June, 2013

Colleagues:

This spring, I asked for your input as OAHHS began a conversation with our Board of Trustees and full membership on their potential shifts in expectations regarding who we represent as an association -- in light of health care reform and the transformation of the delivery and payment system. Thirty-five of you let us know how your associations have dealt with a myriad of challenges and opportunities tied to our changing environments.

We have some members who believe we need to drop the "health system" from the OAHHS name and go back to being the Oregon Association of Hospitals and all which that represents. We have others who have said that we need to explore broadening representation beyond hospitals and partially integrated health systems to include physicians, insurance functions, and the broader table of ACOs and Oregon's Accountable Care Organizations (CCOs). We heard enough differing opinions that we felt it time to call the question by designing a process to reaffirm the mission and focus of OAHHS. The survey data you provided was an important early stage input into that process.

Thanks again for your participation in this environmental scan - the data was very instructive in helping us kick off this work to ensure we have the "who" we represent agreed to before we develop the "what," through our impending strategic planning process.

We have attached a summary of your survey responses as they may provide you some food for thought as you consider similar questions. We have since conducted one hour interviews with every hospital CEO/COO around similar questions and are preparing to take our findings to the full membership next month.

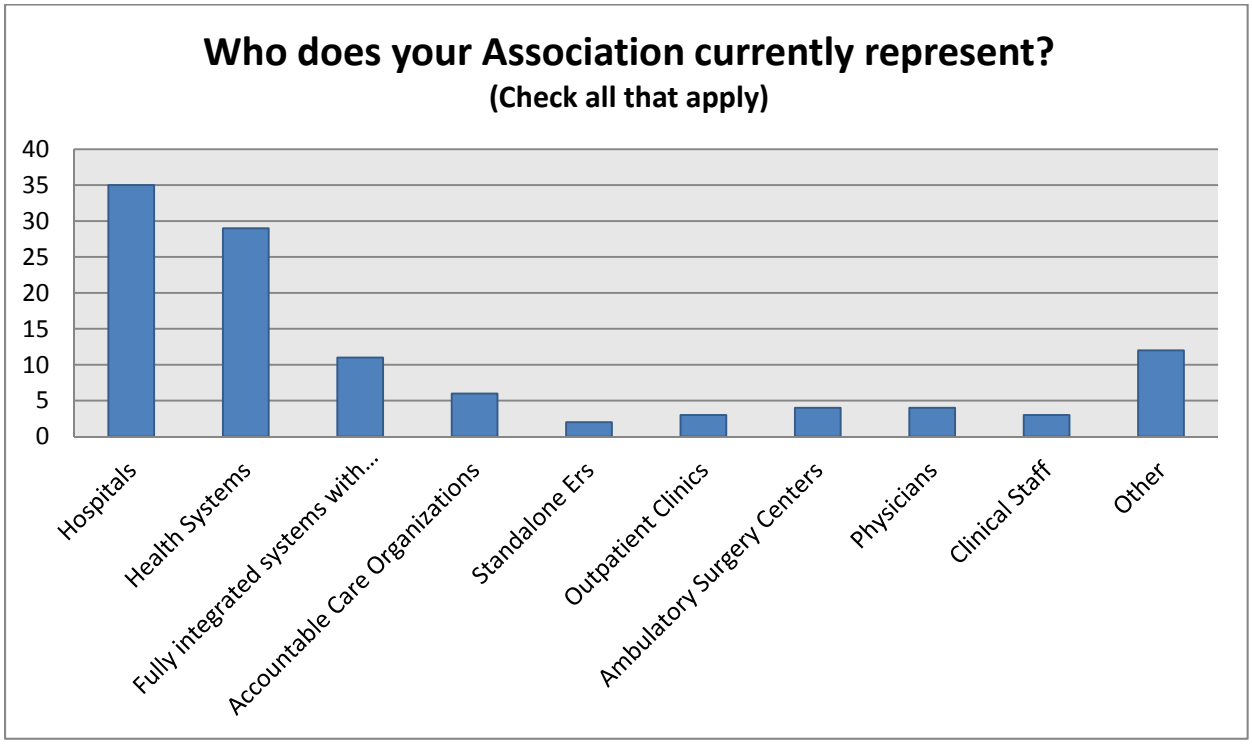
Once complete, I will provide you each a copy of our member interview summary and charts. It's been a fascinating process to date.

Cheers!

