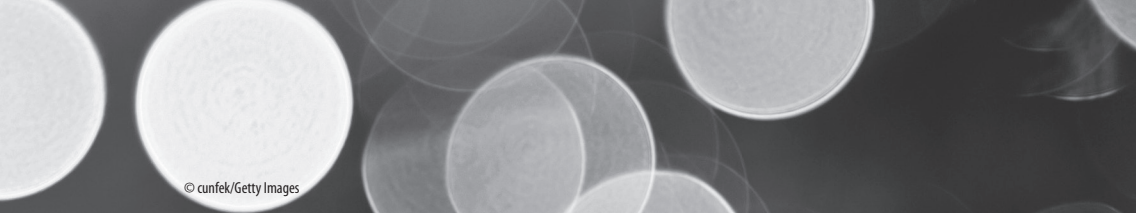

CHAPTER 2

Health Records and Managed Care

"Now is probably the right time in our history to take a fresh approach to data sharing in health care."

—**John Halamka**, Chief Information Officer at Beth Israel Deaconess Medical Center

KEY TERMS

Accountable care organizations
Capitation rate
Consolidated medical groups
Continuity of care
Cost assessment
Covered entities
Direct contract HMOs
Electronic health records
Exclusive provider organizations
Good faith disclosure
Group practice HMOs
Health Maintenance Organization Act
Health maintenance organizations (HMO)
Health record
HIPAA Privacy Rule
Horizontally integrate
Indemnity health insurance
Independent practice associations
Integrated care
Joint Commission
Longitudinal health records
Managed care
Management services organizations
Mandatory reporting laws
Medical necessity
Medicare fee-for-service
Multitiered drug formularies
National Committee for Quality Assurance
Network HMOs
Out-of-network
Peer review organizations
Pharmacy benefit managers
Physician-hospital organizations
Point of service plans
Preferred provider organizations (PPO)
Protected health information
Quality assessment
Quality improvement organization (QIO)
Records owner
Staff HMOs
Tax-exempt
Unauthorized disclosures
Utilization review
Utilization review organizations
Vertically integrated

LEARNING OBJECTIVES

- Define utilization review and utilization review organizations.
- Explain the role of patient data in the utilization review process.
- Compare and contrast the following insurance terms: accountable care organization, consolidated medical group, exclusive provider organization, foundation and physician-owned integrated care, health maintenance organization, independent practice association, management services organization, physician-hospital organization, and preferred provider organization.
- Identify the characteristics of the managed care industry that have changed the nature of health records.
- Describe the changes in health record standards made in response to the growth of managed care—whether started by legislatures, accreditation organizations, or managers of patient-generated health data.
- Define the type of patient data protected by the Health Insurance Portability and Accountability Act (HIPAA) and explain how its Privacy Rule affects health insurance plans.

Principles and Applications

Although the **health record** originally developed as a business record of individual health providers (hospitals and physicians), it is now a document that supplies patient data critical to **continuity of care**, is subjected to substantial state and federal regulation, and is *owned* as much, if not more, by the patient as by the provider. Several forces contributed to this transition, including increased emphasis on the importance of documentation in medical training, health records standards incorporated into accreditation and certification requirements, and development of formal utilization controls for the delivery of health care.

Utilization Review

One factor in the increase in the scope and quality of health records is a requirement that providers document the need for, and provision of, health care in exchange for payment. The establishment of Medicare and Medicaid insurance was a watershed for formal **utilization review** because the insurance programs required health care entities to maintain utilization review programs to obtain and maintain certification.[1] Congress added an additional layer of review by **peer review organizations** and **quality improvement organizations (QIOs)** [2] and imposed a specific obligation upon providers to support their provision of services by evidence of **medical necessity** and quality.[3] Peer review programs now extend not only to health care entities but also to individual physicians and other licensed providers.[4]

Managed Care

The impetus for the development of utilization review was unsustainable health care costs. A related effort by Congress to address quality and cost of health care is found in the **Health Maintenance Organization Act**, which provides for the development and operation of **health maintenance organizations (HMOs)** to ensure

appropriate coordination and quality of care and to contain rising health care costs.[5] This legislation laid the groundwork for the **managed care** revolution.

