[Hospital Name]

Board of Trustees

Orientation Manual

[Hospital Logo]

Revised [Date]

**Table of Contents**

**About [Hospital Name]** X

*History* X

*Our Mission, Vision and Values* X

*Our Board* X

*Board Committees* X

*Meeting Schedules* X

*Board Bylaws* X

*Our Service Area* X

*Physical Facilities* X

*Hospital Organization Chart* X

*Medical Staff Organization Chart* X

*Hospital Quick Facts* X

*Related Entities* X

**Health Care Basics** X

*Types of Hospitals* X

*Regulatory Basics* X

*Federal* X

Health and Human Services (HHS) X

HHS Office of Inspector General (OIG) X

Centers for Medicare & Medicaid Services (CMS) X

Medicare Conditions of Participation (CoP) X

Quality Improvement Organization (QIO) X

Recovery Audit Contractors (RACs) X

Medicare Administrative Contractors (MACs) X

Federal Trade Commission (FTC) and Department of Justice (DOJ) X

Internal Revenue Service (IRS) Form 990 X

Community Health Needs Assessments (CHNA) X

*State* X

Federal Reimbursement Allowance (FRA) X

Missouri Department of Health and Senior Services X

Missouri Division of Professional Registration X

Missouri State Board of Nursing X

Missouri Board of Pharmacy X

*Accrediting Organizations* X

The Joint Commission (TJC) X

Healthcare Facilities Accreditation Program X

DNV Healthcare X

*Other Regulatory Bodies with Oversight over Health Care Organizations* X

*Reimbursement Basics X*

*Medicare* X

*Medicaid* X

*Insurance Companies* X

*Self-Pay Patients* X

*Health Insurance Exchanges* X

*New Payment Structures from the Affordable Care Act* X

Accountable Care Organizations X

Bundled Payments X

Health Care-acquired Conditions X

Readmission Penalties X

Value-Based Purchasing X

**Leadership Role Overview** X

*CEO/Executive Staff.* X

*Medical Staff* X

*System Affiliations* X

**Association Memberships** X

*Missouri Hospital Association* X

*APS* X

*American Hospital Association* X

*Other Association Affiliations* X

**About [Hospital Name]**

**History**

[Insert information about your hospital’s history here, including when the hospital was founded, by whom, for what purpose, etc.]

**Our Mission, Vision and Values**

Our mission is the fundamental purpose or reason for our existence; it serves as the foundation for strategic thinking and strategic planning. Our vision is a projection of the future that describes how our hospital will look in the future — it imagines our future possibilities, guides our strategic choices, and provides a longer-range focus for our near-term and midterm strategic decision-making. Our values are the principles that guide our decision-making.

The responsibility and authority for determining the hospital’s mission, vision and values lies with the governing board. The board also is responsible for working with senior management to develop the goals, objectives and policies that grow out of, and are measured against, our mission, vision and values. Defining the hospital’s mission, and outlining a compelling vision of our future, with a recommended course of action to fulfill that vision, are among the most important contributions the board makes to our hospital’s success.

 ***Our*** ***Mission…***

[Insert your mission statement here]

 ***Our Vision…***

[Insert your vision statement here]

 ***Our Values…***

[Insert your values or principles here]

**Our Board**

|  |  |
| --- | --- |
| [Insert picture of board member here - the picture should be about two inches wide] | [Insert board member name and board title, followed by brief biographical information]**Appointment/Election Date:** [Insert month, year]**Expiration of Term:** [Insert month, year] |
| [Insert picture of board member here - the picture should be about two inches wide] | [Insert board member name and board title, followed by brief biographical information]**Appointment/Election Date:** [Insert month, year]**Expiration of Term:** [Insert month, year] |
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**Board Committees**

Our board consists of [#] committees. Below is a description of each, including its primary responsibilities.

[Insert the committees of your hospital board, and include the duties or mission statement of each committee. Examples include the Executive, Strategic Planning, Quality, Finance, Nominating or Physician Advisory Committees.]

**Meeting Schedules**

Our board meetings are organized and focused on the important, timely, strategic planning decisions facing the organization. These meetings are designed around a carefully-crafted agenda, allowing board members to prepare for discussions and become informed on the relevant topics.

**Board meetings** are [insert day, time and location of meetings].

**Committee meetings** are [list committee and day, time and location of meetings].

**Board Bylaws**

[Insert a copy of your board’s bylaws].

**Our Service Area**

[Insert your service area map here, or briefly describe your primary and secondary service areas, including a geographical description, list of ZIP codes, demographic information, and market by age, gender, income, ethnic mix, other demographic factors, etc.]

**Physical Facilities**

[Insert information about your facilities here (hospital clinics, urgent care centers, home health, long-term care, etc.), including a description of the location, size, length of time in service, personnel and function of each. Maps are a helpful tool.]

**Hospital Organization Chart**

[Insert chart here, or describe the functional levels in the organization and the reporting relationships of each. Include specific information about senior leaders.]

