Texas Healthcare Trustees

THA Family of Companies

Rural Healthcare Governance Workshop

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(Noon - 1:30 pm)

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Today's Agenda

1. Board Legal Duties, Functions and Best Practices (20 minutes)
2. Board Roles and Responsibilities (20 minutes)
3. Healthcare Law 101 (35 minutes)
   a) Compliance
   b) Stark / Kickback
   c) Medicare/Medicaid/commercial
   d) HIPAA Introduction
   e) Medical Staff and the Hospital
4. Top 10 Issues/Trends (15 minutes)

The Details:
Board Legal Duties, Functions and Best Practices

What is your role?

Legal Duties

2023

- Care – act in a reasonable, prepared, and informed manner
- Loyalty – undivided allegiance
- Obedience – faithful to the Mission and goals

Board Functions

- Establish the Mission and Vision
- Determine Strategy
- Set and Communicate Goals For Management
- Hold Itself and Management Accountable
- Oversight of Financial & Operational Performance
- Build a Knowledgeable, Collegial Board Passionate about the Mission and which Operates with Integrity

Are you functional?

FUNCTIONAL

- Strategic
- Consensus
- Positive
- Focused
- Understands Roles
- Clear Goals
- Long-Term
- Strong Relationship with Management

DYSFUNCTIONAL

- Operations
- Divided
- Negative
- Scattered
- Micromanage
- No Goals
- Month-to-Month
- Poor Relationship with Management

Six Common Traits of Health Care Boards

1) Board is the ultimate authority.
2) Board only has authority when they meet in session.
3) Boards may delegate authority to a committee, but those actions are limited by the bylaws.
4) No one individual has the authority to act for the Board. May represent or be given authority, but only the Board as a whole has the authority to act.
5) Board are not like Congress…they need to speak with one voice. Board members are obligated to unite behind the majority decision.
6) Time is precious so Boards must be efficient in their function.

Errol L. Biggs, Health Governance A Guide for Effective Boards, 2011

Is it a Board Matter? – AHA Great Boards

- Is it big? (materiality)
- Is it about the future?
- Is it core to the mission?
- Is a high level policy decision needed to resolve the issue?
- Does it have a major impact on the organization?

Board	Management
Conflicts/Ethics	HR
Executive Comp	Finance Management
Compliance	Patient Care
Community Benefit	Purchasing

Why is Governance Important in Community Hospitals

Because Dysfunction

- Erodes Marketing Performance
- Erodes Market Share
- Diminishes Public Trust = Reputation
- Lack of Shared Vision (no common goals)
  - Stroudwater Associates

Customer Experience

- Favorable = Satisfied with provider 99% of the time
- Google Study – 90% of patients choose on reputation vs. insurance
- 10% increase in customer loyalty = >$20 million revenue

The Details:
Board Roles and Responsibilities

Basic Board Processes

- Set Direction and Goals
  - Financial
  - Patient Experience
  - Access/Scope of Services
  - Clinical Care
- Approve strategies to reach the goals
- Review progress against strategies and targets
- Ensure compliance
- Hire and fire the CEO

Individual Board Member Responsibility

1. Attend Board, Committee meetings and special functions
2. Develop understanding and knowledge of the organization's mission, services, policies and programs
3. Review meeting agendas and read all supporting materials in advance of the board and committee meetings
4. Ask questions—your most important role
5. Apply knowledge and experiences to discussions
6. Avoid conflicts of interest
7. Assist in identifying potential board members

Good Governance: Ask the Right Questions…

Inquiry Questions

- How will this improve patient care?
- How does this fit into our strategic plan?
- Where is our performance now and where does it need to be? How does our performance compare to the best?
- What resources are you committing to solving this problem?
- How will this impact financial performance?
- When will we be able to show measurable results?
- What support from the board do you need?

Attack Questions

- Why haven't you fixed that problem?
- Why didn't you bring this to the board for approval?
- Why aren't you doing something about those doctors?
- Where is your financial justification for this?
- Where are the details for this project?
- What is the FTE count this week?
- Who is responsible for this disaster?

Asking About Quality of Service:

- What are the important quality results we should be monitoring?
- How good do we want to be?
- Where is our performance now?
- Where should our performance be? (benchmarking best in class)
- How does our strategy move this measure?
- What resources are we committing to this effort?

