Hospital and Community Health Systems Funding Model

(by Antonio Paulo Pinto – DRAFT copy updated 7 May 2020)

Overview:

Prior to COVID-19, many hospital systems, especially those in the rural parts of the country, were closing or on the verge of financial collapse and closing. At the end of 2019, it was reported that almost 500 hospitals, some with multiple locations, were at risk of closing; and many hospital systems, including the urban hospital systems, have already sold their physical hospital properties and are basically operating strictly on a cash flow basis. Unfortunately, COVID-19 has exposed the extent of the financial distress under which many hospital and community health care centers were operating.

The goal of this funding model is to consider that hospitals are more than just businesses; and how to properly fund and maintain them as core providers of health care services throughout the country, including in the rural communities. The idea is that hospital systems and community health care systems should be focused on providing health care, and should be viewed as natural monopolies in many parts of the country. Therefore, many should operate as community-owned and managed health care centers overseen by experienced clinical managers with limited liability and profitability, regardless if they are For-Profit or Non-Profit; and all the salaries of those that work within the system should utilize the government systems pay scales that exist for the varying positions within the health care system, inclusive of executive, clinical, service, and support positions.

Background:

Prior to COVID-19, this model was drafted around the basis of stabilizing the financially distressed systems and providing funding opportunities to open new and reopen closed systems with the goal being to maintain local health care services in rural communities and maintain their ability to provider emergency care services that could minimally stabilize patients for transport to larger hospital systems able to provide enhanced and specialized care. The additional consideration would be to convert the excess capacity of these more rural and remote health care systems, both of physical space and medical equipment, into centralized health care hubs within rural and remote communities.

When comparing to typical hospital-based health care systems, the hubs would need fewer hospital beds, which would allow the building layout to be restructured; and this would allow for a providing a care-by-section or care-by-floor model. It is important to note that by consolidating multiple services into one building, the need for testing equipment is limited, reducing the need for capital expenditures for test equipment at multiple locations, by requiring shared utilization of medical equipment. The hubs could have colocation, within separate building sections, of short-term rehab, long-term care, assisted living arrangements, flexible appointment-based doctor's office space, a lab, and a pharmacy, all sharing the same core resources. They could each be operated as separate businesses and bill at their standard non-hospital facility rates, noted in financing methodology. If the hub does not fit into a single building, the design could incorporate adjacent buildings. The main item to consider is that the core hospital beds should be considered transitional, and that patients not in transition to-or-from a larger regional hospital facility would not be kept there for a week or two at a time, with allowance for Hospice care services. There should also be strong consideration to allow the Veteran's Administration to be able to subcontract services to the hubs to serve Veterans living far from or waiting for VA facilities.

Financing Methodology

When originally drafted, pre-COVID-19, there did not exist funding for hospitals and there were no ongoing discussions on providing additional funding to hospitals, other than some stabilizing funding to rural health care systems. However, funding has been allocated and more funding is expected to be allocated to stabilize hospital systems and community health care centers through the various COVID-19 Stimulus packages. Therefore, I have adjusted my original proposal to be more compatible with the available funding, while still focusing on creating an alternate long-term Public-Private funding mechanism for maintaining health care services throughout the country, one that can be applied beyond hospital systems to the creation of health care hubs.

The idea is to fund health care systems and hubs through private funds, bond funds, supported by government approved tax incentives. The bond funds should be designed to focus on maintaining health care services within local communities and allow for changes in management or ownership, contingent that the services are maintained. These health care centers should operate as natural monopolies; and their management teams should be viewed as managing businesses under receivership, meaning experienced clinical managers, not bottom-line and profit-driven executives. This is the reason for the recommendation to utilize the federal pay grade system, which would limit excess compensation to all employees, including executives. From a contracting and payment perspective, these systems should be limited to charging a factor of no-more-than twice the Medicare rate to uninsured and out-of-network people that access care at funded systems, with no balanced billing or separate facility fee billing allowed. In the case of excess year-end profits or cash-on-hand, one-time capital expenses should be allowed, and a rainy-day fund should be established and maintained.

Proposed Guidelines for these Public-Private Bond Funds

Hospital and Community Health Care System Bond Fund Guidelines

Funding should be available to both Non-Profit and For-Profit Organizations
- For-Profit Organizations should have limited profitability and limited non-clinical expenses (SG&A).

Bond Fund Tax Benefits should incentivize corporate and personal donations.
- The bonds should be convertible to donations after a limited waiting period, and the write-off of the bonds should be able to be accelerated, inclusive of future interest, and be a Tax Credit.

HHS/CMS should consider providing annual block grants to support Medicare and Medicaid members.

Funded systems should be required to maintain a Board of Directors composed of a minimum representation of 50 percent of active or retired clinical staff, and 25 percent leadership from the communities served. The Executives of the system (CEO, COO, CFO) should be non-voting members.

Funded health care systems should be extended Limited Liability, focused on maintaining services.

Final Note: This is not my area of expertise. However, I am hopeful that this document will provide ideas to those that better understand hospital and health care operations and financing.