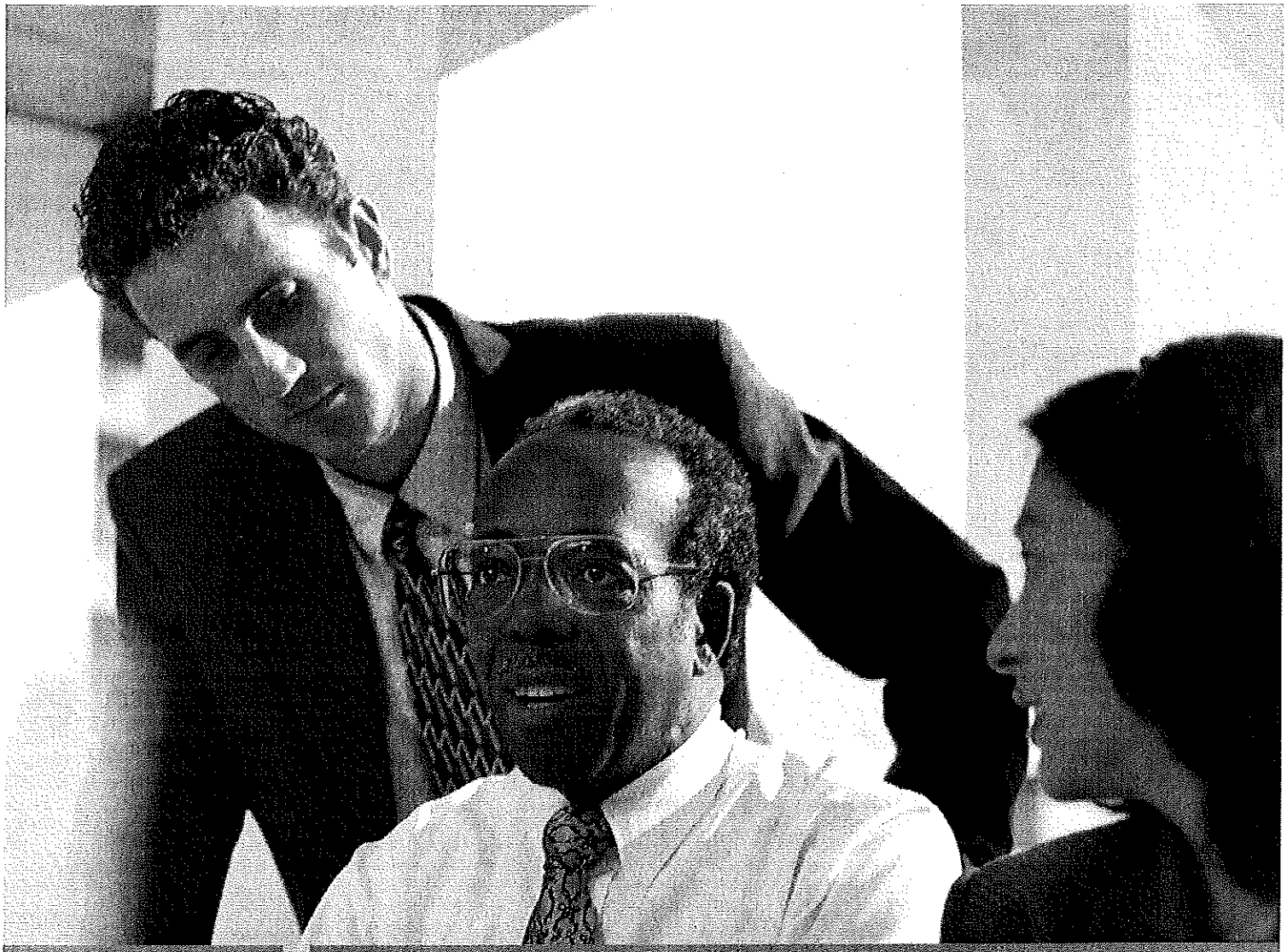
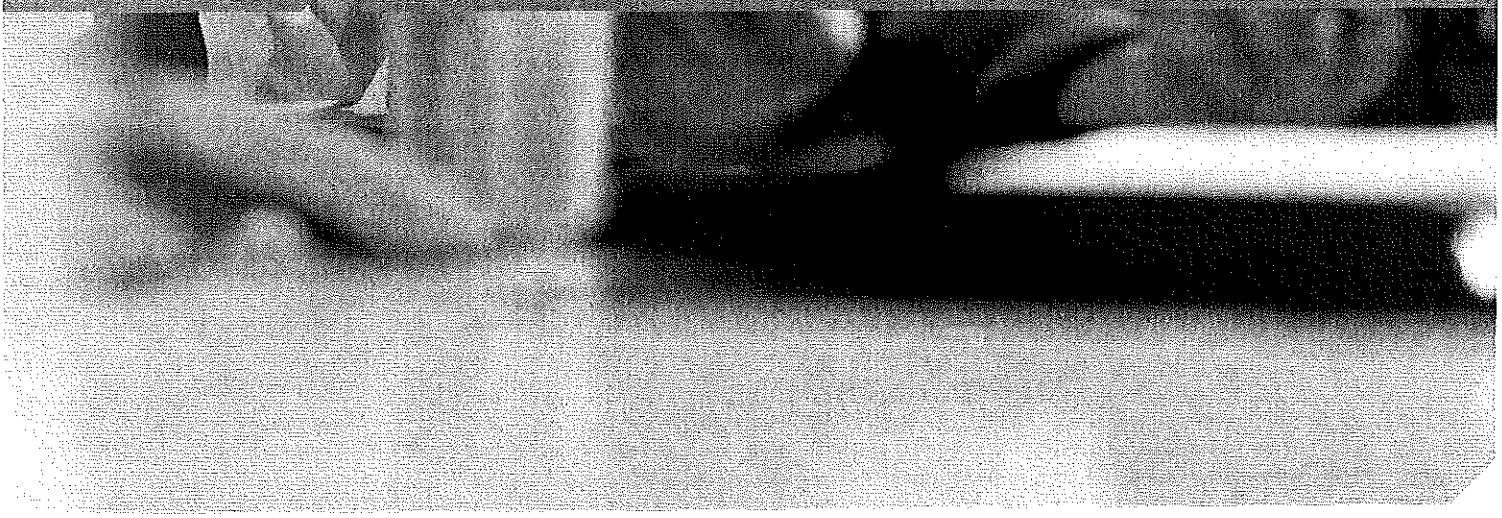


National Association of Public Hospitals and Health Systems

LEGAL STRUCTURE AND GOVERNANCE OF PUBLIC HOSPITALS AND HEALTH SYSTEMS



National Association of Public Hospitals and Health Systems

LEGAL STRUCTURE AND GOVERNANCE OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

Larry S. Gage
Anne B. Camper
Robert Falk

WASHINGTON, DC

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About the National Association of Public Hospitals and Health Systems

The National Association of Public Hospitals and Health Systems represents more than 100 of America's most important safety net hospitals and health systems. These facilities provide high-quality health services for all patients, including the uninsured and underinsured, regardless of ability to pay. They provide many essential community-wide services, such as primary care, trauma care, and neonatal intensive care, and educate a substantial proportion of America's doctors and nurses. NAPH member hospitals and health systems are also major providers of ambulatory care services, providing nearly 30 million ambulatory care visits annually. NAPH advocates on behalf of its members on issues of importance to safety net health systems across the country. NAPH also conducts research on a wide range of issues that affect public safety net health systems.

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About the Authors

Larry S. Gage, Partner, Powell Goldstein LLP
Larry Gage focuses his practice in the areas of federal and state health industry legislation and regulation, health policy, litigation, and corporate representation. He is director of the firm's Washington health practice group and has served since 1981 as president of the National Association of Public Hospitals and Health Systems (NAPH).

Anne Camper, Partner, Powell Goldstein LLP
Anne Camper focuses her practice in the areas of health law, health care transactions, and general corporate and business law. She has successfully represented major public and non-profit hospitals and hospital systems, as well as physician groups and other health care providers, cities and counties, medical schools, technology-based corporations, national trade associations, and other charitable and educational organizations.

Robert N. Falk,
Former Counsel, Powell Goldstein LLP

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Preface

Effective governance has never been more important for hospitals and health systems generally—or for public hospitals in particular. Throughout the hospital industry, there is heightened attention to the importance of governance. Many of the corporate governance controls set out in the *Sarbanes-Oxley Act* have now spilled over to the nonprofit sector. The spotlight is also being cast ever more glaringly on hospital governance by key congressional committees and by the legislatures and attorneys general of many states.

It is more vital than ever for hospital board members and senior management to pay attention to the four "hallmarks" of effective hospital governance, and for board members to accept full accountability for their stewardship in each of these areas:

- **Strategic orientation:** to articulate the mission and establish long-term direction
- **Fiduciary duty:** to preserve fiscal viability
- **Public accountability:** to represent the needs of the public and be accountable to the public
- **Advocacy:** to represent the hospital's needs before the executive and legislative branches and the public.

Yet each of these hallmarks carries additional burdens for public hospitals. Even where there is a separate, dedicated board for a public hospital or health system, responsibility for strategic orientation in the public sector is often shared with political entities and elected officials who respond to competing constituencies and interests that are not always aligned with a health system. Exercising fiduciary duties also can bring board members into conflict with elected officials. Developing and implementing budgets often requires negotiation with and approval from external authorities. These obligations, in turn, reduce incentives for effective bottom-line management and can include constraints on human resources management, purchasing, and other areas—constraints that do not exist in the private sector.

"Public accountability" also takes on a new meaning in the public sector, with board members often responsible to a broader range of constituencies and forced to operate under open meeting and record laws that serve a legitimate public purpose but that, at times, can constrain effective governance. Even the board member's duty to serve as an advocate for the hospital is more complex and multi-faceted in the public sector, albeit more important than ever due to the added external and internal pressures faced by public hospitals.

External pressures include severe, ongoing constraints on federal and state funding sources at a time when most public health systems also face increased demand for already under-compensated services. At the same time, most public health systems are confronting internal pressures on a wide range of fronts, including:

- a compromised ability to recruit and retain key clinical and administrative staff
- difficulty gaining access to capital
- fierce competition for scarce local resources, and

- increased scrutiny from the elected officials who control local funding and policies.

In response to these pressures, many government hospitals and health systems have considered or implemented a reorganization of their legal structure and governance in recent years. Their reasons for considering such reforms—and the various structures they have elected to adopt—are spelled out in detail later in this report. This report also includes detailed "how to" information for those who wish to consider restructuring.

In weighing the decision to restructure, hospitals first should consider a few notes of caution.

- Before considering a major reorganization, it is essential to evaluate the challenges and obstacles that face a given hospital or health system—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; it can be one essential tool, but other tools likely will be needed.
- 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. For example, if civil service or procurement constraints are considered major obstacles, the new organization must be able to adopt new rules and approaches.
- If the creation of a new legal structure and a new governing board is deemed necessary, the new board should be given real operating authority and then permitted to use it. Where restructuring has failed to solve problems or meet expressed goals, it frequently has been due to elected officials withholding too much explicit authority or interfering too often in the ability of the new board to exercise authority.
- In the process of creating a new board, hospitals should establish a process to recruit and retain highly qualified board members, both initially and over time. A board should be composed of successful individuals who possess the range of experience and skills to govern an organization effectively during a crucial transformational period and who fully understand that their primary allegiance when they sit in the board room is to the future viability of the hospital or health system (not to an external constituency). Once such a board has been recruited, the hospital 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.

Having considered these notes of caution, hospital administrators should be able to draw on the materials laid out in this report to make intelligent and informed decisions about the adequacy of their hospitals' existing structure and governance to meet current and future challenges.

