislation of approximately 90 percent – Senate leaders were unable to muster 60 votes to break a Republican filibuster. A final vote was never held and similar legislation appears dead for the remainder of this Congress.

Medicaid and Medicare DSH Reduction Regulations

Medicaid DSH

On September 13, the Centers for Medicare & Medicaid Services (CMS) released a final rule on the ACA's Medicaid DSH cuts for FY 2014 and FY 2015. In this rule, CMS finalized the DSH health reform methodology the agency will use to determine the amount each state's DSH allotment is reduced in those two years. We were very encouraged to see that the final rule incorporates many key concepts and high-level structural approaches from America's Essential Hospitals policy recommendations for implementing Medicaid DSH reductions. Specifically, CMS' final methodology employed two main recommendations the association made to the agency last year: that the initial methodology be applied only in the first few years while post-coverage expansion data remain unavailable; and that the methodology include incentives for states to target remaining DSH dollars to high-need hospitals.

In general, CMS' final methodology would determine allotment reduction amounts based on whether a state is a low- or high-DSH state, the state's relative uninsured percentage, whether the state targets its DSH dollars to hospitals with high Medicaid volumes and high levels of uncompensated care, and whether the state used DSH dollars for coverage expansion.

Medicare DSH

On August 2, CMS released a final rule implementing the ACA's changes to the Medicare DSH program, which will lower overall Medicare DSH payments to hospitals by about $550 million in FY 2014. Under the ACA, Medicare DSH cuts start October 1, 2013, and hospitals eligible for Medicare DSH payments will see their add-on payment reduced to 25 percent of what their payment adjustment would have been – what CMS is calling the "empirically justified amount." These payments will continue to be made under the DSH program moving forward. The remaining 75 percent of payment that would have been paid to Medicare DSH hospitals will be reduced based on the decrease in the percentage of uninsured individuals nationwide and then redistributed among hospitals based on each hospital's level of uncompensated care (UC).

In the final rule, CMS noted that the remaining 75 percent equals $9.58 billion, an increase of $326 million compared with the proposed $9.25 billion. For FY 2014, CMS estimated the decrease in the number/percentage of uninsured individuals to be

approximately 5.7 percent (as opposed to 11.2 percent, as proposed), resulting in $9.03 billion remaining (as opposed to $8.22 billion, as proposed) for UC payments. This amount will be distributed based on each hospital's level of UC as compared with all other Medicare DSH hospitals' UC. In the rule, CMS finalized its proposal to use inpatient days of both Medicaid beneficiaries and Medicare supplemental security income beneficiaries as a proxy for measuring the amount of UC each hospital provides. CMS also noted that UC payments will be made on an interim basis through the claims processing system for each hospital discharge.

Next Steps

Similar to the information the association provided to its members on the impact of the proposed rules, we plan to share with our members the impact of the Medicaid and Medicare DSH final rules. We also intend to monitor the methodologies laid out in these two final rules, especially as CMS considers new data sources and proxies for uncompensated care.

Member Education Efforts and Advocacy on Health Insurance Marketplace Implementation

Since June of this year, the association has actively advocated on members' behalf in front of CMS, the CMS Center for Consumer Information and Insurance Oversight (CCIIO), and the federal Health Resources and Services Administration (HRSA). For example, since hearing from several members regarding their potential exclusion from marketplace plans' networks or unfavorable placement into higher cost-sharing tiers, staff has actively engaged senior leadership at CMS, CCIIO, and HRSA to discuss possible solutions. In addition, on August 28, the association hosted a webinar with the Chief Medical Officer and deputy director for plan management at CCIIO to discuss issues that hospitals face related to open enrollment October 1. In the coming months, we are planning to publish policy briefs and frequently asked questions documents, and host additional webinars with experts from CCIIO.

Member Education Efforts and Advocacy on Delivery System Transformation Waivers

In the coming months, the association will gear up its member education and regulatory advocacy efforts around Medicaid delivery system transformation waivers. We will continue to hold in-person sessions on this topic, publish additional educational materials for the membership, and engage CMS staff with responsibility for waiver negotiations.

