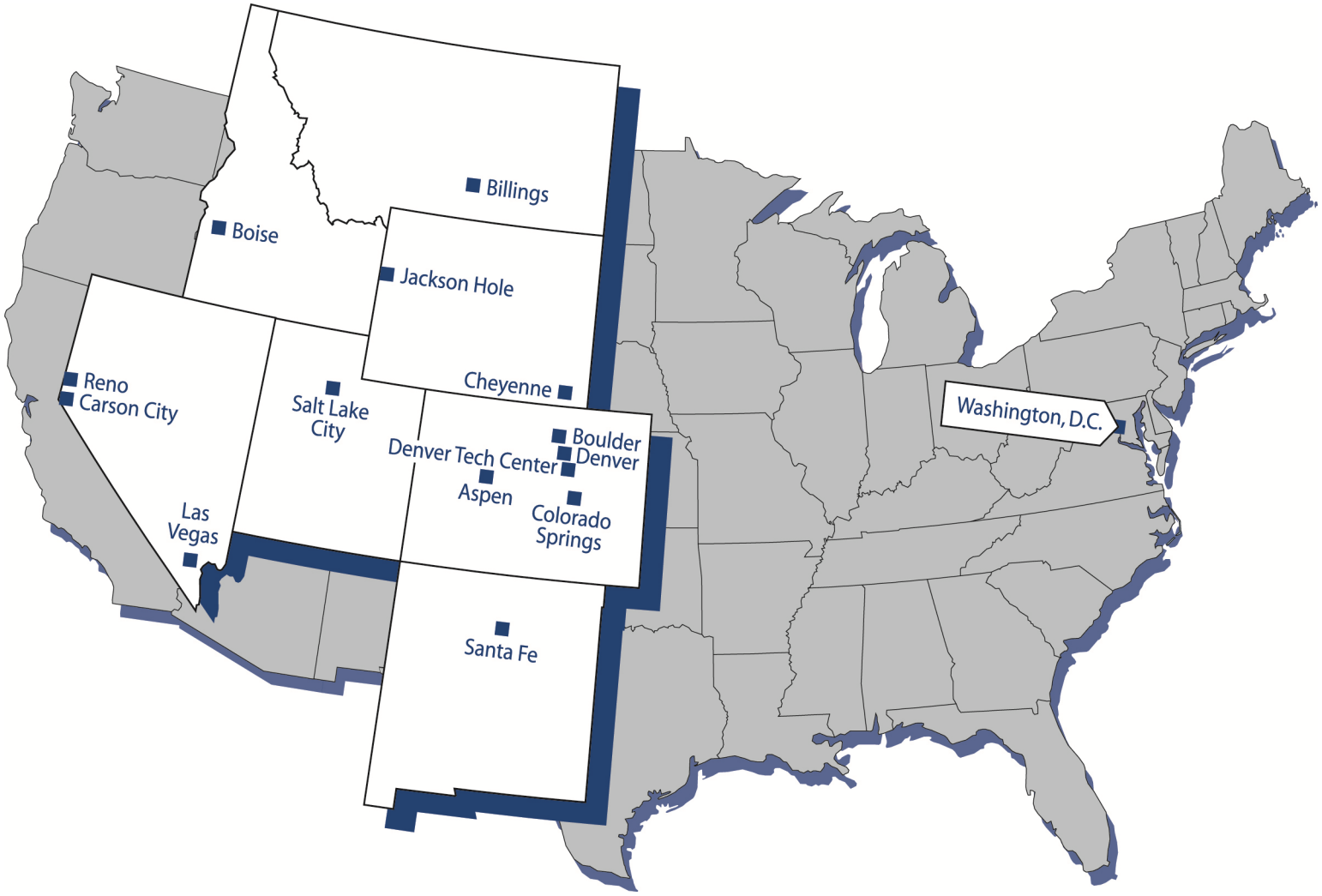
Hospital Board Training Part 1: Board Operations

Kim C. Stanger
Holland & Hart LLP
(5-16)

HOLLAND&HART

This presentation is similar to any other legal education materials designed to provide general information on pertinent legal topics. The statements made as part of the presentation are provided for educational purposes only. They do not constitute legal advice nor do they necessarily reflect the views of Holland & Hart LLP or any of its attorneys other than the speaker. This presentation is not intended to create an attorney-client relationship between you and Holland & Hart LLP. If you have specific questions as to the application of law to your activities, you should seek the advice of your legal counsel.

Holland & Hart LLP



HOLLAND&HART

Preliminaries

- Written materials
- Presentation will be recorded and available for download at www.hhhealthlawblog.com.
- If you have questions, please submit them using chat line or e-mail me at kcstanger@hollandhart.com.

Overview

What board members should know about operations

- Rules Affecting Hospitals
- Board Responsibilities
- Fiduciary Duties
- Hospital Finance 101
- Consolidation and Alignment
- Medical Staff
- Credentialing and Corrective Action
- Protections for Board Members

Key laws board members should know

- Fraud and Abuse Laws
  - False Claims Act
  - Anti-Kickback Statute
  - Stark
  - Civil Monetary Penalties Law
- EMTALA
- HIPAA
- Antitrust

- This is an overview of some of the basic principles.
- Check your own situation when it's time to apply:
  - State statutes and regulations
  - Hospital and medical staff bylaws
  - Contracts

Types of Hospitals

Public (govt owned)

- subject to state laws regarding operations (e.g., open meeting, public records, elections, finance, etc.).
- govt immunity.
- board must act per statutory obligations.

Private nonprofit

- not subject to taxes.
- operate for charitable purpose, not private benefit or for profit.
- provide charity care.
- board must further charitable mission.

Private for profit

- greater flexibility.
- subject to taxes.
- must comply with corporate laws.
- board must act for benefit of shareholders.

Rules Affecting Hospitals

- State licensure laws and regulations.
  - Govern items such as physical facilities, staffing, services, governing body requirements.
- For example, IDAPA 16.03.14.200:
  - Hospital must have governing body responsible for operation of hospital.
  - Governing body must:
    - Implement bylaws governing board operations.
    - Appoint and reappoint medical staff members.
    - Review and approve medical staff bylaws.
    - Hire and supervise administrator.

Rules Affecting Hospitals

There are always strings attached to govt money.

Rules Affecting Hospitals

- If hospital wants to participate in govt payment programs (e.g., Medicare or Medicaid), hospital must comply with rules.
  - Conditions of Participation ("CoPs").
    - Hospitals (42 CFR 481)
    - Critical Access Hospitals ("CAHs") (42 CFR 485)
  - Rules governing payment.
    - E.g., medical necessity, orders, supervision, etc.
    - Fraud and abuse laws.

  Violation may result in exclusion from program and repayment.
- Certification can be achieved through:
  - Surveys by state licensing agency.
  - Accreditation by The Joint Commission.

Rules Affecting Hospitals

- For example, 42 CFR 481.20:
  - "The hospital must have an effective governing body legally responsible for the conduct of the hospital...."
  - Governing body must:
    - Appoint medical staff members.
    - Ensure the medical staff is accountable to the governing body.
    - Appoint a chief executive officer who is responsible for managing the hospital.
    - Ensure that care is provided through licensed and qualified practitioners.
    - Ensure the hospital has a budget.
    - Others.

Board Responsibilities

- Hospital mission, vision and values
- Strategic planning
- Effective administration
- Quality patient care
- Qualified practitioners
- Financial stability
- Community relations
- Statutory and regulatory compliance
- Board education and efficient processes


Don’t get distracted by the unimportant or things outside your responsibility!
#GOBEACH
jetBlue

Shared Responsibility

Board of Trustees:

"ultimate authority and responsibility for the operation of the hospital."

(IDAPA 16.03.14.200;

see also IC 31-3607 and -3617)

Administration

"vest[ed] with general managerial powers over the operation of the hospital…"

(IC 31-3609)

Medical Staff

"responsible to the [Board] for the quality of all medical care provided the patients, and for the professional practices … of the members."

(IDAPA 16.03.14.250)

Board Roles

- Board roles may differ
  - Governing body
  - Advisory body
- In general, board has certain roles for:
  - Decision making
  - Policy making
  - Oversight of management

See D. Arnwine, *Effective Governance: The Roles and Responsibilities of Board Members*

- *Check your bylaws and particular statutes.*

Board Roles: Decision Making

- Strategic plan
- Hire CEO
- Credential providers
- Approve budgets
- Others?

Board Roles: Policy Making

- Board should establish general policies that further hospital mission.
  - Board policies.
  - Review and approve hospital and medical staff bylaws, rules, policies.
- Board delegates implementation of policies to management.