Executive Summary

1

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

The Institute of Medicine 2000 report, *America's Health Care Safety Net: Intact but Endangered*, defines "core safety net providers" as having two distinguishing characteristics:

- By legal mandate or explicitly adopted mission, they maintain an "open door," offering patients access to services regardless of their ability to pay; and
- A substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.[1]

Public hospitals shoulder unique regulatory and political burdens that result from their safety net missions and their government status. As institutions, public hospitals provide services that are needed in the community but may not generate sufficient revenue to cover costs. 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. At the same time, public hospitals face the same fiscal and competitive pressures that confront the rest of the health care industry in America. Consequently, the governing boards of public hospitals face special challenges associated with the mission of their institution and, frequently, their public nature.

The pressure is especially acute for those public hospitals and health systems that rely most heavily on federal, state, and local government funding to pay for their wide range of primary, acute, and public health services. For most such systems, market pressures are intensified by a variety of factors that have far less, if any, effect on their competitors. These include the continuing increase in the uninsured and underinsured population in many areas, reductions in Medicaid funding and local support, the impact of immigration reform, greater competition for Medicaid patients, the explosion in managed care, responsibility for public health and other community services, fettered governance, the obligation to conduct sensitive business in the public eye, and other cumbersome political or bureaucratic obstacles. Many public hospitals have found that public status, in itself, precludes them from implementing efficiencies or taking other steps

PUBLIC HOSPITALS

Throughout this report, the term "public hospitals" is used to refer to public hospitals and health systems, which may include health care providers owned and operated by cities, counties, states, universities, non-profit organizations, or other entities. They share a common safety net mission of providing health care to all, regardless of ability to pay.

that private providers use to improve operating margins.

This report describes organization and governance tools and strategies to aid public hospitals in carrying out their mission and in operating effectively. It describes different governance structures typically used by public hospitals, providing examples of each and presenting their benefits and drawbacks. It then examines the important role of trustees in today's public hospital systems and some of the issues surrounding their appointment, training, and responsibilities. Chapter 4 outlines the challenges that trustees face, focusing on those issues peculiar to trustees of public hospitals. The remainder of the report addresses issues to be considered, first in determining whether a new governance structure is needed and then in pursuing and implementing structural changes.

TYPICAL PUBLIC HOSPITAL STRUCTURES

- Direct Operation by State or Local Government
- Separate Government Entity
- Nonprofit Corporation

This report groups typical public hospital structures into three categories, acknowledging that within these general categories there are many variations.

- **Direct Operation by State or Local Government:** The hospital or health system is directly administered by state or local government, with no separate legal existence or governing board. In certain instances, the health department of the local government is given an advisory board, but the board does not 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:** The hospital or health system has 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 more public accountability and, frequently, access to public funding. On the other hand, it may be subject to many of the regulatory and other burdens of public status.
- **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 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. 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.

A strong, capable and functionally dedicated board is very important to a public hospital's ability to serve its mission. As with other corporations, the three basic duties of the governing board are:

- **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.
- **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.

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. 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.

Public hospital boards typically bear more complicated responsibilities than those of their competitors or other hospitals in the community. Special challenges include legal, regulatory, and political pressures, including an increasing uninsured and underinsured population; reductions in Medicaid funding and local support; the impact of immigration reform; competition for Medicaid patients; responsibility for public health and other community services; fettered governance; the obligation to conduct sensitive business in the public eye; and other cumbersome political or bureaucratic obstacles. In addition, public 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.

The *Sarbanes-Oxley Act*, though not directly applicable to nonprofit and public institutions, has created a new set of standards for internal governance; this report provides an overview of relevant aspects of this act. In a separate but related arena, the number of fraud investigations against health care providers and high-dollar settlements has led health care governing boards to focus increasing resources on compliance oversight.

Due to these and other challenges, public hospitals and health systems often contemplate some form of restructuring as a means of improving their viability and competitiveness. In this process, it is important to assess advantages and disadvantages of the status quo, the goals of any change, and the extent to which the available restructuring options will adequately address these goals. Then, the costs of restructuring—both tangible and intangible—must be carefully and objectively weighed against the expected benefits. This report provides descriptions of successful and unsuccessful attempts to restructure. It also provides an overview of the key steps in any restructuring process.

In addition to operational implications, hospital structure and governance may critically affect a hospital's involvement in the Medicaid program. NAPH members and other public hospitals rely heavily on Medicaid and related reimbursement, and their ongoing ability to make intergovernmental transfers and participate in these programs is critical. The new, restrictive policies of the federal Centers for Medicare and Medicaid Services (CMS) threaten to upend the financial assumptions on which many public hospitals were originally restructured. On a prospective basis, the policies threaten to distort the market by discouraging state and local governments from undertaking public hospital restructurings that otherwise would enhance the hospital's ability to achieve its public mission in a highly competitive marketplace. These policies, their legal ambiguity, their impact, and possible responses are explored in Chapter 6. Chapter 7 examines fundraising, capital access, the transfer of existing debt or reserves, and other financial issues in the context of restructuring.

This report highlights the importance of effective governance in public hospitals and health systems. It demonstrates the many ways in which a public 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 in a situation where the numbers of uninsured and underinsured patients remain high and sources of funding are inadequate. However, careful attention to the adequacy of structure and governance can be an important tool to assist public hospitals in meeting the challenges they will continue to face in the future.

Typical Legal Structures of Public Hospitals and Health Systems

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There is no such thing as a typical public hospital or health system in America today. Rather, these hospitals and health systems make use of many 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 public hospitals, include a clear mission to provide access to vulnerable populations regardless of ability to pay; the actual provision of substantial levels of care to low-income, uninsured, Medicaid, and other vulnerable patients; and historic status as the community's public or safety net provider.

An institution's description as "public" or "governmental" often depends on the purpose of the characterization. For example, a given structure's designation as governmental might vary in determining the applicability of open record or meeting requirements, civil service regulations, procurement codes, etc., and each of these depends on its state or local jurisdiction (see Chapter 4 for more information); still other criteria could apply to designation as public for purposes of antitrust immunity, property or tax law, or Medicaid regulations. Indeed, whether an institution is deemed governmental for purposes of Medicaid calculations is a highly fact-specific determination based on controversial and sometimes ambiguous criteria, and this designation may diverge from the institution's status for other purposes. Nonetheless, the characterization under state and local law should carry substantial weight in any determination. (Medicaid and related reimbursement issues are addressed in Chapter 6.)

This chapter describes the primary models of public hospital governance and offers examples of hospitals and health systems within each category. The range of legal and corporate structures employed by public hospitals can be divided into three main models.

- **Direct Operation:** These hospitals are owned and operated by local governments or by state governments or universities.
- **Separate Government Entity:** Hospitals in this category are governed by a separate board within a government entity, by a hospital authority or public benefit corporation, or constitute an independent taxing district.
- **Nonprofit Corporation:** This category typically includes tax-exempt hospitals

Many public health systems have chosen to design their own structures through new state legislation when the existing models did not adequately address their needs.

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.

These classifications are somewhat arbitrary, since each model can have numerous permutations that may overlap with each other. For this reason, it can be unclear which model most closely describes a specific hospital. In addition, many public health systems have chosen to design their own structures through new state legislation when the existing models did not adequately address their needs. Third-party management and joint venture arrangements represent just such variations. Though they may leave the formal corporate structure intact, these variations can greatly affect system functioning. The discussion below provides descriptions and examples of each model.

Direct Operation

Direct Operation by Local Government

The hospitals or health systems that use this model are directly administered by local government and consequently have no separate legal existence. 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. The public hospital system in Cook County, Illinois, and several major county systems in California exemplify this model.

For many years, the Los Angeles County Department of Health Services (DHS) has directly operated the county's system of five hospitals, one multi-service ambulatory care center, and six comprehensive health centers. The system's only formal governing board has been the County Board of Supervisors, a body of five elected officials responsible for governance of the entire County of Los Angeles. The chief executive officer of the health system is the director of DHS, who reports to the Board of Supervisors. The director is also responsible for a wide array of public health services and other typical health department functions.

In Cook County, Illinois, the Bureau of Health Services operates the County's two full-service hospitals (The John H. Stroger, Jr. Hospital and Provident Hospital). In addition to the hospitals, the Bureau provides public health services to over five million residents through its operation of the public health department, a chronic care and rehabilitation hospital, 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. The sole governing body of the Bureau of Health Services is the Cook County Board of Commissioners: 17 elected officials who serve as the governing policy board and legislative body for the entire county. The president of the County Board of Commissioners appoints the chief of the Bureau of Health Services with the consent of the board.

Direct Operation by State Government or University

Like health systems in the previous category, these state or university health systems have no legal existence separate from the state or the state university of which they are part. Most of the 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.

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 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 Government Entity

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.[2]

Authority or Public Benefit Corporation

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. 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.

For example, in 1945, Georgia adopted hospital authority legislation, providing a vehicle for Fulton, DeKalb, and many other counties to build or expand inpatient facilities for their growing populations. 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 in turn appropriate funds to Grady. Today, the Authority oversees the hospitals, comprehensive community health centers, and other medical and health facilities that comprise the $615 million per year Grady Health System.[3]

In contrast, the Denver Health and Hospital Authority was created under special state legislation drafted and adopted in 1996 to operate the Denver Health system in Colorado. 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 Authority 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 the Authority's public mission and envisions that the Authority will provide health services to city residents, while enjoying funding and in-kind services from the city. The 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.

In 1996, Cambridge, Massachusetts, also obtained special state legislation authorizing a new government Health Commission responsive to its needs.[4] The Cambridge Public Health Commission is similar in key respects to an authority. It is a city commission created to operate the city's government health care facilities. The Commission is governed by a 19-member board, appointed by the city manager subject to certain qualifications. The city manager may remove any member of the board for cause, which includes failure to ensure that the Commission adheres to its mission. The enabling act specifies the Commission's purposes, grants it extensive powers, and transferred to it the Cambridge hospital network. One key constraint is that "no contract or agreement for the management of all or substantially all of the operations of the Cambridge hospital network shall be effective without the prior approval of the city manager."

Public Benefit Corporation: This model is also a function of state law, and its features vary by state and by statute. For the purposes of this paper, 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.

In 1995, the Hawaii Health Systems Corporation (HHSC) was created from an existing state agency, the Division of Community Hospitals. The creation of a new PBC as a government entity was recommended by a broad-based Governor's Task Force, appointed in 1994 to assess the structure of the state-owned hospital system. Special enabling legislation was adopted in 1995.[6]

HHSC is governed by a geographically representative 13-member board, appointed by the governor, with confirmation by the state senate. Members of the board may be removed for cause by the governor or by a two-thirds majority of the board members. The corporate organization is divided into five districts.

The enabling act for HHSC assigned it broad powers to contract, affiliate, create new corporations, prepare and execute budgets, issue revenue bonds, etc. The HHSC budget is subject to review or approval by the governor only when state general funds or capital improvement funds are requested. Due to their detrimental effect on hospital operations, HHSC is exempt from state procurement laws, and certain exceptions to the open records requirements are provided. HHSC employees are generally considered state employees for purposes of civil service and collective bargaining. The legislation mandates continuation of direct patient care service levels at HHSC facilities unless the legislature approves reductions.

Taxing 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 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.

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. 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.

Recently Approved Taxing Authority

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, from 2002 to 2004, voters in at least seven states or major metropolitan areas considered such new, dedicated taxes.[7] 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.[8] 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.

