Observations and the Impact of the Public Health Law and Current Health Department Regulations on Healthcare Organization Governance Structures

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Health Care Organizations in New York Have Evolved in Response to Many Factors

- increased costs
- low profit margins
- shortage of capital
- value based competition
- government health planning through the Berger Commission and the Medicaid Redesign Team
- national health reform
- higher government and public expectations for responsible corporate behavior

The Changes are Dramatic

- Hospitals have consolidated; many have ceased being independent institutions or have closed entirely;
- Hospital systems are functioning as operating companies with centralized control and not as mere holding companies;
- Hospital systems have extended across New York State borders;
- Some private medical practices have grown into megapractices with multiple offices and hundreds of physicians covering a broad geographic area;

The Changes are Dramatic

- Private medical practices have staffed and equipped facilities that look remarkably like Article 28 clinics or small hospitals;
- Hospitals have explored new and old methods to combine with the megapractices and other private practices, including accountable care organizations, IPA's, PHO's and medical practice acquisitions;
- Hospitals, surgery centers, assisted living residences and other providers have attracted private investment without direct private ownership; and
- Hospitals and other providers have outsourced clinical and support services.

Health Care Organizations Outside of New York Have Changed More

- Hospital and nursing home chains continue to be bought, sold and re-shuffled.
- Convenience care clinics have multiplied.
- Substantial private equity has poured into assisted living and dialysis centers.
- Payers are consolidating with providers.
- Taxable/non-taxable hybrid partnerships have proliferated.

The CON Process

Over the years, what has happened to New York laws and regulations concerning the CON process and provider governance and operations?

- The answer is: Very Little.
  - CON thresholds have been raised.
  - Publicly traded dialysis providers have been permitted.
  - Your Committee has made several very welcome administrative streamlining recommendations.

The fundamental law and policies have remained unchanged.

Several New York Laws and Policies Have Shaped How New York Health Care Organizations are Governed.

I will focus on four:

- **The active/passive hospital parent distinction;**
- **Corporate fee splitting;**
- **The laws affecting hospital system operations; and**
- **Accountable care organizations.**

The Active/ Passive Hospital Parent Distinction

- DOH regulations require corporate members/parents with one or more specified powers to have establishment approval. See: 10 NYCRR §§405.1(c).

- Corporate members/parents with other powers need not be approved

The Active/ Passive Hospital Parent Distinction

The purpose of the distinction is to assure that entities exercising key decisionmaking powers judged necessary for provision of health care services will be reviewed, approved and held accountable for those services. Key powers include:

- control of operating and capital budgets and the incurrence of debt;
- choice of management employees and medical staff;
- approval of CON applications; and
- control of operating policies and procedures.

The Active/ Passive Hospital Parent Distinction

The active/passive distinction is problematic:

- First - the distinction may not reflect reality.
  - Passive parents may have a lot of power
  - Subsidiary boards may enjoy only a superficial autonomy
  - Many systems today rest on centralized control

- Second - the criteria for distinguishing active from passive are imprecise.
  - The only widely acknowledged trigger for a CON establishment application is budget approval.

The Active/ Passive Hospital Parent Distinction

- Third, the distinction between active and passive parents has an all-or-nothing impact.
  - Either a parent with some but not enough explicit and significant powers is treated as “passive” and is not evaluated, approved or held accountable in any way at all, OR
  - A parent is considered “active” and must get CON approval and be fully accountable for actions by its subsidiary even if the parent’s power does not extend to all aspects of the subsidiary’s behavior.
  - There is no adjustment of accountability to fit the scope or intensity of the active parent’s power.

The Active/ Passive Hospital Parent Distinction

- Fourth, the burdens of being considered active often cause hospitals to arrange governance just to avoid active parent treatment. For example, a parent will not be considered active if it exercises control only through the designation of subsidiary board members.
- Fifth, and most importantly, the distinction between active and passive may not advance any legitimate public health goal. For example, the free pass given to passive parents may allow them to escape responsibility for the hospitals in their system. The distinction may actually retard the development of financially sound, cohesive and efficient healthcare systems.

