

Transformational Governance

*Best Practices for Public and Nonprofit
Hospitals and Health Systems*



Special Report

About the Author

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About the AHA Center for Healthcare Governance

Backed by the knowledge and resources of the American Hospital Association, the Center for Healthcare Governance provides state-of-the-art education, research, publications, tools, and other resources to help members achieve excellence in governance. Our community is dynamic and diverse, representing board members, executives and governance advisors who are nationally recognized as the foremost voices in the practice of hospital and health system governance. We share a common goal—to advocate and support excellence, innovation and accountability in health care governance.

About the National Association of Public Hospitals and Health Systems (NAPH)

NAPH represents the nation's safety net hospitals and health systems, which provide high volumes of care to low-income individuals. These facilities offer high-quality health services for all patients, including the uninsured and underinsured, regardless of ability to pay. In addition to helping ensure access to health care for all Americans, safety net hospitals provide many essential communitywide services, such as primary care, trauma care, and neonatal intensive care. Safety net hospitals also train many of America's doctors, nurses, and other health care providers. Since its inception in 1980, NAPH has cultivated a strong presence on Capitol Hill, with the executive branch, and in many state capitols. NAPH advocates on behalf of its members on such issues as Medicaid, Medicare, and access to health care services for vulnerable populations. For more information, visit our website at <http://www.naph.org/>.

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By Larry S. Gage



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Foreword

Transformational change is a goal of every hospital and health system today as it adapts to new models of health care delivery and payment. Reaching this goal is especially critical for safety net hospitals, which care for our nation's most vulnerable people.

In *Transformational Governance*, Larry Gage provides an in-depth analysis of how effective governance and legal structures can help safety net hospitals and health systems enhance their operations to control costs and improve quality and safety. Gage brings insights gained over more than three decades of service to safety net hospitals in his examination of their current and emerging structures and discusses more than 30 examples of restructured organizations. He also shares the thoughts of board members and leaders about the complex challenges these organizations face and the critical issues they must address in order to continue to meet the needs of the communities they serve.

Gage reviews the changing landscape of health care delivery and payment, with special attention to the

additional pressures and concerns confronting the safety net. He highlights the role board members play in transforming their governance to effectively guide a changing health care system. He also outlines governance issues and practices boards must attend to, including their composition, size, education and leadership, to achieve the performance, accountability and transparency that safety net stakeholders require and deserve.

Transformational Governance is required reading for all safety net trustees and leaders committed to providing effective stewardship of an essential community trust. The American Hospital Association and its Center for Healthcare Governance are pleased to join the National Association of Public Hospitals and Health Systems in bringing this valuable resource to the field.

Richard J. Umbdenstock
President and CEO
American Hospital Association
Washington, DC

Foreword

In *Transformational Governance*, Larry Gage has captured the crucial role of governance in safety net hospitals and health systems and offered many valuable lessons for those seeking to understand and implement sound governance practices. As Gage notes, the challenges of governance in a safety net hospital are even greater than those faced in a typical hospital. For many of these hospitals, trustees must answer not only to the culturally diverse communities they serve, but also to elected officials, state university boards, and other stakeholders who are invested in funding and organizational decisions. External pressures continue to grow for the safety net, which has limited resources with which to implement the major infrastructure, process, and staffing changes required by health reform.

Gage writes of the need for transformational change in safety net governance, and nothing less is required of these hospitals as a whole. At NAPH, we have undertaken a new strategic direction that adds quality

improvement work to an amplified advocacy and policy agenda to help our members achieve this change. In response, NAPH member hospital boards have heeded the call to increase performance accountability and transparency, all the while ensuring that operational changes taking place at the front line are sustained in the long term.

Transformational Governance will be a significant tool for these leaders as they propel their organizations forward. In a thorough and well-organized monograph, Gage has offered more than 30 years of detailed research and insight into the safety net. With this guide, safety net trustees are well-equipped to face and surmount the challenges ahead.

Bruce Siegel, M.D.
President, National Association of Public Hospitals
and Health Systems
Washington, DC

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Preface

Effective governance and a sound legal structure that encourages innovation and reform are essential elements of survival and success for safety net hospitals and health systems. Throughout the hospital field, there is heightened attention to the importance of governance. All hospitals face challenges today, but safety net hospitals and health systems face a number of added pressures.

It is more vital than ever for such providers to have effective governing boards and a legal structure that minimizes unnecessary bureaucracy, provides adequate operating autonomy and improves the ability to control costs, increase quality and patient safety and obtain access to capital.

Many changes that have occurred in the health field in the years since the last version of this special report was published in 2006. Those changes have included the enactment of the most comprehensive and historic health reform legislation since Medicare and Medicaid. But they have also included a range of other trends and challenges, such as the introduction of publicly reported quality measures by which all hospitals are evaluated (and will soon be paid). We have also observed the rapid growth of vertically and horizontally integrated delivery systems capable of caring for patients through the entire continuum of an illness (or indeed, throughout their lives).

Recent trends also include the increased attention in both the public and private sectors to the “triple aim”—improving efficiency, expanding access and increasing quality and patient safety; new forms of reimbursement, such as value-based purchasing and global payments; and the movement toward robust and interconnected information systems. Safety net hospitals and health systems also face the many specific mandates

and challenges set out in the Patient Protection and Affordable Care Act of 2010, as well as the ongoing pressures of federal and state deficit reduction initiatives and the expanded roles of powerful new players in the hospital sector, including private equity firms, insurers and managed care organizations.

The result is not merely a need for improved governance—as this preface is being written, nothing less than transformational governance will suffice. It is the purpose of this special report to highlight the best current practices in transformational governance, as well as to identify examples of transformational governance for safety net hospitals and health systems

I am pleased and honored that the Center for Healthcare Governance of the American Hospital Association (AHA) has agreed to publish this special report, with the co-sponsorship of the National Association of Public Hospitals and Health Systems (NAPH). Nevertheless, the research and recommendations set out in this publication reflect solely the views of the author. They are based on my 30 years of experience as president of NAPH, as well as my direct participation in more than two dozen safety net hospital governance reforms or reorganizations. At the same time, I could not have conducted the necessary research for this updated monograph without the support and encouragement of the current leadership of AHA and NAPH, as well as the advice and assistance of many valued colleagues, as you will see in the Acknowledgments. My sincere hope is that the information in this special report is helpful to the trustees, administration and clinical leadership of the safety net hospitals and health systems I have come to treasure in my long and satisfying career representing these organizations, which continue to be the heart and soul of our nation’s health system.

I. Introduction

Safety net hospitals and health systems play a crucial role in America's health field. Although their legal structures and approach to governance vary widely, they all provide a significant level of care to low-income, uninsured patients and other vulnerable populations. They share a commitment to provide health care for people who, due to financial or insurance status or health condition, would otherwise have limited or no access to necessary hospital care.

Some observers believe that the need for safety net providers will disappear with the implementation of expanded coverage under health reform, now that the Supreme Court has upheld the Patient Protection and Affordable Care Act of 2010 (ACA). But this is no more true today than it was following the enactment of Medicare and Medicaid nearly half a century ago. The role of safety net hospitals is unlikely to diminish any time soon.

The American Hospital Association (AHA), whose Center for Healthcare Governance is graciously publishing this monograph with the co-sponsorship of the National Association of Public Hospitals and Health Systems (NAPH), understood this dynamic as long ago as the mid-1970s. Less than a decade after the implementation of Medicare and Medicaid, the AHA's Hospital Research and Educational Trust (with a grant from the Kellogg Foundation) convened a Commission on Public-General Hospitals. That Commission's 1978 report highlighted the continued need for—and financial and programmatic fragility of—hospitals that have come to serve as the core of the nation's health safety net.

Some of the public hospitals surveyed in the AHA's 1978 report no longer exist today, or do not exist in the same form. Yet many of those essential hospitals are still

present, and remain vital to our health system, in many cases because of the changes that have occurred in the last 30+ years in their organization, structure and governance.

Throughout this report, the term “safety net hospitals” is used to refer to a range of hospitals and health systems, which may include health care providers owned and operated by cities, counties, states, universities, non-profit organizations or other entities.

While safety net hospitals are often thought of as “public” hospitals, in fact a significant and growing

“The future of the public-general hospitals depends on their ability to become broad-based community resources, providing essential services that contribute to a continuum of care within rationally planned and organized community health care delivery systems.”

“Increasingly in the future, as health services come to be organized according to regional criteria, acute care hospitals and other health care providers will be expected to meet communitywide health needs. As regional health care delivery systems evolve, it will be less material whether a hospital is publicly or privately owned when determining its role or clientele. So long as the public-general hospital is able to play an appropriate role based on broad-based community need, it will be a viable health care delivery resource in the future.”

“The Future of the Public-General Hospital: An Agenda for Transition,” Report of the Commission on Public-General Hospitals, Hospital Research and Educational Trust (1978).

number are structured as nonprofit corporations or public/private hybrids. As the case studies in Chapter V suggest, a number of these organizations have been restructured from governmental entities to non-profit (or occasionally even for-profit) corporate structures. Some nonprofit hospitals and health systems that were not previously structured as governmental entities are nevertheless considered safety net providers by virtue of their geographic location, payer mix, range of services or declared mission. The primary focus of this special report is on safety net hospitals that are now (or once were) governmental entities. However, every effort has been made by the author to provide information and analysis that also will be helpful to other kinds of providers.

This publication highlights the importance of transformational governance in safety net hospitals and health systems. It demonstrates the many ways in which a safety net hospital's legal structure and governing board can assist—or impede—the ability to carry out the multiple missions of these essential providers. Reform of legal structure and governance by itself will not guarantee viability, especially at a time when the number of uninsured and underinsured patients still remains high and sources of funding are often inadequate. The implementation of health reform promises to reduce the number of uninsured eventually, but Medicaid expansions are now optional with the states, while the anticipated funding reductions remain in place. Careful attention to the adequacy of structure and governance can be an important tool to assist safety net hospitals in meeting the challenges they will continue to face in the future.

It is not the purpose of this special report to rewrite the traditional rules of effective governance or to supplant common wisdom about the responsibilities of hospital

trustees. Rather, I have sought to build upon those rules and that wisdom to help trustees identify areas where key elements of traditional governance may benefit from additional observations in the current environment.

My perspectives are based on more than 30 years spent representing public and nonprofit safety net hospitals nationally as president of NAPH, as well as my work with dozens of individual hospital and health system boards across the country.¹ My choice of the word “transformational” is intended to convey the urgent need to respond to the demands of the future, but my use of the term is by no means original. In writing a history of U.S. nonprofit governing boards, Peter Dobkin Hall maintained in 2003 that trustees “exercise unique dual roles as managers of the internal cultures and the external environments of the entities they serve and, as such, are strategically situated to have a broadly powerful transformative influence on the world of which they are a part.”²

The importance of—and demands on—trustees of public and nonprofit hospitals and health systems have escalated significantly in recent years. In researching and preparing this publication, I was fortunate to have the opportunity to interview a number of current and past board chairs of public and nonprofit hospitals around the country. Their message unanimously underscores the urgent need to transform hospitals into fully integrated, patient-sensitive delivery systems. And they universally believe that hard work is still needed by their boards.

The concept of transformational governance is also consistent with many of the current activities of both NAPH and AHA. During my last year as president of NAPH, as part of developing the association's current strategic plan, the concept of a NAPH Transformation

¹ The views and positions expressed herein are solely those of this author and they do not necessarily represent the official policies or positions of NAPH or the American Hospital Association (AHA) or of any AHA affiliate. The information and resources are NOT intended to serve as advice regarding any specific individual situation or circumstance and must not be relied upon as such, nor may such information or resources substitute for responsible legal advice. All legal issues should be addressed with the individual organization's own legal counsel.

² Peter Dobkin Hall, *A History of Nonprofit Boards in the United States* (BoardSource E-Book Series, 2003).

Center was developed by the association's board and senior management. This concept has been implemented by Dr. Bruce Siegel, my successor as president, and the association's outstanding current governing board and staff. The goal of the Center is to position NAPH members and other safety net hospitals to take bold steps to respond to the demand for improvement in quality, access and efficiency that are at the core of health system reform. Supported by funding from the new Center for Medicare and Medicaid Innovation (CMMI), the goal is to assist safety net hospitals to better understand the needs of the many millions of patients who will be newly covered over the next several years.

NAPH's new center hopes to serve as a resource for those hospitals that are intent on serving as laboratories and innovators in helping communities to improve quality and reform the way care is delivered. Such innovations will be needed by current patient populations (insured and uninsured alike) and by the millions who will be newly covered starting in 2014 under the ACA.

NAPH is by no means alone in addressing the transformational imperatives of health reform. AHA has also received substantial CMMI funding to assist in transforming the nation's hospitals and health systems, and NAPH is also pleased to participate in other important AHA initiatives.

Most recently, NAPH has collaborated with AHA and several other organizations to form the Equity of Care Initiative. This is a collaborative effort promoting diversity in leadership, as "greater diversity in hospital leadership positions will ensure that hospitals and health systems reflect diversity in the communities they serve and provide valuable perspective for improvement."³

Their recent publication advances this important goal by collecting data from nine hospitals and health systems and discussing the key elements of success in those systems.

In sum, governance is an essential element of survival and success for both nonprofit and public hospitals today. It is more vital than ever to have effective governing boards that can address the traditional demands of trusteeship, while meeting the new legislative and regulatory challenges, increased competition and a rapidly changing health care environment. It is the purpose of this report to serve as a companion resource for trustees and management of those hospitals that will participate in NAPH's Transformation Center and for any others for which these observations may be relevant.

Chapter II of this monograph describes the different legal structures of safety net hospitals and health systems, discussing the benefits and drawbacks of each structure.

Chapter III examines the important role of board members and discusses a number of important issues surrounding their appointment, training and responsibilities.

In order to move towards truly transformational governance, safety net hospitals and health systems often contemplate reforming their governance or legal structure as a means of improving viability and competitiveness. Chapter IV addresses the issues attendant upon such reorganizations. This chapter discusses how the costs of restructuring—both tangible and intangible—must be carefully and objectively weighed against the expected benefits.

³ American Hospital Association, Association of American Medical Colleges, American College of Healthcare Executives, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems. *National Call to Action to Eliminate Health Disparities. Eliminating HealthCare Disparities: Implementing the National Call to Action Using Lessons Learned*. Chicago: Authors, February 2012, available at <http://www.hpoe.org/hpoe/resources/eoc-eliminating-health-disparities.pdf>.

Chapter V provides summary descriptions of a range of successful safety net hospital reorganizations.

Chapter VI describes in more detail some of the dramatic changes in the nation's health care environment that must be addressed by the trustees of safety net hospitals, including the pending implementation of health reform and a range of policy and competitive trends and issues that are driving the need for reform.

Chapter VII addresses the increased emphasis on accountability in many areas that are essential to effective governance and management of safety net hospitals.

Finally, Chapter VIII provides a brief conclusion underscoring the need for transformational governance.

II. The Legal Structure of Safety Net Hospitals & Health Systems

Safety net hospitals and health systems in America today are organized under a range of different legal and corporate structures, each offering unique benefits and drawbacks. The common features, shared to a greater or lesser extent among our nation's safety net hospitals, include a clear mission to provide access to vulnerable populations regardless of ability to pay; the provision of substantial levels of care to low-income, uninsured, Medicaid and other vulnerable patients; and historic status as a community-wide provider of essential health services.

An organization's description as "public" or "governmental" often depends on the purpose of the characterization. For example, any given hospital's designation as governmental might vary in determining the applicability of open record or meeting requirements, civil service regulations, procurement policies, status under federal and state Medicaid laws and regulations, etc.

This chapter describes the primary models of safety net hospital governance. The range of legal and corporate structures employed by public hospitals can be divided into four main models.

Direct Operation. These hospitals are owned and operated by local city or county governments or by state governments or universities. (The federal government also owns and operates hospitals in America, including the nation's military and veterans hospitals; however, federal hospitals are not a subject of this monograph.) In certain instances, the hospitals owned by a state or local government may be given an advisory board, but such boards do not necessarily exercise the full management and oversight functions of an independent corporate board. An advantage of this

model is the ability to maintain close integration with public health functions as well as with local government policies. However, it permits little flexibility and often imposes civil service requirements, procurement rules, sunshine laws, and other constraints that allow the public hospital little autonomy and may curtail its ability to plan strategically and act proactively in competitive situations.

Separate Government Entity. Hospitals that fall into this category are governed by a separate board of directors or trustees. In some cases, that board is created within a city, county or other government entity. In others, it enjoys more autonomy as a hospital authority, public benefit corporation or independent taxing district. Such hospitals or health systems have a functionally dedicated board with full governance authority, typically housed in a separate government entity such as a public benefit corporation, hospital taxing district, or hospital authority, or in a format designed through new state legislation, when the existing legislative options did not adequately address the needs of the hospital system. Compared to the first category, a separate public entity has the advantages of greater autonomy and a dedicated board. Compared to a nonprofit corporation, a separate public entity has less independence, however, and is often subject to the same bureaucratic rules and regulations as a city or county. On the other hand, a separate governmental entity often has more public accountability and potential access to public funding, including direct state or local subsidies as well as the ability to participate as a governmental provider in the Medicaid program.

Nonprofit Corporation. Many urban safety net hospitals no longer fit one of the traditional models outlined above. Rather, they have been organized as nonprofit

corporations. The corporation is typically created under a state's nonprofit corporation laws and is exempt from federal taxation under section 501(c)(3) of the Internal Revenue Code. Such entities may enter into agreements with a local government to provide safety net health services. The local government may or may not retain some degree of control over board appointments or other aspects of the corporation. Transfer of the health system assets may be achieved through a sale, a long-term lease or management agreement, or by other means. The activities and characteristics of each corporation, and any characterization under state or local law, should determine whether or not it is deemed to be a unit of government for various purposes. This category typically includes tax-exempt hospitals that may contract with a local government to provide safety net health services. Some maintain government participation in their governance while others are run by third-party, existing health systems. Organizations in this category may or may not be deemed government entities, depending on the circumstances and the purpose of the designation.

Contract Management. The fourth major structure for safety net hospitals is contract management by (or affiliation with) a third party. In this model, the hospital is still owned by a governmental entity or other organization, but most or all management (including decisions about budget, finance, operations, personnel and procurement) are delegated to another party. While many public hospitals around the country—particularly in rural or suburban areas—are managed by for-profit companies like HCA or Community Health Systems, the focus in this monograph is on those safety net hospitals that are managed by nonprofit corporations or other governmental entities, such as state universities.

These classifications are somewhat arbitrary, since any given hospital or system may have numerous elements that may overlap with one another. In addition, as described in Chapters IV and V, some safety net hospitals and health systems have chosen to design their

own structures through new state legislation when existing models did not adequately address their needs. Third-party management and mergers or joint venture arrangements also represent variations. The remainder of this chapter provides a summary of each model.

Direct Operation—No Advisory Board

The hospitals or health systems that use this model are directly administered by local government and consequently have no separate legal existence apart from the unit of government that owns them. In certain instances, the health department of the local government is given an advisory board, but the advisory board does not exercise the full management and oversight functions of an independent corporate board. An advantage of this model is the ability to retain close integration with public health functions as well as with local government policies. However, this model permits only the minimum level of autonomy and denies health systems the benefit of a functionally dedicated governing board.

In recent years, there also has been a developing trend to convert governmental hospitals to for-profit companies, primarily through their purchase or long-term lease by such companies. While the legal structure and governance of for-profit corporations and other investor-owned entities is beyond the scope of this monograph, this trend will be discussed briefly in Chapter V below.

Once far more common than today among larger urban public hospital systems, direct operation by a city, county or state is found today only in several major county systems in California and in a very few isolated examples in other states. In addition, a number of teaching hospitals continue to be directly operated by state universities.

An example of a hospital system directly operated by a unit of county government is the Los Angeles County

Department of Health Services (DHS), which operates the county's system of four hospitals, two multi-service ambulatory care centers, six comprehensive health centers, and eleven health centers. Los Angeles County is also financially supporting the opening of Martin Luther King, Jr. Medical Center in 2014 (see Chapter V). The system's governing board is the County Board of Supervisors, a body of five elected officials responsible for governance of the entire County of Los Angeles. The DHS Director reports to the Board of Supervisors and to the County's appointed Chief Executive Officer. Los Angeles County has a separate Department of Mental Health and recently separated public health into a separate department; however DHS is the largest of the three county health departments. One concern about this model is that the attention of elected board members is often spread across all of the interests and activities of government—in this case, a county with a population of over 10 million—and not limited to governance of the hospitals or health system. In addition, elected officials are often beholden to political constituencies whose interests may not always coincide with those of safety net providers, and the political dynamics of elected boards are not always conducive to effective collaboration.

As is discussed in more detail in Chapters IV and V below, many city or county hospitals that once functioned as an agency of local government, with no separate governing board, have now restructured or reformed their governance to rely on an independent or semi-autonomous appointed board.

Direct Operation—State University

Like county health systems, some state or university health systems have no legal existence separate from the state or the state university of which they are part. Most such hospitals are subject to civil service, procurement, and other constraints tailored to a large state government or a university, rather than to a health care system. However, the close relationship facilitates unified planning and allocation of resources, and in the case of university hospitals, it helps integrate the teaching and

research missions with the patient care missions. This advantage may account for the large number of state university hospitals that continue under direct operation of the university.

The University of California provides one example of a system in which the only governing board for the five university medical centers, spread across the state, is the university's Board of Regents. There is clear evidence in recent years of the tremendous pressures on the California regents, in the face of the recession and reduced state spending on education at every level. Rarely can the regents even meet without drawing a crowd of demonstrators, and their agenda is crowded with issues that are unrelated to health care or hospitals. Most recently, one of the five university medical centers—the University of California at San Francisco—has even asked the regents (in a public session) to consider permitting UCSF to spin off into its own more autonomous legal structure within the University system.

Louisiana State University (LSU) is a state university that directly operates a formerly separate state health care system. In 1997, the state legislature transferred the state-owned Charity Hospital System to LSU following a prior effort to restructure that system as a quasi-independent authority. Pursuant to the legislation, the Board of Supervisors of LSU assumed control of the nine hospitals. The legislation effecting the transfer requires the board to operate the hospitals “primarily for the medical care of the uninsured and medically indigent residents of the state and others in need of medical care and as teaching institutions.”

The statute created a new Health Care Services Division in the LSU Health Sciences Center to oversee the day-to-day operations of the hospitals. This division is under the immediate direction and control of the LSU Health Sciences Center, subject to overall direction, supervision, and management by the LSU board. The division is budgeted as a single appropriation schedule, separate from the appropriation schedules or budgets of

other university institutions or schools under the board's management. The division is subject to the procurement laws and the budget and planning systems of the state.

The board appoints a Community Advisory Committee for each area served by a hospital in the division. The committees assist the board in assessing unmet health needs within their communities, reviewing hospital performance, reviewing changes to available health care services, reviewing proposed agreements with other health care providers, safeguarding the patient care mission of the hospital, and assisting with community outreach and education. Committee meetings are subject to state open meetings laws and regulations.

Separate Board Within Government Entity

Under this model, a hospital or public health board has authority to manage the daily operations of the hospital or health system. While these separate boards or divisions typically do not constitute a legally independent entity, this structure entails a higher degree of autonomy than direct operation by state or local government without an intervening dedicated board. However, this structure is sometimes deemed inadequate to the tasks facing a public health system today.

The San Francisco Health Commission in California exemplifies a separate board within local government. The San Francisco Health Commission governs the San Francisco Department of Public Health (DPH). DPH is organized in two divisions: the Community Health Network and Population Health and Prevention. The Community Health Network operates all of the DPH personal health care services, with two hospitals and more than 15 primary care centers. The San Francisco Health Commission is a seven-member board appointed by the mayor for four-year terms. Because they may be removed by the mayor only for

misconduct, members of the commission have a layer of insulation from political pressures. The commission meets twice monthly, setting public health policy and approving DPH budgets. These budgets are subject to the mayor's final approval before they are submitted to the Board of Supervisors.⁴

Dr. Edward Chow, a long-time San Francisco Health Commissioner (and former chair) believes that the commission has been effective in providing a buffer between politicians and the city/county health system, although he agrees that budgeting can be difficult, with multiple parties and avenues of control. At the same time, Commissioner Chow agrees that having a separate governing body gives them an opportunity to focus on the system as a whole, and not just its largest components (like the hospital). He says "A separate commission structure also allows us to focus on the long term issues and strategies, including system development and projecting revenues and shortfalls."

Dr. Chow is convinced that having a separate board within government also provides an opportunity for advocacy on behalf of the system, since "we have strong community representation—and with staggered fixed terms, we have a stability on the commission with gradual turnover."

(Several other safety net health systems that have adopted this structure in recent years are profiled in Chapter V below.)

Separate Governmental Entity—Hospital Authority

While the precise definition of the term may vary from state to state, a hospital authority is typically a distinct government entity, operating with a greater degree of independence from local government. It is governed by a functionally dedicated board, whose development or ongoing appointments often involve local government.

⁴ San Francisco County and City Charter, § 4.110; www.sfdph.org.

A hospital authority may be organized under generic, statewide hospital authority statutes or may require the enactment of special legislation.

During the hospital building boom that followed World War II, hospital authorities were used throughout the country to ease local bond financing of new hospitals. At one point, approximately two-thirds of all of the hospitals in the state of Georgia were structured as county authorities, although many have since restructured as nonprofit corporations (see discussion of the Grady Health System in Chapter V below).

The primary benefit of an authority structure, as opposed to a board that is simply appointed by city or county government, is that it derives many powers from the legislation that authorized its creation—for the most part, authorities cannot simply be disbanded or have their power eroded by elected officials. While city or county governments may appoint their boards, for example, many authorities have limitations on the ability to remove board members without cause. Their enabling legislation often gives the authority's board considerable power to develop personnel systems, issue bonds, manage their own procurement and budget both revenues and expenditures without government approval.

At the same time, there are authorities in various parts of the country that lack some of these powers. Few states have generic “hospital authority” legislation governing all authorities in the state, and for this reason the authority structure is very much a “designer option” that can differ sharply from state to state (and even within states, from hospital to hospital).

(Several recently created hospital authorities, including the Denver Health system and Alameda County Medical Center, are profiled as examples of restructured public hospital systems in Chapter V below.)

Separate Governmental Entity— Public Benefit Corporation

This model is also a function of state law, and its features also vary by state and by statute. For the purposes of this report, its more common use as a distinctive public corporate entity providing a benefit to state residents will be assumed.⁵ It is distinct from a typical nonprofit corporation in that it remains a government entity regardless of its corporate form. While several states have a body of law generally applicable to public benefit corporations (PBCs), this is most often a “designer option,” with unique enabling legislation drafted to address the needs of the particular health system. In many instances, a PBC is specifically exempted from certain laws that govern other instrumentalities of the state, but are inappropriate for a hospital system. New York City and the State of Hawaii, among others, have used a PBC structure to operate their government health and hospital systems.

The New York City Health and Hospitals Corporation (HHC) was originally created by enabling statute in 1969 as a PBC. HHC was explicitly granted the power to borrow money and to issue negotiable notes and bonds, invest reserves, construct health care facilities, establish and maintain a capital reserve fund, and execute contracts, leases, and any agreement necessary to fulfill its purposes. Its stated purpose was to allow legal, financial, and managerial flexibility and to remove constraints and restrictions on personnel and procurement procedures to allow HHC to make technological advances, physical plant improvements, and facilities expansions. HHC informs the public of its programs and plans in an annual public meeting. Annual reports are filed with the mayor and city council at the end of each fiscal year.

This model does carry with it the potential for political interference, but HHC's current board chairman, Dr. Michael Stocker, believes that the combination of

⁵ In contrast to the usage in this paper, California corporate law uses the term “public benefit corporation” to refer to a private, non-membership, nonprofit corporation. Cal. Corp. Code §§ 5110–6190 (2005).

an effective board and strong management, with elected officials who are determined to let them succeed, has generated excellent results:

“I’m not sure how much of our success is random and how much is related to the qualities of our mayor and some wise structuring. Mayor Bloomberg has been in office for 10 years—yet he is not political. He promotes quality—he doesn’t promote people because politicians recommend them. He really doesn’t listen to politicians. There is no patronage now at HHC. We have an excellent president and staff and much stability.”

An alternative form of public benefit corporation has its own directly elected board of directors. Lee Memorial Health System is an example of a non-taxing unit of State government established by statute in Florida in 1963. Lee Memorial owns and operates six hospitals (four acute care, a children’s hospital and a rehabilitation hospital under three different licenses) of varying sizes, as well as outpatient health centers and physician offices staffed by an affiliated multi-specialty physician group. Lee Memorial is autonomous from county government and is governed by an elected board. Although Lee Memorial serves as Lee County’s safety net system, the county provides no financial support. A recent effort to have the county levy a half-cent sales tax on Lee Memorial’s behalf was rejected by the voters. Lee Memorial is authorized to issue revenue and general obligation bonds, although the latter must be approved by the county’s voters.

(Other PBCs, including the Hawaii Health Systems Corporation and the Hennepin County Medical Center, are profiled as examples of restructured public hospital systems in Chapter V below.)

Separate Governmental Entity— Taxing District

A hospital taxing district is an independent instrumentality of state government that has taxing authority and defined geographic boundaries. It is distinct from a hospital authority or PBC in that it has

the ability to levy taxes, subject to specified statutory limitations. Most hospital taxing districts have been organized under generic, statewide legislation. They are common in Texas, California, and Florida, among other states.

In Texas, hospital taxing districts are typically created under state law by county governments. For example, the Parkland Health & Hospital System is operated by the Dallas County Hospital District. Fifty-one percent of the hospital’s income is provided by local taxes from the hospital district. Payments to the hospital are made every three to four months, based on an *ad valorem* tax. In return, Parkland must provide all necessary care to uninsured county residents. The tax base is re-established each year.

The district is governed by a Board of Managers, which is comprised of seven members appointed by the Dallas County Commissioner’s Court, with the hospital administrator as an ex-officio member. The board members have sovereignty under the Texas constitution, resulting in greater autonomy from county government than some of the models described above. The County Commissioner’s Court reviews the hospital’s annual operating and capital budgets and appropriates funding through revenue generated by the *ad valorem* tax.

As a hospital district, Parkland has independent management, procurement, and contracting authority; the ability to issue revenue bonds; and the authority to make necessary expenditures, including facility construction and repairs. As a political subdivision of the state, Parkland enjoys sovereign immunity and may exercise eminent domain. The hospital is subject to state requirements for open meetings and open records and is prohibited from joint ventures with private, for-profit entities.

