

TEXAS DEPARTMENT OF RURAL AFFAIRS  
TEXAS HEALTHCARE TRUSTEES

# TEXAS CRITICAL ACCESS HOSPITAL TRUSTEE GUIDE

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TEXAS HEALTHCARE TRUSTEES

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# TEXAS CAH TRUSTEE RESOURCE GUIDE

The *Texas CAH Trustee Guide* is designed to be used with the *Texas Healthcare Trustees Guidebook for Hospital and Health System Governance* and the *Health Care Terms and Abbreviations* book

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A collaborative project of



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## **Texas Department of Rural Affairs**

Mailing Address: P.O. Box 12887  
Austin, TX 78711

Physical Address: 1700 N. Congress, Ste. 220  
Austin, TX 78701

Phone: 512/936-6701

Toll Free: 800/544-2042

Fax: 512/936-6776

E-mail: [tdra@tdra.state.tx.us](mailto:tdra@tdra.state.tx.us)

Web site: [www.tdra.state.tx.us](http://www.tdra.state.tx.us)

## **Texas Healthcare Trustees**

Mailing Address: P.O. Box 679010  
Austin, TX 78767

Physical Address: 1108 Lavaca  
Austin, TX 78701

Phone: 512/465-1013

Fax: 512/692-2556

E-mail: [tht@tha.org](mailto:tht@tha.org)

Web site: [www.tht.org](http://www.tht.org)

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# PROGRAM RULES AND REGULATIONS

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The Critical Access Hospital (CAH) program was created as part of the Balanced Budget Act (BBA) of 1997. Although the focus of the BBA was to balance the federal budget, it included major Medicare and Medicaid changes affecting rural health care financing. The CAH program's goal is to aid small rural hospitals experiencing financial hardships due to dependence on Medicare, disproportionate share of uninsured patients, declining and aging population, stagnant economies, and escalating operating costs

The Critical Access Hospital program was fashioned after two experimental programs conducted at a time when 33 percent of rural community hospitals were suffering unsustainable losses. Responding to the threatened closure of small, isolated rural hospitals, in 1987 Montana created a limited licensure model known as the Medical Assistance Facility (MAF) demonstration project. Soon after the MAF program launched, the Health Care Financing Administration (since renamed Centers for Medicare and Medicaid Services) created the Essential Access Community Hospital-Rural Primary Care Hospital (EACH-RPCH) Program. It established a type of hospital status that enabled small rural hospitals to reduce the scope of services offered, form networks with larger support hospitals, and receive reasonable cost reimbursement as well as federal grants.

In total, four major laws have been enacted that affect the Critical Access Hospital Program:

1. Balanced Budget Act of 1997 (Public Law 105-33)
2. Balanced Budget Refinement Act of 1999 (Public Law 106-113)
3. Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554)
4. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)

## **BALANCED BUDGET ACT OF 1997**

The Balanced Budget Act of 1997 established what's known as the Rural Hospital Flexibility Program (Flex Program). Its intent: to safeguard access to health care in rural communities. The program, available to all 50 states, sought to stabilize rural health care by providing for the creation of limited service facilities that could operate under less restrictive requirements. The program increased Medicare reimbursement, and established a four-year, \$25 million per year grant program that awarded up to \$775,000 to each state for rural health system improvements.

The Flex Program had five primary goals:

1. Prepare a state rural health plan
2. Convert eligible and willing hospitals
3. Improve quality of care
4. Promote networking among hospitals
5. Improve emergency medical services

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## **Flex Program**

To receive grant money, a state must establish its own rural hospital flexibility program that includes plans to:

- Develop, in consultation with the state’s hospital association, rural hospitals, and Office of Rural Health, a state rural health care plan that:
  - provides for the creation of at least one rural health network
  - promotes regionalization of rural health services
  - improves access to health services for its rural residents
- Designate at least one nonprofit or public hospital as a Critical Access Hospital

A rural health network consists of at least one Critical Access Hospital and at least one full service acute care hospital. The network members agree to refer and transfer patients, communicate and share patient data, and transport patients. Additionally, each network facility must have an agreement for credentialing and quality assurance with either a hospital member, peer review organization, or other appropriate agency identified in the state rural health care plan.

## **Critical Access Hospital Definition**

According to the Balanced Budget Act of 1997, a Critical Access Hospital must:

- Be a nonprofit or public hospital
- Be located in a rural county that is:
  - more than a 35-mile drive (or in the case of mountainous terrain or areas with only secondary roads available, a 15-mile drive) from another hospital; or
  - certified by the state as a “necessary provider” of health care services to residents in the area. “Necessary provider” certification is based on individual state criteria. In Texas, a hospital meets the requirements if it was constructed prior to May 1, 2001; is not located in a city where two or more licensed and operating acute care hospitals exist; and is located in either a Health Professional Shortage Area, Medically Underserved Area, frontier area as designated by the U.S. Census Bureau, or a county with no other acute care hospital.
- Provide 24-hour emergency care services
- Operate no more than 25 available beds
- Use 15 beds or less at any one time for acute care inpatient services. Swing beds are permitted but limited to 10.

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- Have a length of stay of less than 96 hours per patient. In the earlier experimental programs, patients were limited to 72-hour length of stays, which became a deterrent for many hospitals to participate. The CAH Program increased the limit to 96 hours. Hospitals must document weather or other emergency conditions to support any violations of the 96-hour limit, or obtain a case-specific waiver from a peer review organization.
  - Participate in a rural health network

Under the law, exemptions from standard hospital hours of operation and strict attending physician requirements enable CAHs to reduce their staffing requirements. However, a CAH must provide:

- 24-hour emergency care
- 24-hour nursing services
- Medical staff when an inpatient is present
- Emergency room on call physician may be off-site

Because many rural areas face physician shortages, the law allows physician assistants, nurse practitioners or clinical nurse specialists to provide inpatient care with the oversight of a physician. The physical presence of the supervising physician is not necessary.

The Secretary of Health and Human Services must certify a facility as a Critical Access Hospital if it meets these requirements and any other criteria the Secretary deems necessary.

## **BALANCED BUDGET REFINEMENT ACT OF 1999**

Health care industry lobbying efforts resulted in the Balanced Budget Refinement Act of 1999 (BBRA), which made numerous changes to BBA provisions that were negatively impacting hospitals. The revisions eased the criteria for conversion to Critical Access as well as increasing financial incentives.

### **Eligible Entities**

The BBRA expanded eligibility for Critical Access designation by removing the “nonprofit” or “public” criteria as well as adding the following facilities:

- Hospitals that ceased operations within 10 years prior to November 29, 1999
- State licensed health clinics or centers that had been downsized from a hospital

The rural area requirement was broadened to include not only rural counties as defined by the Office of Management and Budget, but also rural census tracts as defined by the “Goldsmith Modification,” or defined as

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rural by state law or regulation. The Goldsmith Modification creates a more equitable distribution of outreach grant funds to small, remote and sparsely populated areas. The Goldsmith Modification identifies segments of large metropolitan counties that lack easy geographical access to services offered in the central areas. In Texas, only six counties contain Goldsmith tracts:

1. Bexar
2. Brazoria
3. Harris
4. Hidalgo
5. Tom Green
6. Webb

There are only three hospitals within these counties that are eligible for CAH status under the Goldsmith Modification criteria.

### **96-Hour Rule**

CAHs no longer have to maintain documentation regarding weather or other emergency conditions, or to obtain a case specific waiver, for individual stays longer than 96 hours. While a CAH still may provide acute inpatient care for no more than 96 hours per patient, the hospital's length of stay is determined on an annual average basis.

### **Billing Options**

A CAH now may elect an all-inclusive billing option for its hospital and physician outpatient services. Under this "Elective Method," a CAH is paid a facility fee of 80 percent of the reasonable cost of furnishing the services, plus the amount payable under the physician fee schedule for professional services. To be eligible, the CAH must choose this billing option in writing 60 days prior to the beginning of the cost reporting period. The option is effective for the entire cost reporting period.

### **Election To Be Treated as Rural**

Urban hospitals also may apply to the Secretary to be treated as a rural hospital. Qualifying facilities are eligible for all categories and designations available to rural hospitals.

### **Lab Services**

Under the revision, outpatient laboratory services are billable under the clinical diagnostic laboratory fee schedule without application of a deductible. No coinsurance is collected.

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## **THE MEDICARE, MEDICAID AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (BIPA)**

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) brought further enhancements and participation incentives to the Critical Access Hospital program.

The majority of the provisions relating to CAHs offered increased financial incentives for becoming a CAH. This new law expanded the categories of services for which CAHs are reimbursed on a reasonable cost basis. They include:

- Skilled nursing facility services provided in swing beds
- On-call emergency room physicians not present on the premises, not otherwise furnishing physician services, and not on call or at any other facility
- Ambulance services if the CAH is the only supplier of ambulance services within a 35-mile drive of the hospital
- Outpatient laboratory services

### **Lab Payments Clarified**

Reasonable cost reimbursement for outpatient laboratory tests was made retroactive to the passage of the Balanced Budget Refinement Act of 1999. Prior to the BBRA's passage, CAHs received cost-based reimbursement for outpatient laboratory services. However, a drafting error in BBRA changed the reimbursement methodology to the fee schedule. Additionally, BIPA restated that coinsurance, deductible, co-payment, or any other beneficiary cost sharing did not apply to clinical diagnostic laboratory services furnished as an outpatient Critical Access Hospital service.

### **“All-Inclusive” Charges**

All CAH outpatient services, hospital and professional, are paid based on a reasonable cost basis, rather than reimbursing professional services under the physician fee schedule. Those CAHs which elect the “all-inclusive” billing method are paid a facility fee based on reasonable costs, and will receive 115 percent of the physician fee schedule for professional services. To be eligible, the CAH must choose this billing option in writing 30 days prior to the beginning of the cost reporting period on an annual basis. The option is effective for the entire cost reporting period.

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## **MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)**

Touted as an “historic piece of legislation” with claims of making the “biggest change to the Medicare program since its inception,” the Medicare Prescription Drug, Improvement and Modernization Act (MMA) was signed into law on December 8, 2003. In addition to making prescription drug benefits and preventive screenings available, the act included several provisions designed to increase the availability of quality health care services by providing incentives for providers to practice in rural areas.

The MMA eased restrictions on CAH size and service, and increased payment for CAH services.

### **Bed Limit**

The MMA increased the limit on the number of beds operated by a CAH from 15 to 25. It eliminated the requirement that 10 of the 25 beds be designated as swing beds for skilled nursing facility care.

### **Reimbursement**

Payment enhancements include:

- Reimbursement based on 101 percent of reasonable costs for inpatient, outpatient and covered skilled nursing facility services provided to Medicare beneficiaries
- Reimbursement for on-call emergency room providers, including physicians assistants, nurse practitioners and clinical nurse specialists
- Payment under the Periodic Interim Payment Method for inpatient services

The new law also eliminated the requirement that every practitioner providing CAH professional services assign billing rights to the CAH before it can elect the “all-inclusive” payment method. However, the “all-inclusive” payment method does not apply to practitioners who have not assigned billing rights to the CAH.

### **Distinct Part Units**

CAHs now have the authority to establish psychiatric and rehabilitation distinct part units within the hospital. These units are subject to some limitations:

- 10-bed limit in each distinct unit
- Requirements that would otherwise apply if established by a short-term, general hospital
- Payment under the Prospective Payment System, not under the CAH enhanced payment system

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The beds in the distinct part unit are excluded from the bed count for purposes of applying the 25-bed limitation.

### **Flex Grant Re-Authorization**

Flex Grant funding was extended through 2008 with \$35 million authorized for each fiscal year from 2005 through 2008. Along with funding, additional Flex provisions impose requirements on states for receiving Flex Grant awards. Among those, a state must consult with its state hospital association and its rural hospitals on the most appropriate ways to use grant money. In addition, grant proceeds used for administrative costs must be 15 percent or less of the grant or the state's federally negotiated indirect rate for administering the grant. Five percent of the total amount allocated is available to the Health Resources and Services Administration to administer the Flex Grant program.

## **MEDICARE CONDITIONS OF PARTICIPATION**

All Critical Access Hospitals are governed by Medicare's conditions of participation. Currently, a hospital must meet these criteria to receive and maintain CAH designation.

### **Geographic Criteria**

- The hospital must be located in a rural area. A rural area is defined as either:
  - a county outside a Metropolitan Statistical Area (MSA)
  - a rural census tract of an MSA as determined by the most recent Goldsmith modification
  - an area or hospital designated as rural by state law or regulation
- The hospital must either be:
  - located more than 35 miles from another hospital
  - located more than 15 miles from another hospital in areas with mountainous terrain or only secondary roads:
    - In areas where there is a combination of mountainous and non-mountainous terrain, a hospital would qualify as long as the route from the hospital to another hospital in mountainous terrain is greater than 15 miles.
    - In areas where there is a combination of primary and secondary roads, a hospital would meet the "secondary roads only" criterion if there is a combination of primary and secondary roads between it and any hospital or other CAH, so long as more than 15 of the total miles from the hospital or other CAH consists of areas in which only secondary roads are available. To apply this criterion, measure the total driving distance, and subtract the portion of that distance in which primary roads are available. If the result is more than 15 miles, then the 15-mile criterion is met. Documentation submitted by the provider will be reviewed by the CMS Regional Office (RO). The RO will consult state transportation or

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highway department maps and/or maps of the U.S. Geological Survey to determine if the secondary roads only requirement has been met.

- certified by the state as being a necessary provider of health care services to residents in the area. As of January 1, 2006, states no longer had the authority to waive the CAH location relative to other facilities requirement, and thus, are not permitted to designate a facility as a necessary provider CAH. Hospitals designated as necessary providers prior to January 1, 2006, will be grandfathered but any new CAH designations must meet the mileage requirement.
- A CAH with a necessary provider designation in effect prior to January 1, 2006 and relocates must serve at least 75 percent of the same service area and provide at least 75 percent of the same services that it served before relocation; and must be staffed by 75 percent of the same staff (including medical staff, contracted staff and employees) that were on staff at the original location in order to continue to meet the location requirements in the previous paragraph.
- A CAH with a necessary provider designation that shares a campus with another hospital or CAH (co-located) will continue to meet the location requirements above only if the co-location arrangement was in effect before January 1, 2008, and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change.

*\*(A primary road is a numbered federal highway, including interstates, intrastate, expressways or any other numbered federal highway; or a numbered state highway with two or more lanes each way; or a road shown on a map prepared in accordance with the U.S. Geological Survey's Federal Geographic Data Committee (FGDC) Digital Cartographic Standard for Geologic Map Symbolization as a "primary highway, divided by a median strip.")*

### **Operating Criteria**

- Length of stay cannot exceed 96 hours, calculated on an annual, average basis
- Operation of up to 25 beds for acute inpatient care is allowed and there is no limit on the 25 beds for providing swing bed services
- 24-hour emergency care must be provided. Emergency care may be provided by a physician, physician assistant, nurse practitioner or clinical nurse practitioner. A registered nurse on site and immediately available may be utilized to conduct patient medical screening examinations when requested, if the request is within the scope of practice of the registered nurse and consistent with applicable state laws and the critical access hospital's bylaws and rules and regulations. In limited cases, a registered nurse can satisfy the ER personnel requirement for a temporary period if the CAH has no more than 10 beds and the state submits the appropriate documentation to the Center for Medicare and Medicaid Services. The provider need not be present in the emergency room, but must be immediately available by phone or radio and available on site within 30 minutes. Availability is extended to 60 minutes if the CAH is located in either a frontier area or remote location as defined by the state's rural health care plan. Although the emergency response provider does not need to be a physician, a doctor of medicine or osteopathy must be immediately available by telephone or radio on

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a 24-hour basis to receive emergency calls, provide information on treatment of emergency room patients, and refer patients to the appropriate location for treatment. Drugs, biologicals, supplies and some equipment commonly used in life-saving procedures must be readily available at the CAH for treating emergency cases. This requirement extends to the procurement, safekeeping and transfusion of blood products.