Andy

Andrew S. Davidson
President and CEO
Oregon Association of Hospitals and Health Systems
www.oahhs.org

503.636.2204 (ofc)
503.705.7068 (mobile)



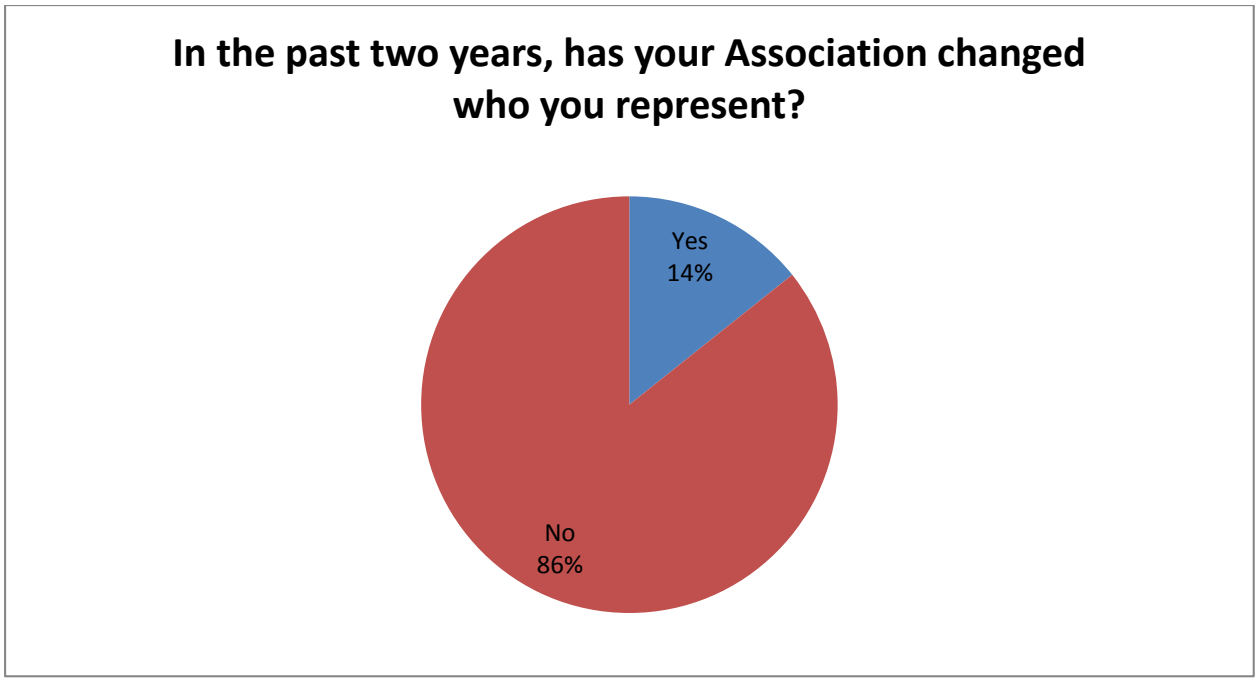
Sample Responses:

We represent all of these if they are owned by a hospital or health system. We have never had a request from other owners of clinics or surgery centers, so to speak. We have 8 ACO's. All but one are owned by hospital systems. One is owned by docs. I haven't heard and interest from them yet, but it is too early.

To some extent, it really depends on the definitions. We include in our definition of member any entity that as long as it is part of and owned and operated by the health system...ASCs, home health, physicians. One hospital has a health plan so I checked that above. However, dues revenue still is derived from hospital operating expenses and that will not change.

Nursing homes, hospice, home health - All professional staff societies/associations are affiliate members.

Half the members of long-term care association quit and asked to affiliate with us. Our members declined to accept them.



