



AMERICA'S  
ESSENTIAL  
HOSPITALS

## Board of Directors Meeting

October 28, 2014

The Liaison Capitol Hill | Washington, DC

[essentialhospitals.org](http://essentialhospitals.org)

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## Table of Contents

Agenda .....	2
Board of Directors Roster 2014–2015 .....	3
2014–2015 Association Board Meeting Dates.....	4
June 25 Meeting Minutes.....	5
New Member Applications.....	13
Association Nominating Committee Report.....	15
Institute Nominating Committee Report.....	20
Financial Update.....	21
Office Move Update.....	27
Education Committee Report.....	30
Corporate Affiliate Membership Proposal .....	33
Policy Advisory Committee Report .....	39
Policy/Advocacy Update.....	41



**Agenda**  
**Board of Directors Meeting**  
**October 28, 2014**  
**11 am–5 pm**

11 – 11:05 am	Call to Order and Disclosure of Conflicts of Interest (Dr. Walker)	
11:05 - 11:15 am	Approve Consent Agenda (Dr. Walker)	ACTION
	<ul style="list-style-type: none"><li>• June 24 minutes</li><li>• New members</li></ul>	
11:15 – 11:30 am	President's Report (Dr. Siegel)	
11:30 – 11:45 am	Nominating Committee Report (Ms. Spisso)	ACTION
	<ul style="list-style-type: none"><li>• Appoint new association board secretary</li><li>• Appoint new director to association board</li><li>• Appoint new member director to Institute board</li></ul>	
11:45 – noon	Finance Committee Report (Dr. Coopwood)	ACTION
	<ul style="list-style-type: none"><li>• 2014 financial update</li></ul>	
noon – 12:30 pm	Office Relocation and Lease Terms (Ms. Gold)	ACTION
12:30 – 1 pm	Lunch	
1 – 1:30 pm	Board Member Expectations: Initial Discussion (Dr. Walker)	
1:30 – 1:45 pm	Education Committee Report (Dr. Belzer)	
1:45 – 2:15 pm	Membership Committee Report (Mr. Traylor)	ACTION
	<ul style="list-style-type: none"><li>• Approve corporate affiliate membership category</li></ul>	
2:15 – 2:30 pm	Break	
2:30 – 2:45 pm	Policy Advisory Committee Report (Mr. Haupert)	
2:45 – 4 pm	Policy/Advocacy Update (Dr. Feldpush)	
4 – 5 pm	Executive Session	
5 pm	Adjourn	



# AMERICA'S ESSENTIAL HOSPITALS

## America's Essential Hospitals Board of Directors 2014–2015

### **CHAIR**

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

George B. Hernandez Jr., JD (2014–2016)  
President and CEO  
University Health System

### **CHAIR-ELECT**

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

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

### **PAST-CHAIR**

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

Wright Lassiter III (2014–2015)  
CEO  
Alameda Health System

### **SECRETARY**

Vacant

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

### **TREASURER**

Reginald W. Coopwood, MD  
President and CEO  
Region One Health

Ramanathan Raju, MD, MBA (2014–2015)  
President and CEO  
New York City Health and Hospitals Corporation

### **AT-LARGE DIRECTORS**

Michael B. Belzer, MD (2014–2016)  
Medical Director and Chief Medical Officer  
Hennepin County Medical Center

Sheldon Retchin, MD, MS, MSP (2014–2016)  
CEO  
Virginia Commonwealth University Health System

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

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EVP, for Regional & Governmental Affairs  
UF Shands HealthCare

Roxane Townsend, MD (2014–2016)  
Vice Chancellor for Clinical Programs and CEO  
University of Arkansas for Medical Sciences

John Haupert (2014–2016)  
President and CEO  
Grady Health System

**EX OFFICIO**  
Irene M. Thompson  
President and CEO  
UHC



## 2014–2015 Association Board Meeting Dates

Tuesday, October 28, 2014

11 am – 5 pm

Liaison Hotel

Washington, DC

Held in conjunction with October 29 Innovations Summit

Monday, March 16, 2015

11 am – 5 pm

Westin Georgetown

Washington, DC

Held in conjunction with March 17–18, 2015, Policy Assembly

Tuesday, June 23, 2015

11 am – 5 pm

Westin Gaslamp Quarter

San Diego

Held in conjunction with June 24–26, 2015, VITAL2015



# AMERICA'S ESSENTIAL HOSPITALS

America's Essential Hospitals  
Board of Directors Meeting Minutes  
June 24, 2014  
San Antonio, TX

Board Members Present (15)	Board Members Absent (4)	Staff Present (11)
Michael B. Belzer Reginald W. Coopwood, MD John M. Haupert George B. Hernandez Jr. Michael Karpf, MD David S. Lopez Stephen W. McKernan Santiago Muñoz Ramanathan Raju, MD, MBA Sheldon Retchin, MD, MS, MSP Donna K. Sollenberger, MA Roxane A. Townsend, MD Irene M. Thompson Thomas P. Traylor, MBA William B. Walker, MD	Steven G. Gabbe, MD Timothy M. Goldfarb, CEO Wright L. Lassiter III Johnese M. Spisso, MPA, RN	Bruce Siegel, MD, MPH David Engler, PhD Beth Feldpush, DrPH Rhonda Gold, CPA Kristine Metter, CAE Sarah Callahan, MHSA Carl Graziano Shawn Gremminger, MPP Xiaoyi Huang, JD Bianca Perez, PhD Sandy Laycox

Agenda Items	Minutes
Call to order and disclosure of conflicts of interest (Traylor)	<ul style="list-style-type: none"><li>Traylor called the meeting to order at 11:10 am and asks for conflicts of interest; none disclosed.</li><li>Retchin noted he is a director of a public company that provides post-acute care.</li></ul>
Welcome new board members (Traylor)	<ul style="list-style-type: none"><li>Traylor welcomed new board members Raju, Haupert, Sollenberger, Lassiter, and Townsend.</li><li>Traylor also recognized members leaving the board and those returning.</li></ul>
Approve consent agenda (Traylor)	<ul style="list-style-type: none"><li>Members reviewed March 31 meeting minutes. <i>Traylor requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.</i></li></ul>

President and CEO report (Siegel)	<ul style="list-style-type: none"> <li>• Siegel noted appreciation of Traylor's leadership.</li> <li>• Siegel recognized four new members: Care New England, East Alabama Medical Center, University of Chicago Medical Center, University of Mississippi; noted efforts of existing members in recruiting the new members.</li> <li>• Siegel described work to document the history of the association and release at VITAL2014 of a history book and video.</li> <li>• Siegel reported on several policy activities: <ul style="list-style-type: none"> <li>◦ contacts with senior leadership of the U.S. Department of Health and Human Services (HHS), association's response to HHS request for anecdotes of network exclusion—including story from Grady Health—and desire by new Centers for Medicare &amp; Medicaid administrator to work with America's Essential Hospitals</li> <li>◦ increasing interest in adjusting performance measures by socioeconomic factors</li> <li>◦ association support of member work and association education around Medicaid Section 1115 waivers, including association's September 29 summit in Chicago</li> </ul> </li> <li>• Siegel recounted conversation to recast memorandum of understanding with UHC and to broaden work beyond UHC supply chain members.</li> <li>• Traylor pointed out value of education on waivers.</li> </ul> <p><i>Traylor requested a motion to approve new members. There was a motion, a second, and unanimous approval.</i></p>
Employee Climate Assessment (Siegel)	<ul style="list-style-type: none"> <li>• Siegel described survey of staff to assess work climate.</li> <li>• Siegel noted use of association's core values used as a foundation for the survey design.</li> <li>• Society for Human Resource Management (SHRM) conducted the survey.</li> <li>• Siegel described overall findings: relative to SHRM database of all employers, association's overall job satisfaction higher (81 percent versus 70 percent), but a little behind organizations of similar size.</li> <li>• Siegel discussed association strengths: the work itself, benefits, financial stability.</li> <li>• Survey revealed opportunities: career advancement, professional developments, communication with senior management, pay compared with local market.</li> <li>• Overall employee engagement found to be similar to that of other organizations.</li> <li>• Siegel described action plan: employee committee, lunch with senior leaders, brief presentations at all-staff meetings.</li> <li>• Sustainability—going green—important to staff; new office space will reflect this.</li> <li>• Traylor suggested use of members as staff mentors; Siegel agreed.</li> </ul>

	<ul style="list-style-type: none"> <li>Feldpush noted planned site visit by advocacy and policy staff to Einstein Medical Center Philadelphia.</li> <li>Haupert pointed out positive aspect of high staff satisfaction with management.</li> <li>Traylor asked about differences in results between association and Essential Hospitals Institute; Siegel reported none significant.</li> <li>Engler described work of inter-departmental staff work groups around collaboration, storytelling, communication.</li> <li>Walker complimented Siegel for his efforts to solicit feedback.</li> <li>Thompson noted opportunities to increase staff collaboration between association and UHC.</li> </ul>
Treasurer's Report (Lopez)	<ul style="list-style-type: none"> <li>Lopez presented reports in board book, noted results of audit.</li> <li>Lopez presented second action item: budget update.</li> <li>Gold reported that association on target to meet budget.</li> </ul> <p><i>Lopez requested a motion to approve audit. There was a motion, a second, and unanimous approval.</i></p> <p><i>Lopez requested a motion to approve budget update. There was a motion, a second, and unanimous approval.</i></p>
Education Committee Report (Belzer)	<ul style="list-style-type: none"> <li>Belzer described various aspects of committee's work, including these: <ul style="list-style-type: none"> <li>goal of broadening participation in educational activities beyond C-suite members</li> <li>new session types at VITAL2014, including mini-sessions, Rapid-Fire sessions, interest groups, networking opportunities, and popularity of track structure</li> <li>use of education committee members as session moderators and ambassadors for first-time attendees at VITAL2014</li> <li>new call for proposals for VITAL2015 and education committee proposal evaluation process</li> <li>upcoming educational opportunities on waivers and start of Fellows Program sessions on adaptive leadership</li> </ul> </li> <li>Engler reported 34 fellows this year from 15 organizations.</li> <li>Traylor recognized strongly positive feedback from past fellows and inquires about changes to the current year's program.</li> <li>Engler described new use of education committee to refresh, renew curriculum; change to adaptive leadership; re-evaluation of fellows mix to broaden beyond clinical leaders.</li> </ul>
Policy Advisory Committee Report (Walker)	<ul style="list-style-type: none"> <li>Walker described previous year's work to develop principles for entitlement reform and current effort on principles for Medicaid changes at the state level.</li> <li>Walker noted desire to keep principles in mind as health care moves toward new world of alternative payments.</li> <li>Feldpush noted need to educate members on alternative payment models as waivers spread.</li> </ul>