Bad Board and CEO Manners

- Domination of discussion-speeches
- Not being prepared
- Coming late and leaving early
- Not being honest about CEO performance or organizational performance
- Secret/off the record meetings
- Playing politics
- Conflicts of interest/Nepotism
- Breach of confidentiality
- Being an "ear" for employees or medical staff
- "Representative" vs. board member
- Bringing operational issues to the board that are not related to strategy or performance indicators

Why Boards and CEOs get into trouble…

- Failure to ask questions
- Forgetting your Mission
- Managing vs. Governing
- Failure to set and understand performance expectations
- Failure to choose the right CEO or take action
- Failure to achieve a shared vision between the board, medical staff and management
- Failure to balance community responsibility w/fiduciary responsibility
- Failure to implement appropriate board processes and structures
- Individual interests/COI
- The Chair as Czar

New “Simple Rule”

If you as a board member personally have a care or patient experience problem or if you hear from other patients or sources (ie: employees) about problems...

“Take it to the CEO”

Role of Board Committees

- 90 minute meeting at tops—plan on it
- Where the month-to-month detailed work of the board is accomplished
- Where concerns can be shared and questions answered
- Where procedural and routine board decisions can be efficiently processed and become consent agenda items
- Where board members and management team members can form a collaborative relationship
- Committee chairs report out to the full board on committee actions and recommendations

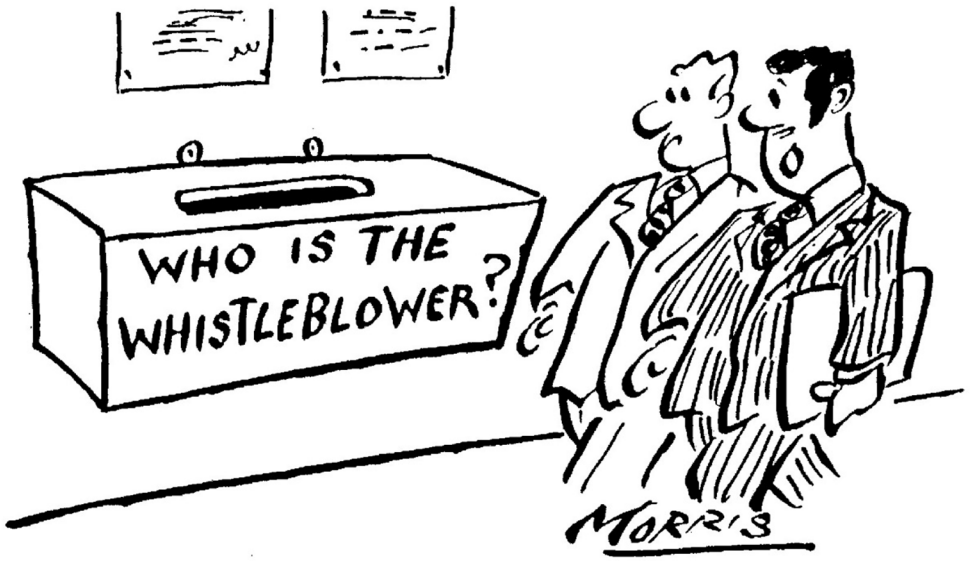
Healthcare Law 101:

A. The Board's Role in Compliance

CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
DEA	Drug Enforcement Administration
DME	Durable Medical Equipment
DOJ	Department of Justice
DOL	Department of Labor
DOT	Department of Transportation
EPA	Environmental Protection Agency
ERISA	Employment Retirement Income Security Act
FAA	Federal Aviation Administration
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FDA	Food & Drug Administration
FEMA	Federal Emergency Management Agency
FTC	Federal Trade Commission
GSA	General Service Administration
HHS	Health & Human Services
HRSA	Health Resources & Services Administration
IRS	Internal Revenue Service
NIOSH	National Institute for Occupational Safety & Health
NRC	Nuclear Regulatory Commission
OCR	Office for Civil Rights
OIG	Office of Inspector General
OPO	Organ Procurement Organization(s)
OSHA	Occupational Safety & Health Administration
PRRB	Provider Reimbursement Review Board
QIO	Quality Improvement Organizations
SEC	Securities & Exchange Commission
TJC	The Joint Commission

