A doctor makes inappropriate remarks and engages in inappropriate conduct with hospital staff. Another “rants & raves” in an ER. A reporter is invited into an operating room as part of a doctor’s political campaign. In each of these cases, the physician’s disruptive behavior resulted in the hospital terminating the physician’s privileges and having its action upheld in court. But they also share something else in common.

The Joint Commission (TJC) standard on disruptive behavior (LD.03.01.01, EP 4 and 5) has been in effect for only two years. As a result, the issue of disruptive behavior by physicians remains in the spotlight. However, all of the cases above involved actions predating the issuance of the new standard.

Instead, to one extent or another, each court relied upon Meyers v. Columbia/HCA Healthcare Corp., a case involving a physician with an “inability to get along with others.” Meyers has been cited almost on an annual basis for key rulings by the Sixth Circuit on disciplining disruptive physicians. Meyers is worth reviewing as more actions can be expected in light of the new TJC standard addressing disruptive behavior by physicians.
A Pattern of Disruptive Behavior

Dr. Meyers, an orthopedic surgeon, applied for and received provisional medical staff privileges at Logan Memorial Hospital (LMH), a ninety-two-bed hospital located near Bowling Green, KY. After a year, he was re-evaluated for advancement to active staff privileges. A credentials committee comprised of three board members voted to deny staff privileges to Meyers. The committee’s reasons included Meyers’s “temper tantrums, . . . condescending remarks towards women, refusal to speak to a member of his surgical team during surgical procedures, and several instances of throwing a scalpel during surgical procedures.”

Meyers was provided a hearing. Pursuant to LMH’s bylaws, typically three members of the medical staff were to serve on the Fair Hearing Committee (FHC). However, for Meyers’s hearing, the FHC was composed of a retired judge, an attorney, a bank president, an industrialist, and a dentist. The FHC met on eleven occasions, with thirty-five witnesses testifying. Meyers was represented by counsel and had the opportunity to offer evidence and witness testimony and cross-examine LMH witnesses. The FHC recommended not appointing Meyers because of his “failure to meet LMH’s ethical standards and his inability to work cooperatively with others.” The board adopted the FHC’s recommendation.

Meyers (and his wife, also a doctor) sued LMH and individuals involved with the review action. His claims have become almost boilerplate in physician complaints for peer review actions, e.g., breach of contract, antitrust, violations of the Emergency Medical Treatment and Active Labor Act (or other whistleblowing statutes), tortious interference, and defamation. From this lawsuit would come several rulings that subsequent courts would rely upon in dealing with disruptive physicians.

An Unusual Summary Judgment Standard

The hospital moved for summary judgment claiming immunity under the Health Care Quality Improvement Act of 1986 (HCQIA). HCQIA provides immunity if a professional review action was taken in a combination of four circumstances: (1) in the reasonable belief that the action would further quality healthcare; (2) after a reasonable investigation; (3) with adequate notice and hearing procedures afforded; and (4) in the reasonable belief that the action was warranted by the facts and the process.

The district court’s grant of summary judgment was affirmed by the Sixth Circuit. Quoting from a previous case, the district court’s analysis of the summary judgment standard for HCQIA in Meyers has become relied upon regularly.

Meyers highlighted that professional review actions are presumed to have satisfied HCQIA’s elements for immunity. For a summary judgment motion by the health system, then, rather than the movant having to demonstrate that there is no genuine issue of fact, HCQIA’s presumption puts the onus on the non-movant physician. The physician must demonstrate not just that a genuine issue of fact exists, but that “a reasonable jury, viewing the facts in the best light for [the plaintiff], [might] conclude that he has shown, by a preponderance of the evidence, that the [hospitals] actions are outside the scope of [HCQIA].” Cases discussed below (and several others not involving disruptive behavior) have cited to the Meyers recitation of this summary judgment standard.

For Hearing to be “Fair,” It Does Not Have to Comply With Bylaws or Be Conducted by Physicians

Meyers has been used in more recent decisions to refute common claims made by disciplined physicians. Physicians complain regularly that actions should not be entitled to immunity because the process failed to comply with the hospital bylaws, thereby breaching a “contract.” Also, physicians complain that the action was not truly “peer review” because the FHC did not include a physician of the same specialty as the plaintiff.