	<ul style="list-style-type: none"> <li>• Hernandez pointed out concern in Texas of funding shift from ambulatory to hospital inpatient and impact on systems with large outpatient networks.</li> <li>• Traylor noted need to acknowledge reality that Medicaid rates are lower than Medicare rates—a parity principle, perhaps.</li> <li>• Walker said that given wide variation in waiver design, principles are needed to establish common goals.</li> <li>• Lopez asked whether intragovernmental transfers were considered in principle development and noted need to make sure states have “skin in the game.”</li> <li>• Coopwood noted opportunity for the association to serve as a clearinghouse on waiver information; Feldpush said the association tracks updates on waivers monthly.</li> <li>• Hernandez suggested expressing values, as well as principles in the document.</li> <li>• Karpf suggested coordinating with similar American Hospital Association work on alternative payment models principles.</li> <li>• Feldpush summarized suggested changes: <ul style="list-style-type: none"> <li>◦ make more explicit that Medicaid underpays</li> <li>◦ include distinction between ambulatory and inpatient and recognition that hospitals do more than inpatient—clinics, pharmacy</li> <li>◦ incorporate accountability into principles (skin in the game by other stakeholders)</li> <li>◦ expand on values</li> </ul> </li> <li>• Munoz suggested gearing up to identify negative elements of alternative payment models and preparing to articulate concerns.</li> </ul> <p><i>Walker requested a motion to approve the proposed principles with changes as summarized by Feldpush. There was a motion, a second, and unanimous approval.</i></p>
Membership Committee Report: New Dues Structure (Lopez)	<ul style="list-style-type: none"> <li>• Lopez summarized significant discussion around dues structure, recognition of “no perfect solution,” and varying perspectives on fairness.</li> <li>• Siegel thanked Lopez for his leadership and discussed current dues structure.</li> <li>• Siegel noted current structure relatively unordered and a potential disincentive for membership, especially among smaller organizations.</li> <li>• Goals of new structure: dampen extreme swings, minimize changes, reflect size, help smaller hospitals, encourage inclusion of all hospitals in multihospital systems, compete on price.</li> <li>• Siegel described proposed methodology: expenses-based, tiered, phased in for those with increases.</li> <li>• Siegel pointed out that, now, some large, multihospital systems pay a single hospital rate and might resist change.</li> </ul>

	<ul style="list-style-type: none"> <li>Hernandez asked whether expenses metric includes whole system, including managed care plan; Siegel says whole system, but not managed care plan.</li> <li>Siegel described revenue projections and comparison of association's dues with other associations. He noted that market tests revealed a general understanding of need but questions about where increased revenue goes, concerns about driving out larger members.</li> <li>Siegel described next steps: board vote, communications, and dues invoices.</li> <li>Coopwood asked whether plan is budget neutral; Siegel responds that it is not budget neutral, includes wiggle room, and assumes loss of four members.</li> <li>Retchin complimented board and staff for a careful, deliberative process, and recommended flexibility for the largest systems.</li> </ul> <p><i>Lopez requested a motion to approve the new dues structure. There was a motion, a second, and unanimous approval.</i></p>
Policy/Advocacy Update (Feldpush)	<ul style="list-style-type: none"> <li>Feldpush provided overview of recent congressional activity, including actions to delay disproportionate share hospital (DSH) payment cuts and require reporting on DSH need.</li> <li>Feldpush reported Republican Party swinging more conservative as reaction to rise of Tea Party.</li> <li>Enrollment trends and uncompensated care are complex issues. Even as uncompensated care declines, Medicaid shortfalls might increase. Reports of coverage successes must be tempered by these realities—essential hospitals remain vulnerable to funding difficulties.</li> <li>Traylor noted that Massachusetts experience might be a good case study for current issues and that statewide numbers don't necessarily apply to essential hospitals. For example, the uninsured rate is 1 percent statewide, but 10 percent at Boston Medical Center.</li> <li>Siegel noted challenge of calibrating message and communicating that coverage expansion is playing out with great variation.</li> <li>Raju pointed out that new Medicaid patients are very expensive because they haven't been getting care for years, so more costly despite new coverage.</li> <li>Coopwood cautioned against losing benefits of expansion in financial message.</li> <li>Traylor noted that bottom lines might look better, but DSH cuts haven't happened yet.</li> <li>Karpf recommended national and state messaging, as financial impact of expansion on state budgets will come into play.</li> <li>Raju warned about competition for safety net funding by hospitals not traditionally considered safety nets; Siegel said association's work on an essential hospital designation will be sensitive to this concern.</li> <li>Lopez asked about likelihood of DSH payments ultimately being tied to performance; Feldpush said recent history shows performance increasingly part of discussions on funding streams.</li> </ul>

	<ul style="list-style-type: none"> <li>• Karpf noted need to emphasize continued funding for trauma, other high-acuity services.</li> <li>• Feldpush discussed evolving “1 plus 4” essential hospitals designation definition.</li> <li>• Conversation shifted to 340B.</li> <li>• Retchin characterized essential hospitals as victims of 340B abuses by other hospitals with respect to public perception.</li> <li>• Raju suggested association should not flatly oppose regulation, but should work to make 340B program better; Siegel noted association support of appropriate regulation.</li> <li>• Feldpush said association adamantly opposed to scaling back program, given its benefits to patients and taxpayers.</li> <li>• Walker asked about association’s working relationship with Safety Net Hospitals for Pharmaceutical Access; Feldpush reported a good working relationship, but sensitivity to differences in stakeholders.</li> <li>• Feldpush moved to discussion of premium assistance.</li> <li>• Coopwood asked whether foundations may provide assistance; Huang responded that federal government might allow this.</li> <li>• Traylor predicted CMS will embrace premium assistance when it becomes clear people can’t afford even federally subsidized premiums.</li> <li>• Feldpush continued with overview of socioeconomic status adjustment, Children’s Health Insurance Program funding, workforce issues, the two-midnight rule, network adequacy, Medicaid payment parity, Medicaid waivers.</li> </ul>
Update on NQF Risk Adjustment (Engler)	<ul style="list-style-type: none"> <li>• Engler described National Quality Forum (NQF) work and recommendations on socioeconomic (SES) adjustment of performance measures and importance to association members.</li> <li>• Work, as required by CMS, included creation of expert panel in October 2013 to study pros and cons of SES adjustment. Panel include several association members: David Nerenz, PhD (Henry Ford Hospital), Nancy Garrett, PhD (Hennepin County Medical Center), and Nancy Sugg, MD, MPH (University of Washington).</li> <li>• About 30 risk-adjustment models exist and none is perfect. The current readmissions model explains only about 60 percent of variants in readmissions.</li> <li>• The NQF expert panel drafted a report in March, and opened it up to public comment in April. America’s Essential Hospitals responded in support of the draft report and worked with members to respond. Overall, NQF received 160 comments, 140 of which were supportive of SES adjustment.</li> <li>• Association stance is that NQF should change its current policy to endorse performance measures used in accountability applications that risk adjust for both clinical and SES patient factors.</li> <li>• Traylor asked about CMS motivations to require this work. Engler pointed to growing concern about SES’ effects on outcomes. Siegel noted concern about lack of alignment within CMS on SES adjustment.</li> </ul>

	<ul style="list-style-type: none"> <li>• NQF also recommended that performance measures should be stratified to identify disparities and that a standard set of measures and recommendations on their use should be developed.</li> <li>• Belzer asked about member hospitals responses. Engler said NQF received more than 30 comments from member hospitals and UHC. Feldpush added that hospitals previously non-active in policy work responded.</li> <li>• Engler said the literature supports the use of SES adjustment and that the association had published a list of literature on its website. A recent article in Health Affairs also explored the issue.</li> <li>• Engler noted opposition arguments that SES adjustment would mask disparities or lessen expectations for improvement.</li> <li>• Engler said next steps include a final expert panel report June 30, review by the NQF Consensus Standards Approval Committee, and a NQF board of directors final vote July 23.</li> <li>• Raju predicted CMS reluctance to adjust for SES because it would be a “slippery slope”—some stakeholders may ask for geographic adjustment, for example. He called on the association to have a leadership role in ongoing discussions.</li> <li>• Engler agreed about the role of the association to emphasize a scientific basis, supported by literature, for risk adjustment.</li> <li>• Retchin pointed out the argument is more complex than SES adjustment—essential hospital face resource challenges that also factor into differences.</li> <li>• Coopwood asked about the goal. What should come out of this effort and how will it improve care of this population?</li> <li>• Engler said the end game should be a level playing field for performance metrics by accounting for differences in patient population.</li> <li>• Siegel pointed out that the NQF recommendation doesn't require use of a specific model or adjustment generally. He said that while many people agree on the value of SES adjustment, strong opposition exists in some quarters, particularly among consumer groups (a majority of NQF members) and that consensus is crucial.</li> <li>• Raju noted a scientific basis for adjustment is necessary; Siegel agreed strongly.</li> <li>• Lopez suggested that separate adjustments for emergency department admissions versus other types of admissions might be a useful approach; several members indicated support for considering this..</li> </ul>
Investment Policy (Gold & Raffa Wealth Management)	<ul style="list-style-type: none"> <li>• Gold described the association's request for proposal process to choose an investment adviser; she introduced Mark Murphy, with Raffa Wealth Management.</li> <li>• Murphy described company's work, which focuses on non-profit organizations with portfolios of \$3 million to \$5 million; the association falls within that range.</li> <li>• Murphy described a three-step onboarding process for new clients: review financials, conduct interviews, conduct survey.</li> </ul>

	<ul style="list-style-type: none"> <li>• Murphy provided an overview of investment recommendations.</li> <li>• Retchin asked about alternative investments; Murphy responded that high fees make alternatives unattractive.</li> <li>• Walker asked for Murphy's opinion on investing in index versus actively managed funds. Murphy indicated preference for a passive (index) investment strategy.</li> <li>• Murphy reviewed changes to investment policy.</li> </ul> <p><i>Traylor requested a motion to accept revised investment policy statement. There was a motion, a second, and unanimous approval.</i></p>
Executive Session	The board went into executive session and the meeting was adjourned.

