AGENDA

I. Welcome and Approval of Today’s Agenda
   Walter A. Zelman, PhD
   Chair
   Howard A. Kahn
   Chief Executive Officer

II. A Future Look at the Health Care System Under the Affordable Care Act (ACA)
   • Introduction of Board and brief remarks by Board members (20 min)
   • Presentation (40 min)
   • Board discussion (30 min)
   Duane Dauner
   President/CEO, California Hospital Association
   Patrick Kapsner
   CEO, MemorialCare Medical Foundation

BREAK

III. ADJOURN TO CLOSED SESSION

REPORT INVOLVING TRADE SECRETS
Pursuant to Welfare & Institutions Code 14087.38 (n)
Discussion concerning New Product Lines
Estimated date of public disclosure: July 2014

RECONVENE IN OPEN SESSION

LUNCH BREAK

IV. Current and Future Board Structure and Processes
   Board Discussion
   Facilitated by Bobbie Wunsch

BREAK

V. ADJOURN TO CLOSED SESSION

REPORT INVOLVING TRADE SECRETS
Pursuant to Welfare & Institutions Code 14087.38 (n)
Discussion concerning New Product Lines
Estimated date of public disclosure: July 2014

RECONVENE IN OPEN SESSION
BUSINESS MEETING

VI. A. Approval of Entering into a Joint Exercise Powers Agreement between L.A. Care Health Plan and Los Angeles County to Establish L.A. Care Health Plan Joint Powers Authority.

Motion BOG 100.0712
1) To approve entering into a Joint Exercise of Powers Agreement (“Agreement”) between L.A. Care Health Plan and Los Angeles County to establish L.A. Care Health Plan Joint Powers Authority (“JPA”) to serve as a new Knox-Keene licensed health care services plan which will enroll members currently enrolled in L.A. Care’s programs other than Medi-Cal, and any new programs or lines of business which may be developed by the JPA, subject to the extension of the Managed Care Organization (MCO) Tax or similar tax beyond July 1, 2012; and

2) To authorize and delegate to Howard A. Kahn, CEO, discretionary authority to negotiate, enter into and execute the Agreement, and to take any necessary actions and execute any necessary documents relating to the Agreement and the JPA.

VII. Public Comments

VIII. Adjournment

The order of items appearing on the agenda may change during the meeting.

Please keep your comments to three minutes or less.

THE PUBLIC MAY ADDRESS THE BOARD OF GOVERNORS ON ALL MATTERS LISTED ON THE AGENDA BY FILLING OUT A “REQUEST TO ADDRESS” FORM AND SUBMITTING THE FORM TO L.A. CARE STAFF PRESENT AT THE MEETING BEFORE THE AGENDA ITEM IS ANNOUNCED. YOUR NAME WILL BE CALLED WHEN THE ITEM YOU ARE ADDRESSING IS DISCUSSED. THE PUBLIC MAY ALSO ADDRESS THE BOARD ON L.A. CARE MATTERS DURING PUBLIC COMMENT.

AN AUDIO RECORDING OF THE MEETING IS MADE TO ASSIST IN WRITING THE MINUTES AND IS RETAINED ONLY FOR 30 DAYS.

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Notification at least one (1) week before the meeting will enable us to try and make reasonable arrangements to ensure accessibility to the meetings and to the related materials.
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| I. 8:25 – 8:45 am | **Welcome/Opening Remarks**  
• Setting the stage  
• Goals for the day | Walter Zelman, PhD  
Board Chair  
Howard Kahn  
CEO, L.A. Care |
| II. 8:45 – 10:25 am | **A Future Look at the Health Care System Under the ACA**  
• Introduction of Board and brief remarks by Board members (20 min)  
• Presentation (50 min)  
• Board discussion (30 min) | Duane Dauner  
President/CEO, California Hospital Association  
Patrick Kapsner  
CEO, MemorialCare Medical Foundation |
| 10:25 – 10:40 am | Break                                                                   |                                                                              |
| III. 10:40 – 12:30 pm | Closed Session                                                           | Facilitated by Bobbie Wunsch                                                  |
| 12:30 – 1:15 pm | Lunch                                                                   |                                                                              |
| IV. 1:20 – 2:30 pm | **Current and Future Board Structure and Processes**  
• Board discussion | Facilitated by Bobbie Wunsch                                                  |
| 2:30 – 2:45 pm | Break                                                                   |                                                                              |
| V. 2:45 – 3:45 pm | Closed Session                                                           | Facilitated by Bobbie Wunsch                                                  |
| VI. 3:45 – 4:00 pm | **Closing Remarks**  
• Board of Governors business meeting | Howard Kahn                                                                  |
| 4:00 – 5:00 pm | Reception                                                               |                                                                              |
L.A. Care 2012 Retreat Goals
- To deepen Board member understanding of the impact of the changing health care system on L.A. Care.
- To explore L.A. Care’s potential roles in the transformed health care system.
- To review L.A. Care’s mission and board committee structure to identify changes needed to remain an active player in the new health care environment.

L.A. Care’s Mission
To provide access to quality health care for Los Angeles County’s vulnerable and low income communities and residents and to support the safety net required to achieve that purpose.

L.A. Care’s Vision
A healthy community in which all have access to the health care they need.

L.A. Care’s Values
We are committed to the promotion of accessible, high quality health care that:
- Is accountable and responsive to the communities we serve and focuses on making a difference;
- Fosters and honors strong relationships with our health care providers and the safety net;
- Is driven by continuous improvement and innovation and aims for excellence and integrity;
- Reflects a commitment to cultural diversity and the knowledge necessary to serve our members with respect and competence;
- Empowers our members, by providing health care choices and education and by encouraging their input as partners in improving their health;
- Demonstrates L.A. Care’s leadership by active engagement in community, statewide and national collaborations and initiatives aimed at improving the lives of vulnerable low income individuals and families; and
- Puts people first, recognizing the centrality of our members and the staff who serve them.
Purpose of Session

- To explore what the health care delivery system will likely look like following the implementation of health care reform.
- To exchange perspectives on the changing health care landscape and transformation of the delivery system over the next three to five years.
- To discuss drivers of behavior for key health care players in Los Angeles.
- To discuss impact, challenges, and changes to L.A. Care.

Board members will be asked to take a minute to introduce themselves to the speakers and briefly offer their thoughts on the changing health care system from the viewpoint of their constituency. Board members may outline the biggest challenge they anticipate facing in a post-reform environment and/or the greatest opportunity they see as a result of reform.

Background

On June 28, 2012, the Affordable Care Act (ACA) was deemed constitutional – by one vote of the Supreme Court. While the Court limited Medicaid (Medi-Cal) expansion in individual States, the majority of the law was upheld. By upholding the ACA, the Supreme Court has ensured millions of Americans who had no access or limited access to health care will soon become eligible for health coverage through the expansion of Medicaid.

In Los Angeles County alone, 2.1 million uninsured adults under 65 years of age currently have little or no access to preventive care, chronic disease management tools and affordable prescription drugs. With the court upholding the expansion of Medicaid, at least 900,000 of them will become eligible for health coverage that will make it possible for them to secure these much-needed health care services.

Other game changing initiatives underway as well include the health benefit exchange and the duals pilot. All of these programs stand to impact and change the way health care is delivered and organized nationally and locally. During this session, we will hear from two thoughtful experts in the health care delivery arena to better understand what our health care delivery system might look like after reform. The discussion that follows will help Board members understand L.A. Care’s role in the post-reform environment.

Background Materials

1. Bios for C. Duane Dauner and Patrick Kapsner.
Discussion Questions

- How will the role of hospitals and medical groups be changing as we move toward 2020? How will that changing role impact L.A. Care?
- How will the safety net be impacted by these potential changes?
- Where do we want L.A. Care to be in 2015 and 2017?
- How do we ensure that we remain a key player in the health care system?
C. Duane Dauner was appointed President and CEO of the California Hospital Association (CHA) in 1985. CHA is devoted to statewide representation and advocacy for California hospitals. CHA is one of the nation’s largest state health care associations, representing more than 400 hospitals and health systems.

Mr. Dauner has been active in national hospital and health care issues, serving on numerous American Hospital Association and American College of Healthcare Executives (ACHE) boards and committees. He has authored numerous articles and a book; is a nationally known leader on health issues; and has lectured at several California university graduate programs.

In 2002, Mr. Dauner received ACHE’s highest honor, the Gold Medal Award, and he has been honored by the Partners in Care Foundation, National Health Foundation, UCLA and Health Care Executives of Southern California.

Mr. Dauner was an assistant professor at Washburn University of Topeka, Kansas, prior to beginning his hospital association career at the Kansas Hospital Association in 1966. In 1975, he became President and CEO of the Missouri Hospital Association.

Mr. Dauner holds bachelor and master’s degrees from Wichita State University. He and his wife, Diane, reside in Sacramento, California.

2012
Patrick E. Kapsner  
Chief Executive Officer  
MemorialCare Medical Foundation

Patrick E. Kapsner is the Chief Executive Officer of MemorialCare Medical Foundation, where he has the authority and responsibility to operate the Corporation in all activities including quality of services, cost effectiveness, economic performance and implementation of system strategies. The MemorialCare Medical Foundation is a non-profit, public benefit corporation, serving patients through portions of Los Angeles and coastal Orange County.

Mr. Kapsner currently serves on the board of directors of the California Association of Physician Groups and the California Medical Group Insurance Company, Risk Retention Group. He is past chairman of the Healthcare Association of Southern California and California Association of Physician Organizations, as well as past president of the Medical Group Management Association Western Section, Orange County Medical Group Management Association, Unified Medical Group Association and American Medical Group Association.

Mr. Kapsner earned his Bachelor of Arts from the California State University at Long Beach and was elected to the Economics Honor Society, Omicron Delta Epsilon, in recognition of high scholastic achievement. Mr. Kapsner then earned his Masters in Public Administration from the University of Southern California. He is a member of Pi Alpha Alpha, the National Honor Society for Public Affairs and Administration. He is an adjunct professor in USC’s Health Administration Program and serves on USC’s Health Advisory Board. Mr. Kapsner also serves on the advisory board for The Center for Health Care Management and Policy at UCI’s Paul Merage School of Business. Mr. Kapsner is a fellow of the American College of Medical Practice Executives.