In 2000, Palm Drive Hospital became the Palm Drive Health Care District (also known as the West Sonoma County Hospital District), after local voters approved ballot measures to create the district and support it with a tax levy. Pursuant to California law governing hospital districts, the Sonoma County Board of Supervisors and its subcommittee for health services governs the Palm Drive Health Care District, and a dedicated five-member Board of Trustees oversees the daily operations and management. 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. The $11.61 parcel tax approved by voters in 2000 to support hospital operations was estimated to raise enough revenue to allow the district to issue $5.9 million in bonds.

In 2001, the Board of Trustees returned to the voters with a second parcel tax ballot measure, and again the measure passed. This second measure 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.

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.

Newly Created Nonprofit Corporation with Ongoing Government Participation

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 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. While the CEO and board do not directly report to any county officials, the mayor and commission have the power not only to appoint but also to remove board members.

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 the 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.[9]

A nonprofit corporation, the Truman Medical Centers (TMC), operates the two government hospitals in Kansas City, Missouri (located in Jackson County). 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 33-member board. Three board members are appointed by the mayor, three by the county executive, two by the state university that includes the medical school, two by the hospital medical staff, two 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 the two hospitals and, along with Kansas City, maintains 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 help offset the cost of indigent care.

Operation by Existing 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

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

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.

In the early 1990s, Austin began considering a reorganization of Brackenridge Hospital to respond to growing operating losses and the fear of increased future reliance on city taxpayer funds. In addition, the hospital wished to avoid certain local and state regulations that made it difficult to attract and retain highly qualified employees and that restricted management's effective operation of the hospital, affecting personnel, purchasing, and public disclosure. City officials convened a Health Care Task Force in 1990 that ultimately recommended Brackenridge remain a city-owned hospital but suggested that the city needed taxing authority to help fund indigent care.

The taxing authority proposal was not well received by city officials, who feared that they could not obtain the necessary new legislation and voter approval. The city government authorized a second task force to consider additional options for reorganizing Brackenridge, including a new taxing district, a hospital authority, and an outright merger with a private hospital. The task force recommended the hospital authority option in order to allow the city to maintain control of the hospital.

Despite city support, the hospital authority option ultimately proved unworkable as a result of conflicts concerning financial and control issues. In the wake of bad publicity about Brackenridge, followed by aggressive consolidation among other hospitals in the city, the city council adopted as its strategy the merger option it had previously discarded. There were complications related to an outright sale of Brackenridge, including community opposition and public procurement requirements. In the end, a long-term leasing arrangement with a private hospital evolved as the most workable option for Brackenridge hospital and the city. As a nonprofit system with a historic commitment to charity care, Seton was identified as the most desirable partner for Brackenridge.

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.

Variations of Governance Models

Third-Party Operation or Management

In certain instances, the public health system is placed under the management of an existing health system or management company. 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 (the state university) under contract since 1984. 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 county continues to govern HMC through its board of trustees and through financial oversight. The county executive appoints the 13 HMC board members, including one from each of the nine council districts, subject to confirmation by the county council. The trustees may be removed only for cause. The board of trustees oversees operation of HMC within budgetary limits approved by the council. The county council sets comprehensive public health policy, monitors board performance, controls capital and long-range planning, and approves the HMC annual operating and capital budgets.

Under the University of Washington management contract, the university is responsible for overall management of the hospital and provides the hospital administrator and medical director as well as medical and other professional services, subject to the approval of the HMC board. The administrator is accountable to the board of trustees, as well as to the University Executive Director of Hospitals. The management contract conveys neither financial risk nor benefit to the university. The university employs the medical center staff and is reimbursed by HMC for salaries and fringe benefits. The management contract may be cancelled upon a one-year written notice by either party.

Wishard Memorial Hospital in Marion County, Indiana, has been managed by the Indiana University School of Medicine (a state institution) since 1975. Under this management structure, the hospital's chief executive/medical director position is filled by a faculty member of the medical school.[10] The hospital is owned by the Health and Hospital Corporation of Marion County, a municipal corporation

formed in 1951.[11] 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.[12] 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.[13] 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.[14] The City-County Council must approve the Corporation's budget, though changes made by the Council can be appealed to the state.[15]

Joint Venture

In certain instances, public hospital services have been preserved by joint ventures with other entities in the community. These arrangements can take different forms, ranging from joint clinical projects to full mergers.

The Boston Medical Center (BMC) provides an example of a comprehensive joint venture. 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.[16] 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:

- to provide accessible health care services to all, regardless of insurance status or ability to pay
- to maintain a commitment to vulnerable populations
- to maintain a full range of primary through tertiary care
- to serve urban and suburban communities in a "culturally and linguistically competent manner"
- to enhance its role as a major academic medical center
- to provide managed care services to its community.

BMC 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 10 representatives each from the City Hospital and BUMC; four represen-

tatives 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.[17]

The Commission is a unit of government.[18] 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.[19] The legislation explicitly authorizes the Commission to issue bonds and notes, with approval of the city council and the mayor.[20]

The University of Louisville has gone through a series of joint ventures to preserve its public hospital and indigent care services. The state university owns, and until 1981 operated, the University of Louisville Hospital (University Hospital). The hospital was in a state of financial distress, receiving insufficient funding for unreimbursed care and often running large deficits. When the university informed the Commonwealth of Kentucky that it could not afford to open the new public hospital facility then under construction, the Commonwealth turned to the Humana hospital management company. Under the terms of the management contract signed in 1981, Humana would manage the hospital, assume all financial risks, and pay 20 percent of its pre-tax profits to the University of Louisville. Indigent care would be reimbursed each year from a combined local, county, and state fund, with any costs exceeding the available funding for the year being carried over to the following year. In 1983 the new hospital building opened.

In 1993, Columbia Healthcare Group (later Columbia/HCA after a 1994 merger with Hospital Corporation of America) acquired Humana's hospital company and the management of University Hospital. A renegotiated contract was signed in 1994, under which Columbia would continue to provide indigent care in exchange for a fixed government payment, make improvements to the emergency room and cancer center, and locate its headquarters in Louisville. A year into the contract, Columbia/HCA decided to move its headquarters to Nashville, Tennessee, and the Commonwealth cancelled the management contract.

The Commonwealth turned again to experienced providers to manage the hospital, and after several legal battles with Columbia/HCA, the hospital trustees voted in October 1995 to enter a management agreement with the newly created, nonprofit University Medical Center. University Medical Center (UMC) is a partnership of the University of Louisville with Jewish Hospital HealthCare

Services and Norton Healthcare.[21] The agreement provided for governance by a 12-member board—six appointed by the university and three by the two other partners. Under the contract, the university would retain UMC net revenues, and the partnership would expand the emergency room, improve the cancer center, and maintain health care education programs. UMC also agreed that University Hospital would continue to provide indigent care and that the university would retain stronger control over academic programs than it had under prior management agreements.

Public-Private Partnership

In certain situations, public and private entities have come together in creative ways to preserve a safety net hospital for a community. Healdsburg General Hospital in Sonoma County, California, is an example of a public-private partnership developed to preserve a formerly private safety net hospital.

Healdsburg General Hospital has been owned and operated by nine different entities in its 100-year history. In 1995, Columbia Healthcare, Inc. acquired the hospital along with its owner, HealthCare Trust, Inc. Despite major renovations, Healdsburg General faced ongoing losses. Columbia initially intended to spin off the hospital into a separate corporation, but in 1998, announced its plan either to sell or close the hospital. A local business group created Nuestro Hospital, Inc. and purchased the hospital from Columbia for $3.7 million to prevent its closure. Nuestro Hospital continued operating at a loss, ultimately generating a $2 million deficit. In 2000, the owners sought to lease the facility to a local hospital system, but negotiations fell through.

In November 2001, local voters approved two separate ballot measures related to the hospital: Measure G created the North Sonoma County Hospital District and provided the district with a $10 million appropriations limit, and Measure H allowed the district to levy a parcel tax of $85 per $100,000 assessed value. Nuestro Hospital, Inc. then donated the facility to the newly formed district.

As a public hospital district, the North Sonoma County Hospital District remains under the supervision and control of the Sonoma County Board of Supervisors and its subcommittee on health services. A dedicated board of trustees oversees hospital operations and management. Pursuant to California law, the initial five trustees were appointed by the Board of Supervisors, but their successors are elected by district voters in at-large elections. The board of trustees has subcommittees on budget, planning, operations, and community relations. Day-to-day operations are handled by the chief executive officer of the facility.

More limited public-private partnerships also can prove advantageous for public hospitals, particularly when the private partner can provide much-needed capital or management resources (capacity as well as specialized expertise) for the new venture. In return, the hospital may offer a large and diverse patient base,

highly skilled physicians, and, in many cases, clinical differentiation and a strong "brand name." A recent study of joint ventures in academic health centers revealed that in the majority of cases, these ventures result from unexpected opportunities instead of proactive strategic planning; this underscores the importance of a flexible management culture open to innovative ideas.[22] It is also important to consider tax and other regulatory consequences when structuring a joint venture.

Examples of specialized public-private partnerships include an ambulatory imaging center jointly owned by the University of Virginia Health System and a for-profit specialty imaging firm, and staffed exclusively by the health system's faculty. Using a different model, the University of Michigan Health System paired with various community hospitals to create radiation oncology partnerships. The health system provides the clinical staffing and expertise, and each local hospital provides the facility, patient base, and administration. A key benefit of these ventures is to allow the public hospital to take advantage of new business opportunities that otherwise would have been beyond reach.[23]

In the majority of cases, joint ventures result from unexpected opportunities instead of proactive strategic planning.

3 The Role of the Board

As institutions, 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 institution and, frequently, with their public nature.

General Board Duties and Responsibilities

Public 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 public hospital boards may face.

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

- **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.
- **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.

As with any complex organization, a public 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 towards 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

Public hospitals need a strong and independent board to bring vision, leadership, and perspective to bear on present operations and future needs.

numbers such as historic performance or the performance of comparable institutions, 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.

In addition, hospitals seeking accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) have to meet the specified leadership standards.[21] Most hospitals seek JCAHO accreditation because it is recognized by the Medicare program as a means of confirming that the hospital meets certain required conditions of participation. JCAHO 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. JCAHO 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.

Issues Specific to Members of Public Hospital Boards

Public hospital board members might experience certain pressures that make it seem harder to honor their general board duties. First, public hospital board members may be appointed by elected officials. Those officials may have the ability to remove the member or at least refuse to reappoint that member. In certain instances, the political appointment process may encourage greater loyalty to the appointer than to the institution. Even when the appointed board member defines his or her primary allegiance to the institution, the threat of removal or non-renewal may color the board member's decision making. He or she may be more likely to compromise a position if the political appointer desires a different outcome.

Similarly, certain board members may be appointed to a public hospital board as a representative of a specific constituent group. Certain board seats may be reserved for clients of the institution, for members of certain ethnic communities, or for representatives of other organizations. Because of their appointment from these constituencies, these board members may feel their primary allegiance is to the group from which they came.

Local or state "open meeting" laws also may complicate the board deliberation process. Local news organizations frequently cover the community public hospital and may attend board meetings routinely. Board members of numerous public hospitals indicate that the presence of media dampens the candor of their discussions and curtails their ability to debate crucial issues.

In many instances, the cycle of political and constituency-based appointments may produce a less stable board structure. If the political appointment process leads to frequent turnover in board positions, especially when there is a new elected administration, the board may lose experienced members who have invested significant time in understanding the institution's complex needs. Also, it is possible that some of the appointees will not have experience serving on boards. This turnover effect may require more frequent board training and rebuilding of relationships among the board members themselves.

On the other hand, a public hospital often can benefit from the diversity and the political connections of its members. In particular, the political appointment process may give the institution direct lines of communication with highly placed elected officials. This connection may be especially important if the hospital needs to renegotiate financial support from the local government entity. The connections may extend to the state level as well, which may be especially valuable if the state is

restructuring its Medicaid reimbursement program or other potential funding.