Meyers argued that the hospital failed to meet HCQIA’s third element of a fair hearing, regarding notice and hearing procedures requirements, because LMH failed to follow its bylaws for the hearing process. He disputed that the FHC could be considered “peer review” because not one member was a physician and, therefore, could not have been his “peer.” Both the Sixth Circuit and the district court noted that the bylaws only instructed that medical staff members should be FHC members “when feasible,” and there was evidence that no staff member was available to serve.

The district court further ruled that a departure from the hospital bylaws was immaterial, provided that HCQIA’s requirement for a fair proceeding were met. This was so because HCQIA establishes national standards for peer review actions that, if met, entitle the reviewers to immunity. The district court further stated that “there is no statutory requirement set forth in the HCQIA that professional review activity or actions must be conducted by physicians.”

Meyers’s rulings on HCQIA’s third element have since been relied upon in actions involving disruptive physicians.

In Taylor v. Kennestone Hospital, Inc., a physician had sexually harassed staff and inappropriately touched patients. The physician complained that notice procedures had not been followed according to the hospital’s bylaws. Relying on Meyers, the court repeated that “HCQIA does not require that hearing procedures satisfy hospitals’ bylaws in order for immunity to apply.”
Further, Sternberg v. Nanticoke Mem’l Hosp., Inc. involved the politicking surgeon referenced above and a professional review action where no hearing was conducted. The court rejected the physician’s arguments that the hospital’s failure to follow its bylaws denied HCQIA immunity because the court found that the procedures followed were otherwise reasonable for HCQIA purposes.

“Quality Health Care” Includes General Behavior and Ethical Conduct

The Meyers decisions, both from the district court and the Sixth Circuit, made a key finding concerning how disruptive behavior alone can justify termination of privileges.

In Meyers, both courts ruled that “general behavior and ethical conduct” provide grounds for a professional review action. This phrase has been quoted verbatim ever since by courts in response to another regular argument by physicians: that disruptive behavior, absent any actual patient injury, is not enough to justify a summary suspension or termination of privileges.

Indeed, the district court addressed this very argument made by Meyers:

[The behavior of Dr. Meyers had the potential of affecting the health and welfare of patients, despite the fact that no patients were actually injured. * * * LMH did not have to wait until a patient was injured or a nurse refused to work with Dr. Meyers. Its concerns for quality health care were reasonable and legitimate.]

The Sixth Circuit’s decision was expressly relied upon in Isaiah v. WHMS Braddock Hospital Corp. There, the doctor argued that any concerns about his ethics and compulsive behavior did not affect quality healthcare, as they were not related to his skills. The court, referring to Meyers, stated, “I am in agreement with the Sixth Circuit that ‘“quality health care’ is not limited to clinical competence, but includes matters of general behavior and ethical conduct.”

The Tennessee Court of Appeals in Curtsinger v. HCA, Inc., addressed the doctor ranting and raving in the ER. The physician argued that his disruptive behavior could not hinder healthcare because his behavior had no effect on his competence as a surgeon. The court rejected this argument relying on the quote from Meyers. The court held that disruptive conduct under HCQIA need not actually harm patients and therefore found that the hospital’s review action was taken in furtherance of quality healthcare.

Meyers Demonstrates the “Breadth” of Conduct That Can Justify Action

In Gordon v. Lewiston Hospital, the subject physician harassed and intimidated elderly patients by calling them to disparage the skills of another physician. The court relied on Meyers in finding immunity for an action taken based solely on the physician’s unprofessional conduct. It explained that “[s]uch unprofessional conduct is within the purview of a ‘professional review action’ under the HCQIA. The plain language of the statute indicates the breadth of ‘conduct’ . . . by the inclusion of conduct that ‘could affect adversely the health or welfare of a patient.’”

In Abu-Hatab v. Blount Memorial Hospital, the physician was disciplined for improper conduct toward several nurses, including his refusal to work with one. The physician disputed the truth of the allegations. The court, relying on Meyers, responded, “[t]he Court of Appeals for the Sixth Circuit, when faced with a similar argument . . . explained that [HCQIA] review . . . is not directed at whether each of the complaints were undisputedly true, but whether Defendants acted reasonably in considering and relying on them.” After noting that the hospital had to spend many hours and meetings over their concerns that the physician was creating disruptions and interfering with patient care, the court found that the hospital’s termination of his privileges was reasonable for HCQIA immunity purposes.