Board Roles: Oversight

- Board should oversee administration.
  - Establish strategic plans.
  - Ensure policies and processes are in place.
  - Require and review periodic reports from administration and medical staff.
  - Ask appropriate questions.
  - Follow up on issues that arise.
  - Hold administration accountable.

Board Roles: Oversight

- Board should <u>not</u> try to manage day-to-day operations itself.
  - Board lacks time, training, experience, and information to manage effectively.
  - Board needs to focus on achieving the hospital's mission, not micromanaging operations.

Governance v. Management

Board

- Focuses on long term objectives.
- Establishes or ensures policies are in place.
- Hires and requires reports from CEO.
- Credentials practitioners.
- Reviews and responds to reports.

Administration

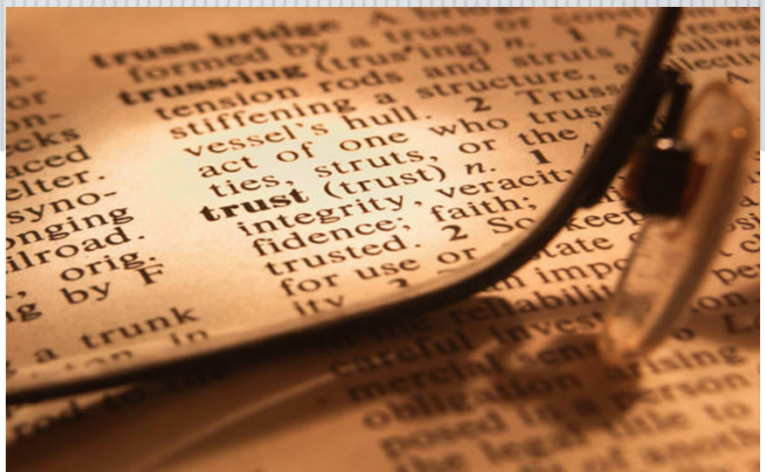
- Tactical steps to achieve strategic plan.
- Implements and enforces policies.
- Handles day-to-day operations.
- Deals with employment issues.
- Prepares and makes reports to board.

Board Authority

- The Board has the authority, not individual members.
  - Board must have quorum to act.
  - Board may delegate authority to committees or individuals.
  - Individual board members lack authority to act on their own unless authorized by the board.
- Board member may expose themselves to liability if he or she acts outside scope of authority.

Fiduciary Duties

Fiduciary Duties



Trustee = Fiduciary

- "Trustee"
  - Holds or cares for property for benefit of others.
  - One in whom trust is placed.
- "Fiduciary"
  - Holds or cares for property of another.
  - Faithful, loyal, true, e.g., fidelity.

Fiduciary Duties

- Found in statutes
  - Corporate code
  - Internal Revenue Service code
  - Public hospital acts
  - Ethics in government acts
- Found in common law
  - Duty of care
  - Duty of loyalty
  - Duty of obedience
  - Duty of confidentiality

Duty of Care

- Board members must act –
  - In good faith
  - With the care that a person in a like position would reasonably believe appropriate under similar circumstances.
    - Take reasonable steps to become informed
    - Make reasonable inquiry where appropriate
    - May rely on officers, committees, or outside professionals if reliance is reasonable.

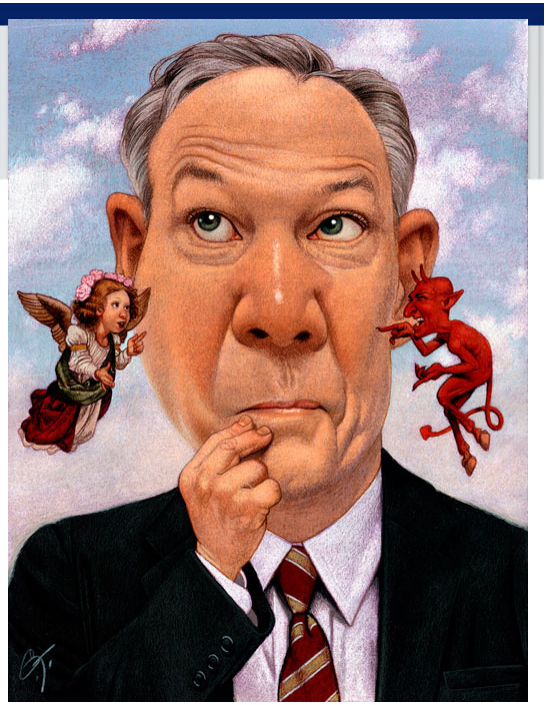
Duty of Care

- Do not do this…

Duty of Care

- Do not abdicate responsibilities.
- Prepare for meetings.
- Attend and participate in meetings.
- Review relevant info before making decision.
- Ask questions.
- Seek advice from experts, consultants or advisors.
- Document efforts and information in board minutes.
- Exercise independent judgment; do not “rubber stamp” decisions.
- Vote no when necessary.
- Do not act in haste.
- Establish process for requiring and then review periodic reports.
- Establish appropriate committees to address key areas.

Duty of Loyalty



- Board member must act in a manner the member reasonably believes to be in the best interests of the hospital.
  - Do not use position to gain secret profit or compete with hospital.
  - Do not usurp hospital opportunity.
  - Beware conflict of interest…

Conflict of Interest

- Conflict of Interest = board member (or related person) has a financial interest in matter such that it would reasonably be expected to exert an influence on the member's judgment.
- Board members must—
  - Avoid conflicts of interest.
  - Disclose conflict of interest to the Board.
  - Abstain from participating in any discussion or voting regarding any matter in which member (or related party) has a conflict of interest.
- *Check statutes and policies.*

Conflict of Interest

- Examples: Board is considering—
  - Contract with entity owned by member, member's family, or other related person.
  - New service that may affect member or related person for good or bad.
  - Credentialing or corrective action against physician who is a partner or competitor.
  - Rules or policies that may result in material financial impact on member or related person.
- *Test: Is interest such that it would reasonably influence member's judgment?*

Duty of Obedience

- Board members must act consistent with goals and mission of hospital and in compliance with:
  - Applicable laws.
  - Bylaws.
  - Delegation by board.
- Board members may be liable for *ultra vires* acts, i.e., "beyond powers" or outside scope of authority.
  - Breach of fiduciary duty.
  - Loss of statutory immunity.
  - Loss of directors and officers insurance.

Duty of Obedience

- Health Insurance Portability and Accountability Act (HIPAA): board members who knowingly engage in improper practices or who deliberately ignore or recklessly disregard their legal obligations may be subject to penalties.
  - False claims laws
  - Anti-kickback statute
  - Stark law

  See AHLA/OIG Guidance

Duty of Obedience

- Become generally familiar with governing rules.
  - Bylaws.
  - Statutes relevant to board operations.
  - Basic statutes relevant to hospital operations, especially fraud and abuse laws.
- Stay within scope of authority.
  - When in doubt, seek expert guidance.
- Document "no" votes when appropriate.
- Ensure hospital has effective compliance plan.

Duty of Confidentiality

- Do not use or disclose confidential, non-public info obtained in capacity as board member without authorization.
- Peer review privilege applies to many board functions, e.g.,
  - Credentialing and peer review
  - Quality improvement

  May waive privilege if make improper disclosures.
- May be liable for improper disclosures, e.g., HIPAA penalties, peer review statute, breach of fiduciary duties.
- Public entities: just because you can say it doesn't necessarily mean you should…

Business Judgment Rule

- Board members are generally not liable for mistakes in judgment if they act—
  - in good faith;
  - with the care that an ordinarily prudent person in a like position would exercise under similar circumstances; and
  - in a manner the directors reasonably believe to be in the best interests of the corporation.

Business Judgment Rule

- *Stern v. Sibley Memorial Hospital*
  - Trustees deposited hospital assets at local banks at low or no interest; no reasonable investments.
  - Board members had ties to the bank.
  - Finance committee never met in 10 years.

✓ Breach of fiduciary duty

- *In re Caremark*
  - Caremark had to pay millions in fines due to violations of fraud and abuse laws.
  - Board members sought legal advice from lawyers.
  - Lawyers were wrong…

✓ No breach of fiduciary duty

Hospital Finance 101

- Hospitals do not operate like other businesses!

Hospitals don't operate like other businesses

* Consumers (customers) pay same price.
* Prices set above cost to make profit.
* If you can't pay, you don't buy.

* Must provide quality care.
* Highly regulated; can't do things you can do in other business.
* Consumers (payers) pay different prices.
* Some payers (govt) pay below cost.
* If you can't pay, hospital may still have to provide services.

