HCMC GOVERNANCE TASK FORCE

REPORT AND RECOMMENDATIONS TO THE HENNEPIN COUNTY BOARD OF COMMISSIONERS

SEPTEMBER 2, 2003

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Acknowledgments

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EXECUTIVE SUMMARY

In April 2003, the Hennepin County Board created a Task Force and charged it with the responsibility of recommending a governance structure for the oversight of the Hennepin County Medical Center ("HCMC"). The stated purpose of any recommended governance structure was "to maximize the effectiveness and the efficiency of HCMC, while meeting its mission as a public safety-net, teaching hospital."

Throughout the summer, the Task Force has met bi-weekly and studied a great deal of material, some relating to national trends in public hospital governance, and some related to HCMC specific issues. As a result of that study, the Task Force is now prepared to report its findings and recommendations to the County Board. In doing so, the Task Force highlights that the County Board did not ask for, nor does the Task Force recommend, any change in HCMC's mission. HCMC's service as a public safety net, teaching hospital, providing high quality health care for multiple constituents is a vital resource in our community; one that should be preserved. However, the Task Force believes HCMC's mission cannot be preserved by leaving things the way they are. There are too many challenges in the delivery of health care services to believe HCMC can continue to maintain its mission without increased flexibility and agility. There are and will continue to be serious financial issues in HCMC's future. A change in governance will not, by itself, solve those financial issues, but it will give the institution the flexibility it needs to meet those challenges.

A summary of the Task Force Findings are as follows:

- HCMC is an outstanding health care provider;

- The mission of HCMC as a public safety-net, teaching hospital is critical to the needs of the community, particularly as it relates to the provision of indigent care;
- Financial resources for HCMC's mission have been and will continue to be severely impacted by reductions in federal and state funding for many of its mission-driven initiatives; and
- The status quo puts HCMC's mission at risk; the current governance model does not provide the diversity or experienced oversight needed for a large, complex institution in so dynamic an industry.

A summary of the task force's recommendations is as follows. The Task Force recommends that Hennepin County:

- Create a not-for-profit corporation with a diverse and experienced board, which will hold management accountable for maximizing the effectiveness, efficiency and operation of HCMC, while meeting its mission as a public, safety-net teaching hospital;
- Accelerate capital expenditures to bring technology and physical plant to competitive levels; and
- Enter into an agreement with HCMC providing reimbursement for indigent care on a formula basis rather than funding deficits.

1. Background to Task Force Review Project

a) Purpose

The Hennepin County Board of Commissioners ("The County Board") established the HCMC Governance Task Force ("Task Force") by Resolution No. 03-4-132R1 (*Exhibit 1: Resolution*). The Task Force was charged with the responsibility of studying hospital governance and existing laws in order to recommend a new governance structure for Hennepin County Medical Center ("HCMC").[1] The stated goal of the task force was to find a structure that would "maximize the effectiveness, efficiency and operation of HCMC, while meeting its mission as a public safety-net, teaching hospital serving the needs of its multiple constituents."[2] In addition, the County Board asked the Task Force to address the following:

- Guidelines for determining roles and responsibilities between the County Board and any oversight or advisory board recommended by the Task Force.
- To the extent that the Task Force recommends an advisory or oversight board, such recommendation shall include the roles and responsibilities of its members, their method of selection, tenure and other relevant matters.

The Task Force has reviewed the scope and nature of certain strategic operating challenges and threats at HCMC that catalyzed the formation of this Task Force (*Exhibit 2: Strengths, Weaknesses, Opportunities, and Threats Analysis*). It has studied hospital governance, national and local health care trends, Minnesota Statutes, existing County policy, and the division of control between Hennepin County and HCMC. This Report summarizes the Task Force's conclusions and recommendations.

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[1] Resolution No. 03-4-132R1
[2] ibid.

The Task Force wants to ensure the services vital to the community HCMC serves are continued and improved. The Task Force recommendations are neither an attempt to provide HCMC with operational guidelines, nor solutions to every concern identified during the review process. Rather, the recommendations are an attempt to provide the organization with a governance structure that will offer HCMC increased strategic and operational flexibility, while maintaining access to capital and County trust. The Task Force believes an alternative governance model can continue HCMC's provision of excellent care, while enhancing its ability to be more efficient and financially viable.

The Task Force was not asked to modify the mission or service delivery model of the hospital and the Task Force affirms the importance of HCMC maintaining its role as a safety net teaching hospital. The Task Force believes that its recommendations are necessary to preserve HCMC's mission, which is more likely threatened by a failure to address governance issues, than by making any of the suggested changes.

b) Members

The County Board selected the 14-member Task Force. They represent a broad range of constituents, backgrounds and disciplines. The Task Force is composed of a diverse group with various attachments and affiliations to business, civil rights, corporate governance, finance, government, health care management, law, organized labor, and HCMC itself. The Task Force has reached a consensus on the recommendations in this Report.

c) Approach

Since its first meeting on May 20, 2003, the Task Force has held six bi-weekly meetings; a series of staff review and planning meetings, a public hearing; and a meeting with selected leaders of community clinics.

The members have discussed the issues that impact HCMC, aspects of the health industry, alternative structures of governance, policy and legislative options, and strategies to deal with HCMC's pending financial and operating challenges in face of competitive market threats from third party payers and private sector hospitals. Throughout this process, administrative staff at HCMC, as well as various consultants and attorneys, including lawyers in the County Attorney's office, have advised the Task Force.