Meyers Relied Upon as Recently as February 2010

The Meyers case was relied upon even as recently as February 2010, this time by the Northern District of Ohio in Badri v. Huron Hospital. In 2002, Dr. Badri was involved in an automobile accident, after which he “tailed” the other driver, forcing him to pull over. In the ensuing exchange, the other driver allegedly choked the physician, leaving Badri with pain in his neck. For his pain, the doctor self-medicated, including taking steroids. Thereafter, he became more irascible in the work environment, doing such things as expressing his displeasure for any inconvenience, chastising a medical resident excessively, discussing a patient’s drug addiction
in the presence of other patients and staff, and numerous other incidences of “disruptive and harassing conduct directed toward hospital employees, residents and patients.”

In granting the hospital’s motion for summary judgment and finding HCQIA immunity, the district court followed the Meyers decision as a template. Specifically, concerning disruptive behavior, the court stated, “in Meyers, the Sixth Circuit approved of the district court’s observation that ‘quality health care’ is not limited to clinical incompetence, but includes matters of general behavior and ethical conduct.”

The New Standard and the Meyers Line of Cases

TJC announced its standard on disruptive behavior in a sentinel alert in Summer 2008. In that alert, it recognized many of the justifications for dealing with disruptive behavior expressed in the above-cited cases. Namely, TJC noted that such behaviors “undermine team effectiveness and compromise the safety of patients” and “should not be tolerated.”

In future actions involving physicians’ disruptive behavior, it can be expected that the starting point for a hospital’s defense will be the new TJC standard. The standard is an affirmation of Meyers and its progeny. These cases developed a body of law that recognizes that disruptive behavior alone can justify that a hospital’s action taken against the physician was done in furtherance of quality healthcare.

*Mark W. Leach is a member of the Louisville, KY, office of Stites & Harbison PLLC. His firm represented the hospital in the Meyers cases, however, he was not involved in those matters.

4 341 F3d 461, 464 (6th Cir. 2003).
5 Id. at 465.
6 Id.
7 Id. at 466.
8 42 U.S.C. § 11111(a)(1), 11112(a).
9 Id. at 468 (quoting Austin v. McNamara, 979 F2d 728, 734 (9th Cir. 1992)).
10 Id. at 468 (quoting Austin v. McNamara, 979 F2d 728, 734 (9th Cir. 1992)).
15 Id. at 185.
16 Supra note 3.
17 341 F3d at 469.
18 101 S.W.3d 76 (Tenn. App. 2002).
19 Id. at 87 (citations and quotations omitted).
21 Id.
22 Supra note 2.
24 Id. at 203-204 (quoting 42 U.S.C. § 11151(9)).

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Eleventh Circuit Finds Contractual Relationship Necessary to Support Section 1981 Discrimination Claims

Section 1981 Race Discrimination Claim Cannot Survive Without a Contractual Interest as Its Basis

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Under certain circumstances, 42 U.S.C. § 1981 (Section 1981) creates a federal cause of action for individuals claiming intentional racial discrimination. To support such a claim, a plaintiff must allege that he is a member of a racial minority and that he was discriminated against within a particular group of activities set forth in the statute. Those activities include the right to “make and enforce contracts . . . as is enjoyed by white citizens.” The Eleventh Circuit recently dismissed the claims of a physician who claimed that the suspension of his medical staff privileges violated rights protected by Section 1981, holding that such privileges did not constitute contractual rights as defined by the statute.

Dr. Omar Jimenez, an African-American physician with a specialty in neurosurgery, held medical staff privileges at Wellstar Health System in Georgia. In January 2006, Jimenez was asked to appear before Wellstar Surgery Department’s Medical Care Evaluation Committee to address a number of complaints received by the committee regarding Jimenez’s medical performance. The complaints included allegations that Jimenez had failed to: promptly respond to emergency room calls; make patient rounds in a timely manner; and manage certain surgeries appropriately. Based on those allegations, Wellstar suspended Jimenez’s medical staff privileges, which meant that Jimenez was precluded from treating patients at Wellstar’s hospitals. Although Jimenez initially requested a hearing on the suspension, a year passed during which no hearing was held, for reasons not explained in the court’s opinion. At that point, Jimenez withdrew his request.