Whistleblowers: A Major Source Of Enforcement Information

The Rise of the Whistleblower

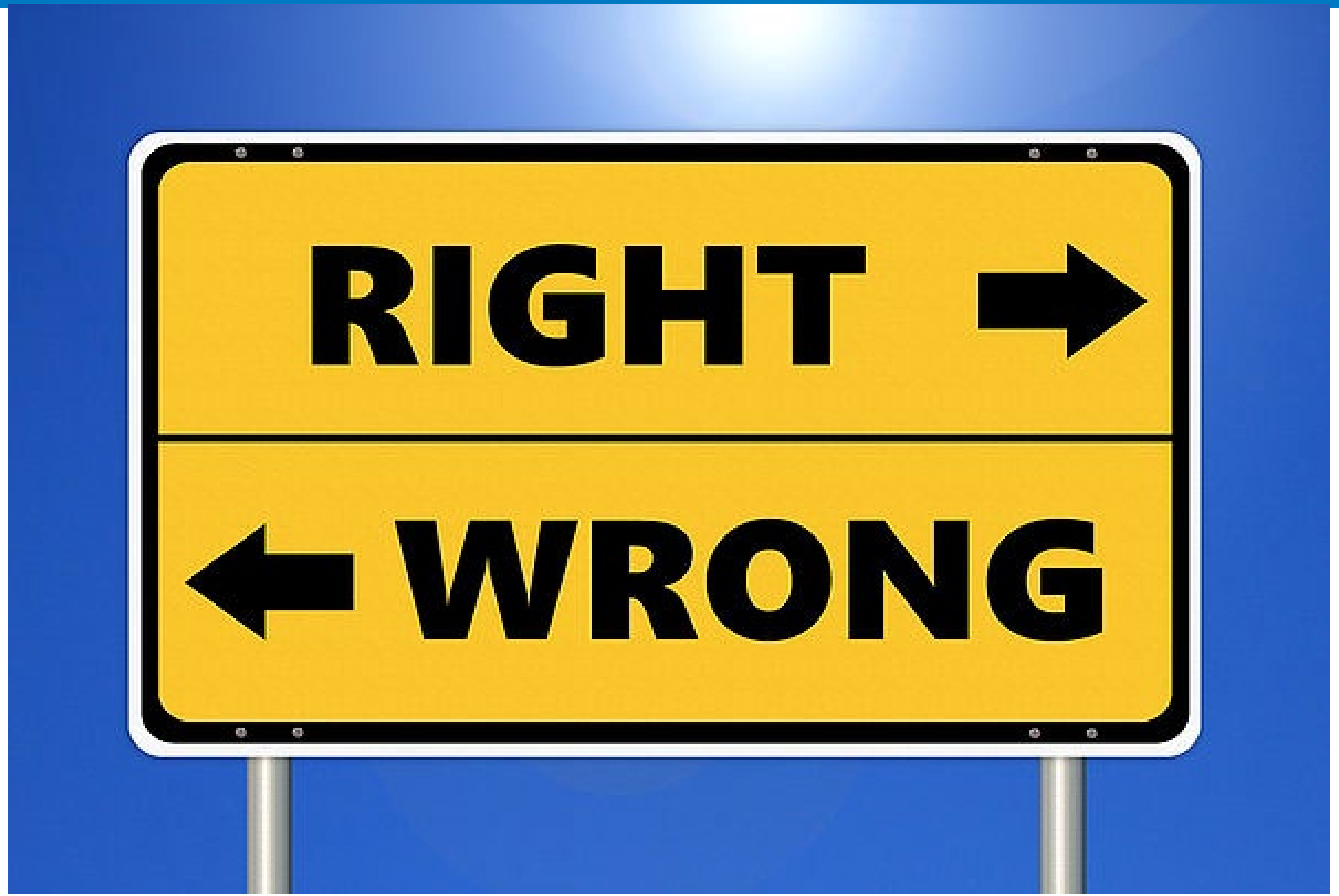


"Remember the good old days when it was a suggestion box?"

What is compliance?

