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# THE ALLIANCE BULLETIN

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February 2010

## Update on Washington Developments and Alliance Advocacy Efforts

As reported to the Board in our February 9 conference call meeting, the prospects and timing for any federal health care reform legislation this year remain unclear. Given this uncertainty, we shall continue to advocate our ideas and will keep the Board apprised of any major developments

There were a few notable health care news stories out of Washington this past month

*continued on page 2*

## INSIDE THIS ISSUE

Update on Washington Developments and Alliance Advocacy Efforts

2010 Financial Outlook for Nonprofit Health Care

Unproductive “Sniping”

More Evidence That Ownership Matters in Long Term Care

Can Nonprofit Health Care Ever Avoid Criticisms Over Executive Compensation?

Calendar

## 2010 Financial Outlook for Nonprofit Health Care

Moody’s recently announced that it is maintaining a “negative” outlook for nonprofit hospitals as a result of high unemployment, weakened employer insurance coverage, and unprecedented federal and state budget deficits ([February 12, “Moody’s Outlook for Nonprofit Hospitals in 2010”](#)).

These same forces are impacting other types of nonprofit health care providers as well as nonprofit health plans, and collaboration among all of them at the community level in addressing cost, access, quality and health status issues will be all the more critical if major federal health care reform legislation remains stalled. This brings me to the next news item...

## Unproductive “Sniping”

You probably noticed last year political efforts by both the American Medical Association and the American Hospital Association to bring

*continued on page 3*

related to health promotion and health information technology (HIT):

- The President, First Lady Michelle Obama, and HHS Secretary Kathleen Sebelius announced the administration's intent to launch a major initiative, to be coordinated with "private sector companies, nonprofits, and government agencies" to "solve the problem of childhood obesity within a generation" ([February 9, "Obama Wants to Solve Childhood Obesity Problem"](#)). This could present new opportunities or added impetus for community benefit collaboration among nonprofit health care organizations and other stakeholders.
- HHS Secretary Sebelius announced that \$650 million of funding from the stimulus legislation will be made available to fund comprehensive, coordinated programs at the community level, "Communities Putting Prevention to Work," to increase physical activity, improve nutrition, decrease obesity and decrease smoking. Successful applicants for such grants must use evidence-based interventions referenced at <http://www.cdc.chronicdisease/recovery/>.
- HHS Secretary Sebelius also announced that over \$750 million in

grants have been awarded for state health information exchanges and health IT training for health care providers through nonprofit "regional extension centers." ([February 12, "HHS Announces \\$750 Million in Grants for Health IT Training and State Exchanges"](#)). HHS may, however, be putting the cart before the horse. Where are the federal grant programs called for in the stimulus legislation to: (1) assist states in overall HIT planning, in particular to identify the needs and capabilities of individual nonprofit and other health care providers to adopt HIT; and (2) assist states in establishing HIT loan programs for health care providers in need?

Speaking of HIT loan programs, at least some nonprofit health care providers may be able to take advantage of a small provision in the stimulus legislation called the Bank-Qualified Rule ([February 2, "Little Known ARRA Provision Can Help Finance Health IT"](#)).

As a final note, we remain eager to hear our members' concerns with the proposed regulations to implement the Medicare and Medicaid incentive payment provisions for HIT adoption. The public comment deadline is March 15.

about increased scrutiny by the Federal Trade Commission and the Department of Justice of private health insurance competition and to eliminate anti-trust exemption provisions for insurers as part of federal health care reform legislation.

Now America’s Health Insurance Plans is trying to take advantage of a new report released by the Massachusetts Attorney General ([January 29, “AG Finds Clout of Hospitals Drives Cost”](#)) to point fingers at hospitals and physician groups that have consolidated in their markets to achieve more negotiating leverage with health plans ([February 9, “AHIP–Hospital Consolidation Is Driving Health Costs”](#)).

In some states and regions there are one or two dominant private health plans. In some of those and other markets there are one or a few dominant hospitals/systems and/or medical groups. From my perspective, whether there are dominant nonprofit health plans, nonprofit hospitals/systems, and/or physician groups, they have a special obligation to use their financial leverage responsibly—in the best interests of their communities. They should be leaders in developing and implementing partnership arrangements that reward value over volume and share cost savings from quality and efficiency improvements.

If we in the nonprofit health care sector don’t work more effectively together at the community level in containing cost increases, where could we be headed? State rate regulation? For example, the Governor of Massachusetts has introduced a bill to give the state insurance commissioner the power to review and reject rate increases by hospitals, physician groups, medical imaging centers, and health insurers ([February 11, “Patrick Wants Health Cost Veto”](#)). Or could we be headed toward federal rate controls, or a single-payer system? All of these approaches would prove to be bad choices but unraveling them once in place would be exceedingly difficult, however, will be more difficult than preventing their enactment. Instead, the health care sector must show some real leadership. Who better than the nonprofit providers and financiers – and when better and more necessary than now?

The good news is that we are beginning to see this kind of leadership. I noticed two new examples in the news just this month:

- [February 8, “Four SC Hospitals Form Network for Uninsured”](#)
- [February 2, “Blue Cross Blue Shield of Texas Setting Up Medical Home Model”](#)

## More Evidence That Ownership Matters in Long Term Care

In recent Bulletins I have reported on new studies confirming superior quality in nonprofit nursing homes.

A news story just appeared about inferior quality in for-profit long-term care hospitals, most notably those owned and operated by Select Medical Corporation, which in 2007 and 2008 were cited for four times as many violations as those of regular hospitals ([February 10, "Long-Term Care Hospitals Face Little Scrutiny"](#)).

## Can Nonprofit Health Care Ever Avoid Criticisms Over Executive Compensation?

I don't see how. Look at what just happened with an outstanding public hospital, no less: Parkland Memorial. In 2008 Parkland's board offered for the first time incentive pay for its top three executives. In 2009 this arrangement was extended to twenty-four other managers. In 2010 the board intends to extend the program to department heads. Some employees, however, receiving increases of only 2-3% in 2009 complained to reporters ([January 26, "Parkland](#)

*More Evidence That Ownership Matters in Long Term Care Continued from previous column*

[Board Defends Executive Bonuses"](#)). As CEO Ron Anderson explained, even with his incentive pay, his total compensation came to a little over \$800,000, "about 50% of what CEOs in private hospitals with 1,000 beds and a billion-dollar budget are getting."

Will the board's and Ron's explanations mollify all the internal and external critics? Don't count on it. Would below-market pay attract the requisite skills to manage these complex organizations? Clearly the answer is no. Both extremes must be avoided – paying more than performance merits and being penny-wise and dollar-foolish.

## HAVE YOU MARKED ON YOUR CALENDARS?

- ◆ ALLIANCE BOARD OF DIRECTORS MEETING  
Washington, DC (Marriott Washington at Metro Center)  
April 14-15, 2010 (Noon to Noon)
- ◆ ALLIANCE BOARD OF DIRECTORS CONFERENCE CALL MEETING  
August 10, 2010, 3:00 – 4:00 p.m. EDT
- ◆ ALLIANCE BOARD OF DIRECTORS MEETING  
Chicago, IL (Embassy Suites-O'Hare, Rosemont)  
November 15-16, 2010 (Noon to Noon)