The concept of managed care now includes not only HMOs but also **preferred provider organizations (PPO)**, **point of service plans**, and other health care entities involved in the coordination and delivery of patient care. In the 1970s, conventional **indemnity health insurance** covered over 96% of eligible employees; by 2016, indemnity plans covered less than 1% of the employer-provided health insurance market. Preferred provider organization plans now cover 58%, HMOs hold 9%, and the combined market of other managed care plans cover the remaining 32%.[6]

A tenet of managed care is that coordination of care will produce higher quality and lower cost outcomes. The pioneering HMO model sought to furnish most health care, if not all, covered medical services required by members in-house through physicians employed by and health care entities owned and operated by the HMO. This approach suggested a comprehensive central health records database. Other forms of managed care had to obtain patient data from a broad range of health providers and suppliers to coordinate care, and compiling and maintaining this centralized database would prove to be difficult. To understand health records in the managed care space, this chapter discusses the range of health care entities that operate today.

Managed Care Organizations and Related Health Care Entities

The term *managed care* is used to encompass various forms of health care coordination: **accountable care organizations**, HMOs, **exclusive provider organizations**, **independent practice associations**, **physician-hospital organizations**, **management services organizations**, point of service plans, preferred provider organizations, **consolidated medical groups**, and **integrated care** models. Each entity seeks to manage health care spending and increase quality care. All will remain consistent actors within the future of health records.

Accountable Care Organizations

The newest form of managed care is termed an *accountable care organization*. Groups of physicians, hospitals, and other health providers voluntarily come together to give coordinated care to their **Medicare fee-for-service** patients. Providers are accountable for the quality, cost, and overall care of the patients assigned to them.[7]

Health Maintenance Organizations

HMOs are organized health care systems that are responsible for both financing and arranging for the delivery of a broad range of medical services to a defined member population. HMOs can be viewed as a combination of health care insurer and health care delivery system. Whereas traditional health insurers are responsible for reimbursing policyholders for the cost of their health care, HMOs are responsible for arranging for the provision of health care to their policyholders through affiliated providers who are reimbursed under various methods. There are different models of HMOs, including **staff HMOs**, **group practice HMOs**, **network HMOs**, and **direct contract HMOs**, depending on the relationship between the HMO and its participating physicians.

Exclusive Provider Organizations

An exclusive provider organization is similar to an HMO. It generally does not cover health care provided outside the plan's provider network, and coverage is limited to policyholders in certain geographic areas, such as specific counties in a state. Policyholders may not need a referral to see a specialist.

Independent Practice Associations

The members of an independent practice association are independent physicians who affiliate with the association to contract with one or more HMOs. The independent practice association negotiates with HMOs for a **capitation rate** that covers all physician services. The independent practice association, in turn, reimburses the member physicians, although not necessarily by using capitation. The member physicians are at risk for a portion of their patients' health care costs. Therefore, if the capitation payment is lower than the required HMO reimbursement to the physicians, the member physicians must accept lower income. An independent practice association may serve physicians in all specialties in a specific geographic area or only a single specialty.

Physician-Hospital Organizations

A physician-hospital organization is a business entity that allows a hospital and its physicians to negotiate with health insurers. In its simplest and most common version, the participating physicians and the hospital develop model contract terms and reimbursement levels, and they use those terms to negotiate with health insurers. Governance of the physician-hospital organization is shared between the hospital and physicians.

A physician-hospital organization represents a first step toward greater integration between a hospital and its medical staff. This type of organization has the advantage of being able to negotiate contracts on behalf of a group of physicians allied with a hospital. Another advantage of a physician-hospital organization is its ability to track and use health records to manage the delivery system, at least from the standpoints of utilization review and **quality assessment**.