In Florida, hospital or health care taxing districts are structured somewhat differently, with board members generally appointed by the governor. For example, the South Broward Hospital District, doing business as Memorial Healthcare System, is an independent special

taxing district that operates five acute care hospitals, a children's hospital, nursing home, and primary care centers. The district was established by State law in 1947. The district is authorized to levy a property tax on residents of the district of up to 2.5 mill (i.e., \$2.50 per \$1,000 of taxable property value). Because the district has been financially successful, however, it does not levy taxes up to the statutory cap; tax revenue currently constitutes only 1.1 percent of total net revenue. Independent from Broward County, the district generally is accountable only to the State. Note that the South Broward Hospital District is not the only hospital district in Broward County—there is also the North Broward Hospital District with a similar structure, governance and mission.

In California, yet another model of taxing district exists. There are over 140 health care and/or hospital districts across the state, with directly elected Boards of Trustees. These districts typically raise only a limited amount of funding from directly levying taxes—primarily to support the interest and principal payments on bonds sold to build or renovate the hospitals or other facilities in question. Nor do California health districts typically serve as safety net providers, especially in metropolitan areas where county or university hospitals and health systems also exist. However, a number of California health districts have experienced financial difficulties in recent years due to their deteriorating payer mix, urban location and the general state of third party reimbursement in California. In some cases, troubled districts have entered into sale, lease or joint venture agreements with governmental and private providers to operate their hospitals.

(The Maricopa Integrated Healthcare System, a recently created Arizona taxing district, is profiled as an example of a restructured public hospital system in Chapter V below.)

Nonprofit Corporation

Many urban safety net hospitals no longer fit the traditional model. Rather, they have been converted to

the nonprofit corporate form. The corporation is typically tax-exempt under section 501(c)(3) of the Internal Revenue Code and often enters into agreement with the local government to provide safety net health services. The local government may or may not retain some degree of control over board appointments or other aspects of the corporation. Also, transfer of the health system assets may be achieved through a sale, a long-term lease or management agreement, or by other means. The activities and characteristics of each corporation, and any characterization under state or local law, should determine whether or not it is deemed to be a unit of government for various purposes.

The ongoing government role often depends on whether the hospital is transferred to an existing, wholly private health system or whether a new corporation is created for the purpose of operating the government health system. Depending on the type and extent of government involvement, the new corporation may be deemed private for certain purposes and public for others.

A nonprofit corporation, the Truman Medical Centers (TMC), operates the two former government hospitals in Kansas City, Missouri. TMC was one of the first public hospitals to convert to nonprofit corporate status, restructuring in 1961 after the failure of legislation to create a separate hospital district with taxing authority. The initial goals of the reorganization included desegregating the facilities, maintaining the public mission, creating a medical school, streamlining purchasing procedures and improving the personnel system, as well as attending to pressing capital needs. In large part, the nonprofit model was chosen so that TMC could obtain capital financing using a federal mortgage insurance program, under the restrictive regulations of the time.

TMC is governed by a 32-member board. Three board members are appointed by the mayor, three by the county executive (with TMC management providing recommendations to the city and county), two by the

state university that includes the medical school, one by the hospital medical staff, one by the main faculty physician group, and two by hospital employees; most of the remainder of the board is “self-perpetuating,” i.e., the board nominates and elects succeeding members. Jackson County retains title to parts of the two hospitals and, along with Kansas City, maintains limited accountability through contracts and otherwise. The city and county help finance the operation of TMC through annual lump-sum appropriations from dedicated local property tax levies to partially offset the cost of indigent care.

State university hospitals also can be structured as nonprofit corporations. State universities of Maryland, West Virginia, Georgia, Vermont, Massachusetts and Florida have adopted this model.

Shands Jacksonville Medical Center is a nonprofit academic medical center affiliated with the University of Florida and the largest of nine hospitals in the Shands HealthCare network.

Shands Healthcare was formed in Gainesville in 1980 when the University-owned hospital and clinics were converted into a private non-profit system. Shands Jacksonville was created in 1999 when Shands HealthCare assumed control of the private, non-profit University Medical Center. At that time, University Medical Center was on the brink of financial collapse, and Shands HealthCare was concerned that this collapse would greatly disrupt the university’s graduate medical education programs.

The reorganization of University Medical Center required a \$200 million cash infusion over five years, the majority provided by Shands HealthCare and about \$70 million provided by the City and State. Shands Jacksonville still receives approximately \$24 million from the City annually, although this is more than \$20 million below the costs of the services the City receives. Over the years since its acquisition, Shands Jacksonville has been relatively successful under Shands Healthcare’s

control, realizing significant improvements in hospital management and almost complete autonomy from local or state government. However, in recent years, the university has elected to restructure the Shands system again, effectively spinning off Shands Jacksonville into a more autonomous entity, imposing more control on the Shands system board and management, and even entering into a joint venture with a Florida for-profit company (Health Management Associates) to share ownership and operation of some of the smaller, rural community hospitals in the Shands system.

(Additional recently created nonprofit corporations, including the Martin Luther King, Jr. Hospital, Grady Health System, and Tampa General Healthcare, among others, are profiled as examples of restructured public hospital systems in Chapter V below.)

Contract Management— Private Health System

Some public or formerly public health systems are operated by third parties. Some have been sold or placed under a long-term lease to, or merged with, an existing private nonprofit or for-profit health system. While the health system may continue to offer certain safety net services, local government does not retain a significant role in governance or operations.

In October 1995, Seton Healthcare Network assumed management and control of the city-owned Brackenridge Hospital through a 30-year lease from the city of Austin, Texas. Seton is owned by the Daughters of Charity National Health System, a Catholic health system that operates 46 hospitals across the country. Prior to its reorganization, Brackenridge Hospital was a city hospital with management that reported directly to the city manager and city council. The hospital CEO was the equivalent of a city department head. The hospital had a dedicated board, but it was advisory in nature. Although the city funded only about 12 percent of Brackenridge Hospital revenues, city approval was required for the hospital’s line-item budget, salary scales, procurement, and all capital projects.

The city council took nearly a year to approve the proposed lease of Brackenridge to Seton. Under the terms of the lease, Seton agreed to continue Brackenridge's mission of providing indigent care and to be monitored by a five-member oversight council appointed by the city. The council holds monthly, open meetings for purposes of evaluating Seton's performance in access to care, level of services, and quality. If the council observes that Seton has failed to meet acceptable levels of performance in these areas or in the provision of indigent care, it may recommend that the city council withhold indigent care funds from Seton. Pursuant to the lease, Seton also agreed to continue providing certain of the "essential community services" Brackenridge had traditionally delivered, such as inpatient and outpatient pediatric care, emergency and trauma services, and maternity and women's services. Seton paid \$10 million at closing and will make rental payments of approximately \$2.2 million per year for 30 years.

(Another aspect of the Brackenridge situation—the recent creation of a new health care district—is described in Chapter V below.)

Contract Management—University

In certain instances, a public safety net hospital or system is placed under the management of an existing university health system. The degree of ongoing involvement by the local government varies, as does the length of the management contract. The details of each arrangement will determine whether or not the health system continues to be considered a unit of government for various purposes.

Harborview Medical Center (HMC) in Seattle is organized under the County Hospital law of Washington State and has been managed by the University of Washington under contract since 1967. HMC is owned by King County and governed by a county-appointed board of trustees. Its statutory mission is to provide health care to "priority groups"—defined by the current HMC mission statement as persons incarcerated in the county jail; mentally ill

patients, particularly those treated involuntarily; persons with sexually transmitted diseases; substance abusers; indigents without third-party coverage; non-English-speaking poor; trauma victims; burn victims; and patients requiring specialized emergency care.

The King County executive appoints the 13 HMC board members, including one from each of the nine council districts. Each of the nine council members makes a recommendation for an appointee and the county executive appoints the remaining four members subject to confirmation by the county council. The trustees may be removed only for cause. The board of trustees is responsible for governing the medical center and provides fiduciary oversight. The board approves the annual operating and capital budgets. The hospital operates at approximately a 1 percent total margin. The county provides no operating funds to the medical center, but does provide a conduit for voter-approved bonds. Approximately every 10 years, the citizens of King County are asked to support a bond measure to help upgrade or expand the buildings on the campus.

Under the University of Washington management contract, the university is responsible for overall management and operations of the medical center, risk management, compliance, human resources, labor relations and hospital policy and procedures. The University appoints the executive director and medical director subject to approval of the board. All employees at Harborview are University of Washington staff and all physicians are UW faculty. The executive director is accountable to the Chief Health System Officer, UW Medicine, who also serves as the Vice President for Medical Affairs, University of Washington. The executive director is also accountable to the board of trustees. The management contract has a 15-year renewable term.

Wishard Memorial Hospital in Marion County, Indiana, has been managed by the Indiana University School of Medicine (a state organization) since 1975. Under this management structure, the hospital's chief

executive/medical director position is filled by a faculty member of the medical school.⁶ The hospital is owned by the Health and Hospital Corporation of Marion County, a municipal corporation formed in 1951.⁷

The public corporation operates both Wishard Health Services, which includes Wishard Memorial Hospital and its community and specialty health services, and the Marion County Health Department.⁸ A seven-member board of trustees governs the corporation. Three are appointed by the mayor of the city of Indianapolis, two

by the City-County Council, and two by the County Commissioners. All members are appointed to four-year terms.⁹ The board has the authority to make and adopt ordinances that constitute the Code of the Health and Hospital Corporation of Marion County. The board also has authority to levy property taxes, though any tax levy must be approved by the State Board of Accounts.¹⁰ The City-County Council must approve the corporation's budget, though changes made by the council can be appealed to the state.¹¹

⁶ Jeff Swiatek, "Pay is Healthy for Hospitals' Executives," *The Indianapolis Star*, Feb. 6, 2005 at 1D.

⁷ Ind. Code § 16-22-8 (2004); Health & Hosp. Corp. of Marion Cty., *Background on Health & Hospital Corporation*, at <http://hhcdatamart.com/mica/who.html>.

⁸ Health & Hosp. Corp. of Marion Cty., *General Information*, at http://www.hhcorp.org/hhc_geninfo.htm.

⁹ *Ibid.* One of the members appointed by the City-County council serves only a two-year term, as required by Indiana Code §16-22-8-9(c) (2004).

¹⁰ The Lewin Group, Inc., *Revisioning the Delivery of Health Care Services to Uninsured Patients in Harris County: Executive Summary*, June 2004, at 6, available at <http://www.saveourers.org/SOE.ExecutiveSummary.pdf>.

¹¹ Ind. Code § 36-3-6 (2004); *Ibid.*

III. The Role of Trustees in Achieving Transformational Governance

At its foundation, effective governance results when a well-qualified, well-educated board of trustees exercises stewardship over an explicit community trust, balancing the mission and success of the organization with the needs of those it serves. Transformational governance takes these expectations to another level.

The importance of—and demands on—trustees of public and nonprofit hospitals and health systems have escalated significantly in recent years. In preparation of this monograph, the author interviewed current and past board chairs of public and nonprofit hospitals around the country, including several who have served as board members and board chairs of both NAPH and AHA. Their message is unanimous in underscoring the urgency with which safety net hospital boards across the country should take the steps necessary to transform their hospitals into fully integrated, patient sensitive delivery systems.

Former Harborview Medical Center Board Chair (and current Chair, AHA Committee on Governance) Kimberly McNally describes the role of the trustee today as one of needing to respond to a “near constant pace of change.” Since first becoming active as a trustee of Harborview (which is described in the previous chapter), Ms. McNally has seen dramatic changes in both the Seattle health care environment and the delivery system of which Harborview is a part.

Harborview (as noted above) is managed under a long-term contract by the University of Washington (UW), which operates an additional teaching hospital, the University of Washington Medical Center. In recent years, the UW system has also expanded to include a community nonprofit hospital and a public district

hospital. Keeping up with the changing health care environment has been “challenging” for the Harborview board.¹²

Ms. McNally believes strongly that “a strong, capable, functionally dedicated and educated board is very important to a safety net hospital’s ability to meet those challenges.”

General Board Duties and Responsibilities

Safety net hospital board members have duties and obligations similar to those of board members of other corporate entities. However, they also face unique challenges. This section addresses the duties and obligations generally applicable to board members and examines the challenges members of safety net hospital boards may face.

“Boards are far more than the sum of the individual values and viewpoints of their members; they are arenas in which individual members work actively toward mutually acceptable decisions and outcomes. But board decision making involves more than the affairs of the particular organizations the boards govern: both draw on and contribute to the sum of public values and actions. ...

In a very real sense, then, boards exist—at least for now—to serve as the binding which holds together the “sticks”—political, economic, cultural, public, and private—that comprise public life.”

Peter Dobkin Hall, “A History of Nonprofit Boards in the United States.” BoardSource E-Book Series (2003).

¹² Please note that whenever a quoted remark is otherwise unattributed, it is taken from the author’s interview with the individual being quoted.

From a corporate perspective, board members of any entity are said to have three fundamental legal and fiduciary duties, or guiding principles: care, loyalty, and obedience.

- *Care.* The duty of care requires board members to act in a conscientious and informed manner with respect to all board decisions. They must be aware of and consider the reasonably available and relevant information prior to making a board decision. They must act in good faith and with the care that an “ordinarily prudent businessperson” would exercise in similar circumstances. For example, each board member is responsible for reviewing and understanding background documents, such as financial analyses, provided by staff. If any element seems inconsistent or raises questions, the board member should not take it at face value but must follow up until the questions are satisfactorily answered.
- *Loyalty.* Most important, the duty of loyalty requires that every board decision be made in the best interests of the health system and its mission, rather than in the interests of individuals or external constituencies. This can be difficult or confusing since public board members are often selected from a particular constituency. In this case, the needs of the constituency should be considered in the context of the organization’s overall mission; they must never override the interests of the health system.
- *Obedience.* This duty requires board members to adhere to the legal mandates set forth when the organization was established. That is, they must ensure that the health system operates in conformance with its organizational documents (e.g., its enabling act, charter, or articles of incorporation) and its mission. To do so, board members must have a solid understanding of the fundamental purpose and mission of the health system.

In addition, hospitals seeking accreditation from The Joint Commission have to meet the specified leadership standards.¹³ Most hospitals seek Joint Commission accreditation because it is recognized by the Medicare program as a means of confirming that the hospital meets certain required conditions of participation. Joint Commission standards with respect to leadership require the hospital to:

- Identify its governance structure.
- Define governance responsibilities in writing.
- Designate an individual or individuals responsible for operating the hospital in accordance with the authority conferred by governance.
- Have leadership engage in short-term and long-term planning.
- Have leadership develop and monitor an annual operating budget and long-term capital expenditure plan.

There are many additional requirements. Joint Commission accreditation surveys focus heavily on documented activity. Consequently, the governing body of the hospital not only has to perform these activities, but it also needs to document its process and action steps.

In carrying out these fundamental legal and fiduciary duties, board members must attend to key areas of responsibility: strategic orientation, public accountability, financial oversight, quality assurance, advocacy, and board development.

At the same time, safety net hospital boards typically bear more complicated responsibilities than those of other hospitals in the community. Special challenges include legal, regulatory and political pressures, including the need to care for uninsured, underinsured and low income populations; reductions in Medicaid funding and local support; the impact of the nation’s failure to address the need for immigration reform; competition for Medicaid patients; responsibility for public health

¹³ See generally, *Comprehensive Accreditation Manual for Hospitals: The Official Manual*, Joint Commission on Accreditation of Healthcare Organizations, 2004.

and other community services; the obligation to conduct sensitive business in the public eye; and other cumbersome political or bureaucratic obstacles.

In addition, safety net hospitals and health systems often differ significantly from community hospitals in their physician staffing arrangements. Community hospitals rarely pay physicians to provide medical services. But patients seeking care at public hospitals typically lack sufficient insurance or other reimbursement to attract community-based physicians to provide services. Consequently, many public hospitals employ physicians or use an affiliation with an academic medical center to fill this need. These affiliations often promote excellence both in patient care and education, but their complexity necessitates strong oversight and communication between the parties.

As organizations, public hospitals provide services that are needed in the community but may not generate sufficient revenue to cover costs. In addition, because of the safety net role of these hospitals, as well as their public ownership or financial support, many community constituents feel a vested interest in what services they provide and how they conduct their business. Consequently, the governing boards of public hospitals face special challenges associated with the mission of their organization and, frequently, with their public nature.

The likelihood of attaining a capable and successful governing board is enhanced by an appropriate appointment process and statement of qualifications, with active recruitment of qualified, dedicated individuals representing a diversity of relevant experiences and professions. Once appointed, it is important to ensure ongoing training opportunities and board development activities.

As with any complex organization, a safety net hospital needs a strong and independent board to bring vision, leadership, and perspective to bear on present operations and future needs. The public hospital can be

strengthened if board members bring a variety of relevant expertise as well as a range of experience and perspectives. Above all, it is critical that the board members be dedicated to the health system and its mission, placing its interests above any others in the conduct of their fiduciary duties.

In carrying out these fundamental legal and fiduciary duties, board members must attend to key areas of responsibility: strategic orientation, public accountability, financial oversight, quality assurance, advocacy, and board development.

- *Strategic Orientation.* Board members should be actively involved in shaping the strategic orientation of the health system, including reviewing and approving a strategic plan that is consistent with the health system's purpose and mission. To make informed decisions regarding strategic orientation, board members should keep up to date on the health system's regulatory and competitive environment, including health system trends, opportunities, and threats. Once strategic priorities are set, they should be reassessed regularly and the health system's progress toward those goals monitored regularly.
- *Public Accountability.* Public accountability refers to the responsibility of board members to assess the short- and long-term needs of the community and the health system's patient population and to monitor the fulfillment of these needs. The board may accomplish this by facilitating regular communication with political leaders, the press, relevant organizations, and the public at large. Board members must coordinate these communications within the health system, rather than undertaking them haphazardly or on their own. They also should ensure that the health system is in compliance with all applicable laws and regulations.
- *Financial Oversight.* Financial oversight responsibilities include reviewing and approving financial plans, evaluating organization goals, and

ensuring that internal and external independent financial audits are completed on a timely basis. Board members also should be prepared to participate if needed in negotiations with the local government and to monitor the health system's investment strategies and otherwise ensure protection of invested assets. It is helpful to have comparative numbers such as historic performance or the performance of comparable organizations, to gauge the health system's financial status.

- *Quality Assurance.* The board must ensure that an effective quality improvement system is in place, with ongoing, systematic assessment resulting in action plans to strengthen performance. A board member's responsibilities include regularly reviewing quality performance data, holding management and clinical staff accountable for patient safety and quality of care, and ensuring that resources are available for these purposes. Quality goals should be linked to performance ratings and incentives and staff privileges. Through continuous quality management, an effective board can decrease the likelihood of adverse outcomes and encourage a culture of quality and patient safety.
- *Advocacy.* A governing board has the responsibility to engage in advocacy on behalf of the health system. Members of the board should identify proactively both informal and formal opportunities for advocacy. Specific goals should be set with respect to public advocacy, and the role of the board in fund development and philanthropy should be articulated. Board members should have a common understanding of the health system's goals, needs, and key issues. Equally important is the ability of the board to present a unified message. The board or its chair should therefore establish a protocol as to who may speak on behalf of the board and when, both generally and in the context of a specific advocacy agenda.

- *Board Development.* A separate yet critical board responsibility pertains to board development and self-assessment. Board members should routinely assess the health system's bylaws to identify areas that need improvement. Additionally, mechanisms should be established to evaluate the performance of individual board members. Board education also should be a regular aspect of the board's activities.

Each of the issues and functions summarized in this overview will be addressed in more detail in the remainder of this chapter.

Functionally Dedicated Governing Body

As discussed in Chapter II above, some safety net health systems lack a functionally dedicated governing board with responsibilities limited to the governance of the medical center. Instead, this role may be filled by an elected body with broader responsibilities, the members of which are subject to competing demands for their time and attention.

Hospitals without dedicated governing bodies report special problems arising from their governance structure. First, elected officials for a local jurisdiction have many other programs to oversee. Consequently, they may not have adequate time to oversee and provide direction to the hospital or health system. Further, members of the governing body are not held accountable to the public solely on their management of the safety net provider. Rather, the electoral process may force them to focus on the hot issues of the day and not on developing a long-term vision for the public health system. Given that local governments increasingly face severe financial constraints, the elected official structure may leave the hospital without a dedicated advocate. Public officials facing difficult budgetary decisions may choose to reduce hospital funding in favor of other local programs. Finally, elected officials rarely have undivided allegiances, as other competing hospitals and health systems in the jurisdiction also may be important constituents to the elected official.

“All learned occupations have a definition of professionalism, a code of conduct. It is where they spell out their ideals and duties. The codes are sometimes stated, sometimes just understood. But they all have at least three common elements.

First is an expectation of selflessness: that we who accept responsibility for others—whether we are doctors, lawyers, teachers, public authorities, soldiers, or pilots—will place the needs and concerns of those who depend on us above our own. Second is an expectation of skill: that we will aim for excellence in our knowledge and expertise. Third is an expectation of trustworthiness: that we will be responsible in our personal behavior toward our charges.”

Atul Gawande, *The Checklist Manifesto: How to Get Things Right*. Picador; 2010: 182-3.

Sometimes hospitals structured as operating divisions of local government are given advisory boards. While these boards sometimes have little or no formal power to oversee management or provide direction to the hospital, they can serve a number of useful purposes. First, they establish a body of individuals who can serve as dedicated advocates for the hospital. Second, they can be a mechanism for gathering the diversity of interests served by the public provider to ensure that there are direct lines of communication from various communities to hospital management. In some cases, they conduct effective strategic planning for the health system. Finally, they can help the hospital access community leadership and expertise to assist with its mission.

Other, more independent, safety net hospitals described in the previous chapter (authorities, PBCs, districts, nonprofit corporations) are more likely to have

substantial autonomy and delegated powers. At the same time, it is also important for these entities to have well-qualified and well-functioning boards.

Composing a Transformational Board

The Board Source’s 2010 *Handbook of Nonprofit Governance* states that “the reasonable or rational purpose of governance is to assure that an organization produces a worthwhile pattern of good results while avoiding an undesirable pattern of bad results.”¹⁴ Of course, this begs the question—good results for whom? The trends shaping the health system of the future require that public and nonprofit hospital and system trustees govern for the benefit of the entire community, not just for the benefit of their health care organization. However, some boards still struggle with putting their duties to the organizations they govern ahead of other interests.

Public and nonprofit hospitals and health systems often must balance three forces: the need to be responsive to the public and governmental entities; the need to maintain organizational and financial integrity; and the demands of key local constituents. These tensions are frequently reflected in and addressed through the composition of the hospital board.

While board members must bring many different perspectives to their role, it is equally important that they avoid placing loyalty to external interests above loyalty to the organization, as Atul Gawande suggests in the sidebar on this page and as illustrated by how the University Medical Center of El Paso has transformed its governance (see profile on this page).

Governance Transformation at the University Medical Center of El Paso

University Medical Center of El Paso (UMC) has undergone a radical transformation over the last eight years, not least in the area of governance. Throughout

¹⁴ Board Source, *The Handbook of Nonprofit Governance* (Jossey-Bass, 2010).

the 1980s and 1990s, El Paso's county hospital district was governed by board members each appointed to a single two-year term by a different elected official. Often, board members felt that they were more beholden to the elected official that appointed them than to the hospital. While some good, well-qualified board members were appointed during this period, the single two-year term ensured that good and bad board members alike would be gone almost before they knew anything about the system they governed.

In 2007, governance reforms for the district were adopted by the Board of Managers and County Commissioners Court, including allowing multiple terms for appointees and developing criteria for board membership. While its board is still appointed by the County, UMC today is a soundly governed organization with a highly qualified and dedicated board. As a result, the system has achieved remarkable success in rebuilding its core physical plant, shepherding the development and growth of a new medical school and new nursing school, building a new separately licensed regional children's hospital, opening the city's first hospital just for women, adding residency programs and El Paso's first-ever fellowship programs, and taking many other steps to benefit the entire community. According to an April 13, 2012 communication from UMC's President and CEO Jim Valenti, UMC's board today has both stability and the benefit of an impressive range of skills: the newly installed chair has served on the board since 2008 and is the managing partner of a regional consulting firm. Other board members include the community affairs manager for a major natural gas company, a chief lending officer for a major regional bank, a retired financial executive of a global IT company and a retired executive of El Paso's largest credit union.

Members of UMC's board also have far more influence on choosing their successors than under the previous structure. While not self-perpetuating, a more stable board also has contributed to greater stability in achieving numerous transformations of the system.

Board Size

The trend over the last 20 years has been toward smaller governing boards, which are thought to operate with greater flexibility and make decisions more easily. However, the greater complexity of the current environment may require rethinking that trend, at least within larger and more complex systems.

Boston Medical Center's (BMC) large board (30 members) is unusual, but given the complexity of the various components that went into the merged system, the 12 board committees divide up board work, thus helping the board function smoothly. On the other hand, Illinois' Cook County Health & Hospitals System board has only 11 members. What the board lacks in size it makes up in its diverse composition. While the board has undergone recent turnover, its directors have included a former Chicago public health commissioner, the chief medical officer of its major teaching affiliate, retired hospital CEOs, and a current county commissioner.

Dr. Michael Stocker, chair of the 16 member board of the New York City Health and Hospitals Corporation, acknowledges that "We have a few missing skill sets. The head of the Audit Committee is stretched. It is the hardest position to fill. We have a screening process for prospective board members. Leadership makes a huge difference—but with a board this size, the quality of management support is also important."

Appointment and Removal Processes

The power of removal also affects the independence of the board. If a board member can be removed from office at will by the appointing officer or body, he or she may be pressured into voting for or against an issue simply through fear of removal. There have been instances when a mayor (or other elected official) has announced that he would not reappoint any board member voting against his wishes on a key issue, regardless of the best interests of the hospital system; the pressure is more intense if immediate removal is threatened. For this reason, it is generally preferable to

permit removal only for cause or only on approval of a super-majority of the board, rather than by a separate appointing entity acting alone. For example, board members at Parkland Memorial Hospital, a public teaching hospital in Dallas, can only be removed by the Dallas County Commissioner's Court for cause.

Dr. Edward Chow, a member of the San Francisco Health Commission, clearly endorses the need for long term stability: "You can't always achieve true self-perpetuation in the public sector, but public and private hospitals alike can certainly achieve both stability and a high level of quality and expertise in their boards."

Dr. Chow strongly believes that "any trustee of a hospital needs to believe in the role and mission of the hospital and has a fiduciary responsibility to it. This role is more clear with a self-perpetuating board, which has the responsibility to select its successors, than in a board where members are elected or appointed by elected officials or other political appointees. However, self-perpetuating boards have the disadvantage of potentially being isolated or insular, which may not bring about innovation or creative thinking."

Self-perpetuating boards—those that not only nominate but appoint succeeding members—are generally the most effective at exercising the necessary level of leadership and loyalty to the organization. This alternative is often used by hospitals structured as nonprofit corporations, including those that have converted from direct operation by a local government.

With respect to governmental hospitals, many safety net hospitals have now become legal entities separate from a local government, yet some remain highly dependent upon government for financing uncompensated or under-compensated care. Also, many public hospitals and health systems that currently operate separately were formerly operated directly by a local government. To ensure accountability, many local governments retain the authority to make appointments to the board of the public hospital; often, this authority is laid out in the

hospital charter. There are a number of variations on this theme. For instance, at one point members of the governing board for the Regional Medical Center at Memphis were nominated by existing board members but appointed by the county mayor and confirmed by the county commission. RMC Memphis has recently been further restructured to function more like a traditional nonprofit board.

Truman Medical Centers has a 33-member board, which is partially self-perpetuating. The size of the board makes it possible to include political appointees to the nonprofit system, since a majority of the Truman board is self-perpetuating. Truman system receives dedicated tax support from both the city and county, so some political appointees are helpful. Three members are appointed by the mayor, three by the county executive, and two by the state university that includes the medical school.

Warren Batts, a retired corporate CEO, is chairman of the relatively new Cook County Health and Hospitals System Board of Directors. Chairman Batts considers it a good board because a number of stakeholder constituencies had an active role in nominating its members. If there is one weakness, it is the board's limited charter, since the board does not have any separate statutory or corporate existence apart from the County ordinance that created it. But Mr. Batts points out that with a strong membership, the board is using all the power that they were given, and many votes have been unanimous.

Effective public and nonprofit hospitals and health systems take great care in the selection of their trustees. Boston Medical Center, which was created in the 1990s as a nonprofit merger of public and private teaching hospitals, is one example. BMC's board chair, Ted English, has spent 35 years in the business world. He takes business ideas and applies them to BMC. He was asked to serve on the BMC board because he was on the board of a regional bank with Elaine Ullian, who was BMC's first CEO. She recognized that Mr. English's

business experience, coupled with his long involvement with other nonprofit organizations, would be an asset to BMC. (Mr. English has long been a trustee of Northeastern University, for example.)

David Passafaro, another BMC board member, also joined the board at the time of the merger. However, while Mr. Passafaro is currently a businessman, his background was political rather than business—he had been chief of staff for Mayor Thomas Menino, who had led the effort to create BMC in the first place. Mr. Passafaro believes that a charismatic leader like Mayor Menino was critical to pulling off the merger. And while the current board is perhaps larger than many, it represented the need to balance multiple governmental and private sector constituencies.

Finally, even if a board is not fully self-perpetuating, it is essential to build in a coherent transition and succession process so that future trustees and officers can be identified and groomed for leadership. As Douglas Brown, Senior Vice President and General Counsel of the University of Massachusetts Memorial Health System put it in a recent AHA presentation, it is important to have “an heir and a spare” when it comes to board leadership. Kimberly McNally, former Harborview board chair, believes that it is important to have a Governance Committee to manage transition and succession. After stepping down as chair, Kimberly now serves as chair of Harborview’s Governance Committee: “While the ultimate appointing power remains with the county supervisors, we are able to play a substantial role in selecting new board members as a result of this committee.”

Although no selection process can guarantee continued excellence in board performance, certain mechanisms can improve the chance of success. One method of fostering independence and a balance of perspectives is to broaden the appointive powers so that no single

individual or body appoints most or all of the board. Also, the appointing entity can be required to appoint from nominations made by an independent source; most often by the board itself but sometimes from various community groups or other constituencies. For example, under the 1990 enabling act of the (now defunct) Louisiana Health Care Authority, the leaders of specified agencies and organizations (such as the Louisiana Medical Association, chambers of commerce, bar associations, voluntary councils on aging, and medical societies) were designated as a “regional nominating council” for each facility. The regional nominating council submitted nominees for appointment to the local boards. When a vacancy arose, the governor appointed a new board member from a list of three names submitted by the local board.¹⁵ One advantage of permitting the board to nominate candidates is that the board is likely to be keenly aware of the specific skills or experience required at a given time.