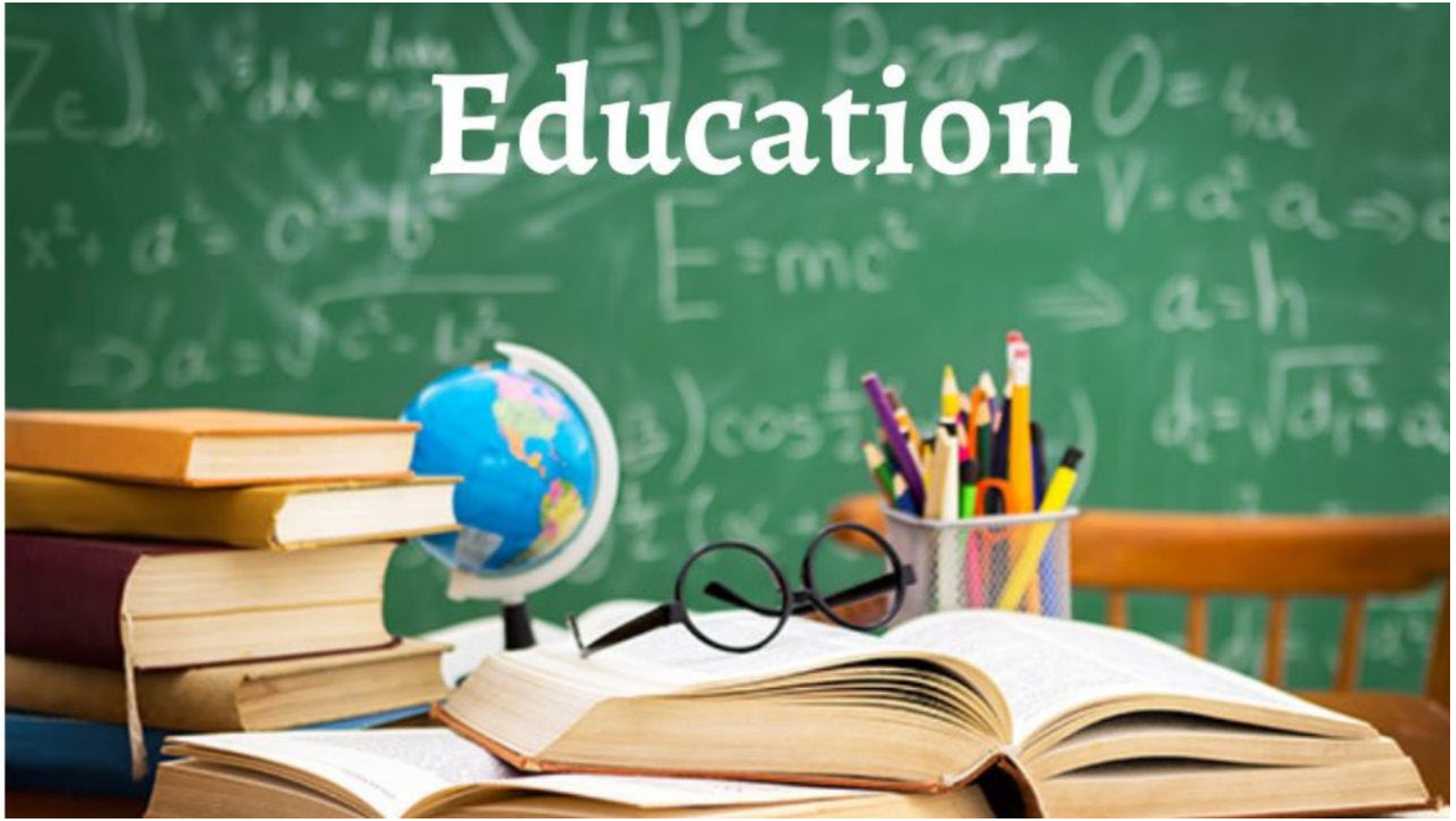
A comprehensive strategy to ensure that the healthcare entity consistently complies with the applicable laws relating to its activities and the delivery of health care, providing internal reporting and follow-up to reduce chance of violating laws.


LAW


RIGHT
WRONG


Policies and
Procedures


I'm the
BOSS
around here.


Education


JKL
PRS
TUV
Z


YOU ARE
FIRED!

The Board's Role in Compliance

- Oversight
- Commitment to compliance
  - Active board leadership
  - Attentiveness to compliance issues
  - Allocation of resources
  - Support for Compliance Officer

Stark Law

Stark Law a/k/a Ethics in Patient Referrals Act of 1989 (the "Act"), effective 1/1/1992.

Congressman Pete Stark sponsored the bill.

Stark I prohibited physicians from ordering clinical laboratory services for Medicare patients from an entity with whom the physician or an immediate family member of that physician had "financial relationship".

Stark Law (cont'd)

Now Prohibits:

1) A physician from referring Medicare patients to entities for the provision of designated health services (DHS) if the physician (or an immediate family member) has a direct or indirect financial relationship with that entity; and
2) An entity that furnishes DHS pursuant to a prohibited referral from billing the Medicare program or any individual, third-party payer, or other entity for the DHS.

Penalties

1) Denial of payment
2) Refund of payments
3) Imposition of civil monetary penalties by CMS
4) Assessment of a penalty by the Office of the Inspector General (OIG)
5) Civil monetary penalty for involvement in a circumvention scheme

What is “Designated Health Service?”

1) Clinical laboratory services;
2) Physical therapy, occupational therapy, and outpatient speech-language pathology services;
3) Radiology and certain other imaging services;
4) Radiation therapy services and supplies;
5) Durable medical equipment and supplies;
6) Pre-enteral and enteral nutrients, equipment, and supplies;
7) Prosthetics, orthotics, and prosthetic devices and supplies;
8) Home health services;
9) Outpatient prescription drugs; and
10) Inpatient and outpatient hospital services.