Hospitals don't operate like other businesses

- Must provide quality care.
  - Consequences are life and death.
- Highly regulated.
  - Can't do in healthcare what you can do elsewhere
- Must provide some level of uncompensated care.
  - EMTALA
  - Charitable purpose
  - Public hospital obligations
  - Avoid malpractice or abandonment
  - Moral obligation
- Consumers (payers) have bargaining power.
  - Medicare, Medicaid, etc.
  - Commercial payers

Payers all pay different rates

- Government programs
  - Medicare
  - Medicaid
  - CHIP
  - Tricare
  - Other programs
- Commercial payers
  - Health insurers
  - Employer plans
- Self-pay
  - Co-pays and deductibles
  - Uninsured
  - Underinsured

- Politicians and bureaucrats determine rates and conditions.
- Govt can impose penalties for failure to comply.
- Providers can opt out, but difficult to survive.

- Negotiated rates and conditions depends on bargaining power.

- Self pay = "no pay"
- Individuals often lack resources to pay bills.
- Difficult to collect.

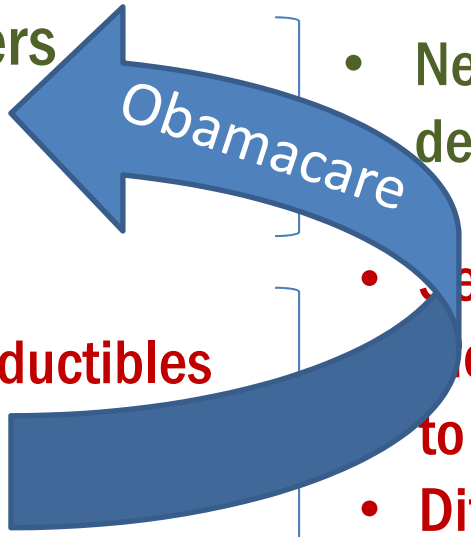
Payers all pay different rates

- Government programs
  - Medicare
  - Medicaid
  - CHIP
  - Tricare
  - Other programs
- Commercial payers
  - Health insurers
  - Employer plans
- Self-pay
  - Co-pays and deductibles
  - Uninsured
  - Underinsured

- Politicians and bureaucrats determine rates and conditions.
- Govt can impose penalties for failure to comply.
- Providers can opt out, but difficult to survive.

- Negotiated rates and conditions depends on bargaining power.

- elf pay = "no pay"
- dividuals often lack resources to pay bills.
- Difficult to collect.



Medicare and Medicaid

In 2012, Medicare, Medicaid and CHIP spent $1 trillion ($1,000,000,000,000), 36% of the USA's total health care expenditures.

Medicare and Medicaid

Health & Human Services ("HHS")

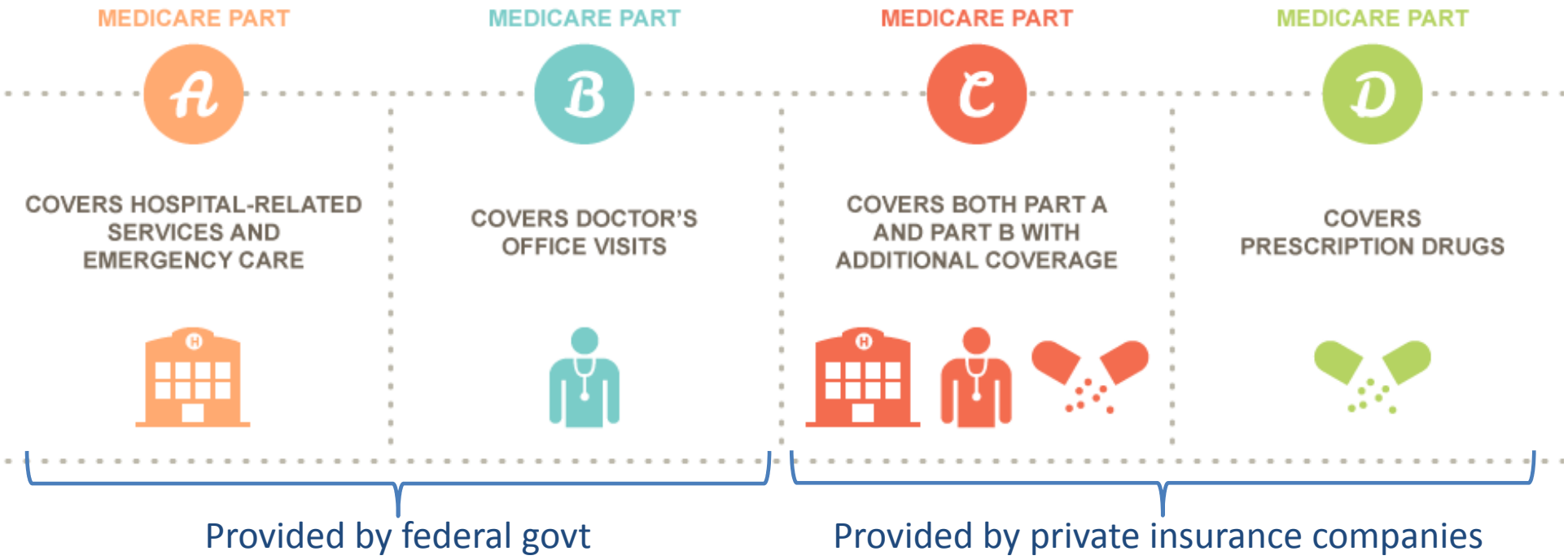
Centers for Medicare and Medicaid Services ("CMS")

Medicare (Federal)

Medicaid (Federal + State)

Medicare

- Federal medical insurance for:
  - Over age 65 who have paid or do pay into program.
  - Certain persons with disabilities
  - Persons with end stage renal disease ("ESRD")



Medicare: Hospitals

"The good old days..."

- Fee for Service
  - $ per service provided.

Medicare: Hospitals

- Inpatient: Prospective Payment System ("PPS")
  - Set $ based on patient's diagnosis using Medicare Severity Diagnosis Related Groups ("MS-DRGs"), not services provided.
    - Creates incentive to be efficient, reduce utilization and costs, and reduce length of stay ("LOS").
    - "Average Length of Stay" is a common metric.
- Outpatient: Outpatient Prospective Payment System ("OPPS")
  - Set $ based on Ambulatory Payment Classification ("APC") groups, not services provided.

Medicare: Hospitals

- Critical Access Hospital ("CAH")
  - Inpatient
  - Outpatient

  101% of reasonable costs based on cost report (but not all costs included in report).

- Disproportionate Share Hospitals
  - Higher reimbursement to partially offset losses from uncompensated care.

- Sole Community Hospital ("SCH")
  - Inpatient: cost-based reimbursement
  - Outpatient: APC

Medicare: Physicians

- Provider-Based Clinics:
  - Paid as outpatient department of hospital.
- Freestanding Clinics.
  - Paid the lower of—
    - The submitted charge, or
    - Medicare fee schedule based on the relative value score ("RVS") associated with specific service.
  - Services assigned a Current Procedural Terminology ("CPT") code.
- New MACRA rules will shift to value-based purchasing.

Medicare Claims Processing

- **Medicare Administrative Contractors ("MAC"):** private contractors review and process Medicare Parts A and B claims.
- **Recovery Audit Contractors ("RAC"):** Private contractors who audit compliance and recover improper payments.
  - E.g., medical necessity, improper coding, lack of documentation, lack of required supervision, etc.
  - Receive % of amounts recovered (bounty hunters).

