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Business Lawyers—What's New in Health Care Law?

By Theresamarie Mantese, Douglas L. Toering, and Fatima Bolyea

Introduction

It is common for physicians and other health care providers[1] to retain business lawyers for matters involving business transactions or litigation. Business lawyers and business litigators have the best skill set to advocate for the business interests of health care providers in court and other forums. These business matters include: corporate formations, contracts, general business litigation, and business dispute resolution. Experienced business lawyers know how to easily navigate these complex business matters for a variety of industries. Yet, there are certain health care law issues that business lawyers should recognize in their representation of health care providers.

This article is intended to provide business lawyers with an overview of the key health care law developments of the last year that may have an impact on physicians and other health care providers. This list is not exhaustive, but it covers the critical topics that business lawyers may confront in their practice. The article also provides some useful tips on proposed language to use in business agreements and other strategy ideas. The topics addressed in this article are: (1) Licensing, (2) Stark Law Clarifications, and (3) Staff Privileging and Credentialing Issues. Business lawyers should understand how these changes affect the legal landscape for physicians and other health care providers in the business context.

Licensing

Michigan Physician's Assistant Statute—Statutory Practice Agreement

Often, business lawyers are retained to write agreements related to physician practices. Licensing statutes can have an impact on these agreements. In 2016, the Michigan Legislature enacted a significant statute related to physician's assistants, who are increasingly being employed in physician practices. 2016 PA 379 gives greater autonomy to physician's assistants to perform health care services under the terms of a practice agreement. The expanded health care services include: (1) the authority to make rounds and house calls;[2] (2) the ability to prescribe drugs;[3] and (3) the ability to perform routine visual screening or testing, postoperative care, or assistance in the care of medical diseases of the eye.[4] The statute further eliminates the requirement that physician's assistants be supervised at all times by a physician.

A physician's assistant's ability to provide these expanded health care services requires that physician's assistants enter into a practice agreement with a participating physician or podiatrist. The practice agreement[5] *must* include all of the following terms:

1. A process for communication, availability, and decision-making between the physician and the physician's assistant when providing medical treatment to a patient.[6] The agreement must provide that the physician's assistant and physician use the knowledge and skills based on their education, training, and experience in the performance of this process. A practice agreement should not give responsibilities to physician's assistants that are outside their scope of license. For example, a physician's assistant should not be given responsibility to perform heart surgery under a practice agreement. Thus, business lawyers should review the powers of physician's assistants as outlined in MCL 333.18051 before drafting a practice agreement. This is necessary to avoid giving physician's assistants authority over health care matters outside the scope of their license.
2. A protocol for designating an alternative physician for consultation in situations when the participating physician is not available.[7] The purpose of this protocol is to create a chain of authority, such that the physician's assistant always has access to a physician if a medical situation occurs in which the physician's assistant may need advice or infor-

mation from a physician.

3. A termination provision that allows the physician's assistant or physician to terminate the practice agreement by providing at least 30 days' written notice before the date of termination.[8] It appears that this requirement is to provide for a continuity of patient care and to avoid abrupt termination in the patient care by either a physician or physician's assistant.
4. The duties performed by the physician's assistant must not include any act or function that the physician's assistant or physician is not qualified to perform or is not within their license to perform.[9] It is advisable for a business lawyer to carefully review the scope of license for a physician's assistant[10] and a physician[11] in order to avoid including any activities that are beyond the scope of the license of either the physician's assistant or physician.
5. The physician must verify the physician's assistant's credentials.[12] While this provision is to be included in the practice agreement, it should be remembered that the physician must actually verify the credentials of the physician's assistant. Oftentimes, physicians prefer to delegate credentialing to administrative staff. However, physicians will ultimately be responsible for any mistakes in the credentialing of the physician's assistant.
6. The practice agreement must be signed by the physician's assistant and the physician.[13] As with all agreements, business lawyers should make sure it is both signed and dated by both parties, and that the parties keep a fully executed copy for their records.