The public hearing was held on July 21, 2003, mid-way through the Task Force meetings to provide a forum for interested parties to share their perspectives on the mission and role of HCMC and its future governance *(Exhibit 3: Public Hearing)*. Findings from the public meeting are considered in the recommendations to the County Board.

The Task Force also convened a meeting on August 11, 2003 at the offices of the Minneapolis Urban League to provide a forum for community clinic leaders to offer concerns from a broader patient group. The meeting was attended by the Task Force Chair, two members of the Task Force and several community leaders. The Task Force felt this provided an opportunity for representatives of various populations, (primarily minority populations) to voice their views on the services provided by HCMC.

2. HCMC: A Highly Valuable Regional Resource

a) Background

Hennepin County Medical Center's history dates back to 1887 when it was founded as Minneapolis City Hospital. HCMC has been owned and operated by Hennepin County since 1963.

HCMC provides a comprehensive array of services, including primary and specialty care, and does this through the largest emergency department in the state (with 100,000 visits), inpatient services (including 23,000 admissions annually, and an average midnight census of 320 patients) and an outpatient clinics system with more than 375,000 visits annually. HCMC is comprised of 1.3 million square feet over four city blocks in downtown Minneapolis, and three off-site community-based clinics. Eighty percent of the patients seen at HCMC are residents of Hennepin County. Reflecting the highly specialized services at HCMC, patients from every county in the state are seen at HCMC. Sixty percent of HCMC's patients are persons of color.

HCMC is highly respected for the quality of its patient service, education, and research accomplishments. The documented clinical outcomes meet or exceed the community standard. HCMC is perhaps the only county hospital that has been named one of America's Best Hospitals by U.S. News and World Report for six consecutive years.[3]

HCMC plays important roles in the community and region. It is the only remaining "downtown" hospital in Minneapolis. Patient service volumes at HCMC have

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[3] "America's Best Hospitals: Exclusive Rankings in 17 Key Specialties", *U.S. NEWS & WORLD REPORT*, July 22, 2002.

never been higher, as the population continues to grow, age, and require hospital services. HCMC trains physicians, and aspiring health professionals in more than 50 clinical disciplines. HCMC employs more than 4,000 persons and represents a payroll of $200 million. HCMC is an enterprise department of the County, i.e. is at risk for its revenue stream from user fees. Less than 5% of HCMC's $400 million annual budget is derived from property tax dollars.

b) HCMC's Mission and Unique Role in the Community

The formal mission statement for HCMC, approved by the Hennepin County Board, is as follows:

> *Hennepin County Medical center is a public teaching hospital that provides outstanding health care services in an environment that promotes excellence in education and research*

As a public hospital, there is a clear commitment and legacy to "treat first", with payment considerations made secondary. Public hospitals are considered to be safety net providers, which are defined by the Institute of Medicine as those providers that organize and deliver a significant level of health care and other related services to the uninsured, Medicaid, and other vulnerable patients.

The unique role of HCMC in patient service is demonstrated in its mix of clinical programs, and through its payer mix. The needs of vulnerable populations drive the clinical and enabling services provided. HCMC is the exclusive provider of selected specialized services (e.g. hyperbaric oxygen, poison control), and is the Minnesota site that provides a plurality (if not majority) of specialized services (trauma, burn care, oncology, high risk obstetrics and neonatal care, crisis intervention, infectious diseases) to vulnerable populations. In Minnesota, there are public health care (insurance)

programs offered to low-income persons. The proportion of HCMC's patients covered by those programs approximates 40%; the State-wide average proportion in all hospitals is only 10%.[4] In addition, HCMC has by far the largest volume of uninsured patients in the State; there are 75,000 uninsured persons in Hennepin County alone.[5]

The unique and important role played by HCMC is further demonstrated in its stand-ready capacity, medical education, and research programs. HCMC is the designated Regional Hospital Resource Center and an integral component of the region's disaster preparedness program. HCMC's role in medical education is vital in providing physicians for both the metropolitan area and Greater Minnesota; nearly 50% of the State's physicians have had some or all of their clinical training at HCMC. The role that HCMC and its medical staff play in research is also important to our region, as those investigations in basic or clinical research are the foundation for the dissemination of clinical advancements to the region at large.

Again, it is important to note that the Task Force was not asked to and does not recommend any change in the unique and important role that HCMC plays in our community. To the contrary, the Task Force recommends that this role be continued, but believes that this role can only be preserved if certain challenges are successfully met.

3. National Health Care Trends

a) Motivation for Change

The original impetus for a study of governance for HCMC can be traced back to the passage of the Federal Balanced Budget Act in 1997, when payments to hospitals that are

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[4] HCMC demographics: Internal HCMC Payer Segment Analysis: State-wide demographics: MDH (MHA) data.

[5] Minorities Uninsured: Findings from the 2001 Health Access Survey, *Minneapolis Department of Health*, April 2003.

indigent care.[8] Numerous state and local funds are also undergoing cuts and reductions. With the gradual erosion of federal subsidies (both direct and indirect), local revenues become increasingly important to the future viability of safety net providers.[9]

Second, the number of uninsured individuals in the U.S. increased by 11 million over the past decade. The uninsured comprise more than 18% of the total, non-elderly population. This increase coupled with rising insurance costs relative to family income and the impact of welfare reform have greatly contributed to these worsening trends.[10]

Third, the full impact of mandated Medicaid managed care in a more competitive health care market place is still unfolding. The most likely effect of managed care is to steer Medicaid patients away from safety net hospitals, leaving such hospitals with proportionately more uninsured patients.

c) Identifying the Key Challenges

In the face of these major health care cuts and an increasingly competitive health care marketplace, hospitals have opted to find alternative structures of governance and organization to cope with the changes. The ten key challenges driving the search for new governance nationally are: [11]

1. Payer squeeze: Medicare, Medicaid, private
2. State constraints on County Budget
3. Increasing wages and operating costs
4. Need for working capital for innovations in research & medical education
5. Growing pharmaceutical and supply costs
6. Growing stand ready costs

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[8] The Balance Budget Act of 1997 cut Medicaid disproportionate share hospital payments by $10.4 billion over 5 years. See Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered,* Washington, DC: National Academy Press, 2000, p.2.
[9] ibid., p.9.
[10] ibid., p.5.
[11] McKinsey Report.