Jimenez ultimately filed a federal lawsuit, including a claim under Section 1981 alleging race discrimination based upon contractual rights. He claimed that Wellstar discriminated against him when it suspended his privileges and when it delayed a hearing on that suspension, and that those privileges established a contract between Jimenez and Wellstar. The district court dismissed the lawsuit for Jimenez’s “failure to state a claim,” and the case was appealed. The Eleventh Circuit upheld the dismissal, finding that the suspension of Jimenez’s medical staff privileges did not violate rights protected under Section 1981.

Wellstar’s policies include specific language that membership on the system’s medical staff “does not create a contractual relationship between Wellstar or any Medical Staff and the Medical Staff Member.” In addition, medical staff members at Wellstar must meet certain minimum objective criteria, and failure to do so can result in automatic termination of medical staff privileges, which runs counter to a typical contractual relationship. Importantly, under Georgia state law, medical staff bylaws do not create a per se contractual right to the continuation of medical staff privileges. According to the court, interpreting the bylaws as a contract in Jimenez’s case would run counter to the state’s policy of allowing a hospital to suspend or withhold privileges from doctors that it believes are unqualified to serve on its medical staff. Therefore, Jimenez did not possess the contractual relationship necessary to support his Section 1981 claim.
It is noteworthy that because Jimenez was not an employee of Wellstar, he was unable to base his claim for racial discrimination on Title VII of the Civil Rights Act, the federal “anti-discrimination” statute that prohibits race and national origin discrimination (as well as gender and religious discrimination) by employers against employees. Had Jimenez been a direct employee of the hospital system, the fact that his medical staff privileges did not constitute a contract would not have precluded a federal claim by Jimenez, because Title VII would have been available to him. Healthcare providers that are moving toward an employment model with physician staff members should take this issue into consideration and should assure that managers and supervisors are trained to recognize and resolve complaints of discrimination when they arise to avoid legal liability under Title VII, regardless of whether Section 1981 applies.

2  Jimenez v. Wellstar Health Sys., 596 F.3d 1304 (11th Cir 2010).
PPACA’s Implications for Medical Staff Oversight, Credentialing, and Peer Review

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This article is drawn in part from research performed on behalf of AHLA’s Quality in Action Task Force in connection with its forthcoming publication, “Quality in Action: Paradigm for a Hospital Board-Driven Quality Program,” to be published as part of AHLA’s Public Information Series later this year.

Introduction

The Patient Protection and Affordable Care Act, as amended by the Healthcare and Education Reconciliation Act, (collectively, PPACA) has major implications for hospitals and their medical staffs. PPACA is informed and infused by a foundational presumption that the key to higher-quality, more-efficient care is in the implementation of a systems-based approach to care delivery. The systems-based approach elevates the importance of care coordination and teamwork over individual skill and judgment. It promotes the use of evidence-based protocols and clinical guidelines that “standardize” care delivery. Hospital credentialing and peer review processes have traditionally focused on individual competence and professionalism as opposed to the quality and efficiency of the system of care delivery. PPACA thus challenges hospitals to re-examine the efficacy of the physician-centric approach to credentialing and peer review as a means of promoting high-quality, efficient care. It may be time for the development of new peer review models to meet PPACA’s imperative for effective, systems-based delivery of clinical care.

PPACA’s Promotion of Systems-Based Models of Care

PPACA’s promotion of systems-based practice is evident in its articulation of its national strategy for quality improvement in healthcare, the creation of new governmental entities for healthcare innovation, its new insurance and payment models, and the numerous demonstration projects linking quality and cost. This article will briefly discuss each of these.

National Strategy for Quality Improvement in Healthcare

PPACA calls for the development of a national strategy for quality improvement in healthcare, guided by the following specific priorities:

• Improving the health outcomes, efficiency, and patient-centeredness of care for all populations;
• Identifying areas that have the potential for rapid improvement in the quality and efficiency of patient care;
• Addressing gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data-aggregation techniques;
• Improving federal payment policy to emphasize quality and efficiency;
• Enhancing the use of healthcare data to improve quality, efficiency, transparency, and outcomes;
• Addressing the healthcare provided to patients with high-cost chronic diseases;
• Improving research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and healthcare-associated infections; and
• Reducing health disparities across populations and geographic areas.

Implicit in this statement of priorities is the principle that quality improvement requires a global approach that focuses not so much on promoting individual competence but on improving the overall system by which care is delivered. This principle is evident throughout the individual programs mandates that PPACA creates.