Medicaid

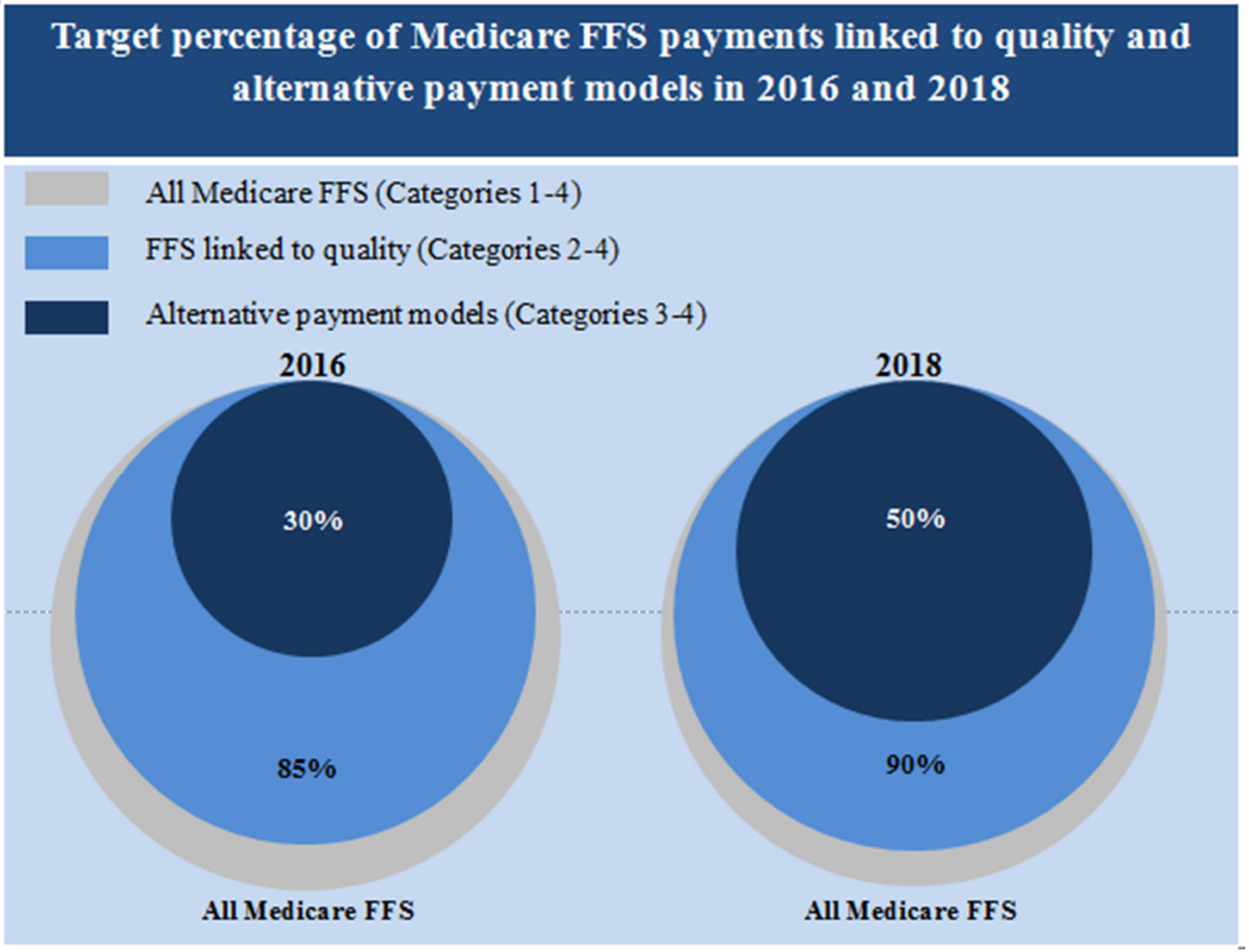
- State welfare program for:
  - Low-income
  - Disabled
- Funded by federal and state.
  - Feds: 60% to 75% (Federal Medical Assistance Percentage or "FMAP")
  - State: 25% to 40%
- Coverage varies by state.
  - Must provide certain benefits to receive federal funds.
  - State may opt to provide additional benefits.
- Payment methodology varies by state.
  - Discounted fee schedule
  - Per diem
  - Case rate
  - Other?

Medicare/Medicaid: the Future?

- Medicare trust fund is not sustainable.
- Federal govt is looking for ways to change.
  - Reduced reimbursement for providers.
  - Eliminating favorable payment programs.
  - Medicare Shared Savings Program ("MSSP")
    - If Accountable Care Organizations ("ACO") achieve cost and quality goals, they receive a percentage of savings to Medicare program.
  - No payment for hospital-acquired conditions.
  - Pay for Performance ("P4P")
  - Value-Based Purchasing

Medicare: Value-Based Purchasing

- ACOs
- Medical homes
- Bundled payments
- Others



Commercial/Private Payers

- Reimbursement based on negotiated rates and terms.
  - **Discounted fee-for-service:**
    - Fee schedule
    - % of usual and customary charges
  - **Case-based:** Set $ for diagnosis regardless of services provided (e.g., DRGs).
  - **Per-diem:** Set $ per day regardless of services provided.
  - **Capitation:** Set $ per member per month regardless of services (i.e., paid "per capita").
  - **Pay for performance:** $ (including bonuses) based on achieving outcomes or quality metrics.

Providers share risk

Commercial/Private Payers

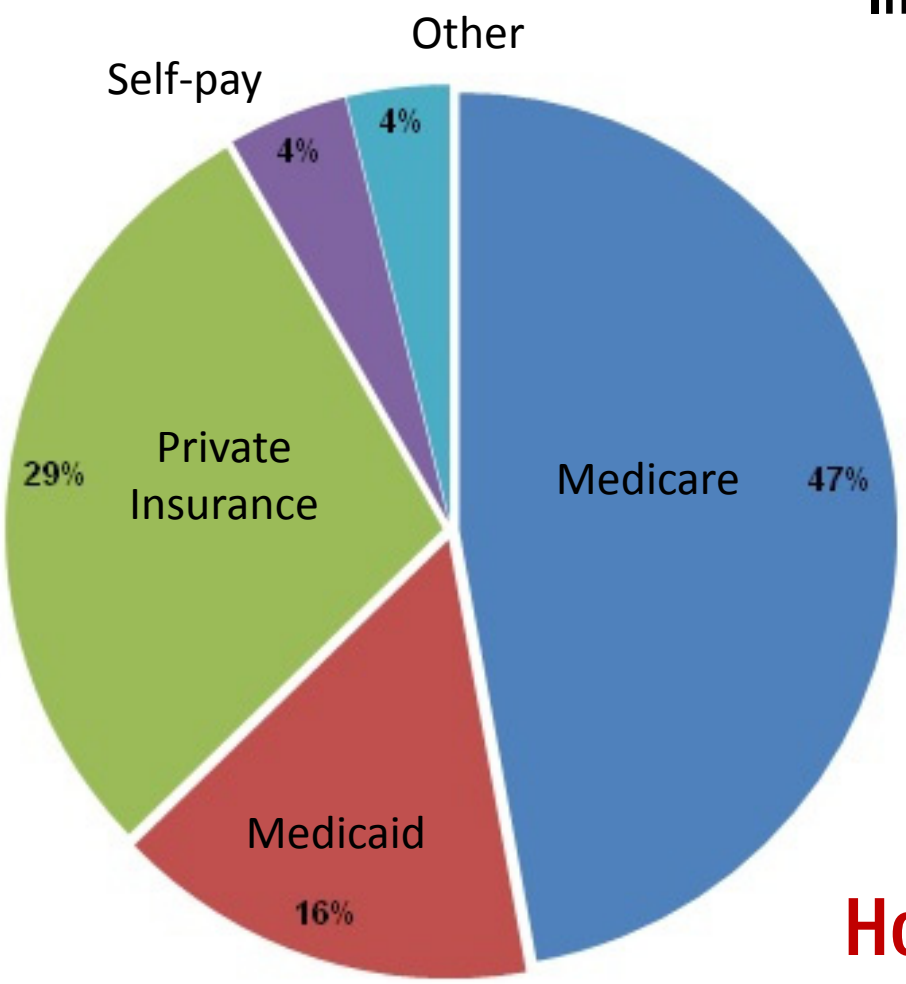
It's all a matter of contract!

The more power you have, the better deal you can get!

Payers

Patient	Payer	Cost	Standard Charge (Charge-master)	Reimbursement Method	Actual Reimburse-ment (Contractual Adjustment)
Amy	Medicare	$100	$150	PPS or APC Cost-based	$90 or $101
Bob	Medicaid	$100	$150	Discounted fees Case rate	$85
Cathy	Private insurance	$100	$150	Discounted fees Case rate Capitation Per diem	$120
Don	Self-pay	$100	$150	If able to collect Charity care	$150 to $0
Actual Revenue		$400	$600	Increase standard charge to cover unprofitable cases	$295 to $456

Payer Mix



Inpatient Hospital Stays (2011)

38,591,000 total hospital stays

$387.2 billion in aggregate costs for hospitalization

- Medicare
- Medicaid
- Private insurance
- Uninsured
- Other/Missing

Hospital's payer mix is key factor in profitability.

Service Mix

- Some hospital service are more profitable than others, depending on market and payers.
- Service mix is another key factor in profitability.