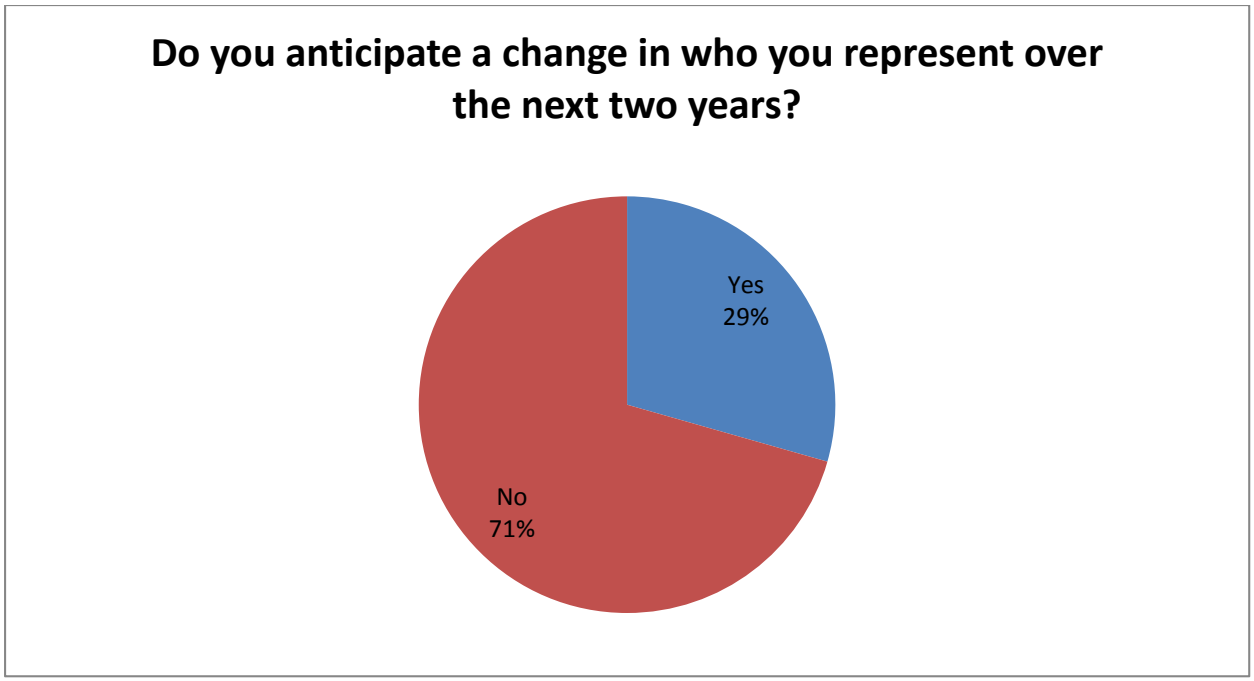
Sample Responses:

To the degree that our members have evolved into something more than hospitals - serving the needs of member ACOs.

Just added a new membership category for PHOs, POs and IPAs; we are implementing that right now.

Physician management directors and we also represent home health, hospice, and LTC.

Renamed ourselves the "_____" Hospital Association to emphasize we represent hospital interests only. Rebranded that change throughout the state. I found political leaders and the public were confused as to what constituency we represented.



Sample Responses:

In general, we currently have 26 community hospitals, with all but 4 of them remaining independent; that is not sustainable and members are beginning the mating ritual and it is creating a number of membership challenges for us, but in the end, there will be fewer freestanding hospitals and more systems.

Maintaining focus on hospitals and health systems but broadening who we represent within the member enterprise including post-acute services, employed docs and member managed care plans. As the members change so shall we.

Beginning discussions with Board about being a ***provider*** association and not just a singular focus on hospitals.

Maybe. Looking into ACO representation along with large medical group practices, but board has not adopted yet.

My sense is that there is general satisfaction with our current membership structure.

What, if any, state health reforms could affect who you represent in the future?

Sample Responses:

Movement to state based ACOs, total cost of care arrangements for Medicaid and commercial insurance. Also, transparency initiatives and value based purchasing.

We have not focused on it to date, but our members remain committed to the hospital association brand name - will not prohibit us from considering other members in the future.

None that I can see at this time.

State ACO designations; large MD groups accepting risk

A new Medicare waiver, global budgets, bundled payment, focus on population health management.

None at this time. Although we will have state health reform, I think we are pretty well situated to meet the challenges it will bring.

Movement of state Medicaid toward regional provider-led risk-bearing entities.

What, if any, federal health reforms (e.g. ACOs) could affect who you represent in the future?

Sample Responses:

Like the rest of the country, we see movement toward systems development whether ACO or not. This will be a game chamfering how we move forward.

No interest to date by any of our members to engage in the ACO model. We may see some physician integration with our health systems, but I do not expect any impact on the operations of our association.

This will be dependent upon some of my members' attempt to align themselves with other hospitals and systems.

The ACA might very well change who we represent in the future because of the ever increasing employment of physicians by our members and the track our larger members are taking toward ACOs. This will be down the road always, likely after I retire.

ACO/bundled payments could change our future. Much of our current advocacy centers around reimbursement to hospitals. That gets murkier when payment streams are merged for numerous provider groups.

Not that we see or anticipate at the current time. Hospitals are accepting risk and we are developing the capacity to help them but that will not change who we represent.

In what way do you currently represent the physician community in your state? (e.g., employed physicians only, collaboration with medical societies, separate membership levels, etc.)

Sample Responses:

Physician Leadership Council - made up of physicians employed by and/or aligned with our members. Collaboration with state medical association and other physician groups.

Collaboration with specialty societies, particularly on quality-related matters.