### **Additional Conditions of Participation**

CAHs also must comply with requirements relating to personnel, physical plant, non-medical emergencies, organizational structure, recordkeeping, documentation and provision of services. The complete Conditions of Participation: Critical Access Hospitals is found at 42 CFR 485, subpart F. They include, but are not limited to:

- Federal, state, and local laws and regulations on:
  - certification and licensure of personnel
  - patient health and safety
  - provision of patient care services
  - fire and safety code
- Housekeeping and maintenance procedures for:
  - safe operating conditions
  - proper storage and disposal of trash
  - clean and orderly premises
  - proper ventilation, lighting and temperature in all pharmaceutical, patient care and food preparation areas
- Emergency procedures for non-medical emergencies such as:
  - proper staff training
  - emergency power, lighting, fuel and water supply systems
- Organizational structure containing either a governing body or individual that assumes full legal responsibility for determining, implementing and monitoring operating policies. Any owner with more than 5 percent direct or indirect ownership interest is disclosed.
- Sufficient staffing to provide essential services:
  - a registered nurse or clinical nurse specialist on duty whenever the CAH has one or more inpatients
  - at least one doctor of medicine or osteopathy on staff and present at least once every two weeks to provide medical treatment, direction and supervision
  - at least one physician assistant, nurse practitioner or clinical nurse specialist on staff
- Written policies covering:
  - provision of services—furnished directly and through agreement

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- storage, handling, dispensation and administration of drugs and biologicals
  - reporting adverse drug reactions and errors in drug administration
  - identifying, reporting, investigating and controlling infectious and communicable diseases
  - ensuring that patient nutritional needs are met
  - ensuring that contractor services comply with all applicable conditions of participation
  - maintaining complete, accurate and readily accessible clinical records containing all reports of treatment, medications, nursing notes, documentation of complications and other pertinent information, dated and signed by the patient’s health care providers.
- Written protocols for organ, tissue and eye procurement. The protocols designate a trained individual to initiate the request to the family. The protocols contain a written agreement with an organ procurement organization that provides for timely notification of individuals whose death is imminent or who have died in the CAH.

## **Reimbursement**

Services provided to Medicare beneficiaries are reimbursed based on cost. Current reimbursement provisions include:

- Hospital services are reimbursed at the lesser of 80 percent of 101 percent of the CAH’s reasonable costs, or 101 percent of the reasonable costs less the Part B deductible and coinsurance amounts. If the CAH chooses the optional, elective billing method, reimbursement for hospital services is paid in the same manner as under the standard payment method listed above. In addition, physician professional services are reimbursed based on 115 percent of the Physician Fee Schedule amount, after allowable deductions. The CAH cannot be required to have all of its practicing physicians assign billing rights to the CAH in order for the CAH to use the optional billing method.
- Ambulance services owned by the CAH are reimbursed at cost if they are the only ambulance provider within 35 miles of the hospital.
- Laboratory tests are reimbursed at cost with no patient deductible or coinsurance due.
- Periodic Interim Payment (PIP) is available for CAHs. Hospitals electing PIP are paid every two weeks.
- Distinct part psychiatric units and rehabilitation units, limited to 10 beds and meeting the same requirements as units established in short-term care hospitals, may be established in a CAH. These distinct part units do not count toward the CAH bed limit and are reimbursed based on the Prospective Payment System.
- On-call emergency room physicians, as well as physician assistants, nurse practitioners and clinical nurse specialists are reimbursed on a reasonable cost basis.

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## **PROGRAM ADMINISTRATION**

The Texas Department of Rural Affairs, formerly the Office of Rural Community Affairs, administers the Flex program in Texas and is responsible for facilitating the state CAH designation process. The Texas Department of Rural Affairs was created by the 77th Texas Legislature to develop policy specifically addressing economic and quality of life issues affecting small and rural communities across Texas. The office administers programs supporting rural health care, the federal Community Development Block Grant non-entitlement program, and programs designed to improve the leadership capacity of rural community leaders. It also coordinates and monitors the state's effort to improve the results and cost-effectiveness of programs affecting rural communities, as well as provide an annual evaluation of the condition of rural Texas communities.

House Bill 7 created TDRA by merging two existing programs administered by the state: the Center for Rural Health Initiatives (CRHI) previously associated with the Texas Department of Health, and the Texas Community Development Program (TCDP) from the Texas Department of Housing and Community Affairs.

TDRA supports access and availability of health care services to rural citizens by coordinating the efforts of local communities trying to solve local problems. TDRA works to integrate rural health care services and programs, consult with rural communities, and research and implement innovative models to maximize area resources.

For more information, contact the Texas Department of Rural Affairs :

Mailing Address: P.O. Box 12877  
Austin, TX 78711

Physical Address: 1700 N. Congress, Suite 220  
Austin, TX 78701

Phone: 512/936-6701  
Toll Free: 800/544-2042  
Fax: 512/936-6776  
Email: [tdra@tdra.state.tx.us](mailto:tdra@tdra.state.tx.us)

## **SUMMARY**

Congress created the Critical Access Hospital program in 1997 to provide financial incentives to small, rural hospitals struggling to remain viable health care providers to their communities. Since then, the program has undergone numerous updates through several key pieces of legislation. These laws specify eligibility requirements to participate in the program, and how CAH facilities are operated and reimbursed. It is important that Critical Access Hospitals be familiar with these continually changing rules and regulations impacting their operations.

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Texas Department of Rural Affairs, [www.tdra@tdra.state.tx.us](http://www.tdra@tdra.state.tx.us)

# FINANCES AND REIMBURSEMENT

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Most hospitals in the U.S. are paid under a Prospective Payment System (PPS) that bases payment on predetermined rates for each patient diagnosis (inpatient) or item of service (outpatient). These payments are set in advance each year and generally do not vary based on charge levels, cost of care or length of stay.

Because many small hospitals historically have not had high volume, their PPS payments often were not sufficient to cover the cost of providing care. This resulted in many hospitals closing over the years, and in large losses at others. To assist small hospitals, Congress created the Critical Access Hospital (CAH) program to pay qualifying hospitals the cost of providing services to patients.

Critical Access Hospitals are reimbursed a proportion of reasonable cost for care rendered to Medicare beneficiaries for inpatient, outpatient and covered skilled nursing facility services. The intent of the cost-based reimbursement methodology is to provide improved reimbursement that helps small, rural hospitals' financial viability. The cost-based reimbursement structure for CAH facilities is unlike any other health care payment system currently available.

## **BASICS OF COST REIMBURSEMENT**

Cost reimbursement means just that — Medicare pays the cost of providing services to patients. However, only "allowable" costs are paid. Allowable costs generally include:

- Salaries and benefits
- Drugs
- Supplies
- Depreciation and interest
- Utilities
- Rent/leases

Costs that are not covered include:

- Bad debts and charity
- Physician recruitment
- Costs of physician offices that are not rural health clinics
- Many other statutorily excluded items

Since 2004, Medicare pays the hospital 101 percent of allowable costs, allowing for a very small profit margin from serving Medicare patients. Otherwise, the best a hospital can do is "break-even" on cost-reimbursed patients.

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To compute allowable costs, each hospital must file a cost report each year. The cost report takes the hospital's total expenses and makes adjustments for nonallowable costs. It also allocates costs of overhead areas (administration and general, pharmacy, medical records, business office, etc.) to patient care areas (nursing floor, lab, radiology, emergency room, etc.).

Medicare pays costs in two ways:

1. Routine costs (that is, the nursing floor costs) are paid based on a per diem rate. If total routine costs are \$2,000,000 and total days for all patients are 2,000, then the "per day routine costs" are \$1,000. If there were 1,000 total Medicare days, then Medicare would pay the hospital \$1,000,000 (1,000 days x \$1,000 per diem costs.)
2. Ancillary costs (radiology, lab, operating room, etc.) are paid based on a ratio of costs to charges. For example, if the radiology department had \$500,000 in total charges and the cost report showed \$250,000 in total costs, then the cost-to-charge ratio is 50 percent. If Medicare was billed \$300,000 for radiology services, then it would pay the hospital \$150,000 (\$300,000 x 50 percent.)

CAHs are paid estimated rates during each year and then the estimated payments are compared to the actual costs on the annual cost report. If Medicare paid too much, the CAH must repay some money to the program. If Medicare's estimated payments are less than what the cost report says they should have been, the hospital will receive additional payment from Medicare.

Keep in mind that just because a hospital converts to CAH status does not mean its financial challenges are forever resolved. Cost-based reimbursement afforded through the CAH program is not intended to be a financial cure-all solution. CAH facilities must continue to diligently manage operations to ensure the hospital's ongoing financial stability.

## **RATE-SETTING**

CAHs rely heavily on the Medicare cost-reporting process. Since both inpatient and outpatient services are reimbursed through this cost-based system, accurately allocating costs on the cost report is critical.

A CAH's initial payment rates are based on the last cost report filed as an acute care hospital. Just as the cost structure or utilization trends fluctuate, costs per day or cost-to-charge ratios also fluctuate. Payment rates to a CAH are updated based on the hospital's most recently filed cost report as a CAH. It is not uncommon for the updated rates to be higher or lower than the hospital's actual year-end costs. Any fluctuation between the interim rates set and paid throughout the year, and the actual costs for the year, is reflected in the end-of-year cost report settlement.

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Each CAH should establish a process for monitoring deviations between the interim rates paid throughout the year and the hospital's actual costs for the year. This process is an important cash flow management tool for the hospital. Interim cost reports prepared monthly, quarterly and semi-annually enable hospital management to monitor the accuracy of interim rates. At any time during the year, the hospital may request changes to the interim payment rates if supportable with data from interim cost reports.

Without such a monitoring process in place, at year end the hospital may find it owes Medicare a significant amount of money. Similarly, it may find that Medicare owes the hospital significant shortfall — money that the hospital could have used to manage cash flow during the year.

## **BILLING AND COLLECTION**

CAHs struggle with many of the same billing and collection issues as other hospitals. Accurately billing and charging all payors is important.

A CAH has an option that is not applicable to an acute care facility:

- Standard Method versus Elective Method
  - Standard Method: Cost-based facility services with billing of carrier for professional services. The CAH facility is paid under this method unless it elects the Elective Method.
  - Elective Method: Cost-based facility services plus fee schedule for professional services. 115 percent of the allowable amount is paid under the Medicare Physician Fee Schedule for physician professional services. Payment for non-physician practitioner professional services is 115 percent of 85 percent of the allowable amount under the Medicare Physician Fee Schedule.

Before choosing a billing method, consider operational issues such as:

- Does the hospital already have the staff in place to provide additional billing services under the Elective Method?
- Does the hospital already provide the billing services for the physicians for professional fees?

Answering yes to these questions makes the decision to opt for the Elective Method simpler.

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The following issues directly affect the CAH:

- CAHs are exempt from the 72-hour rule. All outpatient services provided 72 hours prior to an inpatient stay will be paid separate from the inpatient services.
- CAHs may operate up to 25 beds for acute inpatient care, subject to the 96-hour length of stay for acute care patients. When there is a swing bed agreement, any of the beds may be used to furnish either inpatient acute care or swing bed services.
- When a Medicare Hospice patient is admitted into a CAH bed for inpatient care, the days do not count against the 96-hour length of stay rule.
- Outpatient clinical diagnostic lab tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are CAH outpatients at the time the specimen is collected.
- CAHs are eligible for periodic interim payments (PIP) for inpatient services.
- A CAH must provide 24-hour emergency care services.

CAH rules are established by the Centers for Medicare and Medicaid Services (CMS) for a Medicare-designated facility. These rules apply to a CMS/Medicare facility only. The CAH must bill all other services under the rules and regulations directed by the applicable contractual arrangements. Do not change the CAH facility billing for Texas Medicaid claims. Texas Workers Compensation reimburses physicians and other professional providers based on the coding and current Medicare Part B fee schedule. Texas hospitals are paid for outpatient services based on the 1995 CPT book.

## **COST SETTLEMENT**

CAH Medicare reimbursement uses a standardized cost report to determine the cost for the amount of dollars paid to a hospital. The cost report uses direct and indirect costs and makes reclassifications of costs to match proper principles of cost allocations. Some costs are not allowable, such as patient phone costs. These non-allowable costs are removed prior to cost apportionment.

The apportionment process involves stepping down the indirect costs to the revenue producing departments and non-reimbursable departments. The costs are then allocated to the various payors, including Medicare, by multiplying Medicare routine days, times the cost per day for routine cost, and the ancillary cost-to-charge ratio, times the allowable Medicare revenue for the ancillary cost. After the correct cost is calculated, the hospital's interim payments are compared with the appropriate cost. The difference is a receivable from, or payable to, Medicare.

The cost report must be filed within five months of the hospital's fiscal year end. A "Tentative Desk Review" identifies initial adjustments and makes a tentative determination of the amount due to or from the program. Either a tentative

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settlement check is issued to the hospital, or the hospital receives a payment due notice. Within two to three years, the hospital will receive a “Notice of Program Reimbursement (NPR)” letter, which outlines the final settlement. The hospital has 180 days after receiving the NPR letter to appeal to the Provider Reimbursement Review Board. The file can be reopened by request within three years of the NPR for mistakes made during the process.

Payment methodologies are very different between a CAH and an acute care facility, making the cost report a critical tool. The payment for a CAH is based on the end-of-year costs as reported and identified in the cost report. The final cost settlement payment is based on the accurate filing and reporting of that cost report.

CAH reimbursement strategies must be properly reported to accurately reflect CAH operations for the year. Examples of some of those include:

- Coverage of costs for on-call emergency room providers are allowable for a CAH.
- CAHs are allowed 100 percent reimbursement of Medicare bad debts. All bad debts should be reviewed to ensure they are written off according to the Medicare regulations.
- Cost-based reimbursement demands the use of proper statistical methods to insure proper cost allocations of overhead to the correct hospital departments.
- Cost-based reimbursement also requires careful allocation of square footage to each department to insure proper cost allocations.
- Salaries also must be carefully allocated by department for accurate departmental cost allocations.

## **ANNUAL OPERATING AND CAPITAL EXPENDITURE BUDGETS**

CAHs must maintain spending plans as a part of Medicare’s conditions. The budget development process can and should be a cornerstone of the overall planning process.

The hospital should develop projections for its future operations. The review should encompass:

- Projected revenues
- Projected inpatient days
- Projected utilization by financial class
- Projected community needs
- Projected fixed and variable costs of the hospital
- Condition of the building and plant
- Other capital needs

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Facilities should prepare both an annual operating budget and a capital expenditure plan for a three-year period.

In the annual operating budget, include and identify anticipated revenue sources and expenses. Also detail sources of revenue between inpatient and outpatient services, inpatient days by the different financial classes and fixed versus marginal costs.

The three-year capital expenditure budget plan should include and identify specific expenditures that would be considered capital in nature and note the anticipated sources of financing.

## **MONITOR AND REVIEW THE ORGANIZATION'S STRATEGIC FINANCIAL PRIORITIES OR TARGET**

The Board should review and update the overall plan and budget at least annually. Effective strategic planning is the hallmark of a thriving hospital. Trustees are responsible for assisting the administrator and staff to see past the daily operational details, and to help the hospital succeed in meeting its unique mission. The annual operating budget is the outgrowth of the strategic planning process.

To monitor performance, request monthly reports comparing actual operations to budget, as well as actual to the prior year both on a monthly and year-to-date basis. Compare days and discharge statistics as well.

Each month, compute a receivable or payable to Medicare and Medicaid based on the operations to date. This can be done by running a mini-cost report or by using a sophisticated spreadsheet model to estimate the effect. Make a journal entry to address both the balance sheet and the income statement for the hospital.

At least annually, review performance data to determine whether it is in the hospital's best interest to remain a Critical Access Hospital.

## **TEXAS DEPARTMENT OF RURAL AFFAIRS (TDRA)**

The Texas Department of Rural Affairs specifically provides opportunities to Critical Access Hospitals in several areas. TDRA:

- Provides periodic meetings and workshops, technical assistance services, and program evaluations.
- Provides financial assistance for health care facilities to conduct a financial and operational feasibility study through grants. The grant is referred to as a CAH Planning Grant.