7. Tightening capacity/capital constraints
8. Growing service demands from target populations
9. Increasing IT investments for care, administration and HIPPA
10. Increased competition

4. Major Challenges at HCMC

In addition to reviewing national trends in public hospital governance, the Task Force reviewed existing laws and methods of operation applicable to HCMC. The Task Force concluded that, on balance, these laws and methods created significant impediments to the efficient and agile operation of the hospital, even though some of the laws offered the hospital distinct advantages.

Specifically, the Task Force noted that HCMC is subject to the following:

1. The hospital's employees are subject to Hennepin County's Human Resource System, which includes a classification system applicable to most of the jobs in the Hospital.
2. This system does not provide sufficient flexibility to respond to the competitive health care market environment and leaves the hospital at a distinct disadvantage. HCMC ranks significantly higher than benchmarks of other hospitals for both the number of full time equivalents/employees per adjusted occupied bed (FTE/AOB) and average hourly salary *(Exhibit 4: HCMC Operational and Financial Benchmarks)*. While the reasons behind these relatively high numbers was not the focus of the Task Force's charge, the reality is that they must be addressed and that operational flexibility will be required to successfully.
3. The County's financial procedures apply to the financial procedures of the hospital. Among other things, this means that the hospital administrator is only authorized to execute contracts involving less than $25,000, the county administrator is only authorized to execute contracts up to $50,000, and all other contracts must go before the Hennepin County Board for approval. This

results both in time delays and in a lack of accountability for contract negotiation and execution.

4. Until the 2003 legislative session, many of the positions in the hospital were subject to the "compression" factor created by the requirement that most all of the employees of the hospital receive less than the governor's salary.
5. The open meeting law applies to the hospital (with an exception for meetings discussing competitive information).
6. The Minnesota Data Practices Act applies to the hospital, (again with an exception for competitive information).
7. The hospital is subject to many of the constraints of Hennepin County's purchasing rules and regulations.
8. HCMC is ultimately governed by the elected Hennepin County Board of Commissioners, a body with responsibility for a host of governmental operations, ranging from roads to corrections to the protection of vulnerable children and adults. The demands of oversight over a system of 12,000 employees and $1.5 billion budget make it difficult for the County Board to provide the level of involvement and health care expertise most advantageous to an institution such as HCMC.

The Task Force concluded that each of these laws or methods of operation constrained, to a greater or lesser degree, the flexibility and competitive maneuverability of the institution.

Other laws, however, are distinctly advantageous to HCMC and its stockholders. These include:

1. HCMC may access the capital market through the County, and take advantage of the County's excellent bond ratings;
2. The Municipal Tort Liability Act limits HCMC's exposure to tort claims to $300,000 per claim and $1,000,000 per occurrence;
3. HCMC's employees are public employees who are therefore eligible for the benefits of the Public Employees' Retirement Act system (PERA); and

4. As a public hospital, HCMC is governed by the Charitable Hospital Act (CHA), which prohibits strikes.

After reviewing the national trends and local realities of public hospital governance, the Task Force spent considerable time trying to define the characteristics it would most value in a governance model for HCMC. The attributes it identified include the following:

1. That Hennepin County continue to own the hospital's assets, which it may choose to lease (net asset value of building and equipment is approximately $120 million).
2. That Hennepin County remain responsible for providing indigent care for its citizens, but that it pay for that care on a consistent formula negotiated with the hospital in a contract multi-year.
3. That the hospital continue to be able to access capital markets through County's borrowing capabilities and credit auspices.
4. That the hospital can create its own employment system, free from the regulations generally applicable to public employment.
5. That the hospital management be directly accountable to a new, focused hospital board.
6. That the new board and its management be empowered to create a culture of entrepreneurial performance at the hospital.
7. That the new organization have agility to respond to the rapidly changing health care market, and position itself in that market without the public scrutiny of its competitors.
8. That the new organization have the ability to joint venture and otherwise align its interest with strategic partners (including Hennepin Faculty Associates).
9. That the hospital be accountable to the public both for its mission and financial performance.

10. That the County be able to step back into management of the hospital should the new organization fail to perform either financially or on its mission.

Recognizing that this list of attributes may not be attainable in its entirety, the Task Force then looked at whether specific governance models could deliver on some or all of these attributes. The Task Force also looked at whether specific governance models might have other consequences which should be considered, such as whether the Municipal Tort caps would apply, or whether the hospital would remain subject to the Charitable Hospital Act. Based on that work, the Task Force turned to specific issues of governance.