Business lawyers should emphasize that failure of a physician or physician's assistant to comply with the practice agreement may be grounds for a disciplinary action.[14]

No specific form is required for a practice agreement. The statute gives the business lawyer flexibility. Therefore, business lawyers may opt to draft a separate practice agreement to comply with the statutory requirements or to draft a single agreement that incorporates the statutory requirements along with provisions contained in other agreements related to the employment of a physician's assistant.

Finally, the practice agreement should be consistent and not conflict with other physician's assistant's agreements such as employment agreements or independent contractor agreements. Caution should be taken to make sure that terms related to job duties, scope of practice limitations, and termination notice period are consistent with the statutory requirements.

Business lawyers should also carefully consider entity formation issues related to physicians having a practice agreement with a physician's assistant. Specifically, MCL 333.17048(3) addresses business entity formation by physician's assistants. Under the statute, if physicians and physician's assistants organize a professional corporation or professional limited liability company after July 19, 2010, then the physician who is a party to a practice agreement with the physician's assistant must also be a shareholder or member in the same corporation or limited liability company as the physician's assistant. Professional corporations and professional limited liability companies formed before July 19, 2010 may be made up solely of physician's assistants, but the participating physicians who are parties to the practice agreements must satisfy the requirements of their medical discipline.[15]

Often, business lawyers are retained to write agreements related to physician practices. Licensing statutes can have an impact on these agreements.

Michigan Midwifery Legislation—Statutory Implied Consent Authorization

On January 3, 2017, House Bill 4598 ("HB 4598") was enacted by the Michigan legislature. HB 4598 adds Midwifery to the Public Health Code and provides new licensure requirements for the practice of midwifery in Michigan. The statute establishes midwife licensure and scope of practice requirements. The statute: (1) prohibits the practice of midwifery without a license;[16] (2) enables the midwife to directly obtain supplies and devices, to order and obtain screening tests including ultrasound tests, and to receive verbal and written reports of the results of those tests;[17] (3) requires a midwife to obtain informed consent from a patient;[18] (4) requires a midwife to establish a protocol for the transfer of care to a physician or hospital;[19] and (5) prohibits a midwife from using certain surgical instruments, prescribing medications, or performing surgical procedures other than episiotomies or repairs to perineal lacerations.[20]

Accordingly, business attorneys should draft informed consent forms that, at a minimum, include these statutory provisions and should revisit the professional standard of care related to informed consent that applies to a health care provider.

Business lawyers should be aware that the Midwifery legislation requires that a midwife "shall obtain informed consent from a patient at the inception of care and continuing throughout the patient's care." [21] Informed consent is continuing and is of critical importance for patient care issues related to using a midwife in a physician's practice. The Michigan Midwifery licensing statute provides guidance on informed consent. At a minimum, informed consent shall include: (1) a requirement that at the inception of care for a patient, the midwife provide a copy of the rules promulgated by the Michigan Department of Health under the Midwifery licensing section; and (2) a requirement that at the inception of care for a patient, the midwife orally and in writing disclose whether the midwife has malpractice liability insurance coverage and, if so, the policy limitations of that coverage.[22] Accordingly, business attorneys should draft informed consent forms that, at a minimum, include these statutory provisions and should revisit the professional standard of care related to informed consent that applies to a health care provider.

Business Litigation – Spillover Licensing Proceedings

In 2017, the Michigan Court of Appeals dealt with a licensing action that arose out of a collection lawsuit for the payment of medical bills to a chiropractic business. In *Serven v Health Quest Chiropractic, Inc*,[23] Bruce Serven, a licensed chiropractor, was retained by State Farm Insurance Company to perform an independent chiropractic examination on a patient who was treated by Health Quest. Health Quest was owned, in part, by Solomon Cogan and Silvio Cozzetto. Cogan was also the chairman of the Michigan Board of Chiropractic. Serven advised State Farm that Health Quest's services were not medically necessary in connection with the treatment of a patient. Based in part on this advice, State Farm denied payment to Health Quest. Health Quest filed suit against State Farm seeking payment. Serven testified on behalf of State Farm, and Cogan testified on behalf of Health Quest. State Farm prevailed. Shortly thereafter, Cogan's business partner, Cozzetto, filed a licensing complaint against Serven with the Michigan Board of Chiropractic. Cozzetto accused Serven of improperly rendering an opinion without reviewing Health Quest's records in connection with his consultation. The case was referred to an administrative law judge who found in favor of Serven and issued a proposal for a decision to this effect. Instead of adopting the decision of the administrative law judge, the disciplinary subcommittee found that Serven was negligent and put him on probation claiming that he had not reviewed Health Quest's chiropractic records before issuing his opinion regarding the independent chiropractic examination. Cogan was present at the disciplinary subcommittee meeting.