**Medical Staff Organization Chart**

[Insert chart here, or describe the medical staff structure based on the medical staff bylaws.]

**Hospital Quick Facts:** **[Year - NOTE: Some of this data can be pulled from the MHA annual licensing survey.]**

|  |  |
| --- | --- |
| ***Staffed Beds:*** | [Insert data] |
| ***Admissions:*** | [Insert data] |
| ***Inpatient Days:*** | [Insert data] |
| ***Average Daily Census:*** | [Insert data] |
| ***Average Stay:*** | [Insert data] |
| ***Surgical Operations:*** | [Insert data] |
| ***Births:*** | [Insert data] |
| ***Emergency Department Visits:*** | [Insert data] |
| ***Other Outpatient Visits:*** | [Insert data] |
|  |  |
| ***Active Medical Staff:*** | [Insert data] |
| ***Total Number of Employees:*** | [Insert data] |
|  |  |
| ***Payroll:*** | [Insert data] |
| ***Employee Benefits:*** | [Insert data] |
|  |  |
| ***Patient Service Revenue:*** | [Insert data] |
| ***Other Revenue:*** | [Insert data] |
| ***Total Revenue:*** | [Insert data] |
| ***Operating Expense:*** | [Insert data] |
| ***Excess Revenue:*** | [Insert data] |
| ***Market Share:*** | [Insert data] |
| ***Unsponsored Care (charity care + bad debt):*** | [Insert data] |
|  |  |
| [Insert key quality indicators or quality dashboard here] | [Insert data] |

**Related Entities**

***Hospital Auxiliary*** [Describe the roles and value of the hospital auxiliary, including how it is structured, its leadership and how it is financed.]

***Hospital Foundation*** [Describe the role and value of the hospital foundation, including its structure, legal relationship to the hospital and leadership structure.]

***Other*** [Describe any other important hospital organizations, including the purpose and value of the relationship, how long it has been in effect and the hospital relationship to the organization.]

**Health Care Basics**

**Types of Hospitals**

There are many different “types” of hospitals, owned and governed through different methodologies. However, regardless of the type of ownership, community leaders have an opportunity – in fact, an obligation – to recommend qualified and viable candidates for board positions. This holds true whether the board is selected through local elections, appointed by a government entity or a corporation with headquarters located out of town, or selected through a self-perpetuating process.

Regardless of the type of hospital, board members must work closely with the hospital CEO/administrator and their leadership team who are responsible for the day-to-day operations of the hospital.

[Hospital name] is a [Insert type of hospital].

***General Hospitals (Community, Full-Service Hospitals)***

There are more than 6,100 hospitals in the U.S. (The American Hospital Association). The majority of them are general hospitals set up to deal with the full range of medical conditions for which most people require treatment. There are 140 Missouri Hospital Association member hospitals. Of those, 69 are general acute care/medical surgical facilities and two are “other” acute care hospitals.

***Critical Access Hospitals***

Missouri has 35 Critical Access Hospitals. These are hospitals that are certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance, and thereby maintain access to basic health care in rural areas. CAHs are certified under a modified set of Medicare Conditions of Participation that are more flexible than acute care hospital CoPs.

To be a CAH, hospitals must meet the following specific requirements.

* Being located in a rural area, and meeting one of the following criteria:
	+ located more than 35 miles from another hospital;
	+ located 15 miles from another hospital in mountainous terrain or areas with only secondary roads; or
	+ state-certified as a necessary provider of health care services to residents in the area.
* Having a maximum of 25 acute or swing beds.
* Maintaining an annual average length of stay of 96 hours or less for acute care patients (there is no length of stay limit for swing bed patients).
* Providing 24-hour emergency services, with medical staff on-site, or on-call and available on-site within 30 minutes (60 minutes if certain frontier area criteria are met).
* Developing agreements with an acute care hospital related to patient referral and transfer, communication, and emergency and nonemergency patient transportation. CAHs also may have an agreement with their referral hospital for quality improvement or choose to have that agreement with another organization.

***Behavioral Health Hospitals***

Behavioral health hospitals specialize in the inpatient treatment of patients with a serious mental disorder. In Missouri, there are 15 active behavioral health hospitals, including six state mental health facilities that have an MHA membership.

***Long-Term Acute Care Hospitals***

Six MHA member hospitals are classified as long-term acute care hospitals. LTACs specialize in treating patients with serious medical conditions after they have been discharged from the acute care hospital setting. Patients that qualify for this service still require complex, ongoing medical treatment; however, they no longer need to recover in the intensive care unit or acute care setting.

***Freestanding Children’s Hospitals***

A freestanding children’s hospital provides medical treatment to patients that typically are 18 years and younger in a building that is not connected to an acute care hospital. These hospitals are designed, from care coordination to the physical facility, with children in mind. Three of the Missouri Hospital Association’s members are considered freestanding children’s hospitals.