Submitted by:



Johnese M. Spisso, RN, MPA  
Secretary



# AMERICA'S ESSENTIAL HOSPITALS

**DATE** October 21, 2014  
**TO** Board of Directors  
**FROM** Kristine Metter, Vice President for Member Services  
**RE** New Member Applications

**MEMORANDUM**

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

- Interim LSU Hospital, New Orleans, Louisiana
- Rhode Island Hospital, Providence, Rhode Island

## Interim LSU Hospital

Cindy Nuesslein, RN, MBA, President and CEO

Interim LSU Hospital is the successor to Charity Hospital, which was closed following Hurricane Katrina. Interim LSU is the major teaching hospital for the LSU Health Sciences Center—New Orleans schools of medicine, nursing, dentistry, and allied health professionals. It is also a major teaching hospital for Tulane University School of Medicine. In 2015, Interim LSU Hospital will become University Medical Center and part of the Louisiana Children's Medical Center system.

### Interim LSU Hospital Statistics

Beds	390
Employees	1,866
Discharges (Medicare)	43.2%
Discharges (Medicaid)	23.9%
Outpatient visits	269,243
Total admissions	11,544
Births	N/A

Source: American Hospital Association (AHA) 2012 utilization statistics

## Rhode Island Hospital

Timothy Babineau, MD, President and CEO

Founded in 1863, Rhode Island Hospital is a private, nonprofit hospital. It is the principal teaching hospital of The Warren Alpert Medical School of Brown University. A major trauma center for southeastern New England, the hospital is dedicated to

cutting-edge medicine and research. It is also home to Hasbro Children's Hospital, the state's only facility dedicated to pediatric care.

#### Rhode Island Hospital Statistics

Beds	719
Employees	5,699
Discharges (Medicare)	41.0%
Discharges (Medicaid)	18.6%
Outpatient visits	357,273
Total admissions	34,089
Births	N/A

Source: AHA 2012 utilization statistic



DATE      October 21, 2014  
TO          Board of Directors  
FROM        Johnese Spisso, Chair, Association Nominating Committee  
RE          Nominating Committee Report

MEMORANDUM

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The association nominating committee met October 1 to consider two openings on the board, both created by the departure of David Lopez. The committee considered candidates for secretary from among existing directors. The committee also considered candidates to fill the open at-large director position created by moving a director into an officer slot.

**Candidate for Secretary**

The nominating committee recommends Michael Karpf, MD, for secretary. The initial term for this position runs until June 30, 2015. He is eligible for re-election to a second term. See Karpf's bio in Appendix B.

**Candidate for Director**

The nominating committee considered four candidates to join the board as an at-large director:

- Akram Boutros, MD, president and CEO, The MetroHealth System
- Dennis Keefe, president and CEO, Care New England Health System
- Sharon O'Keefe, MSN, president, University of Chicago Medical Center
- Sam Ross, MD, MS, CEO, Bon Secours Baltimore Health System

Dennis Keefe was removed from consideration because he is being asked to join the Institute board.

The committee rank-ordered the three remaining candidates to provide backup should the preferred candidate decline the invitation to serve on the board. The committee asked Bruce Siegel to contact each of the candidates to assess their willingness to serve. Sharon O'Keefe accepted her nomination. See O'Keefe's bio in Appendix B.

***Requested Board Action:***

***Appoint Michael Karpf as secretary.***

***Appoint Sharon O'Keefe as an at-large director.***

## Appendix A: 2014–2015 Board of Directors

### **CHAIR**

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Director and Health Officer  
Contra Costa Health Services

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Chief Health System Officer, UW Medicine and  
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Region One Health

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Senior Vice President for Health Sciences, CEO  
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Donna Sollenberger, MA (2014–2016)  
Executive Vice President and CEO, UTMB  
Health System  
The University of Texas Medical Branch

Timothy M. Goldfarb (2014–2016)  
EVP, for Regional & Governmental Affairs  
UF Shands HealthCare

Roxane Townsend, MD (2014–2016)  
Vice Chancellor for Clinical Programs and CEO  
University of Arkansas for Medical Sciences

John Haupert (2014–2016)  
President and CEO  
Grady Health System

**EX OFFICIO**  
Irene M. Thompson  
President and CEO  
UHC

## Appendix B

**Michael Karpf, MD  
Executive Vice President for Health Affairs  
UK Health Care**

Karpf, who assumed his current role in 2003, is responsible for the clinical and administrative leadership of the clinical enterprise at UK Chandler Medical Center, including UK Chandler Hospital, Kentucky Children's Hospital, Kentucky Clinics, and associated health programs and entities. The dean of the college of medicine reports to Karpf for all clinical operations. Karpf has joint oversight with the UK provost of the clinical activities in the colleges of dentistry, nursing, pharmacy and health sciences.

Karpf's academic interests have been in developing and evaluating innovative educational and clinical programs. He also developed a strong presence in health services focusing on the evaluation and management of common medical problems at the University of Pittsburgh. At UCLA, Karpf was instrumental in establishing a Center for Medical Ethics and a Center for Patient Quality and Safety. He has received many honors and awards, published extensively, and reviewed numerous journals. He also has been involved in a wide variety of civic and professional organizations.

Karpf earned bachelor's and medical degrees from the University of Pennsylvania. After completing an internship in medicine at Johns Hopkins Hospital, he served as a research associate in the laboratory of immunology, Institute of Allergy and Infectious Disease, at the National Institutes of Health until 1974. He returned to the Hospitals of the University of Pennsylvania to complete his medical residency. During that time, Karpf completed a fellowship in hematology/oncology and, from 1976 to 1977, served as chief medical resident at the Hospitals of the University of Pennsylvania and Veterans Administration Hospital.

From 1976 to 1978, Karpf was an assistant professor of medicine (hematology/oncology department) in the internal medicine department at the University of Pennsylvania. In 1978, Karpf went to the University of Miami School of Medicine, where he served as an assistant professor of medicine.

In 1979, he was recruited by the University of Pittsburgh to develop a division of general internal medicine. From 1979 to 1994, Karpf served in many capacities—from assistant professor of medicine to the Falk Professor of General Internal Medicine and vice chair of the department of medicine. He also held a joint appointment as professor of diagnostic services, dental medicine, department of diagnostic services. At the University of Pittsburgh, Karpf was instrumental in restructuring the educational programs for medical students and house staff, as well as the clinical programs of the department of medicine.

From 1994 to 1995, Karpf served as senior vice president for clinical affairs at Allegheny General Hospital in Pittsburgh, and professor of medicine at the Medical College of Pennsylvania-Hahnemann University.

In 1995, Karpf was recruited to the University of California, Los Angeles. During his tenure, he integrated three hospitals into one corporate entity. He was responsible for the planning and rebuilding of two replacement hospitals and was instrumental in developing a primary care network for UCLA. In addition, as a member of the senior leadership team of the UCLA Medical Enterprise, Karpf was instrumental in forging a working partnership between the practice plans and the hospital system. This partnership inspired the development of UCLA Healthcare as an integrated health delivery system. He is a member of the executive committee of the California Hospital Association and the University Health System Consortium.

**Sharon O'Keefe, MSN  
President  
University of Chicago Medical Center**

Sharon O'Keefe, a nationally recognized authority on hospital operations, health care quality, patient satisfaction and employee engagement, was named president of the University of Chicago Medical Center in Feb. 2011.

O'Keefe comes to the Medical Center from Loyola University Medical Center, in Maywood, Ill., where she served as president since April 2009. Prior to that position, she served for seven years as chief operating officer at Barnes-Jewish Hospital in St. Louis.

As Medical Center president, O'Keefe works with clinical faculty and the senior management team to improve the patient experience, develop outstanding clinical programs, and enhance staff and physician satisfaction. She reports to Kenneth Polonsky, dean of the Division of the Biological Sciences and the Pritzker School of Medicine and executive vice president for medical affairs at the University of Chicago, who worked with O'Keefe at Barnes-Jewish Hospital.

O'Keefe began her health care career as a critical care nurse. O'Keefe soon advanced into more administrative roles, where she focused on improving hospital operations and performance, enhancing health care quality and safety, and increasing patient as well as employee satisfaction.

Her quality-improvement efforts led to national recognition. O'Keefe was appointed an examiner for the U.S. Department of Commerce's Malcolm Baldrige National Quality Award in 2005. O'Keefe currently serves on the National Institutes of Health Advisory Board for Clinical Research.

A Chicago native, O'Keefe, 58, received her bachelor of science in nursing from Northern Illinois University in 1974. In 1976, while working as a nurse at Loyola University Medical Center, she earned a master of science in nursing from that university's nursing school. In 1979, she was recruited to Johns Hopkins Hospital as the director of nursing for surgical services. After six years at Hopkins, she became an associate hospital director at the 900-bed Montefiore Hospital in the Bronx, N.Y.

From 1987 to 1989, she was senior manager for health care at the accounting firm, Ernst & Whinney (now Ernst & Young), where she developed a consulting practice focused on organizational design, operations improvement and large-scale change management. Clients included large, complex academic medical centers. She returned to hospital administration in 1989 and spent ten years as senior vice president for operations at the University of Maryland Medical System in Baltimore, where she focused on clinical program development and customer satisfaction. Her efforts helped the Medical System become the first health care organization to receive the State of Maryland Quality and Productivity Award.

In 1999 she moved to Boston's Beth Israel Deaconess Medical Center, a teaching affiliate of Harvard Medical School. As executive vice president and chief operating officer, she developed and implemented a financial recovery plan for the recently merged but financially challenged hospitals. In 2002 she became chief operating officer at Barnes-Jewish Hospital, consistently ranked as one of the top ten hospitals in the United States.

O'Keefe took over from Ken Sharigian, who had been serving as interim president of the Medical Center. O'Keefe is married to Hal Moore. They have a daughter, Mackenzie.



DATE      October 21, 2014  
TO          Board of Directors  
FROM      Anna Roth, Chair, Institute Nominating Committee  
RE          Nominating Committee Report

MEMORANDUM

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The Essential Hospitals Institute Nominating Committee met September 30 to consider one opening on the Institute board, created by the retirement of John Bluford. The committee considered two candidates for the open slot and recommends Dennis Keefe to complete Mr. Bluford's term which runs through June 30, 2015.