Serven appealed the disciplinary subcommittee's decision. The Michigan Court of Appeals held that the disciplinary subcommittee erred, reversed the decision, and remanded with instructions to expunge Serven's record.[24] Thereafter, Serven filed a lawsuit against the disciplinary members, including Cogan. Serven claimed that Cogan was an equity partner in Health Quest and bore a financial interest in the outcome of Serven's disciplinary matter and, therefore, should have played absolutely no role in the decision. The appellate court held the board's disciplinary subcommittee was immune from a lawsuit because it was cloaked with absolute quasi-judicial immunity, and the case was remanded to the trial court for dismissal.

As noted in *Serven*, spillover disciplinary proceedings and litigation resulted from a seemingly straightforward collection lawsuit for medical bills. *Serven* provides several lessons for business lawyers. First, business lawyers should keep in mind that parties involved in a business matter cannot agree to refrain from filing a licensing complaint against a medical provider as part of a business transaction. Michigan law recognizes that medical providers may not absolve themselves from professional liability via an exculpatory agreement because of the great importance of medical services to the public.[25] However, a business lawyer could use other drafting techniques in order to protect a medical provider from subsequent licensing proceedings. For example, a business lawyer could draft detailed recitals indicating that licensing issues are not relevant to the business matter. These recitals can be invaluable to provide a window into the reasoning of the parties and provide outside reviewers with information as to why licensing issues are not relevant. Finally, business lawyers should consider whether an indemnity clause would be valuable in connection with a business matter involving a medical pro-

vider. An indemnity provision would provide a means in which the medical provider could recover costs, including attorneys' fees, to cover spillover proceedings resulting from a business matter.

Stark Law

Stark Law Overview

The Stark Law prohibits a physician from referring Medicare patients for certain "designated health services" to an entity with which the physician or an immediate family member has a "financial relationship."[26]

A Stark Law prohibited referral is broadly defined and includes more than just a commonly understood referral. A "referral" under Stark Law could include physician orders for physical therapy, prescriptions, and care plans. The general prohibition applies to specific designated health services including: (1) clinical laboratory services; (2) physical therapy services; (3) occupational therapy services; (4) radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; (5) radiation therapy services and supplies; (6) durable medical equipment and supplies; (7) parenteral and enteral nutrients, equipment, and supplies; (8) prosthetics, orthotics, and prosthetic devices and supplies; (9) home health services; (10) outpatient prescription drugs; (11) inpatient and outpatient hospital services; and (12) outpatient speech-language pathology services.[27] The Stark Law's prohibition applies *only if* the physician has a "financial relationship" with the recipient of the referral.[28] A "financial relationship" can include a compensation arrangement between the physician and the entity that receives the referral.[29]

Physician agreements that implicate the Stark Law must fall within a Stark Law exception. Stark Law exceptions include statutory and regulatory exceptions for in-office ancillary services, bona-fide employment relationships, personal services, and physician recruitment. Business lawyers need to be very sensitive to create bona fide agreements in order to fall within the safe harbors of the Stark Law and the Anti-Kickback Law. For example, the Anti-Kickback Law is not violated for a payment "by an employer to an employee (who has a bona fide employment relationship with such employee) for employment in the provision of covered items or services."[30]

United States v Marder[31] is on point. In this 2016 case, a qui tam action was brought against a dermatologist and pathologist alleging problems with the provision and the billing of dermatology services and related pathology services. Drawing every inference in favor of the defendants, the court could not determine as a matter of law that the purported employment relationship between the dermatologist and pathologist for pathology services was a mere smokescreen for kickbacks, sufficient to take it out of the safe harbor provisions expressly provided by the Anti-Kickback Act and Stark Act. At the very least, there were factual issues remaining on whether (1) defendant pathologist was an employee entitled to the applicable safe harbor protections and, (2) defendant dermatologist actually performed the professional components of the pathology services for which he billed.