More Profitable

- Surgery
  - Neurosurgery
  - Interventional cardiology
  - Orthopedics
- Ancillary services
  - Imaging
  - Pharmacy
  - Labs
- Pathology

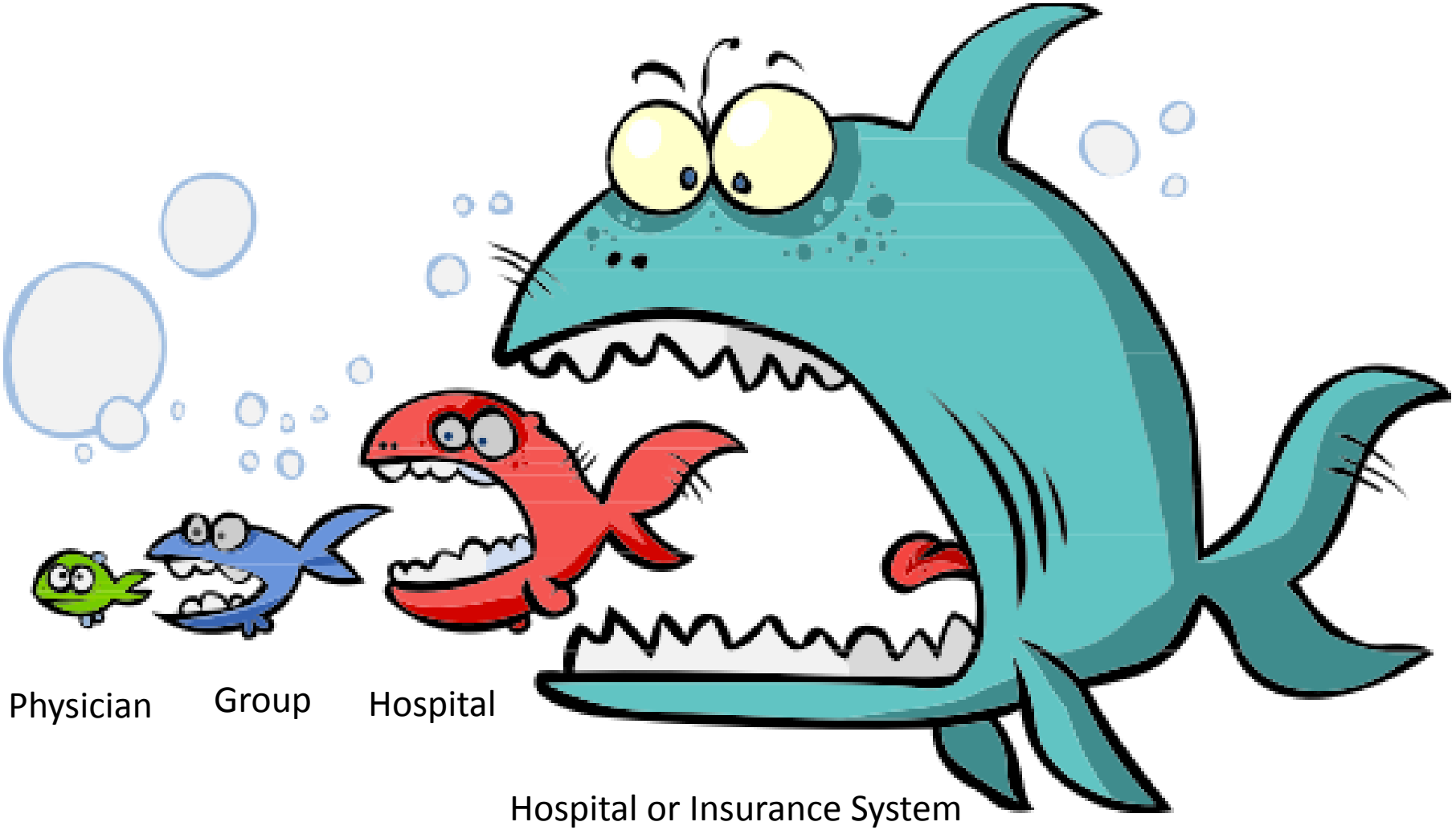
Less Profitable or Unprofitable

- Emergency department
- Obstetrics
- Intensive care unit
- Medical groups
- Mental health

Healthcare Finance

HOLLAND&HART

Healthcare Consolidation



Healthcare Consolidation

Trends:

- Hospitals purchasing physician practices and employing physicians ("physician integration")
- Larger hospitals acquiring smaller hospitals.
- Hospitals merging to join larger system.
- Hospitals and physician practices forming joint ventures.
- Physicians forming networks.

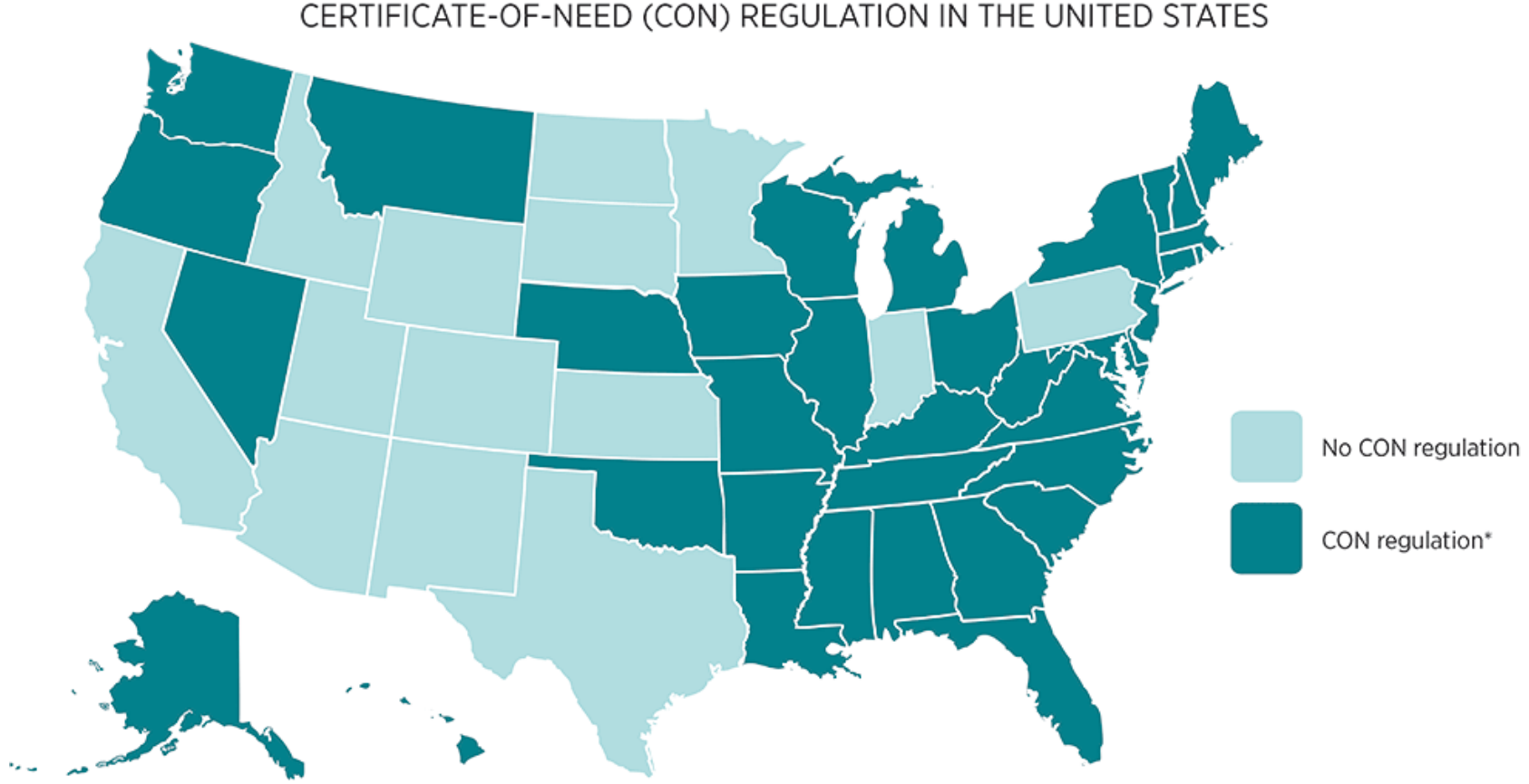
Why?

- Provide coordinated care across spectrum.
- Capture referral sources.
- Increase bargaining power with payers.
- Participate in new payment models, e.g., ACOs, MSSP, etc.
- Leverage increasing costs of providing care, e.g., technology, compliance, etc.