New Governmental Entities for Healthcare Innovation

PPACA creates two new entities specifically charged with the development of more systems-based models of healthcare delivery. First, PPACA creates the Center for Medicare and Medicaid Innovation (CMI) within the Centers for Medicare and Medicaid Services (CMS), and charges it with testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care. Among the wide range of potential models CMI may develop is one that focuses in particular on the development, implementation, and dissemination of “best practices and proven care methods” as a way of promoting improved quality and reduced cost. In
identifying the criteria that CMI should use in determining which innovative models to develop, PPACA gives particular emphasis to coordination of care between providers, over time and across settings, and developing a team-based approach to interventions. 

PPACA also mandates the development of the Center for Quality Improvement and Patient Safety (Center) within the Agency for Healthcare Research and Quality (AHRQ), which focuses on supporting the development of best practices that will “include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for healthcare providers in team-based healthcare delivery and rapid cycle process improvement), and facilitation and adoption of improved workflow.”

**Insurance and Payment Requirements**

The promotion of a systems-based approach to care is evident in the insurance and payment requirements created by PPACA. One of the legislation’s centerpieces is the creation of insurance exchanges. The program requirements for these new exchanges require a commitment to a systems-based care delivery model by mandating financial incentives for participating providers to meet the following quality objectives:

1. Improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication, and care compliance initiatives;

2. The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate healthcare professional;

3. The implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage;

4. The implementation of wellness and health promotion activities; and

5. The implementation of activities to reduce health and healthcare disparities, including through the use of language services, community outreach, and cultural competency trainings.

PPACA also imposes financial incentives directly on hospitals to adopt a systems-based approach to care by expanding the “pay-for-performance” payment model for hospitals. For instance, PPACA confirms and extends CMS’ “never events” payment policies by mandating that by 2012, a payment system will be implemented to reduce diagnosis-related group payments for those hospitals that fail to meet certain benchmarks with regard to hospital acquired conditions (HACs). PPACA also provides that starting in 2015, hospitals falling in the bottom quartile for HACs will, in addition to any other payment penalties for HACs, be subject to a 1% reduction in reimbursement. With regard to Medicaid, PPACA now mandates new regulations that will deny payment of federal Medicaid funds to the states for any amounts expended on the treatment of the designated HACs that are non-payable by Medicare, and states can be expected to pass on the new payment reductions to their Medicaid providers.

**Demonstration Projects Linking Quality and Cost**

PPACA has a host of new demonstration projects, waiver, and grant programs designed to promote innovation in the development of new delivery models linking quality and cost. One such program is the new Medicaid Waiver program for states to develop “Health Homes” for the treatment and management of patients with chronic conditions such as a mental health condition, substance abuse disorder, asthma, diabetes, heart disease, or obesity. A Health Home is a designated provider that operates in coordination with a team of healthcare professionals to provide services such as comprehensive care management and coordination across a continuum of inpatient and outpatient care. One of the waiver program’s key objectives is to promote innovative alternative payment models that will reward the coordination and management of the patient’s care.

PPACA also provides for episodes of care demonstration projects designed to evaluate the use of bundled payments for the provision of episodes of care that include hospitalization. The goal is...
to give providers an opportunity to improve the quality of care while reducing total expenditures through coordinated care.22

Through a host of new initiatives, PPACA also promotes the development of Accountable Care Organizations, in which groups of providers align themselves to provide coordinated service across a continuum of care, and are provided payment incentives to increase the overall quality and efficiency of care.23

As part of its overall objective of dramatically improving the quality of care, PPACA places a high priority on the development of effective measures by which the quality of healthcare services can be evaluated.24 PPACA authorizes the U.S. Department of Health and Human Services (HHS) to award grants for developing, updating, improving, or expanding quality measures.25 These quality measures are specifically targeted at enabling HHS to assess the success of its efforts to achieve the healthcare priorities identified above through various programs and initiatives authorized by PPACA.26

**Implications for Medical Staff Oversight, Credentialing, and Peer Review**

PPACA’s new emphasis on systems-based care will challenge hospitals to re-evaluate the design and effectiveness of their medical staff oversight, credentialing, and peer review processes. Under the existing model, each provider is evaluated—whether for appointment/reappointment or as part of an internal peer review or corrective action process—in isolation and in accordance with a community “standard of care.” PPACA’s pervasive emphasis on systems-based medicine challenges this individualized approach by suggesting that the primary question is not so much whether a physician (or other independent practitioner) demonstrates reasonable judgment and skill as an individual, but whether that physician functions effectively within system of care that is designed to achieve maximum safety and efficiency.27 This inquiry raises a variety of questions that are not easily managed through existing credentialing and peer review standards and processes, such as:

- The practitioner’s level of adherence to evidence-based clinical protocols established and approved by his department or division, medical executive committee, and/or hospital governing body.
- The practitioner’s level of teamwork, coordination, and communication with nursing, ancillary providers, and other physicians.
- The practitioner’s appropriate use of the hospital’s electronic health record.
- Whether the practitioner engages in disruptive conduct that creates hostility and divisiveness on the treatment team.
- Whether the practitioner demonstrates a pattern of inefficiency or squandering of hospital supplies, equipment, and other resources.
- Whether the practitioner’s personal financial interests manifest themselves in referral patterns that are adverse to the hospital’s broader quality and efficiency objectives.

Moreover, all too often, hospitals find that even when they can effectively measure and detect lack of adherence to the requirements of a systems-based practice, the traditional credentialing and peer review processes and standards do not provide effective modes of intervention.

If hospitals are to rise to the challenge that PPACA has placed before them of radically improving the quality and efficiency of care through a systems-based approach, the industry’s traditional medical staff oversight processes will need to be significantly refined to give hospitals the ability to intervene with regard to clinical practices that undermine the effectiveness of the systems-based approach that the hospital has implemented as part of its quality/safety program.

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4 Id. Section 3011 (new Section 399HH(a)(2)(B)).
5 Id. Sections 3021(a) & 10306 (amending Title XI of the Social Security Act by adding new Section 1115A).
6 Id. Section 3021(a) (new Section 1115A(a)(1)).
7 Id. (new Section 1115A(b)(2)(B)).
8 Id. (new Section 1115A(b)(2)(C)).
9 Id. Section 3501 (amending Part D of Title IX of the Public Health Service Act by adding new Section 933).
10 Id. (new Section 933(b)(2)(I)).
11 Id. Sections 1311(g) & 10104(g).
12 Id. Sections 3025(a) & 10309 (amending Section 1886 of the Social Security Act, 42 U.S.C. § 1395ww).
13 Id. Section 3008(a) (amending Section 1886 of the Social Security Act, 42 U.S.C. § 1395ww).
14 Id. Section 2702.
15 Id. Sections 3001(a) & 10335 (amending Section 1886 of the Social Security Act, 42 U.S.C. § 1395w).
16 Id. Sections 3022 & 10307.
17 Id. Section 2703(a) (amending Title XIX of the Social Security Act, 42 U.S.C. § 1396a et seq., by adding at the end new Section 1945).
18 Id. (new Section 1945(h)(2)).
19 Id. (new Section 1945(h)(3)-(4)).
20 Id. (new Section 1945(c)).
21 Id. Section 2704.
22 Id. Section 2704(b)(2).
23 Id. Sections 3022 & 10307 (amending Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq., by adding new Section 1899).
24 Id. Sections 3013(a) & 10303(a) (amending Title IX of the Public Health Service Act, 42 U.S.C. § 299 et seq., by inserting a new Section 931).
25 Id. Section 3013(a) (new Section 931(c)).
26 Id. Section 3013(a) (new Section 931(c)(2)).
27 Notably, The Joint Commission’s (TJC’s) current medical staff standards require hospitals to inquire about a physician’s adherence to systems-based practice as one of the “six general competencies” evaluated for appointment and reappointment to the Medical Staff. (See TJC’s 2010 Hospital Accreditation Standards, MS.06.01.01 (Introduction) and MS.06.01.03 (Introduction).) In actual practice, however, that requirement is often met through a routine “yes box” answer on a credentialing questionnaire, which may not provide the most helpful information as to whether the physician practices effectively in a systems-based care model.
A Medical Professional Liability Claim: The First Critical Sixty Days
Tuesday, November 16, 2010

This webinar is brought to you by the Enterprise Risk Management Task Force (a joint endeavor of the Hospitals and Health Systems, Healthcare Liability and Litigation, and In-House Counsel Practice Groups)

Healthcare reform will touch all aspects of care delivery. How we provide, track, report, and receive payment for patient care are all changing. Managing serious adverse events that are or have the potential to become a claim will be impacted as well. The management of those critical events becomes even more important in the age of transparency and disclosure, and at a time when cost efficiency is vital to an organization’s success.