Importantly, as stated in *Marder*, because compliance with the Anti-Kickback Law and the Stark Act is a condition of payment for Medicare and Medicaid, claims submitted for services rendered in violation of these statutes can form the basis of liability under the False Claims Act.[32]

Stark Law Update: Final Rule

The Centers for Medicare and Medicaid Services ("CMS") posted a final rule on November 16, 2015 ("Final Rule") modifying the regulations implementing the Stark Law.[33] These new regulatory provisions became effective on January 1, 2016, with the exceptions of a few clarifying changes of existing policy, and amended the definition of "ownership or investment interest," which was effective January 1, 2017. Business lawyers should be aware of the following changes that have a significant impact on business transactions related to physician agreements.

Clarification on the Writing Requirement

For business lawyers, the clarification of "agreement" is very significant. The Final Rule comes in line with the business law concept of an agreement. Stark Law formerly provided a strict definition of "a contract." The Final Rule provides flexibility. With the Stark Law changes, a single "formal contract" is no longer required. The following may satisfy the contract requirement: (a) a collection of documents may satisfy the writing requirement; and (b) a collection of documents may include "contemporane-

Business lawyers need to be very sensitive to create bona fide agreements in order to fall within the safe harbors of the Stark Law and the Anti-Kickback Law.

> The key statute business lawyers should review in connection with staff privileges is the Healthcare Quality Improvement Act of 1986 ("HCQIA").

ous documents evidencing the course of conduct between the parties."[34] This change is consistent with the business law concept that various writings can constitute "an agreement" under certain circumstances.

Clarification on the One-Year Term Requirement

For business lawyers, the flexibility for the duration requirement for office space rental, equipment rental, and personal service arrangements is important. The Final Rule clarifies that a formal "term" provision for one year in a contract is not required under the Stark Law. Instead, the duration requirement for one year can be shown through contemporaneous documents establishing that the contract lasted for at least one year. Further, if the contractual arrangement is terminated during the first year, the parties must be able to show they did not enter into a new arrangement for the same space, equipment, or services during the first year.[35] Thus, this change allows more flexibility in establishing the one-year duration under the Stark Law.

"Temporary Noncompliance With Signature" Requirement

The Final Rule provides a blanket 90-day period to comply with the signature requirement, regardless of whether the failure to obtain a signature was inadvertent or not.[36]

Holdover Arrangements

The Final Rule provides for an indefinite holdover provision in the Rental of Office Space Exception, Rental of Equipment Exception, and Personal Services Exception. CMS also finalized its proposal to amend the Fair Market Value Compensation Exception to allow arrangements of any time frame to be renewed for any number of times (as long as the arrangement continues to comply with the other requirements of the exception). Previously, the Fair Market Value Compensation Exception referred to renewals of arrangements made for less than one year.[37]

Stand in the Shoes

The Final Rule clarifies that a physician who is standing in the shoes of his or her physician organization has satisfied the signature requirement of an applicable exception when the authorized signatory of the physician organization has signed the writing. For purposes other than the signature requirement, all physicians in a physician organization are considered to be "parties" to the compensation arrangement.[38]

Timeshare Arrangements Exception

This exception covers "use" arrangements only, which includes the use of premises, equipment (*excluding* advanced imaging equipment, radiation therapy equipment, and (most) clinical or pathology laboratory equipment), personnel, items, supplies, or services. Traditional office space leases and arrangements conveying a possessory leasehold interest in office space are not covered under this exception. Compensation for such arrangements must be carefully structured because percentage compensation and per-unit services fees (i.e., "per-use" and "per-patient" rates) are prohibited. Hourly or half-day rates, however, are acceptable.[39]