Certificate of Need

- Some states require proposed operator to obtain regulatory approval ("certificate of need") to build or operate certain types of healthcare facilities.
- Purpose
  - Ensure existing providers maintain sufficient volume to maintain proficiency.
  - Ensure availability of cost-effective necessary services.
  - For existing providers, avoid competition.
- *Check your state law.*

Certificate of Need



MERCATUS CENTER
George Mason University

* As of 2011, after the period covered in this study, Wisconsin has repealed its CON regulations.

Source: American Health Planning Association. National Directory: State Certificate of Need Programs, Health Planning Agencies. Annual volumes, 1994–2012. Falls Church, Virginia: American Health Planning Association, 2012.

HOLLAND&HART

Corporate Practice of Medicine

- Some states prohibit hospitals from directly employing physicians.
- Purpose
  - Medical practices act do not allow corporations to practice medicine.
  - Concern that corporations may interfere with physicians' independent medical judgment.
- *Check your state law.*

Hospital Medical Staff

Practitioner—Hospital Relationship

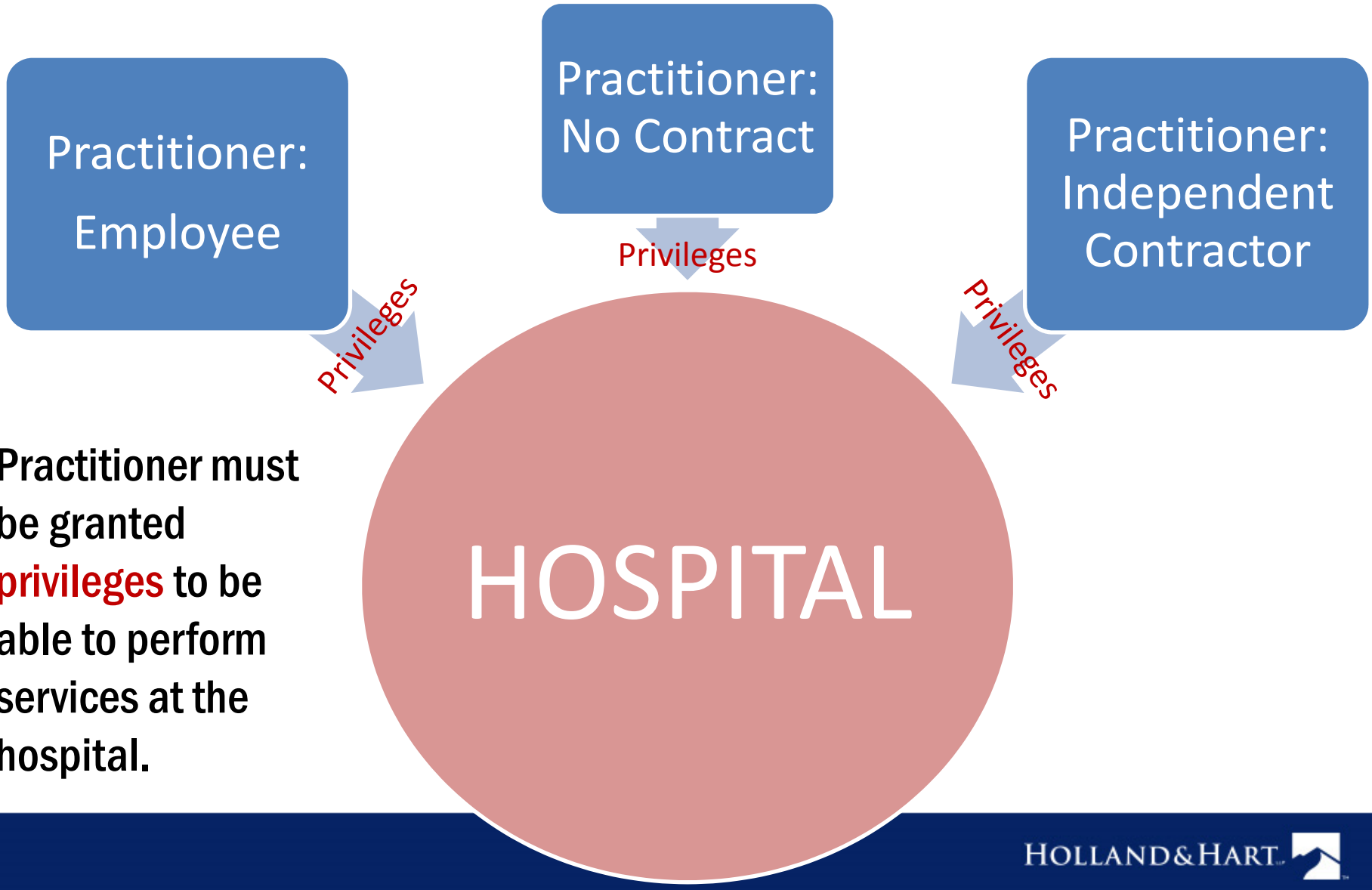
Practitioners:

Rely on hospitals to provide resources needed for practitioner to perform some services or provide other services to patients.

Hospitals:

Rely on practitioners to admit patients, perform services at, or refer patients to the facility.

Practitioner—Hospital Relationship



Practitioner must be granted privileges to be able to perform services at the hospital.

Credentialing

Credentialing

Medical staff membership

- Group of practitioners with privileges at facility.
- Membership = certain rights and responsibilities.
- Must apply for membership.
- Facility's governing board may grant or deny membership.
- Governed by med staff bylaws, rules and policies

Clinical privileges

- Privileges = privilege to perform specified services or procedures at facility.
- Must apply for privileges.
- Facility's governing board may grant or deny privileges.
- Governed by med staff bylaws, rules and policies

Board Responsibilities

- **Quality patient care**
- **Qualified practitioners**

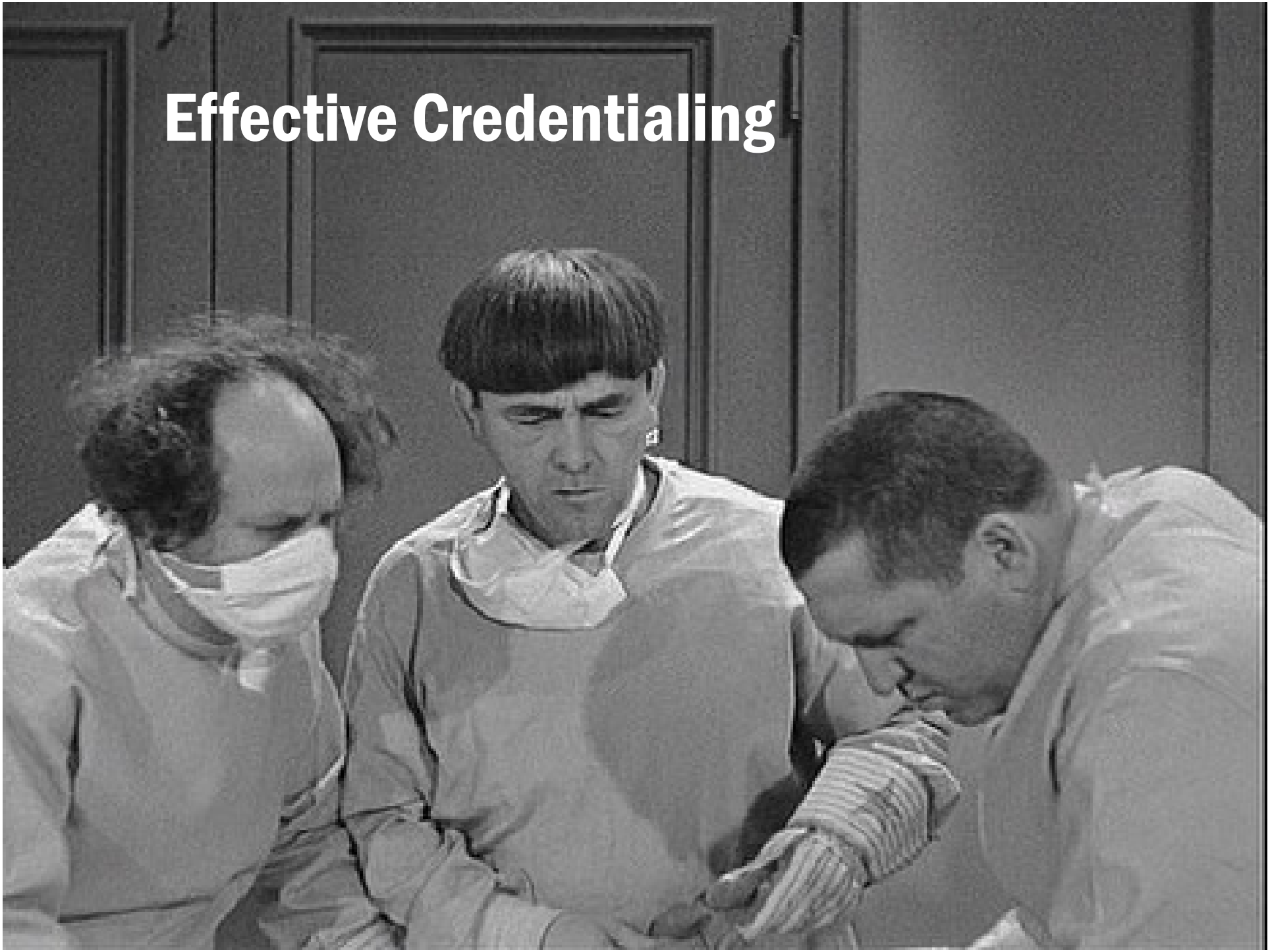
Effective Credentialing!