Diversity

Safety net hospitals and health systems must strive for diversity in the composition of their boards in order to reflect the demographics and needs of the vulnerable populations and constituencies they serve. Former Cambridge Health Alliance (CHA) board chairman and current CHA trustee Rick de Filippi (who also served in 2010 as the AHA’s board chair) underscored this need, especially in a restructured safety net system.

“Cambridge is an interesting community and the board reflects this,” he says. “It is two communities—west Cambridge is academia, with great housing, professionals, progressive politics—but east Cambridge is a very different place, with working class and immigrant communities, a mini-New York City. CHA also represents the interests of six other cities in this part of the state. When we choose board membership we need the right combination of people.”

¹⁵ Act of July 24, 1990, 1990 La. Acts 855 (repealed 1997).

“We have managed to identify people with feet in both worlds,” de Filippi said. “For example, a recent board chair is a senior administrator of the Harvard Dental School and grew up in Somerville. She herself has been a patient in the system her entire life. Our mission and location also helped us recruit some of the true stars of the public health universe, like Dr. Lucien Leape, one of the most influential leaders of the patient safety movement.”

Other boards also put a premium on diversity, or require a certain number of board positions to be reserved for representatives of minorities, patients or other key constituent communities. For example—to ensure that the board includes perspectives from each region—nearly half of the members of the governing board of the Hawaii Health Systems Corporation must be from specified regions of the state.

In an effort to make hospital governance more robust, some restructured safety net hospital boards are composed to ensure adequate diversity in relevant professions. A hospital’s enabling act or bylaws may include guidelines on the characteristics to be sought in board members. While there need not be specific qualifications for individual directors, the board as a whole should represent a diverse group of stakeholders, have a high degree of interest in improving the hospital system, and, as a group, have the requisite experience and knowledge to operate the hospital system effectively. For example, the enabling legislation of the Westchester County Health Care Corporation (a New York public benefit corporation that operates a former county hospital system) specifically states the “objective of ensuring that the corporation includes diverse and beneficial perspectives and experience, including, but not limited to, those of business management, law, finance, medical and/or other health professionals, health sector workers, and the patient or consumer perspective.”¹⁶

Leadership vs. Management

One of the most important criteria for public and nonprofit board members is that they have an appropriate understanding of their role as leaders. Author and futurist Ian Morrison, in a 2011 book on *Leading Change in Health Care*, asks a key question about leadership: “Health care is complex. It is full of professions, guilds, unions, and community stakeholders, which make leadership difficult. How do you lead in such an environment?”¹⁷

One of Morrison’s answers, for which he cites John Gardner’s 1990 book *On Leadership*, is to “distinguish between managing and leading.”¹⁸ Morrison suggests that health care at all levels “is overmanaged and underled” and he offers the following prescription for successful leaders:

- They think longer term.
- They understand the relationship between their organization and the wider environment.
- They reach and influence stakeholders beyond their own organization’s boundaries.
- They put heavy emphasis on the intangibles of vision, values, and motivation, and they understand intuitively the nonrational and unconscious elements in both leading and following.
- They have the political skill to cope with the conflicting requirements of multiple constituencies.
- They think in terms of renewal and adaptation to an ever changing reality, not just sticking to the system.

New York City HHC Chairman, Dr. Michael Stocker, underscores the need for leadership by trustees (as opposed to over-involvement in day-to-day management): “Getting the right balance in what is on our agenda as a full board is essential. In the past we have had huge projects that the board never reviewed, while we spent too much time reviewing small things.”

¹⁶ N.Y. PBA, §3303(1)(c).

¹⁷ Ian Morrison, *Leading Change in Health Care: Building a Viable System for Today and Tomorrow* (AHA Press, June 2011).

¹⁸ *Ibid.*

Dr. Stocker reports that the HHC Board has recently spent a lot of time developing high-level policies to guide both board and management, while enabling the board to focus on longer term planning and management to focus on implementation and operations. In particular, Dr. Stocker has led the board to develop new procurement policies and operating procedures to provide more managerial autonomy, as well as new compliance policies.¹⁹ This also frees up time for essential long-range strategic planning. HHC faces a potential shortfall of hundreds of millions of dollars from the loss of future subsidies that will be diverted to pay for expanded coverage under health reform. “Unless we pay attention to this now by restructuring our delivery system, there may not be a safety net in this city in the future,” says Dr. Stocker.

The fine line between management and board leadership also extends to the response to events that can become public relations crises for a large, complex safety net system. Dr. Stocker says that the HHC board tries to live by the adage “nose in, fingers out—don’t let staff or the public or the press end run management. Advocacy by board members is important, but not everyone does it well—it comes down to individual skills.”

Rick de Filippi also commented on the importance of an appropriate division of labor between board and management: “Our board has always worked towards excellence—we haven’t always achieved it, looking back. Perfection is elusive—we need to keep examining it. When we get distracted by day-to-day operations, the board has done less introspection and evaluation. A lot of good material is presented to us in committees. It is essential to have good relationship with staff and you have to depend on them.”

Board Education

Board member education is required for accreditation purposes and is highly advisable for all hospitals. For

safety net providers, especially restructured systems with newly created boards, education and training is essential to achieving the needed governance to transform a health system at a time of uncertainty and turmoil.

Mr. de Filippi notes that the Cambridge Health Alliance Board has been forced to mature quickly in recent years, due to the head start in Massachusetts on health reform:

“Frankly, we were blindsided by the changes in financing the uninsured. What we thought were commitments to bring rates in line with costs didn’t happen, especially in primary care. We had to implement a re-engineering plan, under the scrutiny of the state. They understood our situation but wanted commitments.”

Mr. de Filippi said that initially, for board members, being educated was a heavy load: “Many board members didn’t have perspective on what was happening across the system when they were first appointed. They were very capable individuals but many had a more local perspective.

Education and Training

When things were going well, it was enough for CHA board members to just be kept up to date—exercising primarily an “operations management” oversight function. But when CHA hit a crisis following the implementation of health reform in Massachusetts, they had to strategize and look many years into the future. Many board members needed additional training, and the education process took a whole year. Mr. de Filippi points out that this process ultimately brought a sufficient number of board members to a position of using their sophistication to make decisions.

New board members should without fail receive initial board education and orientation; and ideally a board should hold regular retreats, which include participation

¹⁹ See 18 N.Y.C.R.R. §521.

by senior management. Such retreats provide an opportunity to ensure that all stakeholders are “on the same page” with respect to their roles in governing and managing the health system. After the initial orientation retreat, the governing board and senior management development sessions are typically conducted separately, although periodic joint meetings may help unify organizational leadership and goals.

Orientation sessions, as well as ongoing educational updates, should cover the following areas:

- Obligations associated with duties of obedience, care, and loyalty.
- Roles and responsibilities of board, officers, committees, and members.
- Financial management of the organization.
- Governing policies and procedures, including bylaws and articles of incorporation.
- Procurement, personnel and operational policies that maximize efficient use of the board’s time and create an effective board/management balance.
- Strategic planning, with particular attention on the impact of state and national coverage, payment and service delivery reforms.

Safety net hospital board training and development often lags behind the education and training accorded to trustees of community hospitals due to the more complex duties and multiple constituencies of their systems. Yet effective training and education is every bit as important to safety net trustees, in that they may need to address issues not typically covered for other boards. For instance, if the organization is covered by open meetings and open records acts, board members will need to learn what constitutes deliberative discussions and when and how these may occur. On the flip side, they will need to understand when they can meet in private or executive session and what activities can be undertaken at those times.

Board Leadership and Advocacy

A final essential responsibility of the members of a transformational board is to serve as advocates for the hospital in the community and with policymakers at every level of government. The hospital may be threatened with cuts in local funding, or it may need access to additional capital in order to take advantage of new opportunities. Relationship with the state, and especially the Medicaid program, may be more complex for safety net providers.

While there is always the need to be mindful of the legal restrictions on lobbying by staff and trustees of nonprofit and public hospitals, a certain measure of advocacy is not only permitted in most safety net systems but can be essential. Board leadership in the community may take many forms. Some board members may feel comfortable going directly to legislators and executives to plead the hospital’s case, particularly if they have personal connections with those officials. Other board members may have a background in grassroots organizing and may be particularly skilled in going into the general community to explain the hospital’s need for financial support. In many instances, public hospital boards can profit from member experience in public relations as the organization formulates a media campaign strategy. As the organization tries to compose an effective board, search committees may want to reach out to potential new board candidates with these skill sets.

In addition to being leaders in their communities, it is also essential for board members to advocate for the hospital in the community and in broader forums. Board leadership in community advocacy can take many forms. Some board members may feel comfortable going directly to legislators and executives to plead the hospital’s case, particularly if they have personal connections with those officials. Others may have a background in grassroots organizing and be particularly skilled at going into the community to explain the hospital’s story. In many instances, boards can profit from members who have experience in

working with elected officials or the media. As the organization tries to compose an effective board, the board's nominating or governance committee will want to reach out to potential new board candidates with these skill sets.

Transformational board members should be willing as needed to serve as advocates in the public policy arena. They can play a critical role in educating policymakers about key issues affecting hospitals and their communities. As with any public communication by a board member, it is critical that both the content and delivery of these messages be carefully coordinated between management and the board. It also is important to take into account the legal constraints on certain advocacy activities by nonprofit and governmental providers; such constraints do not, however, prohibit all advocacy-related activities by trustees or management.

There are a variety of ways board members can be effective advocates for their hospitals beyond simply contacting their own senators and representatives. Other activities may include:

- Meeting with policymakers when they visit the hospital,
- Visiting with policymakers or their staff in their local district offices to discuss the hospital,
- Sending a letter or contacting policymakers by phone to convey the importance of a particular issue,
- Traveling to Washington, DC, or to the state capital to meet with legislators to discuss important policy issues,

- Engaging other influential community leaders to help reach out to policymakers on behalf of the hospital, and
- Last but by no means least, becoming active participants in the advocacy-related activities of organizations like NAPH and AHA (and their equivalents at the state level).

Policymakers need to hear from constituents, and no one is better positioned than a trustee to convey the extraordinary contribution hospitals make to their communities. Among the many responsibilities of a board member, advocating to policymakers is one of the most rewarding and important to ensuring the hospital's continued success.

Rick de Fillipi believes that certain CHA trustees were important in resolving their initial health reform crisis: "The issue of governance was essential at the time of health reform in Massachusetts. The board chair at the time was involved directly in the negotiations with the state, and they were successful."

Given their stature and leadership role in the community, board members can be effective advocates even if they do not have a personal relationship with legislators. This leadership status is an important part of their role as a board member. In addition, board members should help the hospital by engaging other influential community leaders, especially those that are politically involved, to help reach out to policymakers on behalf of the hospital.

IV. Restructuring for Transformational Governance

The implementation of health care reform is now on the immediate horizon, and safety net hospitals will soon be required to compete for patients who had previously had little or no choice of hospital. Traditional sources of public revenues are already evaporating in many states, and new competitors are springing up for many of the services such hospitals historically have provided. As a result, many safety net hospitals and health systems are seeking to keep pace and improve their ability to carry out their mission by reforming their organization, governance and legal structure.

While the pace of governance reform has accelerated in recent years, the restructuring of public hospitals and health systems is not a new phenomenon. Indeed, it is a little known fact in Washington, DC, that one of the most prominent regional nonprofit health systems started its life as a county hospital. In 1947, the Fairfax County (VA) Board of Supervisors established a public body called the Health Center Commission, under a 1946 state law.²⁰ In 1955 that commission fostered the creation of the Fairfax Hospital Association, a private non-profit corporation, which was an organization of private individuals who paid \$5 each to become members.

FHA operated Fairfax Hospital, which grew to 600 beds, for several decades. The hospital facilities and the land on which they stood were leased to FHA by Fairfax County. The lease required FHA to advise the county of its actions, submit its budget to the county before its adoption and also to submit for comment important contracts before their execution. The lease provided that at its expiration the facilities would become, and the land would remain, the absolute property of the county. Two more hospitals and a range

of other programs and services later joined FHA, and in 1987 the system was renamed the Inova Health System. Inova has continued to expand and is known today as one of the mid-Atlantic region's most successful private nonprofit systems—yet it started out 65 years ago as a county-operated safety net hospital.

Governance reform and restructuring have long been considered means of improving the viability and competitiveness of safety net hospitals. Such steps are not always part of an improvement strategy, however. Sometimes state or local governments have sought to restructure or “privatize” their public hospital systems to shield taxpayers from the uncertainty of growing subsidies. In other cases, external parties have promoted reorganization as a means to their own ends, such as gaining control over a competitor or gaining entry to new markets. In any case, without careful planning, and broad consultation, the concept of reform can be provocative, galvanizing employees, medical staff, or patient advocates into opposition. Even where there is general consensus and strong political support, some restructuring initiatives have failed for lack of adequate planning or resources or the relative weakness of the system as a stand-alone entity. The failed reorganizations of St. Louis City Hospital and D.C. General Hospital come to mind.

Notwithstanding these concerns, restructuring can be an important tool to help level the playing field for public hospitals and health systems. Reorganization can take many forms, from simply restructuring a hospital (or a city or county agency) into a separate public organization, to privatizing through sale, merger, or lease with an existing private nonprofit or for-profit health system.

20 “Hospital and Health Center Commission Act” Va. Code Ann. the §§ 32-276, et seq., as amended (1976 Cum.Supp.)]

The key goals of a public hospital reorganization, whatever form it may take, often dictate the structure selected. Motivations range from the defensive (e.g., fear of the need for increasing funding or fear of fierce competition for previously uninsured patients) to the constructive (a desire to improve the efficiency and competitiveness of a public system). Most often, it is a mixture of the two.

The reasons for a proposed restructuring must be sufficiently compelling to justify the costs of implementation and outweigh the loss of the benefits and protections that the current government status affords a hospital or health system. For example, in some cases a government structure provides sovereign immunity protections or easier access to capital through the issuance of lower-cost tax-exempt “general obligation” government bonds. Also, public entities in some states are given extra benefits under Medicaid reimbursement methodologies. On the other hand, being structured as a state, county, or city agency or department, with no independence, may subject public hospitals to unacceptably burdensome constraints such as slow and cumbersome decision making, ill-suited civil service requirements, complex procurement rules, or sunshine laws that prevent effective planning. These constraints can lead to severe fiscal and competitive disadvantages. They may ultimately diminish the financial viability of a public system and its ability to carry out its mission without increased taxpayer funding. The careful balancing of these public benefits and constraints must play a critical role in decisions to restructure.

Powerful justifications exist for restructuring when a host of legal, administrative, and financial obstacles have an adverse effect on the patient care mission of the hospital or place the public hospital system at a disadvantage in relation to its private counterparts. While most government rules, regulations, and constraints exist for valid reasons, the operation of a health system—including acute care hospitals, stand-alone clinics, managed care, and medical education

functions—is fundamentally different and often far more complex than most of the government functions for which such legal and administrative controls were created. Organizationally, a hospital comprises a set of intricate and interrelated programs and functions operating in close proximity.

In sum, in response to these pressures, the goals of reorganization are usually multifaceted and include at least some of the following:

- Enhance competitiveness
- Maintain public/safety net mission
- Reduce or stabilize dependence on tax dollars
- Reduce financial risk to local government
- Create a dedicated board for nimble decision making
- Improve personnel system
- Maintain public accountability
- Streamline purchasing
- Reduce bureaucracy
- Enhance access to capital
- Enhance professionalism/managerial autonomy
- Depoliticize operations
- Retain public funding

The remainder of this chapter will identify a number of the key elements and concerns that attend to a decision to consider, and then implement, structural and governance reform.

Evaluating the Status Quo and Identifying Needs

Most safety net hospitals and health systems have explored a reorganization of their governance or legal structure from time to time, without necessarily taking the steps needed to implement a restructuring. The driving factor is often a culminating event following a series of long-standing frustrations. The hospital may have experienced a significant challenge, lost a political

“So what should public sector leaders do to enable their organizations to adapt and excel during these challenging times?... By understanding the “state of bureaucracy” in their own organizations, leaders can address the root causes of their challenges and—more quickly than they think—elevate the performance and efficiency of their organizations to meet changing demand.”

High-Performance Bureaucracy™,
The Monitor Group, 2011

battle, or missed a significant opportunity. Either management leadership or the governing body may see restructuring as the solution to a litany of problems.

While consideration of organizational or structural reforms can be a helpful exercise in and of itself, a restructuring initiative will rarely solve all of an organization’s problems. At best it will remove certain barriers to success. Further, undergoing a restructuring can generate significant costs, in terms of both financial outlays and good will with core constituencies. The process merits careful deliberation.

The first substantive step in this process should be to examine the safety net hospital or health system as it is now. This is often undertaken as part of a strategic planning process.

- What are the system’s strengths and weaknesses? What functions does it perform well? What functions are more difficult to fulfill?
- Which aspects of its legal structure enhance its ability to attain its goals and which aspects hinder its performance? For example, in some cases a public entity structure provides easier access to capital through the issuance of lower-cost tax-exempt government bonds. On the other hand, such a legal structure may be subject to sunshine laws, civil service requirements, or procurement procedures that lead to inefficiencies.

- What are the system’s operational strengths and weaknesses? For example, the dedication of staff may be one of the greatest assets. Any change that is perceived to impair compensation, benefits, or job stability could have a significant negative impact on morale. On the other hand, a decaying infrastructure and insufficient capital to renovate may be infringing on the organization’s ability to attract and retain patients.
- How does the corporate culture affect operations? Operationally, perhaps the safety net mission has enabled the organization effectively to reach out to sectors of the community that are neglected by other providers. On the other hand, a longstanding mission of serving all who walk through the door may impede behavioral changes required among staff to operate in a managed care environment.

It is often helpful to catalog the system’s strengths and weaknesses in an organized fashion as a starting point. Ideally, such a catalog is developed with the input of many individuals connected with the health system. Many hospitals have found it useful to have outside assistance in interviewing key stakeholders to solicit their views on the organization. Sometimes, when assured that their remarks will not be attributed, these individuals are more willing to open up to outsiders who can therefore elicit more accurate and penetrating observations. In any case, soliciting widespread input should lead to a more useful assessment of the status quo (and at the same time serve some of the communication goals discussed below). Once such a list is developed and agreed on, it can serve as a basis for comparison of proposed reorganization options.

Another major consideration in the restructuring process is ensuring the perceived objectivity of the decision makers. In most cases, one or more of the key constituencies, such as patient groups, including advocates for vulnerable patient populations, physicians, and hospital employees, will be deeply suspicious of any potential change. Even if the decision makers ultimately identify the best solution for local needs, the

restructuring may be doomed politically if there hasn't been sufficient community "buy-in."

Consequently, the first step in reorganizing a public hospital generally involves laying out a rationale for the change and developing credible support for it. Often the process begins through the appointment of a public commission. For example, the conversion of Denver General Hospital to the Denver Health and Hospital Authority and the merger of Boston City Hospital (BCH) and Boston University Medical Center (BUMC) (both described in the case studies below) grew out of the reports of mayoral commissions in those cities.

In some cases an internal task force or committee with a lower public profile than a public commission may be desirable, particularly where it is not yet clear whether reorganization is the desired outcome. In this case, if the internal process leads to a decision to move forward, a more public process subsequently can be established to lay the political groundwork. Indiana University Medical Center convened a 14-member internal joint steering committee without members of the public composed of key administrative personnel from organizations, physicians, and the respective board chairs. The charge to the committee was to consider the feasibility of aligning the hospital with Methodist Hospital of Indiana.

Some organizations find it helpful to have an independent body study the hospital's situation and make strategic recommendations. The objectivity of an independent body can lend needed credence to its recommendations. The danger in such an approach, however, is that without sufficient political will to implement the recommendations, the study will have little impact. For example, at least nine separate studies were conducted on the New York City Health and Hospitals Corporation before a fiscal restructuring agreement was concluded in 1992.

As a preliminary matter, those considering restructuring should consider whether no action is the best action. Even the process of considering restructuring can impose

costs on an organization. Key managers must devote significant time to the evaluation process, diverting them from other duties or opportunities. Further, a significant investment in public relations and outreach is needed to ensure that the public has adequate knowledge of the process. Threatened stakeholders may commence opposition campaigns that exacerbate existing friction. For instance, labor unions may use the restructuring discussions to galvanize members to oppose not only the change being contemplated but other issues as well. Similarly, fearful members of the dependent patient community may seek opportunities to challenge the hospital's agenda with local government. Finally, the uncertainty of possible change almost inevitably takes some toll on employee morale.

Given the costs of considering and then implementing change, decision makers must carefully consider the advisability of maintaining the status quo or making minor modifications to the existing structure. Strategically, after creating the inventory of issues arising from the hospital's current structure, it may be useful to rank them in order of importance. In certain instances, hospital leadership will decide that certain issues must be resolved, while other issues are of secondary importance. Other hospital leaders have stated that they try to identify opportunities where addressing 20 percent of the issues will give 80 percent of the benefit. In this context, there may be opportunities to live with the status quo.

In many instances, minor modification of local laws or policies can help the hospital avoid the complexity and cost of major restructuring, or can serve as an achievable first step toward broader reorganization. For instance, if cumbersome procurement restrictions are perceived to be a significant handicap, it is possible that the solution may be separate local legislation giving the hospital independent procurement authority or at least the ability to use group purchasing organizations. Similarly, it is possible that a hospital could work within local civil service restrictions if the local government human resources authority is flexible enough to create

job titles and compensation packages that reflect sector standards. In addition, the local governing body such as the city or county council may be able to grant the hospital greater budgetary autonomy by focusing on net revenue and net expenditure budgets, rather than budgeting by line item.

On the other hand, the hospital may operate under so many significant limitations that maintaining the current structure will, at best, continue to hobble the organization or, at worst, lead it down the path to failure. Decision makers evaluating the possibility of restructuring should keep two principles in mind. First, not all change is inherently good or will solve problems. Second, organizational leadership needs to focus on issues that are important over the long term, whether or not they are urgent today. Even though structural barriers may not create a crisis on any given day, they can, in the long term, cause the organization to deteriorate to the point where it can no longer compete.

Consensus on Goals of Change

It is important that early in the process, key players achieve a consensus on the goals of the reorganization. The goals may flow from an assessment of the strengths and weaknesses. For example, a key goal may be to maintain the health system's mission, which is deemed its greatest strength. Or it may be to rebuild an aging facility or to address weaknesses by enabling the hospital to affiliate or consolidate with other facilities. In any case, it is often worth investing time and energy to attain consensus on a list of explicit goals for any change. Without such explicit agreement, the players may find themselves pursuing conflicting ends without even recognizing the difference of opinion. Early acknowledgement of goals can help facilitate subsequent decisions on the details of the reorganization, as the options can be analyzed against clear criteria.

Balancing Factors and Assessing Structural Options

After developing a firm understanding of the strengths and weaknesses of the hospital system's current structure, and having agreed on the goals and objectives of a reorganization and any non-negotiable constraints, the next task is to determine which restructuring options, if any, will meet the organization's needs. As Chapter II demonstrated, there are today a wider variety of legal structures among the nation's safety net hospital systems than in any other segment of the hospital sector. Within each category, variations can be developed to tailor the model to each system's unique needs.

However, restructuring options need to be considered in the context of local legal and political considerations. Many states have defined procedures to establish public hospitals or to convert them from one form to another. In these states, local public hospitals can, if desired, undergo conversion without the action of the state legislature. For instance, California has a statutory process for establishing a hospital district.²¹

In other jurisdictions, special state legislation would be required at a minimum, and in certain instances, state constitutional amendments have been required. In Texas, for example, the state constitution authorizes the creation of hospital districts. From the time this provision was adopted in 1954 until 1962, six hospital districts were created, each through adoption of a new section of the constitution creating the single district.²² A 1962 constitutional amendment finally granted the legislature authority to create hospital districts directly. A 1989 amendment to this section clarified that these districts could be created "by general or special law,"²³ and today hospital districts continue to be created through both means.²⁴

²¹ Cal. Health & Safety Code §§ 32000-03 (2005).

²² Tex. Const. art. IX, §§4-8.

²³ Tex. Const. art. IX, § 9 (amended 1989); David E. Brooks, *Hospital Districts: Constitutional and Statutory Basis*, 36 Tex. Practice Series § 26.20 (2d ed. 2002).

²⁴ Tex. Health & Safety Code Ann. §§ 281.001-283.136, 286.001-951 (2005); Vernon's Ann. Texas Civ. St. Art. 4494q (2005). For example, West Medical District was created by a special act of the Texas state legislature in 2001. H.R. 3691, 2001 Leg., 77th Sess. (Tex. 2001).

In the context of evaluating options, decision makers need to take into account what level of state government would have to be involved in the restructuring. In many states, legislatures are not in session at all times and may only consider new legislation at the start of the legislative session. To the extent that the proposal requires action at the state level, the process could be significantly delayed.

Similarly, political realities need to be taken into account. In many jurisdictions, the local hospital is a major employer, and hospital employees as voters may have significant clout with elected officials. In these instances, it may be politically infeasible or cost too much political capital to seek a restructuring that dramatically affects employee compensation, benefits, or rights. In numerous instances, restructured hospitals have assumed employment obligations either identical or similar to civil service systems that were part of their previous operations.

To get a full perspective on the options, it is important to present the status quo as an option warranting full consideration.

Communication and Education

Although the substantive content of a reorganization plan is of paramount concern to those affected by it, the experience of many safety net hospitals indicates that the process by which that plan is developed also will be important to its ultimate success or failure. Laying the proper groundwork can significantly increase the likelihood that a reorganization will take place.

Ensuring proper communication with key constituencies greatly improves the likelihood of success in most reorganization projects. While every system (and every community) is unique, most successful reorganizations have been based on some degree of enfranchisement of key constituencies. It is also essential to be open and transparent in most cases about the key elements of a proposed reorganization. In the rare case where reorganization was effected without such

transparency or without widespread community support, implementation took longer and success was harder to achieve. Moreover, in some such cases, the reorganization was plagued by litigation and instability.

Several anonymous examples should offer an appropriate cautionary note:

- An effort to restructure a public state university hospital as a nonprofit corporation in the late 1980s resulted in unanticipated opposition and litigation, including the resistance of employees and even key members of hospital leadership. The reorganization was delayed, litigation was filed and ultimately the state supreme court ruled that the reorganization violated the state constitution.
- Another effort by a county hospital system in the Midwest to restructure as a nonprofit corporation was undone by county government when it was discovered that the senior management of the reorganized hospital had secretly adopted a new executive compensation system. It came to light that top managers of the system were being paid substantially higher salaries by the new corporation—not in itself necessarily problematic, since county salaries were well below market—but they also were drawing full pensions for having “retired” from county government, which generated substantial community and media outrage.
- A third example involved efforts by a governmental hospital in the Southwest to identify potential nonprofit partners for a merger or acquisition. Local elected officials created a task force that included only a limited number of government officials so that it could conduct its business entirely behind closed doors. This resulted in frantic efforts by local media to obtain access to “secret” plans and documents, which ultimately led to the collapse of the effort (and the loss of the next election for some of the elected officials involved).

The point to be made by these examples is that there is usually little to be gained, and much to be lost, by failing to include effective communication and transparency as an integral part of governance reforms. In each of the instances outlined above, the hospital or system in question did go on to implement successful reorganizations, with a better balance in each case between confidentiality and communication. While it is clearly true that some strategic analysis, and the resulting decisions, can require a measure of confidentiality, this must be weighed against the need for “buy-in” by important constituencies of the hospital or system.

Many successful reforms have grown out of the willingness of the governmental entity to inform and be informed by key constituencies. Communication must be considered at every step of the reorganization process. This is not to suggest that every step of the process must be completely open. For strategic, logistical, and other reasons, too much openness can be harmful. Nevertheless, take care to consider incorporating broader constituencies into each step where it is possible without too great a sacrifice of efficiency or necessary confidentiality.

Who are the key constituencies to be consulted, informed, or enfranchised? The answer will vary from system to system, but at a minimum, they would typically include the following:

- *Local Political Leaders.* Because of their ultimate power over the fate of most safety net hospitals, the support of local politicians is an obvious must. The head of the executive branch of local government (the city mayor, the county administrator, the governor if it is a state-owned organization, etc.) is key, as well as his or her top health aides. Local legislators (city councilors, supervisors, etc.), particularly those with special responsibility for health affairs, also may be essential. If state legislation will be necessary to implement the desired structure, then it is important to inform or involve the relevant state legislators, as well.
- *Clinical Staff.* No reorganization can be implemented without the cooperation of the medical staff. Bringing physicians, nurses and other clinicians into the process early on will help ensure both that they accept and support the decision to reorganize and that the new structure will meet their needs. In a teaching hospital affiliated with a medical school, the appropriate university personnel also should be consulted.
- *Non-Clinical Employees.* Non-clinical staff should be involved in the process as early as feasible, including any unions that may represent them. Public health systems tend to be major employers in their communities, and workers are likely to have significant concerns about any reorganization. Allowing rumors to fester without direct communication can only harm the process. Regular updates at staff meetings and in employee newsletters, and even a hotline or anonymous question/suggestion box have been used to encourage internal communication.
- *Patients.* Obviously, patients will be directly affected by the change. Given that the hospital’s mission is to serve their needs, it is worth the effort to solicit their input. Particularly where the hospital is the primary safety net facility in the community, it may be necessary to allay patient fears about ongoing access to care. Patient advocacy groups, neighborhood groups, health advocates, advocates for the poor, representatives of relevant minority/ethnic groups, and similar organizations should be educated and consulted.
- *Business and Community Leaders.* The community at large also will be concerned about the future of their local safety net hospital. Hospitals generate significant economic activity and affect the local quality of life, so local business and community leaders will be interested in the outcome and should be kept informed. Further, if members of this group do not already serve on the health system’s board, this may be an ideal opportunity to secure the informed involvement and support of community leaders.

- *Other Providers.* Although other providers in the community need not be brought into the decision-making process, they should be briefed on the reorganization plans as early as is consistent with strategic goals (particularly if a goal of restructuring is to enable a public hospital or system to partner or affiliate with others). Other providers may have concerns about the reorganization, such as the new entity's ongoing commitment to indigent care, the continuation of specialty services not readily available elsewhere in the community, and the enhanced competitiveness of the reorganized institution.
- *Local Press.* Although it would be unwise to conduct all the details of the planning process in the press, open communication with the media can be important, given their influential role in shaping public and political opinion. To the extent possible, be responsive to the press, maintain good relations, and be sure that the information they have is accurate. Judiciously dispensed, off-the-record briefings, open meetings, interviews, and op-ed pieces are effective tools.

Issues to Be Addressed in a Restructuring

This section provides a framework for addressing some of the central issues in the design and implementation of a public hospital reorganization. Specifically, it addresses the following topics:

- Mission/safety net responsibilities.
- Funding.
- Accountability, managerial flexibility and autonomy.
- Board structure.
- Medical staffing.
- Personnel.