Mr. Kapsner served in the 44th Medical Brigade of the United States Army in the Republic of Vietnam from July 1969 to July 1970. He received an honorable discharge in September 1974 and is the recipient of the Bronze Star and RVN Gallantry Cross.

Mr. Kapsner has been involved in numerous local organizations and committees. He has two adult children, David and Katrina, and resides in Irvine, California.
INTRODUCTION

Seemingly, the only thing predictable about the future is that it lies ahead. The world of health care is undergoing seismic level changes at an escalating rate. Health-related executives must possess or acquire new knowledge, skills and the ability to innovate with ingenuity and vision. From institutional transformation to partnerships, collaborative arrangements and new models, health plans and providers are at the apex of the change curve.

Planning for the future is a growing challenge. However, it is imperative that tomorrow’s health care financing and delivery systems be crafted thoughtfully with vision, efficacy, flexibility and adaptability, affordability and practicality in mind.

This paper describes the environment, issues to be considered and potential actions that will lead to a better future.

Our organization’s long-standing vision is “an optimally healthy society.” The Association’s goal is that “every Californian has equitable access to affordable, safe, high-quality, medically necessary health care.”

With passage and validation of the Affordable Care Act (ACA), dynamic changes in public and private markets, and unrelenting cost pressures, the climate for change is perfect. The opportunities before us are limitless. The challenge is, “Are key stakeholders willing to collaborate, align clinical and financial incentives, improve wellness and redesign the delivery of health care services?”

WHERE WE HAVE BEEN

Historians generally divide past periods in California’s health care delivery as follows:

1870-1915: Rise of modern health care delivery and initiation of calls for national health insurance and Flexner Report on Medical Education.
1916-1929: Transition period highlighted by early insurance efforts, introduction of independent hospitals, emergence of county health systems, creation of multi-specialty group practices, elementary regional systems and injection of health benefits in workers’ compensation and American College of Surgeon Hospital Standardization Program.

1930-1939: Great depression and first major struggle for control of California’s health care marketplace, expansion of private hospitals and organized medicine, scandals, emergence of prepaid health plans and insurance company expansions.

1940-1950: Opposition to osteopathic doctors and “contract or employed” physicians by organized medicine, corporate practice of medicine ban, expansion of regulations, failed attempts to enact compulsory health insurance, formation of Kaiser Permanente and passage of federal Hill-Burton Act to support hospital construction. Many physicians moved to California after World War II, especially to southern California. Creation of Joint Commission of Accreditation Hospitals.

1951-1964: Counter reforms to the proposals that surfaced during the previous decade, founding of Blue Cross in Sacramento, failures to establish statewide “blue plans” by CHA and the California Medical Association (CMA), development of three regional plans, second wave of “New Deal” reforms and finally, creation of statewide health care insurance companies and health care service plans, and establishment of The Joint Commission.

1965-1975: Enactment of Medi-Cal and Medicare, “deemed status” granted to The Joint Commission, adoption of seismic law, intense battles for control of health care, birth of regional competition, expansion of group coverage in private markets, new regulations of payers and delivery organizations, breakdown of barriers against certain physicians (osteopathic and contract) and attention to rising costs (certificate of need, federal comprehensive health planning, cost containment with quality controls through professional standards review organizations and Medicare payment limits and passage of the Knox-Keene Act regulating health care service plans).

1976-1989: Enactment of selective provider contracting program for Medi-Cal, adoption of Medicare Diagnosis-Related Group (DRG) payment system, birth of delegated medical groups, authorization of prepaid health plans for primarily Medi-Cal beneficiaries, new wave of cost controls, suspension of certificate of need law, more struggles for control of health care, next generation of prepaid and capitated plans, scandals and retrenchments, and enactment of seismic safety law creating more rigid standards and timelines.
1990-2009: Emergence of contemporary competition as the driver of “private” health care financing and delivery, failure of risk assumption by providers, expansion and retrenchment of hospital-owned physician practices, horizontal restructuring and diversification followed by cutbacks and consolidations, market differentiation as a result of delegated medical groups and independent practice associations (IPAs), new battles for control of health care in California, Medicare Ambulatory Patient Group (APG) payment system, creation of Medicare drug benefit (Part D) and Medicare Advantage, cost controls of all types, payment cuts as a way to “save” government dollars and exacerbate the cost shift to private payers, conversion of numerous payers from not-for-profit to for-profit status and/or publicly traded structure, enactment of Children’s Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA), failure of health care reform bills in California and nationally, enactment of nurse-to-patient ratios, adoption of Medi-Cal hospital fee program and passage of numerous health care laws establishing the Department of Managed Health Care and expanding requirements on health care service plans.

2010-2012: Enactment and validation of ACA and implementing law in California, continuation of the regulatory train in California on multiple fronts, enactment of additional Medi-Cal hospital fee programs, emergence of significant pressures on hospitals from billings to quality to patient safety to costs, new wave of consolidations and purchases of providers by other providers or non-providers, explosion of “public” and “private” accountable care models, culmination of communications technology and availability of information resulting in new dimensions of consumerism, divisiveness among and within stakeholders in the health care equation, maturation of multiple transformation strategies and cross-disciplinary cost pressures fostering new types of competition. Corporate strategies involving the purchase of physician groups, IPAs, etc. are changing the competitive landscape. The ACA has unleashed another monumental battle for control of California’s health care system.

WHERE WE ARE

California payers and providers are at another crossroads in their evolution. Developments of the past 10 years, particularly during 2010-2012, are having a profound impact on all stakeholders.

Providers are caught in a constellation of laws, regulations, policies, competitive initiatives, market forces, pressures, barriers and opportunities. From one point of view, the second decade of the 21st century will be the golden age of health care financing and delivery. From another view, it can be seen as a period of unprecedented destabilization.
One point is clear: the status quo will not prevail. Consequently, choices must be explored and bold, visionary actions taken by providers and payers. Today’s environment is complex, disjointed and conflict-generating. The futures of many stakeholders are threatened while at the same time more opportunities exist than at any time in the past 40 years.

Our challenge is to use history and its lessons more discriminately. We must accurately evaluate the past and our current situation. Then, it is essential that we create a future in which the health of the population improves to optimum levels, safe, high-quality health care is affordable and coordinated health care is delivered in culturally competent and compassionate ways.

The political environment may change as a result of the November 6, 2012 elections, and political shifts could have profound implications. Immediately following November 6, the environment must be re-evaluated and adjustments made by payers and providers.

WHERE WE SHOULD GO

Stakeholders should evaluate their vulnerabilities, current and future socio-economics and socio-demographics in their service area, competition, opportunities, potential strategic destinations and best options. The best options should be measured against the organization’s core competencies, new key competencies that are required and the feasibility of best options. Ultimately, providers and payers must select options to pursue and develop action plans that best meet the needs of their communities.

L.A. Care Health Plan was formally created as a legal entity by the Los Angeles County Board of Supervisors in 1994. In 1997, L.A. Care was licensed by the Department of Corporations (licensing and regulation of health care service plans was transferred to the newly created Department of Managed Health Care pursuant to legislation enacted in 1999). HCFA, now CMS, authorized the Two-Plan Model in Los Angeles County and the conversion of Medi-Cal beneficiaries into managed care.

L.A. Care, in addition to providing coverage directly or through contracted plans, has supported Clinics, education, oral health, emergency funding for clinics, fitness and obesity initiative, children’s health initiative, healthy kids program, telephonic translation devices, pocket Rx initiative, safety net projects and services, pay-for-performance program, e-health technology, improved access to care, healthy lifestyle campaign, dental clinics, disease registries, electronic health records, better emergency department utilization, smoking cessation, free patient services, information and provider consultation programs, flu vaccine clinics, meaningful use standards through HITEC-LA, outreach to kids that protects their coverage, Community Health Improvement Project (CHIP), interpretation services and many other health-based community activities.

L.A. Care has embarked on a pilot demonstration project with the state to enroll Medicare/Medi-Cal dual eligible beneficiaries in managed care programs. This ambitious effort involves CMS, DHCS, providers and other stakeholders. This is a time of unprecedented opportunity, and L.A. Care is facing the following the following questions about the future:
1. What role does L.A. Care intend to play in the next 10 years (public and private sectors)?
2. What is L.A. Care’s potential future insured population, numerically and by category?
3. Who are L.A. Care’s primary competitive payers? Other competitors?
4. Which of the historical L.A. Care programs and projects should be continued (for example, grants and support activities)?
5. How should L.A. Care position itself in the future with respect to providers, especially hospitals, physicians, clinics and post-acute care organizations?
6. What is the organizational structure that will best serve L.A. Care for long-term success?
7. What strategic partnerships, if any, should L.A. Care consider?

SUMMARY

L.A. Care has much to be proud of – the nation’s largest public health plan with 1 million members, many outstanding health care coverage accomplishments, services to L.A. Care insureds, grants to worthwhile causes, community benefit activities and promotion of healthy lifestyles and wellness. Additionally, L.A. Care and CEO Howard Kahn have received multiple awards and recognition allocades.

Building on the solid foundation of the past, L.A. Care is faced with its greatest challenge: In this dynamic time of health reform and transformation, what should L.A. Care do to maximize its impact on the health status of southern Californians, provide services to persons who select L.A. Care for coverage and achieve its vision, “A healthy community in which all have access to their health care needs?”

As an innovator, aggregator, connector and collaborator, L.A. Care is well–positioned to be a leader in transforming southern California’s health care financing and delivery systems.

CDD:jd
How to save American health care

By Fareed Zakaria, CNN
March 26th, 2012
09:41 AM ET
http://globalpublicsquare.blogs.cnn.com/2012/03/26/zakaria-how-to-save-american-health-care/

America's health care system is really a mess. It is partly free enterprise, partly state-subsidized and overall highly inefficient in delivering quality care at a reasonable price.

I am a big fan of the free market. I think it has an almost magical ability to allocate resources and generate growth. But precisely because it is so powerful, in places where it doesn't work well, it can cause huge distortions.

The Nobel Prize-winning economist, Kenneth Arrow, outlined in the 1960s why markets don't work well when it comes to health care. He explained that people don't know when they will need health care and that when they do need it, the cost is often prohibitive. This means you need some kind of insurance or a government-run system.