***Rehabilitation Hospitals***

Rehabilitation hospitals provide medical, health-related, social and/or vocational services to disabled persons to help them attain their maximum functional capacity. There are five MHA member rehabilitation hospitals.

***Teaching Hospitals***

Missouri has 32 teaching hospitals. Large teaching/research hospitals have a variety of goals. In addition to treating patients, they are training sites for physicians and other health professionals. Teaching institutions are affiliated with a medical school, which means patients have access to highly skilled specialists who teach at the school and are familiar with up-to-the-minute technology.

***Government Hospitals***

Government hospitals are controlled by a local, regional or state governmental agency. Missouri has five federal or government hospitals. There are five primary types of government-supported hospitals.

* state hospitals, controlled by an agency of the state government
* county hospitals, controlled by an agency of the county government
* city hospitals, controlled by an agency of municipal government
* hospital district or authority hospitals, controlled by a political subdivision of a state, county or city created solely for the purpose of establishing and maintaining medical care or health-related care institutions

***Not-for-Profit Hospitals***

A not-for-profit hospital is a community facility operating under religious or other voluntary auspices. Ultimate responsibility for all that takes place at the hospital rests with its board of trustees, the members of which are generally selected (based on board competency) from the community’s business and professional community, and typically serve without pay. The trustees appoint a paid CEO/administrator to manage the hospital. Of MHA’s 140 hospital members, 110 are not-for-profit.

***For-Profit Hospitals***

A for-profit hospital is owned by investors or the shareholders of a publicly traded company. For-profit hospitals typically have a board; however, they don’t have the same responsibilities and are held accountable to the shareholders. In Missouri, there are 30 for-profit hospitals that belong to the association.

***Investor-Owned Hospitals***

Investor-owned hospitals are owned by shareholders. They are profit-making institutions. Investor-owned hospitals are owned by corporations or individuals, such as physicians. Hospital corporations may own several institutions located in Missouri or other states.

**Regulatory Basics**

Hospitals and hospital trustees must be aware of various regulatory bodies, and the health care laws and requirements they oversee and enforce. Below are some of the most important regulatory basics.

***Federal***

Health and Human Services

The United States Department of Health and Human Services is a cabinet-level department of the executive branch charged with protecting the health of all Americans and providing essential human services. HHS includes more than 300 programs, including research, disease prevention, food and drug safety, Medicare and Medicaid, prevention of child abuse and domestic violence, services for older Americans, and health services for Native Americans. Due to the large number of programs under the department’s umbrella, HHS has many operating divisions, which are divided into two sections.

 *Public Health Service Operating Divisions*

* National Institutes of Health (NIH)
* Food and Drug Administration (FDA)
* Centers for Disease Control and Prevention (CDC)
* Indian Health Service (HIS)
* Health Resources and Services Administration (HRSA)
* Substance Abuse and Mental Health Services Administration (SAMHSA)
* Agency for Healthcare Research and Quality (AHRQ)

*Human Services Operating Divisions*

* Centers for Medicare & Medicaid Services (CMS)
* Administration for Children and Families (ACF)
* Administration on Aging (AoA)
* U.S. Public Health Service Commissioned Corps (USPHS)

HHS Office of Inspector General

HHS and Congress established the HHS Office of Inspector General in 1976 to promote efficiency, and to identify and eliminate waste, fraud and abuse in the department’s operations. The OIG addresses these issues through nationwide audits, investigations and inspections. Part of reducing fraud includes investigating violations of the Medicare and Medicaid anti-kickback statute, which penalizes anyone who knowingly and willfully solicits, receives, offers or pays anything of value as an inducement in return for referring a patient or recommending, purchasing, leasing or ordering any facility, good or service payable under Medicare or Medicaid. This carries criminal penalties, as well as exclusion from participation in the Medicare and Medicaid programs.

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services is a federal agency within the U.S. Department of Health and Human Services. CMS is responsible for the implementation, oversight and/or regulation of the following.

* Medicare
* Medicaid
* Children’s Health Insurance Program (CHIP)
* All laboratory testing (except research) performed on humans in the U.S., based on the Clinical Laboratory Improvement Amendments of 1988 (CLIA)
* The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

As a part of running the Medicare and Medicaid programs, CMS 1) establishes reimbursement policies; 2) assures the programs are properly run to avoid fraud and abuse; 3) conducts research on the effectiveness of methods for health care management, treatment and financing; and 4) assesses the quality of health care facilities receiving Medicare and Medicaid funds, taking appropriate actions if necessary.

CMS encompasses eight essential areas that support the organization’s functions.