Functionally Dedicated Governing Body

Many public 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.

An example of this structure is the five-hospital Los Angeles County Department of Health Services. The governing board for this system is the Los Angeles County Board of Supervisors—five officials who were elected to govern the entire county, with an estimated 10.2 million residents.

Similarly, in Cook County, Illinois, the 17 elected officials who compose the county's Board of Commissioners govern a health system that serves a population of more than five million people and includes three hospitals and the largest freestanding correctional health care facility in the country. This board serves as the governing policy board and legislative body for the entire county, which includes the city of Chicago.[25]

In many instances, 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.

Sometimes hospitals structured as operating divisions of local government are given advisory boards. While these boards have 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.

Composing a Public Hospital Board

Public hospitals and health systems often must balance three forces: the demand for responsiveness by the local government; the need to maintain institutional and financial integrity; and the demand to be responsive to key local constituents. These tensions are frequently reflected in and addressed through the composition of the public hospital board.

In many instances, a public hospital may be a legal entity separate from a local government, yet highly dependent upon it for financing uncompensated or undercompensated 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. Truman Medical Centers has a 33-member board, of which three members are appointed by the mayor, three by the county executive, and two by the state university that includes the medical school.

In an effort to make hospital governance more robust, some public hospital boards are composed to ensure an adequate diversity in relevant professions. A hospital's enabling act or bylaws often include guidelines on the characteristics to be sought in board members. For example, in Westchester County, New York, voting directors of the public Health Care Corporation are to possess relevant experience and knowledge and a high degree of interest in the corporation; specifically, the board should include a diversity of perspectives and experience in areas such as business management, law, finance, and the health sector.[26]

Other boards require a certain number of board positions to be reserved for representatives of consumers 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.[27]

Appointment and Removal Processes

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 some-

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.

times 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.[28] 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.

Self-perpetuating boards—those that not only nominate but appoint succeeding members—also can be effective. This alternative is often used by hospitals structured as nonprofit corporations, including those that converted from direct operation by a local government. For example, Truman Medical Centers is a nonprofit corporation, part of whose board is self-perpetuating. Self-perpetuation is less common in more traditionally structured public hospitals.

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 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 supermajority 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. A trade-off here is accountability, though this can be achieved by other means including public meetings (with appropriate exemptions), annual audits and reporting, and reasonable conflict of interest provisions. In any case, the enabling act or bylaws should specify the conditions under which a board member may be removed.

Conflicts of Interest

Many forces are leading governing bodies of all varieties to adopt formal conflict of interest standards. Publicly traded for-profit entities are guided by the conflict of interest provisions of *Sarbanes-Oxley*. The Internal Revenue Service (IRS) strongly advises nonprofit entities to adopt conflict of interest provisions. Further, in many instances, state and local public entity laws impose their own conflict of interest standards.

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 record-keeping
- Procedures ensuring regular distribution of the conflict of interest policy.

Many institutions find the IRS model policy a useful starting point.[29] However, this model can serve only as a starting place because any particular policy will need to comply with all applicable state and local laws, such as those governing public officials. The *Sarbanes-Oxley Act* provides further guidance on appropriate standards for disclosure, recusal, review, documentation, and other details.

Public 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.

Training

Board member education is both required by JCAHO and highly advisable. For newly created boards, an initial board education and orientation retreat should be planned and should include participation by senior management. This retreat provides 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.

Public hospital board training and development may need to address issues not typically covered for other boards. For instance, if the institution 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 other hand, 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 in the Community

One important function of a board and its members is to serve as advocates for the hospital in the community. 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. Often, this means convincing the public or elected officials to permit the issuance of bonds.

Board leadership on behalf of the public hospital 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 institution formulates a media campaign strategy. As the institution tries to compose an effective board, search committees may want to reach out to potential new board candidates with these skill sets.

Board Role in Advocacy

In addition to advocating for their facility in the community, a vital responsibility of board members is to serve as advocates in the public policy arena. Board members can play a critical role in educating policymakers about key issues affecting public hospitals and their communities. As with any public communication by a board member, it is critical that both the content and the mechanism of these messages be carefully coordinated with management and the board.

Often, issues that affect public hospitals are determined in our nation's capital and in state capitals across the country. It is essential that public hospitals actively participate in these public policy debates.

In addition to hospital personnel, board members can be an important link to information for policymakers. Policymakers receive information from many sources on any given issue. One of the most important sources of information is from constituents, especially highly credible, knowledgeable, and respected voices. Board members are

uniquely situated as community leaders to provide just such a voice on behalf of the hospital.

There are a variety of ways board members can be an effective advocate for their hospital. At minimum, board members should contact their own senators and representative to educate the policymakers about the importance of the hospital. 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.

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.

Policymakers need to hear from constituents, and there is no one better positioned than board members to convey the extraordinary contribution public hospitals make to their communities. Among the many responsibilities of a board member, advocating to policymakers is one of the most rewarding and most important in helping the hospital continue its success.

The Challenges of Governing Public Hospitals and Health Systems

4

Public hospitals face the same fiscal and competitive pressures that confront the entire health care industry in America. However, they also shoulder unique burdens that result from their safety net missions and their government status.

This chapter will examine certain legal, regulatory, and political challenges largely peculiar to public hospitals, as well as physician staffing issues of concern to public health systems. Given their importance in today's environment, regulatory compliance issues and the implications of the *Sarbanes-Oxley Act* also will be examined.

CHALLENGES TO THE SAFETY NET

"The funding and organization of the safety net have always been tenuous and subject to the changing tides of politics, available resources, and public policies. Despite their precarious and unstable infrastructure, these providers have proven to be resilient, resourceful, and adept at gaining support through the political process.

"Today, however, a more competitive health care marketplace and other forces of change are posing new and unprecedented challenges to the long-term sustainability of safety net systems and hold the potential of having a serious negative impact on populations that most depend on them for their care."

SOURCE: Institute of Medicine, *America's Health Care Safety Net — Intact but Endangered* (Washington, DC: National Academy Press, 2000).

Legal, Regulatory, and Political Challenges

A landmark study released in March 2000 by the Institute of Medicine clearly summarizes the situation of safety net hospitals (see sidebar).

The last decade has seen a dramatic transformation of the role of the hospital in our nation's health care system, with a profound impact on every important element of that system. From the way we purchase and pay for health coverage, to where and how we provide needed care, the metamorphosis has been swift and intense. New systems and networks spring to life overnight, mergers and acquisitions dramatically shrink the number of players, and traditional payment mechanisms turn upside down in a heartbeat.

These trends have resulted in a number of health system changes with implications for the financial viability of all hospitals. For example, purchasers (public and private) continue to form ever-larger coalitions to demand health cost reductions. And despite some notable failures, in many parts of the country successful providers have responded by developing fully integrated region-wide delivery systems. Ultimately, only the strongest and most thoroughly integrated systems will survive; the ability to control costs and generate strong patient satisfaction will be key.

The pressure is especially acute for those public hospitals and health systems that rely most heavily on federal, state, and local government funding to pay for their wide range of primary, acute, and public health services. For most such systems, market pressures are intensified by a variety of factors that have far less, if any, effect on their competitors. These include:

- the continuing increase in the uninsured and underinsured in many areas
- reductions in Medicaid funding and local support
- the impact of immigration reform
- greater competition for Medicaid patients
- the explosion in managed care
- responsibility for public health and other community services
- fettered governance

- the obligation to conduct sensitive business in the public eye
- other cumbersome political or bureaucratic obstacles.

Many public hospitals have found that public status, in itself, precludes them from implementing efficiencies or taking other steps that private providers use to improve their operating margins. These barriers may include the following:

Decision Making: Many public hospital systems are subject to multiple layers of strategic or operational decision making, which often preclude a rapid response to critical issues. In a swiftly evolving regulatory and competitive environment, public hospitals often lose out on important opportunities for want of quick, decisive action. While a multi-level approval process enhances accountability and serves as an important check on the prudence of engaging in such endeavors, the lack of speedy consideration can result in loss of valuable opportunities.

Budgetary Inflexibility: Close budgetary oversight sometimes deprives the hospital of needed flexibility to deploy resources effectively and to respond to constantly changing needs. Further, with the amount of state or local funding often dependent on the size of the hospital deficit, the incentive to maximize revenue may be inadequate.

Capital Access: Although many major public hospitals have an outdated or deteriorating capital infrastructure, government entities often are subject to constraints on their ability to raise capital (such as limits on total bond capacity). In other cases, the hospital's legal structure or its fiscal relationship with local government may preclude access to various capital financing options.

Strategic Planning: Confidential decision making is critical for effective strategic planning in a competitive local health market. While open meeting and records requirements associated with public status may be an important aspect of public accountability, in many cases they also preclude confidential planning. Public hospital systems often are required to hold even strategic planning meetings in public, allowing the competition to sit in and listen to their most sensitive planning, marketing strategy, recruiting goals, and other information. This can place the public hospital at a serious disadvantage vis-à-vis private competitors in the same market. Moreover, public providers often lose opportunities to contract or venture with private practices and providers because the private entities do not wish for their transactions to be subject to these laws.

Joint Ventures and Entrepreneurial Activity: Legal constraints often prevent public hospitals from entering into affiliations or joint venture arrangements that may be necessary or beneficial. Success or even survival in today's market hinges on cost containment, patient satisfaction,

Nonprofit and public institutions are not required to comply with *Sarbanes-Oxley* standards. Nonetheless, many are looking towards standards to improve transparency and accountability.

demonstrated quality, and the ability to offer payers either a fully integrated health system or one or more of its critical components. In order to respond to the challenges of managed care and greater patient choice, today's public provider must be able to recruit the highest quality physicians and to establish for them an integrated system with private partners that offers the best fit in terms of services, location, culture, and other factors. However, for reasons ranging from restrictions on uses of public funds to a potential partner's reluctance to deal with a public provider or a particular unit of government, public hospitals often suffer from an inability to contract with their ideal affiliates.

Civil Service and Collective Bargaining: Complex civil service ordinances often impede hospitals from recruiting, promoting, or retaining qualified health care personnel. Pay scales or benefits frequently cannot be adjusted quickly enough to respond to the local market, and health care professionals, frustrated with a lengthy and cumbersome application process, may choose to apply elsewhere. This is an increasingly important issue, given the current shortage of registered nurses and pharmacists.

Procurement: Many local government procurement constraints may be manageable for typical government activities, but they are unsuitable for the hospital industry. Under most procurement statutes or ordinances, the hospital cannot independently purchase necessary medical equipment because these high-cost items exceed statutory thresholds. Access to discounts typically enjoyed by private hospitals, through group purchasing organizations or otherwise, is often limited. Acquisition delays impede the efficiency of hospital operations and occasionally compromise patient care. In certain instances, procurement rules actually may raise costs by rewarding equipment leasing at prices below certain thresholds rather than outright purchase.

The Implications of *Sarbanes-Oxley* for Public and Nonprofit Hospitals

The American Competitiveness and Corporate Accountability Act of 2002, commonly known as the *Sarbanes-Oxley Act* (or SOX), was enacted in order to protect investors and restore public trust in U.S. capital markets, after several corporate and accounting fraud schemes were exposed in 2001 and 2002. Although only a small subset of publicly traded corporations are subject to SOX, most for-profit companies are implementing similar audit and compliance policies in an effort to demonstrate financial accountability and responsibility.

Nonprofit and public institutions are not required to comply with *Sarbanes-Oxley* standards. These organizations are not directly governed by SOX, and many of the initiatives required of publicly traded corporations would be prohibitively expensive for them to implement. Nonetheless, many nonprofit and public institutions are looking towards SOX

standards as reference points for their own internal efforts to improve transparency and accountability in their internal governance. Many are incorporating SOX-like features into their own policies and procedures, and for this reason, we provide an overview of the act and its requirements.

