The Health Care Financing and Delivery System:

From the Flintstones to the Jetsons

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Historical Nature of Hospitals

- Pennsylvania Hospital (1751) - First American Hospital
- Exclusively Charities for diseased poor and mentally ill
- Funded by “good men and women, liberal in purse and generous in soul”
- Small staff of volunteer physicians
- People of means sought care in their homes – surgeries performed in their kitchen
- Hospitals viewed as “houses of death” where people went to die
Don’t Worry, Barney . . . I’ve Got This!
Late 19th and Early 20th Centuries

Hospitals go through a “Face Lift” due to:

- Technology advances
- Increased concern for hygiene and sanitation

Self-pay patients began to seek care at hospitals

By 1903, self pay patients = 70% of operating income in 12 States

By 1920, there were 6,000 hospitals

Considered “centers of advanced medical practice”

Began to experience increased financial pressures and competition
1965 – 2010

1965 – Medicare and Medicaid provide an unprecedented public investment in hospitals – Cost-Based Reimbursement

1983 – IPPS established by Medicare program to address expensive hospital care – DRG Payments

1993 – New Jersey dispenses with “All-Payer” system (Chapter 83) and replaces it with competitive market (Chapter 160)

1993-2010 – First wave of hospital consolidations

2010 – Affordable Care Act

2010 - present – Second (accelerated) wave of hospital consolidations and formation of integrated/organized delivery systems/ACOs
U.S. Health Care Delivery System is Functionally Fragmented

- A multiplicity of financial arrangements that enable individuals to pay for health care services
- Numerous insurance agencies employing varied mechanisms for insuring against risk
- Multiple payers that make their own determinations regarding how much to pay for each type of service
- A large array of settings where medical services are delivered
- Numerous consulting firms offering their expertise in planning, cost containment, quality, and restructuring of resources
Feels Like the Wild West . . .
Three Primary Objectives of an Acceptable Health Care Delivery System

It must enable all citizens to **access** health care services

**services must be** **cost-effective**

Services must meet certain established standards of **quality**
Four Functional Components for the Delivery of Health Care Services

- **Financing**
  - Employer-based health insurance as a fringe benefit

- **Insurance**
  - Protects insured against catastrophic risks
  - Determines where and what health services are to be received
  - Processes claims and manages disbursement of funds to providers

- **Delivery**
  - Provision of health care services

- **Payment**
  - Reimbursement to providers for services delivered
Government Programs

**Medicare** - Elderly and disabled individuals

**Medicaid** – Indigent -- Jointly administered by the federal government and state governments

**State Children’s Health Insurance Program (SCHIP)** - Children from low-income families

Government may function as both financier and insurer, or the insurance function may be carved out to an HMO.
Transition from Traditional Insurance to Managed Care

Under traditional insurance, the four basic health delivery functions have been fragmented → financiers, insurers, providers, and payers are separate entities.

During the 1990s, health care delivery experienced a tighter integration of the basic functions of financing, insurance, payment, and delivery through managed care.

MCOs (HMOs, PPOs) controlled costs and ensure quality by using:

- Utilization Management → manage risk that health care costs exceed premiums
- Negotiated provider rates → capitation, discounts
- Limited provider panels
Primary Characteristics of the U.S. Health Care System

- No central agency governs the system
- Access to health care services is selectively based on insurance coverage
- Health care is delivered under imperfect market conditions
- Third-party insurers act as intermediaries between the financing and delivery functions
- Existence of multiple payers makes the system cumbersome
- Balance of power among various players prevents any single entity from dominating the system
- Legal risks influence practice behavior
- Development of new technology creates an automatic demand for its use
- New service settings have evolved along a continuum
- Quality is no longer accepted as an unachievable goal in the delivery of health care
Trends and Directions in Health Care Delivery

Illness → Wellness
Acute Care → Primary Care
Inpatient → Outpatient
Individual Health → Community Well-Being
Fragmented Care → Managing Patient Populations
Independent Institutions → Integrated Systems
Service Duplication → Continuum of Services
What Would an Ideal Health Care Delivery System Look Like?