The treatment of these issues will be shaped by the overall character of the reorganization. A fundamental consideration is the degree of the local government's ongoing influence on and involvement in the operation

of the resulting entity. This can range anywhere from significant involvement to a hands-off transfer. Another key factor is whether local decision makers intend to join two or more previously independent hospitals into a system, or whether they simply wish to convert the public hospital into a new freestanding hospital or health system.

Although the general form of the reorganization will influence how the mission, accountability, governance, and funding are addressed, it is also true that issues in each of those categories will substantially influence the overall structure selected.

Mission/Safety Net Responsibilities

While it must be recognized that some safety net hospital reorganizations are undertaken by government entities in order to reduce taxpayer funding and exposure to the cost of indigent care, the primary goal of many reorganizations is to preserve and enhance the mission. A safety net system's mission may include: (1) ensuring access to care for uninsured indigent patients; (2) ensuring community access to certain essential services, such as trauma, burn units, neonatal intensive care units, etc.; (3) providing community-wide preventive and public health services; and (4) providing medical education. While restructuring or privatization is typically intended to increase the competitiveness of the system (e.g., broadening its payer mix beyond the typical "public" patient), a variety of mechanisms can help ensure that the mission continues to be fulfilled.

Defining an Enforceable Obligation

If control over the public health system will change hands, it is generally desirable to make adherence to the mission enforceable in some fashion. However, given the inevitable tension between the potentially boundless costs of fulfilling a broadly stated mission, and fiscal reality, it is critical to draw a reasonable balance in crafting the new system's obligations. For example, a broad requirement to provide medically necessary care to all, regardless of ability to pay, could either bankrupt a system without general tax revenues to rely on, or

subject it to a costly lawsuit if it tried to limit such care. On the other hand, an overly general statement may not be treated as enforceable, thus also defeating the initial intent.

This highlights another source of tension in defining such obligations. It is important to set out the obligation with sufficient specificity to ensure that it is enforceable. However, the needs of the community may change over time, so there is a danger of locking in requirements that soon cease to serve their purpose. Similarly, there is a tension between the need for standards, which can change with community needs, and the desire to make it difficult to eviscerate the mission in the future through amendment.

In short, the challenge is to memorialize the mission so as to protect it from those who may wish to abandon it in the future, while providing adequate flexibility and discretion to address unforeseen needs and financial limitations.

One method of addressing some of these issues, at least where reorganization is accomplished through legislation, is to include broader language—perhaps a statement of mission or purposes—in the statute, while reserving specific obligations to a contract. In addition, the financial stability of the new health system can be protected contractually by tying its uncompensated care obligations to the receipt of payments by the local government, though this does not in itself guarantee that the needed levels of service will in fact be funded.

There are a number of approaches for preserving the mission. Legislation creating the Denver Health and Hospital Authority, for example, used both the statutory statement of mission and contractual obligations. The statute sets out a four-part mission including “access to quality preventive, acute, and chronic health care for all the citizens of Denver regardless of ability to pay,” and further requires that transfer of assets to the authority be conditioned on a contract by which the authority agrees to fulfill this mission. The contract, on the other

hand, is expected to quantify the authority’s obligation as well as the city’s responsibility to fund it. In the case of St. Paul-Ramsey Medical Center (now Regions Hospital located in St. Paul, MN), state legislation included an unquantified requirement to provide care for indigent patients, as well as a commitment to provide “major or unique” services currently provided by the hospital (e.g., trauma center and burn unit) for a five-year period, and thereafter, to the best of its ability.

The mission may, of course, be protected through contractual agreement, whether or not statutory purposes are enacted. Harborview Medical Center had defined in its management contract 11 categories of medically vulnerable populations that were to be given “priority for care within the resources available.” In many cases, specific requirements are set forth in long-term documents, such as a lease or other transfer document that requires the consent of both parties to amend. This can create an adequate safeguard for important service obligations while permitting the flexibility to alter them if needed.

It also may be desirable to assign responsibility for monitoring compliance through statutory or contractual obligations. When Austin, Texas, contractually transferred city-owned Brackenridge Hospital to a nonprofit competitor in 1995, a community board was created to monitor the required access to care, quality, and patient satisfaction. Failure in any of these areas could jeopardize the city’s payment of indigent care funding. Similarly, in Boston, one of the duties of the Health Commission is to monitor compliance with contractual obligations in the operation of Boston Medical Center.

Funding the Mission

As suggested above, the difference between good intentions and full implementation of the public mission may be the commitment of funding from the federal, state or local government. Continued local funding is typically necessary for a reorganized hospital or health system, at the very least on an interim basis, particularly if the system undertakes to continue costly

aspects of its mission. Because the health system's ability to uphold its mission depends on both good policy and adequate funding, the methodology used to determine payments will be important.

Whether a city or county is legally obligated to fund the hospital typically depends on whether state law places responsibility for indigent care on its doorstep. Of course, even in the absence of statutory obligations, the local government may undertake financial responsibility for indigent care through contractual agreement or on an ad hoc basis through its annual budgeting process.

Once it is established that the local government will provide funding for the health system, the method of calculating the amount of funding must be determined. Typically, funds are provided in one of two ways:

- An ad hoc basis through annual appropriations.
- Formal payment for services rendered, with or without a ceiling.

The method chosen will depend on the degree of oversight the local government wishes to exercise, the political backdrop for the reorganization, and the financial incentives desired for the system. There is often a preference for providing payments for services rendered. This helps increase the managerial autonomy of the health system, create appropriate incentives to provide cost-effective care, and enhance the system's patient care revenues and thus its access to credit.

Ad hoc appropriations were most common in earlier reorganizations. Here, the annual payment or "subsidy" to the health system is set during the city or county's annual budgeting process. It may be based partly or wholly on the proposed budget of the health system, the projected level of uncompensated care, the prior year's deficit, or other factors. While in some cases annual appropriations provide a measure of security for the hospital that its deficits will be filled, this method often fails to provide appropriate management incentives and may leave the local government, as well

as the hospital, with an unacceptable level of uncertainty. Importantly, avoiding this predicament may be a primary motive of local governments for spinning off directly owned hospital systems. The annual appropriations approach also can make it difficult for systems to build needed reserves or fund balances.

In designing a formal payment system, the following approaches can be considered:

- Fee-for-service.
- Discounted charge, cost plus, or other basis.
- With or without annual ceiling.
- Fixed fee contract.
- Capitated rate.

The fee-for-service method may be desirable for coupling the local government's funding with the volume of services. Fee-for-service payments may be figured on either a charge basis or a cost basis, and there also may be a fixed annual ceiling. (If the ceiling is too low, it may constitute a *de facto* fixed-fee contract.)

Often the fees paid by the city for indigent care reflect a modest mark-up over cost. For example, one reorganized safety net hospital in Georgia negotiated a payment of cost plus 3 percent for services provided to those certified under the county indigent care program. Similarly, a Texas city that had transferred its hospital to a nonprofit system under a long-term lease reimbursed the system for charity care up to a capped amount.

The fee-for-service method has the advantage of increased fairness and objectivity, but it may not afford the budgetary certainty desired by local government. This can be addressed by an annual ceiling or fixed-fee contract, but that can end up eliminating the relationship between payment and level of services. And though the health system's obligation may be limited to a fixed annual payment, in practice, services are often provided even after the designated funding has been exhausted, because the organization remains mission-driven regardless of its legal structure.

Another alternative is a per-capita payment for covered lives, similar to reimbursement to health maintenance organizations. This mechanism has the advantages of predictability for the city and creation of incentives to provide cost-effective health care and preventive care. But this alternative is impractical unless there is sufficient data on the covered population to set appropriate capitation rates.

Finally, as discussed in more detail under Medicaid issues in Chapter VI below, regardless of how it is appropriated, governmental funding to a restructured hospital or system can also be leveraged to draw down additional federal dollars through intergovernmental transfers to the state.

Transfer of Reserves and Debt

As part of the reorganization process, the parties need to negotiate the treatment of reserves and debt. The two are related; that is, the necessary level of reserves depends in part on the level of debt undertaken by the reorganized system. The local government can increase the likelihood of the reorganization's success by permitting the health system to retain adequate financial reserves. Without adequate working capital *and* reserves, the health system cannot be expected to function independently—especially if it can no longer rely on tax revenues, access to general obligation (GO) bonds, and other traditional sources of capital.

It is not unusual for the amount of rental or purchase payments from the new entity to the local government to equal the remaining debt service on any outstanding bonds. However, to a nonprofit corporation, this is not always the case. For example, when Detroit General Hospital was transferred from the city in 1980, the parties agreed that \$1,000,000 per year was the maximum realistic level of debt which Detroit Medical Center could assume; this left the city to pay the remaining \$6,000,000 per year from its own resources. In recent years, hospitals operating as enterprise funds often have been faced with either accrued operating debt to the local government, or the flip side, a

significant level of accumulated reserves. In the former case, there is inevitably discussion of whether the debt is appropriately related to the hospital or whether it reflects past city or county decisions to under-budget for hospital operating expenses, and regardless, whether it is practical to saddle the reorganized system with this debt. When the hospital has accumulated reserves, their source may be disproportionate share payments or other health revenues, but it may nonetheless be tempting for a cash-strapped local government to refuse to transfer them into an independent health care entity.

Access to Capital

When designing a financial strategy, an important goal is to maximize the reorganized system's access to capital. One common advantage of direct city or county ownership is access to GO bonds. In some states, an independent public entity still can use municipal GO bonds, but this is an issue that must be explored on a case-by-case basis. Generally, private entities cannot access GO bonds, even through statute, as this violates state constitutional prohibitions on the gift of public funds, also known as “anti-donation” clauses.

Nonetheless, where the local government's credit rating is poor or where it is near a formal or informal capital ceiling, legal access to GO bonds carries little practical advantage. In this case, access to capital, typically in the form of revenue bonds, may be a key motivation for reorganization. Independent public entities (such as authorities or public benefit corporations) and even private, nonprofit hospitals either can issue tax-exempt revenue bonds through a state financing authority or can issue taxable revenue bonds.

Because a freestanding health system may not have the revenues to support a strong credit rating, credit enhancement may be required. Credit enhancement refers to any sort of insurance or guarantee issued by a highly dependable financial organization, quasi-government agency, or government entity. Common forms of credit enhancement include private mortgage or bond insurance, letters of credit, and mortgage-backed

insurance issued by the federal government pursuant to Section 242 of the National Housing Act and backed by the full faith and credit of the United States.

Fundraising

In many instances, a safety net hospital will want to augment its revenues through a charitable giving program. Historically, safety net hospitals operated as part of a government entity have perceived that their public nature would deter donors from making financial contributions. However, a number of safety net hospitals have built vibrant charitable giving programs.

Safety net hospitals seeking to establish a charitable giving program must apply for and maintain 501(c)(3) nonprofit status from the Internal Revenue Service. Not only does this status exempt the hospital from federal taxation, but it also allows donors to deduct their contributions on their individual or corporate tax returns. While local government entities are generally exempt from federal tax, they should still apply for 501(c)(3) status to encourage private donations.

Many safety net hospitals have established or cooperated in the establishment of parallel charitable foundations whose sole purpose is to support the mission of the hospital. These foundations are by no means a requirement of a charitable donation development program, but they can offer some strategic advantages. First, in many states, any funds that are donated directly to a public entity become “public funds” whose use is encumbered by constitutional “anti-donation” clauses. If the foundation’s assets do not constitute public funds, there will be much more flexibility in putting the charitable contributions to use. Also, even if the safety net hospital is subject to sunshine laws, such as open records or meetings acts, the foundation may not be subject to such restrictions. This might prove advantageous for certain capital campaigns. Further, many hospitals and other charitable organizations may load their boards with individuals who are either capable of making large contributions to the organization or of generating large contributions. In

many instances, the composition requirements (formal or practical) for safety net hospital boards may preclude the hospital from placing as many major donors on its board as would be ideal from a charitable contribution perspective. Further, in light of the complexity of governing a hospital, many community leaders may be reluctant to serve on a hospital board. By creating a parallel charitable foundation as a separate entity, the board of that organization can be composed largely of local leaders who are capable of generating revenue for the hospital but who need not make the time commitment or do not have the skills required of regular hospital board members.

There are strategic issues that must be addressed when establishing a charitable foundation. First, the parties involved must decide what overlap, if any, there would be between foundation board members and either the hospital board or the hospital management. The more overlap there is, the more likely it is that hospital priorities will be the foundation’s priorities. Second, before promoting a separate foundation structure, the hospital needs to seriously consider whether it wants to cede control of donated funds to an independent entity. It is possible that such a foundation might at some point decide to restrict the use of its funds to projects that are not top priority for the hospital. Finally, the two entities will need to establish mechanisms to coordinate fundraising campaigns, messages, and donor targets in order to maximize the effectiveness of the donor program.

Next, the parties need to consider the operational issues. Often, the charitable foundation will rely on the hospital to provide the day-to-day staffing and financial management for the foundation. While these arrangements are permitted, they need to be well documented. Because the hospital and foundation are legally distinct entities, there cannot be any commingling of funds. The parties need to establish procedures that ensure that donations to the foundation are deposited into a separate bank account and tracked through separate ledgers. Further, the responsibilities of

employees who perform services for both the hospital and the foundation must be clearly defined. If the hospital provides any direct or indirect support for the foundation, this relationship should be documented in writing, even if no compensation changes hands.

Accountability, Managerial Flexibility and Autonomy

A fundamental challenge in reorganizing public health systems today is to retain a bold and capable management team and ensure that it is empowered to carry out its vision with a minimum of interference but with appropriate oversight and governance. The strategy for accountability may differ depending on whether a public or private structure is chosen, or whether new state legislation is adopted.

Reducing the Burden on Public Entities

A reorganized but still public health system must be able to avoid the exposure of sensitive information to competitors (based on “sunshine” laws), delays due to multi-layered decision making or lengthy approval processes, and otherwise becoming involved in the complexity associated with public endeavors. It takes a sensitive hand to accomplish these goals while maintaining adequate public accountability.

A number of potential strategies are available to ensure a reasonable level of accountability, particularly where public funding or the use of public assets continues. In most cases, these problems can be eliminated or ameliorated, even for a public health system, through statutory exemptions. For example, though it may not be practical (or even desirable) to eliminate all open record and open meeting requirements if the hospital remains public, it may be possible to extend exemptions to include competitively sensitive issues in addition to the more typical sunshine law exemptions. Westchester County, New York, adopted this strategy in drafting legislation to reorganize its medical center, by including an explicit sunshine exemption for certain marketing strategies and strategic plans.

If the decision is to undertake a less radical reorganization through non-statutory means, it may be more difficult for a public health system to obtain relief from many of these constraints. Sunshine, competitive bidding, procurement, civil service, and other consequences (positive and negative) of being a “public employer,” and other statutory requirements generally continue to apply. Even so, it may be possible to amend certain of these constraints through contract or through local ordinance or resolution.

Ensuring the Accountability of Private Entities

Full conversion to private status should afford complete relief from “governmental entity concerns.” However, given the desire to provide accountability for the continuation of the health system’s mission and for use of public assets, it may be advisable to include contractual requirements. To ensure that these requirements are enforceable and remain in effect over time, they are most often included in the lease or other transfer documents. Alternatively, these conditions may be part of a service agreement requiring certain public services, generally in exchange for public funding. Accountability should be tied to funding in this way only if it is acceptable to relinquish public accountability if and when the health system relinquishes public funding.

A number of additional strategies for enhancing the accountability of the reorganized health system require that the city or county government retain the right of approval of certain key decisions. For example, the local government may retain some degree of control over board appointments through nominating or appointing one or more board members.

Similarly, local government may retain approval of certain key acts, such as sale of the facility, approval of management contracts or elimination of certain safety net services. The health system also may be subject to periodic reporting requirements and annual audits. One common requirement, in effect at Regions Hospital, the nonprofit successor to the St. Paul-Ramsey Medical Center, is that the hospital must provide its annual

financial statement to the county, as well as an annual report on improvements to county property. Another common mode of accountability is reversion of the facility and other assets to the government upon dissolution of the corporation or the breach of certain critical statutory or contractual requirements.

Board Structure

Chapter III above addresses some of the issues and requirements for safety net trustees generally. While there is necessarily some duplication, this section will specifically identify those Board issues that should be taken into account in implementing a restructuring of a safety net hospital.

A strong and independent board brings crucial vision, leadership, and perspective to bear on a health system's present operations and its future. A balanced board, whose members exercise independent judgment unimpeded by conflicting loyalties, is essential to any system's optimal functioning. The board should include a variety of relevant expertise and a range of experience and perspectives; and above all, it is critical that the members be dedicated to the health system and its mission.

Selecting Individual Board Members

Many of the same issues addressed in Chapter III above concerning the role and responsibility of safety net hospital trustees also apply to adopting a new legal structure or otherwise reforming governance of a hospital or system. At the same time, there are also issues that are specific to the type of reorganization being undertaken. For example, a merger of existing hospitals creates unique issues involving the control and composition of the resulting system's board. In contrast, if the reorganization involves the transfer of the public hospital's operation to an existing system, the acquiring system's board may take over without internal change. If the restructuring occurs without combining with another system, the central concern is to retain the best of the current board and ensure that new appointments are strong.

The most important element in the success of a board is, of course, the individuals who serve at a given time. A number of issues are central to the selection and composition of governing boards, including:

- *Independence*: responsiveness to the mission of the health system, rather than to political or parochial interests
- *Qualifications*: the necessary range of expertise and an appropriate balance of perspectives
- *Accountability*: through power of appointment and removal, and length of term
- *Stability and Continuity*: as opposed to substantial turnover each time a new city or county administration is elected, for example
- *Dedication*: willingness to place the needs of the health system above potentially conflicting interests and to devote energies to the system and its mission.

Appointment and Removal

Although no selection process can guarantee continued excellence, certain mechanisms can improve the chances of success. For example, independence and a balance of perspectives can be fostered in a number of ways. One method is to broaden the appointive powers so that no single individual or body appoints all or most of the board. Also, the appointing entity can be required to appoint from nominations by an independent source; most often by the board itself, but sometimes from various community groups or others.

On the other hand, self-perpetuating boards can be effective. A solely self-perpetuating board is uncommon among public entities because more direct public accountability is generally desired.

Another method to enhance board independence concerns the power of removal. A board member who can be removed only for cause or only by a supermajority of the board, rather than by a separate appointing entity, may be better able to exercise independent judgment than one who can be removed

at will. A trade-off here is accountability, though this can be achieved by mandating public meetings, annual audits and reporting, and reasonable conflict of interest provisions.

Other Strategies

Staggered terms contribute to stability and continuity on a board and can enhance independence when board members are appointed by a single official, such as the mayor or council chair. The mode and relative importance of accountability may depend on the extent to which the system remains in the public sector; that is, in a system viewed as primarily public, direct accountability to public officials is typically expected, while a system regarded as private may be held accountable more broadly to the public, its patients, etc.

Mandatory qualifications can provide the board with necessary expertise as well as contributing to a breadth of perspectives. However, it is important to avoid rigid qualifications for too large a portion of the board, as this can interfere with the selection of the best person available when a vacancy arises. In addition, it is important to avoid the balkanization and conflicting loyalties that can arise when members feel that they have been appointed to the board to represent specific outside groups or interests. The board and its members must recognize and respect the delicate balance between providing a particular perspective and representing an outside interest.

Perhaps the most constructive element is to establish an ethos among the community, the person or body responsible for board appointments, and the board itself, that the health system board is a place for experience, excellence, and dedication rather than political patronage or outside agendas, and that each member is expected to take the position seriously. The appointment of persons known and respected in the community, so-called “heavy hitters,” can contribute to this, as long as they are indeed willing to be active board members rather than window dressing. This level of involvement is most likely to occur when the board

is invested with real authority, for example, when the CEO is directly responsible to the board and the board is empowered to set and implement policy in central areas of health system operations.

Medical Staffing

Safety net hospitals and health systems often differ significantly from community hospitals in their physician staffing arrangements. In most community hospitals, physicians are neither employees of the hospital nor independent contractors. Rather, they are independent providers on the hospital’s medical staff who use the hospital as their “workplace” for complicated procedures. Generally, community hospitals work with their physicians to establish governing bylaws that dictate who can practice in the hospital and the rules governing that practice. However, outside of certain administrative duties or certain hospital-based specialties such as radiology or anesthesia, community hospitals generally do not pay physicians to provide medical services. Physicians at these hospitals generally bill patients or third-party payers for medical services rendered.

Safety net hospitals, in contrast to community hospitals, often serve a high proportion of uninsured or underinsured patients. The payer mix of the patients may be insufficient to attract community-based physicians to provide services. Consequently, many safety net hospitals have to develop alternative strategies for obtaining physician services.

Employing physicians is one option for obtaining professional services, and many safety net hospitals do employ physicians in certain service areas. However, it can be very expensive to staff an entire hospital with physician employees. Most safety net hospitals facing this issue have historically affiliated with a medical school to obtain professional medical services.

Under an academic center affiliation model, the hospital typically will acquire the services of faculty physicians and residents to provide medical services. Residents are medical school graduates who are

licensed physicians enrolled in post-graduate specialty training programs. The residents may be the employees of the hospital or of the medical school, but typically they can only provide services under the supervision of a physician with a faculty appointment in a designated training program. Resident salaries are typically much lower than those of independently operating physicians. Further, the Medicare and Medicaid programs typically provide enhanced reimbursement to hospitals that serve as training centers for graduate medical education.

The academic center affiliation has potentially significant advantages and disadvantages for the hospital. On the plus side, the relationship typically allows the hospital to acquire a higher caliber of physician, in the form of faculty, than would otherwise be willing to serve the hospital's patient base. Further, the overall cost of acquiring physician services can be lowered significantly by employing residents. Finally, the academic medical center status can add prestige to the organization.

On the other side of the ledger, the training program structure creates certain inefficiencies for the hospital. First, residents tend to order many more tests than experienced physicians, raising hospital costs. Second, the requirements of training programs are not always completely aligned with best principles in customer care. Many patients view the academic staffing model, which often does not provide continuity of care, as being unfriendly or difficult to navigate. Third, individual faculty members may rotate through other hospitals or have other interests such as research, which may divert their attention from patient care services.

The safety net hospital-medical school relationship has a long history of promoting excellence both in patient care and in education. However, because these relationships are often exceedingly complex, they require significant oversight as well as maintenance of strong lines of communication with medical school partners. With the many changes occurring rapidly in the health system today and with the need to realign incentives, a safety net hospital board should expect to

pay considerable attention to issues related to the reform of physician relationships or issues arising from ties to medical schools.

Personnel Issues

A positive and effective relationship with personnel can be the critical element in a health system's success. The labor force constitutes by far the largest single expense for a health system, and in this era of cost competition, efficient use of personnel is critical in containing costs. But even more important than their efficiency are employees' performance and dedication. In a service sector like health care, the employees are a critical element in patient satisfaction, quality of care, and the system's overall success. Moreover, the support of the personnel is often critical in successfully adopting and implementing the reorganization effort.

Many public health care systems find themselves constrained by a civil service system designed for other sectors of the government and by collective bargaining agreements negotiated with little input from the front lines of the health system—i.e., from hospital and clinic management or personnel. As a result, a common goal of reorganization is for the health system to remove its personnel from civil service altogether or, at a minimum, to obtain direct control of its civil service system and to direct its own collective bargaining.

Civil Service Status

Health systems that will retain public status will generally also remain subject to civil service. One strategy to ease the burdens that may be associated with this status is to create an independent civil service system directly administered by the health system. Similarly, separate bargaining units can be created either automatically (by the creation of a separate employer) or through legislation to permit separate negotiation of collective bargaining agreements for health sector workers. Nonetheless, as long as a health system retains its public status, it is generally impossible—whether for legal or practical reasons—to eliminate the application of civil service altogether.

Transfer of Employees

Although civil service requirements will not pertain to a private employer, a privatized health system may opt to provide certain benefits or guarantees to transferred workers. For example, the hospital may guarantee that transferred workers will receive the same positions, pay, or certain terms of employment. Pension rights, seniority, and accrued vacation and sick leave also may be transferred. This approach has been taken in a number of hospital reorganizations, including the transfer of Detroit Receiving to a private corporation in 1980. In that case, while positions in the new organization were not guaranteed, to the extent that positions were available, employees were guaranteed the same rate of pay and transfer of seniority with respect to retirement and other benefits. Even so, labor vigorously challenged this organizational change, including a legal challenge heard in Michigan's Supreme Court.

Another important consideration is the treatment of various subgroups of employees. For example, moving out of the public sector can improve the ability to provide cafeteria benefits and certain other benefits typically desirable to high-end employees. This also may permit the use of various recruiting incentives to attract non-employee physicians.

In a number of cases, the employees of reorganized hospitals have been given the option of retaining their status as local government employees. In other cases, employees wishing to remain employees of the local government have been reassigned to positions outside the hospital setting.

In general, offering employees the right to retain current personnel status can be beneficial. It is important to recognize, however, that compromises resulting in dual, co-existing systems not only increase expenses but can greatly complicate the operation of the health system. Managers who supervise health

system employees as well as those leased from local government must be conversant with two sets of personnel rules, and friction can arise among personnel who resent differences in pay or other treatment.

Implementation Process

Once the parameters of the reorganization have been decided and adopted by the relevant decision-making bodies, the real work begins. The task of implementing the reorganization is substantial, and the prospect can be daunting at the outset. Most find that it becomes much more manageable if a comprehensive implementation plan is developed with clear assignment of responsibilities for tasks or groups of tasks. Specialized consultants, e.g., with legal or accounting expertise, may offer valuable assistance at this stage whether or not they have been used earlier in the process.

A number of organizations have adopted a committee approach to implementation, appointing a series of committees or task forces with responsibility for implementing discrete portions of the reorganization. For example, task forces might be useful in such areas as personnel, finance/budgeting, legal, procurement, capital/strategic planning, and information systems. The task forces should include administrative and clinical staff with particular expertise in the relevant area. It is also helpful where feasible to select individuals whose investment in the process might be parlayed to encourage the support of their peers and co-workers. Each task force can be delegated responsibility for developing a detailed implementation plan in its respective area. It is challenging for critical personnel to staff implementation task forces while continuing their full-time responsibilities, though consultants may reduce the burden by coordinating and focusing task force activities, providing relevant information from similarly situated hospitals or conducting other research, and drafting task force reports. A limited number of site visits to (or from) other reorganized public systems also can be beneficial.

V. Examples of Restructured Safety Net Hospitals & Health Systems

In order to survive and compete in this era of health reform and deficit spending pressures, safety net hospitals and health systems must seek to provide a comprehensive and integrated array of high-quality services. Only by holding itself out as an integrated delivery system or as part of an integrated delivery system can a safety net hospital attract newly covered patients and also improve quality, reduce costs and achieve economic stability during the implementation of health reform.

More specifically, many safety net hospitals have looked to restructuring as a tool to accomplish a wide range of goals, as outlined in Chapter IV above, such as the following:

- Enter into productive relationships with other health systems.
- Act more competitively in the marketplace. Restructuring can facilitate the organization's ability to embrace some of the competitive characteristics of successful not-for-profit hospitals.
- Reduce existing indebtedness and gain access to capital.
- Improve clinical integration and quality of care. Integration of health care services and quality of care are both expected to be increasingly critical drivers in the wake of health care reform.
- Improve and maintain reimbursement, including the ability to respond to the opportunities and challenges of health reform. A strategic restructuring will provide new opportunities for increased third party reimbursement while retaining existing reimbursement streams.

As a result of these imperatives—and others described in the preceding chapter—a large and growing number of safety net hospitals have successfully implemented reforms to their governance and legal structure in recent years. These have ranged from fairly limited reorganizations, such as the creation of a new advisory or management board within local government, to more dramatic reforms, such as the merger or consolidation of safety net providers with a range of other organizations and entities to form broader integrated delivery systems. It is the purpose of this chapter to summarize examples of successful reorganizations across the full range of potential models.

Semi-Autonomous Governing Board Within Local Government

Under this model, a hospital or public health board has authority to manage the daily operations of the hospital or health system. While these separate boards or divisions typically do not constitute a legally independent entity, this structure entails a higher degree of autonomy than direct operation by state or local government without an intervening dedicated board. However, this structure is sometimes deemed inadequate to the tasks facing a public health system today.

Jackson Health System/Miami-Dade County Public Health Trust

The Jackson Health System (JHS) is a multi-hospital integrated health system with more than 2,200 inpatient beds centered around Jackson Memorial Hospital in Miami. In 2010, a grand jury assessed the adequacy of the system's governance and legal structure and recommended changes in both structure and governance. The grand jury also recommended the appointment by Miami-Dade County of a hospital governance task force to assess possible options. The county appointed

the task force in March 2011, which issued its report in May 2011. The task force final report recommended the creation of a nonprofit corporation with a nine-member board of directors, initially appointed by the mayor and county commissioners, but subsequently to be self-perpetuating. The county did not accept the recommendation.

Until 2011, JHS was governed by the Miami-Dade County Public Health Trust. The 17 members of the trust were appointed by the county commission, with certain *ex-officio* members; and the county also retained substantial control over major financial, procurement and personnel policies of JHS. In February 2011, JHS received an offer from a private equity company to purchase Jackson Memorial Hospital for more than \$1 billion, but the offer was subsequently withdrawn. Due to the system's financial instability, in May 2011 the county commission turned over governance of JHS to a financial recovery board for a two-year period. This board consists of seven members, recommended and voted on by the county commission.

Cook County Health and Hospitals System

In Cook County, Illinois, the county's two full-service hospitals (The John H. Stroger, Jr. Hospital and Provident Hospital) are operated by the Cook County Health and Hospitals System (CCHHS). In addition to the hospitals, CCHHS provides public health services to over five million residents through its operation of the public health department, an outpatient center for HIV patients, a network of ambulatory and community health centers, and the largest freestanding correctional health care facility in the country. Prior to 2007, the sole governing body was the 17 elected officials of the Cook County Board of Commissioners, who served as the governing policy board and legislative body for the entire county. In 2007, the county board voted to establish a separate governing board for the health system, and CCHHS was established in 2008. Comprised of 11 members appointed by the county commissioners, this board is permitted to operate with a certain measure of autonomy in areas such as

appointment of the CEO, purchasing, contracting, operations and personnel.