AMERICA'S ESSENTIAL HOSPITALS

DATE September 24, 2013
TO Board of Directors
FROM Shawn Gremminger, Assistant Vice President for Legislative Affairs and Xiaoyi Huang, Assistant Vice President for Policy
RE Successful Advocacy to Stop Outpatient Evaluation and Management Cuts: Lessons Learned

MEMORANDUM

Background

In November 2011, the Medicare Payment Advisory Commission (MedPAC) issued a draft proposal to equalize payment for outpatient Evaluation and Management (E&M) services between hospital-owned clinics and private practice physicians. Currently, hospitals are paid as much as 80 percent more than private practice physicians for the same E&M service. MedPAC contended that the disparity in payment is not only empirically unjustified, but also leads hospitals to make the financial decision to purchase private practice physician offices and reap the increased payment without enhancing services. The hospital industry counters that our outpatient clinics serve a sicker population and provide higher-quality care than private practice physicians. Further, due in part to federal regulations, hospitals have higher overhead costs.

America's Essential Hospitals (then the National Association of Public Hospitals and Health Systems [NAPH]) staff quickly found that this Medicare cut would have a disproportionate impact on our membership, because many of our hospitals operate very large outpatient networks. To wit, while our association represents only 2 percent of all hospitals, accounting for 6 percent of all discharges, we would have taken 15 to 20 percent of the cut.

Armed with this information, America's Essential Hospitals pressed MedPAC to alter its recommendation before finalization in December to account for the impact on our members. After our conversations, MedPAC finalized recommendations to cut E&M payments dramatically but included a stop-loss provision for some essential hospitals (those that serve a safety net role). Specifically, for hospitals with a disproportionate patient percentage (DPP) of 25

percent or greater, the provision would limit E&M cuts to no more than 2 percent of a hospital's Medicare revenue for several years. Unfortunately, this provision was wholly inadequate—very few of our hospitals would have been protected, and the protection ended after three years.

At a time when deficit reduction was the top priority on Capitol Hill, the MedPAC recommendation quickly gained steam there as a significant money-saver—the Congressional Budget Office scored the provision as saving the federal government $10 billion over 10 years. A House-passed deficit reduction bill included the cut in January 2012. With both Democrats and Republicans strongly considering this proposal, America's Essential Hospitals staff perceived this reduction as an immediate threat of the highest priority.

Legislative Campaign

Following the MedPAC recommendation in December, and before Congress returned to session in January, America's Essential Hospitals staff began to develop a strategy to blunt the impact of the cuts on our hospitals. We quickly recognized that a "just say no" approach was not a reasonable strategy for us. The MedPAC recommendation was based in unfortunate realities, and the available federal savings were a significant enticement for both parties. Rather than attempting to fight the cuts altogether, we spent more than one month considering and developing many conceivable alternatives to the proposal. In particular, we sought an alternative that achieved two competing goals:

- Protect our member hospitals from the brunt of the cuts
- Minimize a reduction in federal savings compared to the MedPAC proposal

After careful consideration of alternatives, the association developed a set of policy options that built upon the MedPAC recommendations. Each alternative had the goal of protecting essential hospitals.

With these options, we developed a two-part legislative strategy:

1. Noting the disproportionate impact on essential hospitals, we would continue to publicly urge Congress to reject any cuts to E&M pending further analysis by MedPAC or others on the impact of the cuts on access for low-income and vulnerable patients.
2. We would work with staff on committees of jurisdiction to offer policy alternatives if Congress insisted on moving forward with an E&M cut.

By closely working with committees of jurisdiction in both chambers and with staff in both parties, we became a trusted source of information and a sounding board for staff considering policy options. Throughout 2012, the E&M cuts were a central feature of policy debates on options to reduce federal health care spending, but we succeeded in making the case to all sides that the cuts had unintended consequences on essential and teaching hospitals (the Association of American Medical Colleges also lobbied hard on this issue), and that an alternative was needed before a majority felt comfortable in moving forward with cuts. By the end of the year, the desire for deficit reduction proposals had abated, and both MedPAC and congressional leaders had turned their attention to other potential Medicare cuts, including a proposal to reduce payment for other ambulatory payment classification codes that do not have a disproportionate impact on our membership.

Lessons Learned

- *Work with all sides willing to negotiate—avoid adversarial relationships*
- *Offer reasonable alternatives, even if they are not perfect*
- *Build on others' policies*
- *Work both an "inside" and "outside game"*

AMERICA'S ESSENTIAL HOSPITALS

DATE September 24, 2013
TO Board of Directors
FROM William B. Walker, MD, Chair, Policy Advisory Committee
RE Policy Advisory Committee Update MEMORANDUM

On behalf of the Policy Advisory Committee (PAC), I provide you with this update of the committee's activities. Since the board of directors voted June 18 to move forward with developing a federal designation for hospitals committed to caring for vulnerable people and providing vital community services, the PAC has been working to develop the specifics necessary to advance this concept. On August 14 and September 10, the PAC met by phone to discuss metrics that can be used as proxies for each of the five criteria included in the designation concept. On September 19, the PAC voted by email on the final framework for this designation concept. Background and a description of the designation concept, including the recommended proxies to be used to operationalize this concept, are outlined below, followed by the PAC's recommendation for the board's consideration. A list of PAC members is included in Appendix A.