The Active/ Passive Hospital Parent Distinction

If the State wishes to evaluate the continued utility of the active/passive distinction, it must contend with many questions:

- Does passive parenthood afford a useful engagement period before an eventual marriage?
- Does passive parenthood convey more benefits than even looser connections between providers?
- Is there only an all or nothing resolution?

The Active/ Passive Hospital Parent Distinction

- Can parent accountability be achieved another way?
- What ownership/control changes will the elimination of the distinction cause and are these desirable changes?
- Will elimination of the distinction require expanded character and competence reviews and can these reviews be conducted efficiently?

Corporate Fee Splitting

DOH regulations prohibit an unestablished entity from receiving all or part of the gross or net revenue of a clinic, ambulatory surgery center or hospital. See: 10 NYCRR § 600.9(c). This is the corporate parallel to the limits on fee splitting by physicians in Education Law § 6530(18) and (19).

The purpose of the prohibition is to:

- limit control by an unregulated and unaccountable entity over a licensed provider, and
- to protect the financial viability of the licensed provider

Corporate Fee Splitting

The prohibition:

- forces providers to estimate and adjust a fixed fee that approximates the percentage they anticipate receiving and to allocate fixed fees across different services.
  - The financial result of this gyration remains the same, but the gyration is required to comply with the regulation.

- makes it more difficult to reward good work measured by one universal criteria: contribution to profit.
  - The result may be reliance on other vacuous performance standards.

Corporate Fee Splitting

- pushes revenue sharing from agreements where the fee splitting prohibition applies explicitly (e.g., management agreements) to other agreements between the same parties.
  - This can create a multiplicity of agreements each of which is innocuous and legal but, together, allow an unlicensed entity to withdraw substantial funds from the operations of a hospital, ambulatory surgery center or DTC and exercise substantial control over its operations.

Hospital System Operations

- The major provisions of Article 28 of the Public Health Law, including the CON process, were enacted when hospitals were individual units.

- Health systems in New York today include:
  - Multiple hospitals
  - Providers of other levels of care
- Each provider must have
  - Its own board of directors, however weak
  - Its own operating certificate

Hospital System Operations

Multi-hospital systems that have not merged their constituent entities into one single corporate entity, but seek the efficiencies and other improvements related to size, face many operational hazards because of the outdated focus of the current law.

Hospitals within a system face several questions:

- May one hospital share QA information with another hospital?
- May one hospital share a medical record system and medical records with another hospital?

Hospital System Operations

- May hospitals share credentialing information with another hospital after initial privileges are granted?
- May the hospitals share peer review information?
- If a hospital shares this information, does it lose whatever privileged protection it has against further mandated disclosure?
- May the hospitals have one unified medical staff?
- May the hospitals have one unified board of directors?

Hospital System Operations

Hospital systems have answered these questions in different ways.

I interpret the current state and federal law as follows:

- There is no barrier to centralized credentialing information gathering provided that each physician consents to it.
- There is no barrier to centralized monitoring of credentialing, overall quality assurance functions, and the sharing of non-identifying information.

Hospital System Operations

- Identifying information may be shared across a system provided an “organized health care arrangement” is formed under HIPAA, there is proper notice to patients and physicians, and the system’s and the constituent hospitals’ certificates of incorporation and bylaws are amended.
- Physician identifying peer review information may be shared, with Department approval.
- The system parent may share in credentialing, peer review and quality assurance decisionmaking if there is an overlap in board composition.

Hospital System Operations

- Each hospital must have its own medical staff but medical staff bylaws may provide that a loss of privileges in one hospital is cause for disciplinary action in another.
- Each hospital must have its own board but “mirror” boards are permitted.