**Dennis Keefe**  
**President and CEO**  
**Care New England Health System**

Keefe joined Care New England in August 2011. The system's recent accomplishments include the acquisition of Memorial Hospital of RI, a new academic affiliation with Brown University School of Medicine, an affiliation with the Providence Center for Behavioral Health, and an innovative strategic partnership with Blue Cross/Blue Shield of Rhode Island. Keefe previously served on America's Essential Hospitals' board of directors and as chair of the Essential Hospitals Institute board.

Before joining Care New England, Keefe served as CEO of Cambridge Health Alliance (CHA) and as commissioner of public health for the City of Cambridge, Massachusetts. CHA grew significantly under Keefe's leadership, becoming an over \$1 billion integrated healthcare delivery system. While at CHA, Keefe led the organization through a significant service reconfiguration plan which stabilized the foundation of CHA to serve its employees and patients for the future.

He is a highest honors graduate of Northeastern University, where he received the Dean's Citation Award as the top student in the Health Sciences Program. Keefe also earned a master's degree in business administration, with a focus in health care administration, from Northeastern University, and was honored as the 2005 Alumnus of the Year by Northeastern University.

As outlined in the Institute bylaws, vacancies on the Institute board are approved by the association board.

***Requested Board Action: Appoint Dennis Keefe to the Institute Board of Directors***



DATE    October 21, 2014  
TO       Board of Directors  
FROM     Rhonda Gold, Chief Financial Officer  
RE       Financial Update

**MEMORANDUM**

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This memorandum provides an updated 2014 projection compared to budget. The 2015 proposed budget will be presented on the December 1 scheduled board conference call.

There is one action item requested from the board:

- Approve an additional \$100,000 contribution to restricted net assets for the association's future office relocation.

**Financial Update**

America's Essential Hospitals' 2014 financial projection compared to budget and the June projection is reflected in column 3 of Attachment I. We are projecting 2014 income of \$8.94 million, which is offset by \$7.19 million in expenses (before items funded from reserves), leaving an operating surplus of \$1.72 million after rebranding and moving costs funded from reserves (of \$153,000) and investment gains (of \$129,000). This surplus is \$894,100 more than budget and \$701,100 more than last projected.

After accounting for investment income, projected total net assets are \$8.48 million. We are pleased to report that this projected ending net asset balance represents more than one year of association operating expenses in reserve.

The financial projection reflects an additional \$100,000 contribution to the budgeted restricted net assets (of \$100,000) to fund the anticipated expenses for the association's office relocation. This contribution is in addition to the \$250,000 that has been set aside in 2012 and 2013, for a total of \$450,000. We are estimating an office move budget of \$4.3 million (for 21,100 square feet), of which \$2.4 million would be reduced by a landlord's tenant improvement allowance (of \$115 per square foot), for a net cost of approximately \$1.9 million. This estimate includes build-out costs for the architect and construction, engineering fees, audio-video infrastructure, furniture, a telephone system, computers, and office move expenses. Many of these expenses are depreciable over a three- to five-year period, while the space build-out is amortizable over the life of the lease (15 years). The board restricted net assets (of \$450,000) should cover the non-

depreciable and non-amortizable costs of the office move. We will provide you with additional detail about the move at the board meeting.

These are the significant variances from budget:

**income:** projected income of \$230,700 more than budget because of \$226,700 in new membership dues income.

**personnel:** projected savings of \$190,000 from budget primarily because of delays in filling vacant positions (\$83,000) and the allocation of more staff time spent on Essential Hospitals Institute projects (\$80,000).

**office expenses/equipment rental:** projected savings of \$40,000 due to the reclassification of webinars and other office expenses to the programmatic budget lines for policy, advocacy, and member services.

**conferences:** projected savings of \$158,200 because of lower food and travel expenses for VITAL2014 and governance meetings.

**depreciation/amortization:** projected savings of almost \$45,000 because of the delay in purchasing new computers, and the reflection of the membership database upgrade to the information technology line.

**office move:** projected savings of \$152,000 because we had limited move-related costs (e.g., preliminary architect and legal fees) this year.

### Investment Update

After the board approved the new investment policy statement in June, Raffa Wealth Management made their recommended investments, which align with the association's long-term reserve and operating reserve policies. The long-term reserve was funded with \$2.85 million from the previous long-term reserve, along with a portion of the intermediate-term reserve, and the portfolio targets an allocation of 55 percent to stocks and 45 percent to bonds. The investment, audit and compliance committee has reviewed these investments and was comfortable with the adviser's recommendations.

The following summarizes the funds in which the **long-term reserve** is invested:

- **DFA U.S. Core Equity** fund seeks to purchase a broad and diverse range of U.S. securities with an increased exposure to small cap stocks and those it considers value stocks relative to the market universe. The increased exposure to small and value companies is achieved by decreasing the fund's allocation to large and growth companies relative to their weight in the market. It has an expense ratio of 0.20 percent, which puts it in the top 3 percent for its asset category.

- **DFA Real Estate Securities** fund invests in U.S. based real estate investment trusts and other real estate investments. It has an expense ratio of 0.22 percent, which puts it in the top 2 percent for its asset category.
- **Vanguard FTSE All-World ex-U.S.** fund provides broad exposure to the international developed and emerging markets and aims to track the FTSE All-World ex-U.S. Index. It has an expense ratio of .018 percent, which puts it in the top 25 percent for its asset category. The lower rating is the result of only 20 funds being in the category.
- **DFA International Value** fund invests in what it determines to be value stocks in the international developed market space. It has an expense ratio of 0.45 percent, which puts it in the top 2 percent for its asset category.
- **DFA International Small Companies** fund invests in small-cap companies in developed markets. It has an expense ratio of 0.55 percent, which puts it in the top 5 percent for its asset category.
- **DFA Emerging Markets** fund invests in large-cap companies in emerging markets. It has an expense ratio of 0.61 percent, which puts it in the top 2 percent for its asset category.
- **Vanguard Total Bond Market** fund invests in the broad U.S. fixed-income market covering government, corporate, mortgage, and agency sectors. It is highly diversified with more than 15,000 holdings, has an average credit quality of AA, and an average duration of 5.5. It has an expense ratio of 0.10 percent, which puts it in the top 11 percent for its asset category. The lower rating is the result of only 20 funds being in the category.
- **DFA World ex US Fixed Income** fund invests in international government fixed income of highly rated countries. It has an average credit quality of AA and an average duration of 7.4. It has an expense ratio of 0.20 percent, which puts it in the top 1 percent for its asset category.
- **Vanguard Short Term Federal** fund invests in mortgages and government bonds. It has an average duration of 2.3 and an average credit quality of AAA. It has an expense ratio of 0.10 percent, which puts it in the top 2 percent for its asset category.
- **DFA 5 Year Global Bond** fund invests in the global fixed income market that provides the greatest opportunity to maximize risk-adjusted return with a maximum effective maturity of five years. It can invest in both the

United States and globally, and in government and corporate bonds. Currently, the majority of the portfolio is invested outside of the United States based on superior yield curves, but that can change based on the movement of interest rates. It has an average duration of 3.9 and an average credit quality of AA. It has an expense ratio of 0.28 percent, which puts it in the top 1 percent for its asset category.

The **operating reserve** was funded with \$2.5 million from the previous operating reserve, as well as the intermediate-term reserve. The goal of the portfolio is to meet short-term expenses that the budget cannot cover. The major upcoming cost is the office move, which is expected to use a significant portion of the reserve. The operating reserve targets 100 percent to fixed income, has a weighted average maturity of three years or fewer, and an average credit quality of AA.

The following summarizes the funds in which the operating reserve invests:

- **Vanguard Total Bond Market** fund invests in the broad U.S. fixed-income market covering government, corporate, mortgage, and agency sectors. It is highly diversified, with more than 15,000 holdings, has an average credit quality of AA, and an average duration of 5.5. It has an expense ratio of 0.10 percent, which puts it in the top 11 percent for its asset category. The lower rating is the result of only 20 funds being in the category.
- **Vanguard Short Term Federal** fund invests in mortgages and government bonds. It has an average duration of 2.3 and an average credit quality of AAA. It has an expense ratio of 0.10 percent, which puts it in the top 2 percent for its asset category.
- **DFA One Year Fixed Income** fund is an ultra-short-term bond fund that invests in certificates of deposit, commercial paper, banker's acceptance notes, and bonds. It can hold government and corporate bonds. It has an average duration of 0.97 and an average credit quality of AA. It has an expense ratio of 0.17 percent, which puts it in the top 2 percent for its asset category.

We will review these materials with you at the October board meeting. However, if you have questions before then, please contact me at 202-585-0109 or [rgold@essentialhospitals.org](mailto:rgold@essentialhospitals.org).

#### Attachments:

2014 financial projection compared to budget (Attachment I)