* *Medicare.* The Center for Medicare serves as CMS’ focal point for the formulation, coordination, integration, implementation and evaluation of the national Medicare program policies and operations.
* *Private Insurance,* a cornerstone of the Affordable Care Act.The Center for Consumer Information and Insurance Oversight (CCIIO), oversees the implementation of many provisions of the Affordable Care Act, including provisions related to private health insurance and establishment of the Health Insurance Marketplaces.
* *Medicaid and CHIP Services.* The Center for Medicaid and CHIP Services (CMCS)serves as CMS’ focal point for all national program policies and operations related to Medicaid, the Children’s Health Insurance Program and the Basic Health Program (BHP).
* *Innovation.* The Center for Medicare & Medicaid Innovation, alsoestablished by the Affordable Care Act, supports the development and testing of innovative health care payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care for individuals receiving Medicare, Medicaid or CHIP benefits.
* *Regulations and Guidance* are essential to overall operations of the health care entity and an area in which governance will have a lot of in depth discussion. CMS sets forth the regulatory requirements. Regulations and Guidance includes numerous areas like quality, conditions to participate in Medicare and Medicaid, payment and billing standards, and many more. The Center for Clinical Standards and Qualityprovides leadership and coordination for the development and implementation of a cohesive, CMS-wide approach to measuring and promoting quality, and leads CMS’ priority-setting process for clinical quality improvement. The center coordinates quality-related activities with outside organizations; monitors the quality of Medicare, Medicaid and the Clinical Laboratory and Improvement Amendments; and evaluates the success of interventions.
* *Medicare-Medicaid Coordination.* The Center for Program Integrity (CPI),serves as CMS’ focal point for all national and statewide Medicare and Medicaid programs, and CHIP integrity fraud and abuse issues. It coordinates resources and best practices for overall program improvement in efforts to combat fraud, waste and abuse.
* *Research, Statistics, Data and Systems.* Under the auspice of Research, Statistics, Data and Systems, CMS sets forth for consumers and health care providers the latest guidance on technological requirements and assistance, data availability and protections, and statistical analysis on a variety of topics, which can be used by health care entities to strengthen and benchmark performance.
* *Outreach and Education.* CMS offers providers a variety of topics and training venues. The Medicare Learning Network (MLN) is an excellent source of information. Providers and consumers can sign up to receive notices of new education topics and access a library of current information to keep updated on the most current requirements and trends.

**Medicare Conditions of Participation**

Conditions of Participation are the minimum health and safety standards that health care organizations must meet to be Medicare and Medicaid certified. The requirements are developed by CMS and address a wide range of topics, from medical records and medications to smoke alarms and hand washing procedures. Hospitals must meet or exceed the CMS requirements to participate in Medicare and Medicaid.

Quality Improvement Organization

Since 1984, Medicare Quality Improvement Organizations have been a driving force for quality improvement throughout the country. CMS has transformed the QIO program to more effectively support the National Quality Strategy, and has again looked to the QIO program to work side-by-side with providers and patients in all settings of care. CMS has charged the Quality Innovation Network (QIN) QIOs with implementing strategies facilitating quality improvement throughout the health care system.

[TMF Health Quality Institute](http://www.tmf.org/) has built a strong quality improvement team throughout the region consisting of Texas, Arkansas, Missouri, Oklahoma and Puerto Rico, subcontracting with long-time, successful quality improvement entities, [Arkansas Foundation for Medical Care (AFMC)](http://www.afmc.org/), [Primaris](http://primaris.org/), the Quality Improvement Professional Research Organization, Inc. (QIPRO) and Ponce Medical School Foundation. TMF, along with these subcontractors, serves as the TMF QIN-QIO to partner with providers and stakeholders throughout the region to meet objectives in support of the National Quality Strategy aims.

TMF, along with AFMC, Primaris and QIPRO, provide targeted, technical assistance and engage providers and stakeholders in improvement initiatives through numerous Learning and Action Networks. The networks serve as information hubs to monitor data, engage relevant organizations, facilitate learning and sharing of best practices, reduce disparities, and elevate the voice of the patient.

Recovery Audit Contractors

Recovery Audit Contractors audit Medicare claims submitted by hospitals and other health care providers, working for Medicare to recover overpayments from providers. They are one of many different contractors tasked by CMS to evaluate payment accuracy. RACs differ from other types of audit contractors in that they are paid a commission on each claim they deny, which has created significant burden for many hospitals and health systems across the country as they respond to large numbers of RAC record requests and fight high rates of RAC denials.

Medicare Administrative Contractors

The Medicare Administrative Contractor serves as the first point of contact for the processing and payment of fee-for-service claims from hospitals, nursing facilities, physicians and practitioners. Wisconsin Physicians Service (WPS) Insurance Corporation is the MAC that serves Missouri.

Federal Trade Commission and the Department of Justice

The Federal Trade Commission Act of 1914 created the Federal Trade Commission, an independent administrative agency with the power to study, issue findings and judicially enforce findings regarding “unfair methods of competition” and “unfair or deceptive acts.” The FTC and the U.S. Department of Justice enforce the Sherman Antitrust Act of 1890 and the Clayton Act of 1914 (a supplement to the Sherman Act), which carry both civil and criminal penalties.

Antitrust litigation and enforcement in the health care field was minimal or nonexistent prior to 1975. It has emerged as a major legal issue since then, as the number of health care professionals and alternative delivery systems increased and the health care field became more complex.