Background

Members of America's Essential Hospitals provide access to care for the most vulnerable. Over time, these essential hospitals have evolved with the rapidly changing health care system to play a much broader role as comprehensive, integrated systems of care that are uniquely focused on the needs and challenges of the low-income population. These hospital systems are vital to their communities and will be increasingly important to the successful implementation of high-quality, efficient care for the newly insured. In addition, member hospitals are committed to providing a rich variety of other services to their communities, including training future health care professionals; providing trauma care and other intensive services not otherwise available; and improving population health by preventing unnecessary hospitalizations—whether through extensive primary care networks or public health initiatives.

The breadth of missions served by these essential hospital systems presents an opportunity to be at the core of federal, state, and local efforts to improve health care. At the same time, these hospitals are vulnerable on multiple fronts when policymakers seek to cut program spending—particularly in the face of sequestration and ongoing deficit reduction activities. America's Essential Hospitals seeks to create a federal designation for hospitals that serve the role just described: **vital services hospital**

system. Such a proposal would allow the association to take a proactive stance on accountability for coordination and improved patient care, positioning the association and its members as go-to providers that are part of the solution. Such a designation would also easily identify these hospitals as a group of providers whose continued viability and growth merit support as Congress continues to face tough fiscal decisions. Once a designation is in law, it can serve multiple purposes and be adapted to various future proposals from Congress or the administration.

Overview of Concept

A member of America's Essential Hospitals (and any other hospital able to meet the requirements) would apply to the federal government for a designation as a vital services hospital system. Hospitals meeting these requirements would be eligible for one or more of a range of benefits (examples can be found in Appendix B). These benefits could be flexible and evolve once the initial designation is in federal law. In return, the hospital systems might be responsible for increased accountability and transparency.

There will need to be some balance between the chosen benefits of the designation and the eligibility and accountability requirements. The greater the benefit, the more Congress or the administration likely would expect in terms of commitment to key missions and level of accountability.

A federally designated vital services hospital system would be expected to meet a threshold criterion on commitment to serving vulnerable populations and at least two mission-related criteria from a menu of four to be set out in law and regulation. An example can be seen in the table below.

Threshold Requirement	
X	Commitment to serving vulnerable populations
Must meet at least two of four additional mission-related criteria	
[ ]	Commitment to teaching
[ ]	Commitment to providing specialized, high-acuity care
[ ]	Commitment to public health and essential community services
[ ]	Commitment to providing comprehensive, coordinated care

Recommended Proxies for Each Criterion

Based on work completed this summer, the PAC approved the following recommended proxies for the five criteria listed above:

1. For the commitment to serve vulnerable populations, the PAC approved a combined proxy that would allow public and non-for-profit hospitals to meet this threshold requirement if their disproportionate patient percentage (DPP) is at or above the 75th percentile for DPPs nationwide or their uninsured uncompensated care cost (UCC) share is at or above the 75th percentile for uninsured UCC shares nationwide.

   DPP is the sum of the Medicare Supplemental Security Income (SSI) ratio[1] and the Medicaid Inpatient Utilization Rate[2] (MIUR). The Medicare program uses DPP to determine eligibility for Medicare disproportionate share hospital (DSH) payments.

   Uninsured UCC share is the ratio of charity care cost and bad debt over total costs. Uninsured UCC share is also calculated using Medicare cost report worksheet S-10 data and includes charity care and non-Medicare bad debt.

2. For the commitment to teaching criterion, the PAC approved a combined proxy that would allow public and non-for-profit hospitals to meet this criterion if the number of full-time equivalent (FTE) residents trained above the cap is at or above the 33rd percentile or their resident-to-average daily census ratio is at or above the 33rd percentile.

   Number of FTE residents trained above cap is the number of direct graduate medical education (DGME) allopathic and osteopathic FTE residents trained by the hospital system above Medicare's training cap.

   Resident-to-average-daily-census ratio is used to determine the capital Medicare indirect medical education (IME) payment.