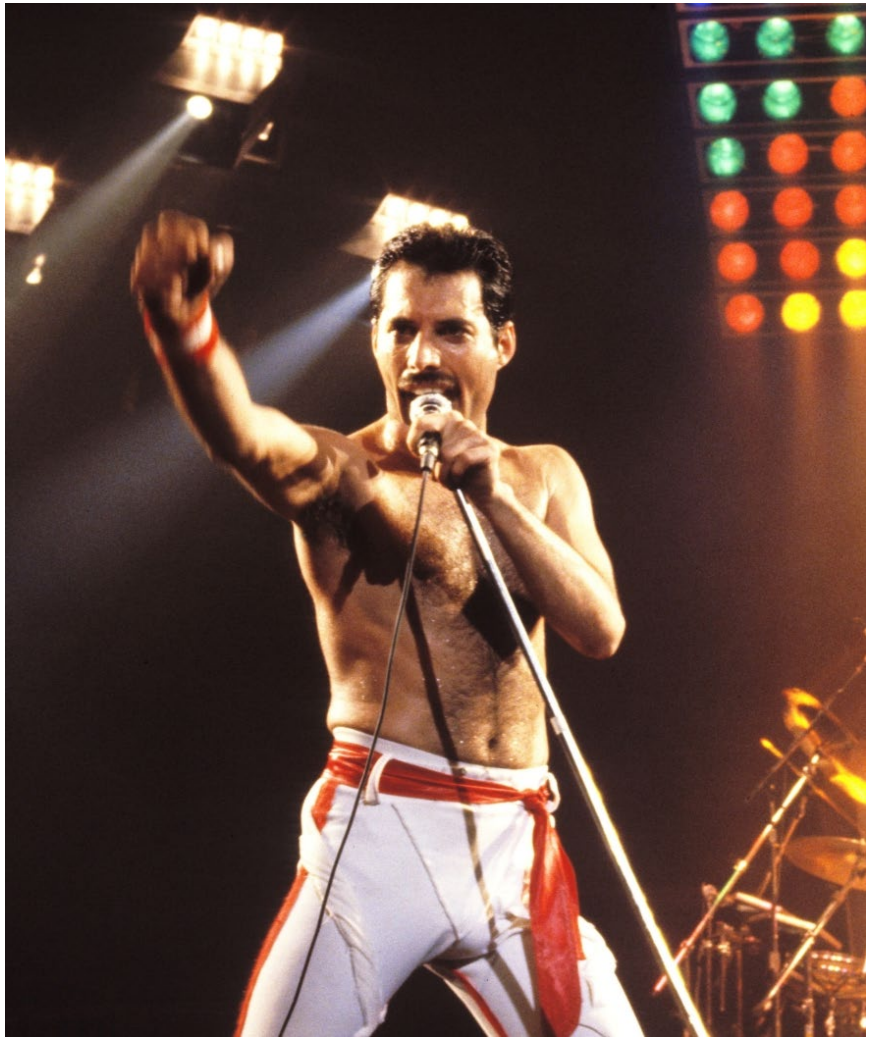
Strict Liability Law

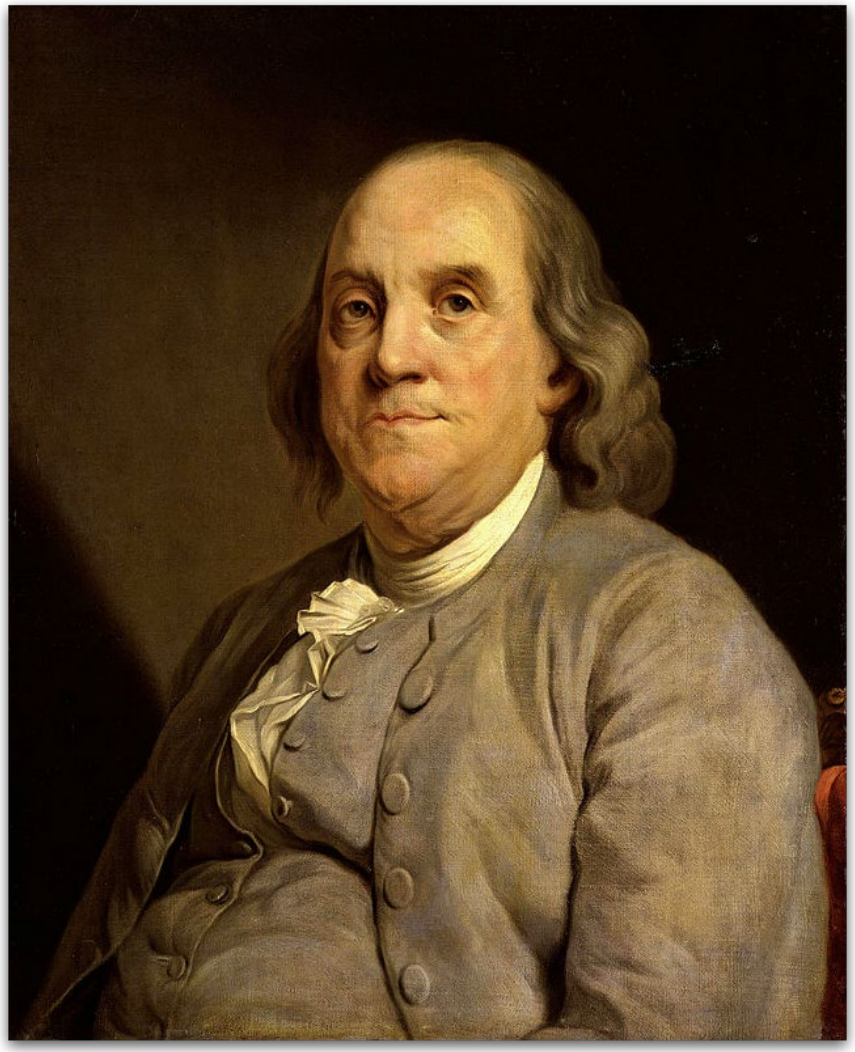
- Intent Is Not Relevant
- Does not matter if the prohibited financial relationships results from innocent error or inadvertence
- Technical Violations = Violations

Basics of the Anti-Kickback Statute

- Criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce referrals of items or services reimbursable by a federal health care program
- No actual knowledge or specific intent required
- "Remuneration" includes the transfer of anything of value, in cash or in kind, directly or indirectly, covertly or overtly
- Anti-kickback statute liability
- Criminal and civil penalties
- $25,000 per offense
- Imprisonment up to 5 years
- Civil monetary penalties (exclusion and $50,000)
- False Claims Act liability (3 times damages)

History





Credentialing

- Oversight of professional practices in the hospital
- Provides objective information collection process and ensures uniform treatment of all practitioners
- Medical Staff self-governance / Board Ultimate Responsibility
  - Does an applicant meet the requirements of the hospital?
  - Is an applicant qualified to provide health care services for the hospital?
- Involves review of 3 parameters:
  - Current licensure and certification
  - Education and relevant training
  - Experience, ability, current competence

Credentialing (cont'd)

- Granting Medical Staff Membership
  - Bylaws should describe Qualifications for Membership
  - Bylaws should describe Conditions and Duration of Appointment
- Granting Clinical Privileges
  - Only those with Documented Education, Training, Experience
  - Proctoring?