Collaborate with medical association, formed a "clinic" committee to address more physician related issues.

No formal representation, but we do maintain good relations with the state medical association - they represent less than 25% of the physicians in our state.

We have a good relationship with state medical association. They are losing members to hospital employment. They would like us to tell hospitals to pay the dues of docs that become employed. We only advocate directly on physician issues that affect our hospitals.

We began exploring this issue in 2012. While we don't formally represent physicians at this time, it will be evaluating its role more thoroughly during the first half of 2013 in regard to representation and support.

No direct representation of physicians in any way. Attempt to collaborate with medical society on key legislation or regulation of mutual interest.

We do not "represent" physicians and will not do so in the future. We work with the state medical association on that point. However, since our hospitals employ more physicians than are members of the state medical society, we help our members on issues that pertain to physicians but we do not represent physicians--that's what the medical community does.

We do not have membership for physicians at this time. We do collaborate w/ state medical association on physician leadership program and other matters, including advocacy.

How do you define "physician community" (e.g., employed physicians only, all hospital physicians, etc.)?

Sample Responses:

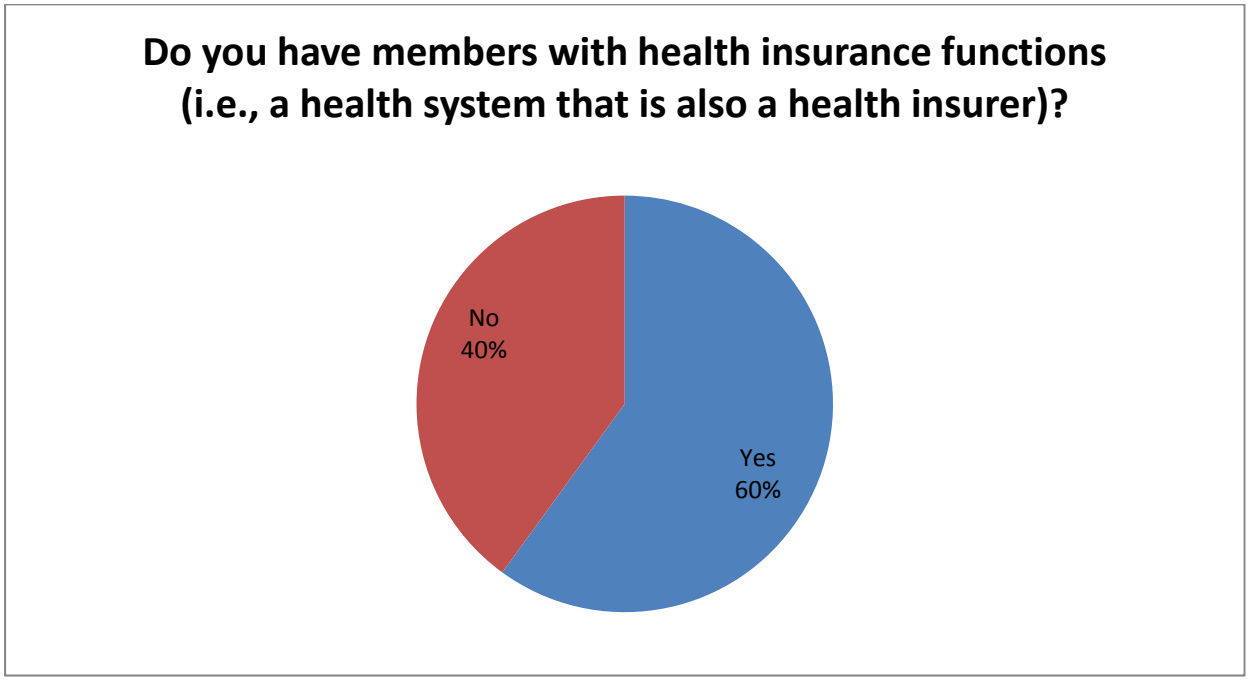
All physicians, regardless of employment.

All physicians, including hospital employed and those who are not.

All practicing physicians in my state.

All hospital-connected physicians.

