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Ethics in Healthcare: Becoming Financially Driven?

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Ethics in Healthcare: Becoming Financially Driven?

Some typical issues around Healthcare Ethics:

- End of Life Issues
- EMTALA
- Access to Care
- Physician Referrals
- Patient's Rights
- Physician or Clinician practices
- Billing Practices

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End of Acute Care Dilemma for Hospitals:

- SNF won't accept the patient
- Fear of Re-Admit due to needed care
- Family dynamics, no one to take patient home, care for patient at home
- Family and/or clinicians concerned about patient compliance post acute care
- Post acute medicine prescriptions
- Some care covered, some care not
- Medicaid Pending patients

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What's a hospital to do?

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has taken a few

CREATIVE PATHS

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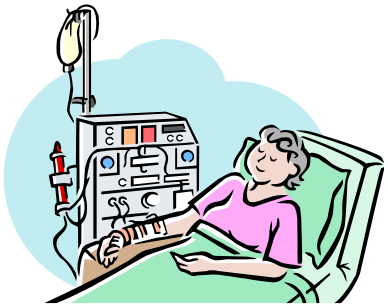
- Acute Dialysis
  - Up to 6 weeks until patient can become well or qualify for chronic diagnosis, sometimes becomes end stage.
  - $400 per treatment



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- Cardiac Life Vest
  - Medicaid Pending
  - $6000 Patient wears for 30 days pending permanent placement of pacemaker
  - Vendor covers half, hospital covers half

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- Extended Care Facilities
  - Unique cases where ECF is best option, per clinicians' choice
  - Single case agreements with ECF

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- Prescription Medications
  - Frequent re-admits due to patient non-compliance with meds
  - Unstable social/family dynamics

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- Home Care
  - 6 month pilot with a $20k grant from RRRG for Stop Gap coverage for home care services where patient doesn't qualify for Home Bound Home care
  - Avoid Re-Admits
  - Cost avoidance of approx $150k in 6 mos
  - $35K spend planned in 2014 and $50k in 2015 due to success of pilot

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So **WHY** would CRH bear these costs?

- ***Integrity and Ethics*** - It's the right thing to do
- ***Costs*** – Inpatient cost to CRH is approx $1000 per day vs the alternatives. It financially makes sense.
- ***Patient and Family Anxiety*** – Making good care decisions while trying to get qualified for Medicaid

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And because it is **who we are** for our patients…

Our **vision** is to be your health and wellness partner **for life**.

We will achieve our vision by **always**:

- **Caring** for you and our community with compassion.
- **Connecting** you to the best health resources.
- **Excelling** in all we do.

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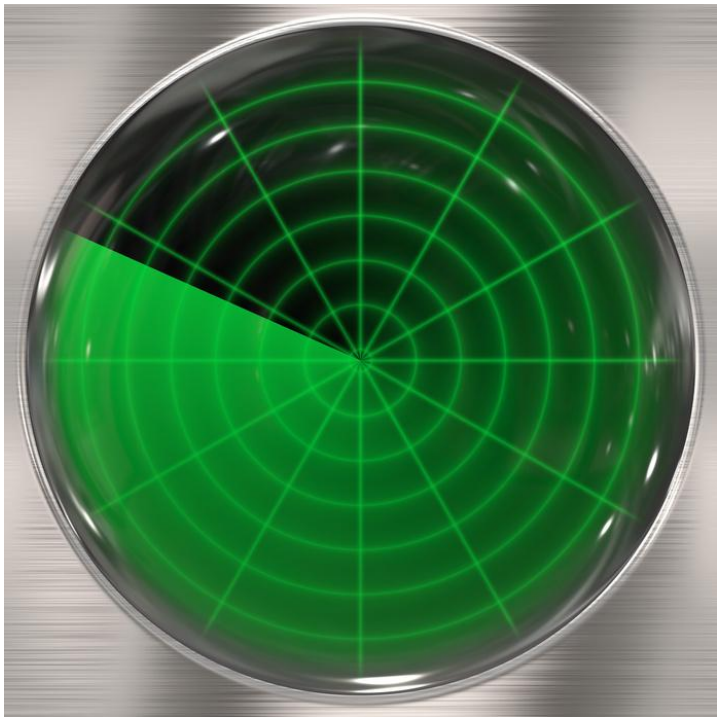
So what else? Outpatient?

- Bariatric Surgery
  - $2000 catastrophic policy



- More to come?

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Federal Exchange Premiums:

Should/Can hospitals pay for these on behalf of their patients?

Is this

Ethical?

Legal?

Appropriate?

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Some fear it creates an incentive to the patient around provider choice violating the anti-kickback statute.

Some have concern that overutilization of treatments and drugs will occur if hospitals and providers are paying for insurance premiums.

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So what does CMS think?

February 7, 2014: CMS released further guidance to clarify that the concerns addressed in the November 4, 2013 FAQ would not apply to payments from private, not-for-profit foundations on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees' health status. In this situation, CMS would expect that the premium and any cost-sharing payments cover the entire policy year. **This is HHS's current position on the issue**.

November 4, 2013: The Centers for Medicare and Medicaid Services (CMS) advised in an FAQ that it has significant concerns with the practice of hospitals and other health care providers subsidizing premium payments and cost-sharing obligations with respect to QHPs purchased by patients on HIEs because it could skew the insurance risk pool and create an unlevel field on the Exchanges.[3] CMS confirmed that it discourages this practice and encouraged issuers to reject such third-party payments. CMS re-affirmed its broad authority to regulate HIEs and its intent to monitor the practice of third-party payments and to take appropriate action, if necessary.

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The American Hospital Association had this to say:

The opinion expressed by CMS it a Nov. 4 Q&A "appears to have no legal force or effect on hospitals [or insurers] and to be unenforceable.

"*If* HHS wanted to try to make this position enforceable, it would have to go through rulemaking. But even then, HHS's authority to adopt the views expressed in the Q&A is highly questionable. By statute, everyone (except incarcerated individuals and undocumented immigrants) is eligible to purchase any QHP [Qualified Health Plan] offered through an exchange so long as the premium is paid."

"The ACA requires tax-exempt hospitals to have a written financial assistance policy that describes the criteria that will be applied and the financial assistance that will be provided to help patients afford health care," the AHA legal advisory said. "Premium subsidies could be one form of financial assistance."

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Evan Albright of insidepatientfinance.com said it well in one of his contributing articles to Forbes:

"The priority, therefore, is to get healthy Americans signed up for insurance. Otherwise, whether they like or not, both healthcare providers and insurers will, in the end, be the ones paying the bills."

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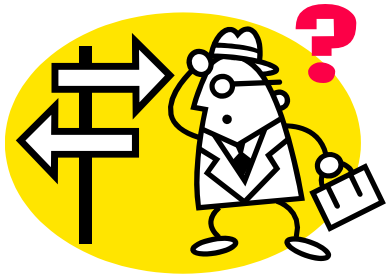
The answer seems to be **YES**.



That, in fact, hospitals **are** facing many *ethical dilemmas* regarding **providing quality care** to their patients and yet making the **best financial decisions** for both the organization and the patient. One could argue it has an industry wide impact when you consider downstream effects of patients not receiving good care.

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Thank You!

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