**IRS Form 990**

IRS Form 990 is comprised of a Core Form and multiple schedules. Included in the Core Form is a section entitled, “Governance Management and Disclosure,” which is comprised of three sub-parts: A) Governing Body and Management, B) Policies, and C) Disclosures. These sections inquire about the governing structure, board member independence, board management and oversight practices, existence of specific policies, and public disclosure of certain governing documents.

Schedule H of Form 990 is specifically for not-for-profit hospitals and is comprised of five parts: I) Financial Assistance and Certain Other Community Benefits at Cost; II) Community Building Activities; III) Bad Debt, Medicare and Collection Practices; IV) Management Companies and Joint Ventures; and V) Facility Information. Among its many questions, Form 990 asks whether a copy of the form was provided to the governing board prior to being filed with the IRS.

Following evidence of abuse in the for-profit sector and enactment of the Sarbanes-Oxley Act, the IRS and others believe increased transparency and disclosure via Form 990 will result in better, more accountable governance, and better insight and perspective into the tax-exempt sector. The IRS aligns effective governance practices and organizational oversight with a greater likelihood of sound fiscal management and tax compliance.

**Community Health Needs Assessments**

The Patient Protection and Affordable Care Act requires not-for-profit hospitals to conduct a community health needs assessment every three years. The assessment must take into account input from persons representing the broad interests of the community, including those with special knowledge or expertise in public health, and be made widely available to the public. Hospitals are required to submit their community health needs assessment information with their Form 990, including a description of how they are addressing the needs identified in the community health needs assessment, a description of any needs not being addressed, and the reasons why those needs are not being addressed. Hospitals that do not fulfill the requirement may incur a $50,000 excise tax. Hospital leadership should expect the IRS and lawmakers to use this information as they determine the need for future laws and regulations governing community benefit and tax exemption.

***State***

[**Federal Reimbursement Allowance**](https://web.mhanet.com/fra.aspx)

Thirty years ago, Missouri’s health care and government leaders were facing significant budgetary challenges. In response, the Federal Reimbursement Allowance program began in 1991 as a voluntary program; it was expanded and enacted into law as a provider tax in 1992. Hospitals provide funds to the state, and Missouri’s Medicaid program (now called MO HealthNet) uses these funds to earn federal matching dollars.

The FRA program evolved to maximize federal matching dollars and reduce the burden of MO HealthNet on state general revenue. The FRA is a major source of revenue to the state, surpassing all but the two largest sources of general revenue. Today, it is a major funding stream for MO HealthNet. This releases traditional general revenue to be used for other state priorities.Twenty-five years ago, Missouri’s health care and governmental leaders were facing significant budgetary challenges. In response, the FRA program began in 1991 as a voluntary program; it was expanded and enacted into law as a provider tax in 1992. Hospitals provide funds to the state, and Missouri’s Medicaid program (now called MO HealthNet) uses these funds to earn federal matching dollars.

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[**Missouri Department of Health and Senior Services**](https://health.mo.gov/)

The Missouri Department of Health and Senior Services was established in 1883 as the State Board of Health. Later in 1985, Gov. John Ashcroft signed legislation to create the Department of Health. In 2001, Gov. Roger Wilson transferred the Division of Aging to the Department of Health to become the Department of Health and Senior Services. Combining senior and public health issues into one system allowed the department to more effectively focus on prevention and quality of life for all Missourians.

DHSS’ mission is to be the leader in promoting, protecting and partnering for health. Their values include accountability, collaboration, commitment, communication, diversity, excellence, integrity and respect.

The department oversees a variety of operations related to hospitals, surgical centers, nursing homes, home health and many others. The department licenses hospitals in the state, sets forth state-specific regulatory requirements for hospital operations, surveillances and reports conditions like infections and communicable diseases, and constructs and provides guidance on what CMS forms and requirements must be met to change or modify essential operations.

[**Missouri Division of Professional Registration**](https://pr.mo.gov/about.asp)

The Missouri Division of Professional Registration provides administrative support to 41 professional licensing boards and commissions responsible for licensing and regulating the activities of approximately 430,000 Missourians.

The division exists to serve and protect the public from incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty by providing an accessible, responsible and accountable regulatory system that licenses only qualified professionals by examination and evaluation of minimum competency and enforces standards by implementing legislation and administrative rules.

[**Missouri State Board of Nursing**](https://www.pr.mo.gov/nursing.asp)

The Missouri State Board of Nursing’s mission it to protect the public’s health and safety through regulation of nursing education, licensure and practice.

[**Missouri Board of Pharmacy**](https://www.pr.mo.gov/pharmacists.asp)

The Missouri Board of Pharmacy serves and protects the public by providing an accessible, responsible and accountable regulatory system that protects the public from incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty.