**Attachment I**

**2014 Fall Projection vs June Projection and Budget**

	col 1 <b>2014 Revised Budget</b>	col 2 <b>2014 June Projection</b>	col 3 <b>2014 Fall Projection</b>	col 4 <b>Projection vs Budget</b>	col 5 <b>Oct Proj vs. June Proj</b>
<b>REVENUE:</b>					
Membership Dues	\$ 5,153,100	\$ 5,338,000	\$ 5,379,800	\$ 226,700	\$ 41,800
UHC Membership Dues and Sponsorships	\$ 3,150,000	\$ 3,150,000	\$ 3,150,000	\$ -	\$ -
Other sponsorships	\$ 245,000	\$ 245,000	\$ 240,000	\$ (5,000)	\$ (5,000)
Conferences	\$ 162,200	\$ 162,200	\$ 167,700	\$ 5,500	\$ 5,500
Publication Sales/Misc.			\$ 3,500	\$ 3,500	\$ 3,500
<b>TOTAL REVENUE</b>	<b>\$ 8,710,300</b>	<b>\$ 8,895,200</b>	<b>\$ 8,941,000</b>	<b>\$ 230,700</b>	<b>\$ 45,800</b>
<b>EXPENSE:</b>					
Personnel Labor & Fringes	\$ 4,140,000	\$ 4,140,000	\$ 3,950,000	\$ 190,000	\$ 190,000
Policy	\$ 246,700	\$ 261,100	\$ 268,000	\$ (21,300)	\$ (6,900)
Advocacy	\$ 456,000	\$ 464,700	\$ 461,800	\$ (5,800)	\$ 2,900
Member Services	\$ 232,500	\$ 253,500	\$ 249,200	\$ (16,700)	\$ 4,300
Consulting/Prof Fees	\$ 135,000	\$ 135,000	\$ 122,000	\$ 13,000	\$ 13,000
Retainer	\$ 400,000	\$ 400,000	\$ 400,000	\$ -	\$ -
Information Technology	\$ 114,000	\$ 114,000	\$ 121,000	\$ (7,000)	\$ (7,000)
Rent	\$ 384,200	\$ 376,000	\$ 376,000	\$ 8,200	\$ (0)
Office expenses/equipment rental	\$ 223,100	\$ 223,100	\$ 183,100	\$ 40,000	\$ 40,000
Communications	\$ 307,600	\$ 307,600	\$ 283,700	\$ 23,900	\$ 23,900
Conferences	\$ 612,200	\$ 568,200	\$ 454,000	\$ 158,200	\$ 114,200
Travel and Prof Development	\$ 125,500	\$ 125,500	\$ 127,500	\$ (2,000)	\$ (2,000)
Taxes, Insurance and Misc.	\$ 69,000	\$ 69,000	\$ 69,000	\$ (0)	\$ -
Depreciation/Amortization	\$ 75,500	\$ 75,500	\$ 30,600	\$ 44,900	\$ 44,900
Project Development	\$ 100,000	\$ 100,000	\$ 100,000	\$ -	\$ -
Contribution /Support to Institute	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL EXPENSE</b>	<b>\$ 7,621,300</b>	<b>\$ 7,613,200</b>	<b>\$ 7,195,900</b>	<b>\$ 425,400</b>	<b>\$ 417,300</b>
<b>Changes in Net Assets before funding from reserves</b>	<b>\$ 1,089,000</b>	<b>\$ 1,282,000</b>	<b>\$ 1,745,100</b>	<b>\$ 656,100</b>	<b>\$ 463,100</b>
<b>Other Items funded from Reserves:</b>					
Office move	\$ (212,000)	\$ (212,000)	\$ (60,000)	\$ 152,000	\$ 152,000
Rebranding (including depreciation on website)	\$ (100,000)	\$ (100,000)	\$ (93,000)	\$ 7,000	\$ 7,000
<b>Changes in Net Assets, after funding from reserves (operating surplus) &amp; before non-operating income</b>	<b>\$ 777,000</b>	<b>\$ 970,000</b>	<b>\$ 1,592,100</b>	<b>\$ 815,100</b>	<b>\$ 622,100</b>
<b>Non-Operating Income:</b>					
Interest/Dividend Income	\$ 50,000	\$ 50,000	\$ 20,000	\$ (30,000)	\$ (30,000)
Realized Capital Gains/(Losses)	\$ -	\$ -	\$ 559,000	\$ 559,000	\$ 559,000
Unrealized Gains/(Losses)	\$ 25	\$ -	\$ (450,000)	\$ (450,000)	\$ (450,000)
<b>Total Non-Operating Income/(Loss)</b>	<b>\$ 50,000</b>	<b>\$ 50,000</b>	<b>\$ 129,000</b>	<b>\$ 79,000</b>	<b>\$ 79,000</b>
<b>Changes in Net Assets, after Non-Operating Income</b>	<b>\$ 827,000</b>	<b>\$ 1,020,000</b>	<b>\$ 1,721,100</b>	<b>\$ 894,100</b>	<b>\$ 701,100</b>

**Attachment I**

**2014 Fall Projection vs June Projection and Budget**

	col 1 2014 Revised Budget	col 2 2014 June Projection	col 3 2014 Fall Projection	col 4 Projection vs Budget	col 5 Oct Proj vs. June Proj
<b><u>NET ASSETS:</u></b>					
Prior Year Net Assets	\$ 6,759,350	\$ 6,759,350	\$ 6,759,350	\$ -	\$ -
Change in Net Assets	\$ 827,000	\$ 1,020,000	\$ 1,721,100	\$ 894,100	\$ 701,100
<b>Total Net Assets after funding of special projects</b>	<b>\$ 7,586,350</b>	<b>\$ 7,779,350</b>	<b>\$ 8,480,450</b>	<b>\$ 894,100</b>	<b>\$ 701,100</b>
<b>Contribution to Restricted Net Assets:</b>					
Office Relocation (restricted net assets)	\$ (100,000)	\$ (100,000)	\$ (200,000)	\$ (100,000)	\$ (100,000)
<b>Total Contribution to Restricted Net Assets</b>	<b>\$ (100,000)</b>	<b>\$ (100,000)</b>	<b>\$ (200,000)</b>	<b>\$ (100,000)</b>	<b>\$ (100,000)</b>
<b><u>Summary of Total Net Assets:</u></b>					
Unrestricted Net Assets	\$ 7,236,350	\$ 7,429,350	\$ 8,030,450	\$ 794,100	\$ 601,100
Restricted Net Assets for office relocation	\$ 350,000	\$ 350,000	\$ 450,000	\$ 100,000	\$ 100,000
<b>Total Net Assets</b>	<b>\$ 7,586,350</b>	<b>\$ 7,779,350</b>	<b>\$ 8,480,450</b>	<b>\$ 894,100</b>	<b>\$ 701,100</b>



DATE      October 21, 2014  
TO          Board of Directors  
FROM       Rhonda Gold, Chief Financial Officer  
RE          Office Move Update

MEMORANDUM

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Since our last board update, staff have toured potential office spaces for our move in December 2015. Finding new space has been challenging in the Washington, DC, market, as many of the available spaces are either too small, inefficient due to column spacing, or too expensive. Despite these issues, we reviewed 35 potential buildings, toured 12, and presented 3 to the leadership team as viable options. We then narrowed our selection to two buildings and subsequently requested proposals from two landlords—Boston Properties at 401 9th Street, NW, and TIAA-CREF at 1900 K Street, NW. During the negotiation process, TIAA-CREF rescinded their counter-proposal and pulled their building from the market; 401 9th Street, NW, was the remaining building, and it also happened to be our first choice.

We are pleased to report that we recently executed a nonbinding letter of intent (LOI) with Boston Properties for the south side of the 9th floor at 401 9th Street, NW. This is a class A LEED Gold building located two blocks from the Archives/Navy Memorial Metro stop and three blocks from the Gallery Place/Chinatown Metro stop. We expect a formal lease from the landlord within the next few weeks, at which point our attorney, Thomas R. Petty of Miles & Stockbridge PC, will negotiate the final lease terms.

The negotiated rental cost, rent abatement, and tenant improvement allowance is more favorable than our real estate brokers' original estimate and is substantially better than the assumptions previously communicated to the board. A summary of the LOI key terms is included with this memo.

We ask the board to approve the following action item:

- Provide board authorization for Bruce Siegel to enter into a formal lease agreement with Boston Properties for 401 9th Street, NW, assuming the lease terms do not differ in any significant way from the LOI.

An important negotiated item in the LOI (and subsequent lease) concerned which entity to name as the tenant on the lease—the 501(c)(6) association or the 501(c)(3) Institute. Boston Properties had requested both organizations be named as tenants; however, we were able to remove the Institute as a named tenant in the executed LOI. We feel it is best to name only the association on the lease, as its revenue stream is more consistent and reliable than the Institute's revenues based on grant and contract receipts. Most importantly, having two entities as co-tenants on a lease makes each entity jointly and severally liable for the entire amount of tenant obligations.

Based on test fits of the space, the architects are estimating an office space footprint of approximately 21,100 square feet. This will accommodate staff growth and a large board room, several small conference rooms, and typical staff office sizes of approximately 100 square feet. With a 15-year lease we were able to increase our bargaining power to negotiate a lower rental cost and more tenant improvement allowances and rental abatements. The negotiated rental rate of \$67.25 per square foot is inclusive of operating expenses and real estate taxes (with a 2.5 percent annual rent escalation), 14 months of rent abatements, and a \$115-per-square-foot tenant improvement allowance. The tenant improvement allowance with a ten-year lease would have been significantly lower than a 15-year lease (approximately \$85 per square foot) with only 7 to 8 months in rent abatements. Our original estimates assumed a rental cost of \$70 per square foot for 20,000 square feet, \$85-\$95 per square foot in tenant improvement allowances, and 8 months of rent abatements.

To accommodate future staff growth, the lease terms will include two expansion options. The first is an expansion of 3,000-4,000 rentable square feet of contiguous space between the 50th and 68th month of the lease. If this option is exercised, the second expandable option is for an additional 3,000-5,000 square feet of contiguous space between months 110 and 132.

Landlords are known to request a security deposit of six to seven months of rent in the form of an irrevocable letter of credit. Boston Properties has reduced this request to four months of the initial base rent (or \$483,400). Our Bank of America advisor recommends we secure a letter of credit with a lien against the association's existing \$1.5 million line of credit. Doing this will require a 2 percent annual fee (approximately \$10,000 per year); we do not draw on the line unless the landlord acts on the letter of credit should we default on the lease. Interest on the line of credit would only apply if the letter of credit is called and acted upon due to the association's default. Under the terms of the LOI, provided the association's annual revenues for the prior year are at least \$8.5 million, the security deposit will be reduced by one month at the end of the second year of the lease and one month each at the end of the third and fourth years of the lease. The remaining month will be held until the end of the 15-year lease term.

We are estimating a total office move budget of \$4.3 million (for 21,100 square feet), which should be reduced by \$2.4 million due to the landlord's tenant improvement allowance (assuming \$115 per square foot as specified in the LOI), for a net cost of approximately \$1.9 million (versus our prior net cost estimate of \$2.3 million). This estimate includes build-out costs for the architect and construction, engineering fees, audio-video infrastructure, furniture, artwork, telephone system, computers, and office move expenses. Many of these expenses are depreciable over a three- to five-year period, while the space build-out is amortizable over the life of the lease (15 years). For financial statement purposes, the rent abatement is amortized over the length of the lease (15 years). We plan to use part of the \$2.5 million from the operating reserves currently invested in fixed income securities to fund the office move.

We will keep you apprised of the office move process as we move forward in our planning. Our anticipated move-in date will be in mid-December 2015. Please feel free to contact me at 202-585-0109 or via email at [rgold@essentialhospitals.org](mailto:rgold@essentialhospitals.org) should you have any questions.