Management Services Organizations

A management services organization represents evolution of the physician-hospital organization into an entity that not only provides a vehicle for negotiating with health insurers but also provides support services to physician practices. The physicians, however, remain independent providers. Management services organizations are based around one or more hospitals with the capacity to provide the support services that form the basis for the organization. In its simplest form, the management services organization operates as a service bureau, providing basic practice support to member physicians, such as billing, collection, administrative support, and electronic data interchanges (such as electronic billing). The physician remains an independent health provider under no legal obligation to use the management services organization on an exclusive basis.

Point of Service Plans

Point of service plans vary but are often a hybrid preferred provider organization. Policyholders may need a referral to see a specialist, but they may also have coverage

for **out-of-network** providers, although with higher cost sharing. HMOs generally provide a point of service option that allows policyholders to use out-of-network providers for an additional fee.

Preferred Provider Organizations

Preferred provider organizations are entities through which employers and health insurers contract to purchase health care products and services from a selected group of health providers. Providers participating in preferred provider organizations agree to abide by utilization review and agree to accept their reimbursement structure and payment levels. In return, preferred provider organizations limit the size of their participating provider panels (networks) and provide incentives for their policyholders to use participating providers instead of other providers. In contrast to individuals with traditional HMO coverage, individuals with preferred provider organization coverage are permitted to use out-of-network providers, although higher levels of coinsurance or deductibles apply for out-of-network coverage.

Consolidated Medical Groups

The term *consolidated medical group* (also known as a medical group practice) refers to a traditional market structure in which physicians combine their resources to share support services as well as contracting with health insurers. Medical practices consolidate and function in a group setting. There is a good deal of interaction among members of the group of participating physicians as well as common goals and objectives for group success.

Integrated Care Models

Three integrated care models are prevalent in the managed care space: two foundation models and the physician ownership model. These health care entities have within their purview testing laboratories, pharmacist services, and related treatment services; all are part of the patient data flow. In integrated care, patient-based **longitudinal health records** are part of the health information infrastructure that contains *all* health-related data for a particular patient, including all test results, diagnostic images, and treatment data.

Foundation Models of Integrated Care

A foundation model of integrated care is one in which a tax-exempt organization, a hospital or a hospital system, creates a nonprofit foundation that purchases and operates physicians' practices. Depending on applicable state law, the foundation may be licensed to practice medicine or may be exempt from licensure requirements, and it may employ physicians or use hospital funds to purchase physician practices. The foundation as a subsidiary of a **tax-exempt** hospital combines with other affiliated entities to operate an integrated health care system.

In another integrated care model, the foundation is an entity that exists on its own and contracts for services with medical groups and a hospital. The foundation owns and manages the practices, but the physicians become members of a medical group that, in turn, has an exclusive contract for services with the foundation. The foundation board of directors is not dominated by either the hospital or the physicians and may include community members.

Physician Ownership Model of Integrated Care

The physician ownership model of integrated care refers to a **vertically integrated** delivery system in which the physicians hold a significant portion of ownership interest in the health care entities that compose the system. Physicians either own the system or own more than 50% but less than 100%. This model necessarily requires greater alignment of and cooperation between hospitals and physicians in delivery of health care, especially in operation and maintenance of health records.

Other Managed Care Organizations

Utilization Review Organizations

Utilization review is an element of managed care that allows coordination among health providers, monitoring of quality, identification of superior or cost efficient providers as well as of inappropriate use of health care, and medical necessity determinations. Utilization review relies on patient data. **Utilization review organizations** by state legislatures and accreditation associations, including restrictions on the type of patient data that may be gathered and the uses to which it may be put, are becoming progressively more regulated because of the growing importance of these organizations in managed health care.