University Medical Center of Southern Nevada

The University Medical Center of Southern Nevada (UMC) is a county-owned hospital that is the major teaching hospital and trauma center for the Las Vegas metropolitan area. Prior to 2010, UMC's governing board was the Clark County Board of County Commissioners. In June, 2010, the commissioners adopted a resolution creating an 11-member University Medical Center Advisory Board, with members who had backgrounds in cardiology, oncology, pharmacy, public health, gaming, senior services, human resources and business. The commissioners delegated a number of duties, responsibilities and functions to the board. Those included strategic planning, oversight of quality, financial oversight and recommendation of the UMC CEO. Approval authority of UMC contracts below a certain dollar threshold also was given to the new advisory board; however, the commissioners reserved final approval. Criteria were spelled out in the resolution for membership in a number of categories, including purchasers of health services, physicians, organized labor, civic or community leader and individuals with legal and business management backgrounds.

Natividad Medical Center

Located in Salinas, California, Natividad Medical Center (Natividad) is a 172-bed public hospital owned and operated by Monterey County. Natividad is overseen by an 11-member board of trustees established by the County Board of Supervisors in 1989. Seven trustees are selected based on their skills in certain areas, including finance, executive, and health care experience. Four individuals in specific hospital and county offices serve in an *ex-officio* capacity. Individual trustees are nominated by the board of trustees but appointment authority is held by the board of supervisors. The board of supervisors also retains a number of powers, including approval of borrowing, contracts, and budgets. Due to external market forces and regulatory pressures, Natividad is shifting toward

more financial autonomy from the county. In July 2011, in order to streamline and integrate operations at Natividad, the board of supervisors approved in principal the creation of a public hospital authority. In December of 2011, the board of supervisors modified their earlier direction on forming an authority, to focus on an affiliation with a struggling local district hospital. Natividad Authority legislation is working its way through the Assembly and the Senate in California in 2012. Passage of state legislation and a county ordinance would be required to achieve this type of reorganization.

San Joaquin General Hospital (SJGH) Interim Board of Trustees

In June 2010, the San Joaquin County Board of Supervisors passed a resolution authorizing the initiation of a reorganization of SJGH as a separate entity from the county's Health Care Services Agency. Specifically, the resolution recognized that SJGH needed to stand apart from the county in order to be more responsive and flexible to changes in the health care market. As part of the approval to move forward with the independence of SJGH, the board of supervisors created an interim board of trustees to serve as advisors to the board of supervisors and help guide SJGH's transition to a separate entity. In doing so, the County Board of Supervisors recognized that SJGH required a hospital-specific board that would better understand the issues that were of particular concern to a hospital system. The 11 members of the interim board were recommended by an ad hoc committee of the board of supervisors and appointed by that board.

Hospital Authority/Public Benefit Corporation

While the precise definition of the term may vary from state to state, a hospital authority is typically a distinct government entity, operating with a greater degree of independence from local government than the advisory boards described in the previous section. It is governed by a functionally dedicated board, whose development or ongoing appointments often involve local government. A hospital authority may be organized

under a generic, statewide hospital authority statute or may require the enactment of special legislation.

During the hospital building boom that followed World War II, hospital authorities were used throughout the country to gain access to local bond financing of new hospitals. At one point, approximately two-thirds of all of the hospitals in the state of Georgia were structured as county authorities, although many have since restructured as nonprofit corporations (see the discussion of the Grady Health System below).

In some states, an alternative "public benefit corporation" (PBC) structure has been adopted. These are also entities created under state laws, and in most cases (as described in Chapter II above) their enabling legislation is very similar to those of authorities. (In California, however, a public benefit corporation is defined in state law as a nonprofit corporation.)

The primary benefit of an authority or PBC structure, as opposed to a board that is simply appointed by city or county government, is that it derives many powers from the legislation that authorized its creation. For the most part, authorities cannot simply be disbanded or have their power eroded by elected officials. While city or county governments may appoint their boards, for example, many authorities have limitations on the ability to remove board members without cause; and their enabling legislation often gives the authority's board considerable power to develop personnel systems, issue bonds, manage their own procurement and budget both revenues and expenditures without government approval.

At the same time, there are authorities in various parts of the country that lack some of these powers, and the authority or PBC structure is very much a "designer option" that can differ sharply from state to state (and even within states, from hospital to hospital).

Alameda County Medical Center

In 1998, the California legislature created an independent governing body, the Alameda Hospital

Authority, and the board of county supervisors by ordinance transferred the governance of the Alameda County Medical Center (ACMC) from the county to the authority. On July 1, 1998, ACMC began managing and operating certain hospitals and clinics which had previously been managed and operated by the county. Three agreements, known as the Transfer Documents and comprised of: (1) the Master Contract, (2) the County Services Agreement and (3) the Medical Facilities Lease, form the basis of ACMC's contractual relationship with Alameda County and lay out the transfer of authority of certain medical facilities from the county to ACMC. Pursuant to the Master Contract, the county is obligated to pay ACMC for the provision of indigent care. Pursuant to the County Services Agreement, the county provides certain support and ancillary services (such as accounting and auditing services) to ACMC that it had provided to the county medical facilities before the transfer of authority. Pursuant to the Medical Facilities Lease, the county leases the medical facilities to ACMC for \$1 per year for a term of 30 years.

Between 1998 and 2004, the county funded the working capital costs of ACMC through weekly or bi-weekly transfers of funds to ACMC. In 2004, Measure A was passed by county voters, which provided funding to ACMC through a tax increase on retail sales in Alameda County. Seventy-five percent of this revenue goes directly to ACMC (although it is collected by the county), while the remainder is allocated to health services in Alameda County at the discretion of the board of supervisors.

ACMC has the power to create its own personnel systems and establish its own procurement policies, although it has tended to follow county guidelines in both areas. ACMC does not own the facilities transferred by the county, although it may purchase, construct or otherwise own other facilities. ACMC does not have authority to issue bonds.

Nassau Health Care Corporation

In New York, state-created public hospital entities that are called "authorities" elsewhere are known as "public benefit corporations." In 1999, Nassau County Medical Center was transferred by the County to the Nassau Health Care Corporation (NHCC), which was created as a public benefit corporation under Section 3400 *et seq.* of the New York Public Authorities Law so that it could assume certain functions of the county in providing health care services to Nassau residents. The enabling statute grants NHCC a range of powers typical of a public benefit corporation, including the authority to issue bonds, create subsidiaries and enter into contracts in order to perform its duties. Resulting either from its designation as a public benefit corporation or from specific provisions of the enabling statute, NHCC must comply with considerable limitations on its operations. For instance, it is subject to New York State pension requirements, civil service laws, procurement rules and open meeting requirements.

After its creation, NHCC entered into several agreements with Nassau County. Among these agreements are those that govern the subsidies provided by the county to fund NHCC capital projects and reimburse NHCC for health care services provided to the local community, establish a county guaranty of NHCC bond issuances, and place restrictions on NHCC's employee relations. In addition, NHCC undertook at its inception substantial debt obligations to fund its initial acquisition of the county's pre-existing health care facilities and defray the cost of subsequent capital projects. In recent years, NHCC, which was renamed NuHealth in 2009, has sought to deepen its clinical affiliation with North Shore-Long Island Jewish Health System, in order to foster a stronger integrated care delivery system and broaden the scope of services available to NuHealth patients.

Hennepin County Medical Center

Hennepin County Medical Center (HCMC), located in Minneapolis, is comprised of a 430-bed hospital and associated clinics and serves as a training site for the

University of Minnesota's medical school. HCMC was owned and operated directly by Hennepin County from 1964 until 2007, when it was reorganized as an independent public corporation. The county board of supervisors spearheaded the reorganization, recognizing that as a county governing board with multiple responsibilities, it was unable to manage HCMC with the expertise and efficiency required. Following separation from county government, the HCMC board developed a new personnel system, improved recruitment (particularly of senior management), and began work on restructuring the hospital's relationship with its medical staff. The county continues to provide up to \$20 million annually to cover uncompensated care and also agreed to provide HCMC with an additional \$100 million over its first five years.

Management has benefited from having an engaged and knowledgeable board that can provide sophisticated and relevant advice and feedback on management's initiatives. Of particular importance to the county, HCMC's productivity has also improved. One of the goals of the reorganization was to realign HCMC with its faculty physician workforce, which had been spun off into a nonprofit corporation, Hennepin Faculty Associates, in the 1980s. In 2011, the two parties made significant progress in achieving the goal of unifying the two entities and aligning their incentives and leadership for the future; Hennepin Faculty Associates merged into HCMC on January 1, 2012.

Denver Health and Hospital Authority

The Denver Health and Hospital Authority (DHHA) was created under special state legislation drafted and adopted in 1996 to operate the Denver Health System. Denver and its Department of Health and Hospitals, which at that time was responsible for the city's health care services, recommended and developed the new government authority. Members of the DHHA board are appointed by the mayor, subject to confirmation by the city council. They serve staggered five-year terms—reducing the likelihood that one mayor will be able to appoint the entire board—and removal requires

an ordinance, further diluting the power of a single individual to control the board. The enabling act spells out DHHA's public mission and envisions that DHHA will provide health services to city residents, while enjoying funding and in-kind services from the city. The DHHA board is granted substantial financial authority, including the right to control its own budget, issue bonds, and contract on its own. It also enjoys autonomy in civil service, purchasing, and other areas.

Hawaii Health Systems Corporation

The Hawaii Health Systems Corporation (HHSC) is a public benefit corporation created by the state of Hawaii to operate a statewide system of hospitals and long term care facilities. The evolution of this corporation began pre-statehood when the major activities of several Hawaiian islands centered around the sugar and pineapple plantations, which in each county were responsible for providing medical care to residents. During the years 1950 to 1965, the cost of this care grew to the point where the individual counties could no longer afford it.

In 1965, the county public hospitals officially became a state responsibility. However, the counties still ran the facilities with very limited state leadership or control. Then in 1967, the state, through the Department of Health (DOH), began the transition from county management to full state control.

Many governmental and private studies were conducted over the years after the state assumed responsibility for this system. Virtually all of the studies undertaken concluded that significant organizational and structural reform was necessary if the system was to ever operate efficiently and effectively.

In 1994, Governor Benjamin Cayetano initiated a Blue Ribbon Task Force to create a new and more autonomous agency, a public benefit corporation, as the prescription for needed reform. The task force included many representatives from the Hawaii health care, labor, and business communities.

Based upon the recommendations of this Blue Ribbon Task Force and with the support of the governor, the legislature passed a law in the 1996 legislative session formally creating the Hawaii Health Systems Corporation with an effective date of July 1, 1996. In November of 1996, the DOH transferred the liabilities and assets to the new 13 member Corporation Board of Directors who were appointed by the governor. In 1999, HHSC was formally divided into five regions.

In response to the unique challenges faced by the regions, the legislature, in 2007, passed another law, which enabled each of the five regions to establish their own governance, thereby creating five regional health systems and boards of directors, while retaining a system-wide corporate board. In 2009, the legislature provided the regions with authority to transition into various legal entities.

Hospital District

A hospital taxing district is an independent instrumentality of the state government that has taxing authority and defined geographic boundaries. It is distinct from a hospital authority or public benefit corporation in that it has the ability to levy taxes, subject to specified statutory limitations. Hospital taxing districts can be organized under generic, statewide legislation (as in California) or through special legislation unique to each district (as in Texas, Arizona and other states).

In California, there are more than 140 health care and/or hospital districts with directly elected boards of trustees. These districts typically raise only a limited amount of funding from directly levying taxes—primarily to support the interest and principal payments on bonds sold to build or renovate the hospitals or other facilities in question. California health districts do not typically serve as safety net providers, especially in metropolitan areas where county or university hospitals and health systems also exist. A number of California health districts have experienced financial difficulties in recent years due to their deteriorating payer mix, urban

location, and the general state of third party reimbursement in California. In some cases, troubled districts have entered into sale, lease, or joint venture agreements with governmental and private providers to operate their hospitals.

Districts also exist in several other states. In Texas, hospital taxing districts are typically created under state law by county governments. In 2003 the voters of Maricopa County in Arizona approved the creation of a taxing district to assume responsibility for the former county health care system. In Florida, hospital or health care taxing districts are structured somewhat differently, with board members generally appointed by the governor.

Through much of the 1980s and 1990s, it was rare to see a new grant of local taxing authority awarded for public health care. However, between 2002 and 2004, voters in at least seven states or major metropolitan areas considered such new, dedicated taxes. Dedicated sales or property taxes were approved in Alameda County (Oakland, CA), Los Angeles County; Polk County (Winter Haven, FL); and the state of Montana. New health care taxing districts were approved in Travis County (Austin, TX) and Maricopa County (Phoenix, AZ). In April 2005, Kansas City, Missouri, voters approved a nine-year increase in the property tax to support health services, with two-thirds of the additional revenue going to the Truman Medical Centers. New taxes were considered but rejected in Oregon in 2004, where roughly one-third of new statewide property and other taxes would have supported the state Medicaid program; they also failed in Monterey County (Salinas, CA) in 2003, where 62 percent voter support fell just short of the necessary two-thirds approval.

Maricopa Integrated Health System

Maricopa Integrated Health System (MIHS), located in Phoenix, is a taxing health care district that operates Maricopa Medical Center, a 450-bed acute care hospital, as well as a burn center, children's center, large

outpatient, multi-specialty clinic and multiple community family health centers. Maricopa County spearheaded the restructuring of the medical center to create MIHS in 2003 and delegated to MIHS the county's responsibility for providing health care. MIHS was approved by the voters and has an elected governing board. It remains subject to Arizona open records laws. MIHS is authorized to receive up to \$40 million annually in tax support (indexed for inflation). To obtain political support for restructuring from other local providers, MIHS agreed to accept certain limitations on its expansion during its initial years of operation. In addition, MIHS is required to offer specified services and provide care to the medically underserved. The MIHS restructuring has been a success: the county is no longer required to provide health care directly and MIHS has achieved greater stability, enhanced control over financial planning, and better physician relations. In addition, the restructuring has given MIHS greater flexibility to expand alliances and position itself as a regional health care sector leader. Most recently, in 2011 MIHS signed an agreement to become the primary teaching center for the University of Arizona College of Medicine in Phoenix, further consolidating its reputation as a source for high-quality and cutting-edge care.

Palm Drive Health Care District

Palm Drive Health Care District (also known as the West Sonoma County Hospital District) was formed in 2000 through a ballot measure that created (and provided support to) the district through a tax levy. Palm Drive Health Care District owns and operates Palm Drive Hospital and the Palm Drive Medical Center. Pursuant to California law governing hospital districts, the Palm Drive Health Care District is governed by the Sonoma County Board of Supervisors and its subcommittee for health services. It is managed by a board of five publicly elected members who oversee the daily operations and management and govern for a four-year term. The initial board members were appointed by the board of supervisors, but subsequent members are elected in at-large elections.

Palm Drive Health Care District has statutory authority to levy taxes, upon approval of district voters. In 2000, voters approved a \$11.61 parcel tax to support hospital operations, which was estimated to raise enough revenue to allow the district to issue \$5.9 million in bonds. Voters approved a second parcel tax ballot measure in 2001 which raised the tax from \$12 to \$75 per \$100,000 assessed value, generating an extra \$2 million annually, earmarked for emergency room and operating room expenses. In 2004, voters again passed a measure that increased the annual property tax, this time to \$155 per parcel, raising approximately \$3.5 million annually.

Travis County Healthcare District/University Medical Center Brackenridge

In October of 1995, Seton Healthcare Network assumed management and control of the city-owned Brackenridge Hospital through a 30-year lease from the city of Austin, Texas. Seton is owned by the Daughters of Charity National Health System, a Catholic organization that operates 46 hospitals across the country.

Prior to this 1996 reorganization, Brackenridge Hospital was a city hospital whose management reported directly to the city manager and city council. The hospital CEO was the equivalent of a city department head. The hospital had a dedicated board, but it was advisory in nature. Although the city funded only about 12 percent of Brackenridge's revenues, city approval was required for the hospital's line-item budget, salary scales, procurement and all capital projects.

The city first began its consideration of a reorganization of Brackenridge in the early 1990s in response to growing operating losses and the fear of increased future reliance on city taxpayer funds. In addition, the hospital wished to avoid public entity regulations that burdened management's effective operation by affecting hospital personnel, purchasing and public disclosure. City officials convened a Health Care Task force in 1990 to study the provision of indigent health care

services. The task force recommended that Brackenridge remain a city-owned hospital, but that the city obtain taxing authority to help fund indigent care.

This proposal was initially rejected by city officials, as was a subsequent proposal to create a new authority structure, and the city instead entered into the long term lease with Seton. However, the creation of a district was revisited in 2004, and a new district was finally created in May 2004 by a vote of Travis County residents. The vote followed a concerted, two-year effort by a coalition of business people, health care providers, community leaders and elected officials dedicated to improving access to and delivery of quality health care to eligible residents of Travis County. Doing business as “Central Health”, the new district now owns Brackenridge Hospital, and has continued to lease it to Seton. The hospital has subsequently been renamed University Medical Center Brackenridge and has been named one of the best hospitals in Texas by *U.S. News and World Report*.

Central Health is a separate political subdivision of the State of Texas and is not a part of Travis County government. The boundaries of its health care service area are contiguous with Travis County. Central Health is governed by a nine-member volunteer board of managers. Four of the members are appointed by the Austin City Council and four are appointed by the Travis County Commissioners Court. Both governmental bodies jointly appoint the ninth member. In addition to its oversight of the Brackenridge lease, Central Health operates a range of other health care services, both directly and through contracting with area providers.

Newly Created Nonprofit Corporation

Many urban safety net hospitals no longer fit the traditional model. Rather, they have been converted to the nonprofit corporate form. The corporation is typically tax-exempt under section 501(c)(3) of the Internal Revenue Code and often enters into agreements

with the local government to provide safety net health services. The local government may or may not retain some degree of control over board appointments or other aspects of the corporation. Also, transfer of the health system assets may be achieved through a sale, a long-term lease or management agreement, or by other means. The activities and characteristics of each corporation, and any characterization under state or local law, should determine whether or not it is deemed to be a unit of government for various purposes. State university hospitals can also be structured as nonprofit corporations. State universities of Maryland, West Virginia, Georgia, Vermont, Massachusetts, and Florida have adopted this model.

The ongoing government role often depends on whether the hospital is transferred to an existing, wholly private health system or whether a new corporation is created for the purpose of operating the government health system. Depending on the type and extent of government involvement, the new corporation may be deemed private for certain purposes and public for others.

In California, county hospital facilities have been granted the authority under state law to establish subsidiary corporations. The California Government Code provides that health care facilities owned or operated by counties may “establish, maintain and carry on their activities through one or more corporations, joint ventures or partnerships for the direct benefit of those health care facilities and the health services that they provide.”²⁵ It is therefore possible for a county to create a nonprofit corporation that also retains the reimbursement advantages of a designated public hospital.

Grady Health System

In 1945, the state of Georgia adopted hospital authority legislation, providing a vehicle for Fulton and DeKalb Counties (encompassing greater Atlanta) to build or expand inpatient facilities for their growing populations.

²⁵ Section 23004.5, California Government Code.

The Fulton-DeKalb Hospital Authority was established to assume management of Grady Memorial Hospital, taking over as its governing body and building new medical facilities. The Fulton-DeKalb Hospital Authority has a volunteer board of 10 members, seven of whom are named by Fulton County Commissioners and three by DeKalb County Commissioners. Grady provides health care services to the uninsured and underinsured citizens of both counties, and the counties provide funding to Grady.

In 2008, a new non-profit corporation was created to take over the management of the Grady Health System, which today comprises a 953-bed acute care hospital, multiple neighborhood health centers and a children's hospital which is managed by Children's Healthcare of Atlanta. In April 2008, at the recommendation of a task force convened by the Metro Atlanta Chamber of Commerce and the authority, Grady was restructured under the governance of the nonprofit Grady Memorial Hospital Corporation (Corporation), as authorized under an enabling statute. The goal of the restructuring was to enable Grady to become more competitive by engaging in activities not permitted under the authority's enabling act, including flexibility to expand geographically and to enter into joint ventures with other health care providers. Under the lease and transfer agreement, the authority agreed to lease Grady's facilities to the Corporation. Although the Corporation has significant autonomy to conduct operations, it remains subject to certain public requirements, including open meeting and open records laws, regular financial reports to the authority, and the continued operation of Grady as a safety-net system. In conjunction with the governance transition, Grady received a cash infusion primarily from the philanthropic community. In particular, the Woodruff Foundation committed a donation of \$200 million over a period of several years for capital expenditures. The board of the Corporation initially held 17 members, appointed by the chair of the authority, and of whom four were members of the authority. Ten of the initial members were selected by the Atlanta Chamber of

Commerce. Board terms are staggered for between one and three years.

The lease and transfer agreement also addressed employment and retirement issues. The parties agreed that the authority would automatically transfer all of its employees to the Corporation, and the corporation agreed to offer employment to all such workers. With respect to retirement benefits, the parties agreed that the Corporation would not be responsible for former or retired employees. The retirement plan for existing employees was frozen at the time of the reorganization. The corporation created a separate 401-K retirement plan for all employees following the restructuring.

Regional Medical Center at Memphis

In 1981, the Shelby County Health Care Corporation (SCHCC) was created as a nonprofit corporation to operate the Regional Medical Center at Memphis (The MED), which had previously operated as a hospital authority. Pursuant to the *Tennessee Hospital Authority Act* and a resolution of the Shelby County Board of Commissioners, The MED's assets were turned over to SCHCC through a long-term lease, with the county retaining ownership of the land and improvements. The MED is required to make the facility available to all Shelby County residents who are in need of care, regardless of their financial status. Members of the SCHCC are appointed by the county mayor and confirmed by the county commission.

The MED submits its budget and audited annual report to the county, which approves and appropriates The MED's budget, including compensation for indigent care. SCHCC also receives capital appropriations from the county, though it maintains independent access to other capital markets through revenue bonds and joint ventures. Board meetings are open to the public, but The MED is otherwise exempt from the state sunshine laws, as well as from public bidding and procurement procedures. Its employees are not subject to civil service provisions nor are they eligible for county retirement benefits.

Reviewing all of these factors, the National Labor Relations Board (NLRB) determined in 2004 that SCHCC is a political subdivision rather than a private employer, and therefore The MED is not subject to NLRB jurisdiction.²⁶

Tampa General Hospital

In 1997, Hillsborough County Hospital Authority, which governed Tampa General Hospital (TGH), voted to transfer control of TGH to Florida Health Sciences Center, a newly-formed private, non-profit corporation. The board of the Florida Health Sciences Center now manages TGH under a county lease. TGH is Tampa's second-largest hospital and the main teaching campus for the University of South Florida College of Medicine. At the time of its privatization, TGH received no direct state or local subsidy, following a decision by Hillsborough County to convert its small subsidy into a county-wide indigent care funding initiative available to all hospitals in the county. At the same time, because of its safety net mission, open door policies, and status as the county's only major provider of tertiary care services, TGH's uncompensated caseload remained essentially unchanged. This burden was a major contributor to the deliberations that led to TGH's decision to privatize so that the hospital could compete on a more level playing field for privately insured patients and selected Medicaid patients. As an entity fulfilling a "public purpose," TGH is still expected to comply with Florida's liberally construed sunshine laws.

Pitt County Memorial Hospital

In February 1951, Pitt County (NC) Memorial Hospital was opened with 120 beds and named for the county's World War II veterans. With help from both a county bond issue and federal grants, construction began on the new hospital in 1974. By 1987, the county hospital employed 2,300 people with 560 beds. In the mid-1990s, hospital administrators realized the only way for the hospital to survive in the dynamic health care environment was through structural reform.

Privatization was a way to streamline the decision-making process to make it more competitive against other hospitals. A vocal group of residents did not want the hospital to change from public to private. The county commissioners voted for privatization by a narrow margin. The hospital restructured from a public entity to a private not-for-profit corporation in 1998. PCMH came under the umbrella of University Health Systems of Eastern Carolina (UHS) in 1999; UHS now manages or owns eight hospitals in eastern North Carolina.

Affiliation or Merger With Existing Organization

In a number of recent instances, safety net hospital services have been preserved by merger, affiliations or joint ventures with other entities in the community (or occasionally with regional or national organizations). These arrangements can take different forms, ranging from joint clinical affiliation to full asset mergers. They also can involve several different kinds of entities. While it may not prove feasible for various reasons to consider all of the different options, in order to provide a comprehensive overview, four different kinds of affiliations are discussed (with examples) in the remainder of this section:

- Nonprofit Hospital or Provider Organization,
- University,
- Health Plan,
- For-profit Entity.

Nonprofit Hospital or Provider Organization

A merger or partnership with an existing nonprofit hospital or health system has also been a prevalent affiliation model for public safety net teaching hospitals. In some cases, the acquisition of a local governmental hospital by a nonprofit hospital or system has resulted for all practical purposes in the disappearance of the public hospital or the substantial diminution of its

²⁶ Shelby County Health Care Corporation d/b/a/ The Regional Medical Center at Memphis, 343 N.L.R.B. No. 48 (2004).

ability to maintain its public mission. Milwaukee County Medical Center and St. Louis City hospitals are examples (which are not described here). However, in many other cases, public/non-profit partnerships have proved to be more effective in maintaining and strengthening the public partner's mission.

Boston Medical Center (Boston City Hospital)

The Boston Medical Center (BMC) provides an example of a comprehensive joint venture that was, for all practical purposes, a merger. BMC was created as a nonprofit corporation in July 1996, to consolidate and manage the public Boston City Hospital and the private nonprofit Boston University Medical Center Hospital (BUMC). As part of this process, the city created a new government agency, the Boston Public Health Commission. The city then transferred to the commission the responsibilities of the Boston Department of Health and Hospitals, including its public health function and ownership of Boston City Hospital. BMC entered into a long-term lease arrangement with the commission, which retains title to the former Boston City Hospital.

The Massachusetts state legislature approved and the governor signed a necessary home rule petition. The city council granted its approval in July 1997. The legislation required BMC to continue the city hospital's public functions, which BMC does under agreement with the commission. BMC also must prepare and file with the city an annual report on its provision of health care services.

BMC is governed by a 30-person board of trustees whose original membership included ten representatives each from the city hospital and BUMC; four representatives from community health centers; the executive director of the commission; the dean of Boston University Medical School; the president and CEO of BMC; the president of the BMC medical staff; the BMC physician in chief; and the BMC surgeon in chief. The chairman is appointed by the mayor. Under

the legislation, the merged hospital is deemed to retain the government status held by the city hospital for the purposes of certain state and federal safety net reimbursement and medical assistance programs. The commission is a unit of government. A seven-member board governs the commission, including the CEO of BMC and six members appointed by the mayor, subject to the approval of the city council. The mayoral appointments must include two representatives of community health centers affiliated with BMC and one representative of organized labor. The legislation explicitly authorizes the commission to issue bonds and notes, with approval of the city council and the mayor.

Fresno County Valley Medical Center

In October 1996, operation of Valley Medical Center (VMC), a county-run hospital in Fresno, California, was transferred through a 30-year lease by Fresno County to Community Hospitals of Central California, a private, nonprofit health system. The hospital was renamed University Medical Center, and Community Hospitals became Community Health Systems (Community) (subsequently renamed as Community Medical Centers). The contract stipulated that Fresno County pay Community an annual amount plus the county's Medi-Cal disproportionate share hospital (DSH) funding. In return, Community agreed: (i) to invest at least \$65 million in a new burn and trauma facility; (ii) to maintain the same access to ambulatory services that VMC had provided; (iii) to fulfill the county's obligation to provide health care to prison inmates and the poor; and (iv) to pay rent for the facility. The reorganization was intended to enhance access to capital and other resources, to better compete in a managed care environment, and to avoid restrictions in government reimbursements that supported hospital operations. The county terminated VMC's workforce, and the majority were rehired by Community. The new system was subsequently deemed a private provider for purposes of participating in Medi-Cal DSH, intergovernmental transfer (IGT), and certified public expenditure programs.

In fiscal year 2010–11, the county paid Community \$20.1 million but Community’s costs in providing medically indigent services were approximately \$82.6 million, a loss of over \$60 million to Community. In 2011, Community proposed modifications to the 1996 agreement in light of the county’s possible implementation of a low-income health plan. In order for the county to receive federal funding for this plan, Community proposed to terminate Community’s responsibility for providing care to inmates and the poor and return this responsibility to the county. However, the county determined that assuming additional costs and financial risks was not feasible.

University

Affiliations, mergers or acquisitions of safety net hospitals with universities have occurred on numerous occasions, both in California and elsewhere. In some instances, a public safety net hospital or system is simply acquired by a university health system. In others, it is placed under the management of a university health system. The degree of ongoing involvement by the local government varies, as does the purchase or lease agreement, or length of the management contract. The details of each arrangement will determine whether or not the health system continues to be considered a unit of government for various purposes.

Martin Luther King, Jr., Community Hospital/ University of California

In 2006, after persistent quality of care concerns, the Centers for Medicare & Medicaid Services (CMS) terminated Los Angeles County’s Martin Luther King, Jr. (MLK), Hospital from the Medicare program. This termination from Medicare ultimately led to the hospital’s closure in August 2007.

Shortly thereafter, the governor and officials from Los Angeles County (LAC) approached the University of California(UC) to discuss opening a new MLK hospital. University representatives met with

representatives from the Office of the Governor and LAC and jointly developed a proposal for the new hospital private nonprofit corporation supported by county funding.²⁷

LAC agreed, at its own expense, to build and equip a seismically-compliant 120-bed community hospital with an emergency room, three operating rooms, and no trauma center. The facility is intended to be ready for staff occupancy in mid-2013 with an intention to open to patients in early 2014. LAC will lease the physical plant to a new 501(c)(3) nonprofit corporation that will operate the hospital. The hospital is intended to be a community asset that addresses the major health needs of the community—hypertension, heart disease, stroke, diabetes, and obesity. The hospital also will provide obstetrical care. The hospital will become part of a larger clinic/outpatient-based community health care system alongside county-operated as well as private and federally qualified health center clinics.

The new nonprofit corporation is governed by a nine-member board of directors, with two directors appointed by the UC president, two directors appointed by LAC, and three directors appointed jointly by the UC president and LAC. Board members cannot be current officers or employees of UC or LAC, and must have at least 10 years of experience in health care or a related field. After five years, University and county may reconsider their authority to appoint members of the board and will, if mutually agreed, jointly request the corporation to modify such board-appointment authority.

Neither UC nor LAC will manage or operate the facility, and LAC has agreed to a number of funding commitments on behalf of the hospital. Those include a \$50 million one-time start-up fund for the hospital to be used for necessary expenses related to opening the hospital (e.g., consultant services, staffing, equipment and supplies, as well as supplemental funding for

²⁷ “Key Elements Between County & University Regarding Operation of MLK Community Hospital”, University of California, 2010

operating expenses incurred during the period before all beds are operational). LAC also will fund a \$20 million line of credit, to be available when hospital operations commence, and a one-time \$8 million reserve which can be accessed only by a vote of five of the seven board members in the case of “exigent” circumstances. LAC has also agreed to make an annual intergovernmental transfer of \$50 million to the state Medicaid program for the benefit of the hospital, initially secured by a \$100 million letter of credit obtained by LAC from a major lending institution, and an annual payment of \$13,300,000 to support indigent care services furnished at the hospital.