Adopting SOX "best practices" may lessen potential liability for board members, e.g., by documenting diligence in oversight and other board duties. In addition, adoption of best practices may be useful in recruiting potential board members, who may hesitate to serve in an organization that lacks these safeguards.

Audit and Compliance

The *Sarbanes-Oxley Act* imposes many new financial and accounting requirements on publicly traded companies subject to the legislation, with the expectation that these new requirements will strongly influence the "best practices" standard for many other organizations.

Audit and Compliance Committee: A key element of SOX 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 board committees closely resembling the audit and compliance committees that SOX envisions. These audit and compliance committees, comprised of independent members of the governing board, are intended to be free of influence from management and others. Accordingly, these committees 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: Corporations subject to SOX

must 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: Many corporations have 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: Another significant element of SOX is companies' obligation to disclose and explain any inaccuracies in financial statements and reports, as well as to disclose related internal policies and procedures that the company 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
- 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, many corporations 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.

Ethics and Conflict of Interest

The *Sarbanes-Oxley Act* requires the adoption of several reforms related to ethics and conflict of interest. Many organizations not covered by SOX are adopting similar reforms.

Codes of Ethics: Companies subject to SOX must 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
- 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.

Conflict of Interest: Under SOX, companies must adopt policies prohibiting actual and potential conflicts of interest in decision making. Conflict of interest policies reduce the risk of "insiders" such as officers, board members, and shareholders making decisions that may benefit themselves rather than the best interests of the corporation. Public and nonprofit health systems have similar concerns, and most have adopted compliance programs with conflict of interest policies. The SOX conflict of interest provisions go deeper than the "board only" provisions described in Chapter 3 in that these policies also need to extend deep into the organization to reach employees.

The conflict of interest policy should obligate employees of the organization to comply with specific guidelines addressing actual or potential conflicts of interest. Employees should be required to disclose any actual or potential conflict of interest, and business transactions that result in special fringe benefits, bonuses, or other windfalls also should be addressed. Such a policy is especially critical at a health care organization, where patients or other health care consumers may be adversely affected by business decisions motivated by self interest.

General Governance

The *Sarbanes-Oxley Act* inspired several significant non-financial reforms that are likely to be beneficial for public and nonprofit health systems.

Confidentiality/Anonymity Policy: SOX requires that companies subject to its

provisions 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 submitted 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, SOX prohibits firing, threatening, or otherwise harming any employee on the basis of the employee's participation in an investigation into potential violations of SOX or other corporate responsibility laws. Nonprofit organizations have adopted similar policies to protect employees from retaliation or retribution. Such policies 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 companies 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 reduce 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.

Compliance

Given the proliferation in the number of fraud investigations against health care providers and in high-dollar judgments and settlements, health care governing boards are focusing increasing resources on compliance oversight. Effective oversight of a compliance program requires a governing board to apply duty-of-care principles to the compliance function,

and to ensure that an adequate reporting system exists and is enforced. This allows boards to measure the effectiveness of—and establish accountability for—the ongoing operation of the organization's compliance program. This is not a light load to carry, especially in this era of increased corporate responsibility. The first compliance program guidance publication from the Department of Health and Human Services Office of Inspector General (OIG) points out that executing an effective compliance program requires a substantial commitment by all the members of a health care organization's governing board.

A governing board must take reasonable steps to ensure that the organization's management appropriately carries out its responsibilities and complies with the law. A governing board is likely ask the management most involved with the compliance function—usually the compliance officer—to explain the organization's compliance program and, in particular, the board's responsibilities with regard to it.

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.

A governing board must take reasonable steps to ensure that the organization's management appropriately carries out its responsibilities and complies with the law.

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, 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.

Physician Staffing

Public 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.

Public 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 public hospitals have to develop alternative strategies for obtaining physician services.

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

Under an academic medical 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 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 medical 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 institution.

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 public 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. A public hospital board should expect that it will be consulted from time to time about changes to or issues arising from ties to medical schools.

Restructuring Public Hospitals and Health Systems

With traditional sources of public revenues evaporating and with new competitors for many of the services they historically have provided, public hospitals and health systems frequently feel the pressure to rely on aggressive reforms to keep pace and to continue financing their multiple missions.

5

Some form of restructuring is often contemplated as a means of improving the viability and competitiveness of public hospitals. Such steps are not always part of an offensive strategy, however. Sometimes state or local government entities seek to restructure or "privatize" their public hospital systems out of fear of growing subsidies, regardless of the implications for the health system's multiple missions. 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. For instance, a competing hospital system may propose acquiring or managing the local public hospital. In any case, the concept is often provocative, galvanizing employees, medical staff, or patient advocates into strenuous and protracted opposition. Even where there is general consensus and strong political support, many restructuring initiatives have failed for lack of adequate planning or resources or the relative weakness of one or both parties.

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.

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) to the constructive (a desire to improve the efficiency and competitiveness of a public system). Most often, it is a mixture of the two.

It is important to note at the outset that 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. Institutionally, 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

Public Hospital Closures

Since 1979, the United States has experienced a number of public hospital closures. Typically, public hospitals in smaller, rural areas have been most at risk, but some large urban hospitals also are struggling. Many factors have contributed to these closures. For example:

- Public hospital revenues have been suffering since the 1990s, when fiscal pressures began to intensify due to public programs and managed care, which cut payment levels and reduced admissions.
- Medicaid managed care transferred patients to lower-price settings, and competition has increased for Medicaid patients due to cutbacks under private managed care.

- Expenses are high due to rising costs of health care generally and to the increasing numbers of uninsured patients seeking out public facilities.
- Public hospitals often have high costs due to low-income patients with poor health status, high staff-to-patient ratios, and outdated facilities.
- Public hospitals often have less management flexibility and access to capital, and they have greater difficulty responding to challenges than their private competitors.
- Localities are averse to raising taxes.[30]

Philadelphia General Hospital and District of Columbia General Hospital are examples of large public hospital closures. The 1977 closure of Philadelphia General Hospital, the oldest hospital in the United States and among the most prestigious teaching hospitals in the country, was one of the most studied and debated public hospital closings in the past several decades. In the 1950s, medical school residency programs began to favor affiliation with public hospitals, and in 1958 Philadelphia's Democratic administration pushed through an affiliation plan that involved five area medical schools in the operation of Philadelphia General Hospital. Although the goal was a reorganized hospital under private management, in practice no one—including the municipal government—remained ultimately responsible for Philadelphia General. The last years of the hospital's operation were marked by declining patient volume, deterioration of the physical plant, and lack of interest on the part of the city and the medical community. The hospital's closure in 1977 was accompanied by the establishment of six outpatient centers, the Philadelphia Nursing Home, and continued outpatient services at Philadelphia General for an additional year. Nonetheless, it remains unclear whether the hospital's patients were absorbed by other facilities, or whether their health care needs simply went unmet.[31]

More recently, the closure of DC General Hospital, the only public hospital in Washington, DC, shows that legal and governance restructuring alone will not necessarily save a troubled medical center. In the 1950s, DC General was owned and directly operated by the District of Columbia as the major provider of care for indigent residents in Washington, DC. After serious ongoing financial and patient care problems, as well as a loss of accreditation from JCAHO from 1975 until 1978, it was restructured in 1977 by the addition of a dedicated board, operating until 1996 as the DC General Hospital Commission.[32]

While the new board improved the situation, the hospital did not thrive, and by 1996 the city decided to create the quasi-independent DC Health and Hospitals Public Benefit Corporation to operate the District's public hospital and community health clinics with significant autonomy. Unfortunately, the District was experiencing a major financial crisis at that time, and before the new PBC began operations, a federal Financial Control Board was granted broad powers

over all components of District government. The PBC was never able to use much of its legislated authority, and as a result of this inability, together with managed care, decreasing population, and other difficulties, the PBC was unable to turn around the performance of the city's health system. DC General experienced declining admissions, administrative and quality issues, rising costs, a deficit of more than $95 million, and an out-of-date physical plant that would have cost $110 million by 1999 to renovate. At that point, more than two-thirds of the city's uninsured were going elsewhere for hospital care.[33]

Despite opposition from the City Council, hospital employees, private hospitals, and community activists, the PBC was dismantled and DC General Hospital was closed as an inpatient facility. The hospital's inpatient services and trauma care were to be transferred to Greater Southeast Community Hospital.[34] The DC HealthCare Alliance, a public-private partnership between the city and private health care providers led by Greater Southeast, replaced the PBC in 2001.[35] A dozen DC General outpatient departments and a satellite emergency room, run by Greater Southeast, remained open until 2003. Immediately following DC General's closure, nearly every private hospital in the area experienced an increase in emergency room visits.[36] Ironically, the exception was Greater Southeast, which was expected to pick up the slack when DC General closed. However, plans for a new trauma center at Greater Southeast never came to fruition, and Greater Southeast and its parent company filed for bankruptcy protection in late 2002.[37]

In 2003, the Council of the District of Columbia passed a resolution directing DC Mayor Anthony Williams to negotiate with Howard University to develop a public-private partnership to build a new state-of-the-art teaching hospital on the grounds of the former DC General Hospital. An agreement was signed by the Mayor and the President of Howard in January 2005. Under this agreement, which was submitted to the District Council for approval, the University and the District would split the estimated cost of $400 million to build the new hospital, which is to be called the National Capital Medical Center (NCMC). While it is clearly intended to provide inpatient and outpatient services (including trauma care) to the under-served residents of the parts of the District previously served by DC General, the 230-bed medical complex "[would] not be a poor person's hospital," according to the Mayor. Rather, the NCMC would have multiple missions and would be intended to serve a broad range of populations, including the insured. At this writing, the proposal has become bogged down in a fierce debate, fed in part by the opposition of other District hospitals with which the new hospital would compete. The District Council itself appears to be almost evenly divided on the issue, with some members arguing that an ambulatory care facility or free-standing emergency room would

better meet the needs of the local population.[38] As of May 2005, Mayor Williams has appointed yet another task force to assess the city's participation in the hospital venture.[39]

Evaluating the Status Quo and Identifying Needs

Many public hospitals and health systems explore reorganization or restructuring from time to time. 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 battle, or missed a significant opportunity. Either management leadership or the governing body may see restructuring as the solution to a litany of problems.

However, a restructuring initiative will rarely solve all of an institution'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 public health and hospital system as it is now.

- What are its strengths and weaknesses? What functions does it perform well? What functions are more difficult to fulfill?
- What aspects of its legal structure enhance its ability to attain its goals and what aspects hinder its performance? For example, in some cases the public entity structure provides easier access to capital through the issuance of lower-cost tax-exempt government bonds. On the other hand, the public 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 institution's ability to attract and retain patients.
- How does the corporate culture affect operations? Operationally, perhaps the safety net mission has enabled the institution 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 institution. Sometimes, when assured that their remarks will not

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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, advocates for the poor, 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 is begun through the appointment of a public commission. For example, the merger of Boston City Hospital (BCH) and Boston University Medical Center (BUMC) grew out of a 1994 report of a mayoral commission.

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 joint steering committee composed of key administrative personnel from institutions, 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 institutions 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 Corporations 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 institution. 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 can help the hospital avoid the trauma of major restructuring. 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 industry 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 institution 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, institutional 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 institution 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

It is often helpful to catalog the system's strengths and weaknesses in an organized fashion as a starting point.

mission, which is deemed its greatest strength. Or it may be 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 institution's needs. As Chapter 2 described, there are today a wider variety of legal structures among the nation's urban public (or formerly public) hospital systems than in any other segment of the hospital industry. 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.[40]

However, 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.[41] 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,"[42] and today hospital districts continue to be created through both means.[43]

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.