This webinar will focus on the first critical sixty days after an adverse event has occurred. A goal during that critical time will be to prevent a formal claim from being initiated through the implementation of an Early Intervention Program.

The key elements of an Early Intervention Program will be discussed and include:

- Protecting the patient and others from further harm;
- Initial and ongoing event investigation;
- Evaluation of liability for the organization and providers;
- Establishing and maintaining privilege;
- Preservation of evidence;
- Service recovery;
- e-Discovery;
- Reporting internally and externally;
- Roles and responsibilities (risk manager, third-party administrator, defense counsel);
- Documentation and communication;
- Compensation/resolution; and
- Lessons learned.

The appropriate management of these first critical sixty days may decrease the likelihood of a claim being made. For those adverse events that continue on as a formal claim, the preparatory work done during the Early Intervention Program will form the basis of the ongoing claim file.

Presenters: Sheila Hagg-Rickert, JD, MBA, MHA, CPCU, CPHRM Senior System Director, Risk Management, Christus Health, Houston, TX; Amy Evans, JD, Executive Vice President, Western Litigation Inc, Houston, TX; Roberta Carroll (Moderator), Esquire, RN, MBA, CPCU, ARM, CPHQ, CPHRM, LHRM, HEM Senior Vice President, Aon Risk Solutions/ Health Care Practice, Odessa, FL

Healthcare Reform and the 340B Drug Discount Program Expanded Eligibility and Expanded Compliance Risks
Wednesday, November 17, 2010

This webinar is brought to you by the Teaching Hospitals and Academic Medical Centers Practice Group, and is co-sponsored by the In-House Counsel and Payors, Plans, and Managed Care Practice Groups

According to the Health Resources and Services Administration, the component of the U.S. Department of Health and Human Services that administers the 340B drug discount program, the 340B program has yielded average savings of 35%-50% on outpatient drugs for participating healthcare providers, including many academic medical centers. The program has recently been expanded to include more categories of providers, including children’s hospitals. This session is intended for hospital internal and external counsel as well as compliance officers and executive leadership. During this presentation, we will provide an overview of the recent changes to the 340B program and highlight compliance risks facing academic medical centers and other hospitals that participate in the program.

The topics covered during this session will include:

- Key changes to the 340B program as a result of the healthcare reform legislation;
- Recent pharmaceutical manufacturer and Medicaid audit and enforcement actions;
- New oversight, audit, and compliance risks for participating hospitals and other 340B eligible providers; and
- Common compliance risks found in many 340B participating hospitals and how to mitigate your own possibility of 340B-related liabilities.

This session is designed for participants who possess a basic awareness of 340B, but who may not fully understand all of the regulatory requirements of the program. Additionally, participants who are well informed about 340B will benefit from discussions of specific recent compliance issues in other 340B entities. The takeaway from this session will include a checklist of high-level 340B compliance tests that can be used to assist in determining the likelihood of compliance risks within a participating 340B entity.

Presenters: Andrew Maurer, Director, Macro Helix Inc., Atlanta, GA; Stephanie Webster, Esquire, King & Spalding LLP, Washington, DC; Richard G. Korman (Moderator), General Counsel/Organizational Integrity Officer, Saint Joseph Regional Medical Center, Mishawaka, IN; Associate Counsel, Trinity Health, Novi, MI.
The New Reality of Stark Self-Disclosures: What to Do and Not Do  
Friday, November 19, 2010

This webinar is being brought to you by the Fraud and Abuse Practice Group, and is co-sponsored by the Hospitals and Health Systems, Physician Organizations, and In-House Counsel Practice Groups.

The much-anticipated Centers for Medicare & Medicaid Services (CMS) Voluntary Self-Referral Disclosure Protocol was released by CMS on September 23, 2010. Now providers are left to grapple with legal and practical questions regarding disclosure of potential Stark violations. This webinar offers an opportunity to hear from key individuals within CMS and the U.S. Department of Health and Human Services (HHS), as well as seasoned practitioners:

- Hear a summary from CMS about the Stark disclosure protocol;
- Learn from CMS and the Office of Financial Management (OFM) about the disclosure process;
- Understand similarities and differences between the CMS and Office of Inspector General protocols; and
- Benefit from a panel discussion about the practical implications of disclosure (i.e., whether to disclose and to whom).