UC will contract with the hospital to furnish a broad spectrum of physician services necessary to operate the hospital, including appointment of the hospital’s chief medical officer and managing and directing medical education activities. This obligation will be contingent upon university’s ability to secure (initially and on an ongoing basis) payments for its physician services that—in university’s discretion—are reasonable for the type, quality, and volume of services furnished. Staffing will likely involve roughly 14-20 UC-employed hospitalists and intensivists, supplemented with community-based physicians.

The new corporation, at its own expense, will employ—or contract with a third party other than UC or LAC for the non-physician personnel working at the hospital.

University of New Mexico Hospital/Bernalillo County Medical Center

In 1978, Bernalillo County transferred management and control of the Bernalillo County Medical Center via lease to the University of New Mexico, with the goal of developing the hospital (which was adjacent to the UNM campus) into a major academic medical center. The university, which is governed by a seven-member board of regents appointed by the governor, agreed to create a new governance structure for the hospital. A hospital board of trustees was created that included two members appointed by the county board of supervisors.

The board of trustees reported to the board of regents of the university.

In 2010, the board of regents approved the creation of a Health Sciences Center board of directors to provide direct oversight to the clinical operations of HSC. All matters affecting the Health Sciences Center—academic, research, student, and clinical—would now proceed to the new Health Sciences Center board of directors for either approval or recommendation for approval to the board of regents. Additionally, this new board of directors would provide oversight and governance of the various component units within the Health Sciences Center, thereby eliminating the need for leadership to proceed through the various committees of the board of regents before approval by the regents. Lastly, the regents’ Health Sciences Committee would be eliminated.

The board structure would be composed of three members of the UNM board of regents; and four members of the community, one of which would be the sitting chair of the UNM Hospitals board of trustees. Through this board of directors, the Health Sciences Center would be able to increase the efficiency of its operations, become a highly integrated organization, create the UNM Health System and assure a balance between HSC’s academic and clinical missions.

The names of the seven people who make up the initial composition of the board of directors were announced in April 2011, and they held their first meeting in May 2011. As a result, all missions at the Health Sciences Center, including the hospital board of trustees, now report to the regents through the HSC board of directors.

While major decisions are still reserved by the regents, this structure has permitted UNM to transform the former county hospital into a multifaceted academic medical center, with substantial renovation and new construction, while maintaining its mission as a safety net health system for the residents of the county and the state.

UNM Hospital today serves as the primary teaching hospital for the UNM School of Medicine and also is the home of the highly regarded UNM Children's Hospital and the National Cancer Institute-designated UNM Cancer Center. The UNM Hospital system includes Carrie Tingley Hospital, UNM Children's Psychiatric Center and UNM Psychiatric Center and shares missions and resources with UNM's College of Nursing and College of Pharmacy as well as the New Mexico Poison Center. In addition to the main hospital, the UNM system operates 43 off-site clinics throughout the state, including the UNM Cancer Center South in Las Cruces, NM.

UMass Memorial Health Care

UMass Memorial Health Care (UMass Memorial), in Worcester, Massachusetts, consists of five area hospitals and several primary care facilities. It was formed in 1998 following state legislation that authorized the separation of all assets, liabilities and obligations of the clinical division of the University of Massachusetts Teaching Hospital (University), a state-owned organization, into a nonprofit corporation. The new nonprofit was then simultaneously merged with Memorial Health Care, a nearby nonprofit hospital system, to form UMass Memorial. The legislation specifically mandated that UMass Memorial not be an entity of state government. UMass Memorial is overseen by a 19-member board of trustees, of whom 10 were initially appointed by the university and nine were appointed by Memorial Health Care.

Under the merger, the university was given the discretion to keep its employees and lease them to UMass Memorial, or to terminate employees and have the new entity hire them. However, for a period of 10 years, longer-term employees could not be transferred to UMass Memorial, except with their consent. Pension benefits for longer-term employees continued to be provided under the state employees retirement system, while the merger created a fixed benefit pension plan for employees who thereafter joined UMass Memorial. In 2006, roughly eight years following the merger,

however, UMass Memorial officials sought to freeze the fixed benefit pension plan and to move nurses to a defined-contribution retirement plan, citing a \$100 million pension deficit. Nurses, with the support of their union, protested the change, and after negotiations, officials agreed to maintain the pension system as established by the initial legislation.

Health Plan

Safety net health systems increasingly have focused on care coordination and integration as tools to expand primary care, improve specialty access, lower costs, and enhance quality. These efforts are ongoing and a necessary component of safety net health system operations, given increasing patient needs. In addition to removing barriers to care, safety net health systems have transformed their delivery systems to maximize limited resources. Demand for care at safety net health systems, particularly during the current ongoing economic crisis, is high, creating an imperative to effectively manage patients and expand capacity to serve more patients where possible.

Coupled with current pressures facing safety net providers, the upcoming Medicaid expansion under health reform necessitates optimal organization of the safety net delivery system—where most Medicaid and uninsured patients are treated—so that these patients can access care. As in the existing Medicaid program in many states, it is sometimes not enough simply to provide uninsured patients with coverage—challenges often remain in providing the needed range of health services.

Many safety net hospital systems across the country have embraced an integrated model that incorporates a managed care organization into their health system. In some cases, the hospital has actually been acquired by the health plan; in others, it is the health plan that was acquired or developed by the hospital or health system. In all cases, these health systems have embraced a close affiliation or corporate relationship with a health plan as part of their overall strategy of developing a strong integrated care network.

Regions Medical Center/HealthPartners

Prior to 1986, St. Paul-Ramsey Medical Center (SPRMC) was organized as a public organization owned and operated by Ramsey County, Minnesota. In 1986, SPRMC was reorganized as a nonprofit “hospital subsidiary corporation” of Ramsey HealthCare, Inc. Ramsey HealthCare was established by the Minnesota legislature as a political subdivision of the state (similar to an authority) to serve as the corporate parent organization of SPRMC, Ramsey Clinic Associates, and Ramsey Foundation. In 1993, Ramsey HealthCare and its subsidiary organizations entered into an affiliation and merger agreement with HealthPartners, Inc., Minnesota’s largest health maintenance organization. Because Ramsey HealthCare was authorized by Minnesota law, the completion of the proposed merger with HealthPartners required changes in Ramsey HealthCare’s governing legislation. In the interim period, the parties agreed that HealthPartners would operate Ramsey HealthCare pursuant to a management agreement.

Effective May 4, 1994, the relevant Minnesota law was amended to allow the board of directors of Ramsey HealthCare to terminate its status as a public corporation and incorporate as a nonprofit corporation. The new law required the hospital to continue to provide hospital and medical care to the indigent of Ramsey County, and required that a number of amendments to the lease be adopted. The amendments addressed, among other things, the public employee status of employees of the newly formed nonprofit corporation and the corporation’s status as a “municipality” for the purpose of tort liability protection under Minnesota law with regard to any claims against the corporation that occurred before the date of its incorporation.

In 1997, SPRMC was renamed Regions Hospital, and it continues to operate successfully under its merger with HealthPartners. Today, HealthPartners is the largest consumer-governed, nonprofit health care organization in the nation, and Regions has received numerous awards for its delivery of care, including the LeapFrog

Group’s recognition as one of the 13 highest-value hospitals in the nation.

Virginia Commonwealth University Health System/ Virginia Premier Health Plan

Virginia Premier Health Plan (VA Premier) was acquired by the Virginia Commonwealth University Health System (VCU Health System) in the 1990s through bankruptcy proceedings. VA Premier offers two products: a Medicaid plan and a Children’s Health Insurance Program (CHIP) plan. Until recently, VA Premier was operated as a for-profit entity which was owned by University Health Services Managed Care, a subsidiary of University Health Services (UHS), itself an affiliate of VCU. On July 1, 2010, VA Premier began operating as a 501(c)(3) nonprofit and its stock was fully transferred to VCU Health System. As a nonprofit, VA Premier receives the benefit of a reduced tax burden. The VA Premier board of directors currently consists of a combination of independent members and employees of the VCU Health System.

Part of the rationale for transferring VA Premier to VCU Health System was speculation that, as part of a public entity, VA Premier could help draw down additional funding for VCU Health System that might become available through health reform. Also, as part of health reform, there was increased interest at VCU Health System in developing an accountable care organization (ACO), with the expectation that VA Premier could play a key role in managing such a system, given the infrastructure and expertise that it has as a managed care organization.

New York City Health and Hospitals Corporation/ MetroPlus

MetroPlus is a wholly owned subsidiary of the New York City Health and Hospitals Corporation (HHC) and began operations in 1985. It operates as a nonprofit with a separate board of directors from HHC, although some directors serve on both the MetroPlus and HHC boards. MetroPlus offers Medicare and Medicaid products, along with a small commercial insurance plan

for employees of HHC. The MetroPlus provider network includes all HHC hospitals, and a limited number of other hospitals and federally qualified health centers. Partnerships outside of HHC are designed generally to respond to capacity issues in the HHC service area, or because HHC does not provide certain services, such as transplants, that are covered under the MetroPlus plans.

HHC has developed a global capitation relationship with MetroPlus, which is seen as a beneficial way to align the interests of the two entities by incentivizing high-quality and low-cost care. With health care reform implementation underway, the global capitation model is considered a positive way to prepare for service delivery reforms. Going forward, MetroPlus will investigate ways to participate in health exchanges. In addition, HHC will strongly consider utilizing funds available under integrated delivery system demonstration projects, and sees their integrated model as a good first step toward developing ACOs. However they proceed, MetroPlus likely will take a lead role in development of an ACO (or other managed care model), given the infrastructure it already has in place for care management and coordination.

Contra Costa Regional Medical Center/Contra Costa Health Plan

Contra Costa Health Plan (CCHP), a federally qualified HMO founded in 1973, is a division of Contra Costa Health Services, a county-run health system. Among other divisions, Contra Costa Health Services also operates Contra Costa Regional Medical Center (CCRMC). CCHP offers a variety of plans, including ones under Medi-Cal managed care, CHIP, Medicare, a commercial plan for companies with employees in Contra Costa County, a subsidized program for low-income families, and a premium-based program for high-risk individuals.

Although CCRMC and CCHP are affiliated by their relationship with Contra Costa Health Services, CCRMC has no control over the operation of CCHP.

CCHP contracts with a number of health centers and community-based providers, and not solely with providers of Contra Costa Health Services. CCRMC and CCHP are not integrated, although there are some joint ventures between the two entities. For example, CCHP provides CCRMC with 24/7 advice nurses for pregnant women who are patients of CCRMC.

As part of health reform, CCHP is contracting with additional providers, recognizing that the numbers of enrollees is likely to increase with a larger base of Medicaid-eligibles. In addition, CCHP believes that it can play an important role for CCRMC should it desire to pursue development of an ACO, given CCHP's experience enrolling individuals in health plans and evaluating important metrics such as access to care.

Boston Medical Center/HealthNet

BMC, the parent of HealthNet plan, established HealthNet in 1997. HealthNet was founded to protect BMC's volume base, to develop a more integrated delivery system, and to reduce the administrative overhead associated with interactions with multiple insurers. Initially, HealthNet was designed to contract solely with providers at BMC, but the Massachusetts Department of Public Health subsequently asked it to expand across the state. HealthNet now contracts with 60 of 70 hospitals throughout Massachusetts, and it provides plans under two programs: one through MassHealth (Massachusetts Medicaid), and one through Commonwealth Care (insurance for low-income uninsured adults). BMC and HealthNet share the same mission plan, though they are organizationally segregated. HealthNet reports through the hospital, and the president of the hospital is the president of HealthNet.

BMC views its affiliated system as a way to respond to integrated delivery system requirements that could be rolled out as part of health reform. With an integrated model, HealthNet has an advantage in bringing the expertise of managed care to providers and to the hospital. In the future, HealthNet will consider expanding into other lines of business, including

Medicare and the commercial market. HealthNet is also considering, as a business opportunity, providing information and data to allow hospitals to run their own managed care organizations. Considering the success HealthNet has provided BMC, HealthNet views this as an opportunity to sell the idea to other hospitals across Massachusetts.

For-Profit Entity

Private investors and for-profit companies have played a significant role in the American hospital sector for over 60 years. Following World War II, the original for-profit hospitals were primarily individual hospitals owned by the doctors who practiced in them. While this model still exists in some parts of the country today, starting in the late 1950s, national hospital companies were created that purchased or built multiple hospitals, often in several states. The business model of such companies was typically to seek out or construct hospitals that could generate both substantial cash flow and ample profits. Their acquisition targets were often hospitals in suburban or rural areas that had relatively small numbers of uninsured or underinsured patients, with a substantial proportion of insured patients that could minimize the risk of losses.

More recently, however, there has been a notable increase in the willingness of private equity investors and for-profit health care companies to seek out acquisitions of governmental or nonprofit hospitals that are considered to be safety net providers. In several cases, far from being profitable, these hospitals were financially distressed, due to a combination of their urban location, increased demand for uncompensated services, and the virtual meltdown of the capital markets in the recent economic crisis. For such hospitals, some of which were on the verge of closure, private equity investment brought needed operational expertise and infusions of capital. At the same time, this trend has also raised governance (and other) challenges for hospitals whose boards are committed to maintaining their public and charitable safety net missions. These challenges are addressed below, following a description of several

examples of the takeover of public or nonprofit hospitals by for-profit investors.

Northwest Texas Healthcare System/Universal Health Services

In 1996, Universal Health Services (UHS), a for-profit hospital management company based in King of Prussia, Pennsylvania, purchased Northwest Texas Hospital System's (NTHS), 360-bed public medical facility in Amarillo, for \$121 million. City voters approved the sale by a margin of 60 percent. Most day-to-day governance and funding operations were transferred to UHS, but the NTHS board of managers still retained control over the pension fund and tobacco settlement, as well as a role in monitoring the level of charity care provided by NTHS.

As part of the agreement, the Amarillo Hospital District (AHD) makes quarterly indigent care payments to UHS for 25 years to ensure that the previous mission—to “own and operate a hospital or hospital system for indigent and needy persons within the District”—is not cast aside. UHS also transfers money to AHD through a provision that grants AHD 15 percent of NTHS's earnings in excess of \$24 million. Outside of the indigent care payments, AHD partially funds NTHS's capital improvements, including \$1.76 million for the construction of a children's hospital floor in 2002.

Since purchasing the facility, many changes have been instituted. New services have been added and other area providers acquired. In contrast to these additions and expansions, the hospital has also trimmed the number of positions, including 33 billing clerks in February 2011 and nine other positions in March 2010. The hospital has also received criticism for not sufficiently funding or staffing the Wyatt Community Health Center, the primary clinic where NTHS treats indigent populations through their agreement with the Amarillo Hospital District.

Despite these criticisms, in April 2012, the TMF Health Quality Institute, an organization founded by Texas physicians with the goal of leading quality

improvement, recognized NTHS for raising its quality of care. NTHS's award is based on its successful achievement of 90 percent of the required 27 quality indicators, including appropriate care measures for heart attack and pneumonia, as well as meeting or beating the national rate for mortality and readmission scores.

Detroit Medical Center/Vanguard Health Systems

On December 31, 2010, Vanguard Health Systems, Inc. (Vanguard) purchased the Detroit Medical Center's (DMC) eight hospitals for \$364 million. DMC included both Detroit Receiving Hospital, a governmental hospital previously owned by the City of Detroit, and nonprofit hospitals. At the time of the purchase, DMC had a few days' cash, an aging plant and equipment, inner city location, declining utilization and a poor payer mix. The state of Michigan had refused to provide DMC with financial support, local nonprofit systems were not interested and DMC was facing the closure of most of its facilities.

As part of the agreement, Vanguard committed to assuming DMC's \$417 million in debt and will invest over \$850 million in capital improvements over a five-year period. Prior to the takeover, DMC had not qualified for tax-exempt revenue bonds since 1998—well before the current financial crisis made borrowing more difficult for virtually all nonprofit hospitals. Vanguard, which is owned in part by the private equity firm Blackstone, issued stock to the public for the first time in June 2011.

Changes that mirror those at NTHS have already begun at the DMC. In January 2012, a new heart hospital broke ground. In February 2012, a proposal was passed by the nearby Royal Oak Downtown Development Authority to build a new children's hospital. Even the well-worn yet respected Detroit Receiving Hospital is receiving \$800 million to increase its floor space by 9,300 square feet. These expansions are accompanied by the closing of a clinic dedicated to serving the indigent; in this case, however, the clinic's building was transferred—at no cost—to the Detroit Community

Health Connection, which will assume responsibility for the taxes and other costs of running the building. Other cost-saving moves, such as outsourcing the management of radiology services to a California provider, may create longer-term physician training issues with the Wayne State University Medical School, for which the DMC serves as a teaching hospital.

In December 2011, just a year after Vanguard's purchase, DMC, in partnership with its 1,100 employed and faculty physicians, became one of the first 32 organizations approved by DHHS to pursue the Pioneer ACO model.

Caritas Christi/Cerberus Capital

The six-hospital nonprofit Caritas Christi System (Caritas) in Boston, Massachusetts was perceived to be failing in the aggressively competitive Boston hospital market. When Cerberus Capital Management (Cerberus) entered, several national nonprofit systems had already turned down the opportunity to purchase Caritas. Cerberus, a private equity firm best known for turning around the Chrysler Corporation, agreed in 2010 to pay \$895 million to assume Caritas' debt and to provide capital infusion over a five-year period.

Cerberus had no previous health sector experience and no management team, resulting in the preservation of Caritas management. Cerberus chose to name its purchasing vehicle Steward Health Care System (Steward) because the concept of "stewardship" had been an integral part of the negotiations. Indeed, stewardship was emphasized in a deal that required the approval of the state attorney general, the local Catholic archdiocese and the state supreme court. As part of these negotiations, Cerberus agreed to keep all of the hospitals open for at least three years and to retain the Catholic hospitals' ethical and religious principles.

Since its formation in 2010, Steward has already acquired five other Massachusetts hospitals and has signaled aggressive expansion goals. In February 2011, Steward sent a letter to the Miami-Dade County Public

Health Trust with an informal offer to purchase the government-owned Jackson Memorial Hospital for over \$1 billion. While this offer was subsequently withdrawn, in April 2012 Steward formally began to acquire—pending state approvals—the New England Sinai Hospital in Brockton. If this deal is approved, Steward will own 10 Massachusetts hospitals. Just a month after the Sinai Hospital announcement, the Rhode Island attorney general approved Steward’s acquisition of Landmark Health Systems in Woonsocket, Rhode Island. The purchase of Landmark, a distressed health system that has been under court supervision since 2008, is another strong indicator that investment in distressed hospitals and health systems trends in the for-profit and private equity sector are likely to continue.

For-Profit Transactions: Implications for Public and Nonprofit Hospital Governance

Why would private equity investors or publicly traded for-profit companies seek out affiliations with distressed safety net providers? Their reasons are no different than their motivation to seek out distressed companies in other industries. Quite simply, they believe that they can bring greater discipline to any business that they perceive to be otherwise inefficient and undisciplined.

While there has been considerable controversy about the restructuring methods of private equity firms in the 2012 presidential campaign, there is likely little disagreement that their goal is to seek to transform underperforming companies into well-functioning ones. The U.S. health care sector is appealing to these companies because it has a reliable customer base combined with relatively stable cash flows. Investors also believe that health reform can generate potentially increased revenue and cash flow.

At the same time, it is well known that private equity investors are rarely in it for the long haul—their goal is typically to restructure an acquisition in anticipation of an “exit strategy” (sale to another company, selling stock

to the public, breaking up a company into its component parts, etc.)

Private equity investments in health care services can also be controversial because investors are motivated, at least in part, by the prospect of making returns of 20 percent or more. The Service Employees International Union (SEIU), for example, has been a vocal critic of private equity buyout. However, investors claim that they understand that employee layoffs are much less effective in a service sector and that lowering the level of quality does not serve to enhance value.²⁸

When a private equity firm purchases a public or non-profit hospital, there are several governance and legal changes that accompany the transition to a for-profit entity. The challenge for local stakeholders who wish to preserve the mission and community obligations of the acquired hospital is to build necessary protections into the transaction itself.

Continuation of Local Governance

While the preferred arrangement between private equity firms and public or non-profit hospitals is typically a complete buyout, it is possible to develop models that preserve local governance and control, through the appointment of local governing boards or through joint venture arrangements. While public and non-profit hospitals’ governing boards often have rules determining membership, for-profit firms have few restrictions. Despite this, private equity firms often find value in retaining board members in the new corporate structure because they have health care experience. Often, new board positions are added to supplement expertise or to provide additional monitoring by the private equity firm.

In the case of Vanguard’s purchase of Detroit Medical Center, a local non-profit board remains in place to oversee community service obligations, including management of over \$140 million that is to be spent

²⁸ Catherine J. Robbins, Todd Rudsenske, James S. Vaughan, *supra*

annually on charity care. In the Cerberus/Caritas transaction, both local governance and local management were preserved for the acquired hospitals. In fact, because Cerberus had no prior hospital management experience, the senior management of Caritas became the management of the new company, Steward; and local boards were also maintained for each hospital in the system.

One privately held company, the LHP Hospital Group, operates under a business model in which the local entity retains both an ownership stake and an ongoing role in governing the acquired hospital. One example would be the purchase of an 80 percent ownership interest in a local community hospital by LHP, leaving the existing public or non-profit organization with a 20 percent stake. In such situations, LHP has also been known to establish a local governing board in which 50 percent of board members are appointed by the local organization, while LHP appoints the other 50 percent. (Within their half of the board, LHP also commits to appointing a certain number of local community physicians.)

Preservation of Public Mission

In most recent transactions involving public or non-profit hospitals, the private equity firm has been required to enter into contractual agreements with either the state's attorney general or with other stakeholders to continue to provide community services, including charity care to uninsured and underinsured patients. In Michigan, the agreement between the state attorney general and Vanguard, in its purchase of the Detroit Medical Center hospitals, stipulated that charity care be provided to "indigent, uninsured, and underinsured patients" for a period of 10 years. In Massachusetts, the attorney general required that charity care requirements for Steward be at least as much as previously performed by Caritas Christi,

and that any successor in interest be responsible for this provision of the agreement as well.

Protections for Personnel

It is also possible for local public or non-profit hospitals to protect their employees as part of an acquisition or affiliation with a private equity investor. In the Vanguard acquisition of DMC, Vanguard agreed to keep the hospitals open for ten years and to protect the rights of employees (including recognition of labor unions). Vanguard also agreed to assume full responsibility for DMC's pension liabilities. In the Caritas transaction, Cerberus guaranteed that there would be no layoffs among Caritas' 12,000 employees and that it would not sell the hospitals or take them public for at least three years. Cerberus also agreed to take over responsibility for the Caritas pension plan and enter into a new contract with a labor union to represent the employees of the new organization (some of whom had not previously been unionized).

As long as public and non-profit hospitals do not lose sight of their mission—and remain aware of the fact that the primary goal of private equity investors and for-profit companies is to make money—it makes sense in this period of scarce capital and rapid system-wide change to keep private equity investment on the list of potential options. Private equity firms and hospital companies can bring both capital and needed management discipline to hospitals and health systems that are often short on both. While it can be a challenge in these transactions to maintain adequate local governance and preserve the public and community mission, that challenge is not an insurmountable one. There are clearly tools and models available to assist public and non-profit hospitals in negotiating arrangements to protect community interests, and private equity firms have demonstrated a willingness to engage in such negotiations.

VI. The Changing Health Care Environment

The health care environment in the United States is itself in the process of transformational change. Even before passage of federal health care reform, substantial change in the health care marketplace was directly and indirectly impacting safety net hospitals and health systems. For example, payers, consumers and regulators are putting an increasing emphasis on quality and pay for performance, and changes in the health care delivery system are leading to an increasing consolidation of providers. In addition, significant economic factors have continued to result in increased numbers of uninsured, while the expanded coverage envisioned in health reform will not occur for several years (and after the Supreme Court decision, the ACA's Medicaid expansion may not happen at all in several states).

Hospitals are consolidating at a furious pace, which will likely close many small and inefficient facilities. Doctors are becoming salaried. Health records are finally going electronic. The federal government is gathering and sharing better data on health outcomes, including quality of care and patient safety—and by October 2012, hospitals will begin to be paid on the basis of their performance on many of these measures. Other trends include new forms of reimbursement such as value-based purchasing, bundling of services for a single payment, and global payments for maintaining and improving the health of individual patients and even entire populations. We also are seeing the dramatic growth of vertically and horizontally integrated delivery systems capable of caring for patients through the entire continuum of an illness.

The implementation of federal health care reform will drive still more dramatic change. Now that the Supreme Court has upheld the constitutionality of the ACA, hospitals should assume that health reform is going to be implemented on schedule, at least in those states that elect to implement the (now optional)

federally-funded Medicaid expansions. As a result, many who are now uninsured will have coverage, either through Medicaid or new plans available through state health exchanges. At the same time, certain Medicaid and Medicare payments that safety net providers rely on will be reduced. For systems that serve substantial numbers of Medicaid, Medicare, and uninsured patients, health care reform will thus have a significant impact. In addition, health reform will also accelerate the reorganization and consolidation of providers within the health care system.

This chapter discusses the major financial and reimbursement trends already underway in the national health system, including the opportunities and threats presented by national health reform, as well as the challenges raised by state Medicaid waivers and growing pressure on hospitals that participate in funding Medicaid in many states. This chapter also discusses radically alternative ways of financing and delivering health care that will be implemented over the next decade, both to improve quality and cut costs.

National Health System Trends

Rising Health Costs

While health care providers are turning their attention to improving quality and patient safety, introducing technological innovations and developing integrated delivery systems, payers and the public continue to focus on rising health costs. It is imperative that public and nonprofit hospital trustees be kept up-to-date about the latest data on rising health costs—and potential solutions proposed by payers and others.

As the *New York Times* recently reported, “The average per capita cost of health care in the U.S. is over \$8,000 annually, double the amount spent in most European Countries. The Congressional Budget Office projects

that unless costs are brought under control in the next decade, the nation will be spending all of its tax revenues on health care, Social Security, interest on the debt and defense—but mostly health care.”²⁹

Total health spending is nearly 18 percent of GDP—as compared to 6–10 percent in Western European countries. In 2011, health costs are said to have averaged \$19,000 (or 26 percent) for a family of four earning the median national income (\$75,000). By 2020, that percent is predicted by some observers to rise to 45 percent.³⁰

Economic pressures have increasingly taken their toll on public and nonprofit hospitals. For example, according to Moody’s Investors Services, median hospital revenue growth slowed to 4 percent in 2010 from a high of nearly 10 percent in 2002. Moreover, both inpatient and outpatient utilization rates of hospitals have shown signs of decline in all patient categories except the uninsured.

The overall trend has been viewed with alarm by many economists, government policymakers and health care providers. The *New York Times* quotes Stanford University Economics Professor Emeritus Victor Fuchs: “Approximately 50 percent of all the health care spending is now government spending. At the state and local level it is crowding out education, crowding out maintenance and repair of bridges and roads. At the federal level we have a huge deficit financed by borrowing from abroad.”³¹

Geographic Variations in Health Care Spending

Significant geographic differences in health care spending, coupled with findings that high-cost does not ensure better quality of care, have led to targeting

high-cost geographic areas and encouraging adoption of practices used in low-cost areas in an effort to reduce overall health care spending. Some believe geographic variations indicate that overall national delivery system reform is necessary to lower health care costs.³²

Much of the research on geographic variations in health care spending has been focused on the fee-for-service Medicare program, though some acknowledge variations across states in Medicaid spending are even greater. The Institute of Medicine is currently conducting two studies focusing on geographic variation in health care spending under Medicare, Medicaid, and private insurance. Results may be used to inform recommendations for lowering costs and improving quality of care.

Impact of Health Costs on Safety Net Hospitals

Economic pressures have increasingly taken their toll on hospital systems in general and on public hospital systems in particular. According to a study by Thomson Reuters,³³ the median profit margin of U.S. hospitals in the third quarter of 2008 was zero percent, with approximately 50 percent of hospitals being unprofitable. Effects of the continuing economic downturn include decreased liquidity, slowing growth in reimbursement rates, bed closures, layoffs and declines in patient volume and elective procedures.

Despite these trends, due in part to initiatives set in place in past years in many states to provide supplemental funding, many safety net hospitals and health systems were able to end 2010 with a small surplus of operating revenue over operating expenses. However, virtually all NAPH members would wind up deep in the red without DSH and other supplemental payments (in 2010 the margin would average minus

²⁹ Gina Kolata, “Knotty Challenges in Health Care Costs,” *NYTimes*, March 5, 2012 at D6.

³⁰ Id.

³¹ Gina Kolata, “Knotty Challenges in Health Care Costs,” *NYTimes*, March 5, 2012 at D6.

³² Jill Bernstein, James Reschovsky, and Chapin White, eds. National Institute for Health Care Reform, *Geographic Variation in Health Care: Changing Policy Directions*, April 2011, available at <http://www.nihcr.org/Geographic-Variation.pdf>.

³³ “The Current Recession and U.S. Hospitals,” available at http://thomsonreuters.com/content/press_room/tsh/TRStudyTracksRecessionHospitals.

10 percent. As discussed in more detail below, such payments are scheduled to be reduced in the future as coverage is expanded under health reform. In addition, both Medicare and Medicaid may well be on the cutting block even in advance of the implementation of health reform, as members of Congress and the Administration seek common ground on reducing the national debt.

In the summer of 2011, for example, following a major showdown between President Obama and the Congress over extending the national debt ceiling, a compromise was reached whereby a so-called “Super Committee” was appointed to come up with \$1.4 trillion in budget cuts. Composed equally of Senators and House members, and of Democrats and Republicans, the committee considered many potential options for reducing the deficit—only to see the effort collapse in partisan disagreement over raising taxes and cutting entitlements. As a result, and if Congress does nothing further in 2012, substantial automatic reductions (called “sequesters”) in both domestic and defense spending will automatically take effect at the beginning of 2013. Those sequesters will include further reductions in Medicare funding as well as substantial cuts in defense spending. On the other hand, if Congress is able to achieve agreement on an interim plan to avoid the sequesters, that plan will also likely have cuts in Medicare and Medicaid funding, over and above those already baked into health reform.

