



THE ALLIANCE BULLETIN

August/September 2010

New Book by Our Board Chair on Nonprofit Management and Governance

We were pleased to provide our Board members recently with a copy of Howard Berman's new book, "Making a Difference: The Management and

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The Debate Continues on the Economic Impacts of the Health Care Reform Law

You probably read or heard about the recently released 2010 Medicare Trustees Report, which projects that the reform law will extend the solvency of the Medicare program for another 12 years, to 2029, due to the legislated reductions in payments to health plans and health care providers (August 5, "Health Law Extends Medicare Solvency to 2029, Trustees Say"). Not so fast, says Medicare's own chief actuary. He finds those projections unrealistic, calling those provider and health plan payment provisions, including productivity improvement adjustments and the sustainable growth rate factor in the reform law, "highly unlikely" ([August 9, "Rosier or Rose-Colored Glasses?"](#)).

I have a more basic question that no one else seems to be asking: Since the savings from the Medicare payment reductions were used to help fund the coverage expansions in Medicaid and in the private health insurance market, how can they also be used to extend the solvency of the Medicare program? Isn't this double-counting the savings? Is this new math, federal style?

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Governance of Nonprofit Enterprises.” Howard made a difference throughout his career in the nonprofit health sector, and continues to do it in his not-so-retired retirement years. As Howard noted in the release of this book, “Nonprofit enterprises are extraordinary organizations, accomplishing both what business will not do and what society does not want government to do. They are organizations created for purposes other than profits. To manage these enterprises well is a challenge worthy of society’s best and brightest leaders.” Copies may be purchased at www.ccepublications.org or 847-724-9280.

More Scrutiny of Executive Pay

Confirming what I reported last month, more and more news stories are emerging about executive compensation. The latest stories include:

- [August 16, “Falling Flat”](#)—Overall, executive pay in nonprofit hospitals and systems has shown only modest growth in 2010, the second year running. That’s a double-edged sword. That trend may be good in the short term for easing public concerns about executive “greed,” but if it continues will it make these organizations less competitive in attracting and retaining the executive talent they need?

- [August 16, “Subsidized Then Scrutinized”](#)—This article makes a basic point very well: Whether you are a financial institution receiving TARP money, a bailed-out General Motors, a large nonprofit receiving tax exemptions, or a large recipient of Medicare or Medicaid program funds, your executive compensation practices are likely to be under the microscope.
- [August 11, “Executives at Health Insurance Giants Cash In as Firms Plan Fee Hikes”](#)—The top executives of the five largest for-profit health insurance companies were paid nearly \$200 million last year, which did not even include the value of exercised stock options. That might make nonprofit health plans look far better by comparison. We need to start pooling data in that regard so that such comparisons can be made and broadcasted widely.

By the way, the Internal Revenue service has announced that it will be looking into executive compensation as well as unrelated business income of nonprofit colleges and universities ([July 15, “Tax-Exempt Colleges and Universities under IRS Microscope”](#)). The IRS found in a survey that many of these institutions have not been availing themselves of the “safe harbor” protections, which raises questions about the quality of their governance.

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Update on Massachusetts: The Bellwether for Health Care Reform

The news out of Massachusetts this past month on implementation of its reform program was generally more upbeat:

- [August 11, “Harvard Pilgrim Seeks Global Payments”](#)—This plan announced that it is taking a leaf out of Massachusetts Blue Cross Blue Shield’s playbook by contacting its 25 largest provider groups to open up contracts to move toward global or bundled payments, on a per member or per episode of care basis.
- [August 6, “Blue Cross Agrees to Reduce Rate Increase”](#)—The plan says that it accepted a compromise on rate increases to resolve immediate uncertainties for its customers, even though the increases will not cover its costs. This is clearly a “quick fix,” covering only rate increases through the end of this year. All parties appear to agree that real control over health care costs is the only answer to sustain their near universal coverage program.
- [August 3, “Tufts Health Will Rein in Rate Increases”](#)—This plan was the first to reach a short-term compromise with state officials.

Update on Massachusetts: The Bellwether for Health Care Reform continued from previous column

- [July 23, “MHA Says Bay State Hospitals Cut \\$3.1 Billion in Expenses”](#)—The state hospital association reported moderation in hospital expense increases over the past two fiscal years, brought about by job cuts, improved purchasing practices, quality and process reengineering, and good old “belt-tightening.”

One bad bit of news for some patients: The first for-profit health insurer approved to offer subsidized coverage was reported to have “dangerously restricted access to primary care” ([July 30, “Massachusetts’ First For-Profit Health Plan Has Physician Access Problems”](#)).

Rhode Island Official Looks at Massachusetts, and Announces Own Cost Control Plan

The Rhode Island Health Insurance Commissioner has announced that because 40 percent of health insurer medical costs in the state are spent on hospitals and that those costs are growing more rapidly than any other medical expenses, he will require next year that all insurer contracts with

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hospitals meet six conditions, among them: (1) a cap on inpatient and outpatient service prices that would be equal to or less than the medical-services inflation index used in Medicare and Medicaid; and (2) rewards for improving performance in at least three national standards for clinical quality, service and efficiency.

To our knowledge, no state health insurance commissioner has ever had the legal authority to mandate health plan/hospital contract and payment arrangements. Whether this one does remains to be seen, but one thing is clear to us. If nonprofit health plans, nonprofit health care providers, physicians and others don't join hands to effectively control health care costs and maximize their value to the communities they serve, we will see more proposed government interventions, which in many cases could be counter-productive.