Launching the Restructuring Effort

Although the substantive content of a reorganization plan is of paramount concern to those affected by it, the experience of many public 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. Following is a description of some of the steps that can be involved in this process and the factors to consider in carrying out those steps.

Communication and Education

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. In the rare case where reorganization was effected 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.

The abortive restructuring of one public hospital in the early 1990s provides a telling example. Unanticipated litigation and resistance of key members of hospital leadership delayed the University of Colorado Hospital's transition from a unit of the University of Colorado Health Sciences Center to a separate hospital authority. The hospital sought to reorganize in response to financial difficulties, believing that it could be profitable if it were freed from the state purchasing system and personnel system, permitted to develop partnership and joint ventures freely, issue debt, and build financial reserves. In 1989, the Colorado Legislature passed legislation permitting operation of the University of Colorado Hospital as a private nonprofit corporation. However, the constitutionality of the legislation was challenged by the Colorado Association of Public Employees. In December 1990, the Colorado Supreme Court held that the initial legislation gave the University Regents so large a role that the hospital in fact remained a public entity for purposes including the civil service status of its employees. As a result, the initial reorganization had to be unwound after a year's operation.

The state legislature then passed legislation establishing the University

Hospital Authority as a separate political subdivision of the State. The legislation authorized the regents of the university to execute a lease and transfer agreement to the new authority. While the hospital now had the necessary legislative authority for the transition, failure to attain the active support of internal hospital stakeholders posed an additional challenge to reorganization. While the president of the university and the chancellor of the health sciences center strongly supported the change, the regents resisted it. The reorganization could be implemented only after the regents' support was secured. As the financial situation of the hospital continued to erode, it became necessary for the governor to intervene to resolve the crisis. Though the process of reorganization was ultimately a success and the financial position of the hospital improved, much delay and controversy might have been avoided by securing adequate support of the hospital system's stakeholders, both the employees and the leadership.

Communication is not a "one-shot deal." It is not sufficient, for example, to hold a community meeting and consider the obligation to solicit community input fulfilled. Rather, the need to inform and be informed by key constituencies must be considered at every step of the reorganization process. For example, when deciding how to identify the goals and objectives of a reorganization, consider who will contribute to the process. Should the medical staff be given a formal role? The employees? The unions? The patients? The community at large? Should the press be invited into the process? Should the goal-setting be blessed or even initiated by the local political leader or legislative body?

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 public 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 institution, 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, may also 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

KEY CONSTITUENCIES OF REORGANIZATION

- Local Political Leaders
- Clinical Staff
- Non-Clinical Employees
- Patients
- Business and Community Leaders
- Other Providers
- Local Press

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 public 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 the privatization or restructuring is to enable the 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. For more than one public hospital, the opposition of a local competitor has derailed a reorganization at the eleventh hour; for others, such as the Louisiana Health Care Authority, major providers desiring to safeguard safety net services offered critical support. To the extent it does not compromise its competitive position, the health system can allay unwarranted fears by giving other providers accurate information about the reorganization.
- **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.

How should these constituencies be involved? There are a variety of means to ensure their input. Regular formal meetings serve a purpose but are not sufficient in and of themselves. Representation on advisory or decision-making bodies (such as commissions, task forces, etc.) is one option. Staff (whether hospital/government staff or outside consultants) should consult with each of the affected groups early in the process to gain an understanding of their perspective on the status quo and their objectives in a restructured environment. If desired, the groups can be given an opportunity to review or comment on proposed reorganization models. In some cases, hospitals have circulated weekly newsletters to employees and other interested parties to keep them updated. Without making the process too costly or unwieldy, the goal should be to provide these constituencies with maximum opportunity for input, both to enhance their commitment to the reorganization and to ensure that the structure developed is substantively sound.

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
- Accountability, Managerial Flexibility, and Autonomy
- Governance
- Personnel
- Funding

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 public hospital reorganizations are under-

taken 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. Your 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 service; 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. For example, 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. For example, 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 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.

The second method, formal payment for services rendered, may be more desirable, provided that reasonable limits can be placed on the city's potential liability for funding while maintaining a reasonable level of payment for these services. However, it may be a consideration that the Centers for Medicare and Medicaid Services (CMS), in a 2004 letter from CMS to Senator Charles Grassley (R-IA), appears to place critical importance on a local government's legal obligation to fund the health system's liabilities without necessity of a contract between them. This position and its ambiguities are discussed in detail in Chapter 6.[41]

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, until 1990 the Memorial Medical Center of Savannah, Georgia, received cost plus 3 percent for services provided to those certified under the county indigent care program. Similarly, the city of Austin, Texas, reimburses Seton Medical Center for charity care up to a capped amount. Seton Medical Center assumed management and control of the city-owned Brackenridge Hospital in 1995.

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 institution 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.

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 "public 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 the St. Paul-Ramsey Medical Center, is that the Center 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

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

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.

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 issues regarding the governance of a reorganized health system 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
- **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 judg-

ment 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.

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 the employees' performance and dedication. In a service industry 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.

In a number of cases, the employees of reorganized hospitals have been given the option of retaining their status as local government employees. The University of Colorado Hospital Authority, for example, agreed to lease from the state those employees who chose not to transfer to the Authority. (As an aside, this concession was made in the University Hospital's second attempt to restructure. The first attempt involved a 1989 conversion to a private, nonprofit corporation. The employees' union successfully sued to overturn this, claiming that the initial legislation gave the University Regents so large a role that the hospital in fact remained a public entity. The reorganization was reversed, and new legislation was passed creating a public hospital authority to operate the medical center.) 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 because hostile employees can be formidable opponents to a reorganization, while those who are comfortable with their own options are more likely to support its implementation. 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.

Other Considerations: 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 other benefits typically desirable to highly compensated employees. This also may permit the use of various recruiting incentives to attract non-employee physicians.

Implementation Process: Once the parameters of the reorganization have been decided and adopted by the relevant decision-making bodies, the real work begins. Most find that it becomes 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.

Some institutions have appointed 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.

Impact of Legal Structure on Medicaid and Related Reimbursement Issues

6

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, 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. Recently, however, the federal Centers for Medicare and Medicaid Services (CMS), which oversees the Medicaid program at the federal level, increasingly has questioned the government status of many of these hospitals and their ability to provide non-federal-share Medicaid funding. CMS has not, however, clearly and definitively articulated in regulations or other official guidance the criteria by which it determines whether a particular provider is public enough to participate in Medicaid funding. The resulting legal ambiguity threatens to upend the financial assumptions on which many of the hospitals were originally restructured. On a prospective basis, the new, more restrictive CMS policy on Medicaid financing threatens to distort the market by discouraging state and local governments from undertaking public hospital restructurings that otherwise would enhance the hospital's ability to achieve its public mission in a highly competitive marketplace.

In addition, designation as a Federally Qualified Health Center (FQHC) 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.

Medicaid

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 longstanding 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 40 percent of the net patient revenues of NAPH member hospitals.[45] Medicaid DSH payments, which support provision of care to large numbers of uninsured and Medicaid patients, finance 23 percent of NAPH members' unreimbursed care. In 2003, NAPH members received $4.3 billion in Medicaid DSH payments. NAPH members provided over $2 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 2003 would have been an unmanageable negative 11.4 percent, instead of the 0.5 percent margins they experienced with these payments (which itself is significantly less than the industry average at 4.8 percent).

Impact of Hospital Structure and Governance on the 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.[46] 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."[47] Historically, CMS has deferred to states in determining whether an entity or a provider is sufficiently public to provide "public funds."

CMS policy with respect to IGTs and CPEs has undergone dramatic changes in recent years, however. Without modifying the current regulation or issuing formal or informal policy statements, CMS no longer accepts state assurances that a particular entity is sufficiently public to provide "public funds" and has begun to apply a new set of standards to make this determination. Because CMS has not made these standards public, however, it is extremely difficult to know whether a particular entity meets the criteria or not.

CMS has indicated, however, that it believes there is a difference between a "public" entity and a "unit of state or local government," and that only the latter is able to make "protected" IGTs (i.e. IGTs or CPEs of the type Congress has prohibited CMS from regulating).[48] According

to hospitals that have been the subject of CMS scrutiny in recent years, CMS does not consider public ownership of a hospital sufficient to establish its ability to contribute to Medicaid funding. CMS therefore has questioned the government status of hospitals operated as public authorities, as public benefit corporations, and those operated by a 501(c)(3) entity but owned by a local government. In some of these circumstances, the state involved eventually convinced CMS that the provider was sufficiently governmental to provide IGTs; in others the dispute is still unresolved.

The one publicly available document that sets out CMS policy in this area is a letter to Senator Charles Grassley of Iowa in 2004.[49] In the letter, CMS asserts that in order to make a "protected" IGT or CPE, a provider must

- be part of a unit of state or local government and
- have access to state or local tax revenues either through : (1) direct taxing authority or (2) the ability to access funding as an integral part of a government unit that does have taxing authority and that is obligated to fund the provider's expenses, liabilities, and deficits so that no contractual arrangement is necessary to receive such funding.

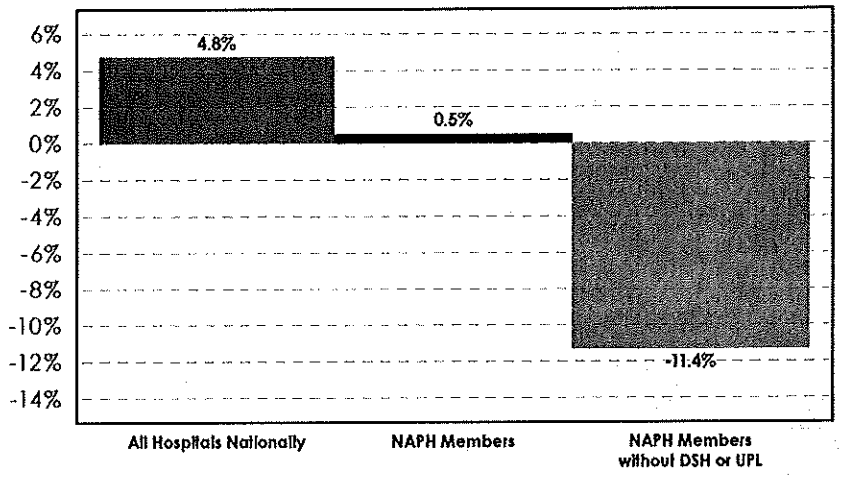
In investigations, CMS has even questioned local funding that cities or counties are providing to the state Medicaid agency in order to support hospitals that historically were part of that local government jurisdiction. Relying on regulations and guidance that have weathered more than 25 years, NAPH continues to assert that local public funding, whether provided by a historically public hospital or its supporting local government, may be used as the non-federal share of Medicaid payments.

Restructuring Analysis: 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 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

FIGURE 1 Hospital Margins, 2003



SOURCES: AHA Annual Survey 2003; NAPH Hospital Financial Profile Survey 2003

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. NAPH has urged CMS to adopt flexible standards on public entity status that recognize and support the ongoing safety net role

played by historically public hospitals. Until it does so, however, 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.

Federally Qualified Health Centers

In certain instances, public 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 industry).[50]

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.[51] There remains some ambiguity, however, about how restrictions imposed on "other entities" may be applicable to public entities in co-applicant situations.[52]

Authority and Responsibilities: The governing board is legally responsible for ensuring that the health center is operated in 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.[53]

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.[54]

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 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).

