Transformational Governance
The Challenges Facing Trustees of Nonprofit and Public Hospitals

Monograph Series
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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.
Transformational Governance

The Challenges Facing Trustees of Nonprofit and Public Hospitals

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Introduction: What Is “Transformational Governance”? 

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.

The dramatic pace of health system change in the last decade has included enactment of the most comprehensive and historic health reform legislation since Medicare and Medicaid. But many of the changes that are transforming health care, such as the need for improved care quality and patient safety and care that is accessible and affordable, were already underway before health reform was enacted.

A dramatic transformation of the organization and structure of hospitals and health systems across the country is underway. Nothing less than transformational governance will suffice for those hospitals that hope to keep pace.

It is not the purpose of this monograph 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 the National Association of Public Hospitals and Health Systems (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 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 preparing this monograph, current and past board chairs of public and nonprofit hospitals around the country were interviewed. Their message unanimously underscores the urgent need to transform hospitals into fully

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¹ The views and positions expressed herein are solely those of this author and they do not 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).
integrated, patient-sensitive delivery systems. At the same time, they almost universally believe that hard work is still needed by many of these boards.

Any discussion of governance reform must start from the classic legal responsibilities of all governing boards, which are grounded in the fiduciary responsibility owed by a trustee to the organization he or she is governing. That fiduciary responsibility is most often reflected in the three basic duties of the governing board:

- **Care:** to take all board actions in a conscientious and informed manner. Board members must consider all reasonably available and relevant information and act in good faith.

- **Loyalty:** to base every board decision on the best interests of the health system and its mission. The needs of a particular constituency must never override the interests of the health system.

- **Obedience:** to adhere to the hospital or health system’s legal mandates and mission. This requires a solid understanding of the fundamental purpose and mission of the health system.

In addition to these underlying duties of care, loyalty and obedience, which are written into the nonprofit corporation laws of many states, hospitals seeking accreditation from The Joint Commission must meet additional governance standards. Most hospitals seek Joint Commission accreditation because it is a way of reassuring the public and third party payers that they meet expected community standards. Accreditation also is recognized as a process for confirming that a hospital meets certain required conditions of Medicare participation.

Federal and state tax laws also impose a substantial number of requirements on nonprofit hospital trustees. Governmental hospital board members face additional challenges of public accountability, such as the need for approval of their decisions by governmental entities and requirements of open meeting and public records laws.

This monograph looks beyond these well-known requirements to articulate additional considerations to assist board members in meeting the challenges of the future. It is organized into two sections: six fundamental building blocks of transformational governance and five

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transformational trends every trustee must take into account. Neither of these lists is meant to be exclusive. They identify issues and trends I believe are of utmost importance.

**Six Building Blocks of 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.

As with all complex organizations, public and nonprofit hospitals need strong, independent boards to bring vision, leadership and perspective to bear on current operations and future needs. The hospital can be strengthened if board members bring a variety of relevant expertise, experience and perspectives and understand the most significant trends and pressures affecting their role and their organizations. To achieve transformational governance, governing boards and their members also must be uniquely and exclusively focused on the mission, success and continuous improvement of the hospital or health system they govern.

Fundamental building blocks of transformational governance include:

**Building Block #1: Composing a Transformational Board.** Transformational governance begins with a board composed of the right individuals to lead the change process.

**Building Block #2: Board Education.** Once selected, board members must receive adequate, ongoing education to understand the important issues and pressures that will affect their hospital or system in the future.

**Building Block #3: Leadership.** Board members should expect to actively engage in leadership, of the organization and, on its behalf, in the community at large.

**Building Block #4: Advocacy.** Trustees should participate, as appropriate, in advocacy efforts with elected and appointed officials at every level of government.

**Building Block #5: Succession Planning.** Mechanisms should be established to evaluate the performance of the board, to identify gaps in the skills and experience of board members, to recruit new board members as terms expire and to develop future board leadership.

**Building Block #6: Strategic Orientation.** Transformational trustees must 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.

Each of these building blocks is discussed in more detail below.
Building Block #1: Composing a Transformational Board

BoardSource’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.” 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 the 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 institutional 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 box at right and as illustrated by how the University Medical Center of El Paso has transformed its governance, summarized in the box below.

"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."


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**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 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

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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 institution 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 board’s
12 board committees divide up board work, thus helping the board function smoothly.
On the other hand, Illinois’ John H. Stroger Jr. Hospital (formerly Cook County Hospital)
board has only 11 members. What the board lacks in size it makes up for in its diverse
composition, which includes a former Chicago public health director, the chief medical
officer of its major teaching affiliate, and a current county supervisor. The board is planning
to add public or health finance experience to its membership in the near future.
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 trustee Rick de Filippi 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.

“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.”

Building Block #2: Board Education
While some level of board education is typically required for accreditation purposes, public and nonprofit boards must acknowledge that a higher level of education is now required.

5 N.Y. PBA. §3303(1)(c).
The dramatic pace of system change and increasing legislative and regulatory demands require leadership by well-informed boards. All new board members should receive initial board education and orientation. Boards also should hold regular retreats that include senior management to ensure all stakeholders are “on the same page” with respect to their roles in governing and managing the health system.

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

According to de Filippi, the CHA board matured quickly in recent years, due to the head start in Massachusetts on health reform. He said being educated about new threats and challenges presented by state health reform was a heavy load initially. “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,” he said.

“The education process took an entire year,” de Filippi said. “We brought a sufficient number of board members to a position where they could use what they had learned to make informed decisions. We needed to understand the difficulty of our financial straits and what steps were needed. We also needed strong advocacy with the city and the state.”