Now, if we decided as a society that it is OK that when people suddenly discover they need health care, they can only get it if they can pay for it - that would work, but it would mean that the vast majority of Americans wouldn't be able to pay for a triple bypass or a hip replacement when they would need it.

The market would work, just as it works for BMW cars - people who can afford it can get it, people who can’t, won’t. But every rich country in the world - and many not so rich ones - have decided that every citizen should have access to basic health care and given that, a pure free market model simply cannot work (and remember, even if one were to have only a catastrophic insurance model, that's where all the costs are.)

Just 5% of the patients in the U.S. account for fifty percent of all health care costs - mostly the chronically ill - and taking care of these catastrophic illnesses is what drives up American costs.

A general insurance system can only work if everyone is insured. That's what the Swiss and Taiwanese found out. Otherwise, only the people who are sick will want to buy insurance and the insurance companies will spend most of their time and effort trying to kick sick people out of the system and denying coverage to those who might get sick.

That's why the Heritage Foundation, a conservative think tank, came up with the idea of an individual mandate, requiring that people buy health insurance in exactly the same way that people are required to buy car insurance.

That's why Mitt Romney chose this model as a market-friendly system for Massachusetts when he was governor. And that's why Newt Gingrich praised the Massachusetts model as the most important step forward in health care in years.
The Obama health care plan is not perfect by any measure. It still maintains the connection between employment and health care, which is massively inefficient and a huge burden on American business.

While businesses often talk about the need to reduce regulations to be competitive globally - a cause I support - they strangely rarely talk about their single biggest handicap against global competitors. American companies have to pay high tens of billions of dollars to provide health care for their employees and former employees while their German, Canadian, Japanese, and British counterparts pay nothing - zero - in health care costs.

The Obama health care bill expands access to 30 million Americans. That's good economics and also the right thing to do, but it does little by way of controlling costs.

There are several experiments and pilot programs in it. There are new trends emerging, but little in the way of systemic cost controls. That's largely a failure of nerve amongst the entire political establishment.

Every expert realizes that no matter what the system of health, you will need to have some kind of board that decides that some things are covered and others are not.

This has been demagogued as “death panels” when it is really the only sensible way to make the system work. No one is saying that you can't get any procedure you want - merely that there are some that your insurance doesn't pay for.

The other unusual aspect of health care, Kenneth Arrow points out, is that the buyers really don't have much knowledge.

You can decide that you don't want a new car, or can comparison shop for a new TV, but you can't decide that you don't want a bypass.

That's why costs have come down in optional areas like LASIK surgery but not in ones where the consumer really can't walk away.

There are powerful ways to incorporate the discipline of the market to make providers lower costs, but the key, as Atul Gawande points out, is to give doctors and hospitals an incentive to make you healthy rather than the current approach where they make money if you are unhealthy and need lots of heroic procedures.

A final thought: One can reason from first principles and that's a good thing but you must also reason from facts on the ground. The fact is that all rich countries try to provide affordable health care for their citizens in some way or the other.

All of them - including free market havens like Taiwan - have found that they need to use an insurance or government-sponsored model. All of them provide universal health care at much, much lower costs than we do.
The United States has the most marketized system in the world and the most expensive and inefficient one with bad outcomes and low levels of customer satisfaction.

Maybe there's a theoretic model out there that would work, but right now, in the world we are living in, some kind of mixed, messy health care system is what we have and our task is not to abolish it in favor of a utopia but to improve it so that Americans can get good care at reasonable prices - like so much of the rest of the world.
In Health Care Ruling, Investors See a Mixed Blessing

By ANDREW POLLACK and KATIE THOMAS

Hospitals will gain millions of paying customers. Insurers, by contrast, could face crimped profits from restrictive rules. Medical device and pharmaceutical companies will bear new taxes and other higher payouts, but they were already expecting such costs.

That, at least, was the immediate view of the impact of the Supreme Court’s ruling Thursday that upheld the nation’s health care overhaul.

It was also a view shared by stock market investors. Hospital stocks rose, with HCA gaining about 11 percent and Tenet Healthcare rising 5 percent. Stocks of insurers like WellPoint, however, lost as much as 5 percent. Some medical device and pharmaceutical stocks had slight declines.

For hospitals, the good news is that the law, which is aimed at extending insurance coverage to more than 30 million people, was upheld.

That will mean fewer uninsured people streaming into their emergency rooms receiving treatment for which they cannot pay.

But executives and analysts say that the Supreme Court decision, and the law itself, are not unalloyed benefits for hospitals. “It’s a huge exaggeration to say just because of today’s action that everything is going to be nice and rosy going forward,” said Michael Dowling, the chief executive of the nonprofit North Shore-Long Island Jewish Health System.

Executives and analysts say that the law will reduce Medicare payments for hospital services. For some hospitals, like MemorialCare Health System, a six-hospital chain in Southern California, those cuts more than offset any potential gains from newly insured patients, said
Barry Arbuckle, its chief executive.

Moreover, the Supreme Court ruled Thursday that the federal government could not withhold certain payments from states that refuse to participate in an expansion of Medicaid. The Medicaid expansion, which was expected to account for at least half of the newly covered people, now will be a choice for states rather than a requirement.

The government “has lost its stick,” said Sheryl Skolnick, an analyst at CRT Capital. “There is a risk here that the Medicaid expansion may not happen as hoped for by the hospital industry.”

Still, some executives said that there were carrots that could induce the states to go along, mainly the fact that the federal government would shoulder a majority of the cost of the expansion.

“The people who need this coverage aren’t going away,” said James G. Carlson, chief executive of Amerigroup, an insurance company that works mainly with Medicaid patients. He said that despite expected comments from some state officials opposing the Medicaid expansion, “We think most of them will come around to the idea that it probably makes pretty good sense.”

Investors seemed to agree. Amerigroup’s shares rose about 5 percent. A competitor, Molina Healthcare, rose about 9 percent.

Shares of commercial insurers like WellPoint and Aetna largely fell. Those insurance companies avoided what had been considered a bad outcome: a decision that threw out the individual mandate to buy health insurance but kept intact the requirements that insurers cover patients with pre-existing conditions and charge sick patients the same as healthy ones. That, they said, would have forced them to pay for the law’s expensive elements without the influx of healthy customers the mandate was designed to bring in.

Still, some investors had apparently been hoping that the law would be tossed out in its entirety, relieving insurers of restrictions like a requirement to spend a certain percentage of the premiums they collect on medical treatments.

“This was a bill that passed with an onerous set of restrictions on how the industry could operate, and the Supreme Court confirmed that this is going to be the lay of the land,” Joshua Raskin, an insurance industry analyst at Barclays, said in an interview.
The stock decline surprised Robert Laszewski, a health industry consultant, who said the law was a known quantity and the result of bargaining between industry executives, including those in the insurance industry, and politicians.

The decision does allow insurers to seek new customers. Cigna, for example, has recently begun a push into providing coverage for individuals. “We see it as an attractive growth market,” David Cordani, Cigna’s chief executive, said Thursday.

Indeed, as the day wore on, some of the stocks of health insurers began to recover, with UnitedHealth Group and Humana actually finishing the day slightly higher.

Under the law, pharmaceutical companies are paying new taxes, additional Medicaid rebates and subsidies to close the Medicare drug coverage “doughnut hole.” But investors and companies had already factored in these costs, so the upholding of the law preserved the status quo.

“Much ado about nothing,” Matthew Roden, biotechnology analyst at UBS, said in a note Thursday.

Had the law been struck down, however, analysts had expected that drug company earnings would have risen in the short term.

Medical device companies will have to pay a new 2.3 percent tax on sales starting in January to help pay for the new law. The House of Representatives recently voted to repeal the tax, but the prospect of such legislation passing the Senate is uncertain.

Device companies and their representatives say the tax will impede innovation and cost jobs. But the new health care law will not bring device companies many new customers because many of the newly covered individuals will be young.

“Most of them are not getting knee replacements and hip replacements and a lot of things you see in the device world,” said Mary Grealy, president of the Healthcare Leadership Council, a trade association representing chief executives of various sectors in the health care industry.

_Reed Abelson contributed reporting._
Call it the united state of health care.

Amid enormous pressure to cut costs, improve care and prepare for changes tied to the federal health-care overhaul, major players in the industry are staking out new ground, often blurring the lines between businesses that have traditionally been separate.

Under pressure to cut costs and prepare for the federal overhaul, the health industry is changing. Read about how the changes are playing out and listen to interviews.

Hospitals are bulking up into huge systems, merging with one another and building extensive new doctor work forces. They are exploring insurance-like setups, including direct approaches to employers that cut out the health-plan middleman.

On the other side, insurers are buying health-care providers, or seeking to work with them on new cooperative deals and payment models that share the risks of health coverage. And employers are starting to take a far more active role in their workers' care.

Such shifts have been gathering force for a while, but the economic downturn has accelerated the push for efficiency. The federal legislation, which creates new health-insurance marketplaces and requires most people to carry coverage, may unleash additional demand for health care once it fully takes effect in 2014. Even if the Supreme Court unwinds part of the law, the changes occurring now aren't likely to stop because the pressure to reduce the price of health coverage won't go away.

It Has All Been Tried Before, Experts Warn

"We're seeing a marketplace reacting to an economic imperative," says Michael O. Leavitt, a former U.S. Secretary of Health and Human Services who is now chairman of a health-information company. "The new delivery models are far more integrated."

The trends have crystallized over the past year in a series of high-profile deals and quiet, under-the-radar developments. For a close look at what they mean, here are snapshots of five people—a doctor, a hospital CEO, an insurance-company official, a human-resources executive and a patient—on the front lines as much of the $2.6 trillion U.S. health-care industry tries to remake itself.

Their stories show where health care is trying to go. The picture wouldn't be complete without a reminder of where it has been. Many of these same efforts were attempted in the 1990s, and
they often failed. Experts caution that there are many signs the current flurry of activity could result in the same problems, with less margin for error in today's unforgiving economic environment.

**Getting the Doctors On Board**

Ultimately, the success or failure of efforts to change the health-care system may hinge largely on doctors like Dan McCullough.