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- Assists to make innovative and strategic technology, health information system, and capital equipment investments aimed at improving the provision and delivery of high quality rural health services through the Rural Health Technology Grant Program.
  - Supports collaborative efforts among rural health care organizations and other community entities in improving access or quality of essential health care and emergency medical services through a grant.
  - Encourages continuing education for all members of CAH Boards of Trustees. CAHs that participate in the approved continuing education programs may receive financial assistance through TDRA. TDRA recommends that each trustee of a CAH participate in 12 continuing education units over a two-year period. At least six of the units are recommended through a public education forum. At least three are recommended through in-person classroom instruction.
  - Supports Emergency Medical Services (EMS) activities which may include, CAH Trauma Team Development, Trauma center designation of CAHS, and/or EMS training.
  - Provides continuing healthcare education services to each CAH through HealthNet/Health.edu offered by Texas Tech University Health Sciences Center.
  - Provides funding for the Rural Performance and Quality Improvement program through Texas A&M University Health Science Center-RCHI to improve patient safety and increase the number of CAHs reporting to CMS Hospital Compare Website.

The available grant funding may vary from year to year depending on the funding source and TDRA's priorities. Additional grants and financial assistance are available for other programs that benefit the rural health care delivery system in Texas.

## **SUMMARY**

Just as Critical Access Hospitals are unique among health care facilities, so are the ways in which they are reimbursed. CAH facilities must diligently monitor costs versus payments through ongoing reporting systems, annual budgeting and strategic planning. These documents are key to ensuring accurate, fair reimbursement for services. Without them, a facility lacks the tools to adequately plan for the future and the evidence required to correct reimbursement mistakes of the past.

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# BALANCING AND DIFFERENTIATING BETWEEN GOVERNANCE & ADMINISTRATION

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## WHAT IS GOVERNANCE?

A thin, but important line separates the duties of the board of directors from those of the hospital chief executive officer (CEO). Understanding the distinction between the CEO's operational jurisdiction, and the board's governance duties, is a significant factor in a Critical Access Hospital's organizational success.

Governance is the process by which a board of directors ensures that an organization is run in the best interests of its stakeholders. The board sets the overall direction and goals of the hospital by:

- Adopting broad policies
- Making major decisions
- Selecting and evaluating the chief executive
- Evaluating company performance

Most hospitals don't have stockholders, but they do have stakeholders — individuals or groups that benefit from the hospital's quality services. Nonprofit hospitals are most often managed and operated by charity driven and faith-based organizations. As with school boards, trustees who serve on public hospital boards are expected to represent the interests of the city, county or district's taxpayers who supply the hospital with financial support.

A hospital's stakeholders can include its patients, families and the community at large. Stakeholders also include employees, physicians, businesses and other community health care providers, all of which have an interest in seeing the hospital succeed. Regardless of the size or type of hospital, there are many external parties to which trustees and the administrator share direct accountability.

An organization as complex as a hospital could never operate properly without a committed group of caring individuals, willing to make difficult decisions about the hospital's future. That is governance at its core. The hospital board is the group tasked with assimilating input received from stakeholders, and then directing the organization to meet the needs of those to whom it is accountable. They serve as the conduit between the hospital and the community.

Effective governance requires the CAH board to:

- Focus on where the hospital is going and how the board will know when it gets there
- Develop a positive and dynamic relationship with the CEO
- Set policy, direction and strategy, but never engage in management activities
- Encourage each trustee to share and contribute their talents and skills to the board and the hospital
- Create an environment of respect and cooperation where trustees can be truthful, ask meaningful questions, speak their concerns and resolve differences

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- Invest in two-way communication with the medical staff
  - Listen to and hear one another
  - Perform an annual board self-evaluation

Remembering the roles and responsibilities of hospital trustees, and staying focused on strategic issues, can help the board provide better oversight and accountability to the population it serves. Governance is a learning process that takes time to perfect. Trustees should continually seek out resources and educational opportunities that expand their familiarity with the complexities of the industry and their role as trustees.

Governing by instinct, rather than by proven governance practices, can lead to dangerous lapses in judgment. Instead, showcase good governance by helping ensure that objectives are realized, resources are managed appropriately and stakeholder interests are being met.

## **THE DIFFERENCE BETWEEN POLICY AND OPERATIONS**

Policies are guiding principles or recommended courses of action that direct current and future decision making. Operations include all activities related to the day-to-day management of the facility and staff. The board sets the policy for the hospital, while management implements it. Implementation is, therefore, the administrator's responsibility.

Very complex organizations, like hospitals, develop countless administrative policies without board involvement. These policies include personnel, budgeting, spending and other operational issues. Tasks such as these are best left to the CEO and other executives who are well-versed on the issues and needs of patients and staff. No board that is properly fulfilling its role would want to be involved in such details.

Experienced trustees limit their involvement to broad policy matters. They spend much of the time developing the long-term objectives they envision the administrator working to achieve. Establishing clear direction and formally adopted policies on important matters helps trustees steer clear of operations by articulating the guidelines for operational decisions that are the CEO's primary responsibility.

Therefore, the chief executive and board members are interdependent. Ideally, they operate in a harmonious, symbiotic way. However, disharmony and agitation can result when the thin line that separates these critical responsibilities is intentionally or repeatedly undermined.

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## THE POWER OF THE BOARD

Governing boards bear the ultimate responsibility for the organization. They must directly or indirectly represent the interests of every hospital stakeholder in an unbiased manner. The board selects an effective chief executive officer and monitors the organization's ongoing performance. The board also defines the organization's mission and vision, and develops the long-range strategic plan for achieving that vision. It is the administrator's most important task to implement the strategic plan successfully.

## THE CEO DEPENDS ON THE TRUSTEES

The administrator is selected by the trustees, and receives management authority from the board. However, the CEO should never view the board and its responsibilities as merely a legal requirement. Most trustees choose to serve out of a genuine interest for the well-being of the hospital and its stakeholders, and the CEO should value the board's collective wisdom.

## TRUSTEES DEPEND ON THE CEO

The board must depend on the CEO to show leadership. That includes putting together a successful team of executives and staff, and helping trustees use their volunteer time most effectively. The chief executive is a vital source of knowledge and education that trustees need to fulfill their fiduciary obligation. Boards turn to the CEO for information on operations, financial performance and quality patient outcomes.

## COMPARISON OF CHIEF EXECUTIVE OFFICER AND BOARD OF TRUSTEES ROLES

<b>Trustees</b>	<b>Chief Executive</b>
Act as a group	Individual
Concentrate on the long term	Concentrates on shorter term
Mainly concerned with policy and strategy	Mainly concerned with implementation of the board's plans
Permanent and continuous	Temporary
No staff	Access to all staff
Ultimate responsibility	Limited responsibility
Typically not experts in the field	Professional; typically expert
Volunteer their time	Paid a salary
Only an overview of the organization	Intimate knowledge of organization

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## SUMMARY

Trustees are focused primarily on governance. Trustees work as one cohesive unit and should not allow themselves to be subdivided by the CEO, hospital staff or become involved in issues that don't require their involvement. They should instead be focused on long-term objectives and work at the policy level, never at an operational level. This means they shouldn't interact directly with staff, but come to rely on the CEO as the hospital staff's collective voice.

Despite the fact that individual trustees might not have much, if any, experience in the health care industry, the board is accountable for the actions of the CEO as well as the success of the entire organization. However, this commitment doesn't need to be a burden. There is tremendous satisfaction in knowing that the hospital provides life-saving health care services for the community. By becoming educated on trustee-related hospital issues, maintaining broad oversight and setting a positive tone for the organization, trustees can help make their vision a reality.

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# BUILDING A STRONGER BOARD/CEO RELATIONSHIP

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No question — today's health care environment is challenging. Critical Access Hospital CEOs and their management teams are working harder than ever, yet often with a sense of dissatisfaction. Regulations are increasing, but margins are declining. Efforts to remain in compliance and reduce costs also have reduced employee morale. New facilities are needed and qualified health care professionals are in short supply. The list of unsolved problems makes it difficult to celebrate the many good things being accomplished.

This reality places significant stress on board/CEO relationships. Board members wonder, does the CEO possess the leadership skills the job demands? CEOs worry if their board has the mix of talent and experience required to govern the organization in such turbulent times. More than ever, the complexities of managing today's hospital demand a strong, positive working relationship between board members and their CEO.

By focusing attention on the maintenance of a positive working relationship with the CEO, you can nurture the investment that is one of, if not the most important factors, of success at your hospital. Experience has shown that rapid turnover at the CEO level causes turmoil and creates a leadership void that diverts attention away from the strategic vision that the board has set for the organization. Let us now consider what actions you can take to maintain your most important source of human capital.

## **BUILDING THE BOARD'S RELATIONSHIP WITH THE CEO**

The foundation for a sound board/CEO relationship begins with a clearly defined long-range vision and strategic direction for the hospital. The vision should be realistic in light of the business environment. However, craft a long-range vision that challenges the organization's leadership to stretch and explore new ways of doing things. Clearly delineate organizational priorities and, given the noted resource constraints, identify initiatives that are not achievable in the foreseeable future.

Sometimes, in order to remain viable, the hospital must increase revenue through focused, disciplined growth or enhancement of services. Don't be afraid to invest resources in new services that can generate positive margins. To do so will require a willingness to take risks, to make and tolerate some mistakes, and to learn from those mistakes. Recognize that these decisions may generate increased conflict and be prepared to manage it.

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## **FOCUS ON LONG-RANGE VISION**

It is well within the CEO's job, with full encouragement and support from the board, to provide leadership in shaping the vision, defining priorities, and creating a true sense of momentum and forward action. While the CEO may lead this process, it cannot be done alone.

The input and involvement of physicians, board members and other key stakeholders ensures that they understand and support the hospital's strategic direction. Expect the CEO to demonstrate a commitment to building and promoting an organizational culture grounded in trust and credibility. This will certainly increase the likelihood of a successful implementation process.

The CEO has a right to expect certain things from the board as well. Among them, the board should:

- Commit to excellence in governance
- Add value to the decision-making process
- Focus on policy-level issues, not operational concerns
- Communicate clear expectations to both the CEO and medical staff leadership, and hold them accountable for their performance
- Be the hospital's advocate in the community
- Actively support the CEO, especially when the hospital faces new challenges

## **THE CHAIR IS THE BOARD'S PRIMARY CONTACT WITH THE CEO**

One way to build a stable environment for good board/CEO relations is to utilize the board chair as the primary or central point of contact. The chair and the chief executive need to support, consult and complement each other. Both have their own responsibilities — the CEO manages the operational activities and the chair leads the board. They share power in their mutual pursuit to advance the mission of the organization.

To make this happen, open and regular communication is the key. This partnership needs constant attention. Personalities change but these positions remain. Each partner needs to adapt to and cultivate the working relationship. Think of the chief executive as the gatekeeper for the staff and the chair as the gatekeeper for the rest of the board. This helps prevent miscommunication or over-communication and allows both leaders to stay aware of the needs that each of the other's constituents may have.

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## **SOME IMPORTANT GROUND RULES FOR EFFECTIVE BOARD-CEO RELATIONSHIPS**

- The board’s expectations of the CEO and of itself should be clearly articulated, and they should not change every time the chair or complexion of the board changes.
- The CEO should be empowered to operate as the single point leader within the organization — not requiring the board’s permission to act, yet demonstrating the ability to keep the board well informed.
- The CEO should be a voting member of the board and an ex-officio member of all board committees. The board should not hold executive sessions without the CEO present, except as part of the performance review process.
- The CEO should work in collaboration with the board chair to ensure sound governance and the on-going professional development of the board.
- The CEO should write goals and objectives that are updated annually and approved by the board at the beginning of each fiscal year.
- The CEO evaluation process should be conducted by a committee, not by the chair alone. The CEO’s salary and benefits should be reviewed and approved by the full board.
- The healthy board/CEO relationship is one that is grounded in mutual respect, honest and open dialogue, a willingness to disagree, and mutual support.

## **UNHAPPY BOARD/CEO RELATIONSHIPS: WARNING SIGNS**

Some hospitals do seem to have a ‘revolving door’ where upper management is concerned. This often results from a lack of trust between the board and CEO. The delicate balance of trust and oversight must be fostered in order for a hospital to successfully address its obligation to the community. CEOs respect trustees that are open and honestly interested in seeing the hospital succeed. CEOs and trustees must respect each other’s autonomy and focus on their own spheres of influence. Here are some “red-flag” situations to watch for:

- A board that engages in micro-managing, rather than concentrating on long-term issues and can’t seem to leave the implementation and day-to-day management to the staff
- A chief executive who controls the agenda, filters information and frustrates the trustees’ efforts to set policy and plans
- A board that has an unreasonable set of expectations and then offers little in the way of guidance or support
- A board that is fractious and has trouble making decisions or articulating a unified vision for the hospital

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## **SUMMARY**

CEO and board tenure is a major feature of many successful hospitals. Along with this tenure comes experience, institutional knowledge and a healthy respect for the many complexities that are common to the hospital business. It also helps to build a tremendous amount of trust and respect when a group of individuals has remained engaged during even very difficult times.

However, relationship building must not ebb just because times are good. The board and CEO should continually look for new ways to improve communication and enhance interaction. Unfortunately, many administrators don't even realize they are out of step with the board of directors until they are suddenly asked to resign. While CEO recruitment is a critical board function, building a relationship that fosters CEO retention is where much of the board's time and energy should more effectively be spent.

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# BOARD RECRUITMENT, SELECTION & EVALUATION

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Unlike other rural hospitals, Critical Access Hospitals (CAHs) must meet certain criteria to participate in the Critical Access Hospital program. However, there is no difference between the responsibilities and functions of a CAH board member and those of any other rural hospital board member.

## **BOARD RECRUITMENT AND SELECTION**

A board should consist of individuals with a variety of skills and expertise, occupations, ages and backgrounds. Prospective board members also should be well connected within their communities.

Board members must have the time, commitment and interest in serving on the board, and they must be able to work well with a diverse group of colleagues. Before recruiting new board members:

- Identify the skills and attributes needed on the board
- Identify the skills and attributes of current board members
- Develop selection criteria for new board members
- Recruit prospective candidates
- Build a commitment for them to serve

## **BOARD PROFILING**

It is also helpful to create a profile of the existing board. Focus on characteristics such as:

- Age
- Sex
- Race or ethnicity
- Residence
- Occupation
- Governance experience
- Industry and market knowledge
- Clinical expertise
- Financial knowledge
- Management experience
- Experience with acquisitions and mergers
- Community and political contacts

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Use the Board Profile Worksheet (Figure 1) to compile information. Once completed, the worksheet provides a clear picture of the current board's attributes, and the skills and criteria needed to complement the existing board members.

## **BASIC BOARD MEMBER SELECTION CRITERIA**

Begin narrowing the pool of prospective candidates by focusing on basic selection criteria. These include such things as:

- Willingness to serve
- Sufficient time and energy to do an effective job
- Willingness to participate in board orientation and ongoing continuing education activities
- Objectivity
- Integrity
- No serious conflicts of interest
- Values consistent with those of the hospital's mission, goals and objectives

Only individuals meeting these basic criteria, as well as any additional criteria developed by the hospital board, should apply for board positions.

## **SUPPOSE MY BOARD IS EITHER ELECTED OR ADVISORY?**

In some cases, the hospital may have little choice in who serves on the board. For instance, hospital district boards run for office, and proprietary hospital boards often are appointed by the parent corporation. However, regardless of the type of ownership, community leaders have an opportunity — in fact, an obligation — to recommend qualified and viable candidates for board positions. This holds true whether the board is selected through local elections, appointed by a corporation with headquarters located out of town, or selected through a self-perpetuating process. Once the board profile and new board member criteria have been adopted, it is incumbent upon the existing board leadership to promote candidates who will best serve the interests of the hospital, its patients and the community.

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## **NEW BOARD MEMBER SELECTION CRITERIA**

Some of the new board member selection criteria which may be adopted include:

- Past Board experience
- Professional and business experience
- Demonstrated leadership skills
- Record of community involvement and commitment
- Political involvement or connections
- Skills and competencies aligned with the strategic direction of the hospital
- Experience in a specific occupation

Other criteria for new board members may be adopted, dependent upon the specific needs of the organization.