Health Care Reform

Efforts to lower costs and improve quality and safety over the last decade were accelerated by passage of the ACA. One recent observer, writing for the AHA’s *Trustee* magazine, has suggested that “on June 28 [when the Supreme Court decision was announced] it became time to push the reset button on board education concerning the ACA and delivery system

“In their 2010 Report to Congress, MedPAC acknowledged that since 1996, hospital margins from Medicare have declined by approximately 1 percent per year (MedPAC 2010). Their data show that the average hospital lost 7.2 cents of every dollar of care provided to Medicare patients in 2008. (Note: MedPAC’s methodology is different from AHA’s.) Even before the \$155 billion hospital payment reduction through PPACA, MedPAC expressed its intention to force hospitals to operate more efficiently by continuing to provide updates to hospitals at rates that are significantly below cost inflation.”

Nathan S. Kaufman, Managing Director,
Kaufman Strategic Advisors, LLC,
“Changing Economics in an Era of Healthcare Reform,” *Journal of Healthcare Management*,
56:1 (Jan./Feb. 2011).

transformation.”³⁴ This section discusses several provisions of the ACA that are especially relevant to safety net governing boards.

Expanded Coverage vs. Reduced Supplemental Funding

While some states may reject expanding Medicaid coverage, in light of the Supreme Court’s decision, in most states the ACA will substantially decrease the uninsured population and, therefore, (in theory at least) reduce uncompensated care for hospitals. While this outcome could greatly benefit hospitals, the gradual implementation of coverage expansions and uncertainty surrounding their consequences could increase administrative costs and prompt other challenges for safety net hospitals. Several recent studies have expressed caution about the implications of the coverage/funding tradeoff for safety net providers.³⁵

³⁴ “The Supreme Court Acts, and So Must Boards”, Michael W. Peregrine, July 16, 2012, at www.trusteemag.com.

³⁵ For an excellent list of articles and other materials on the impact of health reform on the safety net, see the materials list prepared for a June 4, 2012 seminar by the Alliance for Healthcare Reform at <http://www.allhealth.org/briefingmaterials/MATERIALSLIST-FINAL-2301.pdf>

In particular, although the ACA will expand coverage, it will also adversely impact federal dollars available for Medicaid and Medicare disproportionate share hospital (DSH) payments, an important source of revenue for many of the 2,000 hospitals and health systems that now qualify for these payments. DSH cuts are intended to compensate for the anticipated reductions in uninsured populations and uncompensated care. Additionally, the ACA decreases Medicare payments to certain hospitals for hospital-acquired conditions and excess hospital readmissions.

The ACA also reduces certain federal funds currently flowing to hospital systems. Reductions in “market-basket” updates, by which Medicare providers receive additional annual reimbursements based on growth in the costs of goods and services or on the Consumer Price Index are projected to result in more than \$150 billion in cuts from 2010 – 2019. These changes also include a productivity adjustment that could result in a negative market-basket update, with corresponding reductions in payment rates.

At the same time, administrative costs could increase as hospitals develop new compliance programs to meet new standards and reporting requirements at state and federal levels. Although the lasting effects of such changes are still uncertain, hospitals will need to focus and streamline efforts to ensure compliance and increase operational efficiencies.

The ACA also encourages collaboration among providers and establishment of care networks, which are designed to improve care and cost efficiency and may be the basis for future payment systems.

Accountable Care Organizations (ACOs) and Other Models of Care

ACOs are a group of providers and organizations responsible for the overall costs and quality of care for a defined patient population. They are designed to improve care management and quality through integrated delivery of care while reducing the overall cost of care to the population.

The ACA established the Medicare Shared Savings Program (MSSP), which will reward ACOs for delivering integrated care at lower costs while meeting quality standards. Specifically, participating ACOs that meet quality-of-care targets and reduce costs relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. ACO structures under the MSSP include practitioners in a group practice arrangement, networks of practices, hospital and physician partnerships or joint venture arrangements, and hospitals that employ physicians. CMS also has announced additional ACO initiatives through the CMMI, such as the Pioneer ACO Model. This model is designed to provide a faster path for organizations that are already functioning as an ACO or other accountable care model and to work in conjunction with similar “outcome-based” payment systems developed by other payers, such as Medicaid and commercial insurers.

ACOs come in several forms, each with its own governance challenges. In some cases, the current health care organization board of directors also may be the board of the ACO, as in the case of a hospital system. However, if a multiple physician practice wishes to associate with other providers, the resulting ACO must have its own governing board.³⁶ Providers must have 75 percent control of the board, but are not required to have equal voting capacity—which still allows flexibility in having a multi-disciplinary and skilled board.³⁷

³⁶ M. A. Zezza, The Final Rule for the Medicare Shared Savings Plan, The Commonwealth Fund, December 2011, available at <http://www.commonwealthfund.org/Publications/Other/2011/Proposed-Rules-for-ACOs.aspx#citation>.

³⁷ *Ibid.*

MSSP ACOs, for example, require a “qualified health care professional” to oversee a common quality assurance and improvement plan.³⁸ While these plans will have general goals, such as promoting evidence-based medicine and reporting internal cost and quality metrics, their structure and execution are largely left to the ACO.³⁹ In this situation, governing boards must understand how to encourage interaction among the many ACO participating providers, and work toward achieving the quality plan. The structure of Pioneer ACOs, with their population-based capitation payment models, amplifies the need to maintain and retain the patient populations they serve. Innovative governing board strategies that increase patient satisfaction while sustaining the organization’s financial health will be imperative.

Safety net hospitals seeking to form integrated delivery systems through the employment of physicians, such as the formation of an ACO, must also take into account whether the state in which they operate has a “corporate practice of medicine” (CPOM) prohibition. The CPOM doctrine generally prohibits unlicensed entities from practicing medicine or employing physicians to provide medical services under the rationale that a physician’s independent medical judgment must be preserved. A state’s CPOM prohibition may be the result of statutes, regulations or court opinions. Most important for public hospitals, is that most states adhering to the CPOM doctrine also allow for a number of exceptions to its prohibitions. These exceptions vary across states and can include exempting hospitals, non-profit corporations, hospitals serving rural areas, and federally qualified health centers (FQHCs) from CPOM prohibitions.

Finally, there are also antitrust issues that should be taken into account in the development of integrated

delivery systems such as ACOs. The main antitrust statutes are the Sherman and Clayton Acts, as well as the 1914 Federal Trade Commission Act that declared “unfair methods of competition” illegal, all of which are enforced by the Federal Trade Commission (FTC) and the Department of Justice (DOJ). The two key factors of concern for integrated delivery systems seeking to avoid violating antitrust laws are financial and/or clinical integration, including risk-sharing, and market share.

The enactment of the ACA, with its focus on greater care coordination and cost-savings through integrated delivery systems, has focused more attention on health care antitrust violations and the need for additional guidance. Though there is no waiver authority for antitrust similar to the DHHS Secretary’s fraud and abuse waiver authority in the ACA, the DOJ and FTC recently issued a joint Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. This proposed statement is fairly narrow in its protections due to its confinement to the ACA’s Medicare Shared Savings Program. However, public hospitals may be shielded from antitrust liability under the state action doctrine, which has been construed by courts to immunize public hospitals exercising the authority conferred by their state legislature from antitrust laws.⁴⁰

The Center for Medicare and Medicaid Innovation

The Center for Medicare and Medicaid Innovation (CMMI) was established to design, implement, test, evaluate, and potentially expand innovative payment and service delivery models under Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). Early in 2012, CMMI provided major grants to both

³⁸ Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations, Final Rule, *Federal Register*, Nov. 2, 2011 76(212): 67802 – 990.

³⁹ Katherine Saral and Michele Garvin, Accountable Care Organizations Health Care Provider Interactions, 13th Annual New England Hospital & Health Law Conference, 2012.

⁴⁰ See *Jackson, Tenn. Hosp. Co., v. West Tenn. Healthcare, Inc.*, 414 F.3d 608 (6th Cir. 2005); *FTC v. Phoebe Putney Health Sys., Inc.*, No. 1:11-cv-58(WLS), 2011 WL 2550729 (M.D. Ga. June 6, 2011).

the AHA and NAPH to assist their respective members in achieving transformation to efficient, high-quality integrated delivery systems.

Population Health and Chronic Disease Management

Better health for populations as a whole is one of the concepts underlying delivery system reform. Improving population health is also one of the three interrelated goals of the Institute for Healthcare Improvement's "Triple Aim Initiative," which has informed both national and state health reform. This broader perspective requires addressing the underlying drivers of health, such as environment, education, and financial status. Improvements in underlying factors that affect health status are expected to reduce costs and improve productivity and quality of life. Integrated delivery systems are better poised to improve the health of an entire community because they provide patients with multiple points of entry to care while engaging providers across a community to provide continuity of care. The newly formed CMMI will test innovative community and population health models for Medicare, Medicaid, and CHIP beneficiaries, including models focused on decreasing smoking and obesity, major underlying causes of poor health.

Care coordination is crucial to effectively managing chronic diseases such as diabetes, heart disease and asthma because individuals with these diseases tend to use more health care services from a variety of providers. An integrated delivery system is better able to offer this necessary care coordination. The patient-centered medical or health home has recently emerged as a model for managing chronic disease. CMS is now conducting demonstration projects to test this model.

Other Provider Payment Reforms

Pay-for-Performance

Pay-for-performance (P4P), also known as value-based purchasing (VBP), aligns payment for health care services with the quality and value of care by offering financial incentives to providers for meeting or exceeding quality measures and outcomes. Although

P4P can be used within fee-for-service payment arrangements, proponents argue that it alters the usual fee-for-service incentives by rewarding providers for supplying higher quality care at better value. Financial incentives generally include bonuses to providers, and can take the form of savings shared among payers and providers. CMS, as part of its goal to transform Medicare from a "passive payer of claims to an active purchaser of quality health care," has offered a number of P4P pilot and demonstration opportunities, such as the Premier Hospital Quality Incentive Demonstration and the Medicare Hospital Value-Based Purchasing Program.

Implemented in April 2011 by CMS, the Medicare Hospital VBP program reduces certain Medicare payments beginning in fiscal year 2013 to fund incentive payments to hospitals achieving specific quality-based performance scores. To determine incentive payments, CMS will use measures of clinical processes of care for acute myocardial infarction, heart failure, pneumonia, surgical care activities, health care-associated infections, and patient experience of care, as well as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Hospitals will be eligible for incentive payments based on their performance compared to peer hospitals and for improvements in their own performance.

Alternative Payment Initiatives

Section 3023 of the ACA establishes a Medicare pilot program for alternative payment methodologies, including bundled payments that encourage integrated care and help improve outcomes of hospitalizations. The program will evaluate 10 conditions selected by CMS. Participating providers eligible to take part in the pilot program include hospitals, physician groups, skilled nursing facilities, and home health agencies. The ACA requires CMS to establish the program by 2013 for a five-year period, with the option to expand the scope and duration of the pilot program if certain criteria are met. The pilot will be funded via existing Medicare payments.

In the summer of 2011, CMS announced a Medicare payment bundling demonstration, in which applicants and CMS would agree on a target payment amount for a defined episode of care and prospectively determined payment rate. Applicants would propose a target price based on historical payment data, with participants then paid under the original Medicare fee-for-service program but at a negotiated discount. At the end of the episode, the total payments would be compared with the target price and the participating providers would share in the savings.⁴¹

The ACA also provides for a Medicaid bundled payment program under section 2704 that is similar to the Medicare program. The Demonstration Project to Evaluate Integrated Care Around a Hospitalization will evaluate the use of bundled payments for integrated care delivered to Medicaid beneficiaries by a hospital and physician during an “episode of care that involves a hospitalization.” The demonstration program will only be available for up to eight states, and each participating state may target particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions.

The Medicaid Global Payment Demonstration, established by section 2705 of the ACA, is a demonstration program allowing up to five states to adjust the payments made to a safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model. Under the ACA, CMS is supposed to establish the demonstration from fiscal years 2010 through 2012 through the CMMI; however, the demonstration has not been funded and no guidance has yet been issued by CMS.

CMS’s bundled payment initiatives may provide alternative opportunities to ACOs for public hospitals seeking to increase integration of care. Although participating in a bundled payment initiative will still require associated infrastructure costs, such as determining how to distribute payments to

participating providers, it likely will not require the same significant level of investment as an ACO. Furthermore, under the bundled payment initiatives hospitals will only be responsible for patients who receive hospital services as compared to all patients receiving care through an ACO. This allows hospitals greater control over improving outcomes.

Community Health Teams and Health Homes

Section 3502 of the ACA authorizes a Grant Program to Establish Community Health Teams that allows the Secretary of HHS to provide grants to or contract with eligible entities that can establish community-based interdisciplinary, inter-professional teams to support primary care practices within the hospital service area served by the entity. To be eligible for the grants, entities must be a state or state-designated entity or an Indian tribe or tribal organization.

Section 2703 of the ACA provides for a State Option to Provide Health Homes for Medicaid Enrollees with Chronic Conditions beginning in 2011. Under the program, 90 percent of the cost of which is paid by the federal government for the first two years, states have the option through a state plan amendment to allow Medicaid beneficiaries with chronic conditions to select a “health home” consisting of a designated provider, team of health care professionals, or “community health team” as defined under section 3502. A designated provider includes physicians, group practices, rural clinics, community health centers, and other entities or providers deemed eligible by states. A team of health care professionals includes those that are hospital-based. Health home services must include comprehensive care management, care coordination, transitional care, social service referrals, and the use of health information technology to link services. Participating states would make payments to a beneficiary’s selected health home for health home services using a methodology to be determined by the state and approved by CMS. Suggested methodologies under the ACA include

⁴¹ AHLA Connections, October, 2011, at 18.]

fee-for-service, capitated payments, and the possibility of payments based on the severity of patient conditions and provider capabilities.

Community-Based Collaborative Care Networks

Section 10333 of the ACA authorizes the Community-Based Collaborative Care Network (CCN) program to provide grants to consortia of health care providers with joint governance who provide comprehensive, coordinated and integrated health care services for low-income populations. Under the CCN program, eligible networks must include a safety net hospital that serves a high volume of low-income patients and federally qualified health centers within the network's geographic area. Funding priority is given to networks that include a county or municipal department of health and can provide the broadest range of providers and services to low-income individuals. Funding can be used to assist low-income individuals access and appropriately use health services, provide case management, perform health care outreach, provide wrap-around services, and expand capacity.

Despite the ACA's authorization to carry out the program between fiscal years 2011 through 2015, no funding has been appropriated for the program. However, there are well-developed examples available for safety net hospitals that wish to develop integrated networks similar to those envisioned in this provision of the ACA. For example, the South Florida Community Care Network (SFCCN) exemplifies the establishment of a network developed out of otherwise unrelated entities. The SFCCN became operational in 2000 and is owned and operated by three public health care systems in Miami-Dade and Broward Counties: Public Health Trust of Miami-Dade County, Broward Health/North Broward Hospital District, and Memorial Healthcare System/South Broward Hospital District. The SFCCN is one of Florida's Provider Service Networks (PSNs), which were first authorized by the

Florida legislature in 1997 to operate as integrated networks consisting of a health care provider or a group of affiliated providers that directly provide a substantial proportion of Medicaid services to their enrollees. The network providers are reimbursed on a fee-for-service basis. The SFCCN receives an administrative fee to manage the Medicaid benefits of its enrollees. If cost savings is achieved, the savings is shared with the state. The administrative fee is at risk if there is no cost savings. Florida's contract with SFCCN imposes performance standards, and a portion of shared savings is dependent upon meeting these performance standards. Additionally, SFCCN has been required to develop and maintain disease management programs for certain chronic diseases and conditions.

Denver Health is another example of a successful highly integrated system comprised of an acute care hospital with a Level I trauma center; all of Denver's eight federally qualified family health centers which provide enrollment services, dental, pharmacy and the women, infants and children nutritional programs; 14 school-based clinics in Denver public schools; the Denver Public Health department; a non-medical detoxification center for public inebriates; a large call center which contains a regional poison center, a medical drug consultation center, a 24/7 Nurse Advice Line, a central translation service, a transfer center, a centralized appointment center and a worker's compensation reporting line; correctional care facilities and a licensed HMO. The HMO offers a commercial plan for Denver Health and City employees, a Medicaid managed care plan, a CHP plan and two Medicare Advantage plans.

Denver Health exemplifies the development of a "wholly owned" integrated delivery system capable of responding to health system reform's opportunities and challenges. Denver Health has been recognized for its sophisticated health information technology infrastructure and success in providing high-quality care for lower costs than its peer health systems.⁴²

⁴² Nuzum, R., et. al, "Denver Health: A High-Performance Public Health Care System," The Commonwealth Fund Commission on a High Performance Health System, July 2007. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jul/Denver-Health--A-High-Performance-Public-Health-Care-System.aspx>.

Additional integrated delivery systems that may serve as models for other safety net providers include the systems developed by NAPH members Virginia Commonwealth University, New York City Health and Hospitals Corporation, Contra Costa County and the Boston Medical Center. These models are described in Chapter V above.

Medicaid Reimbursement Issues

In addition to operational implications, hospital structure and governance may critically affect a hospital's involvement in the Medicaid program. Many state Medicaid programs provide supplemental payments to hospitals that deliver special services or a high volume of care to low-income patients. NAPH member hospitals depend substantially on these payments. However, participation in these programs may be explicitly or implicitly dependent on a hospital's ability to finance the non-federal share of Medicaid payments. Under federal regulations, only "public funds" may be used as the non-federal share, including funds transferred from or certified by "public agencies." Traditionally, many public hospitals, including restructured public hospitals, have contributed to the non-federal share of Medicaid expenditures and have therefore been able to access Medicaid funding that has been crucial to maintaining their public mission. Restructuring may impact the ability of a public hospital to provide such funds. However, it is not entirely clear when this impact would occur. Much care must be taken if a hospital desires to retain the ability to provide public funds.

Medicaid provides health care services for over 52 million low-income and uninsured individuals. Federal and state governments share in paying for Medicaid, and states administer the program within broad federal guidelines. Since the original enactment of the Medicaid program in 1965, the statute has required that financing for all Medicaid payments include a "federal share" and a "non-federal share." The non-federal contribution to Medicaid spending currently ranges from 33 to 50 percent, depending on state per-capita income.

States have never been required to provide the non-federal share strictly from state general revenue funds. Rather, the Medicaid statute has always authorized the use of local funds as a source of financing for the program, and states may derive up to 60 percent of the non-federal share from local sources other than state general revenues. Federal laws and regulations permit public hospitals—as well as cities, counties, and other public entities—to use intergovernmental transfers (IGTs) and certified public expenditures (CPEs) to claim federal Medicaid matching payments for public funds spent on Medicaid services.

An IGT is the transfer of funds from a state or local government entity to the state Medicaid agency, for use as the non-federal share of Medicaid expenditures. The non-federal share is matched in a defined percentage by federal Medicaid funds. Similarly, CPEs are certifications by public entities that they have expended funds on items and services eligible for federal match under the Medicaid program. The federal government recognizes the local government expenditure as a matchable non-federal Medicaid expenditure and provides the federal share to the state Medicaid agency.

Although CMS acknowledges the fact that states may use local funds as the non-federal share, the agency has become increasingly suspicious of IGTs and CPEs since they allow states to draw down federal Medicaid funding without committing state general revenue funds to the program. As a result, CMS has sought to restrict the use of IGTs and CPEs in a variety of ways, including narrowing the definition of government entities that are capable of providing the non-federal share of Medicaid funding.

Medicaid Supplemental Payments

Hospitals that do not retain their government status when they are restructured may lose access to key supplemental payments that are an integral and frequently long-standing piece of public hospital budgets. Often, a state's ability to provide supplemental payments depends on the availability of local funding

(such as IGTs or CPEs) to serve as the non-federal share of the payments.

Local funding has enabled many states to establish a variety of Medicaid supplemental payments that support the various safety net roles that public hospitals (including reorganized public hospitals) typically play. Probably the most common supplemental payments are Medicaid disproportionate share hospital (DSH) payments, which are used to help offset the enormous cost of providing uncompensated care. States also provide supplemental Medicaid payments to hospitals to subsidize their role in providing access to graduate medical education, trauma care, pediatric specialty services, and a host of other specialized services that are important to the community. Other states attempt to target supplemental payments to hospitals with high volumes of Medicaid care or in hard-to-reach rural or urban areas. In most cases, these supplemental Medicaid payments provide key financial support for services and missions that are not always recognized and compensated in the commercial market.

Medicaid payments, including Medicaid DSH and other supplemental payments, provide 35 percent of the net patient revenues of NAPH member hospitals. Medicaid DSH payments, which support provision of care to large numbers of uninsured and Medicaid patients, finance 24 percent of NAPH members' unreimbursed care. In 2010, NAPH members received \$4.1 billion in Medicaid DSH payments. NAPH members provided roughly \$1.5 billion in IGTs, some of which funded the non-federal share of DSH payments. Without Medicaid DSH and other supplemental payments, NAPH member margins in 2010 would have been an unmanageable negative 10.6 percent, instead of the 2.3 percent margins they experienced with these payments (which itself is significantly less than the sector average at 7.2 percent).⁴³

Ability to Finance the Non-Federal Share of Medicaid Expenditures

Federal regulations, which have remained unchanged since at least 1977, authorize states to use public funds from public agencies as the source of the non-federal share of Medicaid expenditures.⁴⁴ These terms have not been further defined. In 1991 legislation, Congress specifically prohibited CMS from restricting states' use of funds "derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider."⁴⁵ Historically, CMS has deferred to states in determining whether an entity or a provider is sufficiently public to provide public funds.

In the mid-2000s, CMS began applying a stricter policy regarding IGTs, and in 2007 issued a proposed and final rule that would have made broad changes. However, CMS's efforts were stymied first by Congress and later by the courts, which found that CMS had finalized the rules in violation of a congressional moratorium. Official CMS policy with respect to IGTs and CPEs is now roughly where it has been historically, although some of the preamble language from the 2007 rule is informative in terms of understanding CMS leanings.

Protecting Hospitals' Ability to Participate in Medicaid Financing

CMS efforts to determine whether a hospital is properly able to make an IGT may have significant implications for public hospitals that are evaluating their corporate structures and considering governance changes. The continued ability to make an IGT or CPE may be an important issue to address when reforming hospital structure and governance. At the same time, hospital structures that pose the least problem regarding

⁴³ Zaman OS, Cummings LC, Laycox S. America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey. National Association of Public Hospitals and Health Systems: Washington, DC. May 2012.

⁴⁴ 42 CFR 433.51. See 42 Fed. Reg. 60564 (Nov. 28, 1977).

⁴⁵ 42 U.S.C. § 1396b(v)(6)(A).

continued ability to provide Medicaid financing through IGTs or CPEs may not be ideal from other financial or management perspectives. When public hospitals reorganize into separate public entities, hospitals may wish to consider ways to protect their public status and their ability to make IGTs and CPEs.

From the CMS perspective, hospitals with direct taxing authority present little question about their ability to make IGTs. However, taxing authority may not be feasible or even desirable in many cases. At the same time, including in the restructuring statutes the *ability* to levy taxes might be extremely helpful in ensuring that CMS considers the hospital able to make IGTs, even if there is no current intention of using the ability to tax. Another option is to ensure that the enabling statutes clearly state that the hospital will have direct access to state or local appropriations after it is reorganized (again, even if there is no current intention by state or local government to provide those appropriations). Beyond access to state or local tax revenues, hospitals may wish to consider ways to retain ultimate state or local government responsibility for funding any hospital deficits or liabilities. If the restructured hospital is solely responsible for its debts, CMS may be more likely to view the entity as non-public and, therefore, not authorized to make an IGT. Hospitals also may wish to consider other indicia of government status, such as the owner of the hospital license, the name on Medicaid provider agreements, corporate registration status with the Secretary of State, etc. Hospitals also may consider requesting an IRS ruling confirming public status.

The unwritten, ambiguous, and evolving CMS criteria regarding the ability of public entities to participate in Medicaid financing have complicated efforts to restructure public hospitals. Because of the importance of Medicaid supplemental payments, CMS policy on this issue cannot be ignored, yet this policy is not always consistent with the best interests of the local community in meeting its safety net health care needs.

Hospitals considering restructuring and wishing to preserve their ability to finance the non-federal share of Medicaid expenditures should consult with attorneys who practice in this area. It may even be wise to consult with CMS directly regarding proposed new structures and their government status.

Medicaid Issues: Waivers and Demonstrations

Not all health reforms are taking place at the federal level—many states also are getting into the act, with both opportunities and challenges for hospitals that must be taken into account by trustees. For example, California's Section 1115 Medicaid Demonstration Waiver, which was approved by CMS in late 2010, establishes a number of goals to improve health care quality and prepare the state for implementation of coverage expansion and delivery system reform. Among other goals, the waiver calls for expansion in Medicaid coverage to certain low-income adults and improved coordination of care for vulnerable populations through enrollment in managed care plans.

Many state Medicaid waivers and demonstrations have served as models for health system reforms encouraging quality and cost-containment through development of integrated delivery systems and coordinated networks. In addition to serving as vehicles for insurance coverage expansion, states have used Medicaid waivers to expand managed care, preserve and restructure the safety net, and pilot new payment models.

The expansion of managed care under state Medicaid waivers continues to affect safety net hospitals. In response many have developed integrated models involving Medicaid Managed Care Organizations (MCOs). It is estimated that although Medicaid enrollment in commercial MCOs has stayed level since 2003, enrollment in Medicaid-dominated MCOs largely owned by safety net hospitals or health systems has exceeded commercial plan enrollment.⁴⁶ Additionally, the expansion of managed care to higher-need,

⁴⁶ Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: Key Data, Trends, and Issues*, Feb. 2010, available at <http://www.kff.org/medicaid/upload/8046.pdf>.

complex populations such as the elderly, disabled, and children and adults with chronic illnesses, is also a growing trend impacting safety net hospitals.

In addition to expanding managed care, states such as California and Massachusetts use their Medicaid waivers as a mechanism for retaining funding for their public hospitals that has been otherwise reduced through changes in CMS policy. California has recently developed an innovative Delivery System Reform Incentive Pool through its Medicaid Demonstration Waiver that will support public hospitals while promoting system reform. Finally, state proposals seeking to use alternative payment systems within their Medicaid programs, such as Massachusetts' global payment proposal, will likely serve to encourage the development of integrated delivery systems. The following are brief summaries of states exemplifying these trends.

California

On November 2, 2010, California signed a five-year Section 1115 Medicaid waiver agreement, "The Bridge to Reform," with CMS. The waiver builds on California's 2005 Medicaid waiver, under which California had established a Safety Net Care Pool (SNCP) and expanded coverage for uninsured individuals up to 200 percent of the federal poverty level (FPL) in 10 counties. The Bridge to Reform consists of four main components: coverage expansion through the Low Income Health Program (LIHP); new funds for public hospital health reform investments through the Delivery System Reform Incentive Pool (DSRIP); mandatory managed care for seniors and people with disabilities (SPDs); and \$2 billion in funding over the five-year life of the waiver to support various health care programs for low income people.

The LIHP is similar to Medicaid in that it applies many of the Medicaid standards related to access, consumer protections, network adequacy, etc. It extends coverage to the uninsured through two programs that expand the county-based coverage initiative under the previous

waiver. The Medicaid Coverage Expansion (MCE) program allows counties, at their option, to provide coverage for individuals with incomes up to 133 of FPL. The Health Care Coverage Initiative (HCCI) program allows for coverage of individuals with incomes above 133 percent through 200 percent FPL. Counties that elect to participate in the LIHP will provide the required 50 percent state share of Medicaid spending in the form of certified public expenditures (CPEs).

Under the previous waiver, most coverage initiative counties built delivery services around the county's public hospital, some through the development of medical homes, and the current waiver allows for provision of benefits through a county-based delivery system with a closed network of providers. The LIHP will phase out at the end of 2013 when ACA coverage expansion takes effect.

The DSRIP supports the California public hospital system by providing a source of federal matching funds for delivery system reform investments. The four specific investment areas under the DSRIP include infrastructure development, innovation and redesign, population-focused improvement, and urgent improvement in care, all of which encourage the development of integrated delivery systems. In order to draw down DSRIP funding, each hospital must develop and implement a five-year plan addressing one or more of the four categories above, meet specific, ambitious milestones approved by both CMS and the state, and provide the non-federal share of its DSRIP payments through intergovernmental transfers.

The Bridge to Reform also seeks to achieve care coordination and cost containment by transitioning SPDs into mandatory managed care. As part of this process California is required to submit procedures to CMS for approval that address the full range of care coordination necessary for individuals with disabilities, multiple and chronic conditions, and individuals who are aging.

Tennessee

Tennessee's Medicaid program, TennCare, is operated as a state-wide mandatory managed care program in which all physical, behavioral, and long-term care services are covered by one of four MCOs. The program began in 1994 and operates under Medicaid section 1115 waiver authority. Under the program, Tennessee is divided into three regions and enrollees have their choice of one or two MCOs serving the region in which they live. TennCare Select spans all three regions and is the MCO for foster children, children receiving supplemental security income, and children under 21 in a nursing facility. TennCare Select also serves as the state's "back-up MCO," such that if a contracting MCO leaves TennCare its enrollees will be transferred to TennCare Select. Each TennCare enrollee is matched with a primary care provider that coordinates their care. In 2010, Tennessee implemented the TennCare CHOICES in Long-Term Care Program, bringing long-term care services for the elderly and disabled into its managed care program.

Florida

On July 1, 2011, Florida's governor signed into law two bills aimed at restructuring Florida Medicaid into a statewide managed care program. The law directs the Florida Agency for Health Care Administration to seek any necessary federal waivers in order to implement the restructuring. Under the proposal, there would be two managed care programs, one for primary and acute care and one for residential and community based long-term care. Similar to the TennCare program, Florida would be carved into regions with MCOs competing through a procurement process to secure contracts. Enrollment in a MCO would be primarily mandatory, with a limited carve-out for immigrants and women who are only eligible for family planning services or only eligible for breast and cervical cancer services. The proposal also seeks to impose premiums on all Medicaid enrollees regardless of income, require co-payments for emergency room visits, and limit benefits.

Massachusetts

Massachusetts' Medicaid program, MassHealth, has operated under a section 1115 waiver since its inception in 1997. Under the initial waiver, Medicaid coverage was expanded by both increasing income limits for existing eligibility categories and by creating new eligibility categories. Mandatory managed care was also expanded for Medicaid beneficiaries by requiring most children and families to enroll in either the state-operated Primary Care Clinician (PCC) Plan or in one of four private MCOs. Massachusetts also received CMS approval to provide MCO supplemental payments to two of its safety net hospitals, Boston Medical Center (BMC) and Cambridge Health Alliance (CHA).

In 2005, Massachusetts created a Safety Net Care Pool (SNCP) through its second waiver extension in order to subsidize the purchase of health insurance for low-income individuals as an alternative to paying providers directly for uncompensated care. Based on changes in federal rules, CMS decided that Massachusetts could no longer provide the MCO supplemental payments to BMC and CHA. Massachusetts was successful, however, in persuading CMS to allow the former MCO supplemental payments to fund the SNCP. The SNCP is also funded by diverted state and federal expenditures that would have gone towards Disproportionate Share Hospital payments.