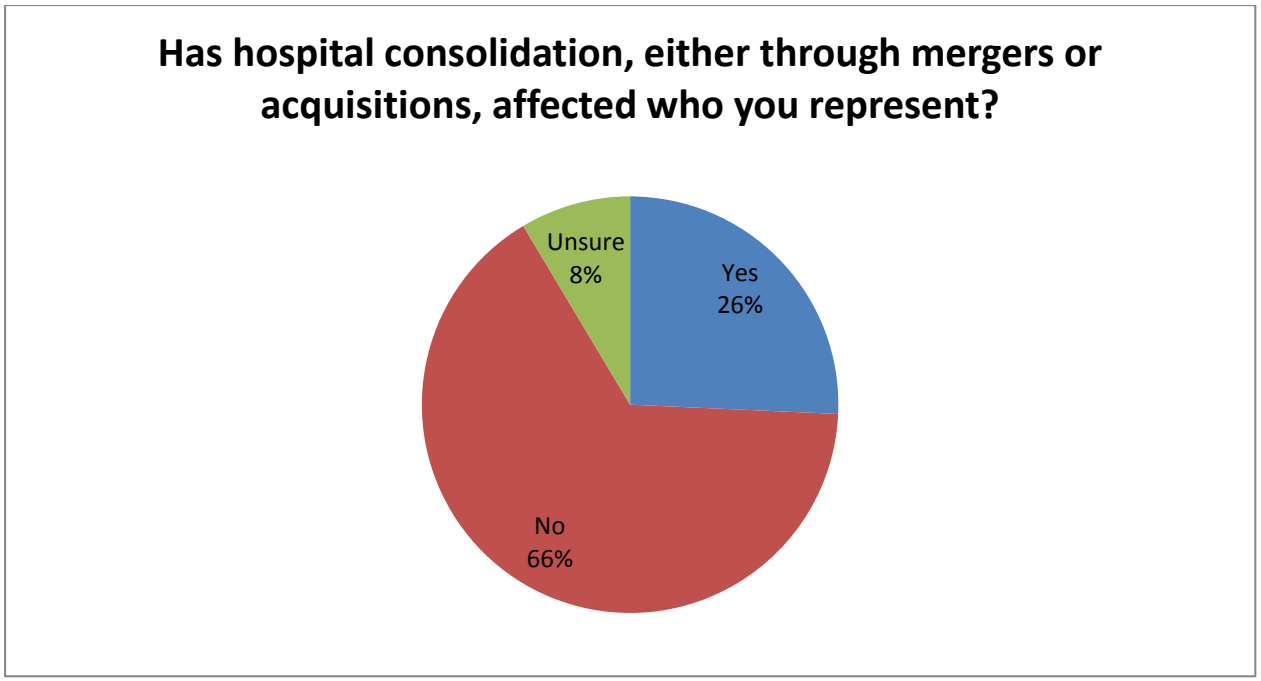
Employed physicians only.



Sample Responses:

Not in a significant way. We have hospital owned and non-profit health plans doing Medicaid managed care, but it is more with education, information, data analysis, etc. that we serve them. Representation is only coincidental to when their needs and the hospitals coincide.

No. We make every effort to keep arm's length from representation of insurance, but we do try to coordinate legislative and regulatory efforts.



Sample Responses:

We have had some mergers over the last few years that have cost us dues revenue due to the way our dues millage is calculated.

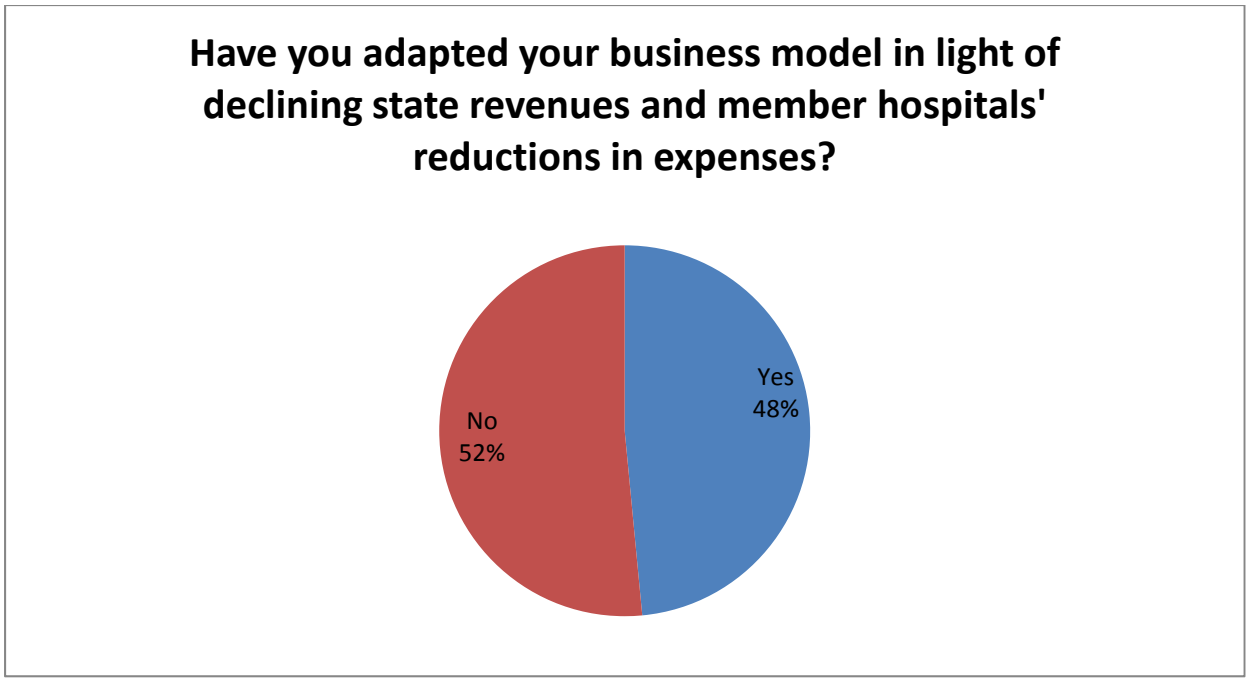
Not yet, but it will.