## **RECRUITMENT METHODS AND TIPS**

Try the following suggestions for recruiting board members:

- Share the skills and attributes desired for board member candidates with both existing board members and community leaders, so that both parties can help identify viable candidates
- Ask advisory boards and/or community members on board committees to help identify and recruit new board members
- Hold candidate forums
- Share prospective board member qualifications with the community at large
- Invite community leaders to the hospital to see if future new board members emerge in the process

## **BOARD ORIENTATION AND CONTINUING EDUCATION**

Conduct an orientation for every new board member. Focus on the hospital's unique organizational characteristics, and discuss the expected functions and responsibilities of board members.

Continuing education for board members is also an important tool in helping members better understand hospital programs and services, industry and technological changes, financing and the delivery of care. Tools for continuing education include board manuals, committee activities, article review, board retreats and trustee conferences.

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## **QUALIFICATIONS FOR TERM RENEWAL OF BOARD MEMBERS**

The re-election or reappointment of board members should be determined based upon how well the member:

- Contributes at board and committee meetings
- Prepares for each board meeting
- Supports board actions, and does not push personal agenda items
- Avoids conflicts of interests, states potential conflicts, and abstains in voting on such issues or matters
- Carries out committee and board duties as assigned
- Communicates effectively with key constituents
- Works well with other board members

## **THE ROLE OF THE BOARD CHAIR**

A good board chair is essential to effectiveness of a hospital board. This is especially true on smaller boards, where the board chair may cast the deciding vote or preside or mediate over contentious matters. The board chair's most important functions are to:

- Preside over all meetings of the board and executive committee
- Designate committee chairs, with the advice and consent of the executive committee
- Serve as an ex-officio member of all board committees (not expected to participate)
- Serve as the board's primary representative to key stakeholder groups
- Serve as counselor to the CEO on matters of governance and board/CEO relations

In addition, the chair and executive committee:

- Specify annual board objectives
- Approve board meeting agendas
- Help recruit, develop and act as mentors to other board members

A strong and influential board chair can make a significant difference in the overall effectiveness of the hospital's operations.

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## **BOARD SELF-EVALUATION AND PERFORMANCE**

All hospital boards are responsible for evaluating their own level of performance, as well as that of the hospital and its CEO. As the policy-making body for the hospital, the board sets the tone for evaluating performance by conducting a factual and candid annual performance self-assessment.

A successful board self-assessment will:

- Objectively assess the level of common trustee understanding, expectations and direction
- Facilitate goal setting
- Pinpoint organizational improvement opportunities
- Help senior management understand the board's educational development needs
- Build broad consensus-based trustee decisions
- Create opportunities to address major issues and ideas in a non-threatening, collaborative manner

Six key steps in the self-assessment process include:

1. Developing and gaining consensus on the board's performance criteria
2. Conducting the assessment through a thorough, anonymous written survey
3. Summarizing the assessment results and reporting back to the full board
4. Engaging in a dialogue about the meaning and implications of the key findings
5. Identifying specific leadership improvement opportunities
6. Creating a board work plan for implementation of the board's direction

The criteria for board self-assessment may vary somewhat from hospital to hospital. Adopt a method most meaningful to the hospital's specific needs. Make board self-assessment a continuous process, documented annually. Include appropriate follow-up actions for needed improvements in the board's functioning. CAH hospitals can contact Texas Healthcare Trustees for Sample Board Self-Assessment Questionnaire as a guide in developing their own forms.

### **SUMMARY**

A diverse, committed group of directors is essential to an effective Critical Access Hospital. The key is to understand the characteristics needed in each board member and recruit members who possess those selection criteria. Once on the board, trustees need continual education, clearly defined responsibilities, good communication and ongoing opportunities to assess their performance individually and collectively.

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**FIGURE 1**  
**BOARD PROFILE WORKSHEET**

Name of Board Members					
Age					
Sex					
Race or Ethnicity					
Residence					
Occupation					
Governance Experience					
Industry and Market Knowledge					
Clinical Expertise					
Financial Knowledge					
Management Experience					
Experience with Acquisitions and Mergers					
Community and Political Contacts					

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# CEO, RECRUITMENT, SELECTION AND EVALUATION

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The most important decision a CAH board must make is selecting a capable CEO to manage the hospital. Once that is achieved, the effective board will empower the CEO, offer strong support and ongoing feedback, conduct annual evaluations, and provide a fair and reasonable compensation package and contractual protection. CEOs deserve these actions at a minimum, so that they can carry out their duties without concern for their own security, as well as that of their family.

## **ROLE OF THE BOARD, CEO AND MEDICAL/HOSPITAL STAFFS**

Perhaps one of the most important concepts a hospital's board must understand is the difference between their role and the role of the CEO in managing the hospital. The board is responsible for setting policy for the hospital, and the CEO is responsible for managing the operations of the hospital on a daily basis. Adherence to this one simple governance principle can make the difference between a highly effective hospital organization, and a marginal hospital with frequent CEO turnover. A board must resist the temptation to become involved in operational matters, or the organization will be doomed to a history of turnover at the top levels and mediocre or poor performance.

The board chair, board members and CEO must take the lead in developing good working relationships. Key components of those relationships are trust, mutual respect, open and honest communication, and a commitment to the best interests of the hospital, its patients and the community. The board, CEO, medical staff and hospital staff are full partners in the hospital's success. It is the CEO's responsibility to document the hospital's organizational and reporting relationships in a formal organization chart. Board of trustee bylaws and medical staff bylaws govern the affairs of their respective groups. Both groups should have input into these documents, prior to board approval.

## **THE HOSPITAL ORGANIZATION**

The CEO develops, and revises as needed, an organization chart appropriate for the hospital's complexity, size and scope of operations. Most Critical Access Hospitals provide general and medical care. They are required to have 24-hour emergency services, although that particular service may be staffed and covered in a variety of ways, using a combination of both internal and external staff. All CAHs have a core nursing staff, although it may be supplemented by contracted staff in certain areas.

Most CAH facilities have a swing bed unit, and some have a nursing home, either attached to or separate from the main hospital. While only a few CAH facilities provide OB/GYN services, many offer surgical services, typically on an outpatient basis. Other professional services — such as lab, pharmacy, radiology, respiratory therapy, home health services and physical therapy — primarily are provided in-house, although some or all of those services may be contracted. Plant or support services such as dietary and food service, engineering, maintenance, housekeeping, laundry and central supply might also be in-house, contracted, or a combination.

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Be sure the organizational chart accurately reflects:

- The services or programs provided
- Reporting relationships in each department
- Direct (line) and indirect (staff) relationships
- The CEO's relationship to staff, medical staff and board of trustees

The sample hospital organization chart in Figure 1 can be customized for each CAH's scope of programs and services.

## **THE CEO SELECTION PROCESS**

A qualified CEO must have the experience and ability to manage the hospital within a complex health care environment and regulatory system. A CAH CEO must stay well-educated on the unique rules and regulations that apply to Critical Access Hospitals. A number of educational resources are available to help CAH boards and CEOs, including programs through the Texas Department of Rural Affairs (TDRA), Texas Hospital Association (THA), Texas Healthcare Trustees (THT), Texas Organization of Rural & Community Hospitals (TORCH) and National Rural Health Association (NRHA).

Small hospital administration requires the CEO to wear many hats. The CAH executive must be knowledgeable in finance, personnel administration, purchasing, employee relations, public relations and governmental affairs. Because they often work in remote areas, CAH executives risk becoming isolated from their colleagues. Trustees should encourage the CEO to attend meetings and seminars to stay abreast of current Medicare/Medicaid issues, as well as leading-edge management trends.

Selecting a CEO is time-consuming. Have a selection process in place before it is needed. The first step is to identify the experience and skills the hospital needs now and into the future. Things to consider include:

- The hospital's mission, strategic plan, goals and objectives
- Reasons why the former CEO left
- The hospital and community's environment
- Current hospital challenges, and plans for addressing them
- An objective assessment of the board and its present functioning
- Degree of effectiveness

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Conduct this review process internally, but consider involving a consultant who can objectively guide the process. Request a list of qualified individuals and consulting groups from THA and TORCH.

Once needs assessment is complete, begin the CEO candidate search in earnest. The next step is to select a search committee:

- Develop job specifications and position description
- Begin recruiting candidates
- Screen resumes and develop a list of top candidates
- Develop a rating system to compare candidates
- Arrange and conduct interviews with the top two to three candidates
- Review the interview results, schedule and conduct follow-up interviews, if needed
- Select the best candidate and develop an offer
- Present the offer to the preferred candidate and manage negotiations
- After the candidate has accepted the hospital's offer, notify the other candidates

The ideal CEO will possess not only the technical qualifications required, but individual character traits crucial to success in the position. When evaluating candidates, consider such traits as:

- Human relations skills — motivation, leadership, sensitivity, communications and team building
- Leadership and management skills
- Track record — what is the candidate's history of being able to achieve profitability, growth and community support in past positions?
- Personal traits — character, stability, dependability, initiative, decisiveness, ability to conceptualize and articulate ideas and concepts, and creativity or innovative thinking
- Involvement in professional and community activities
- Comprehensive knowledge of health care services and delivery
- Involvement and commitment to advocacy activities to improve conditions of the health care industry, and in particular CAHs

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## CANDIDATE SOURCES

Naturally, the first place to seek qualified candidates is within the organization itself. Since the hospital is small and may not offer a suitable number of qualified applicants, other recruitment sources include:

- Advertisements in professional journals such as *Modern Healthcare* or *Texas Hospitals*
- Professional associations, such as THA, TORCH or the American College of Health Care Executives (ACHE). The rural departments of THA and TORCH both provide this service, at no charge to association members. In addition, TORCH provides interim management services, which enable the hospital to take the needed time to make the right hiring decision. Interim management often helps “settle out” and stabilize the hospital before pursuing a replacement CEO and may lead to a better selection process in the long run.
- Executive search firms — seek recommendations from THA and TORCH, and ask colleagues for references before selecting a firm to conduct the CEO search.
- Colleagues, including referrals from other CEOs and board members outside the area.

## THE CEO CONTRACT

Today’s complex and volatile hospital environment calls for a contract of employment with the hospital’s CEO. A contract makes it easier for the CEO to deal with politically sensitive issues and to manage the hospital without fear of reprisal. It also provides the CEO and his family with some personal protection from the whims of local politics. A contract is a clear signal to the medical staff and community that the CEO has the strong support of the board of trustees. A well-written, fair contract can be a major draw in recruiting and retaining a superior CEO.

An employment contract should include:

- Contract duration
- CEO’s duties
- Compensation
- Benefits
- Termination and severance provisions that help the board objectively decide if and when a CEO should be terminated

Bonuses and incentive pay also serve to attract and retain top executive talent. A bonus program rewards the CEO monetarily for the extreme time, effort and professional commitment required to perform effectively in the complex, and highly regulated, hospital environment. Any bonus or management incentive program needs to be in place before hiring a CEO. Both the board and the chosen CEO candidate should have input into defining the

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benchmarks to be met to receive bonus pay. Monitor the CEO's performance against the objectives established on a regular basis and provide constructive feedback.

## **THE CEO POSITION DESCRIPTION**

Once the board hires a CEO, the next key step is to create (or revise as needed) the CEO's job description. The written job description clearly outlines the board's performance expectations in light of the organization's strategic goals and objectives. In addition, negotiate with the candidate the measures upon which any bonus or incentive compensation will be awarded.

While the functions and duties of a CAH executive are somewhat unique to each facility, all CEOs share some common responsibilities that should be in any CEO position description:

- Board, medical staff and hospital staff relationships and reporting requirements
- Fiscal or financial management responsibilities
- Quality and patient process improvement review
- Planning and community health status needs
- General management responsibilities
- Regulatory compliance
- Community relations
- Marketing and fundraising
- Human resources
- Advocacy and governmental relations
- Familiarity with and educational activities relevant to Critical Access Hospitals

In addition, the board should have organizational policies that clearly define the CEO's authority. These help avoid potential conflicts of interest and misunderstanding between the board and CEO. At a minimum, address these areas:

- Capital equipment purchases, and spending threshold limits beyond which the CEO must seek board approval
- Wage and salary policies for hospital personnel
- Review and setting of hospital room rates and the rates for other procedures
- Entering into contracts for consultants, accountants, architects, physicians and other outside consultants
- Purchase or sale of property or equipment with spending thresholds

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Perhaps the greatest potential area of misunderstanding between the board and CEO is the crossing of boundaries between setting policy and managing hospital operations. Simply stated, it is the board's responsibility to establish hospital policy. Once policy has been established, the board should empower the CEO to implement it in the form of hospital procedures and operational practices.

While it is tempting for a board to cross the line into operations, particularly when observation or feedback from various sources in the community indicate there may be problems, it is a recipe for long-term disaster to undermine the CEO's authority. The organization will succeed in the long run only if the CEO and board members develop a good working relationship built on trust, mutual respect, open communication and a commitment to what is in the best interests of the hospital, its patients and the community. There is no place in the organization for self-interests.

To establish trust between the board and CEO, trustees should:

- Give the CEO the authority to do the job and then help that person succeed in their position
- Provide the CEO with an employment contract with severance provisions
- Consider incentive compensation as a way to motivate and reward the CEO for superior performance
- Evaluate the CEO's performance at least annually, and provide periodic and regular feedback throughout the year
- Have realistic expectations about what your CEO can and cannot accomplish. Like a good football team, a coach can only achieve what the players can do through good teamwork. The CEO can provide a good climate for team performance, but all the other members of the team must work together under the CEO's leadership for optimum effectiveness.
- Tell the CEO what you expect
- Provide the CEO with key community and political contact information
- Listen and ask good questions
- Offer to the CEO the board members' individual skills and expertise
- Handle any potential terminations with great deliberation and sensitivity. A sudden termination not only can harm the CEO and his or her family, but it can have a negative effect on the hospital and medical staffs, the hospital reputation, the patients, and the community as a whole.

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## CEO PERFORMANCE EVALUATION

Annual performance evaluations, conducted by a board committee, serve two primary purposes. First, they evaluate how well the CEO achieved the standards of performance previously agreed upon for the year. Secondly, the performance review process offers an opportunity to address performance concerns, and set performance objectives for the coming year.

There should be no surprises when it comes to evaluation factors or standards for performance. Be sure these are agreed upon and in writing at least one year before they are applied in an evaluation. As part of the review process, the CEO will meet with the performance evaluation committee, which shares its findings and recommendations. The executive then has an opportunity for comments and questions. If the CEO did not meet objectives in certain areas, include in the review specific recommendations to correct those deficiencies.

Criteria for evaluation may include:

- Financial performance against budget
- Operating indicators, such as length of stay
- Physician satisfaction as evidenced by survey scores
- Employee satisfaction as evidenced by survey scores

Other measurements may include specific targeted objectives, such as net revenue targets, establishment or performance of selected programs and services, renovation program objectives, or other specific measurable objectives relevant to the hospital's established goals and objectives for the period in which the CEO is being evaluated.

Annual evaluations are only one component of performance review. Provide the CEO continuous feedback throughout the year. Again, there should be no surprises to either party at the end of the year. Most CEOs expect to be evaluated and want feedback on their performance. Do not underestimate the value of a simple thank you. Complimenting the CEO for job well done costs nothing, yet this simple act of professional courtesy helps buffer the CEO from burnout in the highly competitive health care industry. In addition, a vote of confidence, made known publicly to the hospital and to the community, will go far in solidifying excellent performance and the strong support of your hospital's management team.

Performance evaluation is most effective when conducted by a small committee of the board. The board chair, the executive committee, or a designated group of trustees can be assigned to carry out this important duty. Include some of the CEO search committee, since they know the criteria used to select the CEO. Also include a mechanism for patients and community leaders to have input in the performance evaluation process.

Several excellent CEO performance models exist. Contact Texas Healthcare Trustees for examples.

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## TERMINATIONS AND CEO SUCCESSION PLANNING

Terminating a CEO is sometimes necessary, but should be undertaken only after serious deliberation, as a termination can have negative repercussions on the organization and the CEO. In fact, in today's job market, it may take a year or longer for a terminated CEO to find comparable employment.