Pharmacy Benefit Managers

Pharmacy benefit managers provide managed care services to HMOs, self-funded employer group health insurance plans, and Medicare and Medicaid insurance programs. Pharmacy benefit managers may be at financial risk for managing the prescription drug utilization of a defined pool of policyholders or they may contract as third-party administrators. Also, pharmacy benefit managers negotiate rebates and price concessions from manufacturers or pharmacies.

Pharmacy benefit managers apply a variety of managed care techniques to the delivery and financing of prescription drug benefits. These mechanisms include **multitiered drug formularies** that require varying levels of financial participation by policyholders, such as higher co-payments for brand name drugs and lower co-payments for generics. Also, pharmacy benefit managers use prospective, concurrent, and retrospective utilization review to ensure appropriate usage. Pharmacy benefit managers **horizontally integrate** and own mail-order pharmacies, which reduces dispensing fees.

The Effect of Managed Care on Patient Data Management

As the number and complexity of organizations and enterprises involved in the delivery of medical services increase, health records law has been forced to develop along with them. Health record administrators, who have performed quantitative and departmentally focused tasks, must now adopt a systems approach to management of patient data in a managed care space. Traditional health records management—such as forms control, record content analysis and control, record tracking, release of information monitoring, record storage, and record destruction—are now performed within large, diverse health care systems, requiring that decision making and problem solving address the system as a whole. The range of personnel, facilities, and medical

equipment that are connected and supported by a health information management system also dictates a comprehensive approach to the subject of health records and the law.

Traditional legal issues affecting the collection, maintenance, and access to patient data have evolved with today's health care systems. **Electronic health records** are having a profound effect on the law surrounding management of patient data. The traditional approach to health records law focused on the hospital's role in creating and maintaining patient data, and the early legislation focused on the responsibilities of hospitals for ensuring that the patient data are accurate and complete and that patient confidentiality is protected. Health records law also deals with hospitals as primary players in the delivery of health care, often involving claims for improper disclosure of information or access to peer review records.

With managed care as the dominant form of health insurance coverage, the hospital's prominence as the keeper of the health record is reduced. A patient may consult many health providers—including primary care physicians, specialists, hospitals, laboratories, surgical centers, and rehabilitation centers—and each of them will participate in creating a record for that patient. Numerous individuals hold records containing patient data held by health care entities in different locations, many of which are part of a provider network established by a managed care plan. The clinical information gathered by these providers needs to be shared in the interest of optimal care of individual patients. Also, managed care plans rely on health records, and the plans accumulate enormous amounts of data for **cost assessment** and utilization review. Employers also become part of this data integration and collect and store patient-generated health data as part of the process of providing health insurance to their employees and documenting workers' compensation claims.

The penetration of managed care into the health care delivery system has also been an impetus for the computerization of patient-generated health data as data networking becomes necessary to link consumers, employers, health insurers, and health providers. Many health care reforms include recommendations for network information systems that may achieve managed care goals of cutting costs while safeguarding the quality of patient care. The establishment of this type of data exchange, however, has raised concerns about protecting the privacy of patient data as the control of any individual provider over the release of the information decreases. Health care reform proposals also factor into their recommendations the growing difficulty of determining who owns and assumes responsibility for protecting against unauthorized access to electronic health records.

HIPAA and State Privacy Rules

Passage of the Health Insurance Portability and Accountability Act (HIPAA) and subsequent implementation of the **HIPAA Privacy Rule** changed the way health care entities use and disclose patient data.[8] The Privacy Rule governs the use and disclosure of **protected health information**, a term that includes any patient-generated health data (including payment-related information) that is linked to an identifier (such as a birth) that could be used to identify the individual. Most health insurance plans, health providers, and clearinghouses are **covered entities** subject to the Privacy Rule.