As a family physician, Dr. McCullough, who works for a hospital system in Beverly, Mass., is on the front lines of efforts by health-care providers and insurers to boost preventive care and rein in costs. Hospitals and insurers are both rushing to employ and ally with primary-care doctors in all of their new schemes to blend their various functions and integrate the health-care system.

But doctors, the gatekeepers of the system, often react sharply to efforts to control their practice styles. A survey this spring of medical administrators and doctors by health-staffing firm AMN Healthcare found that doctor and staff cooperation was the most frequently cited "serious obstacle" to creating accountable-care organizations.

In Dr. McCullough's case, around 28% of his pay for the fiscal year ended in September was tied to patient-satisfaction, quality and efficiency goals, a mix of his own results and those of the entire physician group affiliated with the hospital. The quality portion involves measures like patients' blood-pressure control and preventive care like mammograms. The efficiency part is tied to statistics including how often doctors refer patients to specialists outside the system and how often their patients go to the emergency room. But much of the rest of Dr. McCullough's pay is still tied to his productivity, a typical style of doctor compensation that parallels the traditional fee-for-service model.

Dr. McCullough's current pay structure took effect last year, when he started working under a contract with the state's biggest insurer, Blue Cross Blue Shield of Massachusetts, that enables providers to effectively earn more if they keep costs down and meet quality goals. Upping the ante, Dr. McCullough's employer, Northeast Health System, ties an additional chunk of his pay to quality and patient-satisfaction measures.

Dr. McCullough, 44 years old, says he likes the incentives. It used to be true that "quality doesn't pay the bills," he says. Now he focuses more on closely tracking the care of patients with chronic conditions, including hiring a new case manager. He says the new payment method also makes him think twice about allowing some services or specialty care from doctors outside his hospital's network. In the past, he "would just rubber-stamp the referral," he says."
Recently, he got a call from a doctor's office because one of his patients had gone there seeking surgery for chronic heartburn. Dr. McCullough refused to sign off. Instead, he called the patient and asked him to come in for an appointment. After he prescribed a stronger heartburn medication, the man, who had seen the surgery advertised, decided he no longer needed the procedure.

Dr. McCullough, who has a master's degree in medical ethics, says he doesn't skimp on care that he believes will help patients. Indeed, many aren't even aware that his compensation has changed. Sometimes, though, patients question his motives. One woman wanted an ovarian-cancer test because a friend of hers had suffered from the disease, but Dr. McCullough refused to order it. The patient was "a little miffed," and she said "it's because the insurance company doesn't want to pay for it," Dr. McCullough says. He responded that there was no evidence she needed it. Still, he says, such encounters are "not the highlight of my day."

An older, recently widowed patient who kept going to the emergency room when he ran out of his asthma medication got a house call from Dr. McCullough, whose office then helped get the man into adult day care. The traditional fee-for-service model has no reward for that, he says. But "we got really aggressive with him not just because it's the right thing to do, but because we were incentivized to do it."

**Mergers Help Hospital Bulk Up**

Jim Taylor, the chief executive of the University of Louisville Hospital, says his institution's future depends on an ambitious statewide merger with two other hospital systems. Now, he has to persuade others that he's right.

In June, Mr. Taylor helped unveil a plan to merge with nearby competitor Jewish Hospital & St. Mary's HealthCare and Saint Joseph Health System, an eight-hospital group based in Lexington, Ky., that is part of Catholic Health Initiatives of Englewood, Colo.

If the deal is approved by the state's governor and the local Catholic archbishop, the nonprofit Catholic Health Initiatives will provide a $320 million infusion of cash and will hold 70% of the combined system. The merger would create Kentucky's biggest hospital network, with 14 facilities stretched across the state and $2.5 billion in annual revenue. It would also account for 22% of the acute-care beds in Louisville and 13% of those statewide.

Mr. Taylor says the money, along with the better bond rating the merged combination will get because of Catholic Health's backing, will provide a vital buttress for University Hospital. "We couldn't grow, and our role was going to decline as we face revenue pressures" from declining government reimbursement, says Mr. Taylor, 64, a second-generation hospital executive.

Mr. Taylor says University is in the black now but can't afford to buy advanced electronic medical records or upgrade and expand its main facility,
built in 1980. University, which is the region's only adult trauma center and main safety-net hospital, is routinely overcrowded, particularly its emergency department, a spokesman says. Over the years, executives have drawn up plans to build a new $150 million patient tower and spend $33 million to expand emergency capacity, among other options, but had to shelve them. Mr. Taylor and other executives say the merger will achieve savings when duplicated functions are consolidated.

Nonprofit hospitals had their slowest revenue growth in at least two decades last year, according to Moody's Investors Service. The financial challenge is leading many to merge in hopes of cutting expenses and gaining leverage in negotiations with insurers. In the first three quarters of this year, there were 71 hospital mergers, compared with 53 at that point last year. The full number for 2010, 75, was already the highest since 2001.

Hospital deals can touch a nerve, because of the institutions' central economic and emotional position in their communities. Often, the debate centers around whether a for-profit company based elsewhere will continue to provide charity care and meet other local needs.

In Mr. Taylor's case, the controversy has mostly focused on whether University Hospital will be affected by Catholic care guidelines, which ban or restrict various reproductive procedures including abortion and sterilization. The buzz-saw of resistance has put Mr. Taylor in an unaccustomed spotlight after 15 years as the hospital's CEO. A community forum on the deal drew more than 200 questions. There are also dueling lawsuits over whether University Hospital merger documents are covered under state public-records laws.

"I don't think a hospital that belongs to the people of Kentucky should be merged and be dictated to by people who put restrictions on certain procedures," says Rep. Tom Burch, a Democrat who chairs the health and welfare committee in the state's House of Representatives. "It has hit a sore spot with people."

Mr. Taylor says the merger won't significantly affect service offerings at his hospital, which doesn't currently provide elective abortions. University Hospital has made arrangements for women who want tubal ligations to get them at a different facility, he says.

The new network will have more than 3,000 doctors. Though University Hospital doesn't employ its own physicians, the other two merger partners have significantly expanded their employed doctor staffs in recent years, including primary-care doctors, a common pattern in U.S. hospitals recently.

The new system will be able to integrate patients' care and to take on the financial risk tied to overseeing groups of patients, says Paul Edgett III, a Catholic Health Initiatives senior vice president. It will look at "warranty"-style payments, he said, under which a set sum is paid for an episode of care, including any complications. Such setups, under which hospitals can sometimes lose money if costs run too high, move hospitals into a space that has largely been the purview of health insurers.
Mr. Taylor said that on its own, his hospital is "poorly positioned" to do such deals, because it's "too small, too limited."

**An Insurer Partners With Hospitals**

Negotiations between health insurers and hospitals typically focus on clashes over payment rates. Chris Day, an executive with Aetna Inc., is supposed to change that.

Mr. Day, 36, spearheads Aetna's efforts to create new cooperative deals with health-care providers. The details vary, but the main idea is that Aetna and the provider try to work together to trim costs and track the quality of care. In the most ambitious cases, they are creating jointly marketed health plans that effectively blur the line between insurer and provider.

Instead of Aetna simply paying the hospital for services, the two exchange patient data and may share the risk of coverage, acting more like an integrated company. These plans aim to leverage the hospital's local brand-name recognition and the insurer's back-office know-how. They also may be the insurer's best shot at competing in many of the new state-based health-insurance marketplaces where some 24 million people are eventually expected to buy coverage. Chief Executive Mark Bertolini recently highlighted the new "HMOs on steroids" as a key Aetna initiative at an investor conference.

But after years of head-butting between the two industries, a warm-and-fuzzy partnership isn't always an easy sell. "When I walk in that room, I'm seen as a health-plan person," says Mr. Day, who estimates that he has met with more than 100 medical providers around the country. Sometimes he breaks the ice by referring to his own background, which includes running a sleep clinic and an early stint as a hospital data-entry clerk.

Aetna recently unveiled a jointly marketed health plan with Banner Health, a not-for-profit 23-hospital system based in Phoenix, Ariz., after more than a year of talks. At one point early on, Mr. Day had to keep some locally based Aetna executives out of key strategy meetings with Banner. After one of them raised the idea that Banner might need to grant some rate discounts, a Banner official suggested "we needed to find ways to keep the conversations strategic," Mr. Day says.

On the other side, Chuck Lehn, vice president of managed care for Banner Health, says Mr. Day earned his trust by sharing closely held information, including certain details of how the insurer sets premiums. Aetna also agreed it wouldn't build a guaranteed profit margin into providing administrative services for the new product, he says, though both sides will share its earnings.
"We shared a lot more information than we normally would" with an insurer, including detailed cost and utilization data, Mr. Lehn says. "I remember thinking, 'I'm putting my total trust and faith that they're not going to use this'" against Banner to winch down rates.

The two sides zeroed in on areas where they could potentially shave costs and improve care, such as relatively high use of imaging scans by some Banner doctors, Mr. Lehn says.

During a different effort to strike a deal with a provider, Mr. Day's talks broke down for months because a separate contract-rate negotiation between the hospital system and local Aetna executives got so contentious that details leaked to the local media. In another case, a mistrustful hospital executive demanded written pledges that his company's patient information wouldn't be used in setting the patients' insurance rates.

Like other insurers, Aetna is making moves into the business of providing services to providers partly to prepare for another change tied to the federal overhaul law. It requires health plans to spend a set share of premium dollars on health-care expenses, which can crimp insurance profits.

**An Employer Gets Into Health Care**

A few years ago, Robert Jacobs, a human-resources executive at MasterBrand Cabinets, felt he was running out of options to blunt annual double-digit health-coverage price increases. Employees had already shouldered as much as they could bear, he felt. He had hit the limit of discounts from health providers. Wellness programs like free health-club memberships had shown little impact.

Then Mr. Jacobs read a research report that said about three-quarters of health costs are linked to lifestyle-related conditions. That persuaded him to try a radical new tack: Last year, MasterBrand, which has some 7,000 U.S. employees, started tying their insurance-premium contributions to their health-risk factors. Those who score poorly on measures such as cholesterol, blood pressure, body-mass index and tobacco use pay more each week.