- Hospital mission, vision and values
- Strategic planning
- Community relations
- Financial stability
- Effective administration
- Statutory and regulatory compliance
- Board education and efficient processes

Who must be credentialed?

- All independent practitioners, i.e., those who are licensed to practice independently.
  - Physicians, podiatrists, dentists, dental surgeons, etc.
  - Allied health practitioners ("AHPs")
    - Advance practice nurses (e.g., nurse practitioners, CRNAs, etc.)
    - Physician assistants
    - Psychologists
    - Therapists
- "Credentialing" may not apply to others (e.g., nurses, techs, etc.), but must ensure they are qualified.

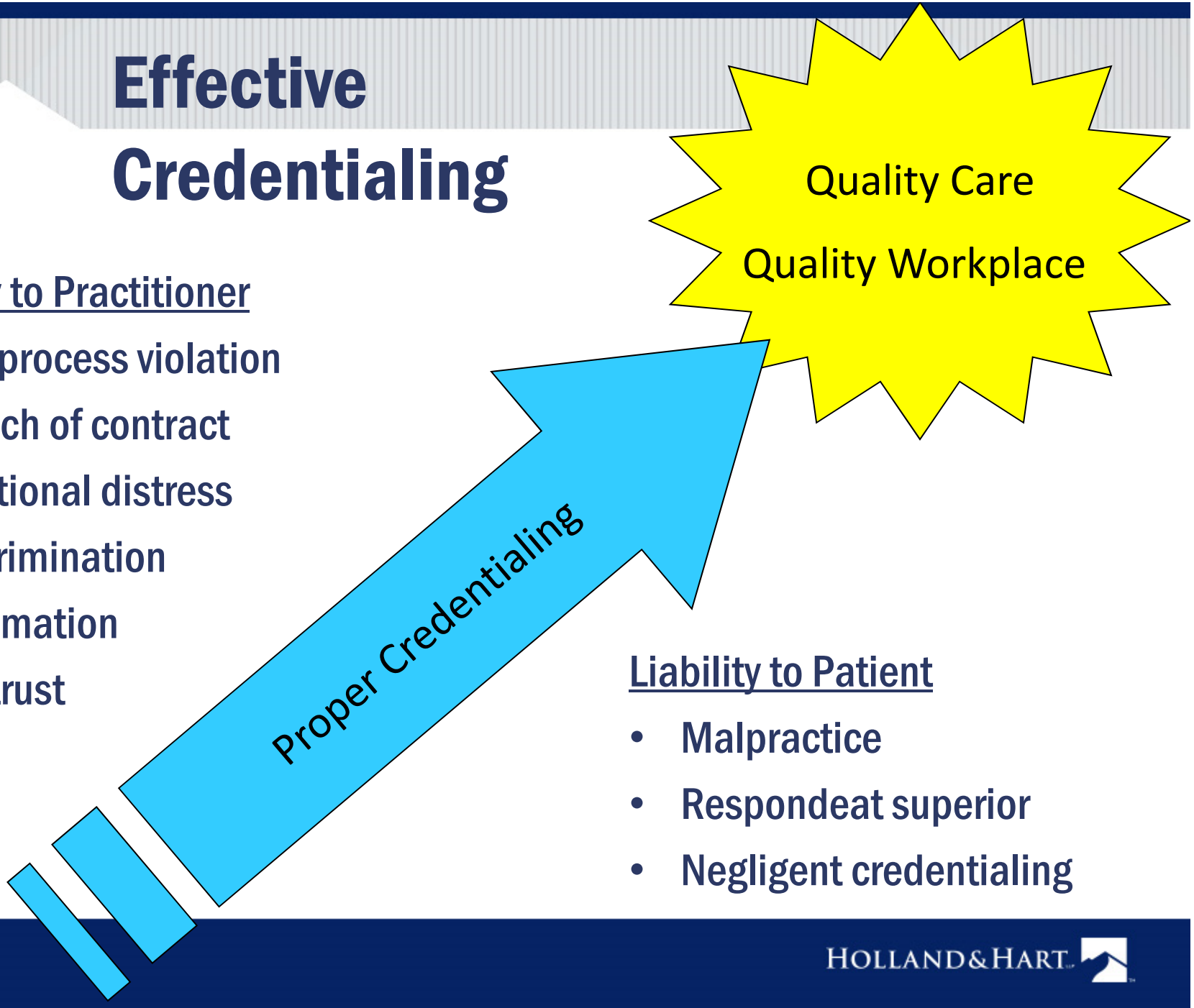
Effective Credentialing



Effective Credentialing

- Effective credentialing = preventive medicine
  - Promotes quality health care.
  - Avoids problem practitioners.
    - Incompetent.
    - Disruptive.
    - Poor fit for organization.
  - Facilitates a professional workplace.
  - Prevents liability to patients, practitioners, employees, and the government.

Effective Credentialing



Liability to Practitioner

- Due process violation
- Breach of contract
- Emotional distress
- Discrimination
- Defamation
- Antitrust

Liability to Patient

- Malpractice
- Respondeat superior
- Negligent credentialing

"Darn it, Jim! I'm a doctor, not a..."

- *businessperson!*
- *farmer!*
- *mechanic!*
- *lawyer!*
- *engineer!*
- *teacher!*
- *accountant!*
- *manager!*
- *salesperson!*

Credentialing

- Courts usually do not second guess hospital's decision if:
  - Followed standards in bylaws and statutes.
  - Based on legitimate, documented reasons
    - Patient care or hospital operations
    - NOT arbitrary or capricious
    - NOT improper motive, e.g., discrimination, anti-competition, retaliation, etc.
- From legal liability standpoint, the process is more important than the decision.
- *Board's job: to ensure the process is followed and decisions are reasonable and supported by facts.*

Legal Standards

Credentialing actions must comply with:

- Statutes and regulations
  - State statutes and regulations
  - 42 CFR 482.12
- Medical staff bylaws, rules and regulations
- Accreditation standards
- Practitioner contracts
- Common law standards, e.g., what other reputable hospitals do

Substantive Standards

Credentialing may be based on:

- Current licensure
- Education, experience, competence, and judgment
- Physical and mental capability
- Character and professionalism
- Hospital capacity and capabilities
- Geographic proximity
- Ability to satisfy medical staff responsibilities
- Any other reasonable, non-discriminatory basis

Credentialing should not be based on:

- Unlawful discrimination (e.g., race, religion, sex, etc.).
- Anti-competitive motives of med staff
- Retaliation
- Licensure or membership alone
- Credentialing done by other entities except telemedicine if certain conditions met.

Credentialing Process

Process is usually set out in medical staff bylaws and policies.

- Application
  - Gather information
  - Verify information
  - Databank searches

  } Administration, e.g., Medical Staff Services
- Active medical staff review
  - Review file
  - Interview physician
  - Recommendation to board
  - If recommend adverse action, give fair hearing
- Board review

* *Process may vary for physicians v. allied health professionals.*

Credentialing Process: Board Review

- Board should exercise due care in credentialing decisions.
  - Do NOT rubber stamp medical staff recommendation.
- May rely on reasonable advice of experts, e.g., recommendation of medical staff.
- Board should take reasonable steps to:
  - Become informed.
  - Ask questions.
- *To Medical Staff: "What is the basis for your recommendations?"*

Credentialing: Board Review

Ensure med staff recommendation is supported by records

- Administration and med staff checked relevant sources.
- Administration and med staff followed process in bylaws.
- Med staff recommendation is reasonable and based on appropriate factors.
- Documentation supports med staff recommendation.