***Accrediting Organizations***

A hospital may choose to be accredited by one or more accreditation organizations. Accreditation is voluntary. Accreditation requires application to the AO, as well as an inspection to determine whether the hospital meets the organization’s standards and requirements. These surveys are performed by employees of the AO, not by DHSS surveyors. The hospital pays the AO for the costs of the survey and related services.

AOs are private entities, not government agencies. Some AOs, such as the organizations with deeming authority (TJC, HFAP, DNV Healthcare and HFAP), may survey the entire hospital. Other AOs, with and without deeming authority, may focus on other health care operations (for example, the laboratory, home health agency, hospice, ambulatory surgical center, etc.). Some managed care plans require a hospital to be accredited to be included in their network of participating providers.

A hospital that is accredited for Medicare participation by an AO does not fall under the jurisdiction of the state survey agency for recertification surveys. Instead, the AO is responsible for oversight of their ongoing compliance with the CoP, unless CMS directs the SA to perform a validation survey.

[**The Joint Commission**](http://www.jointcommission.org/)

The Joint Commission is an independent, not-for-profit organization that serves as the nation’s predominant standards-setting and accrediting body for health care organizations. The standards established by TJC are for each component of the health care organization. The emphasis is placed on meeting the standards through performance and continuing to improve performance.

TJC requires each accredited hospital to provide evidence of planning for performance improvement. The purposes of planning are to describe the hospitals leaders’ approach to improving performance and ensure that the efforts are systematic and involve all applicable departments and disciplines.

While trustees do not necessarily have to know each area in detail, they should make sure that the CEO has pertinent review activities taking place on a scheduled basis, that significant results are reported and that needed follow-up is occurring.

[Healthcare Facilities Accreditation Program](https://www.hfap.org/)

The Healthcare Facilities Accreditation Program is a nationally recognized health care facility accreditation organization, with deeming authority from CMS. HFAP meets or exceeds the standards required by CMS to provide accreditation to all hospitals, ambulatory care/surgical facilities, mental health facilities, physical rehabilitation facilities, clinical laboratories and CAHs.

[DNV Healthcare](https://www.dnvglhealthcare.com/)

DNV Healthcare is a wholly owned subsidiary of Det Norske Veritas, a global organization with 8,600 employees operating in more than 100 countries. DNV Healthcare is a provider of hospital accreditation, infection risk management and standards development. CMS approved the DNV program in 2008 to accredit acute care hospitals in the U.S., and since then, also has been granted CMS deeming authority for CAHs. DNV also developed quality-based certifications for medical specialty areas.

*Other Regulatory Bodies with Oversight over Health Care Organizations*

Several other regulatory bodies also have varying levels of oversight of health care organizations.

* Drug Enforcement Administration (DEA)
* Organ Procurement Organizations (OPOs)
* Securities and Exchange Commission (SEC)
* Internal Revenue Service (IRS)
* Environmental Protection Agency (EPA)
* Federal Trade Commission (FTC)
* Federal Commerce Commission (FCC)
* Health Resources and Services Administration (HRSA)
* National Institute for Occupational Safety and Health (NIOSH)
* Nuclear Regulatory Commission (NRC)
* Department of Labor (DOL)
* Federal Bureau of Investigation (FBI)
* Occupational Safety and Health Administration (OSHA)
* Department of Transportation (DOT)
* Food and Drug Administration (FDA)

**Reimbursement Basics**

Hospitals and health systems are reimbursed for services provided through four primary methods.

* Medicare, the federal insurance for individuals over age 65 or with disabilities
* Medicaid, the state insurance program for low-income individuals
* insurance companies
* self-pay patients

***Medicare***

Medicare is a health insurance program for people 65 years of age and older, some people with disabilities under age 65, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Medicare has four parts: Part A, Part B, Part C and Part D. Part A is hospital insurance; most Medicare recipients do not have to pay for this part. It helps pay for care in hospitals as an inpatient, CAHs, skilled nursing facilities, hospice care and some home health care. Part B is medical insurance; most people pay monthly for this part. It helps cover doctors’ services, outpatient hospital care and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part C is the Medicare Managed Care program for HMOs and the Medicare Advantage PPOs. Part D is the Prescription Drug Program for seniors. Hospitals must accept the payment from Medicare and may not bill the patient for the difference other than the patient’s deductible and co-insurance.

***Medicaid***

Medicaid is a state-administered health insurance program available to certain low-income individuals and families who fit an eligibility group that is recognized by federal and state law. Each state has its own guidelines regarding eligibility and services. In Missouri, the Medicaid program is called MO HealthNet. Specific requirements often include age; whether the recipient is pregnant, disabled, blind or aged; and whether he/she is a U.S. citizen or a lawfully admitted immigrant. The rules for counting income and resources vary from state to state and from group to group.

In large part due to state and federal budget limitations and deficits, adequate, stable and predictable financing is one of the most critical issues facing health care organizations today. According to data collected by the American Hospital Association, the majority of hospitals lose money on both Medicare and Medicaid patients. This issue is compounded for hospitals – while they are struggling with Medicare and Medicaid reimbursement, demographic changes are resulting in a significant growth in enrollment in both programs.