Hospital System Operations

These ad hoc solutions are not ideal.

Explicit and clear legal authority to share such information across all entities within a health care system will allow systems to enhance patient protection and realize the quality assurance benefits that size may offer.

Unified medical staffs may be appropriate and efficient in some situations.

Accountable Care Organizations

The formation and operation of accountable care organizations ("ACO") have been facilitated by State and federal laws that address some of the questions noted above for hospital systems.

- By authorizing ACOs under the Public Health Law, the State hopes to:
  - reduce health care costs
  - promote effective allocation of health care resources, and
  - enhance the quality and accessibility of health care.

Accountable Care Organizations

Under New York State law an ACO is an organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population. PHL §§ 2999-o(1), 2999-p(1).

Under existing law, DOH is authorized to establish the standards for governance, leadership, management structure of the ACO including the manner in which clinical and administrative systems or clinical participation will be managed.

PHL § 2999-q(2)(a)

Accountable Care Organizations

If the Governor signs legislation now before him, the PHL will offer certain legal protections to State certified ACO's. The PHL will:

- create a state action exemption from anti-trust prosecution for ACO's;
- protect ACO's from prosecution under the corporate practice of medicine prohibition;
- seek to protect ACO's from prosecution under the State's Mini-Stark law; and
- by treating an ACO as one "hospital," seek to avoid the application of the non-disclosure limitations noted above for hospital systems.

Accountable Care Organizations

Why will the same consideration not be shown to hospital systems?

Most systems seek the same outcomes as ACO's

- reduction of costs
- effective allocation of resources, and
- enhanced quality and accessibility of health care.

Other Current Regulations and Policies Have a Major Impact on Governance

The two most distinctive New York laws are:

- the prohibition against publicly traded corporations owning hospitals and other Article 28 facilities (see, e.g.: PHL § 2801-a (4)(e)); and

- the prohibition against the corporate practice of medicine and other licensed professions (see, e.g.: Education Law § 6522, PHL Article 28, and Business Corporation Law § 1503).

Other Current Regulations and Policies Have a Major Impact on Governance

The prohibition against publicly traded corporations is actually stated as a prohibition against the stock of a corporate operator being held by another corporation;

- with a publicly traded corporation, corporate stock ownership is always possible.
- business corporations without corporate shareholders may own a hospital.

The prohibition against the corporate practice of medicine is not articulated in any one statute or regulation.

- permits (with limited exceptions) only professional corporations and licensed hospitals and other licensed providers to employ physicians and other professionals.

Other Current Regulations and Policies Have a Major Impact on Governance

- These two prohibitions, more than any others, shape facility governance arrangements in New York.
  - The two prohibitions are linked to the fee splitting.
  - The prohibition on publicly traded hospitals and corporate practice pushes investors to other forms of engagement with New York providers and other means to secure profits on their investment in these providers.

Other Current Regulations and Policies Have a Major Impact on Governance

Also worth the Committee's attention are:

- the out-of-date distinctions between private practices and Article 28 clinics;
- the imprecise distinction between management agreements and administrative services/consulting agreements;
- the unresolved state policies on co-location and convenience care clinics; and
- the burdensome and somewhat arbitrary standards for both character and competence.

Conclusion

What, if anything, should be done with current statutes, regulations, policies and procedures?

The evaluation should be guided by the following principles beyond the obvious primary goal of doing what is best for the public's health:

- No law or regulation, no matter how old and cherished in New York, should be immune from review and change.
- Laws should be adjusted to achieve the accepted goals for the health care system and not to advance abstract principles or New York exceptionalism.

Conclusion

- Laws should not ignore economic realities.
- All laws should be enforceable and enforced. If the state does not have the resources, will or desire to enforce a law, it should repeal the law.
- The interrelationship between all of these laws and policies (e.g.: between fee splitting and corporate practice and between active/passive and character and competence) must be taken into account in the evaluation.