5. Governance

a) Governance Trends

Governance is the platform that enables effective operation of an organization. Major governance changes (both institutional and operational) are often a necessary step to position safety net hospitals for success. In an attempt to determine how safety net hospitals are responding to the challenges presented by the changing health care financing environment, a *Kaiser Commission Report* (2001) on Medicaid and the Uninsured examined the circumstances surrounding five hospitals that underwent governance change and the outcome of the change *(Exhibit 11: Kaiser Commission, 2001).*[12]

The Kaiser Report concludes that overall administrative separation from governmental entities increases one's flexibility to operate and control costs at hospitals more effectively.[13] Governance change can permit hospitals to develop a competitive,

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[12] Niall Brennan, Stuart Guterman, and Stephen Zuckerman, "How are Safety Net hospitals Responding to Health Care Financing Changes?", *The Kaiser Commission on Medicaid and the Uninsured,* The Henry J. Kaiser Family Foundation, 2001.
[13] Ibid.

market-based salary structure for physicians and other professionals, to enjoy operational flexibility, and to support major capital improvements from operations.[14] Stable leadership at both the hospital and the county is a crucial step in improving a hospital's operating ability. Finding ways to maintain stable, high-quality leadership in locally controlled institutions is critical.

The health care marketplace is undergoing a major transformation characterized by a market-driven focus on competition, consolidation, cost control, and the ascendancy of managed care.[15] These financial pressures have forced safety net providers across the U.S. to adopt strategies to cope with the changing health care environment in an attempt to maintain their missions while protecting their financial margins.[16]

To survive these pressures, many administrators of safety net hospitals have had to restructure to focus on new revenue opportunities, reduce some services, and become more efficient through mergers and streamlining of internal operations. The number of public hospitals in the US has been decreasing for more than a decade through both conversions and closures *(Exhibit 12: Privatization of Public Hospitals).*[17] A National Association of Public Health and Hospital Systems (NAPH) member survey indicated that more than 66% of public hospitals have already undergone some form of restructuring to better manage the challenges facing Safety Net Hospitals *(exhibit 13: NAPH, 1996).*[18] In Minnesota, the percentage of hospitals controlled by state and local

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[14] Patricia A. Gabow, "Making a public hospital work", *Health Affairs,* 20(4), 2001, p.3.
[15] ibid., *America's Health Care Safety Net: Intact but Endangered*
[16] ibid., *America's Health Care Safety Net: Intact but Endangered.*
[17] The Economic and Social Research Institute, *Privatization of Public Hospitals,* Henry J. Kaiser Family Foundation, 1999, p.1.
[18] National Association of Public Hospitals and Health Systems, *The Safety Net in Transition: Reforming the Legal Structure and Governance of Safety Net Health Systems,* Washington, DC: National Association of Public Hospitals and Health Systems, 1996, p.8.

government has declined from 43% to 32% since 1994.[19] HCMC is the only publicly owned hospital in the 7 county metropolitan area. As most public hospitals are determined to preserve their safety net to care for vulnerable populations, alternative organizational and governance models have become a growing phenomenon in public service health delivery systems.

The source of this phenomenon stems from the desire to improve the competitiveness of the public health and hospital systems by moving away from certain constraints on the public hospital system such as government control. Competitors are often working with better information systems; more independent and entrepreneurial management; and more flexible use of scarce capital and human resources to better sustain their safety net missions. New governance can provide an important step forward, leveling the playing field as the safety net hospitals are forced to compete with private hospitals for scarce personnel, patient volumes and payer contracting terms.

b) Range of Governing Models

Determining an appropriate governing model requires an understanding of the goals and objectives of reorganization with a clear awareness of essential characteristics that must be met by any governance model. There are multiple variations of models that could be adopted to address the needs of a specific system. The following options are generic outlines. The models are listed in order of increasing autonomy.

HCMC Governance – Options Considered:[20]

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[19] AHA hospital statistics
[20] ibid., NAPH, 1996, p.8.

1. **Direct Operation by Local Government: Status Quo:** HCMC would continue to function with direct operational control from the County.

2. **Separate Board within Governmental Entity/Subsidiary Board:** A hospital board appointed by the County Board has authority to manage the daily operations of the hospital. This entails a higher degree of autonomy than direct operation by the County.

3. **Hospital District:** An independent instrumentality of the state government is created with taxing authority and defined geographic boundaries. A district is typically organized under generic state legislation. The board of the hospital district is usually elected by the citizens in the district.

4. **Non-Profit Corporation (a. Independent 501(c)(3) b. Public Benefit Corporation (PBC)):** A non-profit corporation is a charitable organization with a primarily public service role. Within the category of non-profit corporation are two variations, a public benefit corporation (PBC) and an independent 501(c)(3) corporation. A public benefit corporation is a distinct public corporate entity. While several states have a body of law applicable to PBCs, this model is generally developed with unique enabling legislation drafted to address the needs of the particular health system. Independent 501(c)(3) corporations are tax-exempt corporations, which establish a contractual agreement with the local government to sustain the provision of safety net health services. In some situations, the local government may retain some control over board appointments or other aspects of the 501 (c)(3) corporation.

5. **Contract with to a Private Hospital**: This model encompasses a sale, long-term lease to, or merger with, an existing hospital or health system. In this model, the private health care system may undertake contractual obligations to continue certain safety net services. This model is some times criticized because often, the local government does not retain a significant enough role in governance or operations to protect or enhance the safety net responsibilities of the institution.

6. Evaluating the Options

a) Implications of the Models

The Task Force received information concerning the implications of each of these governing options from its consultants and county staff. Each option was subjected to an analysis of the predicted changes and outcomes. The details of this analysis are compiled as a leverage analysis and are included as an exhibit to this report *(Exhibit 5: Leverage Analysis)*. The Task Force also examined the issues in terms of the likely regulatory/legal consequences of each organizational model *(Exhibit 6: Likely Regulatory/Legal Consequences)*. These analyses help differentiate the features of the models as a function of the criteria rated most important by the Task Force.