Ownership of Health Records

Although the Privacy Rule does not govern ownership of patient-generated health data, the rule requires covered entities to respect patient rights, including the right to

access and amend their information. Notwithstanding this focus on privacy rights, health providers own the health records, which may be released or accessed only under specific circumstances. Some states have begun to respond to the ambiguities that arise in today's managed care space where providers are in fact employees of larger health care systems. Florida law, for instance, provides that the term **records owner** refers to

> any health care practitioner who generates a health record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person; any health care practitioner to whom records are transferred by a previous record owner; or any health care practitioner's employer, including but not limited to group practices and staff model HMOs, provided the employment contract or agreement between the employer and the health care practitioner designates the employer as the records owner.[9]

The Florida law goes on to list providers and health care entities that are not authorized to acquire or own health records but are authorized to maintain such documents under their respective licensing laws (for instance, pharmacies and pharmacists, nursing home administrators, and clinical laboratory personnel). Owners of health records, as defined in the Florida law, bear the responsibility of maintaining a register of all disclosures of patient data to third parties.

Unauthorized Disclosures

Also, with legislation in the majority of states imposing on physicians and other health providers the duty to guard against **unauthorized disclosures**, state legislatures have had to respond to changes affecting the way health care is delivered and recorded. In a minority of states, legislatures have adopted more generic laws governing patient data. Many states (for instance, Tennessee) now impose confidentiality requirements on HMOs and managed care organizations;[10] numerous other states impose similar obligations on utilization review organizations, health insurers, insurance agents, and insurance support organizations.[11]

Mandatory Reporting

Recognized exceptions to patient privacy in **mandatory reporting laws** relating to child abuse, infectious diseases, or dangers to third parties impose a duty to report certain conditions or events. This duty to report is imposed on the health provider who is closest to the patient in the treatment relationship. These laws have been in effect before the computerized distribution of patient data that is occurring in today's managed care environment.

Increasingly, however, managed care plans are acquiring patient data that can generate the same duty to disclose information as that imposed on primary providers, such as the physician or the hospital. Independent practice associations, utilization review organizations, third-party administrators, and employer-sponsored health insurance plans that lawfully access patient data may be considered health providers for the purposes of mandatory reporting obligations, even though they do not directly deliver health care to patients. In Maryland, for instance, the definition of health provider under the state Health Records Act includes HMOs and the agents, employees, officers, and directors of a health care entity.[12] Because managed care plans generally fall within the statutory definition of an HMO, the agents of these plans who work in claims processing, utilization review, or cost or utilization assessments have duties to

disclose information on patients under specific circumstances and are protected from liability for **good faith disclosure** actions, such as elder abuse.[13]

Changes in Health Record Standards

State regulations and professional associations that accredit health care entities have also responded to the growing number of organizations that collect patient data. For instance, the **National Committee for Quality Assurance** accredits managed care organizations and health insurance plans and has elaborated health record standards that apply to these organizations and plans.[14] Also, the **Joint Commission** accredits health care entities—including hospitals and preferred provider organizations—and has health record standards that govern the type of patient data they collect. In addition, the Joint Commission accreditation standards govern information management and require that the health record contain information to facilitate continuity of care.[15] The Joint Commission's accreditation manuals also address appropriate levels of security and confidentiality of patient data while at the same time ensuring that health care entities have adequate capability to integrate and interpret data on individual patients.[16] Increasingly, the standards governing health records must consider the roles of a variety of actors and organizations with regard to a multitude of evolving standards addressing the definition, permitted use, ownership, content, access, reporting, and retention of health records.

Chapter Summary

- Health records are critical to continuity of patient care, are the basis for medical billing, are subject to significant regulations, and are owned by both patients and providers.
- Managed care organizations subject health records to scrutiny, called utilization review, in order to both minimize unnecessary care in an effort to contain health care costs and maximize care coordination in an effort to improve patient outcomes.
- There are many different kinds of managed care organizations, all aimed at managing health care spending and improving health care quality.
- The various forms of managed care organizations aimed at providing affordable, high-quality patient care include accountable care organizations, health maintenance organizations, exclusive provider organizations, independent practice associations, physician-hospital organizations, management services organizations, point of service plans, preferred provider organizations, consolidated medical groups, and integrated care models.
- Other forms of managed care organizations not aimed directly at providing patient care include utilization review organizations and pharmacy benefit managers.
- The number and complexity of managed care organizations complicate health records management as well as the related laws governing the privacy and security of patient data.
- Laws governing health records are aimed at ensuring completeness and accuracy as well as the confidentiality of patient data.
- Electronic health records developed as the need to connect patients, their employers, health insurers, and health providers arose, but as more parties have access to the records in managed care organizations, it becomes more difficult