**Appendix A – Summary of Business Terms for Lease Space at 401 9<sup>th</sup> Street, NW, Washington, DC**

**Summary of Business Terms for America's Essential Hospitals  
to Lease Space at 401 9<sup>th</sup> Street, NW, Washington, DC**  
(based on the executed letter of intent dated 10/1/14)

**Premises** - 21,036 rentable square feet on the 9<sup>th</sup> floor

**Term** - 15 years

**Lease Commencement** - January 1, 2016

**Base Rent** - \$67.25 per square foot on a full service basis, including operating expenses and real estate taxes (year 1 rent is \$1,414,671, not accounting for rent abatement).

**Rent Escalation** - Base rent escalates 2.5% annually.

**Operating Expenses and Real Estate Taxes** - Commencing 1/1/16 Tenant pays its proportionate share of increases in building operating expenses and real estate taxes in excess of those incurred during calendar year 2016.

**Rent Abatement** - The first 14 months of base rent, operating expenses and real estate taxes are abated (total value of \$1,658,823). Tenant can convert up to 6 months or rental abatement into additional improvement allowance.

**Improvement Allowance** - Landlord shall provide an allowance \$115.00 per rentable square foot for the construction of the improvements to the Premises and the purchase of furniture and fixtures (total value of \$2,419,140).

**Option to Terminate** - Tenant has the right to terminate the lease at the end of the 11<sup>th</sup> lease year.

**Options to Expand** - Tenant has the right, at tenant's option, in years 5 and 10 to expand into 3,000-4,000 rentable square feet of contiguous space. If the first expansion option is not exercised by Tenant, the second option shall be forfeited.

**First Right to Lease Additional Space** - Tenant has the ongoing first right of refusal to lease up to 5,000 square feet of space on Tenant's floor.

**Option to Extend the Term** - Tenant has the right to extend the lease for 5 year at the then fair market rental rate including market concessions.

**Security Deposit** - \$483,326, reduced to \$362,495 at the end of the second lease year, reduced to \$241,663 at the end of the third lease year, and reduced to \$120,832 at the end of the 4<sup>th</sup> lease year.



DATE      October 21, 2014  
TO          Board of Directors  
FROM       Michael Belzer, MD, Education Committee Chair  
RE          Education Committee Report

MEMORANDUM

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On behalf of the education committee, I am pleased to share the following update on educational programming.

**Medicaid Section 1115 Delivery System Reform Incentive Program (DSRIP) Waivers**

The association focused this year on a series of educational activities on DSRIP waivers. The series, which included two briefs, three distance learning programs, sessions at the annual conference, and a one-day summit, is now complete. The summit, held September 29, resulted in 80 participants and a 4.1 overall satisfaction score. Based on the success of this year's program, staff are considering holding another one-day summit in 2015.

**Innovations Summit**

The 2014 Innovations Summit is scheduled for October 29. This year's summit will focus on population health and social networks. Nicholas Christakis, MD, PhD, MPH, author of *Connected*, will be the keynote speaker. Rapid-fire presentations by four of our member hospitals and a panel discussion will round out this year's summit.

**Fellows Program**

Thirty-four fellows from nineteen member hospitals have completed the first two sessions of the 2014 Fellows Program under this year's theme of adaptive leadership. We have expanded our consulting panel to include consultants from Cambridge Leadership to educate the fellows on the Heifitz model of adaptive leadership compared with technical solutions to operational challenges. The fellows' projects are well underway as are the individual coaching sessions conducted via webinar. CEO/sponsor updates are being emailed routinely to keep the sponsors informed of fellows' work progress and expectations.

Applications for the 2015–2016 fellows class will open December 1 and close January 31, 2015. As discussed at the June board meeting, a new enrollment process will be

implemented this year to ensure sponsors and fellows understand their obligations and financial commitments.

#### 2015 Annual Conference

Planning for the annual conference is well underway. The program will largely stay the same as in 2014, but the association is conducting a call for proposals (CFP) this year to help populate a portion of the conference program. The education committee believes the CFP will enhance member engagement and help uncover innovative programs within the membership that should be shared with others. The proposal deadline is November 14 and the education committee will review and select proposals in mid-December.

#### 2015 Educational Programming

Educational programming in 2015 will again feature distance learning and in-person events. In addition to the usual broad swath of current topics that are important to member hospitals, staff are planning deep dives into three topics: the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), behavioral health, and DSRIP waivers.

Also in the 2015 work plan is the development and launch of the Essential Women's Leadership Academy. During its September meeting, the education committee reviewed a staff recommendation to launch this new program geared toward increasing aspirations and executive competencies of female leaders in essential hospitals. The Essential Women's Leadership Academy has four components: mentorship, assessments and coaching, didactic webinars and meetings, and networking. The education committee reviewed and discussed ideas for the mentorship component of the program, including mentorship roles, responsibilities, and time commitments, as well as strategies for matching mentees to mentors.

## Appendix A – Committee Roster

Michael B. Belzer, MD Chair (2014-2016) Medical Director and Chief Medical Officer Hennepin County Medical Center Minneapolis	Delvecchio S. Finley, MPP (2014-2016) CEO Harbor-UCLA Medical Center Torrance, California
Sherrie D. Williams, MD, MHS Vice Chair (2014-2016) Medical Director of Pulmonary Rehabilitation and Smoking Cessation The MetroHealth System Cleveland	James R. Gonzalez, MPH (2014-2016) President and CEO University Hospital Newark, New Jersey
D. Craig Cathcart, RN (2013-2015) Director of Legislative Affairs and Advocacy Swedish Covenant Hospital Chicago	Thomas J. Quattroche, PhD (2013-2015) Senior Vice President of Marketing, Planning, and Business Development Erie County Medical Center Buffalo, New York
Theodore Chan, MD (2013-2015) Chair of Emergency Medicine UC San Diego Health System San Diego	Arnold Tabuenca, MD (2013-2015) Chief Medical Officer Riverside County Regional Medical Center Hospital Administration Moreno Valley, California
Susan R. Cooper, MSN, RN (2014-2016) Chief Integration Officer, Senior Vice President of Ambulatory Care Regional One Health Memphis, Tennessee	Stephanie Thomas, MBA (2013-2015) Chief Operating Officer Denver Health Medical Center Denver
Susan A. Currin, RN, MS (2014-2016) CEO San Francisco General Hospital and Trauma Center San Francisco	Joseph Woelkers, MA (2013-2015) Executive Vice President and Chief of Staff UT Health Northeast Tyler, Texas



DATE      October 21, 2014  
TO          America's Essential Hospitals Board of Directors  
FROM       Stan Hammack, Membership Committee Chair  
RE          Proposed Corporate Affiliate Membership Category

MEMORANDUM

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### Overview

America's Essential Hospitals has looked closely at its place in the industry today and has made strides toward becoming an all-encompassing and more equitable association, as evidenced by the recent restructuring of dues for full members. To continue to add value to our membership base, staff continue to examine our membership categories and consider new opportunities to bring together not only hospitals serving vulnerable populations, but also other industry leaders, supporters, and providers.

We continue to recognize strength in numbers. With nearly 250 members in 35 states and the District of Columbia, we know the value of our collective voice and aim to create a membership model that attracts hospitals, health systems, and supporting organizations from all 50 states, strengthening our ability to represent hospitals serving the most vulnerable.

Staff from America's Essential Hospitals researched the various membership models of other associations, including the Healthcare Association of New York State, LeadingAge, the California Hospital Association, American Hospital Association, Children's Hospital Association, and more. This research provided staff with insight and tips on how to offer valuable membership options, as well as confirmed our belief that offering more membership categories puts us on par with other trade associations.

### Current Membership Categories

The association currently has two membership categories defined by our bylaws:

**full members:** public and non-profit, acute care hospitals and multihospital systems with common missions and purposes, including patient populations or other significant characteristics and interests consistent with the purposes of the association

**associate members:** associate members: other health care providers that are not general acute care providers or other health systems not considered for full membership, but share characteristics with the association's full members

### **Proposed Membership Category**

Within our bylaws, we also have the option of creating additional "affiliate" membership categories. The membership committee recommends to the board the adoption of a new membership category for corporations and vendors. This proposed membership category is primarily a recategorization of some existing event sponsors:

**corporate affiliate members:** companies or organizations providing products and services for essential hospitals

Currently, the only option for such companies to be involved in the association is through event sponsorship. Creating a corporate affiliate membership allows for companies to be involved with the association on a more consistent and year-round basis, as opposed to visibility within our membership solely through one sponsored event. The corporate affiliate category serves mainly as a recategorizing of some of our smaller-dollar sponsors, as many of the benefits are the same, and can serve as a component of larger-dollar sponsorships, to enhance their value.

The creation of this new category also provides both the option of membership or sponsorship to interested companies, allowing the association to capture funds that may be specifically budgeted in one area or the other.

The basic benefits provided to corporate affiliate members (see appendix A), include one registration to our annual conference, a subscription to our monthly *Best of* newsletter, and recognition in our member listing. While corporate affiliates certainly will benefit from our industry advocacy, they will not have access to governance committee positions and other activities that could influence our advocacy agenda. Corporations or vendors may choose to upgrade to a "premier" corporate affiliate membership, benefits of which include an email introduction to member CEOs by Bruce Siegel, as well as eligibility to participate on a new business advisory council.

These principles will guide the corporate affiliate member category:

- Per our current corporate relations policy, America's Essential Hospitals will not consider for membership companies in the gambling, tobacco, alcohol, or firearms industries.
- Corporate affiliate members will not influence or impact the advocacy agenda of America's Essential Hospitals.

- Corporate members are not designated as preferred vendors and their membership will not include any procurement implications. Hospital and health system members have no obligation to conduct business with corporate affiliate members.
- Corporate affiliate members will adhere to a signed code of conduct.

#### Requested Action

*The board is asked to approve a corporate affiliate membership category for implementation in January.*

## Appendix A – Member Benefits

	Full Members	Associate Members	Corporate Affiliate Members*
Dues	varies by size	\$25,000	\$5,000/ \$15,000
Vote	X		
Considered for board appointments	X		
Eligible to participate in Gage Awards program	X		
Leadership program participation (Fellows Program, GR Academy, Women's Leadership Academy)	X	X	
Participation on select committees, task forces, and interest group steering committees	X	X	
Access to scholarship opportunities	X	X	
Participation in distance learning opportunities	X	X	
Access to members-only website content (including policy alerts, analyses, and more)	X	X	
Subscriptions to association email newsletters on policy, EHEN, quality, research, and education	X	X	
Advocacy resources, including biweekly government relations calls	X	X	
Participation in members-only, in-person events	X	X	
Participation on select interest groups	X	X	
Annual conference registration at the discounted member rate	X	X	X
Subscription to monthly “ <i>Best of</i> ” newsletter	X	X	X
Health care industry advocacy	X	X	X
Listing in America’s Essential Hospitals membership directory	X	X	X

\*Proposed. Additional benefits apply to corporate affiliate members; see below.