All too often, the termination of a CEO occurs amidst a heated controversy, and sometimes can result from an incident that builds into an almost unmanageable situation. An employment contract and severance clause allows both the hospital and CEO to expedite the process and move on.

Unless the CEO is found guilty of a crime or unethical behavior, the severance agreement should be handled in a fair and expeditious matter. Nothing is to be gained from contesting the amount and circumstances of a severance clause, if the CEO has rendered an honest and good faith effort to perform the duties of the position. Likewise, the hospital's reputation will be enhanced when a termination is handled in a professional, forthright and thoughtful manner, making the hospital attractive to future high quality CEO candidates.

Since terminations can and often do occur abruptly, succession planning is important. Developing potential leaders who can step into key roles over time helps ensure smooth transitions when unexpected personnel issues arise.

Succession planning is useful for:

- Backup emergency planning — CEO is incapacitated or dies
- Unexpected vacancy — CEO leaves for another job
- Anticipatory planning — CEO has indicated a planned retirement or departure date

The succession planning process is board-driven, but should include the input of the CEO. An outside consultant can help coordinate, facilitate and evaluate the succession plan when finalized.

Key steps in the succession planning process are:

- Determine the plan's goals and focus on those
- Keep it simple
- Address compensation matters
- Form a board committee charged with developing the plan
- Develop a list of questions that need to be addressed.
- Ensure there is a champion of the process — usually the board chair

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## SUMMARY

The CEO is the leader of the hospital management team. For the CEO to be successful, all members of the hospital management team must work together. The board sets the tone for the hospital by selecting, empowering, supporting and regularly evaluating the CEO's performance. It is vitally important that both the CEO and the board clearly understand the responsibilities, duties and functions that accompany each of their roles. Changes in who holds the CEO position are inevitable, but having an effective succession plan in place shortens and eases the transition process.

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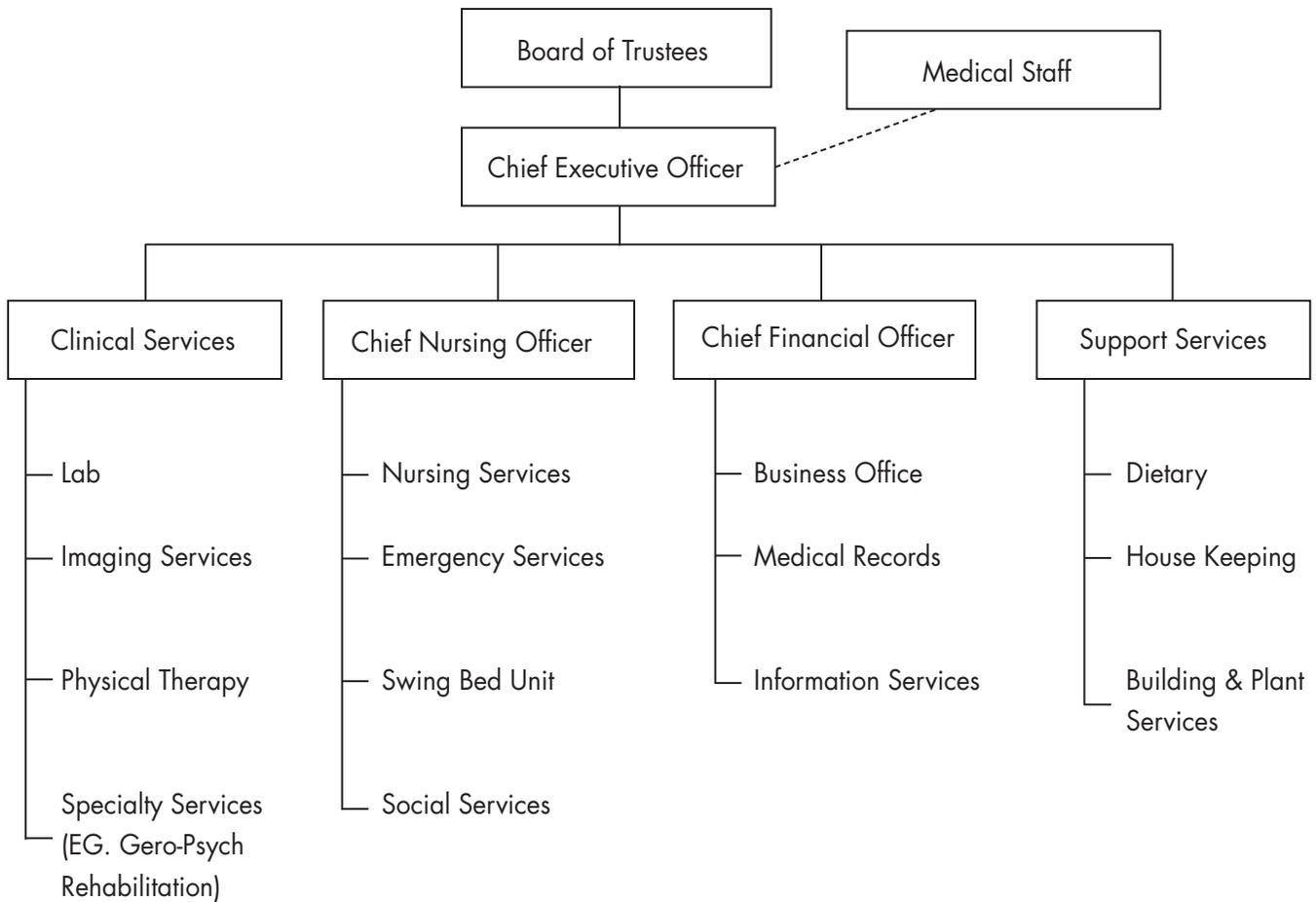
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**Figure 1**  
**SAMPLE CRITICAL ACCESS HOSPITAL ORGANIZATION CHART**



Date Effective: \_\_\_\_\_

Authorized by: \_\_\_\_\_

CEO

NOTE: The types and numbers of services and reporting relationships may vary depending upon the scope and complexity of the critical access hospital, as well as the staff and their various levels of experience.

# PHYSICIAN RECRUITMENT AND MEDICAL STAFF RELATIONS

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All hospitals, including Critical Access Hospitals, must adhere to specific procedures for granting medical staff privileges. In addition, they must establish reasonable credentialing criteria and protocol. Regardless of whether a hospital handles physician recruitment internally, or contracts with outside firms to attract qualified physicians, a variety of laws regulate hospital-physician relationships. Those laws include the Texas Medical Practice Act, the Federal Anti-Kickback Statute and the Stark Law.

## THE MEDICAL STAFF

Each hospital in Texas has the authority and discretion to select the members of its medical staff. A “medical staff” is statutorily defined in Texas as a physician or group of physicians who by action of the governing body of a hospital is privileged to work in and use the hospital’s facilities. The Texas Hospital Licensing Law and the Texas Medical Practice Act outline procedures for hospitals to follow in granting or refusing privileges or medical staff membership

First, an applicant for medical staff membership and clinical privileges must complete the Texas Standardized Credentialing Application, available through the Texas Department of Insurance. Completed applications that meet the initial credentialing criteria for medical staff membership are then forwarded to the appropriate medical staff committee for investigation and recommendation, as outlined in medical staff bylaws. It is the medical staff’s responsibility to recommend the applicant favorably or unfavorably to the hospital’s board. By law, the hospital board must make a final decision regarding privileges within 90 days after receiving a completed application, and within 60 days after receiving a recommendation from the medical staff. Include the definition of a “completed application” in medical staff and hospital bylaws so all parties clearly understand deadlines for credentialing decisions.

Critical Access Hospital Boards are required to be “reasonable” in their credentialing decisions. They also must provide procedural due process to applicants, including the applicant’s right to a hearing and right to counsel. Hospitals can be liable for damages if they fail to adhere to the procedural requirements set out in hospital or medical staff bylaws, when considering requests for medical staff membership.

The goal of the medical staff and hospital should be to promote quality, patient-centered care. A hospital’s governing body is ultimately responsible for choosing the practitioners who care for patients in the hospital, so exercise caution in selecting and supervising medical staff.

Initial credentialing criteria may include:

- Education
- Current licensure
- Relevant training

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- Current competence
  - Board certification
  - Pledge of cooperation with other physicians and the hospital's staff.

## **RECRUITMENT AND PHYSICIAN CONTRACTING**

Critical Access Hospitals actively recruiting physicians face several potential legal issues. Among them:

- Prohibition on the practice of corporate medicine
- Fraud and abuse laws
- Tax regulations for nonprofit hospitals
- Restrictions on the expenditure of public funds by public hospitals.

## **CORPORATE PRACTICE OF MEDICINE**

The Texas Medical Practice Act prohibits hospitals from employing physicians. Specifically, the law prevents lay persons, including hospitals, from practicing medicine or hiring physicians and sharing in the professional fees earned by the physician. Although a hospital may not *employ* a physician, a hospital may *contract with* physicians to provide services in the community or at the hospital as long as certain requirements are met:

- The physician must be an independent contractor, not an employee, of the Critical Access Hospital.
- The physician does not receive employee benefits.
- The hospital exercises no control over the physician's decisions related to the practice of medicine. Only the physician holds a professional license and medical judgment must be left to the physician.
- The hospital may not collect and keep professional fees of the physician. If the hospital does handle billing and collection for the physician, the contract with the physician should ensure that any professional fees billed and collected are passed on to the physician.

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## **FRAUD AND ABUSE LAWS**

In contracting with physicians, hospitals must comply with federal fraud and abuse laws, often referred to as the Federal Anti-Kickback Statute. The anti-kickback statute prohibits direct or indirect compensation to a physician in order to induce referrals. The law stipulates criminal penalties for individuals and entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business for which payment may be made under a federal health care program.

Federal courts have interpreted the statute very broadly, and use the “one purpose” test to determine if a hospital has unlawfully compensated a physician. Under this test, if only one purpose of the compensation was to induce referrals, then the statute has been violated; it does not matter if the payments also were intended to compensate for professional or other services.

To be sure the hospital is in compliance with the anti-kickback statute, never compensate a physician in any way that takes into account the value or volume of the physician’s referrals to the hospital or to hospital-owned entities. Scrutinize every financial relationship between the Critical Access Hospital and physicians to assure compliance with the anti-kickback statute.

## **SAFE HARBORS**

### **Safe Harbor Background**

Because the anti-kickback law is broadly interpreted and carries potential criminal penalties, the Department of Health and Human Services adopted a series of “safe harbors” to guide hospitals and health care practitioners. If an arrangement meets one of these “safe harbors,” it is fully protected from both criminal and civil liabilities. Conduct outside the current safe harbors is judged on a case-by-case basis.

### **Practitioner Recruitment Safe Harbor**

This safe harbor allows payments to induce a practitioner to initially establish his or her practice in, or relocate to, a health professional shortage area (HPSA) for his or her specialty. While there are other safe harbors, this is the only one directly applicable to recruitment.

A recruiting arrangement must meet the following standards to satisfy the Practitioner Recruitment Safe Harbor:

- Arrangement is in writing
- Practitioner is leaving an established practice — at least 75 percent of the revenues of the new practice must be generated from new patients not previously seen by the practitioner at his or her former practice

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- The benefits are for no longer than three years
  - The practitioner is not required to make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the entity as a condition for receiving the benefits
  - The practitioner may establish staff privileges at, refer services to, or otherwise generate business for other health care entities
  - The amount or value of the benefits provided by the entity may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any expected referrals to, or business otherwise generated for, the entity by the practitioner for which payment may be made in whole or in part under Medicare or a state health care program
  - The practitioner agrees to treat patients receiving medical benefits or assistance under any federal health care program in a nondiscriminatory manner

## **THE STARK LAW**

Like the anti-kickback statute, the federal Stark Law must be considered in every hospital physician relationship. The Stark Law is a federal prohibition against self-referral. The law prohibits a hospital that provides certain health services from billing for services rendered to patients referred from a physician with whom the hospital has certain financial relationships.

A hospital in violation can face significant civil sanctions, including denial of payment, refunds of amounts collected in violation of the statute, and a civil monetary penalty of up to \$15,000 for each bill or claim for a service a person knows or should know is not eligible under the statute.

Recruitment payments to induce a physician to relocate so he or she may become a member of the hospital's medical staff would potentially violate the Stark Law. However, Stark contains a number of exceptions that work much like the anti-kickback statute's safe harbors.

For instance, one exception allows a hospital to pay a physician relocation inducements if all of the following conditions are met:

- The arrangement is in writing and signed by both parties
- The arrangement is not conditioned on the physician's referral of patients to the hospital
- Payment is not based on the volume or value of any actual or anticipated referrals by the physician or other business generated between the parties
- The physician may establish staff privileges at any other hospital(s) and may refer business to any other entities (except as referrals)

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- The “geographic area served by the hospital” is the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients. A physician will be considered to have relocated his or her medical practice if:
    - The physician moves his or her medical practice at least 25 miles; or
    - The physician’s new medical practice derives at least 75 percent of its revenues from professional services furnished to patients not seen or treated by the physician at his or her prior medical practice site during the preceding three years.

## **TAX REGULATIONS**

When it comes to physician recruitment incentives, the Internal Revenue Service places some unique requirements on nonprofit, tax-exempt hospitals. The hospital must show that the physician will be an asset in furthering the nonprofit hospital’s charitable purpose, and protecting the health of the community in which the hospital is located. The IRS has set out guidelines that tax-exempt hospitals should be aware of and should follow when contracting with physicians.

## **EXPENDITURE OF PUBLIC FUNDS**

Many Critical Access Hospitals in Texas are public/governmental hospitals, which include hospitals owned by counties, municipalities, hospital authorities and hospital districts. These hospitals also must comply with state law restricting how political subdivisions use public funds. The Texas Constitution prohibits political subdivisions from appropriating public funds or property without a public benefit in return. In general, these constitutional provisions against the payment of public funds to private persons are not violated when the following requirements are met:

- Public funds are expended for the achievement of a public purpose
- The public receives adequate consideration in return
- The governmental body retains control over the use of the funds to ensure that the public purpose is achieved.

Any contract between a public Critical Access Hospital and a physician must assure that an equal benefit is received in return for the public funds used to recruit the physician. To ensure the “public benefit” requirement is met, Critical Access Hospitals can:

- Include language in the contract that identifies the public need for the physician’s services
- Require the physician to perform community service, such as indigent care, ER call or wellness seminars
- Require a physician to remain in the community for several years after the initial payments end

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## PHYSICIAN RECRUITING CHECKLIST

The following checklist may be useful in the recruitment process.

- Is this physician appropriate for your community and hospital? Does this candidate have the documented education and training needed? Does the candidate have good references? Are there any “issues” in the candidate’s past?
- Did the physician have an existing practice with a stream of referrals within the recruiting entity’s service area? Remember, to meet the safe harbor the physician must be “recruited” not “retained.”
- Is there documented evidence of an objective need for the physician’s services? Is there documented need for a physician in this specialty?
- Has the hospital’s board approved the terms of the recruitment?
- Are the incentives offered narrowly drafted and reasonably necessary to recruit the physician?
- Is a reasonable and documented basis for each recruitment benefit’s value and duration?
- Does the duration of benefits last more than 3 years?
- Is the hospital offering an income guarantee?
- How will the guarantee be calculated?
- Will there be a forgiveness or a payback requirement? If there is a forgiveness requirement, what will be the duration of the support/forgiveness period?
- What will be the physician’s specific obligations?
- Are there any verbal agreements or private understanding? The complete agreement between the parties should be in writing.

### SUMMARY

When recruiting physicians to the medical staff, hospitals must carefully consider compensation arrangements to ensure compliance with federal and state fraud and abuse laws. Additionally, be wary of contracts involving compensation arrangements that appear to be above fair market value for the services rendered or have the potential to result in prohibited referrals. Consult legal counsel prior to finalizing any contractual arrangement with a physician.