***Insurance Companies***

Hospitals have an opportunity to negotiate individually and accept payment directly from individual insurance companies. For certain managed care insurance plans, which require contract agreements, hospitals may be subject to reduced reimbursement if they are not part of the managed care network.

***Self-Pay Patients***

Patients that are not covered by either Medicare or Medicaid, or by an insurance company, are generally classified as “self-pay.” Self-pay patients are subject to the hospital’s usual and customary charges from the services they receive. Oftentimes, these individuals lack sufficient financial means to pay for the services received. The ACA requires not-for-profit hospitals to publicize their financial assistance policy, which must specify eligibility criteria. The ACA also prohibits hospitals from charging patients who are eligible for financial assistance more than they charge patients with insurance. The Act further prohibits not-for-profit hospitals from engaging in “extraordinary collection practices” until making an effort to determine if a patient is eligible for financial assistance.

***Health Insurance Exchanges***

One of the key provisions of the ACA is the establishment of health insurance exchanges. The exchanges are marketplaces where individuals or small businesses can buy health insurance coverage. States have had the choice to develop state-based exchanges, a federally supported state based exchange, a state partnership exchange or a federally facilitated exchange.

Definitions of health insurance exchanges:

* ***State-Based Marketplace.*** States running a State-Based Marketplace are responsible for performing all marketplace functions. Consumers in these states apply for and enroll in coverage through marketplace websites established and maintained by the state.
* ***Federally Supported State-Based Marketplace.*** States with this type of marketplace are considered to have a State-Based Marketplace and are responsible for performing all marketplace functions, except that the state will rely on the federally facilitated marketplace IT platform. Consumers in these states apply for and enroll in coverage through heatlhcare.gov.
* ***State-Partnership Marketplace.*** States entering into a Partnership Marketplace may administer in-person consumer assistance functions, and HHS will perform the remaining marketplace functions. Consumers in states with a Partnership Marketplace apply for and enroll in coverage through healthcare.gov.
* ***Federally Facilitated Marketplace.*** In a federally facilitated marketplace, HHS performs all marketplace functions. Consumers in states with a federally facilitated marketplace apply for and enroll in coverage through healthcare.gov.

***New Payment Structures from the Affordable Care Act***

One of the primary objectives of the ACA’s new payment methodologies is to shift the nation’s health care delivery system from one that is paid based on volume (the services received are paid for as they are provided, commonly referred to as “fee-for-service”) to a payment system based on value (payment for high quality, cost-effective care). Accountable Care Organizations, bundled payments, readmission penalties, and value-based purchasing are among the payment methodologies being implemented under the ACA to encourage the shift toward payment based on value.

 **Accountable Care Organizations**

An ACO is a group of providers and suppliers who agree to be accountable for achieving three aims.

* better care for individuals;
* better health for populations; and
* lower growth in health care spending

If successful in achieving predetermined quality thresholds and benchmark savings, the ACO will be eligible for a share of the cost-savings. ACOs also must be willing to assume risk for potential losses.

 **Bundled Payments**

The Bundled Payments for Care Improvement Initiative was rolled out by CMS under the requirements of the ACA. Designed to improve quality and control costs, a bundled payment is one single payment for multiple services received by a patient from one or more providers during an “episode of care.”

Organized systems of hospitals, physicians and other providers participating in a bundled payment program agree contractually to work together to coordinate the patient’s care. They also agree on how the single payment – and financial risk – will be shared. Designed to align the financial incentives of all providers, the initiative includes four different models of bundled payments. The four models differ by the type of health care providers involved and the services covered in the bundled payment for that model.

**Health Care-Acquired Conditions**

The Deficit Reduction Act of 2005 required payment adjustments to be implemented for certain health care-acquired conditions. For discharges beginning on or after Oct. 1, 2008, CMS stopped paying for certain HACs. To identify applicable conditions, hospitals are required to report “present on admission” (POA) information on diagnoses for discharges. Under the new rule, hospitals do not receive the higher payment for cases when an HAC is acquired during hospitalization (meaning it was not present on admission). Hospitals are paid if the secondary diagnosis is not present. Hospitals’ HAC performance is published on the Hospital Compare website.

CMS also issued the final rules implementing nonpayment to Medicaid programs for hospital-acquired conditions. The implementation essentially extends Medicare HAC provisions to Medicaid programs. The rule is broader than Medicare; however, states may add other conditions for nonpayment as long as implementation doesn’t result in a loss of access to care or services for Medicaid beneficiaries.

**Readmission Penalties**

Beginning in fiscal year 2013, CMS reduced its payments to hospitals with “high rates” of readmissions in an effort to improve quality and reduce costs. Whether a hospital’s payment is cut depends on how well the hospital controls its preventable readmissions. This is defined as a patient’s return to an acute care hospital within 30 days after discharge to a non-acute setting (home, skilled nursing, rehabilitation, etc.). CMS’ methodology takes into account planned readmissions for applicable measures. The reduction, which applies across all discharges, is limited to 3 percent. Readmissions are counted following discharge for six conditions.