Additional corporate affiliate member benefits:

	Premier	Basic
Dues	\$15,000	\$5,000
Participation on a business advisory council	X	
Introduction letter to member CEOs from America's Essential Hospitals president and CEO	X	
Complimentary annual conference registration and additional registrations at the member rate	two	one
Recognition at America's Essential Hospitals events	X	X
Standing company profile and link to homepage on America's Essential Hospitals' website for duration of membership	X	X

## **Appendix B - Membership Committee Roster**

### **Stan Hammack – Chair (2014-2016)**

CEO  
University of South Alabama Medical Center  
Mobile, Alabama

### **LaRay Brown (2014 -2016)**

Senior Vice President, Corporate Planning  
New York City Health and Hospitals  
Corporation  
New York

### **Timothy M. Goldfarb (2014-2016)**

CEO  
UF Health Shands Hospital  
Gainesville, Florida

### **Stephen W. McKernan (2013-2015)**

CEO  
UNM Hospitals  
Albuquerque, New Mexico

### **Santiago Muñoz III (2014-2016)**

Chief Strategy Officer  
UCLA Health System  
Los Angeles

### **Jim R. Nathan (2013 -2015)**

President and CEO  
Lee Memorial Health System  
Fort Myers, Florida

### **Thomas P. Traylor, MBA (2014-2016)**

Vice President, Federal, State, and Local  
Programs  
Boston Medical Center  
Boston

### **James N. Valenti (2013 -2015)**

President and CEO  
University Medical Center of El Paso  
El Paso, Texas



DATE      October 21, 2014  
TO          Board of Directors  
FROM      John Haupert, Chair, Policy Advisory Committee  
RE          Policy Advisory Committee Report

**MEMORANDUM**

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On behalf of the policy advisory committee (PAC), I provide you with this update of the committee's activities.

Over the past several months, the committee has worked to develop principles on equity of care and health disparities. A commitment to reduce disparities in health and health care is inherent in the mission of association members and the association itself. The latest member survey, *Essential Hospitals Vital Data—Results of America's Essential Hospitals' Annual Hospital Characteristics Survey, FY 2012*, indicates that more than half of those cared for by essential hospitals are minorities. So, as leaders in serving the most vulnerable, we are uniquely positioned to pave the way to reducing disparities.

Given our position as an industry association, stakeholders often call on us to be a national voice for reducing disparities in health and health care. We engage in various activities that demonstrate our commitment to identifying potential disparities in care and finding solutions, including webinar series and the recent development of an online training module on collecting patient race, ethnicity, and language (REAL) data. But in terms of policy, we have not authored a formal position statement on the goal of reducing care disparities.

Currently, this topic is playing out prominently at the national level in the context of discussions about risk adjusting certain quality measures, such as those for hospital readmissions, for sociodemographic factors. America's Essential Hospitals has long supported including sociodemographic and socioeconomic factors in the risk-adjustment models of outcomes measures when scientific evidence shows these factors play a role in health outcomes. As equity issues continue to percolate on Capitol Hill and nationally, including discussions on risk adjusting quality measures, it would be helpful to have well-crafted principles and position statements that association staff may share during the ongoing discussions and debate.

The committee expects to complete its work on the equity principles this fall and will bring the draft principles to the board for its review during the board's December 1 conference call.

A list of PAC members is included in Appendix A.

## Appendix A - Policy Advisory Committee Roster

### **John M. Haupert - Chair**

Chief Executive Officer  
Grady Health System  
Atlanta

Kirk Calhoun, MD  
President and CEO  
UT Northeast  
Tyler, Texas

Susan P. Ehrlich, MD, MPP  
CEO  
San Mateo Medical Center  
San Mateo, California

Jeff Feasel  
President and Chief Executive Officer  
Halifax Health  
Daytona Beach, Florida

Steven G. Gabbe, MD  
Senior Vice President for Health Sciences,  
Chief Executive Officer  
The Ohio State University Wexner Medical  
Center  
Columbus, Ohio

John McCabe, MD  
CEO and Senior Vice President for Hospital  
Affairs  
SUNY Upstate Medical University  
Syracuse, New York

David Pate, MD, JD  
President and Chief Executive Officer  
St. Luke's Health System  
Boise, Idaho

### Steve Purves

Chief Executive Officer  
Maricopa Integrated Health System (MIHS)  
Phoenix

Sheldon Retchin, MD, MSPH  
Vice President, Health Sciences and Chief  
Executive Officer  
VCU Health System  
Richmond, Virginia

Nancy Schlichting  
CEO  
Henry Ford Health System  
Detroit

Joseph F. Scott  
President and CEO  
Liberty Health/Jersey City Medical Center  
Jersey City, New Jersey

Paul S. Viviano  
CEO, Associate Vice Chancellor for Health  
Sciences  
UC San Diego Health System  
San Diego

Michael R. Waldrum, MD, MS, MBA  
UAHN President and CEO  
The University of Arizona Health Network  
Tucson

Patrick Wardell  
President and Chief Executive Officer  
Cambridge Health Alliance  
Cambridge, Massachusetts



DATE October 21, 2014  
TO Board of Directors  
FROM Beth Feldpush, DrPH, Senior Vice President of Policy and Advocacy  
RE Policy/Advocacy Update

## MEMORANDUM

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This memo outlines advocacy and policy activities of America's Essential Hospitals since the June in-person board of directors meeting, and details our advocacy agenda and expectations for the next several months, including for the fall elections.

### 2014 Election Forecast and Impact on America's Essential Hospitals' Legislative Agenda

After the least productive legislative session in modern history, Congress has entered the 2014 midterm elections with near record-low approval ratings. Just 14 percent of Americans approve of Congress' work. Despite the general antipathy toward Congress and Washington in general, some of the upcoming elections are shaping up to be hotly contested races.

Republicans will almost surely retain control of the House of Representatives. This outcome has less to do with a swing toward Republicans than clever gerrymandering of congressional districts after the 2010 census. In 2012—the first election after redistricting—House Democratic candidates actually won the aggregate popular vote, but won just 45 percent of the seats in that chamber. Such an outcome is likely again in 2014. As of October 1, Republicans are expected to pick up between 5 and 15 additional seats in the House.

The race for the Senate is more dynamic. Currently, Democrats hold a 55-45 seat majority, which means Republicans need a net gain of 6 seats to win control of the Senate. Of the 36 Senate seats being contested, Democrats hold 21 seats and Republicans hold 15. Democrats not only have to defend more seats than Republicans, but many of their seats are in hostile territory. Of their 21 seats, 7 are in states that President Obama lost in both the 2008 and 2012 elections. Republicans need only defend 1 seat (Maine) where President Obama won. As of October 1, Republicans appear to have many ways to gain 6 seats. They are nearly guaranteed to win three Democratic open seats: Montana, South Dakota, and West Virginia. They are also competitive in (even leading some polls) an additional eight states: Alaska, Arkansas, Colorado, Iowa, Louisiana, Michigan, New Hampshire, and North Carolina. If Republicans are able to hold all of their current seats and win the three that seem likely, they would only need to win three out of those eight races to claim the majority.

Opportunities for Democrats to take away a current Republican seat are very limited. Democrats are waging competitive elections in Kentucky—attempting to defeat current Senate Minority

Leader Mitch McConnell (R-KY)—and Georgia. Though the Democratic candidates are strong in both races, they trail by small to moderate margins in most polls. The wild card election is in Kansas, where long-time incumbent Sen. Pat Roberts (R-KS) is facing a stiff challenge from an independent candidate. Currently, major election analysts in Washington give Republicans a 50 to 75 percent chance of picking up six seats and winning the Senate.

The immediate impact of the election will be felt in the upcoming lame duck session of Congress, which will begin November 12. If Republicans win the Senate, we expect the lame duck session to be short and unproductive. Likely, Congress will only stay in session long enough to extend funding for the federal government, which currently expires December 11. If Democrats retain the Senate, the lame duck could be more active, as Democrats may attempt to pass leftover priorities from the current Congress. Included in that list may be a funding extension for the Children’s Health Insurance Program (CHIP).

In the longer term, the elections could broadly impact the association’s priorities. While we expect that our current top issues—340B, risk adjustment for socioeconomic status, Medicare and Medicaid disproportionate share hospital (DSH) payments, and others—will remain on our agenda, a Republican-led Congress could lead to a more active re-litigation of the Affordable Care Act (ACA) and significant potential threats to essential hospital priorities, particularly Medicaid. Sen. Orrin Hatch (R-UT), who would be chair of the Senate Committee on Finance should the Republicans win the Senate, has developed a comprehensive plan to repeal and replace the ACA. While a full repeal would surely be vetoed by the president, other significant changes appear possible. Included in Hatch’s plan is a move to establish per capita caps in the Medicaid Program. This proposal, which has some Democratic supporters, could fundamentally undermine essential hospitals’ funding.

### CHIP Funding Extension

The ACA reauthorized CHIP through 2019, but only included funding for the program through 2015. While funding for CHIP will not end for another year, leading Democrats in Congress are working to extend funding through 2019 as part of this year’s lame duck session. Their argument for immediate action is based on both programmatic and political considerations. Democrats argue that it is important for state lawmakers, health plans, providers, and beneficiaries to have confidence in the continuation of CHIP funding. Early next year, many states will begin to draft biennial budgets. Failure to extend CHIP funding now would make it difficult for states to accurately plan for their health coverage costs. Politically, leading Republican Senate staff have been clear that if CHIP is not extended during the lame duck, they will use the CHIP funding extension as an opportunity to reopen the ACA and force a conversation with Democrats about significant changes to the law. In the unlikely event that CHIP funding is not extended, as many as 2 million children are projected to become uninsured; the rest are expected to gain coverage in health insurance marketplace (exchange) plans.

America’s Essential Hospitals supports an immediate extension of CHIP funding. A CHIP funding bill during the lame duck could also serve as a helpful legislative vehicle on which to attach other legislative priorities.