3. For the criterion of commitment to providing specialized, high-acuity care, the PAC approved a combined proxy that would allow public and non-for-profit

[1] SSI ratio is the ratio of Medicare SSI days over total Medicare days. SSI days are those attributable to people with low income who are 65 or older or are blind or have a disability. SSI ratio can serve as a proxy for the amount of care provided to individuals who are dually eligible for Medicare and Medicaid. SSI ratio does not account for Medicaid or uninsured or uncompensated costs.

[2] MIUR is the ratio of Medicaid inpatient days over total inpatient days. MIUR is one of three factors proposed to be used to determine the size of state Medicaid DSH allotment reduction amounts. MIUR also is used to determine hospitals that are deemed eligible for state Medicaid DSH payments. Specifically, MIUR that is one standard deviation above the state mean is a federal minimum criterion for being eligible for state Medicaid DSH payments. MIUR does not account for the uninsured or for uncompensated costs.

hospitals to meet this criterion if they operate a level I trauma center, provide burn care, provide transplant services, or have a Medicare case mix index at or above the 75th percentile.

4. For the criterion of commitment to public health and essential community services, the PAC approved a hospital ownership metric whereby a hospital owned by a state, county, city-county, hospital district, or hospital authority would be deemed to have a demonstrated commitment to public health and essential community services.

5. For the criterion of commitment to providing comprehensive, coordinated care, the PAC approved the National Committee for Quality Assurance (NCQA) recognition program for patient-centered medical homes (PCMH) as the proxy for demonstrating a commitment to this mission. A hospital system would need at least one NCQA-recognized PCMH to demonstrate a commitment to this mission.

Based on the overall framework and the above-described recommendations, below is a summary describing the results of requiring public and non-for-profit hospitals to meet the commitment to serve vulnerable populations and **at least two of the four** additional mission-related criteria:

Total hospitals with data	5,223
Total members with data	142
Total hospitals that can meet the vulnerable populations criterion	1,506
Total members that can meet the vulnerable populations criterion	118
Total members that cannot meet the vulnerable populations criterion	24
Number of hospitals that can meet vulnerable populations criterion and at least two of the four additional mission-related criteria	297
Members that can meet vulnerable populations criterion and at least two of the four additional mission-related criteria	95
Members that can meet vulnerable populations criterion and at least two of the four additional mission-related criteria as a percent of all members with data	67%
Members that can meet vulnerable populations criterion and at least two of the four additional mission-related criteria as a percent of all hospitals that can do so	32%
Members that can meet vulnerable populations criterion but not at least two of the four additional mission-related criteria	23
Non-members that can meet vulnerable populations criterion and at least two of the four additional mission-related criteria	202
Non-members that can meet vulnerable populations criterion and at least two of the four additional mission-related criteria as a percent of all hospitals that can do so	68%

The PAC made its recommendation for these reasons:

- It would include a vast majority of our members while keeping the total number of hospitals to a manageable number.
- While requiring hospitals to meet one or more of the four additional mission-related criteria would include more members (18 more), it would also bring in 570 additional non-members.
- Given that this is the first step in an anticipated long legislative process, starting at 297 also can help ensure that the final number of hospitals does not grow into an unmanageable amount.
- From a political feasibility perspective, highlighting a small group of hospitals (less than 6 percent of all hospitals) as vital services hospital systems sounds more plausible than highlighting a group that encompasses thousands of hospitals.
- Furthermore, requiring at least two or more (rather than one or more) of the four additional mission-related criteria is more in line with the importance we've placed on each of the additional mission-related criteria.
- This recommendation would also bring in an overwhelming majority of our partner's member hospitals. For example, for Association of American Medical Colleges members that can meet the vulnerable populations mission criterion, more than 80 percent would be able to meet the requirements of this federal designation. For UHC members that can meet that criterion, more than two-thirds would be able to meet the requirements of this federal designation.
- Metrics and data used for the recommended proxies for each criterion were based on, as much as possible, those that the Centers for Medicare & Medicaid Services already use in the Medicare and Medicaid programs. This clears a major regulatory hurdle in terms of implementation feasibility.

Action Item: Recommendation for Board of Directors

The association should pursue a federal designation for "vital services hospital system," which is a hospital that demonstrates a commitment to serving vulnerable populations and meets at least two of the following four mission-related criteria:

1. commitment to teaching
2. commitment to providing specialized, high-acuity care
3. commitment to public health and essential community services
4. commitment to providing comprehensive, coordinated care

Appendix A - List of Policy Advisory Committee Members, 2013

William B. Walker, MD - Chair
Director and Health Officer
Contra Costa Health Services

Alan D. Aviles
President and CEO
New York City Health and Hospitals Corporation

Jason E. Boyd, MBA
Interim CEO
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Appendix B - Potential Benefits of the Designation and Possible Accountability and Transparency Requirements

Potential Benefits of the Designation

America's Essential Hospitals would need to tie some specific benefit(s) to the initial designation proposal to get the designation into federal law. Once in law, however, the designation could be used to target a range of benefits from new funding to protecting existing funding. The table below details some examples of potential benefits of a vital services hospital system designation.