"We had to do something more," Mr. Jacobs says. After wood and salaries, health care is the company's third-biggest expense, and "I can't pass that along to my customers in prices on kitchen cabinets."

The program at MasterBrand, a unit of Fortune Brands Home & Security Inc., is an example of companies' growing willingness to push workers toward better health, a role once left to health-care providers. MasterBrand, like others, offers the health tests right at the offices and factories where its employees work.
A survey this year by consulting firm Towers Watson and the National Business Group on Health found that 13% of U.S. employers are tying financial incentives to health outcomes like cholesterol-test results, and another 33% plan to do so. Forty-three percent of the biggest employers are taking an even more direct path into health care by offering onsite clinics, according to a survey by Mercer.

Some of these efforts are controversial. In a letter to federal regulators in March, groups including the American Heart Association, the American Diabetes Association and the American Cancer Society's advocacy arm said such programs were backed by little evidence and risked discrimination against people based on their health.

Mr. Jacobs, a blunt-spoken 60-year-old who himself is managing elevated blood pressure, says he is giving employees accountability. "It's almost like going to a risk-based insurance like automotive," he says. "If you have a health risk you're not managing, you'll pay a little more."

So far, MasterBrand hasn't set very stringent standards, he says. Also, the most a worker has to pay extra based on test results is $10.50 a week, while a person with the best health indicators gets a $2-a-week discount.

The program is administered by Bravo Wellness LLC, a vendor that oversees an appeals process that is supposed to let workers opt out without penalty or aim for alternative goals if they have a medical condition that makes it impossible to achieve the targets. Those who choose not to participate without a medical excuse pay an extra $37.50 a week in premiums.

Around a half-dozen workers got urgent calls after they took the health tests, warning they were in imminent danger of heart attacks, Mr. Jacobs says, and a couple had heart-related surgery.

He also points to employees like Sandra Kaufman, 47, who works in shipping at a MasterBrand facility in Goshen, Ind. She says she initially thought the program was "an invasion of my privacy." But she couldn't afford the penalty for refusing to participate, so before it launched two summers ago, she went to a doctor for the first time in years. When she learned she had high blood pressure, elevated cholesterol and diabetes, Ms. Kaufman started dieting and exercising, and she says she has lost about 50 pounds.

Mr. Jacobs says he fielded complaints when the program was started. One man asked him angrily, "Why are you doing this to us?" The worker didn't think the company should be imposing health standards. "That's personal," he said, according to Mr. Jacobs, who says he responded that MasterBrand had a stake as well, since it was paying around 80% of the cost of workers' health coverage.

The worker is now a "willing participant" in the program, Mr. Jacobs says.

A Patient Gets Care From His Insurer
On a recent day, Louis E. Kauder Jr., an 86-year-old suffering from advanced diabetes, arrived at a storefront clinic in La Mirada, Calif., for his weekly checkup.

Nurse Eugenia Chang looked at his blood-sugar result and started quizzing him. What had he eaten? Mr. Kauder confessed to a dinner the night before of macaroni and cheese and chocolate chips. "Your sugar is a lot higher than normal," she chided, urging him to avoid desserts and eat more protein.

Then she zeroed in on his toe, which had a small sore. Was he wearing the protective shoes the clinic provided? She painted the toe with a disinfectant and wrapped it in gauze.

Finally, she examined a gaping six-inch-long wound on Mr. Kauder's left calf. That was improving, she said, and she would continue the daily home visits from a nurse to dress it.

Hospitals and doctors are increasingly promoting this type of health care – close, constant monitoring, with strong efforts to push preventive measures – as the best way to treat chronically sick patients.

But Mr. Kauder's clinic is different: It's owned by a health-insurance company, CareMore Health Group, that offers Medicare Advantage plans. CareMore says it can improve patients' health and save money in the long run by taking an active hand in their care.

It's a bet that more insurers are making, hoping to trim costs and lock in some doctors in case the influx of newly insured consumers leads to a shortage. CareMore was bought in August for slightly less than $800 million by WellPoint Inc. The big insurer said it plans to more than double the number of "care centers" that CareMore operates and spread it across the country.

Last December, Humana Inc. spent $790 million for Concentra, an operator of urgent- and occupational-care clinics. And Humana late last month announced it would buy SeniorBridge, which focuses on care for complex chronic conditions.

UnitedHealth Group Inc.'s Optum health-services arm recently purchased the operations of Monarch HealthCare, an Irvine, Calif., association that includes some 2,300 doctors, the latest of several doctor groups in which the company has taken ownership stakes. Cigna Corp. announced in October that it would spend $3.8 billion to buy HealthSpring Inc., a Medicare Advantage carrier that works closely with doctors and owns some of its own clinics.
CareMore says the heavy upfront investment it makes in preventive care for patients like Mr. Kauder pays off because its members end up spending less time in the hospital than most traditional Medicare beneficiaries. They have fewer readmissions and lower rates of events like heart attacks, says the company's chief medical officer, Ken Kim.

A hospital stay can run $3,000 or more a day, Dr. Kim says. Amputation of a limb for a patient with advanced diabetes like Mr. Kauder can cost about $16,000, he says, and CareMore's amputation rate is about 60% lower than the average for traditional Medicare.

"We get to them at the front end" and keep medical conditions from worsening to catastrophic levels, he says. As a result, CareMore is more profitable than many rival Medicare plans, he adds.

Mr. Kauder started with CareMore last October. "They really take care of me," he says. He doesn't pay a premium for the CareMore Medicare Advantage plan, and he doesn't have out-of-pocket fees to see CareMore staff, though he does pay charges for some other things, like certain medications.

His case illustrates many of the challenges of managing chronically ill patients. After repeated medication tweaks and sessions with a nutritionist, Mr. Kauder's blood sugar level has improved, but it's still not at CareMore's target. The retired auto mechanic also has heart problems, and he had a bypass operation a few years ago.

A CareMore staffer asked a visiting wound-care nurse whether his home, where he lives alone, showed signs of neglect such as rotting food. On another occasion, when a visiting nurse spotted Mr. Kauder trying to clamber over a wall in his backyard, she informed clinic personnel. A case manager phoned Mr. Kauder to make sure he wasn't showing signs of dementia and booked him for an immediate checkup.

Still, Mr. Kauder's major leg lesion has lingered since February, a common circumstance for someone with advanced diabetes. It became infected, and his home-visit nurse started administering an intravenous antibiotic. In June, he ended up in the emergency room after he tripped and opened up the wound, which bled heavily. Doctors at the hospital urged him to consider amputating the limb below the knee.

"I said, no way," says Mr. Kauder, whose mother lost a leg to diabetes. After a night in the hospital, where CareMore doctors visited him, he returned home. Since then, he hasn't been in the hospital, and the wound has improved. He's off the IV antibiotic. The clinic tracks the wound's progress with weekly digital pictures.

Dr. Kim, the CareMore chief medical officer, who wasn't personally involved in Mr. Kauder's case, says the care almost certainly saved his leg.

Write to Anna Wilde Mathews at anna.mathews@wsj.com
Implementing National Health Reform in California: Payment and Delivery System Changes

Prepared for California HealthCare Foundation

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1. Introduction and Background

Federal health reform will change the way millions of Californians purchase health insurance and receive health care services. More than 3 million uninsured Californians will be able to obtain coverage under the Patient Protection and Affordable Care Act (ACA) — 2 million of whom will be newly eligible for Medi-Cal.1,2 Beyond these large numbers of newly insured, the ACA will have an even wider impact with its provisions altering how providers and hospitals are reimbursed for and deliver care. The ACA includes changes to mandatory reimbursement rules that will reduce fees paid to institutions under Medicare fee-for-service (FFS), and establishes demonstration projects and grant programs intended to test and rapidly deploy new care delivery models.

In many respects, the reimbursement changes and care delivery reforms complement each other. The care delivery projects may help providers and hospitals accommodate the lower reimbursement rates by helping them find ways to reduce costs while improving quality.

Taken as a whole, the payment and care delivery reforms discussed in this report have broad implications for the health care delivery system, and they stand to impact all health care consumers in the United States.

A. Reimbursement and Care Delivery Reforms

Central to ACA’s payment reform efforts are reimbursement changes that will reduce FFS payments to hospitals for preventable hospital readmissions and hospital-associated infections, and budget-neutral or cost-saving provisions such as the Hospital Value-Based Purchasing program intended to pay incentives to hospitals that meet specific performance measures. These changes are projected to save Medicare $11.4 billion over 10 years (2010 to 2019).2 In addition, ACA establishes a number of reimbursement pilot programs to test alternate payment models.

Besides reimbursement reforms, ACA features a series of pilots and demonstration projects focused on coordinating and improving care delivery for Medicare FFS and Medicaid beneficiaries. These efforts include several projects such as the Medicare Shared Savings Program establishing accountable care organizations (ACOs), as well as patient navigator and community-based care transition programs. Some observers believe these demonstrations represent a comprehensive realignment of the health care delivery infrastructure; others are skeptical that they will prove sustainable or replicable on a national scale. What is clear is that in order to reach their full potential, these programs will require support from state policymakers and program administrators, and very close collaboration among a wide range of providers, payers, state and local health agencies, and consumers.

Woven throughout ACA’s payment and care delivery provisions is the principle of transparency. The ACA outlines a number of requirements to support open and transparent program oversight and fraud and abuse monitoring. These programs typically include a substantial set of reporting obligations and mandates for a broad range of participating stakeholders. The data generated by these reporting requirements, if made broadly available to support detailed program and policy analyses, could greatly enhance decisionmaking by state and federal policymakers and program administrators and staff, as well as by providers, consumers and purchasers.
B. Potential Outcomes

It remains to be seen whether payment and care delivery reforms can produce enough savings — and to what extent those savings will accrue to the public programs that administer them — to offset ACA's expansion of coverage under the Medicaid program. In California where the market is far ahead of the national curve in adoption of managed care, the low-hanging fruit in terms of savings opportunities may not exist. The burden of implementation of many of ACA's Medicaid provisions and the state's 1115 waiver programs will fall squarely on the shoulders of California's Medicaid managed care plans. The pressure they will face to increase capacity, enroll new members, expand their networks to accommodate them, reduce costs, and improve outcomes will be enormous and may not be achievable without policy, programmatic, and fiscal support.