7

Other Financial Issues

Typically, funding issues are responsible, partly or wholly, for the underlying need to reorganize. Although a number of factors influence decisions related to funding, some of the considerations central to a health system's long-term stability following reorganization include the need to provide the system with sufficient operating funds to fulfill its mission; provide the system with enough funding to weather the normal cyclical demands of the marketplace through its own reserves; and ensure adequate access to capital.

A financial feasibility study is typically part of the reorganization analysis. This feasibility study will assess the total financial picture of the reorganized health system, including

- payments from the local government for indigent care (see discussion in Chapter 3),
- additional operating revenues anticipated as a result of the added efficiency and flexibility of the new structure,
- capital needs, and
- capital access.

The long-term success of the system, its degree of autonomy, available services, and the quality of care are all closely linked to financial stability of the institution.

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, etc.

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, 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 underbudget 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.

Service Revenues: Another important area of negotiation is the amount of payment the local government will give and the payment method it will employ to compensate indigent care (see the discussion in Chapters 5 and 6). The requisite financial support depends also on the volume of uncompensated or undercompensated services that must be provided, as well as the scope and availability of state and federal programs for indigent patients, including Medicaid funds for disproportionate share hospitals.

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 institution, 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 public 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 public hospitals have built vibrant charitable giving programs.

Public 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 public 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 public 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 public 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.

Appendix

Reorganization Task List

This task list is intended to give an overview of the issues that will arise in several key areas during reorganization.

A. Personnel

The personnel task force should include employee representation. It is wise to have ongoing communication with employees (e.g., regular meetings, newsletters, etc.) throughout the implementation phase to ensure that they are accurately informed, to dispel fears, quell rumors, etc.

Depending on the circumstances and the personnel decisions made in structuring the reorganization, some or all of the following tasks may be necessary:

- Negotiate/discuss outstanding personnel issues with unions.
- Draft the policies, contracts, and other materials needed to execute decisions regarding any transfer or payout of employee benefits (pensions and accrued leave, as well as accrued seniority).
- To the extent that employees are offered choices (e.g., whether to transfer to the new entity or remain with current employer; whether to cash out benefits; etc.), develop a realistic timetable and ensure that full, clear information is distributed well in advance of deadlines and that financial or other relevant counseling is available.
- If employees will remain in the civil service but hospital administration is to be brought in-house, develop an appropriate civil service system and in-house administrative capabilities.
- Develop a new personnel system.
- Draft personnel policies and procedures.
- Develop new job descriptions where necessary.
- Establish employee performance criteria and/or incentive plan.
- Determine the management structure and prepare/revise the organization chart including clear lines of authority.
- Develop or modify as necessary an employee relations program.
- Develop a payroll system or contract out for one.
- Conduct training/retraining where necessary.

B. Finance/Budgeting

Financing and budgeting issues could be significant in the implementation efforts, depending on the degree of former dependence on local government and the degree of financial independence to be attained. For example, if the institution was previously deficit-funded (i.e., local government funding simply filled any budget shortfalls) and has now assumed bottom-line budgeting responsibility, substantial preparation will be necessary to handle the increased financial autonomy (and risk). Even where the change will be less dramatic, most or all of the following tasks will be necessary:

- Create a budget development and approval process.
- Develop a budget monitoring process, including an early detection and adjustment system for deviations from budget.

- Analyze impact on third-party reimbursement, including Medicaid and Medicare.
- Prepare short- and long-term budget projections for the reorganized entity.
- Develop pro forma financial statements.
- Develop new accounting systems, records, and methods of accounting, as appropriate.
- Adjust pricing if necessary.

C. Capital/Strategic Planning

Enhanced autonomy should permit more efficient and effective planning—both capital and strategic. Capital planning will become easier if the approval process has become less bureaucratic, and access to capital may be improved. Freedom from some of the typical government restrictions (such as limitations on the ability to joint venture, geographic limitations on area of operation, restrictions on forming subsidiaries, etc.) should improve flexibility and creativity in strategic planning.

Effective capital and strategic planning typically includes some or all of the following steps:

- Determine the impact of the reorganization on access to capital.
- Explore various prospects and costs for capital funding.
- Establish or revise the process for developing and approving capital plans.
- Conduct a capital needs assessment.
- Develop short-term (three-year) and long-term (ten-year) capital plans.
- Develop a monitoring process for the capital plan.
- Review strategic planning processes and determine any needed changes.
- Develop or modify short- and long-range strategic plans.
- Develop a monitoring process for measuring progress toward strategic goals.
- Establish methods to ensure consistency among capital, strategic, and financial plans.

D. Legal

As health system reorganization is typically a complex process from a legal perspective, it will be important to have an experienced legal team in place. Not only must numerous legal documents be developed and drafted, but multi-faceted issues must be explored, filings accomplished, and details attended to in order to ensure a smooth and successful transition. When assigning responsibility for these tasks, particularly for drafting agreements, it is important to keep in mind that, while such drafting can be burdensome, time-consuming, and costly, having its own internal or outside counsel assume primary responsibility will provide the health system with maximum control over the terms and subtleties of the arrangements being memorialized.

Below are examples of the legal tasks involved in implementation:

- Assist in developing or negotiating overall terms of restructuring, including property transfer, ongoing obligations between local government and restructured system, board structure, etc.

Appendix

Reorganization Task List

- Draft necessary implementation documents (agreements for transfer of real and personal property and intangibles, service or indigent care agreements, articles of incorporation, etc.).
- Draft board bylaws and rules.
- Review medical staff bylaws and revise as necessary.
- Review all outstanding contracts to determine any modifications required, including assignment.
- Determine federal, state, and local licensure requirements (e.g., hospital, pharmacy, laboratory, x-ray, radioactive materials, federally controlled substances, food services, incinerator, boiler, elevator, special services) and file as required.
- Negotiate and draft any necessary agreements with government agencies for services.
- Analyze any local, state, or federal tax implications and comply with filing requirements.
- Analyze local, state, or federal employment law implications and comply with filing requirements.
- Notify officials of change in status as needed, e.g., JCAHO; Secretary of HHS, for Hill-Burton purposes; etc.
- Obtain new provider numbers if necessary.
- Comply with any state and local business filing requirements (e.g., nonprofit corporation status).

E. Information Systems

Greater independence from the local government may mean that the health system is no longer wedded to the information systems chosen and used by the rest of the government. If most key systems (personnel, financial, accounting, medical records, etc.) are now independent of the local government, it may be time to reevaluate information systems. If the health system has merged with another provider, then the need to address information systems issues is not a luxury but a must. Here are some of the steps involved:

- Conduct an information systems needs analysis.
- Identify and address compatibility issues.
- Develop an information systems capital budget (in conjunction with capital planning process).
- Assess and select appropriate system(s).
- Develop acquisition and implementation plans if necessary, including staff training program.

F. Procurement

The existing government procurement bureaucracy is often a motivating factor for reorganization. If the new structure provides greater control over purchasing, several steps should be taken to exercise this new responsibility effectively:

- Develop new written procurement policies and procedures.
- Develop/update inventories.
- Develop an oversight process to ensure procurement policies are being appropriately implemented.
- Develop a training program in new procurement procedures for all relevant staff.

G. Miscellaneous

There are many other tasks which, while not falling into any of these subject areas, are critical to successful implementation. These tasks include:

- Conduct board training and orientation. If a new board is created, its members must be brought up to speed; where an existing board is being given enhanced powers and new responsibilities, training also will be important.
- Determine the impact, if any, on the medical education program and any medical school affiliation agreements.
- Determine the impact, if any, on the mix of services.
- Where the new structure creates a multi-facility system, issues will arise regarding allocation of responsibilities between a central office and the facilities themselves. These will need to be carefully addressed in each of the substantive areas set forth above.
- Determine what services are best to contract out, if only on a transitional basis, and what services the system is capable of performing in-house (e.g., payroll).
- Determine and reserve new name, if any, and design new logo, signs, stationery, etc.

Glossary

Centers for Medicare and Medicaid Services (CMS). Federal agency within the U.S. Department of Health and Human Services that administers the Medicare, Medicaid, and State Children's Health Insurance programs.

Certified Public Expenditures (CPEs). Expenditures by public entities on items and services eligible for federal match under the Medicaid program. Upon certification of these expenditures, federal matching funds are provided for the federal share of the expenditures. Unlike IGTs, CPEs do not involve an actual "transfer" of funding to the state Medicaid agency. Instead, the federal government recognizes the local government expenditure as a matchable Medicaid expenditure and provides the federal share to the state Medicaid agency.

Disproportionate Share Hospital (DSH) Payments. Made either by Medicare or by a state's Medicaid program to hospitals that serve a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments that hospitals receive for providing care to Medicare and Medicaid beneficiaries. Medicare DSH payments are based on a federal statutory qualifying formula and payment methodology. For Medicaid DSH, there are certain minimum federal criteria, but qualifying formulas and payment methodologies are largely determined by states.

Federally Qualified Health Center (FQHC). FQHC services are primary care and other ambulatory care services provided by community health centers and migrant health centers funded under Section 330 of the Public Health Service Act, as well as by "look-alike" clinics that meet the requirements for federal funding but do not actually receive federal grant funds. States are required to include services provided by FQHCs in their basic Medicaid benefits package.

Intergovernmental Transfers (IGTs). Non-federal public funds transferred from a local government entity (including a locally owned hospital or nursing facility) to the state Medicaid agency, or from another state agency (including a state-owned hospital) to the state Medicaid agency. These transfers are usually made for the purpose of providing the non-federal share of a Medicaid expenditure in order to draw down federal matching funds. IGTs are often used in connection with payments to DSH hospitals and UPL transactions.

Medicaid. A jointly funded program by the federal and state governments to provide health coverage to those who qualify on the basis of income and eligibility, e.g., low-income families with children, the low-income elderly, and persons with disabilities. Many states also extend coverage to groups that meet higher income limits or to certain "medically needy" populations. Through waivers, some states have expanded coverage even further.

Medicaid Upper Payment Limits (UPLs). Limits set by CMS regulations on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds. The UPL generally is keyed to the amounts that can reasonably be estimated would be paid, in the aggregate, to the class of providers in question using Medicare payment rules.

Medicare. Provides health coverage for individuals 65 and over, and for certain disabled individuals under age 65. In contrast to Medicaid and the State Children's Health Insurance Program, Medicare is a purely federal program. The program provides coverage for hospital care through what is known as "Part A" and physician and other ambulatory care through what is called "Part B." However, the program leaves major gaps in coverage, including many preventive services.

National Association of Public Hospitals and Health Systems (NAPH). Represents more than 100 hospitals and health systems that together comprise the essential infrastructure of many of America's largest metropolitan health systems. Since its inception in 1980, NAPH has cultivated a strong presence on Capitol Hill, with the executive branch, and in many state capitols. NAPH educates federal, state, and local decision makers about the unique needs of and challenges faced by member hospitals and the nation's most vulnerable populations.

Safety Net Provider. Health care provider organization with a mandate or mission to deliver large amounts of care to uninsured and other vulnerable patients. Examples include community health centers, clinics, public hospitals, and some teaching hospitals.

***Sarbanes-Oxley Act* (SOX).** Strengthened existing legislative audit requirements and briefs organizations on appropriate auditing and accounting practices and corporate responsibility. Enacted to protect investors and restore public trust in U.S. capital markets, after several corporate and accounting fraud schemes were exposed in 2001 and 2002.

Notes

1. Marion Lewin and Stuart Altman, eds. Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academy Press, March 2000).

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

3. The system's 2004 cash-based revenues were $614,766,031 million. Grady Health System, *Grady Highlights At-a-Glance*, at http://www.gradyhealthsystem.org/financial.asp.

4. 1996 Mass. Acts ch. 147.

