Hospital and Community Health Systems Funding Model

(by Antonio Paulo Pinto – DRAFT copy updated 6 May 2020)

Overview:

Prior to COVID-19, many hospital systems, especially those within rural health care systems, 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 have already sold their physical properties and are basically operating strictly on a cash flow basis. Unfortunately, COVID-19 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 how 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 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 reopen closed systems with the basic goals being that of maintaining local health care services in rural communities and maintaining their ability to provider emergency care services that could minimally stabilize patients for transport to larger hospital systems with enhanced and specialized care. The additional consideration would be to convert the excess capacity of these existing systems, both of space and medical equipment, into centralized health care hubs within rural and remote suburban communities.

When considering typical health care services, these hubs would need fewer hospital beds, which would allow the building layout to be restructured; and this would allow for 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. The hubs could have colocation, separate building sections, of short-term rehab, long-term care, assisted living arrangements, flexible doctor's office space, and a pharmacy, all sharing the same core resources. They could each be operated as separate businesses and bill at their standard non-hospital 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 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 the exception of 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 local Veterans far from 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 through private funds backed by government guarantees on the debt, basically bond funds. The issued debt, bond funds, should be designed to focus on maintaining health care services within the local communities, even if there is a future change in management or ownership. 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, primarily the hubs, that utilize this funding method 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 these funded centers, with no balanced billing allowed. If there are excess revenues at year-end, the funds could be partially invested in one-time capital expenses and should be partially set aside as a rainy-day fund, for future years.

Proposed Guidelines for these Public-Private Bond Funds

- What financing program options are available through Treasury; and can they issue need bond guidelines to address gaps without legislation, under existing law?
    - Require that all these facilities be Non-Profit 501(c3)'s to best fit existing laws.
    - Can these "municipal" bonds be specially designated and have incentive features?
        - Can they be forgivable by the lender/purchaser of the bonds?
        - Can the owner of the bond get a tax write-off as a donation for the forgiveness?
        - Can they additionally get Net-Present-Value of the Interest to be consider a donation?
        - Will any incentives, like naming of facility be allowed for forgiveness?
    - Target large corporations for "give-back" programs to the older rural communities that helped build than, as a way of showing gratitude to their past, the people that made them.
        - Example, target Oil & Gas companies to support these initiatives in closed producing sites by committing to pre-commit to purchase some or all of the initially required start-up bonds!

- Private Funding and Community Support Ideas
    - 1% Tax on Capital Equipment (above $100k value) and Real Estate for community support.

        - The taxes should specifically offset (should require) Public Sector health care expenses!
            - Reducing "spend" has a greater impact on current and future city/town/BOE budgeting than charging healthcare fees and paying taxes.
            - If you keep budget dollars low, and the rate of growth low, it should assist in managing long-term cost increases.
    - Municipalities need to design and enact an economic development plan and incentives designed around these facilities (critical for re-opening closed facilities).
        - Can they get a pharmacy to locate within or within a block of the facility?
        - Can they get a basic grocery store to locate close to the facility?
        - Can they get other community services to be available within or close to the facility?
        - Etc. (Noting that they could approach Amazon, Walmart, CVS, Walgreens, etc.)

CRITICAL: These facilities need to be limited liability facilities! (CAP on lawsuits! Reason, fraud protection!)

requiring 50% Clinician membership on boards of directors, requiring community leadership representation on boards of directors, Executives of the system (CEO, COO, CFO) should be non-voting members of the board of directors), and maximum allowed Bill Rates should be 2 times Medicare, regardless of the health insurance plan contracts. The bonds should be allowed to be purchased by individuals and corporations and the bond value and full bond-term interest should be able to be written-off or donated as a full tax credit to the individual or corporation and spread out over up-to 5 tax years.]