Further, planned ACA reductions in reimbursement to hospitals may cause significant financial hardship for a number of institutions, including safety-net hospitals, and will likely also result in further cost-shifting onto the commercial market, applying upward pressure on commercial premiums. Given the state's ongoing fiscal crisis and concerns over the national debt, additional reductions in spending for entitlement programs, including Medicaid, are likely. Policymakers will need to consider how to address these critical contingencies as more individuals receive insurance coverage under ACA and test the capacity of the health care delivery system. In some states such as Oregon and Florida, policymakers used legislation to enable the creation of state-based ACOs for Medicaid and other populations. It will be important to consider the extent to which these arrangements could be established in California, how they align with the current Medi-Cal migration from FFS into managed care, and what additional benefits could result from Medi-Cal ACOs.

This report is the third in a series commissioned by the California HealthCare Foundation (CHCF) describing the implications of ACA and their expected impact on California's health care delivery system, public coverage programs, and private insurance markets. The initial policy analysis, published in June 2010, focused on health insurance coverage provisions; the second report, published in March 2011, addressed access to care. This policy report focuses on reimbursement changes, ACA pilot programs, grants, and other provisions designed to demonstrate alternative health care delivery and payment models. It also reviews related transparency provisions that are intended to make information and data more forthcoming for individuals, health care purchasers, and policymakers. The report has been informed by the perspectives of 11 federal and state officials, stakeholders, and thought leaders; the list of interviewees is included in Appendix A.

(A copy of the full report can be accessed here:
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/I/PDF%20ImplementingHealthReformPaymentChanges.pdf)
IV. CURRENT AND FUTURE BOARD STRUCTURE AND PROCESSES
1:20PM – 2:30PM

DISCUSSION GUIDE

Purpose of Session

• To identify changes that L.A. Care should make to Board composition and operations in order to stay strong and effective as the health care environment changes.
• To identify process improvements to make Board activities as efficient and meaningful as possible.

Background

Below is a list of discussion questions that will guide our discussion on Board processes, roles and functions that derive, in part, from a review of Board activities conducted by the Chair earlier this year.

That review by the Chair produced a variety of suggestions, which are listed below. Some of these suggestions have already been implemented by the Board and/or staff.

• The Board should expand use of the consent calendar to free up more time for strategic discussions.
• Staff presentations on strategic topics should, when possible, be placed in the Board packet so the Board can review them in advance and the discussion can focus on key questions defined by staff regarding decisions still to be made, options, input, etc.
• Other regular staff presentations—finance, medical, etc.—should, when relevant, raise questions for the Board regarding the most significant issues confronting that area of the organization.
• Some Board members have expertise that makes them good candidates for various committee positions. Still, there should be more rotation of committee members so that Board members can attain greater understanding of a broader range of L.A. Care issues and processes. Rotation will also provide Board members more opportunity to interact with more Board members.
• Time should periodically be allotted at Board meetings for members to review key issues from the perspective of their constituency.
• To the extent possible, the Board should not be asked to make quick decisions. Bringing complex and/or controversial issues to the Board as soon as possible for airing and input better enables the Board to effectively address the issue.
• The board/staff should consider a more comprehensive training session or process for new Board members, especially in the area of finance.
• The Board should focus more on how L.A. Care can work to improve the delivery system.
• L.A. Care should move toward establishment of a modest-sized research unit to assist in planning and evaluation of ongoing and future activities.
• The Board should consider the value of an annual or every-two-year two day retreat.
**Background Material**


**Discussion Questions**

- Which, if any, of the above recommendations does the Board believe might be particularly valuable or not so valuable? Which, if any, deserve more consideration?
- What are the primary roles that the L.A. Care Board needs to play in the organization? Should the changes in the health care system or marketplace, or in the scope and complexity of L.A. Care’s operations make any difference in defining the role of the Board?
- In what ways can the Board can best contribute to the capacity of L.A. Care to achieve its mission? Aside from providing public accountability and evaluation of the CEO, what is the value of the Board?
- Given the Board’s view of its role and potential contribution to L.A. Care, does the Board make the best use of Board and committee meetings? If not, how might these be improved? Are there some decisions, activities or subject areas on which the Board should spend more or less time? Do we have the right committee structure?
- Assuming that the L.A. Care Board is performing reasonably well and getting good commitment and service out of its members, individually and as a group, what lies behind that success? What factors or processes help get the most of our board members?
- Are there things that might be done to increase the capacity and desire of Board members, individually or as a group, to carry out their responsibilities? (E.g., Orientation, training, two-day retreat?)
- Recognizing the changes in L.A. Care, its responsibilities and its environment, what skill sets are now required on the Board? Are the designated appointing organizations and the directions given to them, in terms of Board appointments, likely to produce a Board with those skill sets? If not, what adjustments might be considered?
- Given the constituency make-up of the Board, are there some constituencies that should have representatives on the Board, at least on a rotating or occasional basis? Are there any that should not?

**Notes:**
Governance for Nonprofits

From Little Leagues to Big Universities

A Summary of Organizational Governance Issues and Principles for Directors of Nonprofit Organizations

Society of Corporate Secretaries & Governance Professionals
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BOARD OF DIRECTORS/TRUSTEES

Basic Board Responsibilities

Some nonprofits are organized as nonprofit corporations with a board of directors, others as trusts or foundations with boards of trustees. Whatever their name, these governing bodies have similar responsibilities. Their function depends on the size and goals of the organization. The larger the organization and the greater the professional staff, the less “hands on” the board will be. However, directors or trustees of smaller organizations may, by necessity, find themselves more involved in the day-to-day operations.

Basic board responsibilities include:

1. Determining the organization’s mission and purpose.
2. Selecting the chief executive.
3. Providing proper financial oversight.
4. Ensuring adequate resources.
5. Ensuring legal and ethical integrity and maintaining accountability.
6. Ensuring effective organizational planning.
7. Recruiting and orienting new board members and assessing the board’s own performance.
8. Enhancing the organization’s public standing.
9. Determining, monitoring and strengthening the organization’s programs and services.
10. Supporting the chief executive and assessing his or her performance.

These responsibilities are largely discharged through meetings of the board and its committees, during which there are group discussions, and the adoption of resolutions passed by directors present at the meetings. The concept that directors act as a body is important to keep in mind in joining a board. Individual directors generally have no authority to bind the organization or take action on its behalf unless they have been given delegated authority from the board. That said, some of the work of the board may be accomplished outside of board or committee meetings. Many boards expect that directors will serve as advocates for the organization throughout the community. Board members may be asked to represent the organization in public meetings. And, in order to act effectively as a director, it may also be necessary for individual directors to meet outside of board meetings with managers, employees, clients, donors, other board members, and other constituents.

Legal Obligations of the Board

In conducting the business of an organization, directors have certain legal obligations. Failure to observe these obligations may subject nonprofit directors to liability. It’s a mistake to believe you can’t be sued just because you are a volunteer director serving an organization with a great cause.

Exemptions from state taxes, such as sales taxes, are available in many states, but the rules and procedures necessary to obtain these exemptions vary from state to state. Nonprofit organizations typically work with professionals for help in establishing and maintaining their federal and state tax-exempt status.

**Personal Qualities of Effective Board Members**

**a. Fundamental Characteristics**

Great boards don’t just happen. It takes a lot of work to make a board effective. That work begins with selection of individual board members who, regardless of the type of organization, have certain fundamental characteristics:

- **Vision and Leadership**: the ability to see the big picture, and to help create and, if necessary, re-set strategy and policy to help the organization achieve its mission.

- **Advocacy, Stewardship and Integrity**: the ability to serve and promote the interests and goals of the organization without forgetting the interests of the public and the organization’s intended beneficiaries.

- **Knowledge**: the willingness to become thoroughly familiar with the mission and how the organization actually carries out the mission day-to-day through its organizational structure and operations.

- **Personal Commitment and Diligence**: the willingness to take the necessary time and make the necessary effort to fulfill director responsibilities, including understanding strategic, financial and operational issues facing the organization, asking questions and following up as needed, engaging personally with the organization, whether through financial support, advocacy, networking, personal service, or other personal support activities, and staying current on sound governance principles and working to apply them to the organization.

- **Collegiality**: the ability to work well with others and to show respect for the ideas and views of fellow board members and staff; the understanding that boards operate as a body.

Beyond these fundamental characteristics, nonprofit boards typically seek directors with particular backgrounds or types of expertise, financial capacity, positions in the community, or access to key constituents or professionals that can be helpful to the organization. In recent years there is a trend for boards to seek individuals representing specific ethnic or minority groups, or women, so that the board has an ethnically or gender diverse membership. One effective way to help make sure that boards are sourcing directors who meet the needs of the organization is for the board, or nominating committee, to create and maintain written criteria for board membership focusing on key characteristics being sought and, in addition, to conduct an annual review of the strengths and weaknesses of the existing board so that future recruiting can focus on the organization’s needs. (The Society website — [www.governanceprofessionals.org](http://www.governanceprofessionals.org) — has samples of written criteria that have been developed by some nonprofit boards.)
Having a good understanding of a board’s criteria for membership, and the specific reasons why the organization has selected you as a director, can go a long way in helping you determine whether service on a particular board is right for you. Don’t be afraid to ask! This is particularly true with respect to financial commitment expectations, or for operating boards, anticipated time commitments. Understanding these matters at the outset can help keep embarrassing situations from arising as a result of mutual expectations not being met.