Staff Privileges and Credentialing

Overview

In general, business lawyers may be confronted with issues involving physician's staff privileging and credentialing in several contexts, including: (1) business agreements, (2) settlement agreements, and (3) legal consultation on whether litigation is proper arising from an adverse staff privileging decision. Business lawyers should be aware of certain health care laws in the event they are retained by physicians for any of these matters. The key statute business lawyers should review in connection with staff privileges is the Healthcare Quality Improvement Act of 1986 ("HCQIA").[40]

HCQIA was enacted by Congress to promote peer review by providing certain immunity from civil money damages to participants who participate in the peer review process. The goal of peer review is to identify potential violations of a standard of care by medical staff and to eliminate these issues as quickly and effectively as possible. HCQIA also created the National Practitioner Data Bank ("NPDB"). The NPDB receives and maintains records of adverse actions taken by healthcare entities against physicians and makes these reports available to all health care entities for background checks and credentialing. The NPDB enables hospitals and health care entities to obtain information about physicians regardless of state lines.

Federal reporting requirements codified in HCQIA require health care entities to report certain "reportable events" to the Board of Medical Examiners. These events include:

(1) a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days; (2) the surrender of clinical privileges of a physician (i) while the physician is under an investigation by the entity relating to the physician's possible incompetence or improper professional conduct, or (ii) in return for not conducting such an investigation or proceeding; or (3) in the case of a professional society, a professional review action by the professional society which adversely affects the membership of a physician in the society.[41]

Michigan reporting requirements are codified in MCL 333.20175 and are broader than those found in the federal statute. The Michigan statute requires that a health facility must report: (1) a disciplinary action based on the health professional's competence, (2) a disciplinary action that results in a change of employment status, or (3) disciplinary action that adversely affects the professional's clinical privileges for a period of more than 15 days. The health facility must also report its restriction or acceptance of a professional's surrender of clinical privileges, if the professional is under investigation by the health facility or if there is an agreement in which the health facility agrees not to conduct an investigation. Lastly, the health facility must report a case in situations in which the professional resigns or the health facility does not renew the professional's contract in exchange for the facility's not taking disciplinary action. Such reporting must take place within 30 days of the disciplinary action.[42]

Business Agreements

Business lawyers should carefully review physician agreements for the presence of triggering events that could lead to termination of the physician's employment. Physicians can more easily be terminated where the conduct triggering such termination or professional review action is vague or broad. For example, in *Taylor v Spectrum Health Primary Care Partners*,[43] the court was faced with interpreting whether a physician engaged in "unethical behavior" warranting summary termination. In *Taylor*, there had been reports that the physician engaged in angry outbursts at work and that the physician acted unethically in the handling of a patient's deceased fetus. In particular, the physician preserved a fetus in a jar of formalin that was turned over to him for disposal by one of his patients who had suffered a miscarriage. Thereafter, he took the fetus home to show his daughters, who were interested in attending medical school, and also displayed it on other occasions. The physician was summarily terminated from employment because of the handling of the fetus, which the employer determined was "unethical behavior." In *Taylor*, the court held that the facts fell squarely within the employer's right of sole discretion to determine what constituted "unethical behavior," and thus the employer could terminate the physician under the circumstances.[44]

To further illustrate, in *Murphy v Goss*,[45] the physician, while on cardiac call, consumed one or two glasses of wine. The Oregon Medical Board found, in a final order, that the physician violated Oregon law by engaging in unprofessional conduct. Specifically, the board found that "consuming alcohol while on cardiac call places the physician at risk of impaired function, and as such, constitutes conduct which does or might adversely affect a physician's ... ability to safely and skillfully…practice medicine."[46] The board reported its final order to the NPDB.

Taylor and *Murphy* demonstrate how physician agreements can result in termination or credentialing issues, depending on the facts of the situation and the particular provisions of the physician agreement.

As such, business lawyers should analyze whether vague or ambiguous provisions in physician agreements are in their physician-client's best interest. This is particularly important because, as illustrated by *Taylor* and *Murphy*, issues related to staff privileges and credentialing can fall into vague or broad language of an agreement covering "unethical behavior" or "unprofessional conduct."

