



Active/Passive Models

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Presentation to the Public Health and Health
Planning Council Health Planning Committee

Active/Passive Models

July 28, 1993 – from General Counsel Peter Millock to Establishment Committee: “Review of Passive Control of Not-for-Profit Hospitals.”

... a single not-for-profit hospital corporation could acquire, through membership status and/or the ability to install common directors, indirect control over every other voluntary hospital in the state. The possibilities are even greater. NFPCL 601 (a) does not limit potential members to individuals or voluntary corporations. A proprietary corporation could become the sole corporate member of a voluntary operating corporation.

Passive Parent Models

- NY Presbyterian Hospital (8)
- North Shore / Long Island Jewish (10)
- United Health Services (4/2)
- Bassett Health System (5)
- Continuum Health Network (3)
- NYU/NYU Hospital (1)
- Medisys (2)
- Rochester Strong Memorial and FF Thompson
- St. Peter's Health Partners / Catholic Health East (4)
- Long Term Care Models

Active Parent/Governance

- Kaleida
- Catholic Health Services
- Kingston and Benedictine
- Guthrie Health System
- Arnot Ogden
- Olean and Bradford
- Fletcher Allen and CVPH/Elizabethtown
(Proposed)
- NSLIJ

Passive Parent Characteristics

- Multiple models and purpose
- Each unique/Driven by vision
- Sole corporate member – maintain distinctive features and autonomy
- Network/Corporate model
 - Sits over system
 - May utilize mirror boards/CEO
- Sponsorship (Catholic Health East/Ascension)

Strengths of Passive Parent

- Preserve local influence and/or identity
- Avoid assumption of financial liabilities
- Establish working relationship – foundation of merger or Active Model
- Significant benefits for affiliate to stabilize system

Benefits to Affiliate

(Building a Relationship or Dependence?)

- Management or Administrative Service Agreement
 - Billing and IT Services
 - Management and Finance expertise
 - Senior Staff (CEO, CFO, etc)
 - Greater purchasing power for supplies
- Medical Services Agreement
 - Access to Specialists (maintain a program or new revenue)
 - Recruitment of physicians
 - On-call support

Benefits to Affiliate

(Building a Relationship or Dependence?)

- Assistance with Managed Care negotiations
- New Insurance products for employees (self-insurance)
- Improved access to credit lines and financial loans
- Improved market position/Image
- Improved quality and patient safety (expertise, access to analytics, etc.)

Benefits to Parent

- Expanded geographical and clinical network
 - New referrals
 - Market strength with Insurers
 - Preparation for direct contracting
- Expand purchasing power for supplies and technologies
- Foundation for population management and new models of care

Market Reforms/Community Improvements

- Potential preservation of failing facilities
- Rightsizing and re-aligning services
- Improved access to specialty services for rural areas and the underserved
- Recruitment of Specialists in Upstate/Rural Areas (need patient population to support)
- New services /areas (Bassett, Southside, and UHS Trauma)
- Coordination of Care across areas/systems
- Improved quality

Problems with Passive Models

- Partial integration/limited savings to system.
- Competition for patients between parent and affiliate.
- Financial alignment is not complete: Dependence without long term sustainability can occur.
- Transparency of governance confusing to community and employees.
- Separation is difficult for affiliate; bankruptcy may still reach parent.
- Regulatory Accountability

Mission/Philosophy Exception

405.1(d)

“Nothing ... of this section shall require the establishment of any member of a not-for-profit corporation, which operates a hospital, based upon such member’s reservation and exercise of the power to require that the hospital operate in conformance with the mission and philosophy of the hospital corporation.”

Catholic Health East (CHE) (1997)

- Multi-institutional health system – cosponsored by 8 religious congregations
- 35 Acute Care Hospitals – 4 Long Term Care Hospitals – 26 Long Term Care Facilities – Largest home care in nation
- Serves 11 states – Alabama, Connecticut, Florida, Georgia, etc.

Ascension Health (1999)

- Serves 21 states
- Ascension Health Care Network (Ascension Health and Oak Hill Capitol Partner – for profit entity)

Passive Parent – Policy Questions

- Accountability and Transparency – Is the licensed entity and Board in charge?
- Do Mirror Boards assure:
 - Duty of Care – act in good faith and informed judgment; in best interest of system
 - Duty of Loyalty – display undivided allegiance when making decisions
 - Duty of Obedience – Faithful to the mission
- Would separate boards undermine collective strength and promote internal disagreements?
- Would regulation of Passive Parent Model discourage affiliations?
- Once aligned through Passive Parent – How does the state and/or community determine accountability for strategic and/or operational actions?
 - (The licensed entity and Board are accountable under Public Health Law but Board is accountable to non-established entity)
- Nothing prevents a not-for-profit hospital board (established) from turning Board over to a distinct individual(s) or investor without review.

Strengthen Governance: Passive Parent Options

- Clarify that appointment of top management is active parent or facility governing body responsibility.
 - Same person may not serve as passive parent CEO and facility CEO.
- No mirror boards.
- Require clinical integration among passive parents and facilities.
- Require DOH approval if 1/3 or more of board is replaced within specified period.
- Require DOH approval of passive parents.