

MANAGED CARE:  
ARE PHYSICIANS AND HOSPITALS  
FRIENDS OR FOES?

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# 1. WHERE HAVE WE BEEN?

## 1. DEVELOPMENT OF PHYSICIAN HOSPITAL ORGANIZATIONS (“PHO”S)

### 1. Potential Benefits of Cooperation

1. Enhance bargaining power
2. Provide seamless healthcare services
3. Improve access to capital for physicians
4. Contain costs through centralization
5. Develop clinical information systems
6. Develop treatment protocols
7. Improve recruitment and retention of physicians
8. Improve marketing activities
9. Improve opportunities for direct contract

### 2. Examples of Potential Confrontation.

#### 1. Management of PHO - Right for Control

- (1) Credentials
- (2) Reimbursement
- (3) Medical Management
- (4) Contracting

#### 2. Acquired Physician Practices

- (1) Hospitals: We are losing money, physicians are not working hard enough.
- (2) Physicians: Hospitals fail to deliver promises of reduced administration time, better collection, better managed care contract.

3. Losing trust
4. Funding the operations of the PHO
3. Legal Issues
  1. Federal
    - (1) Stark II
    - (2) Anti-Kickback Statute
    - (3) Anti-trust Issues
    - (4) Preservation of Hospitals Non-profit Status
  2. State
    - (1) Self-referral
    - (2) Anti-kickback
    - (3) Corporate Practice of Medicine

## 2. MANAGED CARE STRATEGIES

1. Discounted fee for services
2. Capitation
3. Global Rates
4. Other Rate Based Contract

## 2. WHERE ARE WE NOW?

### 1. MANAGED CARE PENETRATION IN NORTH CAROLINA

1. Relevant Statistics
  1. Currently, HMO enrollment is 34.8% of the N.C. market which represents approximately 1.6 million lives.
  2. Increase in PPO enrollment . Providers turn away from risk.
  3. Many N.C. HMO are improving double digit increases to premium for 1999

4. In recent interview, Kenneth Otis, President/CEO of BCBS of NC stated that he expected managed care enrollment to increase in North Carolina to a point where between HMO and PPO enrollment there will be 70-90% commercial enrollment.

What do the statistics tell us?

Managed Care is here to stay, but the form in which it shall evolve remains to be seen.

## 2. CURRENT MANAGED CARE STRATEGIES

1. Reduce Discounts
2. Move away from capitation as risk based contracts forced fee for service medicine
3. Providers (Hospitals/ Physicians) taking on payors regarding slow reimbursement or wrongful denial of claims.
  1. Litigation
  2. Medication
  3. Regulating influence

## 3. DIRECT CONTRACTING

1. Top Ten Reasons to Direct Contract
  1. HMOs are making too much money
  2. Providers need to get a bigger portion of the reimbursement dollar
  3. Providers could be relegated to acting as more vendors in health care delivery system.
  4. Direct contracting allows providers to take control over a particular market
  5. Managed care organizations do not really manage care, they manage cash.
  6. Patients should have more choice in selecting physician and hospitals
  7. Employees want to eliminate the middleman role currently played by HMOs

8. Some managed care systems prepared by HMOs are inherently flawed because these systems encourage under-utilization of services.
9. Managed care companies do not share the savings with employees or providers
10. Providers have natural leadership role in communities this it is only natural for them to work directly with the communities employers.

## 2. Opportunities for Cooperation

1. Align physician/hospital economic and clinical incentives
2. Promote high quality local health care delivery
3. Reduce cost and increase efficiency of health care delivery

## 3. Example of Confrontation

1. Sharing the reimbursement dollar
2. Management issues/control

## 4. Legal Issues

### 1. Federal

- (1) Stark II
- (2) Anti-kickback
- (3) Anti-trust

### 2. State

- (1) Is Direct Contracting the Business at insurance?
- (2) N.C. DoI v. NC. AG  
DoI has very conservative position on this issue:

In general, a direct contract between a provider organization and a self-insured employer will not normally be considered to be insurance nor require an HMO license if it meets the conditions listed below.

- (1) Payment to the provider is a fee-for-service

- (2) Units of service for purpose of payment may be defined as a procedure code, a DRG or diagnosis code, or a hospital day or other unit of time
- (3) Fees and/or discounts must be certain determined in advance, and considered by the provider and payor to be payment in full
- (4) Future adjustment to fees may be based on total plan performance (including claims experience) during past or current period, or individual provider performance in matters other than utilization or charges (such as patient satisfaction, quality measures, availability of appointments.)
- (5) The frequency of future adjustments to fees or discounts should not be so great as to constitute a sham capitation arrangement-adjustments or an annual or semi-annual basis will be considered to be at reasonable frequency.
- (6) The payor must be obligated to continue to pay provider for covered services, in accordance with agreed upon fee schedule for the duration of the contract period, regardless of the total expenditures of the plan (and regardless of any pre-established budget, expenditure targets, etc.)
- (7) The payor may issue an extra or “bonus” payment to provider which may be based on total plan performance (including claims experience) during the past or current period, or an individual provider performance in matters other than utilization or changes (such as patient satisfaction, quality measures, availability of appointments) but may not withhold a portion of payment for possible later distribution to providers.
- (8) Payment to the provider must be made by a licensed insured or single self-funded employer.
- (9) Providers are not paid for service they do not render and do not make payments to non-participation, providers; all payments for non-participation, providers are made directly to the payee.