Similarly, understanding the board dynamic, how board members work together and with staff, is an important topic to explore in advance of joining a board. In the nonprofit world, founders of an organization may still be involved and cast a long shadow over board deliberations. Sometimes organizations may be in a period where there is a disconnect or distrust between the board and current management. Sometimes the sheer size and diversity of members on a board may make communication and consensus difficult. Sometimes the number of “old guard” board members may inhibit participation by new members. Occasionally, lack of staff may limit time and attention that are given to directors or to board matters by management. While none of these issues may be enough to discourage you from joining the board of an organization you care about, understanding how things are can make it easier for you to understand the nature of the task facing the board in achieving good governance.

b. Personal Commitment

Your own ability to be effective as a director is another factor to take into account in considering board service. Expertise, reputation, financial donations and support may have played a role in your being asked to join a board. They alone do not make you a good director. Although there is no magic formula for being a good director, there are a number of actions and practices which are generally considered to represent excellence in board service, including the following:

- Understanding the mission of your organization and helping to keep it current and relevant.
- Becoming familiar with the organization’s basic governance documents.
- Staying current on governance trends.
- Staying current on business and societal issues that may affect the operation or mission of the organization.
- Attending board and committee meetings regularly.
- Actively contributing to the work of the board and the organization.
- Reading board and committee materials in advance.
- Asking questions at meetings on issues you don’t understand.
- Offering suggestions and comments in a positive manner.
- Avoiding micromanaging or nit-picking.
- Being respectful of the management team and other directors.
- Being collegial; refraining from dominating meetings or personalizing debate.
- Supporting the chair in efforts to keep meetings moving.
- Keeping questions and comments relevant.
• Knowing key staff and their roles, but refraining from contacting lower level staff without advising the executive director.
• Meeting periodically with the executive director.
• Getting to know the other board members.
• Supporting the organization financially.
• Attending functions of the organization in the community.
• Helping raise funds from others for the organization.
• Being an advocate for the organization in your community.
• Engaging others in the work of the organization.
• Keeping alert for warning signs of potential trouble—disaffected directors, arrogant or ineffectual executive director, sloppy reports, lack of forward momentum, poor accounting, shortage of funds, etc.
• When you have concerns about the organization or board or staff, raising them with sensitivity to the appropriate person (board or committee chair or executive director) and working to correct the problems.
• Knowing when it’s time for you to rotate off the board in order to help keep the board fresh and viable.

Comparing your performance against these actions and practices will give you a good idea of whether the organization you serve will consider you a valued and effective director.

Board Structure and Operations

The size and sophistication of the organization and the size and function of the board (i.e. governing/oversight board or operating/hands-on board) tend to determine how often a board meets and whether a majority of the work is done at board meetings or through committees of the board.

In the corporate for-profit arena, the trend has been to reduce the size of boards to allow for greater discussion and interchange and to increase efficiency and accountability. However, in the nonprofit world, particularly with respect to educational and arts organizations where directors play a major role in fundraising and the desire to engage a wide variety of constituencies is common, it is not unusual to have boards with 30 or more members, and sometimes as many as 75-100 members. Boards of this size clearly must rely on committees to do much of the work on behalf of the board, either with delegated authority to act on behalf of the board, or with a mandate to present well-vetted recommendations to the board to facilitate full board action.

Committees vary with the needs of each organization. Smaller boards may not need committees and may perform many of the functions mentioned below at the board level itself. However, fairly typical standing committees (i.e., committees which stay in existence year after year) would include:

• The Executive Committee—empowered to act between board meetings if necessary, and sometimes with specifically delegated authority to act in particular areas on behalf of the full board. The make-up of executive committees will vary with the
organization, but many such committees are made up of the board officers and committee chairs.

- The Finance Committee—typically assigned to provide detailed review of financial statements and issues, including budget, accounting, tax and investment issues, and, if there is no separate audit committee, audit issues.

- The Nominating/Governance Committee—typically charged with finding and recommending new directors for board approval, but sometimes also charged with recommending officer and committee appointments, establishing criteria for board service, reviewing performance of existing directors, and providing orientation for new directors. Some nonprofit nominating committees have taken on the additional role of reviewing and making recommendations on governance issues and otherwise playing a leadership role in shaping the nonprofit’s corporate governance.

- The Development Committee—typically oversees the fund raising process of the organization.

Larger boards and organizations may also have additional committees, such as:

- The Audit Committee—responsible for oversight of the independent audit process and for overseeing the financial integrity and finance/accounting controls of the organization. The trend is for members of audit committees to be “independent” board members (i.e., with no significant financial or other relationship to the organization), and to have substantial financial expertise (i.e., experience in reading financial statements and at least one member with an understanding of accounting principles and practices). Audit committees and their membership may be legislatively mandated in certain states for organizations of a certain size.

- Personnel Committee—typically charged with overseeing the development of compensation and benefit programs and guidelines for any paid staff. In some cases, this committee actually approves salaries of the top executives, reviews their expenses, and oversees their formal evaluation. Committee or board approval of the executive/managing director’s (i.e. CEO-equivalent) salary and expenses may be legislatively mandated in certain states for organizations of a certain size.

- Investment Committee—responsible for oversight of the investment of funds, typically endowment funds, of the organization and for creating or recommending investment policies.

In addition to standing committees, many boards create ad hoc committees for particular, short term projects. Typical examples would include a strategic planning committee when the organization’s strategic plan needs updating, or a facilities committee when new premises are needed, or a search committee when a new executive director is sought.

Regardless of the role of standing or ad hoc committees, their effectiveness can be improved by making sure that each one understands its mandate. An excellent way to achieve this is to create written charters for each committee. Some organizations include these charters in their
bylaws. (The Society has sample charters.) Effective staffing of committees by management can also help committees function more efficiently.

Committees also need to report all their activities to the full board, so that body is aware of their work. Depending on the size of the board, or the tradition of the organization, reports can be oral or written.

Nonprofit boards frequently add non-board members to committees, either to broaden the expertise of the committee or to provide an opportunity for getting to know potential board candidates before nominating them for a director role. State law varies on whether such non-director members can actually participate as voting members.

Effective Meetings

Effective meetings can mean the difference between an engaged, effective board and one that doesn't accomplish much. Running effective meetings is the role of the chair, whether of the board or of a committee. This is an art, in many ways dependent on the interpersonal skills of the chair. However, there are certain basics which can help:

- Written agendas focus everyone on the matters to be covered and aid the chair in keeping the meeting on schedule. Agendas are typically developed jointly by the chair and the executive director (or in the case of committees, the staff person assigned to support the committee chair).
- Limiting agenda items helps allow for adequate discussion.
- Focusing principally on strategic and forward-looking issues, rather than reviewing past history, helps keep meetings interesting for board and committee members, and makes the discussion more useful to the organization.
- Providing regular opportunities for discussion of the work of the organization and offering directors key insights into substantive issues allows directors to learn more and to feel more connected to the organization.
- Using executive summaries and cover memos to help guide board and committee members through financial statements or other reports can help focus attention on important issues and eliminate confusion and the need for time consuming questions.
- Using written reports rather than oral reports from committees can be an effective way to deliver a great deal of information without taking much time at board meetings.
- Gathering routine, general business items all together at either the end or beginning of the meeting (sometimes referred to as the 'consent agenda') allows the board or committee to act quickly and all at once on matters that don't require much discussion.
- Having draft resolutions prepared in advance and distributed to directors prior to a vote helps insure that everyone clearly understands what action is being requested.
- Maintaining order, not allowing small side discussions, or dominance of discussion by a small group, helps keep everyone focused and the meeting moving.
• Establishing a culture of open discussion, respect for all views, and free exchange of
information, helps ensure that all views are heard and no one is intimidated.

• Holding regularly scheduled executive sessions (where some or all members of staff
are excused from the meeting) provides an opportunity for directors to ask questions
or raise issues they might not feel as free to do in the presence of management and can
help ensure that such concerns are surfaced and addressed in a timely manner.

• Documenting actions of the board in concise, written minutes not only facilitates
tracking of board actions, but also provides a useful mechanism for keeping directors
who could not attend a prior meeting informed and up-to-date on board
deliberations, particularly if draft minutes are sent out promptly following a meeting.

• Meetings between the chair and the executive director promptly after a board meeting
to discuss what went well, what needs to be improved, and what follow up is needed,
helps create both improvement and continuity from meeting to meeting.

Sample meeting rules and sample meeting agendas are provided later in this booklet, along
with some tips on the writing of minutes.

Building and Maintaining an Effective Board

Effective boards come in many forms, but they generally have several things in common:
They understand the business or mission of the organization; they help move the
organization’s business or mission forward; and they understand and operate in accordance
with legal and fiduciary responsibilities. Increasingly, nonprofit boards are adapting
governance practices from the for-profit arena to help them maintain or improve their
effectiveness. While good governance practices cannot absolutely assure board or
organizational effectiveness, they certainly can help make it more likely than not that the
affairs of an organization are well-managed.

Dysfunctional or ineffective boards are usually easy to spot. Typically they are characterized
by one or more of the following:

• The board does not have, or does not abide by, a regular meeting schedule.

• At board meetings nothing much happens, and many board members don’t attend or
are disaffected.

• Directors don’t understand the mission or business of the organization and aren’t
passionate about either.

• Directors don’t understand the financial underpinnings of the organization.

• Directors attempt to micromanage the staff.

• There’s a lack of trust and confidence between the board and management.

• Directors or management speak disrespectfully of others on the board and/or of
management.

• Directors or management speak publicly, without permission, about confidential
board matters.

• A few directors dominate meetings.
• Directors don’t understand basic governance principles.
• The organization is floundering.

To help gauge the effectiveness of a board on which you serve or are thinking of joining, try asking the following governance-related questions:
BOARD EVALUATION

YES NO

☐ ☐ Does the board get enough information of the right kinds, at the right time, from the right members of management?

☐ ☐ Does the board have an effective director-orientation program?

☐ ☐ Does the board have active committees composed of a small, effective number of members to tackle audit, development/fund-raising, finance, governance, nomination, personnel, program and other key matters?

☐ ☐ Does the board rotate committee members and chairs at appropriate intervals?

☐ ☐ Are meetings conducted effectively, with appropriate frequency, on time and according to well-thought-out agendas circulated in advance?

☐ ☐ Are meetings characterized by open communication and diligent questions discussed in a collegial manner?

☐ ☐ Does the board meet regularly in private apart from the executive director and other managers?

☐ ☐ Are the board's actions motivated by and designed in furtherance of the organization's mission?

☐ ☐ Does the board periodically review the organization's mission statement and implementation strategy?

☐ ☐ Does the board act as if it is accountable to contributors and beneficiaries?

☐ ☐ Does the board communicate effectively on a regular basis with its stakeholders, contributors and beneficiaries?

☐ ☐ Does the board establish goals for the chief executive and review his or her effectiveness and performance on at least an annual basis?

☐ ☐ Does the board have effective processes and structures to evaluate, communicate with and counsel the chief executive?