The governing options were also assessed in terms of their impact on key stakeholders. The Task Force acknowledges that there are many primary stakeholders concerned with the mission and overall operation of HCMC. The following is a partial list of stockholders with brief descriptions of the issues they may be most interested in.

1) **Patients and Community**: customer service orientation; platform for sustainable economic model; scope of service

2) **Employees**: job security; wages; pension benefits (PERA); and labor rules (Charitable Hospital Act vs. National Labor Relations Board)

3) **County**: reduced economic risk to taxpayers; sustain commitment to mission; permits focus on fewer functions; transitional costs; administrative services; e.g. there are cost allocations and services purchased by HCMC from the County

4) **HCMC Medical Staff (HFA)**: preservation of mission; aligned incentives

5) **Other Hospitals**: preservation of mission; competitive orientation

b) Rationale for the Elimination of the Status Quo, the Subsidiary Board, the Hospital District, and Private Ownership

The Task Force went through a deliberative process to reach a consensus about which models to recommend and which models to eliminate. The status quo, the subsidiary board, the hospital district, and private ownership of HCMC were eliminated as possible Task Force recommendations. The justification for these actions follows.

The current governing model at HCMC is one of direct operation by the County. A study by the National Association of Public Hospitals and Health Systems NAPH (*Exhibit 13*) recognizes that while some prefer this model due to its ability to retain close integration with public health functions as well as local government policies, its structure is often too restrictive to allow for the effective operation of a hospital and the efficient allocation of resources, employees, and costs.[21] Direct operation by the County provides the minimum level of autonomy to the hospital and therefore provides extremely limited operational flexibility. The Task Force, determined that maintaining the status quo will not allow the flexibility needed to be competitive in today's market and may lead to

[21] Ibid., NAPH, 1996.

continuing losses and foregone opportunities to maintain or improve existing services. Therefore, the **status quo** was determined to be unacceptable.

The alternative closest to the status quo, **the subsidiary board,** was deliberated and debated. The Hennepin County Board already has the authority to create a separate board of between 3 and 9 members for HCMC and to delegate some authority for HCMC's operation to that board.[22] Therefore, state legislation would not be required to create the subsidiary board. The County Board could, to some degree, customize the powers and authority they retain versus those that are delegated to the subsidiary board. This option would allow the County Board to retain control while obtaining more focused governance. However, a subsidiary board does not involve a substantial amount of relief for HCMC from government regulations. In particular, a subsidiary board does not provide the necessary flexibility to management and the work force to allow rapid changes in the mix and methods of service delivery. Nor would it provide a substantial change in the entrepreneurial nature of the establishment. HCMC needs a governing structure with a much clearer delegation of authorities that will allow it to enhance a performance-driven culture. The Task Force determined that this model lacks the desired level of autonomy and operational flexibility necessary to allow HCMC to compete more effectively in the hospital market.

A **hospital district,** defined as an instrumentality of the state government with taxing authority and defined geographic boundaries, does provide certain operating flexibilities and a greater degree of autonomy. A hospital district, however, requires legislation to be created and is subject to a variety of governmental regulations. In addition, a hospital district board is generally popularly elected and has taxing authority.

[22] Minnesota Statute Section 376.06

It seems unrealistic to think that there would be support for the introduction of a new governmental body with new taxing authority within the confines of Hennepin County. The Task Force therefore did not consider the creation of a hospital district as a viable model.[23]

At the far end of the governing spectrum from the status quo is **private ownership** of HCMC. Although discussed, the Task Force concluded that this option is not appropriate at this time. This form of governance would transfer a great deal of authority and control over the hospital away from the County. In the process, the County may lose control of the hospital's mission and its ability to provide high quality care, as well as its commitment of care to the indigent populations. The Task Force was concerned that the private ownership option might ultimately compromise the public safety-net mission that is a primary part of the County's mission for HCMC. The elimination of the private ownership option at this time, however, does not mean it cannot be pursued in later years, if sufficient progress is not made with the recommended model.

7. Task Force Recommendations

a) Proposed Actions

i. Create a New Corporation to Operate HCMC:

The Task Force recommends that the County Board entrust the operation and management of HCMC to a new non-profit corporation created by the County, reserving to the County selected powers to ensure, on behalf of the community, the preservation and enhancement of HCMC's mission and assets. The benefits of this proposal, and the reasons it is recommended, are that it preserves both the County's

[23] A hospital district is more effective in an environment where multiple municipal entities combined to create a hospital to serve the needs of multiple jurisdictions.

ownership of valuable physical assets and the County's control (via reserved powers and contract) over valuable public objectives (i.e., the hospital's mission to be a public safety-net, teaching hospital). At the same time, this proposal also provides the hospital with a more flexible and competitive governance structure. A new non-profit corporation offers the hospital the opportunity to create an organizational structure where the board of directors and management can better focus on the hospital's need, and where management accountability can be enhanced. In addition, a new non-profit corporate structure will provide the hospital with a greater flexibility in organizing its work force and business relationships to be much more competitive in the dynamic healthcare industry. Some of this competitive enhancement will come from the new entity being free to create its own human resources system, its own contracting processes and its own financial processes. Each of these freedoms will allow it to better compete in a rapidly changing, capital-intensive industry.

Having recommended that the County entrust management of HCMC to a newly created non-profit corporation, the Task Force further recommends that the County Board consider and choose between two alternative methods of creating that corporation. One alternative is to present the 2004 legislature with a specific detailed proposal to create a public benefit corporation for this purpose. The second alternative is for the County Board to create its own 501(c)(3) corporation. The Task Force recognizes that each alternative has certain risks and benefits, and concluded that the weighting of those alternative issues was best done by the County Board itself.