Following the 2005 waiver agreement, Massachusetts implemented its comprehensive health care reform. This reform included the creation of Commonwealth Care, a publicly subsidized health insurance program for low-income adults not eligible for MassHealth. It also expanded eligibility and benefits for MassHealth, providing Medicaid provider rate increases and supplying three-year supplemental payments to BMC and CHA (known as "Section 122" payments). In addition to offsetting uncompensated hospital care costs through the Health Safety Net (formerly the Uncompensated Care Pool), the waiver's SNCP subsidizes premiums for Commonwealth Care.

However, the Section 122 payments (which were never fully funded to begin with) have now been eliminated in the most recent waiver extension at the end of 2011. The extension does include payments similar to the California DSRIP payments described above.

As part of Massachusetts health reform, a commission was tasked with restructuring Massachusetts' health care payment system. The commission's final report recommended that "global payments with adjustments to reward provision of accessible and high quality care become the predominant form of payment to providers in Massachusetts."⁴⁷ Building on the commission's recommendation, the Massachusetts governor has recently proposed legislation directing the Massachusetts Executive Office of Health and Human Services to secure the federal waivers necessary to require all state-funded insurance programs to use ACOs and implement "alternative payment methodologies," including global payments, by 2014.

Vermont

In July 2011, Vermont's governor signed into law legislation that will put Vermont on the path towards a single payer health care system. The law contemplates a state-run health plan, called Green Mountain Care (which currently administers Vermont Medicaid), that would insure almost all Vermont residents. Because of a number of legal and financial constraints, the law does not yet implement Green Mountain Care, and instead establishes a board charged with testing new payment models and recommending the benefits package to be provided under a single payer. The law directs the board to include Vermont's Blueprint for Health initiative, which is a medical home model, in its adopted payment policies. Once the board recommends a benefits package, the Vermont Secretary of Administration must develop a financing plan for universal coverage.

The law also directs the new Director of Health Care Reform to secure the federal waivers necessary to implement a single payer system. In addition to needing Medicare and Medicaid waivers in order to include those programs' beneficiaries in Green Mountain Care, Vermont will need a waiver under the ACA from the federal law's health insurance exchange requirement. The ACA waiver is not available until 2017, though there are political efforts to push that date earlier.

Medicaid Issues: Safety Net ACOs

In early 2012, *Modern Healthcare* reported that "at least eleven states were adding initiatives resembling accountable care organizations to their Medicaid programs" and that "many providers who shied away from the Medicare ACO models are interested in the state versions."⁴⁸

This trend can present opportunities and challenges for safety net hospitals and their boards. On the one hand, it sets out a clear pathway for system reform and integrated system development in a safety net system. On the other hand, with fewer potential obstacles or requirements than Medicare ACOs, Medicaid and safety net initiatives are likely to attract significant competitors, and some are likely to be established by physician groups or by Medicaid managed care organizations, without necessarily involving hospitals. Clearly, this trend also will contribute to the need for safety net provider trustees to be nimble and innovative as they engage in transformational governance.

Public hospitals already part of comprehensive, integrated systems may face obstacles to becoming an ACO depending on CMS requirements for ACO governance structure. If CMS dictates the composition of an ACO's governing board, such representation could potentially conflict with state and local laws that already dictate composition of public hospital or health system boards.

⁴⁷ "Recommendations of the Special Commission on the Health Care Payment System," July 2009. http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf.

⁴⁸ Rich Daly, "Sincerest Form of Flattery: Mimicking Medicare, States Want to Try Accountable Care Models for Medicaid," *Modern Healthcare*, Jan. 9, 2012, available at <http://www.modernhealthcare.com/article/20120109/MAGAZINE/301099972/sincerest-form-of-flattery&template=mobile>.

Public hospitals may face obstacles in establishing ACOs due to the start-up costs and investments necessary to form an ACO and to participate in the CMS ACO programs. Furthermore, the Medicare populations served by safety net hospitals are disproportionately comprised of low-income, dual-eligible patients with complex needs. The cost and challenges of coordinating care for this population are substantially higher than the average Medicare patient, and the returns from shared savings may not be adequate to sustain participation in the shared savings program.

Federally Qualified Health Centers

Designation as a Federally Qualified Health Center or FQHC “look-alike” also can lead to enhanced Medicaid reimbursement. However, the rules that determine which entities qualify for this status contain restrictions on how the provider is structured and governed. In many instances, public hospitals desiring to take advantage of FQHC status must restructure or enter into contractual arrangements with other entities.

In certain instances, safety net hospitals and health systems have considered modifying their governance structure in order to qualify certain outpatient services for FQHC or FQHC look-alike designation. Under federal law, FQHCs get preferential cost-based Medicaid reimbursement for outpatient services, rather than Medicaid fee schedule rates. However, one of the conditions for FQHC status is that the governing board be composed of at least 51 percent of active users of the provider. Many public entities—for example, those operated directly by a local government and governed by elected officials—may not be able to meet this test. In these instances, the public hospital might choose to create or partner with a local community-based organization for the provision of outpatient services.

The Health Services Resources Administration (HRSA) allows public entities to apply for FQHC look-alike status with a co-applicant, whereby the public entity and the co-applicant together meet federal FQHC requirements (including those for governing boards). In this co-applicant model, the public entity generally receives FQHC look-alike designation, and the co-applicant board serves as the health center’s board.

Health Center Boards

A health center’s governing board must have between nine and 25 members, and at least 51 percent must be active users of the center’s services and must reasonably represent the individuals served by the health center in terms of such factors as race, ethnicity, and gender. No more than half of the non-user members may be health professionals (i.e., individuals who derive more than 10 percent of their income from the health care sector).⁴⁹

The board must be chosen through a selection process, subject to approval by HRSA, that is prescribed by the bylaws of the health center. An individual’s leadership role in the community and functional expertise should be major criteria in selecting non-user members. HRSA, however, prohibits “other entities” from participating in actions relating to board members of the health center. For example, other entities are prohibited from selecting a majority of health center board members, and only those board members selected by an outside entity may be removed by an outside entity.⁵⁰ There remains some ambiguity, however, about how restrictions imposed on other entities may be applicable to public entities in co-applicant situations.⁵¹

Authority and Responsibilities

The FQHC governing board is legally responsible for ensuring that the health center is operated in

⁴⁹ Ibid.

⁵⁰ BPHC PIN 97-27.

⁵¹ See BPHC PIN 99-09. HRSA states that requirements relating to selection and composition of board members and limitations on third parties apply to “the public entity applicant as well as other third parties.” Nevertheless, in this same PIN, HRSA states that the “health center” is both the public entity and co-applicant together. Thus, it remains unclear how HRSA would enforce restrictions applicable to “third parties” upon public entities and co-applicants applying for FQHC look-alike status.

accordance with federal, state, and local laws and regulations. Governing boards also must retain specific duties and authorities, which include:

- Approval of the selection and dismissal of an executive director of the health center.
- Selection of services provided by the health center.
- Approval of the health center's budget.
- Approval of the application for a second or subsequent grant or FQHC recertification.
- Adoption of health care policies including scope and availability of services, location, hours of service, and quality of audit procedures.
- Assuring that the health center is compliant with federal, state, and local laws and regulations.
- Evaluating health center activities including service utilization patterns, productivity of the center, patient satisfaction, and development of processes for resolving patient grievances.⁵²

There must be a clear explanation of how governance responsibilities are divided between the public entity and the co-applicant. Recognizing that state and local laws frequently require public entities to retain control over particular aspects of their governance, HRSA provides some flexibility for public entities in relation to the co-applicant governing board. In particular, HRSA public entities may retain "general policy-making authority." Public entities also may "share" in the exercise of the governing board's duties and authorities listed above.

HRSA also allows public entities to retain sole authority in certain areas without providing individual justification. These include:

- establishment of personnel policies and procedures, including selection and dismissal of employees, salary scales, employee grievance procedures, and equal opportunity practices.

- development of management and control systems, including conducting audits for fiscal integrity, approval of the annual health center budget, and establishment of systems for eligibility determinations, billing and collections, and long-range financial planning.

For any other areas in which the public entity seeks sole authority, it must provide some legal basis for the exclusion of the governing board.⁵³

Strategies for Meeting Governance Requirements

Given the flexibility HRSA provides to public entities with co-applicant boards, there are a number of strategies public hospital-based clinics may use in applying for FQHC look-alike status. The following discussion highlights some of the issues to consider when formulating these strategies.

Financial Control

While public entities generally must cede authority over certain operations of health centers to co-applicant boards, public entities may retain significant control over the financial management and budget development process. Particularly to the extent that the public entity funds operations of the FQHC, this allows a substantial degree of practical control. For example, the governing board must have ultimate authority to select or expand services rendered at a health center, though the public entity may play a role. But, if the services chosen by the board are inconsistent with the public entity's objectives, the public entity is not required to fund these selections. In other words, the public entity could reduce (or propose to reduce) its budget allocation to the health center based on its concerns about the service mix.

Decision Making

As explained above, the public entity may share the governing board's responsibilities in an "active joint

⁵² Ibid.

⁵³ Ibid.

decision-making process.” This joint decision-making process may apply to a number of board functions—selection of services, approval of the center’s budget, selection or dismissal of the center’s chief executive officer, adoption of health care policies, ensuring compliance with applicable laws and regulations, and evaluation of center activities.

Although it is difficult in today’s changing FQHC regulatory environment to predict what limitations HRSA may impose on mechanisms for “sharing” responsibilities between public entities and co-applicant boards, there appear to be some clear opportunities. For

example, public entities may assume a significant role in an activity (such as the development of the center’s budget or selection of CEO candidates), as long as there is a mechanism in place for final approval by the governing board. Such mechanisms may include proposals or review of center activities conducted by both the public entity and the governing board. In another option, the public entity makes the initial proposal or review and the governing board gives final approval (with the ultimate check imposed by the public entity’s decision on whether to provide funding for the board’s action).

VII. Accountability & Transparency

This final chapter addresses governance issues related to accountability, or the responsibility of board members to provide oversight of the ability of a hospital or health system to fully carry out its mission while meeting all necessary legal and regulatory requirements. Board members are accountable for assessing the short- and long-term health needs of the community and for monitoring how those needs are being fulfilled. Many of these requirements are regulatory in nature or are imposed under the federal tax code or state laws governing the tax-exempt status of nonprofit hospitals. Others may be more subjective, including funding requirements imposed at the state or local level, and may be met by facilitating regular communication with political leaders, the press, relevant organizations, and the public at large.

Board members should ensure their organizations coordinate these communications, comply with all applicable laws and regulations, and have in place an effective quality improvement system with ongoing, systematic assessment resulting in action plans to strengthen performance.

Quality and Patient Safety

Payers, consumers, and regulators have been putting an increasing emphasis on quality and cost-containment through the development of integrated delivery systems and coordinated networks. Such systems will likely be needed to provide (either directly or through affiliation arrangements) a full continuum of services across all patient populations and all levels of acuity. These organizations will have significant alignment with their medical staffs and will need to position themselves to accept and manage risk.

The federal Centers for Disease Control and Prevention estimates that “at least 1.7 million health care associated infections occur each year and lead to 99,000 deaths. Adverse medication events cause more than 770,000 injuries and deaths each year—and the cost of treating patients who are harmed by these events is estimated to be as high as \$5 billion annually.”⁵⁴

Many of the payment reforms discussed in this section are grounded in policies that seek to improve quality and patient safety while reducing costs. These reforms have prompted implementation of measures that must now be reported to the federal and many state governments. Soon, hospitals will not only have to report on quality measures, but will be paid according to their performance on measures of patient satisfaction and clinical processes and outcomes, as well.

A board’s traditional responsibilities include regularly reviewing quality performance data, holding management and clinical staff accountable for patient safety and quality of care, and ensuring that resources are available for these purposes. In today’s environment quality goals should be linked to performance ratings, incentives and staff privileges. Through oversight of continuous quality improvement, an effective board can decrease the likelihood of adverse outcomes and encourage a culture of quality and patient safety.

Soon, hospitals will not just have to report on quality measures, as described in Chapter VI above, under “pay for performance” and “value based purchasing” programs. They will be held accountable based on their performance, with reimbursement implications. For FY 2014, DHHS has adopted 17 measures for the Hospital VBP Program, including the 12 clinical process of care

⁵⁴ Department of Health and Human Services, Report to Congress: National Strategy for Quality Improvement in Health Care, March 2011, at 9, available at <http://www.healthcare.gov/law/resources/reports/quality03212011a.html>.

measures and the HCAHPS measure that they adopted for the FY 2013 program, one new clinical process of care measure (SCIP-Inf-9: Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2), and three mortality outcome measures (Acute Myocardial Infarction (AMI) 30-Day Mortality Rate, Heart Failure (HF) 30-Day Mortality Rate, Pneumonia (PN) 30-Day Mortality Rate).⁵⁵

Community Benefits

Nonprofit hospitals and health systems are facing new and rapidly escalating community benefit requirements to maintain their tax-exempt status. While most nonprofit hospitals have had a relatively easy time in the past demonstrating that they provide ample community benefits, recent developments have imposed a specific format for reporting these benefits.

The community benefit requirements for nonprofit hospitals date back to a 1969 IRS revenue ruling.⁵⁶ Until December 2009, however, when the IRS introduced the Form 990 Schedule H there was no detailed annual reporting required. The form asks hospitals to report information on policies and activities, including quantifiable information such as the number of persons served, total expenses involved in providing community benefit activities, any offsetting revenues from such activities and resulting net community benefits. The ACA created new requirements for tax-exempt hospitals. In addition to other obligations, each hospital must conduct a Community Health Needs Assessment (CHNA) and develop an implementation strategy every three years and must take into account input from those who represent broad interests of the community served. The IRS is expected to require that an implementation strategy be approved by the hospital's governing board. The end of the first three-year cycle is the hospital's tax year beginning after March 23, 2012. Hospital systems must meet this requirement separately for each facility in its system.

In the meantime, both the Congress and many states have continued to evaluate hospital exempt status carefully, with a number of Congressional hearings challenging the adequacy of both current standards and the efforts of nonprofit hospitals to meet those standards. Several states also have directly challenged the exemption of nonprofit hospitals from state taxation.⁵⁷ To the extent the governing boards and leadership of safety net hospitals and health systems choose to seek the greater autonomy that comes with private nonprofit status, they will need to take these community benefit requirements seriously.

Regulatory Compliance

It also is important for trustees to understand the implications of the dramatic increase in enforcement of a range of other regulatory requirements. Violation of these requirements can lead to draconian penalties, which can include large fines and other severe sanctions. Increased resources have been brought to bear on enforcement of the federal Stark and anti-kickback laws, as well as on their counterparts in many states. Violations of the federal False Claims Act have been alleged by both governmental prosecutors and private whistle-blowers. Several highly publicized violations of privacy and confidentiality requirements of the Consolidated Omnibus Budget Reconciliation Act also have increased scrutiny on all providers. Antitrust scrutiny has increased in recent years, particularly as hospitals and other providers have assembled ever-larger integrated delivery systems. It is beyond the scope of this monograph to discuss these laws in greater detail, but hospitals need to educate their boards about them and have strong compliance policies and training programs in place.

Given the proliferation of fraud investigations against health care providers and high-dollar judgments and settlements, health care governing boards are focusing

⁵⁵ 77 Federal Register 28069.

⁵⁶ Rev. Rul. 69-545, 1969-2 C.B. 117.

⁵⁷ See, e.g., *Provena Covenant Medical Center v. Department of Revenue*, 925 N.E. 2d 1131 (Ill. 2010).

more resources on compliance oversight. Effective oversight of a compliance program requires governing boards to apply duty-of-care principles to the compliance function, and to ensure that an adequate reporting system exists and is enforced.

Governing boards also must take reasonable steps to ensure that management appropriately carries out its responsibilities and complies with the law. The board should ask the hospital's compliance officer to explain the organization's compliance program and related board and board committee responsibilities.

Given that most members of a hospital or health system governing board will not have previous knowledge of compliance principles and infrastructure, it is important to conduct training programs for the board in general and especially for the relevant board committees such as audit, finance, and compliance. Although there are some very general aspects of compliance education and training that can be covered through education and training seminars, the effective implementation, operation, and oversight of a compliance program extends beyond merely understanding its general components. Therefore, in addition to understanding the general elements of the compliance program, a governing board should have knowledge of the responsibilities of the various involved parties, as well as of resources, risks, standards, and reporting procedures associated with compliance.

Board Responsibility

A board should understand that an organization's compliance function is not necessarily a separate component from a health care organization's business operations; rather, compliance encompasses all the organization's existing business operations. The board's oversight of the compliance program will require an adjustment in the board's existing monitoring responsibility for the organization, not necessarily an addition to that responsibility. In most instances, the existence of a compliance officer and a compliance program should provide the board with some assistance

in carrying out its existing fiduciary responsibilities to the organization.

Compliance Officer Responsibilities

Directly tied to the board's understanding of organizational compliance is the board's understanding of the role of the compliance officer and of those who provide daily support in carrying out the compliance program. In addition to clarifying his or her responsibilities, the compliance officer also should discuss his or her goals in developing an effective compliance structure within the organization.

Compliance Program Resources

In order for the compliance program to reach its goals, the board must ensure that sufficient resources are dedicated to set up and operate the program. The board will need to determine the extent of resources to dedicate to the compliance program, in terms of personnel and financial support. As it comes to understand the compliance structure within the organization, the board should be able to effectively monitor whether the resources devoted to compliance are adequate.

Allocation of Responsibility

Although the compliance officer is the focal point of the compliance program, the board should be aware that the compliance officer cannot implement the compliance program alone, and that other management personnel have essential compliance-related responsibilities. If responsibility for a compliance program is not allocated efficiently, implementation will suffer, possibly resulting in deficiencies that could have been avoided. For instance, in those health care organizations with internal legal counsel, that counsel will play an extremely important role in managing issues of legal compliance and issues essential to promoting the overall compliance program. In some organizations, legal counsel may have compliance-related responsibilities commensurate with those of the compliance officer to promote the effective implementation of the compliance program. Therefore, it is imperative that the board assess

the roles of management beyond the compliance officer in both setting up and operating the compliance program. In addition, the board will need to ensure that management is accountable.

Organization Risk Areas

Another important measure of compliance program effectiveness will be the board's increased awareness of risk areas within the health care organization. The board should understand that risk areas evolve with changing rules and regulations applicable to health care organizations, and it should also understand the benefits of regular risk assessment. A risk assessment may be performed by the organization's internal audit function or anyone designated by the compliance office, and it is essential to the board's awareness of new organizational challenges. A risk assessment also will inform the board's evaluation of management priorities and the best method for allocating resources within the compliance program.

Written Standards

Whether or not the governing board is the final adopter of the written standards that support the compliance program, including the code of conduct and compliance policies and procedures, the board should maintain a full set of written standards as a compliance program reference. The board should be familiar with the contents of these written standards and should monitor them to determine whether they provide an adequate foundation on which the compliance program can operate. As the compliance program develops, the board should gain a better understanding of the program's functions and may use this understanding to suggest revisions or modifications to written standards or the compliance program, as necessary.

Reporting

The compliance officer is a direct link between the compliance program and the board and should regularly report to the board on the development of the compliance program. Whether the compliance officer reports to the board quarterly or more often, that

officer and the board should establish criteria for other circumstances when it would be appropriate for him or her to report to the board, such as when the findings from an investigation require reporting to a regulatory or law enforcement agency.

Feedback

Feedback from the board in the form of comments, suggestions, and questions should be encouraged because it indicates the level of board investment in the compliance function. The compliance officer also can use feedback to determine both the board's level of understanding of the compliance program and the areas in which the board may need additional information. However, while feedback is important, absent extenuating circumstances, the board should not involve itself directly in the management of the compliance program.

The governing board should expect the compliance officer to assist it in performing its compliance oversight duties. It should feel entitled to:

- general education on compliance issues,
- the right to approve any compliance action plan developed,
- periodic reporting on the status of the compliance program, and
- direct communication with designated committees when significant compliance issues arise.

Once the board understands the role of compliance in the organization, and its own responsibilities with regard to the compliance function, it will be able to invest in and lend its support to developing an effective and efficient compliance program.

Transparency and Accountability

Increasing governmental and stakeholder demands for greater transparency and accountability have led hospital governing boards to adopt more stringent policies that include higher standards for both organizational and board behavior and accountability.

Taking such steps may lessen potential liability for board members by documenting diligence in oversight and other board duties. In addition, adoption of best practices can be useful in recruiting potential board members.

Even before the implementation of federal health care reform, substantial changes in the national health system are already well advanced. Payers, consumers, and regulators have been putting an increasing emphasis on quality and cost-containment through the development of integrated delivery systems and coordinated networks. The following are brief summaries of movements within the national health system that encourage the need for visionary governance and the development of integrated delivery systems.

Conflicts of Interest

No matter what the structure of the governing board, a clear conflict of interest policy is an important mechanism to ensure that personal or business conflicts do not taint a board member's decisions. A conflict of interest policy, applicable to corporate officers and board members, should include the following:

- Provisions related to identification and disclosure of financial or other interests and related material facts.
- Procedures for determining whether an individual's interest may result in a conflict of interest.
- Procedures for addressing the conflict of interest after one has been identified.
- Procedures to ensure adequate recordkeeping.
- Procedures ensuring regular distribution of the conflict of interest policy.

Safety net hospitals sometimes face additional challenges when they develop a conflicts policy. In many instances, certain board members are appointed by virtue of their affiliation with constituency groups. For instance, two positions on the Truman Medical Centers board are reserved for hospital medical staff, two for the main faculty practice plan, and two for non-management hospital employees. In circumstances

like this, where board conflicts will arise frequently, it is important to ensure that the process is workable. Further, board members who are appointed from designated groups may be in particular need of clear guidance regarding their fiduciary duties to the organization and what role they may play in decisions affecting their constituent groups.

Audit and Compliance Committee

A key element of the trend toward improved transparency and accountability is the establishment of an Audit and Compliance Committee of the board to oversee the organization's financial and auditing procedures. Public and nonprofit health systems should maintain audit and compliance committees, comprised of independent members of the governing board, that are intended to be free of influence from management and others. Such committees should have the authority and autonomy to work directly with internal and external auditors, as well as with legal counsel hired in connection with the corporation's auditing process. Other responsibilities can include following up on recommendations to revise internal financial processes and controls, as well as serving as a resource by which employees can raise ethical questions and concerns directly to the governing board. In some companies this committee also assumes responsibility for overseeing non-finance-related compliance issues.

Auditor and Accountant Oversight

To avoid conflicts of interest for an accounting firm auditing an organization, many corporations now prohibit their auditor from simultaneously engaging in non-audit services for the corporation. Some policies go so far as to require pre-approval by the Audit and Compliance Committee of all non-audit-related engagements, to ensure that no conflicts of interest could thwart financial (or non-financial) assessments of corporate activities. If it is anticipated that a public or nonprofit health system will engage its current or future auditor for non-auditing services, the board should consider developing and implementing formal auditor oversight policies to avoid conflicts of interest.

Rotating Leadership by the Independent Auditor

It also has become more common to rotate independent auditors every several years, or at a minimum, rotate the lead partner of the company's audit team every five years. In addition to providing a check on the relationship between a corporation's management and the leader of the audit team, this policy provides a natural time for the auditor and Audit and Compliance Committee to review the policies and procedures used to evaluate the corporation's finances; the policy is highly recommended for public and nonprofit health systems as well.

Audit Follow-Up and Resolution

Increasing numbers of boards have also set up a formal policy to periodically review internal accounting procedures, including the implementation of recommendations from the auditor. Some companies delegate these responsibilities to the Audit and Compliance Committee; some assign them to senior management, with oversight authority resting with the Audit and Compliance Committee. If a similar process is not already in place, the board should promptly review and improve its internal audit processes and follow up on auditor recommendations.

Financial Disclosure Policy

It also is recommended that hospital boards undertake the obligation to disclose and explain any inaccuracies in financial statements and reports, as well as to disclose related internal policies and procedures that the organization has adopted. Examples of these policies include:

- a code of conduct for senior financial management regarding conflicts of interest, as described below;
- knowledgeable certification by senior management that financial reports are accurate and are not misleading and that the company has complied with applicable financial regulations; and
- timely disclosure of any errors in financial reports and of the controls implemented to preclude their repetition.

Knowledgeable, personal certification of the accuracy of financial reports by one or more members of senior management (e.g., the president, executive director, or CFO) is advisable, if this is not already done. The duties of the Audit and Compliance Committee should include explicit review of any reporting errors or other financial errors or irregularities and approval of remedial action.

Adequate and Accurate Documentation

As part of their new finance-related policies, hospital boards are instituting documentation policies to ensure that all financial data are presented in accordance with Generally Accepted Accounting Principles (GAAP), Governmental Accounting Standards Board requirements, or other applicable principles. Some of these policies further specify that all financial, accounting, and cost data must be capable of being audited, consistent with good business practices and to the extent this is both effective and efficient for the corporation's operations. Although many health systems have adopted these practices, board members should consider adopting a formal policy requiring ongoing compliance with GAAP or other specified accounting principles.

Codes of Ethics

It also is recommended that boards adopt a code of ethics for senior management responsible for corporate financial matters. Many organizations have taken the opportunity to institute a code of ethics applicable to all employees, officers, and directors. Boards of public and nonprofit health systems are encouraged to adopt similar codes of conduct that apply to all individuals who engage in activities on behalf of the organization, regardless of their positions.

The code of ethics should establish standards to promote:

- honest and ethical conduct;
- the avoidance of conflicts of interest;
- full, fair, accurate, and timely disclosure of annual reports and other financial statements;

- compliance with all applicable government laws, rules, and regulations; and
- accountability for adherence to the code.

In addition, the code of ethics could address issues such as the acceptance of gifts and honoraria. As with all governing documents, the code of ethics should be updated regularly, especially as applicable laws, rules, and regulations are amended.

Confidentiality/Anonymity Policy

It is also increasingly considered a best practice for hospital boards to establish procedures for employees to submit complaints, including anonymous complaints, to cultivate a culture for the prevention, detection, and resolution of activities or events that do not comply with laws, regulations, and corporate policies. These companies also must establish procedures to follow through on all logged complaints.

The most common approach that corporations have adopted is a confidential “hotline,” although a small organization may find this approach impractical. Nonetheless, the board should establish a method by which employees may submit comments and complaints, anonymously if desired. The responsibility for receiving such comments may be placed with a member of the Audit and Compliance Committee, perhaps as an additional alternative to reporting to a member of management. This could help minimize any reluctance to speak out and ensure an outlet for complaints involving the designated member of management.

Non-Retribution Policy

To further encourage employees to report questionable accounting or auditing matters, board policies also should prohibit firing, threatening, or otherwise harming any employee on the basis of the employee’s participation in an investigation into potential violations of hospital or regulatory laws and policies and laws. Such policies typically protect employees from retaliation or retribution. They must be drafted with care, as they typically entitle whistle-blowers to reinstatement, back pay, and special damages in appropriate circumstances.

Record Management Policy

Many hospitals also have implemented policies on the retention and management of the organization’s documents, both electronic and paper. These policies are often intended to address documentation related to financial statements, implementation and management of the confidentiality policy, and any investigation that occurs as a result of these policies. It is also important to address the retention of less formal documents such as emails. For example, many organizations have chosen to delete email archives regularly. Not only does this free up necessary storage space, but it can help avoid any demand to conduct a costly review of a multitude of trivial emails in the event of a lawsuit. Document management and retention policies must carefully balance the need to retain important information against the potential price of retaining large and unnecessary archives.

VIII. Conclusion

Transformational governance in today's health care sector requires a unique combination of skills, experience, strategic vision and leadership. The pace of change in health care today clearly rivals the pace of change in the information technology sector, where even the strongest and best known players must continue to transform and reinvent themselves to survive. Public and nonprofit hospital trustees can clearly learn from former IBM CEO Lou Gerstner's candid assessment of his company's near-death experience in the mid-1990s:

"... all the assets that the company needed to succeed were in place. But in every case—hardware, technology, software, even services—all these capabilities were part of a business model that had fallen wildly out of step with marketplace realities.... We had to take our businesses, products and people out of a self-contained, self-sustaining world and make them thrive in the real world.... It was like taking a lion raised for all of its life in captivity and suddenly teaching it to survive in the jungle."⁵⁸

While some safety net hospitals and health systems have been innovators, too many have (like IBM) been living for years in a self-contained, self-sustaining world. It is my sincere hope that the issues, trends and tools summarized in this special report will be of value to the trustees and other leaders who now see the need to "retrain the lions"—to transform their organizations so that they too will survive in the real world.

To achieve the necessary transformation, many of those leaders have looked to a reorganization of their legal structure or reform of their governance. Their reasons for doing so—and the various structures they have

elected to consider or adopt—have been spelled out in detail in this publication. For those who may still be weighing such a step, I would like to make a few final observations.

- Before considering a major reorganization, it is essential to evaluate the challenges and obstacles you face—and to determine which of those challenges can be addressed through improved structure or governance. Restructuring alone will rarely solve all of a hospital's problems, although properly planned and implemented, it can be an important tool.
- If a hospital has identified problems that can be solved through a reorganization of its legal structure or governance, the new structure it adopts must effectively address those problems. Sometimes this can require difficult political decisions—but the alternative of failing to provide a new board or legal entity with sufficient autonomy to get the job done can be worse than the status quo.
- If a new legal structure and a new governing board is needed, the new board should be given real operating authority and permitted to use it with sufficient autonomy. Where restructuring has failed to solve problems or meet expressed goals, it frequently has been due to elected officials withholding too many powers or interfering in the ability of the new board to exercise its authority.
- The creation of a new board must include a process to recruit and retain highly qualified board members, both initially and over time. A board should be composed of successful individuals who can "speak truth to power". The new board should possess the

⁵⁸ Louis V. Gerstner, Jr., *"Who Says Elephants Can't Dance?: Inside IBM's Historic Turnaround"*, Harper Collins, 2002

range of experience and skills to govern an organization effectively during a crucial transformational period.

The new board members themselves must approach their role with their primary allegiance to the future viability of the hospital or health system and to the patients and community it serves. If board members wear other hats—which most of them do—they must be taken off at the boardroom door.

Finally, once a new board has been recruited, hospital management must provide board members with education and ongoing information, must structure their committee and board meetings to permit them to govern effectively without wasting their time, and must provide them with sufficient “job security” to enable them to make tough decisions with confidence.

With these final observations in mind, safety net hospital leadership should be able to draw on the materials laid out in this special report to make intelligent and informed decisions about the implementation of transformational governance.

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