- Marketplace competition based on quality outcome
- Integration where all providers collaborate on patient care
- Reasonable cost containment
- Payments based on outcome rather than transactions
- Attract high-skilled practitioners – “Best and Brightest”
- Emphasis on efficiencies in operations and health care delivery
- Leveraging technology to make sure practitioners have access to patient medical records
Now that we’re on our way to the Jetsons...

- Co-Management Arrangements
- Clinically Integrated Networks
Co-Management Arrangements: Overview

- Arises when a hospital engages physicians to assist the hospital to manage some of its business.

- Typical arrangement involves the engagement of specialists to “co-manage” a hospital’s related service line.

- Ex: cardiologists engaged by hospital to manage the hospital’s cardiology service line.
Co-Management Arrangements: Services

- Services cannot duplicate other services already provided.
- Services must be those of a nature that qualified licensed physicians would be able to provide.
Co-Management Arrangements: Services

Examples of services:

> Medical Director services

> Managing operating room scheduling

> Establishing specialty-specific protocols for admitted patients

> Developing specific inpatient and outpatient quality and efficiency objectives and implementing plans to achieve them
Co-Management Arrangements: Structure

A new legal entity is typically formed to serve as entity contracted by the hospital to perform the services, but the hospital can choose instead to contract with an existing group practice.

The entity is always owned by physicians, but may also be jointly owned with the hospital.
Co-Management Arrangements:
Governance

If utilizing the joint venture model, the entity is governed by a board that consists of physician leadership and, usually with a minority role, hospital leadership.
The entity providing the services is usually compensated with a base fee, which may be a flat fee or a fixed hourly amount.

If using an hourly basis, the physicians should be required to complete time sheets.

The entity may also be compensated with a bonus.
Co-Management Arrangements: Compensation

The bonus is payable based upon the entity meeting or exceeding certain mutually agreed upon quality metrics, NOT volume or revenue.

The metrics should be objective quality indicators that are not tied to cost reduction or revenue increases.

An independent appraiser should be used to verify fair market value.
Co-Management Arrangements: Legal Issues

- Stark Law
  - Fair Market Value Exception
  - Personal Service & Management Contract Exception

- Federal Anti-Kickback Statute
  - Personal Service & Management Contract Safe Harbor
Co-Management Arrangements: Legal Issues

- Civil Monetary Payment Statute
- Tax-exemption
- Provider-Based Status
- Codey Law
- Antitrust Issues
Clinically Integrated Networks (CINs): Overview

- Selective partnership of physicians collaborating with hospitals to deliver evidence-based care, improve quality, efficiency, and coordination of care and demonstrate value to the market
- Alignment exists, but preserves the private practice model
- Enhanced reimbursement for quality and joint contracting
Clinically Integrated Networks (CINs): Services

- Population health management
- Improvements in quality
- Collaboration amongst providers
Clinically Integrated Networks (CINs): Structure

- A new entity is formed, similar in structure to an IPA or a PHO.
- The sponsoring health system and physicians are all members of the new entity (although there can be physician-only CINs).
- Emphasis is on the quality of the physicians, not the quantity.
- Physicians pay participation fees, with owners paying higher fees than non-owners.
Clinically Integrated Networks (CINs): Clinical Integration

- Establishing mechanisms to manage utilization and to control costs and ensure quality
- Selectively choosing network participants who are likely to further efficiency objectives
- Investments in resources needed to realize the network’s efficiencies
A new entity is formed, similar in structure to an IPA or a PHO.
The sponsoring health system and physicians are all members of the new entity (although there can be physician-only CINs).
Governed by a Board, which is usually physician-led, but can include voting requirements that ensure that the health system has sufficient input.
Clinically Integrated Networks (CINs): Distributions

- Distributions from revenue can be made to all owners.
- Certain physicians can receive performance rewards for quality performance and care management fees.
Clinically Integrated Networks (CINs): Legal Issues - Antitrust

Whether joint price negotiations and any competitive restrictions within the CIN are “reasonably necessary” to further the legitimate purpose of the network.