We have seen consolidations that have strengthened the hospital system network.

More systems focus due to consolidation and less independent hospitals

More and more systems are erupting and I have to keep them happy as well as my freestanding rurals.

Not directly but we do tend to interact with corporate offices more than in the past.



Sample Responses:

This is a work in progress but we have moved over the last few years to increase non-dues revenue by grants and activities of our shared services division.

Yes, we've focused more energy on helping hospitals find efficiencies, best practices, etc.

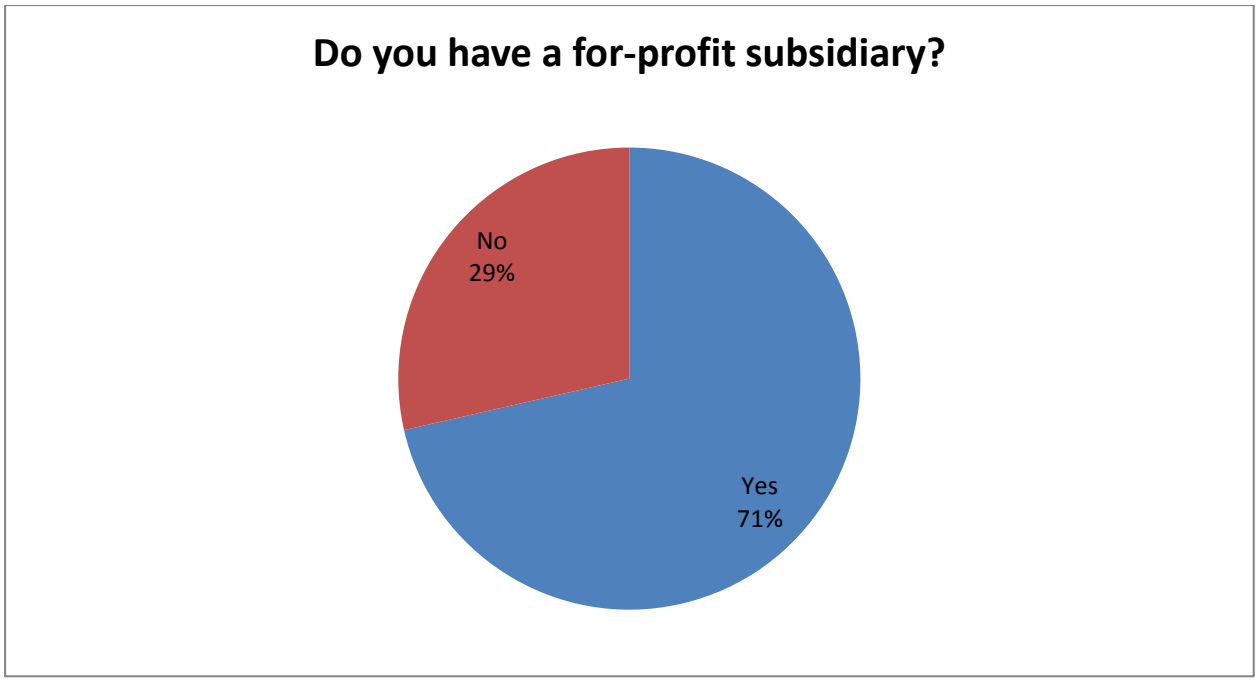
Consolidation has made us redo our dues structure. Our association is so small that we share comparative metrics with members to let them know they're getting a good deal.