Potential Categories of Benefits	**Examples**
Recipients of new funding	• newly created funding stream • grant funding to support infrastructure investments • incentive funding tied to accountability • eligibility for shared savings arrangements • higher reimbursement levels through Medicaid and Medicare (with enhanced match available for states) (could be similar to the primary care bump or to federally qualified health center (FQHC) mandates) • other funding for uninsured care
Protections from particular payment cuts or policy changes *or* partial reinvestment of payment cuts in designated systems	• Medicaid DSH reductions • Medicare evaluation and management (E&M) proposals • other deficit reduction proposals • specific sequestration reductions
Preferential treatment	• Center for Medicare & Medicaid Innovation funding • streamlined approval of certain waiver pools • new or redistribution of Medicare GME slots • differential treatment in pay-for-performance programs
Leverage in private market negotiations	• federal designation may be meaningful advantage in contracting with private payers; indicates concrete commitment to coordination, innovation, and accountability
Support under Medicaid managed care	• permit direct supplemental payments for services to Medicaid managed care beneficiaries • systems could function as alternative to capitated managed care (like Florida Provider Service Network model)

Potential Categories of Benefits	Examples
Model for rationalizing disparate funding streams	• Either as an option or a mandate, current disparate funding streams (DSH, UPL, GME, IME, physician supplemental payments, SNCP, FQHC, etc.) could be combined into an integrated funding stream that would provide both flexibility for the health system to target the funding where needed and accountability and transparency to ensure that federal investments achieve their intended purposes.

AMERICA'S ESSENTIAL HOSPITALS

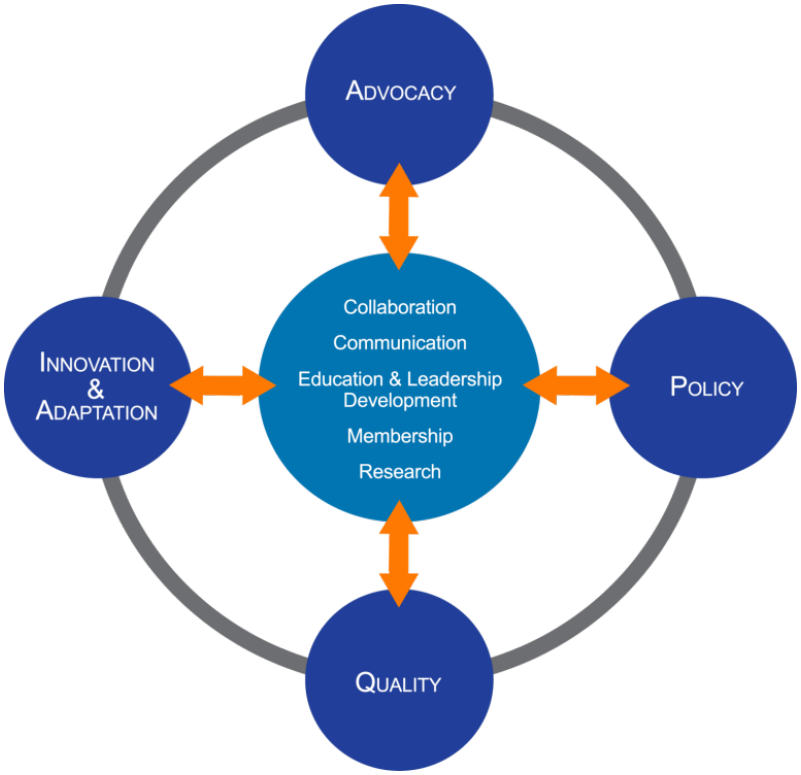
DATE September 24, 2013
TO Board of Directors
FROM Michael Belzer, MD, Education Committee Chair
RE Education Committee Report

MEMORANDUM

Since the last board meeting, the education committee held two meetings—one by phone call in August and one in-person in September. This report highlights several of the key discussions and/or recommendations that the committee made.

Linking Education to the Strategic Plan

The committee and staff discussed the importance of linking all educational programming to the new strategic plan. In particular, each educational offering will be mapped to one or more of the plan's pillars or core competencies.