- Board and Medical Staff should ensure consistent implementation of credentialing requirements

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has 2 parts:

- HIPAA Privacy Rule establishes national standards for the protection of certain health information
- HIPAA Security Rule establishes a national set of security standards for protecting certain health information that is held or transferred in electronic form
- Security Rule applies to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form

Medicare and Medicaid – "CMS"

- Medicaid Certification – Texas Health & Human Services Commission (HHSC) / Texas Medicaid Health Care Partnership (TMHP)

- Medicare Certification – Centers for Medicare & Medicaid Services (CMS)

Medicare History

- Medicare was started in 1965 and provides insurance primarily to U.S. residents over age 65
  - Provides coverage to nearly 50 million beneficiaries
- Medicare initially covered inpatient hospital/long-term care benefits (Part A) and outpatient and physician services (Part B). In recent years, a drug benefit was added (Part D)
  - Medicare Advantage plans fall under Part C of the Medicare program
- Medicare is partially financed by payroll taxes, beneficiary premiums and general revenues
- Medicare is administered by CMS from Baltimore and Maryland. CMS hires "Medicare Administrative Contractors" to pay claims to providers, audit cost reports and enroll new providers
- Medicare requires patients to pay as much as 20% of the amounts due to providers as coinsurance or deductibles

- Reimburses for health care for
  - persons 65 years and older
  - younger persons with disabilities
  - persons with end-stage renal disease
- 100% federal program