* acute myocardial infarction (heart attack);
* heart failure;
* pneumonia;
* chronic obstructive pulmonary disorder (COPD);
* hip and knee arthroplasty; and
* coronary artery bypass graft (CABG)

**Value-Based Purchasing**

Value-Based Purchasing is payment for actual performance versus payment for just reporting hospital performance. With reporting, the Medicare payment is the same whether the hospital’s performance is good or bad. Depending on the program year, , CMS will keep between 1 and 2 percent of hospitals’ payments – and hospitals will have a chance to earn back the withheld depending on earned score of patient safety, clinical outcomes, person and community engagement, and efficiency and cost reduction.

CMS began withholding a percentage of inpatient prospective payment system hospital operating payments in FY 2013 at 1 percent, increasing the amount 0.25 percent annually up to 2 percent in 2017. Hospitals have a chance to earn back some or all of this withhold, either by achieving high-level quality scores on specified measures or, if a hospital’s performance is not at achievement levels yet, by improving its quality performance.

**Leadership Role Overview**

**CEO/Executive Staff**

The [Hospital Name] board/CEO relationship is a trusting partnership in which both trustees and the CEO understand their respective roles and work together as a team to achieve the highest level of organizational success. The relationship is built upon a collective understanding of one another’s needs, clear communication, shared goals and objectives, structured meetings, and a constant sharing of information.

Specific responsibilities of the [Hospital Name] CEO and administrative team include the following.

* Providing input to the long-term strategic plan.
* Establishing and carrying out the details of implementing both short- and long-term plans.
* Making all management decisions, and developing policies and procedures for day-to-day operations.
* Preparing budgets, assumptions and targets to present to the board for approval.
* Preparing requests and information to present to the board for capital purchases and decisions about the hospital’s facility, renovation, leasing and expansion.
* Following board policies regarding supply purchases and repairs.
* Developing a fee schedule and proposing billing, credit and collections policies for the board to approve, and implementing the policies after they are approved.
* Hiring, assigning responsibilities, determining responsibilities, training, evaluating and terminating staff.
* Recommending personnel policies to the board, negotiating labor contracts, and implementing and evaluating employee satisfaction surveys.
* Preparing regular updates about strategic progress for the board.
* Overseeing medical staff affairs and policies.
* Establishing and implementing quality improvement initiatives.
* Establishing a corporate compliance plan.
* Remaining knowledgeable of current issues and developing legislative/political action plans.
* Providing communication and transparency to the community.
* Establishing a plan and priorities to address the community’s health needs.
* Educating the board on issues at the state or national level that could affect the operations of the hospital and/or the delivery of care to the patients you serve.
* [Other may be added here.]

**Medical Staff**

[Insert information about the medical staff: how it is comprised, number of physicians by specialty and how medical staff development (physician needs assessment and recruitment) is undertaken.]

Hospital leadership is a collaborative effort between the medical staff, administration and the board of trustees. The [Hospital Name] medical staff participates meaningfully in hospital governance, serves on committees, and actively contributes to strategic direction and decisions.

**System Affiliations**

[Describe any hospital system or network relationships your hospital has with other organizations.]

**Association Memberships**

[**Missouri Hospital Association**](https://web.mhanet.com/)

Since its creation in 1922, MHA has grown from 50 to 140 member hospitals. As a not-for-profit membership association, MHA represents every acute care hospital in the state, as well as most of the federal and state hospitals and rehabilitation and psychiatric care facilities.

Just as our member hospitals have broadened their scope to embrace the continuum of health care services, MHA also has expanded its services to members' needs and expectations throughout its history. In addition to representation and advocacy on behalf of its members, the association offers continuing education programs on current health care topics and seeks to educate the public and the media, as well as legislative representatives, about health care issues.

MHA manages the HEALTHPAC, a state-registered, non-partisan political action committee that contributes to candidates and elected officials statewide who share the hospitals’ agenda and champion issues of importance to hospitals and their patients. It provides a vehicle through which hospital employees and board members can participate in Missouri’s political process and is an important component of MHA’s advocacy program.

[**APS**](https://www.apskc.org/)

APS (formally Associated Purchasing Services) is a for-profit group purchasing company organized in the state of Missouri. It is owned by the Missouri Hospital Association and the Kansas Hospital Association.

[**American Hospital Association**](https://www.aha.org/front)

The American Hospital Association is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members come together to form AHA.

Through representation and advocacy activities, AHA ensures that members’ perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters. Its advocacy efforts include the legislative and executive branches and include the legislative and regulatory arenas.

The mission of the AHA is, “To advance the health of individuals and communities. The AHA leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement.”

MHA is independent of AHA, but works closely with AHA on federal advocacy and resources.

**Other Association Affiliations**

[List other associations your hospital is affiliated with, and the purpose of each.]