### REFERENCES

Federal Anti-Kickback Statute, United States Code, Title 42, Section 1320a-7b

Internal Revenue Service, Revenue Ruling 97-21, 1997

Texas Hospital Licensing Law, Texas Health & Safety Code, Chapter 241

Texas Medical Practice Act, Texas Occupations Code, Chapters 151 through 165

# LIABILITY AND INSURANCE COVERAGE

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Medical malpractice lawsuits are nothing new. In fact, they can be found in Texas court records dating back more than 100 years. Medical malpractice results when a doctor or hospital fails to use a reasonable amount of care and skill and, as a consequence, the patient is injured. Medical malpractice is considered negligence. The same rules that apply to physicians, surgeons, dentists, nurses, and other health care providers also apply to Critical Access Hospitals.

Medical malpractice law is based on traditional principles of tort law. A tort is a civil or private wrong, other than breach of contracts, which entitles the wronged person to sue for compensation. Tort law is directed toward compensating individuals for losses they have suffered. There are a number of liability theories, but in medical malpractice cases, negligence is usually the one that applies. Because malpractice claims are couched in terms of negligence, they are based on acts or failure to act.

## **ELEMENTS OF NEGLIGENCE**

To prove that a Critical Access Hospital or doctor was negligent, the individual must establish four elements:

1. The hospital or doctor had incurred a duty to care for the patient — a doctor-patient relationship.
2. The hospital or doctor, either by acting or failure to act, breached that duty by deviating from the standard of care expected of a professional — in other words, negligence. With few exceptions, the standard of care must be established by the expert testimony of other health care providers.
3. The patient was injured in a way that can be legally compensated, known as “damages.”
4. The hospital or doctor’s negligence was the reason or a “proximate cause” of the injury or damages.

## **STANDARD OF CARE**

If the hospital or doctor accepts the patient, a hospital-patient or doctor-patient relationship is established, and this implies the duty to perform within acceptable standards of care. The hospital or doctor who fails to provide the level of care required under the law is liable for any injury or losses the patient suffers as a consequence. The level of care by which the hospital or doctor’s conduct is measured is the standard of care. Generally, in tort law the standard of care means “reasonable care” exercised by a “reasonable person.” “Reasonable care” traditionally has meant the skill and care customarily exercised by hospitals and doctors in the same type of practice under similar circumstances.

Thus, under this standard of care, the doctor’s care of a patient should be compared with what other doctors customarily give in a similar situation. A Critical Access Hospital’s care should be compared to the care customarily given by other hospitals in similar situations. Texas courts expect a doctor to exercise a medical judgment equal

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to or greater than the minimum standard of accepted professional practice. They also require hospital employees to exercise skill and judgment equal to or greater than the minimal standard of accepted practice by similar employees.

In the past, hospital and physician actions could be compared only to that of hospitals or doctors in the same community. In recent years, however, the locality rule has been revised for a number of reasons. Hospitals and medical schools now have uniform curricula, and accepted hospital and medical practice theoretically varies only slightly. A doctor's conduct is judged by the standard of care of a reasonably competent doctor practicing in the same or similar community.

Similarly, a Critical Access Hospital employee is judged by the standard of care of a reasonably competent employee practicing in the same or similar community. To establish the standard of care, a patient's attorney usually must present expert testimony, addressing hypothetical questions.

To describe violations of a hospital or doctor's duty, attorneys utilize a variety of theories of liability or causes of action. Merely showing a bad medical outcome, or injury, does not prove malpractice. Rather, a patient must show that the hospital or doctor did not do what the average, reasonable hospital or doctor in good standing, located in the same or a similar community, would have done in a similar case. Medicine is not an exact science; it is a profession that involves the exercise of individual judgment within the framework of established procedures.

## **DAMAGES**

To recover in a malpractice case against a Critical Access Hospital or any other provider, the patient must have incurred damages. Damages constitute the money paid to a patient to compensate for losses the patient suffered. Common types of damages include:

- General damages — necessary and logical consequence of a particular injury such as pain and suffering.
- Special damages — a natural result of an injury, but not inevitable. These include loss of time; impairment of future earning capacity; hospital, medical and nurse expenses; and the cost of drugs.
- Compensatory damages — any damages intended to restore the patient to the position he or she occupied before the injury.
- Punitive or exemplary damages — damages designed to punish the person sued and to deter others from similar conduct.

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## **PROXIMATE CAUSE**

It is not enough for a patient to simply show a breach of the standard of care. The patient also must prove that the breach was the “proximate cause” of the injury. If the doctor’s treatment or lack of treatment did not cause the injury, the doctor is not liable.

The Medical Liability and Insurance Improvement Act governs all health care liability claims against physicians or other health care providers including Critical Access Hospitals. A “health care provider” is defined as hospitals and employees, officers or agents thereof, acting in the course and scope of their employment. Hospitals can be held directly liable for negligence if they breach the standard of care for hospitals. They also can be held vicariously liable for nurses and other allied health professionals who are employees of the hospital and are acting within the scope of their employment. In addition, they may be held vicariously liable for acts of physicians in certain limited situations. Emergency room physicians are among those limited situations. The liability can be placed on the hospital for emergency physicians, because the patient often has no choice in the selection of the physician and may be under the assumption that the emergency room physician is part of the hospital.

## **LIABILITY LIMITS FOR PUBLIC HOSPITALS**

The Texas Tort Claims Act sets limits on damages for public/governmental hospitals. The liability of a local government hospital is limited to maximum money damages of \$100,000 for each person, \$300,000 for each single occurrence for bodily injury or death, and \$100,000 for each single occurrence for injury to or destruction of property. A medical malpractice claim usually involves only one person, so the maximum amount of liability would typically be \$100,000 in any given claim against a public/governmental Critical Access Hospital. However, there is no cap on the number of claims that can be brought in a single year.

## **LIABILITY LIMITS FOR NONPROFIT AND PRIVATE HOSPITALS**

Non-profit and private hospitals have the same general liability limits. For non-economic damages, such as pain, suffering and mental anguish, a \$250,000 per claimant cap applies. If the judgment is against more than one institution, a \$250,000 per claimant cap applies to non-economic damages per defendant and the total non-economic damages awarded are further capped at \$500,000 per claimant.

### **Charitable Hospitals**

Hospitals that provide charity care equal to at least 8 percent of their net patient revenue, and provide at least 40 percent of the charity care in the county in which the hospital is located, are considered “charitable hospitals” eligible for limited liability. Such hospitals have the same liability limits for non-economic damages as a governmental hospital (\$100,000 per claimant and \$300,000 per occurrence).

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## Charitable Care

Hospitals receive extended protection against malpractice liability for a patient's charity care. Charity care liability is capped at \$500,000 for all damages if the patient signed a written statement, before receiving the care. The statement must explain that the hospital is providing care not administered for or in expectation of compensation. It also must explain the limitations on recovery of damages.

## INSURANCE

Texas hospitals typically carry the following types of insurance coverage:

- General liability — protects against liability from common accidents or incidents on the premises.
- Professional liability — protects against liability from professional negligence in patient care.
- Casualty — protects against property damage from fire, etc.
- Umbrella — provides an additional layer of protection above all insurance coverage.
- Boiler — protects from damage due to boiler/mechanical malfunction.
- Directors and Officers — protects board and officers from individual liability for their good faith acts.
- Auto — protects against property and personal injury stemming from use of an automobile.
- Worker's Compensation — protects employees in case of on the job injury.

Carrying appropriate insurance policies is critical for protecting hospitals in the event of litigation. Careful consideration should be given to exactly what and who is covered by an insurance policy. Directors' and Officers' liability insurance (D&O) primarily covers individual board members. It provides defense costs, settlements and judgments when actions of board members, acting in good faith, are legally challenged. D&O also may cover the hospital itself in some situations. General liability insurance and specialized policies such as auto, property or malpractice, primarily protect the hospital. However, they also may cover individual board members in some situations.

Hospitals may opt for commercially available insurance coverage, or self-insure. Since there is significant potential risk in self-insurance, a hospital board should thoroughly analyze the risks and benefits. That assessment should include carefully comparing the risks of operating without general and/or professional liability coverage versus the cost of purchasing such insurance.

Self-insurance is an option to be considered when insurance premiums are so high that the assumption of risk is a reasonable business decision. In the event of a lawsuit, a self-insured hospital would be responsible for all costs normally paid by commercial insurance carriers. To operate under self-insurance, the hospital must adopt a written self-insurance plan and set up a fund, either in a trust or in a designated account, from which it will pay costs and

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damages for claims and lawsuits covered by the plan. For costs to be allowable under Medicare, the provider establishes a trust that meets certain conditions. Because of the inherent risks involved and Medicare requirements, the self-insurance option should be approached with caution and expert assistance.

## **IMMUNITY**

Finally, several Texas statutes protect volunteers and employees of nonprofits from potential malpractice suits. Texas law provides qualified immunity to volunteer board members of nonprofit hospitals when they act in good faith. It also provides limited immunity to public hospital board members when they act within the scope of their authority and in good faith.

## **SUMMARY**

It is important for hospitals to be aware of potential liability for medical malpractice and obtain liability coverage through commercial insurance or a self-insured plan. Despite recent tort reform efforts, hospitals should be prepared to defend against malpractice actions and take necessary steps to protect hospital directors, officers and board members.

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Shevak v. United States, 528 F. Supp 427 (1981)  
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Texas Civil Practice & Remedies Code, Sections 84.003 - 84.004  
Texas Tort Claims Act, Texas Civil Practice & Remedies Code, Chapter 101



# TAX ISSUES

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All Critical Access Hospitals — whether for-profit, nonprofit or public — must adhere to strict IRS rules and state laws. A hospital's tax treatment hinges on the following issues:

- Does the hospital pay income, property and sales taxes?
- Is the hospital authorized to collect property and sales taxes to support its operations?
- If the hospital does not pay income, property or sales taxes, how did it get such an exception and how does it keep the exception?

## INCOME TAX EXEMPTIONS

Texas hospitals generally fall into one of three categories for income tax purposes:

1. For-profit facilities that pay federal income tax;
2. Nonprofit charitable institutions that pay no federal income tax; or
3. Public/governmental entities that are not subject to federal income tax.

### Nonprofit Hospitals

Charitable nonprofit Critical Access Hospitals are tax exempt under Section 501(c)(3) of the Internal Revenue Code.

### Public/Governmental Hospitals

Public/governmental entities are tax exempt under IRS Code, Section 115. Counties, municipalities, hospital districts and municipal or county hospital authorities all may own and operate a hospital. While each type is considered a public or governmental hospital, there are some differences.

- **Municipal/County Hospitals** — a municipal or county-owned hospital functions as an arm of the municipality or county government and falls under the direct control of its governing body. It has no taxing authority.
- **Hospital Authorities** — a hospital authority, in contrast, is a separate political entity. Its hospital board has independent authority over the hospital's operations. It collects no sales, use or property taxes.
- **Hospital Districts** — likewise, hospital districts also are separate political entities. However, unlike hospital authorities, a hospital district requires voter approval before its creation and it may levy both sales and property taxes to support its operations. A hospital district can levy property taxes up to the amount authorized in the election to create the district, which cannot exceed 75 cents per \$100 of property value. In addition, voters may authorize the district to levy a sales and use tax.

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## **PROPERTY TAX EXEMPTIONS**

Just as they must pay federal income taxes, for-profit hospitals also must pay local property and sales taxes.

Nonprofit hospitals that provide charity care are considered charitable organizations. As such, they receive special exemptions from property and sales taxes. Under Texas law, charitable organizations are entitled to an exemption from taxation on land, buildings and tangible personal property owned by and used for the charitable organization.

Property owned by a public hospital is exempt from taxation if the property is used primarily for the public's health, comfort and welfare. Property owned by a nonprofit hospital or a public hospital can lose its tax exemption if the property is leased to or used by a for-profit entity or a private individual.

## **PRIVATE BENEFIT**

The distinction between types of hospitals, and whether or not they qualify initially for tax exemption, is usually clear. However, operating a nonprofit charitable hospital in the manner required to keep that exemption is more complicated. To maintain tax-exempt status, nonprofit CAHs must adhere to IRS rules prohibiting "private benefit" and "private inurement." Private benefit requires the tax-exempt organization to serve a public, not private, purpose. This means that an organization cannot devote a substantial part of its activities to something other than its charitable mission purpose. For example, a tax-exempt entity whose purpose is providing indigent care cannot spend \$1,000 for the indigent and \$500,000 on office furniture.

An exempt organization's activities can result in some private benefit, but the private benefit must be merely incidental to the broader community benefit. In other words, the organization can hire a physician and furnish an office but the expenses must be reasonable and of fair market value for the services rendered. The IRS may deem that there has been a private benefit even if the organization has been fully compensated for a benefit conferred on a private individual or entity.

The IRS examines all relevant facts and circumstances when determining whether there has been enough private benefit to cause an organization to lose its exempt status. A key factor is whether the hospital's tax-exempt purposes can or cannot be achieved without benefiting private individuals. Many times a private individual will benefit, and the benefit is acceptable as long as it is insubstantial to the organization's overall purpose.

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## PRIVATE INUREMENT

Critical Access Hospitals also must avoid violating the IRS prohibition of “private inurement.” Private inurement is similar to private benefit, but applies to benefits to “insiders,” or those who could control or influence the organization’s activities. The IRS consistently regards a nonprofit’s directors, officers, physicians and medical staff as insiders. The IRS looks very carefully at those in positions of control or influence to assure they do not abuse their position for personal gain. If there is private inurement, there also is private benefit. The IRS can revoke the tax-exempt status of a hospital that engages in private inurement. Although this rarely has happened, CAHs should guard against any potential private benefit/private inurement violations that might jeopardize tax-exempt status.

## INTERMEDIATE SANCTIONS

In some cases, the IRS may opt to impose “intermediate sanctions” rather than fully revoke a hospital’s tax-exempt status for private benefit/private inurement violations. These are excise taxes imposed on individuals who engage in “excess benefit transactions.” Excess benefit transactions provide a benefit to a specific person, the value of which exceeds the value the hospital received in return. Anyone with substantial interest in the corporation or ability to substantially influence hospital affairs is subject to these sanctions. This includes key doctors, officers, directors, trustees and those in similar levels of authority. However, physicians are not automatically subject to sanction based on their status as medical staff members.

An individual who has benefited from an excess benefit transaction is taxed at 25 percent of the excess benefit. If the individual does not correct the excess benefit transaction within the taxable period, they are assessed an additional tax of 200 percent of the excess benefit. Also, Critical Access Hospital managers who participate in excess benefit transactions are taxed 10 percent of the excess benefit, unless the managers’ involvement is not willful and is due to reasonable cause.

Excess benefit transactions could potentially arise in an assortment of situations. Be wary of any situation where a person makes or receives a payment that is not supportable with an independent appraisal or which exceeds fair market value. For example, if a nonprofit hospital acquires a medical practice for more than fair market value, the board members and officers involved may be subject to intermediate sanctions. Additionally, if a physician is paid above the prevailing market rate for care or consulting services, a tax may be levied against the physician, managers and board members who knowingly approved the improper transaction.

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## LEGAL PRESUMPTION

The intermediate sanctions rules include a “rebuttable presumption” with three criteria for determining if a transaction is reasonable. The board or committee deciding on the compensation agreement must:

1. Be composed of persons unrelated to the person who received the compensation;
2. Rely on compensation data from comparable organizations; and
3. Adequately document in meeting minutes the review of qualifications and the basis for the board’s decision.

Directors should protect themselves by taking advantage of the rebuttable presumption of reasonableness. They can do this through:

- Meeting their fiduciary duties;
- Acquiring and examining available information about proposed transactions; and
- Obtaining outside appraisals of the reasonableness of compensation packages.

It is also crucial that boards keep detailed minutes demonstrating the disclosure of facts, conflict of interest situations, and the rationale for entering into particular transactions.

## SUMMARY

Critical Access Hospitals should carefully and continually evaluate the activities of directors, officers, and medical staff members to protect and maintain tax-exempt status. Arrangements involving monetary and/or non-monetary compensation merit particular attention for nonprofit hospitals to guard against private benefit and/or private inurement.