Beware red flags

- Discriminatory or inappropriate animus by med staff.
- Deviations from process and standards in bylaws.
- Unresolved questions or problems in applicant's file, e.g.,
  - References indicate problems
  - References refuse to comment
  - Discrepancies in info submitted
  - Unexplained gaps in time
  - Loss or reduction in privileges, licensure, program participation, etc.

Credentialing Process

- *Remember: where there's smoke, there's usually fire…*

Credentialing: Board Review

- Upon receipt of medical staff recommendation, Board may
  - Accept recommendation.
  - Reject recommendation.
  - Send back for more action.
  - Take its own action, e.g.
    - Impose conditions.
    - Require evaluation.
    - Consult independent expert.

Privileges

- Board must determine privileges.
- "Laundry list"
  - Contains list of clinical procedures available at hospital.
  - Works well for small hospitals with limited procedures.
  - Requires regular updating regarding physician and procedures.
- "Core privileging"
  - Identifies "core" qualifications to work in department.
  - Identifies privileges associated with the department.
  - Allows for additional privileges.
- *Ensure your facility has capability to support privileges.*

Telemedicine Privileges

- Hospital and CAH CoPs now allow hospital to rely on credentialing done by remote hospital/entity if:
  - Have written agreement with distant site.
  - Distant site complies with CoP standards.
  - Practitioner privileged at distant site.
  - Practitioner licensed in state where services provided.
  - Hospital reviews practitioner's performance and provides results to distant site.

(42 CFR 482.12 and .22, and 485.616 and .635)

- *Confirm it is allowed by bylaws and state licensing statutes.*
- *Confirm it does not trigger fair hearing rights.*
- *Consider exposure to negligent credentialing claim.*

Emergency or Temporary Privileges

- In limited circumstances, hospital may grant privileges on emergency or temporary basis, e.g.,
  - Practitioner needed but no time for full process.
  - Privileges temporarily granted while formal application processed.
- Subject to expedited review.
- Automatically expires within limited time period, e.g., 60 days.

- *Be very careful and use sparingly.*
- *Ensure bylaws allow for same.*

Reappointment

- Usually must occur at least every 2 years.
- Process similar to initial appointment.
  - Application
  - Review by active staff
  - Governing body determination
- Process should be stated in bylaws, rules or regulations.

Corrective Action

Corrective Action

- As with initial credentialing, courts usually do not second guess hospital's corrective action if:
  - Followed standards in statutes, bylaws, rules, regulations and contracts, if applicable.
  - Based on legitimate, documented reasons
    - Patient care or hospital operations
    - NOT arbitrary or capricious
    - NOT improper motive, e.g., discrimination, anti-competition, etc.
- From legal liability standpoint, the process is more important than the decision.
- *Board's job: to ensure the process is followed and decisions are reasonable and supported.*

Corrective Action: Process

- Check bylaws for process.
  - Peer review or other initial review process
  - Informal response
  - Summary suspension
    - >30 days triggers NPDB report.
  - Formal investigation
    - May trigger NPDB report.
  - Medical staff recommendation
    - If recommend adverse action against privileges, it may trigger fair hearing requirement.
  - Board review and decision
- Obtain waiver if vary from bylaws process.

Protections for Board Members

HOLLAND&HART

Liability Defenses and Protections

- Statutory immunity.
  - Health Care Quality Improvement Act, 42 USC 11101 et seq
  - Volunteer Protection Act, 42 USC 14501 et seq.
  - State protection for non-profit directors
  - State tort claims acts
- Indemnification agreements.
- Directors and officers liability insurance.
- Risk management actions.

Additional Resources

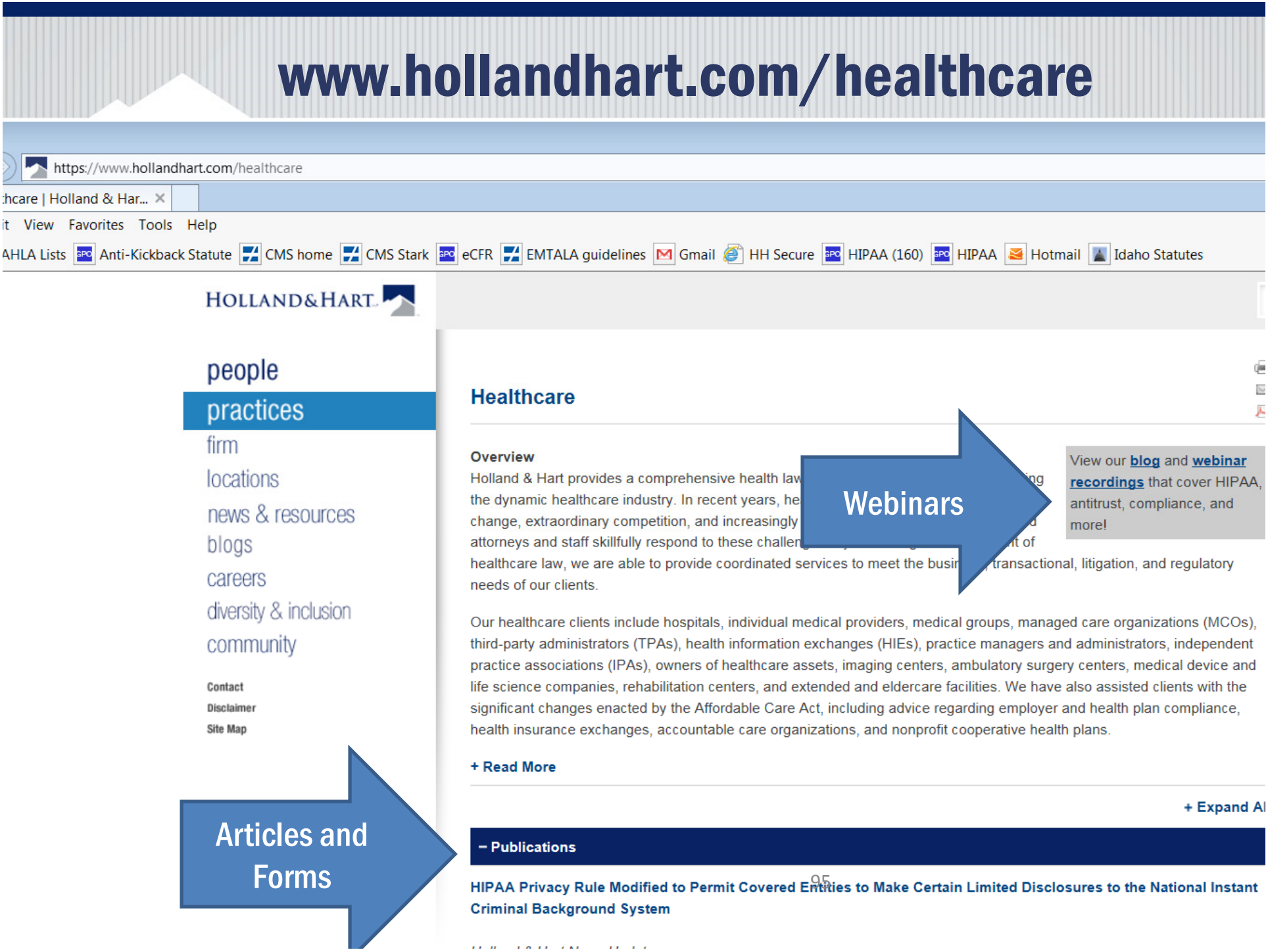
Resources

- Center for Healthcare Governance, http://www.americangovernance.com/.
  - *The Guide to Good Governance for Hospital Boards, http://www.americangovernance.com/resources/reports/guide-to-good-governance/.*
- Kaufman, *A Primer on Hospital Accounting and Finance* (4th ed.)

Holland & Hart Resources

- www.hollandhart.com/healthcare
  - Webinar recordings
  - Articles
  - Forms
  - Checklists

www.hollandhart.com/healthcare



Future Webinars

- *Health Law Basics* monthly webinar series
  - 6/9/16: Cybersecurity: Post Breach Response – Incident Handling and Data Breach Communications
  - 6/23/16: Laws that Board Members Should Know
  - 7/12/16: Provider Compensation Arrangements: Employees, Contractors, and Groups
  - 7/21/16: Network Adequacy
  - 7/28/16: Accountable Care Organizations 2.0
- *Healthcare Update* and *Health Law Blog*
  - Under "Publications" at www.hollandhart.com.
  - E-mail me at kcstanger@hollandhart.com.

Questions?

Kim C. Stanger

Holland & Hart LLP

(208) 383-3913

kcstanger@hollandhart.com