☐ ☐ Does the board have guidelines for managers clearly specifying their authority?

☐ ☐ Does the board micromanage the organization’s operations or, at the other extreme, does it ignore them and let management handle everything with little board oversight?

☐ ☐ Has the board reviewed the operation’s significant legal exposures and assessed the organization’s legal compliance processes and record?

☐ ☐ Does the board have effective audit and financial oversight processes?

☐ ☐ Does the board review and adopt the organization’s capital and operating budgets?

☐ ☐ Does the board have clear and effective procedures on handling funds, contributions and assets?

☐ ☐ Does the board have effective standards and procedures to minimize and disclose potential conflicts of interest?

☐ ☐ Does the board governance and nominating committee regularly assess board practices and structures for effectiveness; evaluate current directors and counsel those whose performance is less than ideal; and continually look for talented potential new directors?

☐ ☐ Does the board have an appropriate level of turnover in its membership -- new members and ideas balanced with experience and continuity?
If you end up with a number of "no" answers, it may be time to suggest a board-effectiveness study. Conducting regular board-effectiveness studies can keep boards from drifting into dysfunctional behavior, help cure them if they are already there, and also help increase the effectiveness of already effective boards. Furthermore, the effectiveness of boards and the implementation of good governance practices are now both of great interest to funders of nonprofit organizations, making it ever more essential for nonprofits to focus on strengthening their governance and their board effectiveness. A board-effectiveness survey:

- Polls the board on a number of issues related to the effective operation of the board, focusing on both substance and process.
- Provides a base line for looking at how the board itself believes it is doing, and for comparing board practices to those of other boards and to governance trends.
- Becomes a starting point for making adjustments and improvements.

The process is relatively simple: A series of questions is developed by the director appointed to lead the project, with input from management and other directors, and if desired with assistance from an outside consultant. Questions typically range from the level of "housekeeping" (e.g., time, place and length of meetings) to the more substantive (e.g., what do you think are the critical issues facing the organization in the next two years?). These questions are used as the basis for eliciting information from directors, although it is common for the answers to bring up issues beyond the questions asked. More detailed and representative results will be obtained by using face-to-face interviews rather than written responses to questions and by interviewing as many of the full board as possible, although that process can be quite time consuming. In addition, responses must be summarized in a format that will be useful to the board and also protect the confidentiality of those who participated.

Once results are summarized, they are shared with the board and a process created for follow-up and adjustments to board procedures and organization. Most effectiveness surveys will not be self-executing, but require changes in how committees or the board operate, who is on the board, what is expected of board members, etc. Issues raised in the survey may need to be worked on by a variety of board committees. But the effort can be well worth it if it improves the effectiveness of the board.

Even without a board-effectiveness study, there are a number of steps which can help improve board effectiveness, including one or more of the following:

- Make a board committee responsible for governance issues:
  - Possibilities include the executive committee, nominating committee, or a separate governance committee.

- At least once a year, have the committee responsible for governance:
  - Look at external trends in governance.
  - Compare trends to board practices.
  - Recommend adjustments as needed.
  - Inform the board about its legal/governance responsibilities.
• Review articles of incorporation, bylaws, committee charters, the board’s own governance guidelines and key policies to make sure:
  - They meet changing governance and legal requirements/standards.
  - The organization actually conducts its affairs in accordance with those documents.

• Create a written document outlining expectations or responsibilities of directors:
  - Be specific, especially about time and money expectations.
  - Have the full board approve it so all directors know exactly what is expected.
  - Use this in recruiting new directors.

• Define other roles:
  - Define the role of the board—is it an operating board, a governing board, does it set strategy, hire/fire the CEO, review finances, approve budgets, etc. Write it down!
  - Create written job descriptions for executive management.
  - Create written job description for the board chair/president.
  - Create written charters for board committees.

• Define what you are looking for in board members:
  - Be rigorous in seeking board members who meet these criteria.
  - Determine an optimum size for the board and do not allow it to become too large or too small.
  - But save a little room to be opportunistic.

• Review who is on the board in comparison to what you need/are looking for:
  - What background and skills do they have?
  - How engaged are they—time, money, attendance, etc.?
  - How do they compare to what you need?

• Establish a process for meeting with directors to re-engage those not meeting expectations or to prepare them to leave the board.

• Consider establishing term limits to ensure that there is always “new blood” on the board.

• Create active dialog with management so the board stays informed:
  - About the accomplishment of the organization’s mission and day-to-day operations—what’s happening: good and bad.
  - About the organization’s financial situation—compare budget to actual performance, conduct tutorials on how to read/understand financial statements (don’t take financial expertise for granted).
  - About the organization’s competition.
  - About the organization’s strategy.
  - About executive management’s “dreams.”

• Keep board members engaged—make sure meetings give them something they can’t get except for being on your board and participating in board meetings.
• Keep committees meaningful and helpful:
  - Review the need for each standing and ad hoc committee annually. Is the
    charter still viable, is the committee actually doing what it is supposed to, is it
    helpful to the board or to management, or a drain on resources?
  - Establish committee goals annually and have committees report on what was
    accomplished by year-end.
  - Rotate committee members to avoid entrenched thinking and to spread
    expertise.

• Establish a board orientation process for new directors and a “board book” to help
  them get up to speed quickly. Such an orientation might include:
  - Meetings with key staff to understand the role of their departments and
    strategic issues facing the organization.
  - Meetings with the chair of the board and committee chairs.
  - Delivery of a book containing key organizational documents, such as the
    organization’s charter, bylaws, mission statement, annual tax report, code of
    conduct or conflict of interest policy, other critical board policies, any written
    expectations of directors, contact information for other directors and key staff,
    and perhaps a “glossary” of terms and acronyms used in the organization that
    outsiders might not know.

Do all these ideas sound too daunting? Well, building and maintaining an effective board is
not a process that happens overnight. It requires leadership from both the executive director
and the chair, or another member of the board. The good news is that building an effective
board can be done in stages. If your organization is not ready for some of the effectiveness
practices described above, start with one or two—perhaps strengthening agendas so they
focus on strategic, important issues based on both director and staff input, or strengthening
the board based on clear criteria developed jointly with the board. With leadership from the
chair or another senior director and executive director it’s relatively easy to bring the board
into the process of improving governance over time. Without such leadership, nothing much
is likely to improve.

Making Board Service Fulfilling

As suggested at the beginning of this document, board service on nonprofits can be fulfilling
and engaging, or the opposite.

Following is a checklist which summarizes a number of the issues that you may want to
consider in reviewing directorship opportunities or in examining your role as a director of a
nonprofit. This checklist is not necessarily all inclusive, but reflecting on the issues raised in
this checklist can help you determine whether you want to join a particular board or, if you
are already on the board, whether there are important issues that may need to be addressed
either personally or organizationally.
Date: July 19, 2012

Committee: Executive

Chairperson: Walter A. Zelman, PhD

Motion No. BOG 100.0712

Issue: Approval of entering into a Joint Exercise of Powers Agreement between L.A. Care Health Plan and Los Angeles County to establish L.A. Care Health Plan Joint Powers Authority.

Background:
To maximize revenue and minimize the Managed Care Organization gross premium tax (“MCO Tax”), which was assessed upon L.A. Care and other California health plans under the terms of California Revenue & Taxation Code § 12201 through July 1, 2012, this motion will delegate authority to L.A. Care’s CEO to enter into a Joint Exercise of Powers Agreement (“Agreement”) between L.A. Care and Los Angeles County to create L.A. Care Health Plan Joint Powers Authority (“JPA”). This motion and the establishment of the JPA will be contingent on the extension of the MCO Tax (or similar tax) beyond July 1, 2012. The primary role of the JPA would be to operate a Knox-Keene licensed health care services plan in Los Angeles County that would enroll members of L.A. Care’s non-Medi-Cal lines of business (including without limitation In Home Supportive Services workers, Healthy Kids and Healthy Families program members).

The JPA would reflect the same governance and same Board members as the Board of Governors for L.A. Care. Los Angeles County would appoint the same individuals it has nominated and appointed to L.A. Care’s Board to serve as its representatives on the JPA’s Board. L.A. Care would appoint the remaining L.A. Care Board members (who were nominated by entities other than Los Angeles County) to the JPA’s Board. The JPA would operate under the same general rules, privileges, laws and restrictions applicable to L.A. Care, and all applicable L.A. Care policies and procedures would apply to the JPA.

The JPA would be capitalized by funding from L.A. Care. Any surplus revenue of the JPA would be used by the JPA, returned to L.A. Care, or otherwise distributed in accordance with the terms under the Agreement to be negotiated. Under the Agreement L.A. Care would serve as a guarantor and Los Angeles County would not be liable for any debts or liabilities of the JPA; as required by California’s Department of Managed Health Care.

The JPA would be operated by L.A. Care pursuant to a separate management and administration services agreement to be negotiated and executed after formation of the JPA. It is contemplated that the JPA would be managed and administered by L.A. Care personnel. L.A. Care would receive reimbursement from the JPA for services rendered, as limited by terms of the Agreement and the administrative services agreement to be negotiated.
**Budget Impact:** Administering the non-Medi-Cal lines of business through the JPA will minimize the MCO Tax that may continue to be levied on L.A. Care, which could result in significant cost savings for L.A. Care. The approval to establish the JPA has minimal direct cost other than staff time in preparing the agreement, related regulatory filings and other components to implement the JPA. It is contemplated that L.A. Care will be reimbursed by the JPA for costs of management and administration of the JPA by L.A. Care personnel.

**Motion:**

1) To approve entering into a Joint Exercise of Powers Agreement (“Agreement”) between L.A. Care Health Plan and Los Angeles County to establish L.A. Care Health Plan Joint Powers Authority (“JPA”) to serve as a new Knox-Keene licensed health care services plan which will enroll members currently enrolled in L.A. Care’s programs other than Medi-Cal, and any new programs or lines of business which may be developed by the JPA, subject to the extension of the Managed Care Organization (MCO) Tax or similar tax beyond July 1, 2012; and

2) To authorize and delegate to Howard A. Kahn, CEO, discretionary authority to negotiate, enter into and execute the Agreement, and to take any necessary actions and execute any necessary documents relating to the Agreement and the JPA.