**Building Block #3: Leadership**

In his 2011 book, *Leading Change in Health Care*, author and futurist Ian Morrison 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?”

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

Dr. Stocker says the NYC Health and Hospitals Corporation board recently spent a lot of time developing high-level policies, particularly for procurement and compliance. These

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7 See 18 N.Y.C.R.R. §521.
policies guide both board and management, enabling the board to focus on long-term planning and management, on implementation and operations.

**Building Block #4: Advocacy**

The fourth essential building block of transformational governance calls 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, hospital boards can profit from members who have experience in public relations as well. As the institution 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.

Board members also should 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.

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.
Building Block #5: Succession Planning

Mechanisms should be established to evaluate the performance of the board as a whole, to identify gaps in trustee skills and experience, and to engage in appropriate planning both for the recruitment of new board members and the succession of board leadership.

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 on public hospital boards is to broaden the appointive powers so that no single individual or body appoints most or all of the board. The appointing entity also 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.

The power of removal also affects the independence of the board. In the case of public hospital boards, 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 has announced 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.

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 approach to board composition often is used by hospitals structured as nonprofit corporations, including those that have converted from direct operation 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 (RMC) at Memphis were nominated by existing board members but appointed by the county mayor and confirmed by the county commission. RMC Memphis recently was 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. The 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.

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. Having the Governance Committee manage transition and succession is one way to ease this transition. Although the appointing power remains with the full board, the Governance Committee conducts much of the leg work by developing and gaining board approval for desired board leadership competencies, helping to establish and employ a formal leadership development process and vetting potential candidates.

Building Block #6: Strategic Orientation

The new world of health care is a rapidly changing one. 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 soon, hospitals will be paid on the basis of their performance on many of these measures. Current trends include new forms of reimbursement such as value-based purchasing, bundling of services for a single payment, 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.

Effective use of the prior building blocks will mean little if trustees are not focused on the most important trends and challenges that will be facing their health care organizations in the coming years. A number of these are summarized below, with observations about how trustees and boards can focus on the right trends and achieve necessary transformation.

Five Transformational Trends Trustees Must Master

This section addresses trends in health care that should guide trustees to implement transformational governance in their organizations. They are:

Transformational Trend #1: Rising Health Costs.

Transformational Trend #2: National Health Reform.

Transformational Trend #3: Quality and Patient Safety.

Transformational Trend #4: Provider Payment Reforms.

Transformational Trend #5: Demand for Greater Accountability.

Transformational Trend #1: 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.”

Total health spending is nearly 18% of GDP—as compared to 6-10% in Western European countries. In 2011, health costs are said to have averaged $19,000 (or 26%) 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%.

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% in 2010 from a high of nearly 10% 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.”

**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. 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.

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9 Id.
Transformational Trend #2: Impact of Health Care Reform

Efforts to lower costs and improve health care quality and safety over the last decade were accelerated by passage of the Patient Protection and Affordable Care Act of 2010, along with the accompanying Health Care and Education Reconciliation Act of 2010 (collectively known as the ACA). This section discusses several provisions of the ACA.

The ACA may substantially decrease the uninsured population and reduce uncompensated care for hospitals. While this outcome could greatly benefit hospitals, the gradual implementation of requirements and uncertainty surrounding their consequences could increase administrative costs and prompt other internal changes for hospitals, including affiliations or mergers with other health care systems.

Although the ACA will expand Medicaid coverage for individuals, it will adversely impact federal dollars available for Medicaid 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.

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

MSSP ACOs, for example, require a “qualified health care professional” to oversee a common quality assurance and improvement plan. 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. 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.

13 Ibid.
14 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.
Other models of care stimulated by health care reform include:

- community health teams and health homes that care for chronically ill Medicaid patients, and
- community collaborative care networks, which involve a consortia of health care providers that deliver comprehensive, coordinated and integrated health care services for low-income populations

**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.

**Transformational Trend #3: Quality and Patient Safety**

The federal Centers for Disease Control and Prevention estimates that “at least 1.7 million healthcare 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.”

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—they will be

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paid according to their performance on measures of patient satisfaction and clinical processes and outcomes.

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.

**Transformational Trend #4: 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**

Alternative payment methodologies, including bundled payments which provide a single payment to hospitals and physicians to care for defined episodes of care, also are being tested to encourage integrated care and improve outcomes of hospitalizations for Medicare patients. The Medicare pilot 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 pilot will be funded via existing Medicare payments.
Medicaid Issues: Waiver Trends

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.\(^\text{17}\) Additionally, the expansion of managed care to higher-need, complex populations such as the elderly, disabled, and children and adults with chronic illnesses, is a growing trend impacting public hospitals.

Medicaid and 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.”\(^\text{18}\)

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.

Finally, 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.


Alternative Payments for System Improvement

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 (the 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.

Transformational Trend #5: Increased Demand for Accountability

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.

Community Benefit

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.\(^1\) 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.

*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 “whistleblowers.” 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 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.

*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.
Conclusion

Transformational governance in today’s health care field 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 industry, 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. [IBM]… had failed to adapt as customers, technology and competitors changed…. 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.”

Many public and nonprofit hospitals also have been living for years in a self-contained, self-sustaining world, while the health care environment has been dramatically changing around them. It is my sincere hope that the trends and building blocks summarized in this monograph will be of some value to the trustees of those hospitals who now see the need to “retrain the lions” —to transform their organizations so that they too will survive in the real world.