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicaid

- Medicaid is a joint federal/state program that provides health care benefits for certain low-income individuals
  - Administered by states
  - Funded with approximately 60% federal money and 40% state money
  - Poverty alone does not qualify an individual for Medicaid; the individual must fall into other defined eligibility categories
- In Texas, Medicaid pays most hospitals a fixed amount per admission, with certain hospitals receiving a cost-based settlement at the end of the year
  - Medicaid reimbursement rates are generally below a hospital's cost to provide the related care

Medicaid (cont'd)

- Reimburses for health care for low-income individuals and families
  - State / federal program
  - Medicaid currently pays more than 60% of all nursing home in the U.S. and almost 40% of all child births

Must Apply

- Hospital must
  - Apply for Medicare and Medicaid certification
  - Meet the Conditions of Participation
  - Pass a formal on-site survey and no re-surveys

2023 Trends

- Center for Association Leadership
- Forbes Nonprofit Council
- Nonprofit Pro
- SalesForce

Strategy

- A written “bold” 3-year plan? (5 years)
  - The Plan Drives the Work!
- Engagement
  - Active regular engagement with stakeholders
- Oversight
  - Keep the train on the tracks on schedule
  - Be prepared when derailed

Planning

Technology

- Are you in 1985 or planning for 2025?
- Leverage technology to increase efficiency

Workforce

- Clearly understand the value of the workforce and what it will take to retain them
- Value DEI not just talk about it

Financial Growth & Flexibility

- Planning for headwinds
- Understand uncertainty of public financing

Staffing Issues

- Association of American Medical Colleges projected physician demand will continue to outpace supply – shortage of 54,100 to 139,000 by 2033
- Biggest gap in primary care and rural communities
- Nurses: need more than 275,000 additional nurses 2020-2030 (US Labor Statistics)

Healthcare Cybersecurity

- RansomeWare attacks targeting healthcare delivery organizations doubled from 2016 to 2021
- Average ransom demand increased by 45% (2020–2021) to $247,000.
- Downtime increased
  - 18 days 2020
  - 22 days 2021

Source: HHS Office of Information Security, 2022 year in review

TEXAS HEALTHCARE TRUSTEES

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State Office of
Rural Health
TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