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# COMPLIANCE

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Compliance with federal and state law, through the development of a voluntary compliance program, should be a high priority for any health care provider, including Critical Access providers. An effective compliance program, including plans, policies, and procedures, enables hospitals to detect and prevent violations of a variety of state and federal laws and rules and regulations. Both the Centers for Medicare and Medicaid Services (CMS) and the federal Department of Health and Human Services Office of Inspector General (OIG) aggressively investigate health care fraud and abuse. A comprehensive compliance program helps hospitals shield themselves from fraudulent behavior, and avoid regulatory scrutiny and legal sanctions. In addition, should a hospital or its personnel be convicted of a violation, penalties can be greatly mitigated if a hospital has an effective compliance program in place.

## COMPLIANCE PROGRAM

An effective compliance program involves internal controls affecting all levels of the hospital's organization and staff. At the highest level, a hospital's board of directors is an integral part of an effective compliance program. The development of a compliance program begins by establishing policies and procedures for reporting compliance issues, which allows the board or hospital administration to respond appropriately. A hospital's board may incur liability if it fails to establish an adequate foundation for its compliance program. One such example is *In re Caremark International Inc. Derivative Litigation*, 698 A.2d 959 (Del. Ch. 1996). In this case, the court established that a board of directors must ensure adequate information and reporting systems are in place to ensure current and accurate information is brought to their attention, which allows the board to make informed decisions. In *Caremark*, the court also established a standard for liability for individual directors. The court reasoned that a director was in breach of the duty to care by failing to maintain information and reporting systems or by failing to monitor and improve such systems, especially when a suspect practice has been brought to the board's attention.

When establishing a compliance program or evaluating its effectiveness, the hospital board should review the minimum requirements of an effective compliance program, which are outlined in the United States Sentencing Commission Guidelines for the Sentencing of Organizations, and in the OIG's Model Compliance Plan for Hospitals, which was released in 1998 and supplemented in 2005.

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## **THE UNITED STATES SENTENCING GUIDELINES**

The United States Sentencing Commission Guidelines for the Sentencing of Organizations outline seven minimum elements to establish an effective compliance program.

### **Compliance Procedures**

First, the organization must have compliance standards and procedures that are “reasonably capable of reducing the prospect of criminal conduct.” Under this requirement, the hospital must establish a multi-disciplinary committee to develop the compliance program. The committee should include individuals from various hospital departments, and the committee should consult legal counsel to maximize the attorney-client privilege of the committee’s work, assess the hospital’s legal issues, and audit the hospital’s current policies and procedures.

### **High-Level Personnel**

Second, the board must delegate to high-level personnel the duty to oversee the compliance standards. “High-level personnel” can include a member of the hospital’s board, the administrator, or CEO. However, most hospitals employ a full-time “compliance officer” to implement their program. The compliance officer should regularly report to the hospital’s board or executive committee, and be primarily responsible for compliance enforcement. In addition, it is the compliance officer’s job to continuously monitor, evaluate and update the program as regulatory changes occur.

### **Avoid Certain Individuals**

Third, the organization must avoid giving authority to individuals the hospital knows, or should know, have the propensity to engage in illegal activities. The hospital should monitor employees and develop policies to address criminal activity that relates to an employee’s job duties.

### **Communicate Standards**

Fourth, the organization must communicate compliance standards and procedures to all employees and agents through an effective means, such as in training manuals or training programs. The hospital must discuss compliance program policies and procedures with all levels of hospital staff. Employees’ participation in education sessions should be documented in their employment files to insulate the hospital from liability in the event of a compliance breach.

### **Auditing and Monitoring**

Fifth, the organization should establish auditing and monitoring activities, and establish methods for employees to report instances of noncompliance with state and federal laws. This element contains two distinct parts. First, the hospital should conduct periodic audits, which are important to ensure compliance with federal and state regulations regarding billing, compensation, contractual issues, etc. The hospital’s legal counsel should be involved in these audits to help protect the confidentiality audit results and establish corrective action, if needed. Second, the

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organization should establish a reporting system that is user-friendly to employees. Many hospitals institute a drop-box where employees may submit reports of non-compliance without the fear of retaliation. Additionally, a hospital may designate an ombudsman or create a telephone hotline to report compliance-related incidents.

### **Enforcement**

Sixth, the hospital must enforce compliance standards consistently and implement appropriate disciplinary mechanisms for compliance violations. Violations should be addressed promptly, effectively and consistently. Disciplinary procedures for different types of violations should be established and included in the employee manual. Discipline is consistent for similar violations should be consistent for all employees regardless of the employee's position in the organization.

### **Response to Violation**

Finally, if a violation of state or federal law occurs, the organization must take "all reasonable steps to respond appropriately to the offense and to prevent further similar offenses." It is important to have reporting and disciplinary procedures in place that will be followed when violations occur. Additionally, the organization should be especially conscious of areas in which misconduct has occurred in the past.

## **THE OIG MODEL COMPLIANCE PLAN GUIDELINE**

The OIG's Model Compliance Plan Guidance for Hospitals (published in 1998) expands upon the seven elements discussed above, and tailors them for the hospital setting. At a minimum, comprehensive compliance programs for hospitals, including Critical Access Hospitals, should include the following elements:

- **Written standards of conduct**, as well as written policies and procedures, which promote the hospital's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals.
- The designation of a **chief compliance officer** and other appropriate bodies such as a corporate compliance committee, responsible for operating and monitoring the compliance program, reporting directly to the CEO and the governing body.
- **Regular education and training** programs for all affected employees.
- **A complaint process.** This might be a hotline, or some other mechanism to allow employees to anonymously report complaints, with full protection from retaliation for making a report.
- **Response and enforcement system** to address allegations of improper/illegal activities and take appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements.

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- **Audits and evaluation techniques** to monitor compliance and improve areas of concern.
  - **Investigation and remediation** of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

## **2005 SUPPLEMENTAL COMPLIANCE GUIDANCE**

In 2005, the OIG published a supplemental guidance to the 1998 document. Its purpose was to:

1. Identify the areas with the greatest risk of fraud and abuse violations
2. Offer recommendations for assessing and improving existing compliance programs and
3. Set forth actions hospitals should take if they discover credible evidence of misconduct.

### **Risk Areas**

The OIG identifies the preparation and submission of claims for payment by a federal healthcare program (for example, Medicare and Medicaid) to be the biggest area for risk of fraudulent activity. The other major risk areas are relationships with physicians under the federal referral statutes (such as the Anti-Kickback statute and the Physician Self-Referral (“Stark”) statute; gain-sharing arrangements; obligations of hospitals under the Emergency Medical Treatment and Labor Act (“EMTALA”); provision of substandard care; relationships with Medicare or Medicaid beneficiaries, to entice them to use the hospital facilities; health information privacy and security under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”); and billing Medicare or Medicaid substantially in excess of usual charges. It is important for the hospital board to employ knowledgeable staff and require continuing education and awareness of federal rules in these risk areas.

### **Compliance Program Effectiveness**

The OIG emphasizes the importance of a formal commitment to compliance by the governing body and senior management. A hospital’s leadership should foster an organizational culture that values and rewards the prevention, detection, and resolution of problems. The supplemental guidance strongly encourages the adoption of a “code of conduct,” which is brief and readable, to articulate values, ethical standards and a broad commitment to compliance.

The supplemental guidance also recommends a regular review of implementation and execution of the compliance program. Evaluation of the compliance officer and the compliance committee activities should be conducted annually. Further, policies and procedures relating to areas of compliance risk should be reviewed and supplemented or updated. Annual training and education for all employees should be conducted, and internal auditing and monitoring should be ongoing activities.

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## **Voluntary Self-Reporting**

Finally, the OIG maintains that a policy of voluntary self-reporting to the government should be implemented. When a compliance officer, compliance committee or member of senior management discovers credible evidence of misconduct, a reasonable inquiry should be made. If the inquiry determines that the misconduct may violate criminal, civil, or administrative law, the OIG recommends that the hospital report the misconduct to the appropriate authorities within a reasonable time, but not more than 60 days. Certainly, hospital legal counsel should be consulted during the inquiry and to determine whether a voluntary self-disclosure should be made.

## **CONSEQUENCES OF NONCOMPLIANCE**

Noncompliance can be costly. Hospitals can face large civil and criminal fines, as well as be subject to an array of requirements that can have a huge impact on the hospital's resources. For example, the Department of Health and Human Services has required noncompliant health care organizations to:

- Prepare an annual report to be submitted to the department
- Perform an annual audit for all services provided for which claims for government payments are made
- Establish new ordering and billing procedures
- Develop educational programs for employees
- Voluntarily disclose misconduct
- Allow the department to examine the organization's records at any time without prior notice
- Provide payment for subsequent government investigations.

## **SUMMARY**

Effective compliance systems are critical for all hospitals, including Critical Access Hospitals. Their importance is well established by the United States Sentencing Guidelines, corporate integrity agreements derived from settlements between health care organizations and the government, and the Office of Inspector General Hospital Compliance Program Guidance. It is the board's responsibility to ensure that effective policies and procedures are in place to protect the hospital from fraudulent, illegal behavior and the potential for litigation and other sanctions.

In summary, a Critical Access Hospital's board of directors must stay informed, establish a strong foundation for its compliance program, and involve all levels of the hospital's organization and staff.

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# QUALITY IMPROVEMENT

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Today's complex health care environment makes providing high quality medical services a challenge for all hospitals, but perhaps even more so for Critical Access Hospitals. For one thing, Critical Access Hospitals' limited scale of operation and resources frustrate efforts to gather meaningful quality data. In addition, national quality guidelines and initiatives that may be appropriate in larger hospitals are less applicable in small, rural hospitals. Certainly, hospitals of all sizes and locales share the universal challenges of medication errors and infection control. But health care in the rural setting is much different than in urban facilities. Its quality must be evaluated with measures specifically designed for the rural environment.

As reported in the Institute of Medicine report, *Crossing the Quality Chasm*, there are six aims to strive for in order to improve the quality of care. These aims are neither urban nor rural, but universal, and provide orientation for where rural communities need to focus. They are the following:

1. Safe care — avoiding injury to patients
2. Effective care — providing services based on scientific knowledge
3. Patient-centered care — providing care that is responsive to individual patient preferences
4. Timely care — reducing waits and harmful delays
5. Efficient care — avoiding waste
6. Equitable care — permitting no variation in quality because of geographic location, etc.

While quality improvement (QI) activities are as important in small rural hospital settings as in their larger urban counterparts, commitment to QI can be undermined in rural settings by several factors. The loss of key staff, financial shortfalls, new requirements and other periodic difficulties often take resources and energy away from rural hospitals' QI activities to handle the crisis of the moment. For this reason, a problem in one section of the hospital can affect quality in another section.

The board bears ultimate responsibility for the quality of patient care rendered within the facility. It must assure that the quality improvement program:

- Reflects the complexity of the CAH's organization and services
- Involves all hospital departments and services, including medical staff and other contractors
- Focuses on improved health outcomes, prevention and reduction of medical errors
- Specifies the frequency and detail of data collection

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## **QUALITY STANDARDS AND REQUIREMENTS**

Critical Access Hospitals must meet quality standards of care to comply with Medicare conditions of participation, state licensing regulations and pressure from commercial insurance payers. They undergo an initial onsite review for certification as a CAH, with a second review a year later.

A CAH's quality improvement program should evaluate the quality and appropriateness of diagnosis and treatment in:

- Patient care services
- Services affecting patient health and safety
- Nosocomial infections
- Medication therapy

## **QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPI)**

Rural Prospective Payment System (PPS) hospitals are required to have a Quality Assessment and Performance Improvement (QAPI) program in place. Many CAHs implement QAPI because they believe they should deliver the same quality of care as their PPS counterparts. QAPI is a good structure for CAHs to use to meet their quality requirements.

In recent years, the Centers for Medicare and Medicaid Services (CMS) has shifted its emphasis on hospitals' reactive "quality assurance" (looking for mistakes) to proactive "quality assessment and performance improvement" (improving the care patients receive within the hospital). This proactive approach requires all Medicare/Medicaid hospitals to use QAPI programs to improve patient care, identify patient safety issues and cut medical errors.

The CMS, in partnership with the University of Minnesota, has developed CAH-specific quality indicators to publicly report data and improve performance beginning in late 2005 or early 2006. The intent is for these to serve as CAH quality standards by which each state's Quality Improvement Organization will evaluate CAHs. In Texas, that organization is the Texas Medical Foundation.

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## **Alliance of Rural and Community Hospitals Program**

The TMF Health Quality Institute created the Alliance of Rural and Community Hospitals (ARCH) to help Critical Access Hospitals meet the QAPI requirements.

The ARCH program is a comprehensive approach to help Critical Access Hospitals comply with QAPI requirements. It helps Critical Access Hospitals:

- Use comparative performance data to benchmark against other hospitals similar in size
- Use comparative data to focus on areas of greatest opportunity for improvement
- Accelerate improved performance on national inpatient quality measures and patient safety
- Help staff learn and apply quality improvement methodologies and evidence-based strategies to improve patient care
- Network with other rural, community and Critical Access Hospitals to share experiences and learn from each other
- Demonstrate to the community the hospital's commitment to quality

The Quality Assessment and Performance Improvement program for the hospital should:

- Look at quality improvement instead of quality assurance
- Pursue quality improvement in identified areas at the facility
- Show improvement in indicators for which there is evidence of improved health outcomes
- Identify and reduce medical errors
- Measure, analyze and track quality indicators
- Demonstrate measurable improvement (not just collect and report data)
- Include data to monitor effectiveness and quality of care and identify opportunities for improvement
- Have board oversight and sufficient resources

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## APPROPRIATE QUALITY IMPROVEMENT MEASURES

Meaningful quality measurement requires good data. Gathering that data in a small, rural hospital can be challenging. Often, the CAH's quality improvement coordinator wears many hats, from infection control to risk management — or even computer troubleshooting. While physicians are generally under less pressure than their urban peers to participate in quality improvement projects, they tend to have less free time to devote to activities other than direct patient care. And, budget constraints and lack of information technology (IT) expertise often do not allow rural institutions to collect and analyze data that large facilities can cull from their computer systems.

Quality measurement should reflect the patient population treated at CAHs, such as pneumonia and heart failure patients. Patients requiring higher levels of care, such as those with Acute Myocardial Infarction, receive initial treatment at CAHs and usually are transferred. The following performance measures apply to Critical Access Hospitals:

### Acute Myocardial Infarction

- Aspirin prescribed at arrival
- Aspirin prescribed at discharge
- ACEI or ARB prescribed for patients with left ventricular systolic dysfunction
- Beta blocker prescribed at arrival
- Beta blocker prescribed at discharge
- Time to EKG
- Time to thrombolytics

### Heart Failure

- Left ventricular function assessment
- ACEI or ARB prescribed for patients with left ventricular systolic dysfunction

### Pneumonia

- Oxygenation assessment
- Pneumococcal vaccination
- Initial antibiotic received within four hours of hospital arrival

### Transfer

- Emergency department transfer communication (composite of 16 items)

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Other

- Other CAH-selected quality measures related to specific issues at their hospital, e.g., medication errors, adverse drug events and antibiotic utilization.

## BALANCED SCORECARD

Robert Kaplan and David Norton introduced the Balanced Scorecard in 1992, as a means of shifting executive thinking from short-term focus on cost-reduction and pricing, to longer-term, more comprehensive organizational performance. The premise behind the Balanced Scorecard concept is that, even in for-profit organizations, reliance on financial measures alone is insufficient for managing complex business environments, especially as organizations become more customer-focused.

The Balanced Scorecard translates an organization's mission, vision and strategy into a comprehensive set of performance measures that provides the framework for a strategic measurement and management system. The Balanced Scorecard incorporates four perspectives of the organization:

1. Financial (business)
2. Customers (patients and community)
3. Internal processes (quality processes)
4. Learning and Growth (staff, facilities and equipment).

This framework provides balance between short- and long-term objectives, financial and non-financial measures, and internal and external performance indicators. Most importantly, the Scorecard balances the outcomes an organization wants to achieve (typically in the financial and customer perspectives) and the drivers of these outcomes (the internal processes and learning and growth perspectives).