## Laying the Groundwork for Continued Support

As we expect little legislation to pass during the lame duck session of Congress, one of our key advocacy goals of 2014 continues to be educating policymakers about what essential hospitals do and what distinguishes our members from other providers (see **Characteristics of an Essential Hospital below**). This concept is critical as we lay the groundwork to seek continued delay of the Medicaid DSH cuts and advance the idea of special designation, or recognition, of essential hospitals.

Over the next several years, as coverage expansion continues while the Medicaid DSH cuts are delayed, we believe some may argue that essential hospitals are sitting in a favorable financial position. However, we know millions will remain uninsured and largely continue to seek care at essential hospitals. We know many states have not yet expanded their Medicaid Program, and even among those that have expanded, Medicaid remains a poor payer. We know some individuals who gain coverage through the marketplaces or through new Medicaid eligibility may face increased cost-sharing obligations they cannot meet. We know that you continue to provide your communities with essential services for which you are not fully reimbursed—training tomorrow's clinicians and providing trauma care and other specialized services, for example.

We will continue our messaging campaign throughout the remainder of this year to clarify and solidify for policymakers the role essential hospitals fill and proactively rebut negative perceptions about the financial status of essential hospitals. We are drafting a policy paper for release later this fall that will showcase the need for continued financial support of essential hospitals. This message will be one of the key points we will ask members to relay to their congressional delegations during our December Policy Assembly.

### CHARACTERISTICS OF AN ESSENTIAL HOSPITAL

Provide care to the vulnerable,  
particularly the uninsured and Medicaid recipients



- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| Train the next generation of clinicians | Deliver comprehensive, coordinated care to communities | Provide specialized, lifesaving services, such as trauma and neonatal intensive care | Advance public and population health |
|---|--|--|--------------------------------------|

## Supporting Equity in Quality Measurement

A large body of emerging scientific evidence shows that sociodemographic factors (e.g., age, race, ethnicity, primary language) and socioeconomic status (e.g., income, education, occupation) can influence health outcomes. These findings are of particular importance in pay-for-performance programs that reward hospitals for providing high-quality care and penalize them for lower quality. America's Essential Hospitals has long supported risk-adjustment of outcomes measures for sociodemographic and socioeconomic factors when conceptual and empirical evidence warrants it. We believe doing so will improve the science of performance measurement by increasing precision and delivering more accurate information to providers, payers, and the public. And, if these factors are not taken into consideration in pay-for-performance programs, hospitals that serve vulnerable populations could be unfairly penalized in this process, which could then worsen disparities in care.

As discussed at the board's June meeting, the National Quality Forum (NQF), the entity that reviews and endorses quality measures for use in national programs, recently reviewed its long-standing position that quality measures should not be risk-adjusted to account for sociodemographic factors and may revise its position. In July, the NQF voted to move forward with a pilot project that would test the use of sociodemographic factors in the risk model for selected measures. The specifics of the pilot project, including which measures will be involved, how the measures will be tested, and when the pilot will conclude, are not yet known.

In light of the fact that the NQF has not taken strong action to permanently change its policies, America's Essential Hospitals believes that pursuing a legislative approach to this issue is the best course of action at this time. The association supports two current bills that, through different approaches, would ensure hospitals caring for vulnerable patients are not unfairly penalized by the Hospital Readmissions Reduction Program (HRRP). In the House, legislation sponsored by Rep. Jim Renacci (R-OH) would direct the secretary of the U.S. Department of Health and Human Services to adjust the readmissions measures used for the HRRP by the proportion of dually eligible patients (a proxy for counting low-income patients) served by hospitals. On the Senate side, America's Essential Hospitals worked closely with Sen. Joe Manchin (D-WV) on legislation that would go farther than the Renacci bill and require the Centers for Medicare & Medicaid Services (CMS) to risk-adjust the actual methodology of the readmissions measure for sociodemographic factors.

At this time, we prefer the approach outlined in Manchin's bill; however, we believe either approach would be an important step forward. In fact, Renacci, Manchin, and Sen. Rob Portman (R-OH)—an original co-sponsor of the Manchin legislation—have indicated a strong willingness to work together on a combined approach and new compromise legislation. America's Essential Hospitals staff have been meeting with these offices over the past several months to offer suggestions on how to find a common approach. We are encouraged that both pieces of legislation enjoy strong bipartisan support. There are 105 co-sponsors of the Renacci legislation and 10 of the Manchin bill, and support is almost evenly divided between Republicans and Democrats on both bills. We continue to be optimistic that this issue will be on the table when Congress next considers health care legislation, likely next spring when they must address the sustainable growth rate (SGR) factor again, if not sooner.

## Partnership for Medicaid–Medicaid Quality Reporting Proposal

The Partnership for Medicaid is a nonpartisan coalition of 23 national organizations representing Medicaid providers, health plans, counties, and labor. Since January 2012, America's Essential Hospitals has served as the Partnership's first co-chairing organization. Over the past 18 months, the Partnership developed and has begun to disseminate a proposal called The Next Step: Improving Health Care Quality and Reducing Costs in the Medicaid Program. The proposal builds on ongoing quality reporting and improvement activities established under the Children's Health Insurance Program Reauthorization Act of 2009 and the ACA. Currently, states may voluntarily report to CMS on a variety of quality measures. To date, this reporting is spotty and largely unhelpful; no state reports on all measures and no measure is reported by every state. The proposal adds vigor to these current activities by ultimately requiring states to report on quality measures.

The proposal envisions a three-step approach to universal quality reporting:

- 1) creation of a succinct, common reporting set of state-level measures determined by a newly created Medicaid quality improvement committee with members from various constituencies, including essential hospitals, health plans, state Medicaid agencies, and CMS
- 2) financial incentives to states to report on the measures included in the reporting set and federal assistance to providers to ensure accurate, comprehensive reporting
- 3) required reporting on the set from all states

In September, the Partnership hosted a roundtable discussion on the proposal with many stakeholder organizations in Washington. Attending the event were representatives from more than 40 organizations, including the National Governor's Association, the National Association of Medicaid Directors, the American Hospital Association, CMS, the Medicaid and CHIP Payment and Access Commission, and the Agency for Healthcare Research and Quality. The Partnership is now talking to key staff on Capitol Hill about legislation to implement this proposal. Such legislation would not be introduced until the next Congress.

## Member Education Efforts and Advocacy on Medicaid Incentive Program Waivers

We continue to focus on member education and regulatory advocacy around Medicaid incentive program waivers. In September, we held a very successful one-day Leadership Summit on State Medicaid Waivers in Chicago. Approximately 80 member participants attended the meeting, far exceeding the 45 participants for which we had initially planned and budgeted. Attendees rated the meeting very highly in their evaluations and indicated a strong interest in any future programming on this topic and in this format.

Concurrent with the September in-person meeting we released a research brief on Medicaid incentive program waivers, sharing in-depth perspectives of leaders from hospitals working with waivers in California, Massachusetts, and Texas. This latest research brief joins an earlier policy brief, several sessions at Vital2014, and a series of webinars to round out our 2014 programming on waivers. We are currently in the planning stages to build out our waiver-related member services for 2015.

## Protecting Hospitals' Medicare Payments

America's Essential Hospitals is concerned about the growing size of the ACA-mandated cuts to Medicare DSH funding. Although we support the policy goal to redirect and target Medicare DSH funding to those hospitals that serve a larger proportion of low-income patients, we know that, over time, the size of the cuts will have a negative financial impact on most, if not all, of our members.

As part of this year's rulemaking process for fiscal year 2015 Medicare inpatient hospital payments, America's Essential Hospitals spearheaded an effort to ensure data used for determining hospitals' Medicare DSH payments in the future are as accurate and reliable as possible. Specifically, we provided comprehensive comments to CMS on the accuracy of the data elements captured on worksheet S-10 of the Medicare cost report. We are also exploring legislative approaches that would provide some financial relief to our members affected by the largest cuts.

## Expecting 340B Regulations

As we discussed this summer, the Health Resources and Services Administration (HRSA) had been preparing to release a large regulation, referred to as the mega reg, on the 340B program. However, due to a court ruling on a separate 340B program issue, which stated that HRSA does not have broad authority to regulate the 340B program, release of the mega reg has been delayed, and its status at this time is unclear. HRSA is most certainly reviewing the proposed rule language to determine if stakeholders could argue that any changes it proposes are outside of its authority. The agency has also indicated that it is reviewing whether or not it could issue any of the regulation through the subregulatory process or as an interpretive rule. This would mean stakeholders would not get the benefit of a formal notice and comment period.

America's Essential Hospital will continue to monitor these events and keep members informed. If and when the rule is released, America's Essential Hospitals will share the rule's contents through analyses and webinars. Also, as we develop formal comments on the rule, we will solicit input from members, including our newly formed 340B steering committee, 340B interest group, and government relations professionals group.

As we wait for more information on the mega reg, America's Essential Hospitals has been advocating for immediate regulatory relief from HRSA's burdensome policy that precludes hospitals from enrolling new outpatient clinics into the 340B program until the clinics' costs appear on a filed cost report. HRSA's policy can delay a clinic's eligibility for the 340B program for up to 21 months from when the clinic opens. We believe this wait is illogical at best and, at worst, detrimental to hospitals' ability to serve patients. We know that many of our members have included ambulatory and primary care expansion as project goals under their Medicaid incentive program waivers, and we know HRSA's misguided policy impacts your ability to perform on these waiver project goals. We have long advocated to HRSA that this policy should and could be changed without the need for formal rulemaking. We are continuing a dialogue with HRSA on this issue and bringing CMS into the discussions in light of the impact on waiver project progress.

## **Meaningful Use**

The association worked with CMS, the Office of the National Coordinator for Health Information Technology (ONC), and industry stakeholders to secure flexibility for members in meeting the requirements set out by the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Specifically, CMS and ONC extended the period hospitals have to meet stage 2 meaningful use requirements by an additional year, to 2016. Thus, hospitals have an additional year at stage 2 before they have to meet stage 3 meaningful use. In addition, CMS and ONC have provided flexibility in how hospitals use certified EHR technology (CEHRT) to meet meaningful use requirements for 2014. Through this effort, hospitals unable to meet the requirements for 2014 using new certified technology (the 2014 edition CEHRT) can use old certified technology (the 2011 edition CEHRT) or a combination of old and new certified technology to meet meaningful use requirements.