Greater reliance on fee for service revenue; reduced operating expenses in various areas like travel, rent, some staffing attrition. There has been some dues adjustment to make up for rapid number of bankruptcies.

We have two government grants we are working on. We have not done much of this type of work in the past.

Only to the extent that we are trying to add more value to the members by convening discussions on Medicaid managed care and health reform. Our state was just informed that it won a CMS planning grant to design a multi-payer integrated delivery system, which will have huge implications for our business model in the future.

We have been able to keep dues flat largely by holding costs down, looking for new revenue sources on the business side and shedding non-core functions (3 FTE library).



Sample Responses:

GPO, data, revenue management support, credentialing and others.

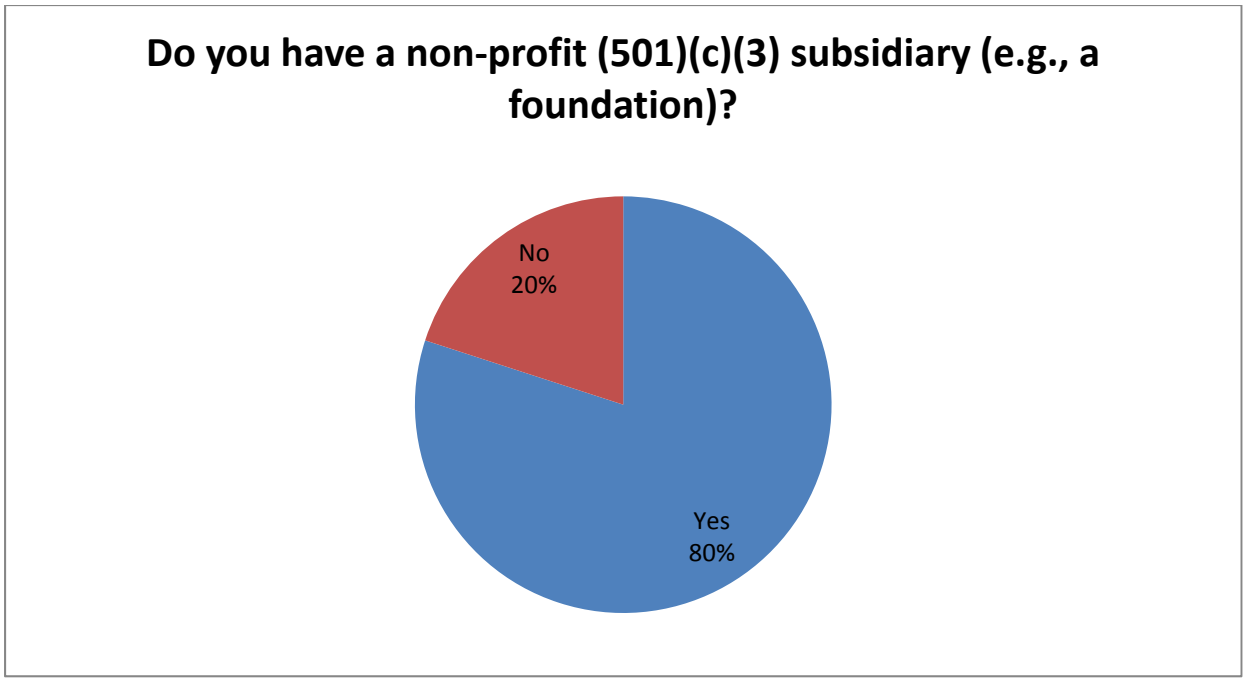
Broker/Dealer and Retirement Consulting to our Members especially regarding their compliance with 401k, 403B etc. rules. Strategic Planning and utilization analysis software products with population health etc. reports. Data Gen - providing impact analysis to 45 state hospital associations Medical Home consulting.

Workers' Comp, Insurance

Insurance products, credentialing service, staffing services, risk management, loss prevention.

Group purchasing partnership with Provista, insurance, coding services, unemployment insurance, RAC audit software, pressure ulcer guide, and strategic partnerships.

Liability insurance



Sample Responses:

Grant management

Education Foundation - for member education and for state and federal grant revenue - approximately $5M per year.