The Balanced Scorecard helps an organization translate vision into action. It starts with the hospital's vision and strategies, and then defines critical success factors. The hospital then constructs measures to aid target-setting and performance measurement in areas critical to the strategies. The process helps the hospital define and manage the most effective indicators of future strategic success, so it can rally the organization around those vital activities.

Kaplan and Norton recommend that managers gather information from four important perspectives:

1. **The customers' perspective.** Managers must know if their organization is satisfying customer needs. They must determine the answer to the question "How do customers see us?"
2. **The internal business perspective.** Managers need to focus on those critical internal operations that enable them to satisfy customer needs. They must answer the question "What must we excel at?"

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3. **The innovation and learning perspective.** An organization’s ability to innovate, improve and learn ties directly to its value as an organization. Managers must answer the question “Can we continue to improve and create value for our services?”
  4. **The financial perspective.** In the private sector, these measures typically have focused on profit and market share. For the public sector, financial measures could include the results-oriented measures required by the government. Boards must answer the question “How do we look to the community, the patients, the legislature and other stakeholders?”

While much has been written about the Balanced Scorecard concept, limited information exists about its application in small rural hospitals. And, while thousands of organizations throughout the world have benefited from Balanced Scorecard applications, only a handful of rural hospitals have used the tool.

By incorporating the Balanced Scorecard into the hospital’s strategic planning activities, a hospital can visually map out its strategies for process-oriented and outcome-oriented objectives. Questions that can help determine process-oriented objectives could include:

- What type of culture, collective skills, technology, etc. does the hospital need to develop?
- What must the staff and clinicians do to meet the service delivery needs of the stakeholders?

Small organizations easily can be overwhelmed by excessive data and often lack skills in both data collection and data analysis. They generally spend a great deal of time collecting data for external reporting purposes, but very little time analyzing that data or using it for decision-making.

A manageable, useful scorecard process in the CAH environment gives equal weight to:

- Quality and Patient Safety
- Operational Effectiveness
- Financial Performance
- Workplace Excellence

The CAH can compare monthly measurements with target goals. Include such quality and patient safety measures as:

- Acute inpatient falls
- Pneumonia antibiotic administration
- AMI beta blockers prescribed at discharge
- Overall inpatient mortality

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- Medication error rate
  - Percent of staff reporting all medication errors
  - Surgical site infection rate
  - Compliance with CDC hand hygiene guidelines
  - Patient satisfaction
  - Prevalence of antibiotic resistant infections
  - Flu/pneumonia immunizations
  - Use of nationally recognized guidelines for prevention of wrong site, wrong procedure, wrong person surgery

Use a chart to showcase the hospital's performance to patients, staff and physicians. Trends can be monitored from quarter to quarter by benchmarking targets and recording accomplishments. The idea is to progressively close the gap between the target and the actual achievement.

For operational effectiveness, include such measurements as:

- Emergency department patients with a length of stay of less than six hours
- Emergency patients leaving before treatment is complete
- Overall length of stay
- Medicare length of stay
- Observation average daily census
- Observation conversion rate
- Full time equivalents per adjusted occupied bed

For financial performance, include:

- Overall cost per case
- Operating room supply cost per surgical case
- Hospital operating margin
- Days in accounts receivable

And for workplace excellence:

- Agency use (nursing and emergency room)
- Nurse turnover rate
- Lost work days per month

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## THE IMPORTANCE OF DATA REPORTING

As quality data reporting and value-based purchasing continue to evolve, rural providers must begin to take notice and prepare not only to comply, but to succeed in this new data-driven environment. The federal government's ultimate goal is only to reward those facilities that show improvement in both efficiency and outcomes. However, several factors can conspire against Critical Access Hospitals and it is these very factors that require you to pay close attention to this section of the guidebook.

When data is reported by a low-volume facility, the issue of small numbers can be a significant barrier. Sometimes, the methodology selected to make judgments about the level of quality or improvement at a hospital simply cannot adequately adjust for the low volume of cases that a rural hospital may treat in a given year. In order to ensure that reported data is statistically sound, some metrics must go unreported.

The fact that a hospital's data sometimes goes unreported may be a disincentive to report. However, consumers can equate a lack of reporting with a failure in the hospital's performance and/or quality standards. In most situations, this is not the case at all, so first report your data, but then be prepared to inform your community about the actual data reporting and evaluation process.

Moving toward a fair value-based purchasing methodology for Critical Access Hospitals and rural facilities is a high priority. However, it is not one that is likely to resolve immediately. A meeting was convened by the Federal Office of Rural Health Policy in 2008 that focused entirely on the need to develop a rural-specific set of metrics that could be used to ensure that reimbursement is incentive-based and that payments to rural providers are not being unfairly skewed due to the low volume issue. A detailed summary of the meeting is available at: [http://www.rupri.org/Forms/RUPRI\\_VBPRresponse.pdf](http://www.rupri.org/Forms/RUPRI_VBPRresponse.pdf).

### **CMS Goals for Value-Based Purchasing Initiatives**

- Improve clinical quality
- Address problems of underuse, overuse, and misuse of services
- Encourage patient-centered care
- Reduce adverse events and improve patient safety
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in structural components and the re-engineering of care processes system-wide
- Make performance results transparent to and useable by consumers
- Avoid creating additional disparities in health care and work to reduce existing disparities

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As state and federal governments continue to develop new standards and reimbursement methodologies that take into account patient outcomes and the efficient delivery of health care services, you must not only report, but to begin to analyze that data and use it for your internal decision making. You must also begin to identify and adopt best practices, both clinical and operational. If done and done well, these efforts will help guard your facility against future payment reductions and increase your overall market share.

## **SUMMARY**

Maintaining and improving quality is a challenge for all hospitals, but perhaps more so for small rural hospitals. Their limited organizational, technological and financial resources impact their data gathering and interpretation abilities. Nonetheless, CAH facilities must comply with quality improvement requirements to participate in the Medicare/Medicaid program. The Balanced Scorecard technique, until now used primarily by larger urban hospitals, also can be an effective quality improvement process for CAHs. The Balanced Scorecard concept is based on one simple premise: measurement motivates. It has been integral to the success of organizations throughout the world, and can be an effective way for CAHs to translate the hospital's vision into measurable action. CAHs should also pay attention to the importance of data reporting, and understand how to compensate for low-volume issues.

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# HUMAN RESOURCES

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As significant employers in their communities, Critical Access Hospitals must be well-equipped to manage a wide range of highly regulated, complex human resource issues. Those issues include:

- Harassment
- Rights of public employees
- Family and medical leave
- Overtime

## **What is Harassment?**

Harassment is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of his or her race, color, religion, sex, national origin, age, disability, or any other characteristic protected by law and that:

- Has the purpose or effect of creating an intimidating, hostile or offensive work environment
- Has the purpose or effect of unreasonably interfering with an individual's work performance or
- Otherwise adversely affects an individual's employment opportunities.

Sexual harassment is unwelcome physical, verbal or nonverbal conduct of a sexual nature. This includes comments about the way an employee looks, indecent remarks, questions or comments about an employee's sex life, requests for sexual favors, sexual demands by a member of the same or opposite sex, any conduct of a sexual nature which creates an intimidating, hostile or humiliating work environment. Even a single remark or incident can, if sufficiently serious, can amount to harassment.

## **Legal Implications**

Harassment occurs when the conduct complained of is so objectively offensive as to alter the conditions of the victim's employment. However, the discrimination must be based on the protected characteristic (e.g., race or sex) and not "merely tinged with offensive connotations." The hospital can be liable for harassment committed by a supervisor — particularly if the employee proves hiring, firing, demotion or undesirable transfer resulted from the harassment. The hospital can also be liable for allowing a hostile work environment to exist after being notified of the existence of such an environment. A hostile work environment can be created by a supervisor or by an employee's co-workers.

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## Harassment Policy

The Critical Access Hospital board can limit its potential liability for harassment by taking four key steps:

1. **Written Policy** — require hospital management to maintain an anti-harassment policy written in plain, easy-to-understand language. The policy should include:
  - a definition and examples of different types of harassment, including sexual harassment
  - disciplinary procedures
  - procedures for filing a complaint, including alternative reporting procedures, confidentiality and a guarantee of no retaliation
2. **Communication** — for the policy to be successful it must be effectively communicated to staff and supervisors. A defense to sexual harassment claims is available to employers who maintain and follow a reasonable anti-harassment policy if the employee does not take advantage of the complaint process established by the policy.
3. **Prompt Investigation** — to further limit liability, the hospital must respond to and thoroughly investigate complaints immediately and take effective remedial action.
4. **Awareness** — ultimately, there must be careful oversight of supervisors. This means thorough screening, meaningful training, and consistent monitoring.

## PUBLIC EMPLOYEE RIGHTS

Critical Access Hospitals owned by governmental entities, such as hospital authorities or hospital districts, are local public employers. As such, public CAHs must be aware of their employees' constitutional rights.

### Due Process Considerations

While state governments are protected by Eleventh Amendment sovereign immunity, local governments don't enjoy such protections. In addition, both the U.S. and Texas Constitutions place due process restrictions on governmental entities, and U.S. law provides a cause of action for deprivation of constitutional rights by public employers.

Public employees may have a property interest in a legitimate expectation of continued employment, i.e., a contract. Public employees also have the right not to have false, stigmatizing statements made public upon discharge and to exercise free speech. They cannot be disciplined for exercising their right to free speech, though there may be exceptions when speech is overly disruptive.

### Employee Privacy

Privacy is another important area of constitutional employee rights. The 4th Amendment prohibition on unreasonable search and seizure extends to public employers.

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## **Drug Testing**

Drug and alcohol tests are considered searches subject to the 4th Amendment. Therefore, a public employer may conduct random drug or alcohol testing only for safety-sensitive positions. The hospital must inform employees upon hiring or promotion that they are subject to random testing and that refusal to submit to testing may result in disciplinary action including dismissal.

Employers may also test when there is a “reasonable suspicion” that an individual employee is under the influence or impaired. Circumstances under which a reasonable suspicion may arise include:

- An employee found in possession of alcohol or drugs at work
- An accident indicating possible impairment of ability or judgment
- Drugs missing at the end of a shift (in which case the hospital should test everyone on shift).

## **Workplace Searches**

The 4th Amendment also protects public employees against some workplace searches. Whether or not an employee should have a reasonable expectation of privacy should be decided on a case-by-case basis, and the factors to consider are whether other employees have access to the workspace and whether there are desks or files with locks, or lockers. Ultimately, workplace searches must be reasonable, and this depends on the context in which the search is conducted. Searches must be justified at their inception and cannot be unreasonably intrusive.

## **Whistleblower Act**

The final issue relating to public employers is the Texas Whistleblower Act. This law says that state and local governments cannot suspend or terminate an employee that, in good faith, reports a violation of law by the government employer to an appropriate law enforcement agency.

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## **FAMILY AND MEDICAL LEAVE ACT (FMLA)**

The Family and Medical Leave Act and related Department of Labor regulations apply to all public employers and private employers with 50 or more employees. Key FMLA features are as follows:

- Provides certain employees up to 12 weeks per 12-month period of unpaid, protected leave for certain family and medical reasons
- Employees must have worked for their employer for at least 12 months (need not be consecutive), and at least 1,250 hours in the past 12 months
- Available for:
  - birth and care of a newborn
  - adoption or foster care and care of the newly placed child
  - care of an immediate family member (spouse, child or parent, not in-laws) with a serious health condition
  - inability to work because of a serious health condition, defined as an illness, injury, impairment or physical or mental condition involving incapacity or treatment with inpatient care in a hospital, hospice or residential care facility
  - pregnancy or prenatal care
  - a period of incapacity due to a chronic serious health condition (such as diabetes or epilepsy)
  - absences to receive multiple treatments by a health care provider (such as chemotherapy)
  - care of a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the service member

Public employees must give notice of the need for leave in advance or as soon as practicable. Employees must also give sufficient information for the employer to qualify the leave under FMLA; however, the employee does not have to mention FMLA. Upon returning from FMLA leave, the employee must be restored to their original position or an “equivalent” job unless the employee would have been terminated anyway. FMLA provides an exception to job restoration for highly paid, salaried employees where restoration would cause substantial and grievous economic injury to the employer’s operations. In order to not restore the employee, the employer must notify the employee in writing of their status as a key employee, the reasons for denying job restoration, and provide the employee with a reasonable opportunity to return to work after notice.

Employers cannot count FMLA-qualifying leave toward a maximum number of absences in absence control policies. Other employer FMLA responsibilities include providing a notice of FMLA rights, including FMLA information in employee handbooks, and providing written notice designating leave as FMLA leave. This must be done either when the employee gives the employer notice of their need for leave, or when the employer becomes aware that the employee is asking for time off for FMLA-qualifying reasons. Finally, employers must ask for a medical certification for leave related to a serious health condition.

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## OVERTIME RULES

Employers must pay employees overtime for hours worked in excess of 40 per workweek. In determining whether an employee must be paid overtime, three different tests are employed: the salary level test, the salary basis test and the duties test.

### Duties Test

The most important of the three tests is the “duties test,” which stipulates that employees in bona fide executive, administrative or professional capacities are exempt from overtime requirements. To determine whether an employee falls within an exempt category, an employer must carefully analyze whether the employee’s position meets any of the following descriptions:

- **Executive Employee** — an executive employee’s primary duty (main or most important duty the employee performs) must be *the management of the enterprise or a recognized department or subdivision* (unit with permanent status and continuous function). Examples of “management” include interviewing, training, setting/adjusting pay rates, planning work, and planning budget. Executives must customarily and regularly (at least weekly) direct the work of two or more employees, and have the authority to hire or fire employees and/or their recommendations are given particular weight.
- **Administrative Employee** — an administrative employee’s primary duty must be performing *office or non-manual work directly related to management or general business operations* of employer or employer’s customers. The employee’s primary duties must include exercising discretion and independent judgment with respect to matters of significance. Administrative employees generally have authority to negotiate on behalf of and bind employers, participate in planning business objectives and represent their employer in handling complaints, arbitrating disputes or resolving grievances. Although their decisions may be reviewed at a higher level, they have authority to make independent choices, free from immediate direction. Finally, their jobs involve more than mere application of techniques, procedures or standards in manuals.
- **Professional Employee** — the third exempt category, and perhaps the most relevant in the healthcare setting, is the professional employee. Professional employees’ primary duties must involve *performing work requiring advanced knowledge in a field of science or learning, customarily acquired by a prolonged course of specialized intellectual instruction*. This includes registered nurses; registered or certified medical technologists with three years of college plus a fourth year in school of medical technology; dental hygienists with four years of college; and physician assistants with three years of pre-professional study plus one year of professional course work.

### Salary Tests

Two additional tests used to determine exempt/non-exempt status are the “salary level test” and the “salary basis test.” Under the salary level test, anyone earning \$455 per week or less must be paid overtime.

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The salary basis test is less clear cut. To qualify as an exempt employee under this test, the employee must be paid a predetermined amount that is not subject to reduction because of variations in quality or quantity of work performed. They must generally receive full salary for any week in which they work, with deductions only permissible when an employee is absent from work for a full day for personal reasons. Salary for sickness or disability cannot be deducted unless there is a plan for compensation of lost salary. Deductions can be made for violations of safety rules of major significance or for violations of written workplace policy applicable to all employees that result in disciplinary suspensions lasting a full day or more. In sum, if improper deductions are made from an exempt employee's salary, the employee becomes eligible for overtime, as do any other employees in the same job classification under the manager responsible for the deduction.

### **SUMMARY**

It is good practice for all Critical Access Hospitals to establish clear policies and procedures for dealing with a variety of human resources issues, including harassment, drug and alcohol testing, workplace searches and whistleblowers. It is also important for CAHs to ensure compliance with federal rules regarding family and medical leave and overtime compensation. All of these issues should be addressed in writing through a hospital's comprehensive handbook of personnel policies and procedures.

### **REFERENCES**

Family and Medical Leave Act, United States Code, Title 29, Section 2601 et seq.  
Texas Whistleblower Act, Texas Government Code, Section 554.001 et seq.



**TEXAS HEALTHCARE TRUSTEES**