New Community Benefit Resources

I am pleased to announce that the proceedings of our most recent roundtable discussion, "Community Benefit: Overcoming Organizational Barriers and Laying the Foundation for Success," co-sponsored with the health care journal *Inquiry*, has been published and posted on our web site.

New Community Benefit Resources continued from previous column

Five community benefit leaders who work "in the trenches" of nonprofit health care systems and hospitals shared their views on how to overcome any organizational barriers to community benefit and describe the basic infrastructure that any type of nonprofit health care organization, whether health care provider or insurer, should have in place to achieve both successful and sustainable community benefit performance. They were: Eileen Barsi, Director, Community Benefit, at Catholic Healthcare West in San Francisco, Calif.; Diane Jones, Vice President, Healthy Communities, at Catholic Health Initiatives, in Denver, Colo.; DawnMarie Kotsonis, Executive Director of Community Benefit and of the Presbyterian Intercommunity Hospital Foundation in Whittier, Calif.; Monica Lowell, Vice President, Community Relations, at UMass Memorial Health Care in Worcester, Mass.; and Carol Paret, Chief Community Benefit Officer at Memorial Hermann Healthcare System in Houston, Tex. I was privileged to facilitate the discussion.

For those looking for good examples of community health needs assessments, please visit the Community Benefit section of the Alliance's web site where we have been posting as many examples as we can find. Also check out the web site created by North Carolina's Office of Healthy Carolinians and Health Education:

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www.healthycarolinians.org/assessment/guidebook.aspx.

You may also be interested in a webinar being sponsored by the Association for Community Health Improvement on September 23 (2:00-3:00 PM EDT), “Community Benefit Strategic Planning: Engaging the Entire Hospital in a Comprehensive Approach.” Representatives of Fletcher Allen Health Care in Burlington, VT will discuss four standards that guide all community benefit decisions, their development of goals and objectives, their community benefit advisory group, and the staffing strategy to execute their plan and deliver value to their community. You can register for this webinar at:

www.hospitalconnect.com/secure/communityhlth/achi_AudioSep2010.jsp.

Nonprofit Health Systems Provide Better Quality

This is the finding of a new study by Thomson Reuters, which found that investor-owned systems had significantly lower performance than all types of nonprofit systems, with Catholic and other church-owned systems more likely to provide higher quality than secular, nonprofit systems ([August 10, “Study Finds Quality in Nonprofit Systems Better, with Church-Owned the Best”](#)).

Recent For-Profit Moves to Acquire Nonprofit Hospitals, Recent For-Profit Moves to Acquire Nonprofit Hospitals, Including “Safety Nets”

There has been a clear “up-tick” in for-profit acquisition activity, summarized in a recent news article ([July 13, “Mergers of For-Profit and Non-Profit Hospitals Raise Questions”](#)). The two most notable moves are by a private equity group with no health care experience (bought Chrysler before the federal bailout), Cerberus Capital Management, offering to purchase Caritas Christi Health Care in Boston, and by Vanguard Health Systems offering to purchase the Detroit Medical Center and its network of eight hospitals. Infusion of capital is clearly what makes these deals attractive to those being wooed, but what is in it for these for-profits, who say that they will maintain the missions of serving the poor? Will they maintain charity care levels beyond some promised time frame? Will they maintain unprofitable programs and services? Do they know more about improving efficiency and quality (See the above news)?

Should the Alliance develop any guidance to assist state or local entities in assessing such acquisition proposals? The Board will be discussing this at its next meeting.

Some Good Facts and News on Patient Safety

For help in prioritizing medical error problems to address, nonprofit health care leaders may want to read the August 11 article that we've posted on our web site, "[Top 10 Most Costly, Frequent Medical Errors.](#)" We also posted on July 20, "[CDC Releases First State-Specific HAI \(Health Care-Associated Infections\) Data Report.](#)"

One of the key patient safety problems has been central line-associated bloodstream infections (BSI). As you may know, a national program, "On the CUSP: Stop BSI," is underway to replicate the highly successful program in Michigan spear-headed by the state hospital association's Keystone Center and Dr. Peter Pronovost at Johns Hopkins. They are partners in this national program, along with AHRQ and HRET, and I have been privileged to serve on its technical advisory panel. The national program has just announced that state entities, which often are state hospital associations, can receive up to \$70,000 to develop and implement their own programs. One of the states that appears to be taking this project very seriously is Tennessee ([July 26, "Tennessee Leads the Way in Transparency"](#)). For more information about this national program, please visit www.safecare.net/OTCSBSI/Home.

*Some Good Facts and News on Patient Safety
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Although the data are somewhat dated, it was pleasing to see a recent report indicating that MRSA infections decreased by 9.4% per year from 2005 to 2008 ([August 11, "Hospital MRSA Infection Rates Plunge 28%"](#)). Perhaps even better news is a new report that researchers have created a "nanoscale coating" for surgical equipment, hospital walls, and other surfaces that they say can kill 100% of MRSA ([August 18, "MRSA-Resistant 'Paint' Kills Bacteria"](#)). Let's pray they are right.

If you have any questions or comments on these stories or other nonprofit health care matters, please contact me at mcphersonbruce@aol.com or 877-299-6497.



Bruce McPherson
Alliance President & CEO

HAVE YOU MARKED ON YOUR CALENDARS?

- ◆ ALLIANCE BOARD OF DIRECTORS MEETING
Chicago, IL (Embassy Suites-O'Hare,
Rosemont)
November 15-16, 2010 (Noon to Noon)

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