Likewise, business lawyers should be aware that a physician's contract may contain unique representations. For example, before being employed at a facility, physicians are typically asked to represent that they have:

> (1) no limits on a license to practice medicine in a specialty; (2) no conviction of, or plea of nolo contendere to, any felony or misdemeanor related directly or indirectly to the practice of medicine; (3) no conviction of, or plea of nolo contendere to, a felony or misdemeanor of any kind; (4) no exclusion or suspension from the Medicare or Medicaid program, and any other third-party payer program; (4) no revocation, suspension, or disciplinary

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> action related to medical staff privileges; (5) no revocation, suspension, limitation, or probation related to the practice of medicine; (6) maintenance of active hospital staff privileges; (7) participation in Medicare and Medicaid and other third-party payer programs.

Business lawyers should take care to review these provisions carefully with their physician-clients to ensure compliance.

Settlement Agreements

Oftentimes, physicians and other health care providers are involved in business litigation involving a variety of matters including, billing issues, vendor issues, and business break-ups. Most litigation results in a settlement agreement, so business lawyers should consider some important factors before recommending that their physician clients sign a settlement agreement. Specifically, business lawyers should consider what reporting requirements might arise under federal and state law (such as HCQIA, discussed herein), and what licensing issues might arise after settlement.

Business lawyers may want to consider asking opposing parties whether they intend to file a collateral peer review proceeding after the dispute has been settled. In this case, business lawyers may want to advise their client to reject such a settlement until there is a final decision on the peer review proceeding. In any settlement agreement involving challenges to staff privileges, business lawyers should include a provision that the settlement is a compromise and is not an admission of liability. Further, the settlement agreement should include a provision describing if or how the resolution will be reported to the NPDB or other entity. Without these provisions, physicians may become involved in another dispute with the hospital over the characterization of the staff privileges settlement. Below is sample language to include in a settlement agreement that may be helpful to address this issue:

> Physician and [other party] acknowledge that Physician's actions under this paragraph are not an admission or finding of any mistake by Physician or of any lack on the part of Physician to qualify for medical staff privileges. This Agreement, including the [specific actions, e.g., withdrawal of application], is a compromise of a legal dispute, made strictly to avoid the expense and stress of the hearing process and litigation. This Agreement, including the [specific actions, e.g., withdrawal of application], shall not under any circumstances be interpreted or used by either party as evidence of anything inconsistent with or contrary to this Agreement.

Legal Consultation Arising From an Adverse Staff Privileging Decision

Many times when physicians obtain an adverse decision that terminates their staff privileges, they request consultation from a business lawyer on whether they can seek relief in court. Oftentimes, the peer review process has been exhausted, and physicians desire to consult with a business lawyer on whether the court system may afford them a remedy. It should be noted that immunity under HCQIA covers only liability for damages; it does not shield covered defendants from a lawsuit or from other forms of relief.[47]

One of the most significant defenses to a lawsuit for *damages* arising from an adverse decision during the peer review process is immunity. HCQIA provides that hospitals and other participants are immune from claims for damages during a peer review *if* the following requirements are met: (1) the reason for the peer review is patient care, (2) the peer review is based on a reasonable investigation, (3) the physician was given fair process during the peer review, and (4) the investigation justifies taking an adverse action against the physician.[48] As a statutorily created immunity, HCQIA immunity is most commonly raised in a motion for summary judgment or motion to dismiss.

Insofar as the peer review process does not comply with all four HCQIA requirements, then the participants lose their immunity from a lawsuit for damages.

Specifically, HCQIA provides physicians with the rights: (1) to representation by an attorney or other person of the physician's choice; (2) to have a record made of the proceedings; (3) to call, examine, and cross-examine witnesses; (4) to present relevant evidence regardless of its admissibility in a court of law; and (5) to submit a written statement at the close of the hearing.[49] After the hearing, the physician has the right to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and to

receive a written decision of the healthcare entity, including a statement of the basis for the decision. If such rights are not provided to the physician, then the hospital may lose its HCQIA immunity for damages claims.