Focus and Key Topics

Given the crowded field of education providers, the committee discussed how America's Essential Hospitals should focus its educational activities. The committee recommends that programming should be broad, but noted that all activities should have a safety net perspective that is unique to our member hospitals' circumstances. The committee also recommends that two key topics be consistently addressed throughout the year: population health and waivers.

2014 Fellows Program

The committee had recommended that the 2014-2015 fellows program focus on "Innovative and Adaptive Leadership: Essential in Times of Change." Staff will begin building the curriculum and recruiting participants in the next cohort this fall.

2014 Distance Learning

Staff have developed the below work plan for distance learning in 2014. The education committee supports this plan.

Webinars

Program Area	# of Webinars	Topic(s)
Policy/Advocacy	4	TBD based on current Congressional and regulatory activity
Communications	2	Communications tools and resources
Research	5	TBD
Quality and Innovation	TBD	• The Targeted Solutions Tool (TST) • Hospital Consumer Assessment of Healthcare Providers (HCAHPs) • Patient-Family Centered Care • Cost/Utilization
Member Services	2-4	TBD. Conducted by corporate sponsors who support the association at the highest levels.
Essential Hospitals Engagement Network (EHEN)	8	Leadership
EHEN	TBD	Special topics on quality improvement
Fellows	TBD	Leadership coaching between in-person sessions

Interest Group Calls

Interest Group	Call Frequency	Target Audience/Topic
Government Relations	Bi-weekly	GR staff/Current Congressional Activity
340B	Bi-monthly	Pharmacists/340B Program
Philanthropic Leadership	Bi-monthly	Foundation Directors

2014 Annual Conference

The committee affirmed its continued desire to grow the conference by both increasing the number of staff attending from a member hospital or health system as well as by attracting at least one participant from a greater number of member hospitals or health systems.

The 2014 annual conference will be marketed under the title, "VITAL2014," with a tag line to be developed later. This new brand is designed to invoke the new association name and brand. The intention is to use this new title for several years: VITAL2015, VITAL2016, etc., with the option of updating tag lines each year.

The 2014 conference schedule largely will be the same as in 2013, with the continuation of a preconference leadership workshop, four tracks, and a poster session. New activities planned for 2014 include a post-conference workshop, breakfast round table discussion sessions, and the possibility of adding research presentations.

The committee affirmed the staff's recommended topics for the four tracks:

- Leadership
- Quality/Patient Safety (could include value/efficiency subtopics)
- Financing (would focus on topics such as disproportionate share hospitals [DSH] and exchanges)
- State Reform (would focus on waivers)

AMERICA'S ESSENTIAL HOSPITALS

DATE September 24, 2013
TO Board of Directors
FROM Kristine Metter, Vice President for Member Services
RE Sponsorships and Corporate Relations MEMORANDUM

Sponsorship/Corporate Relations Overview

Approximately $200,000 of the association's annual revenue is derived from corporate sponsorships that primarily relate to the annual conference. Sponsorship packages range from $5,000 to $50,000. Additionally, UHC's annual payment to the association includes approximately $250,000 that is directed to sponsorship.

Below is a list of sponsors by category that supported America's Essential Hospitals in 2012 and/or 2013.

Health Care Staffing/Placement • B. E. Smith • Supplemental Healthcare	Accreditation/Certification • DNV Healthcare Solutions • The Joint Commission
Association/Alliance • Teaching Hospitals of Texas • UHC	Eligibility/Financing • Accretive Health, Inc. • eScan Data Systems
Health Policy Firm/Research • Breakaway Policy Strategies	Pharmacy/Pharmacy Services • Envision Pharmaceutical Services • Maxor
Consulting/Risk Management • Alvarez & Marsal • Deloitte • DNV Healthcare, Inc. • FTI Consulting • Health Dimensions Group • Kaufman Hall • Precision Practice Management • Siemens • Simpler	Insurance • Amerigroup • Cigna • Love Funding Law Firm • Alston & Bird • DENTONS • Holland & Knight

How the Board Can Help

The association's corporate sponsorship program relies heavily on both retaining existing sponsors as well as attracting new sponsors.

As representatives of the membership, we ask for your support in three ways:

- If you currently do business with any of the association's sponsors, please thank them for their sponsorship.
- If you have recommendations for new companies to consider as future sponsors, please send us their contact information or make an introduction for us.
- During the annual conference, please be sure to visit with all our sponsors and thank them for their support.

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