The public benefit corporation is a creature of statute and, therefore, can be shaped by the legislature in many different ways. For example, the 1986 legislation

creating the public corporation that subsequently operated the St. Paul Ramsey Medical Center stated that existing governmental employees who transferred to the new public corporation could elect to continue to participate in the PERA, but that new employees of the corporation would not be PERA eligible.[24] Similarly, that legislation established that the new corporation was a "municipality" for the purposes of fixing the limits of its tort liability, but not a "municipality" for the purposes of the uniform municipal contracting law.[25]

The potential flexibility of the public benefit corporation, as demonstrated by these examples, is one of its greatest virtues. The fact that the public benefit corporation can only be created by the legislature, however, introduces political considerations beyond the expertise of the Task Force. Included in these considerations is that the public benefit corporation legislation, once established, may not be easy to change. Suffice it to say that the Task Force recognizes that there is an uncertainty inherent in the legislative process.

The second alternative recommended for consideration by the County Board is the creation, by the Board, of a 501(c)(3) corporation for the purpose of operating and managing the hospital. In 2000, the legislature passed a law prohibiting counties and municipalities from creating corporations (profit or nonprofit) "unless explicitly authorized to do so by law."[26] This law does not appear to control in this situation. Another law which is specifically applicable to counties and municipalities owning hospitals, grants them the power of a nonprofit corporation relative to the delivery of

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[24] 1986 Laws of Minnesota Chapter 462, section 12, subds. 5 and 6.
[25] Id. Sections 18 and 19.
[26] Minn. Stat. Section 465.717 (2002)

health care services, and this authority includes the power to incorporate other corporations.[27]

Assuming, as we do, that Hennepin County therefore has the power to create a 501(c)(3) corporation to operate HCMC, other issues involving in this option arise. One of these is whether the hospital's workforce could be successfully transitioned from the county's employ to that of the new corporation. While there may be the legal ability to accommodate that shift, managing the attendant concerns of the labor force over issues such as pension benefits and job security will require a great deal of time and commitment by the County's leadership. In addition, the new 501 (c)(3) would lose its tort liability limitations. On the other hand, however, an independent 501(c)(3) would offer the hospital greater corporate autonomy and flexibility than would a corporation created by the legislature. This was not an option the Task Force wished to recommend to the Board unless the Board itself determined that it had the resources needed to make this model successful.

The distinctions between a public benefit corporation and a non-profit 501 (c)(3) corporation created by the County are nuanced and complicated, but also significant. The Task Force spent a good deal of time studying these alternatives and, as already noted, makes no recommendation as to which alternative the County Board may choose to pursue. Both legal [28]counsel and political judgment will be needed to make the choice, and it may make sense for this issue to be further studied by the Advisory Board whose creation is also recommended by this report. If so, a delegation to study this issue should be given to that Advisory Board.

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[27] Minn. Stat. Section 144.581, subd. 1(d) (2002)

[28] The Law Firm of Hogan and Hartson has done some work on this issue and could be asked for a formal opinion if the Board wishes to further pursue this alternative.

In summary, the Task Force recommends that a new corporation (either a legislatively created public corporation or a County created nonprofit) be established to enter into a long-term lease for the County's hospital assets. Through the structure of the corporation and the lease, the County can ensure that its mission objectives are preserved. Also through the lease, the County can secure the right to resume control of its assets if the new corporation fails to perform, financially or otherwise. The new corporation, however, offers the hospital a more focused board of directors, greater managerial accountability, and greater flexibility with which to compete in the dynamic health care marketplace.

ii. Board Structure and Composition:

A new board will govern the new HCMC organizational structure. The design of the new board should incorporate the following attributes:[29]

1. The County Board initially appoints 11-13 board members who serve staggered three-year terms that allow for only 3 terms for a total of 9 years service before leaving the board for at least one year.
2. Board Chair would serve two year term and would report to the County.
3. Subsequent board members would be recruited and invited to serve by the new HCMC board itself.
4. The board takes full responsibility for the day-to-day operations.
5. The board should be composed of diverse and experienced civic, health and business leaders that offer certain competencies needed for the effective discharge of the board's fiduciary responsibilities and to enhance the board's perspective and effectiveness.
6. The board would hire, support, evaluate, motivate and remove for cause the CEO for HCMC.

iii. County Reserve Powers

[29] McKinsey Report

The new corporation will operate HCMC on a daily basis independent of the County. However, the County reserves powers in the following areas:

1. The County will continue to own the assets of HCMC, with selected controls over the use and disposition of these assets;
2. The County must approve the board and budget on an annual basis;
3. The County will cede strategic and operational control of HCMC to the new corporation subject to only those oversight mechanisms essential to protect the mission and public's access to health services;
4. The County must approve any sale, transfer or related disposition of significant assets;
5. The County must approve any material changes in HCMC's safety net mission; and
6. The County reserves the right to regain full operational control of HCMC if any of the "performance triggers" specified in the lease occur. The triggers may include, for example, loss of accreditation or licensure.

iv. Financing Relations

In addition to the establishment of a new corporation, there are financial considerations that will be necessary to provide HCMC a level playing field in the competitive health care sector. These considerations include:

1. The County should enter into a long-term (5-10 years) agreement with HCMC's new governing body to create a consistent, volume-driven formula for indigent care that addresses its commitment to fully fund care for the medically indigent and vulnerable populations of Hennepin County. To the extent that residents outside of Hennepin County receive care at HCMC, the County should be encouraged to go back to the legislature to seek reimbursement for that care.
2. HCMC is to retain depreciation and earnings *(Exhibit 7: Capital Expenditures History)*. As an enterprise that is expected to be self-sustaining, HCMC should be allowed to retain the cash and other reserves accumulated through depreciation as well as positive operating margins and earnings.