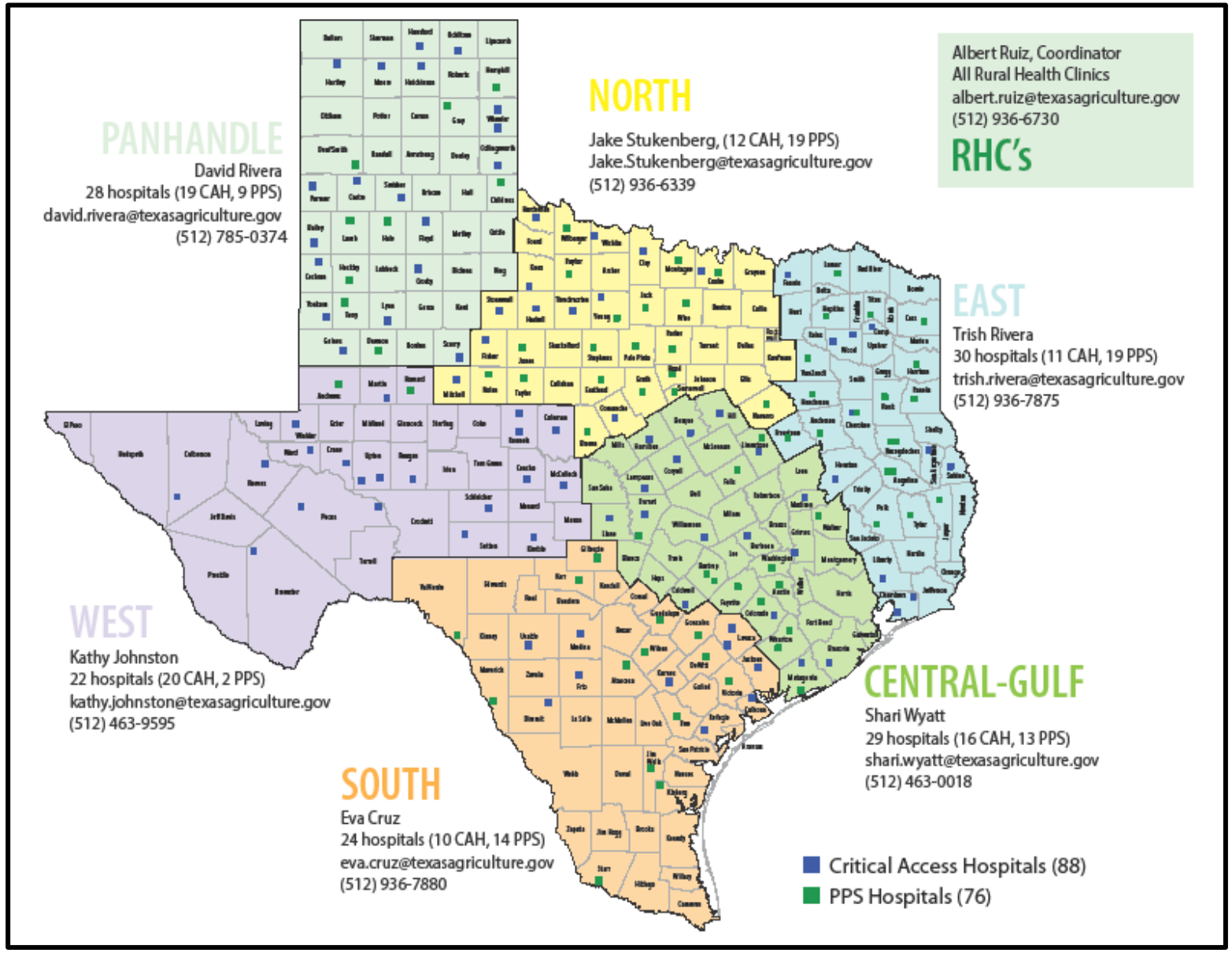
Caring for Those Who Care for Others

Dedicated to serving the health needs of rural Texas. The SORH staff work with local health care providers and other partners to support access to quality health care for rural Texas.

Through a variety of programs, the SORH works to support rural health providers by providing technical assistance on finance, operations, and quality.

A REGIONAL APPROACH

- NORTH
- SOUTH
- EAST
- WEST
- PANHANDLE
- CENTRAL-GULF



SORH SERVICES

RURAL HOSPITALS

Quality Improvement

- QI Training
- MBQIP portal website – one-stop shop for quality reporting needs
- Quarterly QI Webinars
- QI Bootcamps
- Targeted TA to CAH cohort in
- meeting MBQIP reporting
- Targeted TA to CAH cohort in reducing hospital readmissions
- Site Visits
- Regional Meetings

Finance & Operations

- CAH & PPS Data Support Projects
- Triage Initiative to support Vulnerable CAHS
- Regional Meetings
- Site visits
- Funding Resource Guide
- Technical Assistance Workshops & Webinars
  - Grant Writing Workshops
  - Board Leadership
  - Swing Bed
  - E&M Coding
  - Collection Management
  - 340B Pharmacies

RURAL HEALTH CLINICS

- RHC Toolkit
- Data Analytics Tools & support
- Develop & Provide Technical Assistance
- Workshops & Webinars
- Quarterly Listening Sessions
- Cohort learning Collaborative
- Virtual and/or site visits
- Subject Matter Expertise

GRANTS

Small Rural Hospital Improvement Program (SHIP)

This grant is funded thru HRSA to support rural hospitals with forty-nine staffed beds or less. Funds are provided to assist rural hospitals in meeting their transition to value-based payment and to meet efficiency/quality improvement goals by enabling hospitals:

- to purchase health information technology (hardware and software), equipment, and/or training to comply with quality improvement activities.
- to become or join an (ACO); and
- to participate in shared savings programs

Capital Improvement Program (CIP)

This state-funded program provides grants to eligible hospitals in rural counties to make capital improvements to existing health facilities, construct new facilities, or purchase capital equipment. Hospitals eligible to apply for these funds are public and nonprofit facilities.

Quality Improvement Training Program (QTIP)

Funds are used to prepare the participant to sit for the exam to become a Certified Professional in Healthcare Quality (CPHQ).

Rural Communities Healthcare Investment Program (RCHIP)

This is a state grant to attract and retain healthcare professionals in rural communities by providing incentives such as stipends or loan repayment assistance to non-physician healthcare professionals.

Contact the Regional Coordinator Near You!

- **Trenton Engledow, SORH Director** Trenton.Engledow@TexasAgriculture.gov
- **Albert Ruiz, Coordinator All Rural Health Clinics** Albert.Ruiz@TexasAgriculture.gov
- **Erica Lozano, RCHIP Coordinator** Erica.Lozano@TexasAgricutlure.gov
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State Office of Rural Health

TEXAS DEPARTMENT OF AGRICULTURE

COMMISSIONER SID MILLER

Check out the SORH Website for Additional Information

https://www.texasagriculture.gov/Grants-Services/Rural-Economic-Development/State-Office-of-Rural-Health