**Presenters:** Roy Albert, Esquire, HHS OFM, Washington, DC; Troy Barsky, Esquire, Director, Division of Technical Payment Policy, CMS, Baltimore, MD; Lisa M. Ohrin, Esquire, Partner, Katten Muchin Rosenman LLP, Washington, DC; Julie E. Kass (Moderator), Esquire, Ober | Kaler, Baltimore, MD

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**Fundamentals of ERISA Preemption**  
Tuesday, December 7, 2010

This webinar is brought to you by the Healthcare Liability & Litigation Practice Group, and is co-sponsored by the Payors, Plans, and Managed Care Practice Group.

Participants will hear perspectives from seasoned practitioners who regularly litigate Employee Retirement Income Security Act (ERISA) preemption on behalf of plaintiffs and plans on such issues as:

- Why does ERISA preemption matter so significantly in litigation involving health plans?
- What arguments do plaintiffs (members and providers) typically make to avoid preemption?
- What arguments do plans and insurers typically make to invoke preemption?
- Issues in litigating ERISA preemption when provider is suing as an assignee (or where member is suing).
- What is the significance of *Aetna v. Davila* as it relates to the provider’s ability to bring a direct claim against the plan?

**Presenters:** Teresa Renaker, Esquire, Lewis Feinberg Lee Renaker & Jackson PC, Oakland, CA; Mark E. Schmidtke, Esquire, Ogletree Deakins, Chicago, IL; Kenneth E. White, Esquire, Partner, Law Offices of Steven M. Ziegler PA, Hollywood, FL; Steven M. Ziegler, Esquire, Partner, Law Offices of Steven M. Ziegler PA, Hollywood, FL; James W. Boswell (Moderator), Esquire, Partner, King & Spalding LLP, Atlanta, GA

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**What to Do When (and Before) Congress Comes Knocking:**  
The Law and Politics of Congressional Oversight  
Friday, December 10, 2010

This webinar is brought to you by the Teaching Hospitals and Academic Medical Centers Practice Group, and is co-sponsored by the Hospitals and Health Systems, In-House Counsel, and Physician Organizations Practice Groups.

Has your academic medical center or healthcare entity received a letter from Congress requesting information? Would you know what to do if you did receive such a letter? Recently, Congress has knocked on the doors of several healthcare entities to request information about the potential financial conflicts of interest of researchers. Prominent national newspapers often highlight Congressional probes at academic medical centers and other healthcare entities. These public inquiries may put your healthcare organization under an unwanted spotlight. This webinar will be helpful to lawyers and government affairs professionals who are potential recipients of information requests from Congress. Dealing with Congressional oversight is unlike discovery, as the balance of power and legal framework is completely different from litigation. Therefore, it is important that attorneys and others at such institutions understand the law and politics of Congressional oversight, and are prepared to field and respond to such requests.

Here’s what you will learn:

- The basis and scope of Congress’ authority to demand information;
- How to understand the process of accommodation and related negotiations with Congressional staff; and
- How to analyze the applicability of HIPAA and other laws regulating information to Congressional oversight.

**Presenters:** Robert K. Kelner, Esquire, Partner, Covington & Burling LLP, Washington, DC; Alan Slobodin, U.S. House of Representatives Committee on Energy & Commerce, Washington, DC; Demetrios L. Kouzoukas (Moderator), Esquire, Of Counsel, Covington & Burling LLP, Washington, DC
Practice Groups Coordinate to Create ACO Task Force

The Practice Groups listed below have coordinated to create the Accountable Care Organization (ACO) Task Force. The mission of the ACO Task Force will be to monitor and evaluate the implementing statutes, regulations, cases and secondary materials concerning ACOs. The Task Force will develop a strategic plan and a work plan to provide written materials, webinars, and in-person educational activities to assist AHLA’s members to implement ACOs and comply with ACO laws and rules. Since the ACO subject matter is so broad, and impacts the missions and interests of so many Practice Groups, the ACO Task Force will be a multi-disciplinary/multi-group entity, and will focus its efforts on the production of a coherent and effective line of ACO-related educational materials for AHLA members.

Volunteer for the ACO Task Force

Interested in authoring an article for the ACO Task Force? How about proposing a webinar idea, or suggesting a potential webinar speaker? Any member interested in volunteering for the ACO Task Force should simply email the Practice Groups staff at pgs@healthlawyers.org indicating one’s interest in volunteering and potential ideas for the ACO Task Force.