3. To provide new governance with a fair opportunity to develop and implement programs and technologies needed for the long-term viability of HCMC, the County should:
   a) Provide a catch-up grant for the under-funding of capital improvements that has occurred during the last five years. Capital spending at HCMC is currently behind industry benchmarks. Historical depreciation expenses alone are not adequate to fund future capital needs, given evolving technology and inflation and yet, even by this metric HCMC is "under-capitalized" by $17.9 million. Comparisons against local and national hospitals also validate this perspective *(Exhibit 8: Comparisons of Capital Expenditures).*
   b) Provide grant funding necessary for working capital and transitional costs. In the aggregate, this catch-up funding for the transition, information technology, facility renovation, and development of new ventures is estimated to be $25-30 million. While the County should underwrite these costs, going forward capital expenditures will be paid for or retired through HCMC revenues.
4. The County should permit use of their balance sheet and credit rating as is deemed advisable for future capital requirements. However, HCMC will clearly be responsible for retirement of principal and interest incurred. The County has a strong credit rating and debt capacity that should enable HCMC to access, under favorable terms, needed capital for its expensive safety net mission, and to better compete with other hospitals in the market.
5. The County has ultimate title and oversight for the assets of HCMC. If HCMC were to accumulate deficits of $5 million, there should be quarterly financial reports submitted to the County. The County should fund HCMC's losses up to $10 million. If the cumulative deficit exceeds these losses, the County has authority to remove the board and reassert or delegate its operating role.

v. Human Resources and Labor Issues

The key to any proposed governance change is the willingness of the hospital's work force to accommodate a change in an environment to a more performance-based

culture. HCMC is a large employer with approximately 4,400 dedicated and highly skilled employees. *(Exhibit 9: Operating Expenses)* Its national stature is a result of the quality of HCMC's people.

The Task Force recognizes that workforce issues will be paramount in any governance change and recommends that everything possible be done to meet the legitimate concerns and interests of HCMC's employees, physicians and patients. This may require the County to replace PERA benefits for existing employees with a similar plan offered through the new corporation. It may also require an initial agreement from the new corporation to hire any existing employee who wants to move over. The Task Force recognizes this issue and implementation thereof specifically need to be studied further.

In any event, a real commitment to existing employees, physicians and patients must be communicated and substantiated, without encumbering the new corporation with the same problems and costs that currently exist.

b) Implementation Process

Sequence of Events

Transformation from the current governance structure to the new structure will require a great deal of focused effort. The Task Force recommends a small group (3-5) of current Task Force members and/or others be authorized by the County to oversee the implementation process. The major categories of activities (some of which will be conducted simultaneously, while others will occur sequentially)currently identified are the following: (1) County Board and administration processes, (2) legislative and state of Minnesota processes, (3) interim/transitional board formation, (4) strategic/business plan

summary, (5) personnel reorganization tasks (6) financial/budgeting tasks, (7) capital planning, (8) legal: legislation, contract review, other, (9) procurement policies, (10) information systems, and (11) affiliation agreements.

A timeline of events and objectives to begin the implementation process should be clearly defined. The tentative timeframe offered by the Task Force assumes that an initial six-month period is sufficient to seek the initial steps in creating the new entity. By April 30, 2004, either by legislators or lawyers, the entity should be formed. If the PBC is not formed by the end of legislation, the County should create a 501(c)(3).

Roles

The major operational changes under new governance should be made and be in effect by January 1, 2005. To facilitate the creation of the new entity over the upcoming sixteen-month period, a small group of individuals should be selected to drive the changes and deal with the detail. The small group should have the skills to and be responsible for addressing the transitional costs that will occur as a result of the change. The group will also work with the County to determine what services can be better purchased elsewhere and what purchasing constraints management might face.

The management team at HCMC must be held accountable to benchmarks set by the board. An entrepreneurial mindset among all employees is essential to drive changes in a way consistent with the mission. Management must assure that steady communication and trust evolves among employee groups. Together, they must align capabilities and incentives to create a performance-driven culture. Management must work with labor to create a more efficient human resource system. They need to find strategies to increase their operating productivity. Though the Task Force was unable to

determine the cause of HCMC's relatively high FTE/AOB and average hourly salary figures, it is clear that this is an area of significant cost differentiation against industry benchmark.

Costs

The transitional costs encompass legal fees, employee costs associated with the transition, communication, staff development, board formation, and hiring of consultants. These transitional changes are estimated to be in the range of $3-8 million. In addition, the County may incur allocation costs of up to approximately $3 million for services currently paid by HCMC to the County. Some of these allocated costs paid to Hennepin County include technology, infrastructure, and administrative fees *(Exhibit 10: Allocation Costs).*

Concluding Remarks

HCMC is an important county, state, and national asset for patient care, medical education and research. The Task Force believes HCMC's mission must be preserved. The County's ability to sustain and enhance the HCMC asset is threatened on many fronts and may become a substantial economic challenge in the future. The current organization and governance model of HCMC is no longer suitable to protect or sustain the mission and economic vitality of either HCMC or the County.

All HCMC's constituents need to be more accountable in order to fulfill it's mission within a sound financial framework given the budgetary restraints, reduced federal and state funding, and competitive pressures.