Physicians enter into non-exclusive contracts with CIN such that they can engage in contracting independently or through participation in a competing network.

Physicians agree to participate in all payer contracts entered into by the CIN.
Clinically Integrated Networks (CINs): Legal Issues – 501(c)(3)

- If Health System is 501(c)(3) tax exempt, CIN must be operated for charitable purposes consistent with mission
- Health System control over charitable issues and other key issues to ensure operated for tax exempt purposes
- "Investment" in CIN must be reasonable
- Payments to physicians must be reasonable in light of physician contributions or services
Clinically Integrated Networks (CINs): Legal Issues

- Securities Law
- State insurance law
- Civil Monetary Payment Law
- Stark Law
- Anti-Kickback Statute
Historical Nature of Health Insurance

Health Insurer as Underwriter

- Risk selection at the Individual/group level
  - Whoever Got the Healthier Lives Made the Most Money

- Risk pooling at the aggregate level
  - Consumer is Indifferent to Medical Cost

- Health Insurance as “Fringe Benefit”
  - Spurred on By Wage freeze during WWII

- Health Insurer as Healthcare Purchaser
Trends and Directions in Health Insurance

Risk Selection → Risk Adjustment
Fee For Service → Pay for Performance
Life Company as Insurer → Health-only Insurers, CO-OP
Broad Networks → Narrow/Tiered Networks
Independent Institutions → Integrated Systems
Retrospective Reviews → Medical Policy Integration
Broad Coverage → High Deductibles
Affordable Care Act

Commercial Insurance Expansion Through:

- APTC
- Individual Mandate
- Employer Mandate

Medicaid Expansion

Medicare Shared Savings Program
Anticipated Benefits of Provider/Payer Vertical Integration

- Eliminate administrative costs attributable to prospective, concurrent, retrospective reviews of services
- Eliminate redundancies of services inherent in uncoordinated care
- Payers need collaborative relationships with physicians who drive quality and cost efficiencies. Move from fee-for-service to pay for performance
- Payers need to move away from reliance on historical competencies (risk selection)
- Providers may need competencies and resources payers have - claims data mining, actuarial analysis, capital reserves to back risk-bearing.

- Patients experience their payer and providers working together, not at cross-purposes.
Finance and Delivery Integrated – Horizontally & Vertically

Options:

- Healthcare Wholesaler - ACO/ODS contracting with government programs, health insurers and/or directly with self-insured employers.

- Equal Partner - Payer/Provider joint ventures including jointly owned health plans.

- Healthcare Retailer – System-sponsored insurance companies and Multiple Employer Welfare Arrangements organized by hospitals, chambers of commerce and employer trade associations.
Accountable Care Organizations

Medicaid

- July – Camden Coalition, Healthy Greater Newark, and Trenton Health Team certified.

Medicare

Commercial Plans

Push from Gain-sharing to Risk-bearing
Organized Delivery Systems (ODS)

An organization with defined governance that:

- is organized to contract with a carrier to provide substantially all or a substantial portion of the comprehensive health care services or benefits under the carrier's benefits plan on behalf of the carrier; or

- is organized to provide limited health care services that the carrier subcontracts as a separate category of benefits and services.
An ODS is not:

> an entity otherwise authorized or licensed to provide services on a prepayment or other basis in connection with a health benefits plan or a carrier.

> An entity organized under the Medical and Dental Education Act of 1970.

> any professional corporation, professional association or independent practice association (IPA), provided such entity’s shareholders are comprised solely of providers, and the entity performs no services beyond those for which its shareholders are otherwise licensed.
ODS

Certified ODS: Bears no or de minimis risk

Licensed ODS: Bears Risk
Partner - Payer/Provider Joint Ventures Including Jointly Owned Health Plans

Example:

>AmeriHealth and Cooper
Healthcare Retailers – System-sponsored Insurers and MEWAs

Examples:

> Carepoint Medicare Advantage Plan
> Geisinger Medicare Advantage Plans
> AMT MEWA
Until Finally....
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