(but not impossible) to protect patient privacy and assign liability when confidentiality is breached.

- HIPAA was enacted in an attempt to protect the confidentiality of patient data, but major problems with the law include the complexity of its rules and regulations as well as its failure to define who owns the information in a patient's health records.
- A patient's protected health information can be used and disclosed without their authorization in instances of child abuse, infectious disease and illness, and whenever a patient is a potential danger to themselves or others; providers and health care entities are considered mandatory reporters of these instances under certain circumstances.
- Increasingly, the standards surrounding health records and patient privacy are set by professional associations and the health care industry itself, as opposed to legislatures, as the law struggles to keep pace with new technologies and the evolution of electronic health records.

Chapter Endnotes

1. *See, e.g.*, 42 C.F.R. § 482.30 (condition of participation: utilization review) requiring hospitals seeking to participate in the Medicare and Medicaid insurance programs to have a utilization review plan that provides for review of services furnished by the hospital and by members of its medical staff.
2. 42 U.S.C. § 1320c-3 (functions of quality improvement organizations).
3. 42 U.S.C. § 1320c-5 (obligations of health providers and providers of medical services; sanctions and penalties; hearings and review).
4. *Id*.
5. Epstein, J. D. (2017). The government's golden rule: America's attempts to control health care payment. *Journal of Health and Life Sciences Law, 10*(3), 34–57.
6. Frankford, D. M. (2016). Assessing the Affordable Care Act and moving forward: It's the prices, advanced capitalism, and the need for rate setting. *Journal of Law, Medicine and Ethics, 44*, 569–573; Szostak, D. C. (2015). Vertical integration in health care: The regulatory landscape. *DePaul Journal of Health Care Law, 17*, 65–119.
7. *See* 42 U.S.C. 1395 (prohibition against any federal interference) prohibiting "any supervision or control over the practice of medicine."
8. *See* 45 C.F.R. § 164, Subpart E (privacy of individually identifiable health information).
9. *See* Fla. Stat. § 456.057(a).
10. *See* Tenn. Code Ann. § 56-32-225.
11. *See, e.g.*, N.Y. Ins. Law § 4905.
12. Md. Code Ann., Health-Gen. II, §§ 4-301 through 4-305.
13. Kapp, M. B. (2016). The physician's responsibility concerning firearms and older patients. *Kansas Journal of Law and Public Policy, 25*, 159–186; Pearl, S. E. (2014). HIPAA: Caught in the crossfire. *Duke Law Journal, 64*, 559–604.
14. National Committee for Quality Assurance. (2017). *Standards for accreditation of health plans*. Washington, DC: NCQA; *see also,* ___. (2017). *Standards for accreditation of accountable care organizations;* ___. (2017). *Standards for accreditation of case management;* ___. (2017). *Standards for accreditation of disease management;* ___. (2017). *Standards for accreditation of managed behavioral healthcare organizations;* ___. (2017). *Standards for accreditation of wellness and health promotion*.
15. Joint Commission. (2017). *Transitions of care: The need for a more effective approach to continuing patient care*. Chicago, IL: Joint Commission.
16. Joint Commission. (2017). *Accreditation standards for ambulatory care.* Chicago, IL: Joint Commission; *see also*, ___. (2017). *Accreditation standards for behavioral health care*; ___. (2017). *Accreditation standards for hospitals*; ___. (2017). *Accreditation standards for office based surgery*.