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Proposed CMS “Green Light” For Unified System Boards

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On October 18, 2011, the U.S. Centers for Medicare & Medicaid Services (CMS) proposed a noteworthy new interpretation of certain hospital Conditions of Participation (COPs) affecting health system governance. The new interpretation was included as part of a proposed rule, “Medicare and Medicaid Programs Reform and Critical Access Hospital Conditions” (Proposed Rule), addressing a series of existing COPs by which hospitals and critical access hospitals must abide as a condition of continued participation in the Medicare and Medicaid programs.^[1] The Proposed Rule is intended to revise certain COPs in order to allow flexibility, reduce regulatory burden, and improve the clarity of healthcare regulation. As such, the Proposed Rule is a byproduct of President Obama’s Executive Order 13563, “Improving Regulation and Regulatory Review” and is consistent with the U.S. Department of Health and Human Services’ Plan for Retrospective Review of Existing Rules.^[2] The expectation is that the Proposed Rule, when made final, will facilitate the use of a unified governing board for all hospitals in a health system.

Many multi-hospital health systems have considered (or already implemented) use of a “unified” governing board; i.e., when the same individuals serve as governing board members for each of the “parent” entity and every Medicare-certified hospital in the health system, to streamline and better coordinate their governance structures. (In this model, there is no separate “fiduciary board” at the hospital level). The common perspective of these systems is that unified governance enhances the efficiency and effectiveness of system governance, in large part because of the coordination, consistency, and enhanced familiarity with system operations available in such a model. The unified governing body model seeks to limit perceived intra-system governance redundancy, permitting healthcare systems to more appropriately make decisions, affect oversight, and track trends for the health system as a whole.

Notwithstanding the potential benefits of this governance model, the long-standing CMS COP regarding the governing body (Section 482.13) has simply stated that each

participating hospital must have an effective governing body that is legally responsible for the conduct of the hospital as an institution. CMS has, until recently, taken the position on survey that these governing body COPs require *each* hospital in a health system with its own CMS Certification Number (CCN) to have a completely separate governing body (as well as a separate medical staff); i.e., a board that acts for a hospital in a distinct, separate manner. This interpretation effectively prohibited the use of a unified governing body between the health system parent and its hospitals. Some hospital systems have reportedly been cited by CMS for failure to comply with the COP because they maintained a single system-level governing body with jurisdiction over the system's hospitals—to the extent that some systems were instructed by CMS to restructure their governance in order to permit each hospital to have a separate governing body. Hospitals receiving this advice were taken by surprise, as historically The Joint Commission had acknowledged the unified governing body model and did not identify it as problematic during triennial or other deemed status survey activities. The CMS position also provided a basis from which mischievous third parties could theoretically challenge the legitimacy of unified board action (e.g., “if the government doesn’t recognize it as a board...”)

Obviously, the strict CMS interpretation of the COP created great concern amongst healthcare systems with a unified governing board, given both (a) the substantial burden that would arise from having to restructure governance; and (b) the potential risk that long-standing processes would be subject to negative findings upon survey. Furthermore, many systems with a unified governing body argued strongly that quality and safety goals could be better achieved through such a common governing board approach. Their argument was that a unified governing board provides a superior platform from which a healthcare system can compare, benchmark, and monitor quality trends (i.e., on a collective basis). The concern of healthcare systems regarding the CMS interpretation was communicated in a letter from the American Hospital Association (AHA) to CMS Administrator Donald Berwick, in which the AHA identified the issue as one concern for its health system constituents.

CMS’ concern has been that systems with a unified governing body should evidence their oversight of the operations and quality of care provided at individual hospitals in other than an aggregated manner, so that material quality-based issues and concerns are not “masked” through combination with quality data from the entire system or otherwise diluted by looking at the system as a whole. CMS empowered its surveyors, and state department of health surveyors acting on its behalf, to confirm appropriate governance-level quality oversight for each Medicare-participating hospital in a system. However, as noted in the Proposed Rule, CMS has been able to overcome this historical concern based on its experience with hospitals, and comments provided by “stakeholders through anecdotal evidence.” It proposes that Section 482.12 be revised to state that “[t]here

must be an effective governing body that is legally responsible for the conduct of the hospital,” without requiring a separate governing body.

Thus, the Proposed Rule reflects CMS’ new understanding that multiple hospitals can in fact be effectively governed by a single unified governing body, and seeks “to revise and clarify the governing body requirement to reflect current hospital organizational structure whereby multi-hospital systems have integrated their governing body functions to oversee care in a more efficient and effective manner.”

Implications

The Proposed Rule is very good news to nonprofit health systems that have or desire to have a “unified” or “common” governing board for all of the hospitals in their system. The new interpretation essentially would remove the CMS citation risk attributable to the use of such a governance approach, and eliminates the need to restructure health system governance structures for CMS compliance purposes.

Health systems using a common governing board model are not totally “off the hook,” however. It will be incumbent on them going forward to assure the ability to demonstrate an appropriate level of governing board oversight of operations and quality of care on an individual hospital basis. While a unified governing body is no longer prohibited by CMS, each participating hospital in a system that is governed in this manner must be prepared to demonstrate that a governing body is taking actions for and on its behalf on an individual basis. While there is no specific guidance on this issue, the principle generally is understood to require each hospital to maintain documentation (such as agenda, minutes, resolutions, and other documentary evidence) of the actions taken by the unified governing body specifically for that hospital, in order to differentiate the actions for the hospital from those taken by the same individuals on behalf of the healthcare system. Many healthcare systems with a unified governing body anticipate addressing this documentation issue by holding meetings of the unified governing body and recording specific actions taken and resolutions passed for each hospital within the system to make clear what the unified governing body has done on an individual hospital level. The board will want to work closely with system general counsel and governance support personnel to appropriately document these separate meetings and actions—especially as they relate to quality oversight.

While the Proposed Rule should give healthcare systems comfort regarding the use of a unified governing body model, there are several corporate and liability-level governance issues historically associated with the common governing board model that are unaffected by the Proposed Rule. These include:

1. The extent to which the time and burden associated with multiple board responsibilities affects the quality of governance;
2. On a related point, whether the board's oversight function is materially diminished by the board's expanded obligations;
3. Whether the model renders the system more prone to "veil-piercing" challenges based on "alter-ego," "direct participant," or other similar theories of liability;
4. Whether the quality of system governance is diminished by the absence of other fiduciary perspectives (i.e., those of separate subsidiary board members); and
5. The presence of unique restrictions in the mission statements/charitable purposes clauses of individual hospital bylaws that present conflicts of interest/duty of obedience to mission issues.

These issues notwithstanding, the unified governing body is an increasingly popular governance model. Many health systems have successfully addressed the above issues and are leveraging the unified board to obtain substantial governance and operational benefits.

CMS is accepting comments on the Proposed Rule. All comments are due to CMS on December 23 (5:00 p.m.), which is 60 days following its October 24 publication in the *Federal Register*.

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[1] Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation, 76 Fed. Reg. 65891, 65893, 65906 (proposed Oct. 24, 2011) (to be codified at 42 C.F.R. pt. 482).

[2] "A Preliminary Plan for Retrospective Review of Existing Rules" (May 18, 2011), available at <http://www.whitehouse.gov/21stcenturygov/actions/21st-century-regulatory-system>.

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