5. Please note that, 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).

6. Haw. Rev. St. § 323F.

7. Betsy Carrier, Jennifer Cromwell, *Using Ballot Initiatives to Fund Uncompensated Care and Safety Net Services*, (Washington, DC: National Association of Public Hospitals and Health Systems, March 2005).

8. "KC Voters OK Increase in Health Levy," *Kansas City Business Journal*, April 6, 2005, available at http://www.bizjournals.com/kansascity/stories/2005/04/04/daily20.html?t=printable.

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

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

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

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

13. 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).

14. 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.

15. Ind. Code § 36-3-6 (2004); Ibid.

16. 1995 Mass. Acts ch. 147.

17. Ibid., Section 5(f).

18. Ibid., Section 3(a).

19. Ibid., Section 3.

20. Ibid., Section 7(b).

21. U of L Health Care, *History*, at http://www.uoflhealthcare.org/a_ab_history.html (last updated Nov. 10, 2004).

22. *Make, Buy, or Partner? The Role of Joint Ventures in a Revenue Strategy* (Oak Brook, IL: University HealthSystem Consortium, 2005).

23. Ibid.

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

25. Cook County Bureau of Health Services, http://www.cchil.org/Cch/bureau.htm. The Bureau of Health Services is charged with administration of the health care institutions under the board's jurisdiction.

26. N.Y. Pub. Auth. Law § 3303(1)(c).

27. Haw. Rev, Stat. § 323F-3 (2004). A bill was introduced in the Hawaii House on January 27, 2005, that would remove this regional requirement for board members and instead require the governor to select board members from lists of candidates nominated by the Speaker of the House and the President of the Senate. H.R. 922, 23rd Leg., Reg. Sess. (Haw. 2005). The bill was referred to the House Committees on Finance and Health on January 31, 2005.

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

29. Available at http://www.irs.gov/instructions/i1023/ar03.html.

30. R. R. Bovbjerg, J. A. Marsteller, and F. C. Ullman, "Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion." The Urban Institute: Occasional Paper Number 39, 2000. Also see: E. Friedman, "Demise of Philadelphia General an Instructive Case; Other Cities Treat Public Hospital Ills Differently," JAMA 257 (1987):1571-1575.

31. E. Friedman (1987), see full citation in note 30.

32. The DC General Hospital Commission Act of 1977 (DC Law 1-134)

33. P. Offner, "Politics and the Public Hospital in Our Capital," *Health Affairs* 20 (2001):176–181.

34. Ibid.

35. A. Goldstein, "End at Hand for D.C. General; Monday Shutdown a Major Gamble for Patients, City and the Mayor," *The Washington Post*, June 24, 2001, Page A01.

36. Editorial, "A Health Emergency," *The Washington Post*, September 16, 2003, Page A18.

37. A. Goldstein, "Proposal Targets ER at D.C. General; Hospitals Oppose Shift to Non-Emergency Care; 6 Clinics Would Close," *The Washington Post*, January 17, 2003, Page B04.

38. L. Montgomery, "D.C. Has a 'Deal' To Build Hospital; Howard U. to Run SE Medical Center," *The Washington Post*, February 17, 2005, Page B01. E. M. Weiss, "Hospital Proposal Criticized; Mayor, Howard U. Faulted at Hearing," *The Washington Post*, February 18, 2005, Page B03.

39. E. M. Weiss, "Panel Named to Study Hospital Alternatives. Some Advocates of New Facility Question the Task Force's Intent," *The Washington Post*, April 20, 2006, Page B06. "In His Own Words: The Mayor on His Decision to Rethink Hospital Backing," *The Washington Post*, April 20, 2006, Page DZ08.

40. Cal. Health & Safety Code §§ 32000–03 (2005).

41. Tex. Const. art. IX, §§4–8.

42. 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).

43. 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).

44. Letter from Mark McClellan, CMS Administrator, to Sen. Charles Grassley (April 28, 2004).

45. Jennifer Huang, et al., *America's Public Hospitals and Health Systems, 2003: Results of the Annual NAPH Hospital Characteristics Survey* (Washington, DC: National Association of Public Hospitals and Health Systems, October 2005).

46. 42 CFR 433.51. See 42 Fed. Reg. 60564 (Nov. 28, 1977).

47. 42 U.S.C. § 1396b(v)(6)(A).

48. Letter from Mark McClellan, CMS Administrator, to Sen. Charles Grassley (April 28, 2004).

49. Ibid.

50. Ibid.

51. BPHC PIN 97-27.

52. 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.

53. Ibid.

54. Ibid.

NAPH Members

Alameda County Medical Center Oakland CA

Arrowhead Regional Medical Center Colton CA

Boston Medical Center Boston MA

Broadlawns Medical Center Des Moines IA

Cambridge Health Alliance Cambridge MA

Carolinas HealthCare System Charlotte NC

Central Georgia Health System Inc. Macon GA

Community Health Network of San Francisco San Francisco CA

- **Laguna Honda Hospital & Rehabilitation Center** San Francisco CA
- **San Francisco General Hospital** San Francisco CA

Contra Costa Health Services Martinez CA

Cook County Bureau of Health Services Chicago IL

- **The John H. Stroger, Jr. Hospital of Cook County** Chicago IL
- **Oak Forest Hospital** Oak Forest IL
- **Provident Hospital of Cook County** Chicago IL

Cooper Green Hospital Birmingham AL

Denver Health Denver CO

Erlanger Health System Chattanooga TN

Governor Juan F. Luis Hospital and Medical Center St. Croix VI

Grady Health System Atlanta GA

Halifax Community Health System Daytona Beach FL

Harborview Medical Center Seattle WA

Harris County Hospital District Houston TX

Ben Taub General Hospital Houston TX

Lyndon B. Johnson Hospital Houston TX

Hawaii Health Systems Corporation Honolulu HI

- **Hale Ho'ola Kamaku Hospital** Honokaa HI
- **Hilo Medical Center** Hilo HI
- **Ka'u Hospital** Pahala HI
- **Kauai Veterans Memorial Hospital** Waimea HI
- **Kohala Hospital** Kapaau HI
- **Kona Hospital** Kealakekua HI
- **Kula Hospital** Kula HI
- **Lana'i Community Hospital** Lanai City HI
- **Leahi Hospital** Honolulu HI
- **Maluhia Long Term Care Health Center** Honolulu HI
- **Maui Memorial Hospital** Wailuku HI
- **Samuel Mahelona Memorial Hospital** Kapaa HI

Health Care District of Palm Beach County West Palm Beach FL

- **Glades General Hospital** Belle Glade FL

The Health and Hospital Corporation of Marion County Indianapolis IN

- **Wishard Health Services** Indianapolis IN

Hennepin County Medical Center Minneapolis MN

Howard University Hospital Washington DC

Hurley Medical Center Flint MI

Jackson Memorial Hospital Miami FL

JPS Health Network Fort Worth TX

Kern Medical Center Bakersfield CA

Los Angeles County Department of Health Services Los Angeles CA

- **Harbor/UCLA Medical Center** Torrance CA
- **Martin Luther King/Drew Medical Center** Los Angeles CA
- **LAC+USC Healthcare Network** Los Angeles CA
- **Olive View-UCLA Medical Center** Sylmar CA
- **Rancho Los Amigos National Rehabilitation Center** Downey CA

LSU Health Sciences Center Health Care Services Division Baton Rouge LA

- **Bogalusa Medical Center** Bogalusa LA
- **Earl K. Long Medical Center** Baton Rouge LA
- **Huey P. Long Medical Center** Pineville LA
- **Lallie Kemp Regional Medical Center** Independence LA
- **Leonard J. Chabert Medical Center** Houma LA
- **Medical Center of Louisiana at New Orleans** New Orleans LA
- **University Medical Center** Lafayette LA
- **Dr. Walter O. Moss Regional Medical Center** Lake Charles LA

Maricopa Integrated Health System Phoenix AZ

Memorial Healthcare System Hollywood FL

- **Joe DiMaggio Children's Hospital at Memorial** Hollywood FL
- **Memorial Hospital Miramar** Miramar FL
- **Memorial Hospital Pembroke** Pembroke Pines FL
- **Memorial Hospital West** Pembroke Pines FL
- **Memorial Regional Hospital** Hollywood FL

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- **Coney Island Hospital** Brooklyn NY
- **Cumberland Diagnostic & Treatment Center** Brooklyn NY
- **Dr. Susan Smith McKinney Nursing and Rehabilitation Center** Brooklyn NY
- **East New York Diagnostic & Treatment Center** Brooklyn NY
- **Elmhurst Hospital Center** Elmhurst NY
- **Gouverneur Nursing and Diagnostic & Treatment Center** New York NY
- **Harlem Hospital Center** New York NY
- **Jacobi Medical Center** Bronx NY
- **Kings County Hospital** Brooklyn NY
- **Lincoln Medical and Mental Health Center** Bronx NY
- **Metropolitan Hospital Center** New York NY
- **Morrisania Diagnostic & Treatment Center** Bronx NY
- **North Central Bronx Hospital** Bronx NY
- **Queens Hospital Center** Jamaica NY
- **Renaissance Health Care Network Diagnostic & Treatment Center** New York NY
- **Sea View Hospital Rehabilitation Center & Home** Staten Island NY
- **Segundo Ruiz Belvis Diagnostic & Treatment Center** Bronx NY
- **Woodhull Medical and Mental Health Center** Brooklyn NY

North Broward Hospital District Fort Lauderdale FL

- **Broward General Medical Center** Fort Lauderdale FL
- **Coral Springs Medical Center** Coral Springs FL
- **Imperial Point Medical Center** Imperial Point FL
- **North Broward Medical Center** Pompano Beach FL

The Ohio State University Hospital Columbus OH

Parkland Health & Hospital System Dallas TX

Regional Medical Center at Memphis Memphis TN

Riverside County Regional Medical Center Riverside CA

San Joaquin General Hospital Stockton CA

San Mateo Medical Center San Mateo CA

Santa Clara Valley Health & Hospital System San Jose CA

Schneider Regional Medical Center St. Thomas VI

- **Roy Lester Schneider Hospital** St. Thomas VI
- **Myrah Keating Smith Community Health Center** St. John VI

Shands HealthCare Gainesville, FL

Sinai Health System Chicago, IL

Stony Brook University Hospital Stony Brook NY

Thomason Hospital El Paso TX

Truman Medical Centers Kansas City MO

- **TMC Hospital Hill** Kansas City MO
- **TMC Lakewood** Kansas City MO
- **TMC Behavioral Health** Kansas City MO

UMass Memorial Healthcare System Worcester MA

UMDNJ-University Hospital Newark NJ

University Health System San Antonio TX

University HealthSystem Consortium Oak Brook IL

University Hospital, The University of New Mexico Health Sciences Center Albuquerque NM

University Medical Center of Southern Nevada Las Vegas NV

University of Arkansas for Medical Sciences Little Rock AR

University of Chicago Hospitals & Health System Chicago IL

University of Colorado Hospital Denver CO

The University of Kansas Hospital Kansas City KS

University of South Alabama Medical Center Mobile AL

University of Texas System Austin TX

- **The University of Texas Health Center at Tyler** Tyler TX
- **The University of Texas M.D. Anderson Cancer Center** Houston TX
- **The University of Texas Medical Branch at Galveston** Galveston TX

VCU Health System Richmond VA

25th
1301 Pennsylvania Ave. NW, Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax

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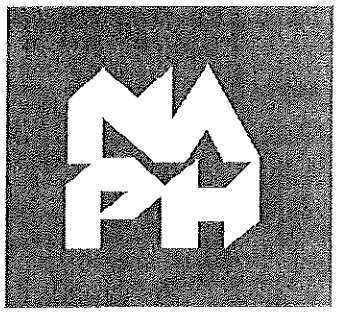

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