- (10) Administration fees may be charged, but may not be put at risk based on utilization or plan experience. The act of labeling charges “administration fees” will not nullify the insurance aspect of the business

All direct contracting relationships should be reviewed and approved by legal counsel

#### 4. UPDATED PHYSICIAN/HOSPITAL JOINT VENTURES

##### HORIZONTAL OVER VERTICAL INTEGRATION

##### 1. Opportunity for Cooperation

##### 1. Development of improved physician/hospital integrated joint venture.

- (1) Decentralized Management
- (2) Establishing trust between physicians and hospitals
- (3) Physician control over clinical issues and hospital control over administrative issues and cooperation by physicians and hospitals were these issues meet.
- (4) Increase educational opportunities of physicians regarding managed care issues.

##### 2. Example of Confrontation

1. Control over decision making.
2. Sharing profits

##### 3. Legal Issues

##### 1. Federal

- (1) Gain Sharing
  - (1) OIG Advisory Letter
  - (2) Advisory Opinion
  - (3) IRS Private Letter Ruling
- (2) Stark II

- (1) Could Stark II be reduced or simplified?
- (2) If so, what will be the impact.
- (3) Anti-kickback Statute
  - (1) What is the effect of United States v. Anderson
- (4) Physician Unions
  - (1) Limited application applies to employed physicians and residents.
  - (2) Recently, NLRB rejected HMO physician panel's request to unionize
  - (3) Could reduce physician/hospital collaborative efforts
- (5) Anti-trust Exemption
  - (1) H.R. 1304 - U. S. Congress. This bill would allow physicians to collectively negotiate with health plan on payment and patient care.

### 3. WHERE ARE WE GOING

#### 1. COOPERATION BETWEEN PPMCs AND HOSPITALS

- 1. Areas of Cooperation
  - 1. PPMC may be able to assist hospitals in managing hospital owned physician networks.
  - 2. Managed care contracting.
- 2. Areas of Confrontation
  - 1. Mismanagement of physician practices by PPMCs
  - 2. Hospital and physicians expectations are not met
  - 3. Added PPMC may also add cost
- 3. Legal Issues
  - 1. Federal

- (1) Stark II - Potential changes to this complicated self-referral law.
- (2) Anti-kickback statute - Advisory opinion 98-4 rejects percentage of premium compensation of PPMC

2. State

- (1) Fee splitting

2. RETHINKING PHYSICIANS/HOSPITAL INTEGRATION

1. Increased Horizontal Integration

2. Disintegration of Vertically and Horizontally Integrated Networks

3. HMO and Managed Care Organization Liability

1. What effect will the risk of HMO/MCO liability providers for healthcare decisions have on providers?

1. Contractual carve outs of liability, indemnification
2. Provider control over decision making

2. Legal Issues

1. Federal

- (1) ERISA
- (2) Patients Bill of Rights

2. State

- (1) H.1133 (N.C.) - Would make MCOs liable for damages for harm to enrollee or an insured person that is proximately caused by an MCO's health care treatment decision. Currently in committee in House.
- (2) Patients Right Legislation- See Texas' legislation
- (3) North Carolina legislation

4. Community Health Plan Development

1. Reasons for Developing a Community Health Plan

1. Declining reimbursement to providers

2. Premium increases to employers
  3. Disproportionate power of insurers
  4. Control of medical decision-making by insurers
  5. Delegation of risk to providers by insurers
  6. Increasing profits by insurers
  7. Increasing accountability for quality of health care services
  8. Increases provider revenues and profits
  9. Maintains local control and medical decision-making
  10. Ensures the delivery of quality and accessible health care services
  11. Controls the costs of health insurance premiums
  12. Integrates provider services
  13. Enhances provider/community relations
2. Description of Community Health Plan
  3. Different Types of Products
    1. Fully insured
    2. Medical Management
    3. Medical Savings Accounts
    4. Provider Owned Insurance Agency
  4. Reasons for Developing Community Health Plan
    1. A community health plan is a low-cost option which allows providers to offer comprehensive health plans to their community
    2. There is no need to obtain an insurance license
    3. There is no need to post insurance reserves
    4. There is no need to invest in costly infrastructure

5. Legal Issues

1. Federal

- (1) Stark II
- (2) Anti-kickback
- (3) Antitrust

2. State

- (1) Is this the business of insurance? No, because we are using an HMO license.
- (2) Approval from NC DOI or NC AG