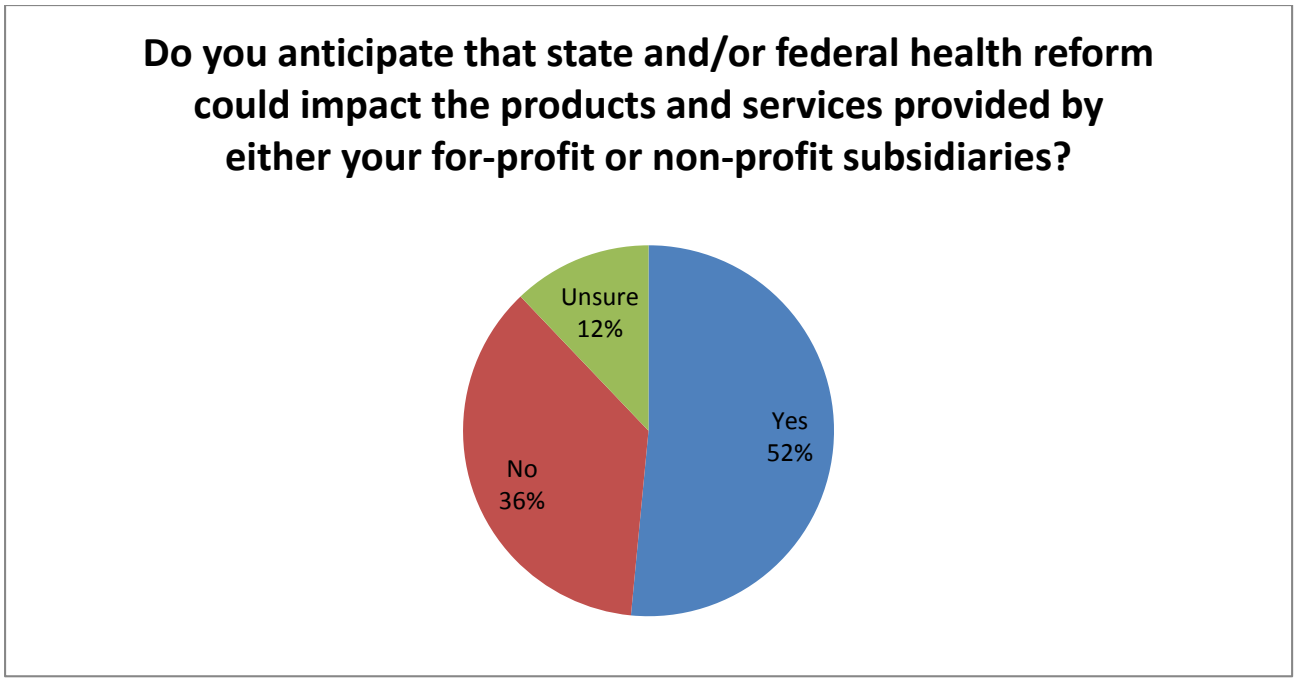
Educational programming

Research and education

It's not very active. Previously was used for emergency preparedness contracts with state. Now being used for HEN contract.

Primary focus on quality/patient safety (health engagement network subcontractor with HRET), access, healthy communities and health equity

Education and disaster relief.



Sample Responses:

Could serve as data "integrity officer" for various data sources the state uses.

We thought perhaps we would go back to some sort of insurance product as members explore assuming risk but the member politics are a barrier

Developing lots of tools, education programming to help members prepare for integration, risk assumption, bundling, private health insurance exchange support, mountain of quality collaboratives.

We would expect opportunities to be in the areas of member education and product endorsements that provide cost savings.

Data functions across the state and at association need to be coordinated better with possibility of us taking more of that on. Subsidiary services need to follow the dollars of new funding streams.

Range of population health management tools to include claims payment, case management analytics, call center services and quality measure support.

Consolidation is limiting sales opportunities for for-profit. Large systems purchase products on their own without using our for-profit services.

Thank you to all the associations that participated in this survey:

Alabama Hospital Association
Arkansas Hospital Association
Colorado Hospital Association
Connecticut Hospital Association
Delaware Healthcare Association
Georgia Hospital Association
Healthcare Association of New York State
Hospital & Health System Association of Pennsylvania
Idaho Hospital Association
Illinois Hospital Association
Indiana Hospital Association
Louisiana Hospital Association
Louisiana Hospital Association
Maine Hospital Association
Maryland Hospital Association
Massachusetts Hospital Association
Minnesota Hospital Association
Missouri Hospital Association
Montana Hospital Association
Nebraska Hospital Association
Nevada Hospital Association
New Mexico Hospital Association
New Hampshire Hospital Association
New Jersey Hospital Association
North Dakota Hospital Association
Ohio Hospital Association
South Carolina Hospital Association
South Dakota Association of Healthcare Organizations
Tennessee Hospital Association
Utah Hospital Association
Vermont Association of Hospitals and Health Systems
Virginia Hospital & Healthcare Association
West Virginia Hospital Association
Wisconsin Hospital Association
Washington State Hospital Association
Wyoming Hospital Association