To address these issues, the County must establish a governance model that optimizes the achievement of these fundamental goals. The model recommended, by the Task Force to meet these performance goals is a new, non-profit entity with ongoing

lease and contractual relationships to the County. The Task Force believes this governance change will provide HCMC with a substantial increase in operating flexibility to compete more effectively and operate more efficiently in the health care marketplace.

Exhibit 2

HCMC Governance Task Force
Strengths, Weaknesses, Opportunities, and Threats Summary
July 1, 2003

Role and Positioning

Condition/Situation	Strength or Opportunity	Weakness or Threat	Impacted by Governance	Comments
Mission and niche	Yes		Yes	▪ Minnesota's only remaining public teaching hospital
		Yes	Yes	▪ Mission-driven programs and self-pay payer segments cost often exceed revenues
County ownership	Yes		Yes	▪ Vast resources, beyond HCMC operation ▪ Legislative influence
		Yes	Yes	▪ Public hospital stigma deemed a negative by many populations ▪ Legislative agenda enmeshed with other issues
Geographic location	Yes		No	▪ Only remaining downtown hospital. ▪ Proximity to 170,000 workers, 30,000 residents, and 90,000 visitors
		Yes	No	▪ More population growth occurring in suburbs ▪ Downtown location as perceived by some as confusing, congested, unsafe, etc.
Physical facilities	Yes		No	▪ Sizable facilities (1.3 million sq ft) ▪ Renovated areas – ED, Cath Lab, Perinatal, etc.
		Yes	No	▪ Portions of facility designed for other uses and aging ▪ Way finding a challenge
Market presence	Yes		No	▪ Steady growth 10 years running ▪ Acknowledged leadership in trauma
		No	Yes	▪ Historically understated in marketplace ▪ Exposures primarily associated with trauma

Financial Situation

Condition/Situation	Strength or Opportunity	Weakness or Threat	Impacted by Governance	Comments
Reimbursement rates set by purchasers/payers		Yes	No	▪ Difficult to achieve profitability given payment levels dictated by third parties.
Cost structure		Yes	Yes/No	▪ Cost structure is high, compared to non-teaching, community hospitals in the region ▪ Absence of operational flexibility estimated as $25 million annually of lost opportunity
Profitability		Yes	Yes/No	▪ Narrow or negative margins inhibits reinvestment in resources
Capital structure and liquidity	Yes		Yes	▪ Backed by County resources, e.g. bond rating, taxing authority
Tax support	Yes		Yes	▪ Provides cushion against operating margin losses
		Yes	Yes	▪ Annual amount variable and determined by situation(s) outside management control

County and Hospital Relationships

Condition/Situation	Strength or Opportunity	Weakness or Threat	Impacted by Governance	Comments
Popularly elected board of commissioners	Yes		Yes	▪ Real-time, grass roots sensitivity
		Yes	Yes	▪ Often lacking sector-specific expertise ▪ Pressure from constituents can impair decisiveness needed at operational level ▪ Philosophical/political alignment
Roles of Board, County Administration, and HCMC		Yes	Yes	▪ Layers of oversight; processes drive business vs. business drive process ▪ Ambiguity: who makes which decisions ▪ Conducive to end-runs
Medical staff	Yes		No	▪ Comparative solidarity of a single practice plan ▪ Reputation and standing as University affiliate
		Yes	Yes	▪ Difficult to achieve economic alignment between hospital and physicians
Employee productivity		Yes	Yes	▪ Civil service personnel system designed for government operations not easily adaptable for enterprises in competitive, dynamic industry sectors
Open meetings and public disclosure		Yes	Yes	▪ Difficult to engage in candid dialogue during policy making/problem solving processes ▪ Ambiguity in determination of trade secret/competitive information ▪ Closed meetings invite anxiety
Tort liability limitation	Yes		Yes	▪ Limits risk exposure per episode
		Yes	Yes	▪ Vastly different exposures between hospital and medical staff

Exhibit 4

Hennepin County Medical Center
Operational and Financial Benchmarks
4th Quarter 2002

	HCMC	CULAID (1)	COTH (2)	UHC (3)
MEDIAN		50%	50%	50%
Reporting Institutions		9	76	24
Volume/Mix				
Discharges	4,945	6,026	5,421	6,073
Average Length of Stay	5.21	5.20	5.74	6.08
IP/OP Adjustment Factor	1.53	1.58	1.52	1.44
Case Mix Index-All Patients	1.21	1.35	1.51	1.63
Outpatient Visits	118,143	135,180	93,910	118,143
Overall Cost				
Cost (excl bad debt) per adj disch	12,754	10,320	11,131	12,171
Cost (excl bad debt) per adj patient day	2,448	1,832	1,915	2,038
Productivity/Personel Services				
FTE/AOB	8.32	6.41	6.21	6.87
Average Hourly Salary	27.51	20.17	22.73	23.75
Salary Cost-WI adj per CMI adj Disch	5,149	3,389	2,961	3,158
Other Costs				
Supply Cost per Adj Patient Day	425	425	411	446
Utility Cost per Adj Disch	0.20	0.21	0.14	0.17
Interest Cost per Adj Disch	56	70	141	128
Depreciation cost per Adj Disch	622	599	600	636
Revenue				
Gross Charge per Adj Disch	20,236	18,636	21,097	25,319
Net Rev per Adj Disch	10,978	10,978	11,344	13,415
Net Pmt as percent of gross	54%	59%	54%	53%

(1) CULAID - Council of Teaching Hospitals member, Urban, Level 1 Trauma, Acute care, Inner city, Disproportionate share
(2) COTH - Council of Teaching Hospitals members
(3) UHC - University Health system Consortium hospitals