Brandner v Providence Health & Servs,[50] which was decided by the Alaska Supreme Court in 2017, provides an excellent legal discussion of the fact-intensive analysis that should be undertaken to determine whether a hospital is entitled to immunity for damages claims. In *Brandner*, the Alaska Supreme Court found that the hospital had lost the immunity defense because the physician was not given any opportunity to be heard prior to the termination of his hospital privileges. The court held that the physician was entitled to the notice and hearing protections under HCQIA *prior* to the termination of his hospital privileges. *Brandner* is also significant because the court disagreed with the hospital on whether dishonesty was grounds for summary suspension. The court stated, "We therefore disagree with the superior court's determination that the connection between Dr. Brandner's "dishonesty" and patient safety was sufficient to override Dr. Brandner's due process right, and we conclude that Providence violated Dr. Brandner's right to due process by terminating his hospital privileges without a pretermination opportunity to be heard."[51]

Thus, business lawyers should perform a fact-intensive review to determine if the HCQIA requirements were met during the staff privilege proceedings. If the requirements are not met, then a lawsuit for damages may be possible. However, it is important for business lawyers to cautiously advise their physician/clients that if they are unsuccessful in proving that the hospital did not comply with HCQIA that they could be subject to costs and attorneys' fees arising out of the lawsuit as provided in the statute.[52]

Conclusion

There is still much uncertainty about how health care law changes will affect physicians and other health care providers and the delivery of health care in the United States. The health care industry is never static, and now, health care law is in a state of flux. There will likely be many more changes facing health care providers in the years to come. Business lawyers should be prepared to be on the front line to help their health care clients navigate these changes and avoid confusion and disruption to their busy practices.

NOTES

1. Health care provider" or "provider," defined in MCL 550.1105(4), "means a health care facility; a person licensed, certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws; any other person or facility, with the approval of the commissioner, who or which meets the standards set by the health care corporation for all contracting providers; and, for purposes of section 414a, any person or facility who or which provides intermediate or outpatient care for substance abuse, as defined in section 414a."
2. MCL 333.17076(1).
3. MCL 333.17076(2).
4. MCL 333.17074(3).
5. MCL 333.17047.
6. MCL 333.17047(2)(a).
7. MCL 333.17047(2)(b).
8. MCL 333.17047(2)(d).
9. MCL 333.17047(2)(e).
10. MCL 331.18051.
11. MCL 333.17001.
12. MCL 333.17047(2)(f).
13. MCL 333.17047(2)(c).
14. MCL 333.16221(u).
15. MCL 333.17048(3).
16. MCL 333.17105(2).
17. MCL 333.17112(1).
18. MCL 333.17109.
19. MCL 333.17107.
20. MCL 333.17111.
21. MCL 333.17109.
22. MCL 333.17117(d).
23. No 330983, 2017 Mich App LEXIS 547 (Apr 6, 2017).
24. *Bureau of Health Professions v Serven*, 303 Mich App 305; 842 NW2d 561 (2013).
25. *Cudnik v William Beaumont Hosp*, 207 Mich App 378, 386; 525 NW2d 891 (1994).
26. 42 U.S.C. § 1395nn.
27. 42 USC 1395nn(h)(6).
28. 42 USC 1395nn(a)(1).
29. 42 USC 1395nn(a)(2)(B).
30. 42 USC 1320a-7b(b)(3)(B).
31. 183 F Supp 3d 1231 (SD Fla 2016).
32. *Marder* at 1316.
33. *See*, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 Fed. Reg. 70886 (Nov. 16, 2015) (to be codified in 42 CFR pts. 405, 410, 411, et al.)
34. *See* 80 FR 71315.
35. *See*, 42 CFR 411.357(a), 42 CFR 411.357(b), 42 CFR 411.357(d).
36. *See*, 42 CFR 411.353(g).
37. *See*, 42 CFR 411.357(l).
38. *See*, 42 CFR 411.354(c)(3)(i).
39. 42 CFR 411.357(y).
40. 42 USC 11101–11152.
41. 42 USC 11133.
42. MCL 333.20175(5).

43. No 323155, 2015 Mich App LEXIS 2311 (Dec 10, 2015 (unpublished).

44. *Id*. at *4.

45. 103 F Supp 3d 1234 (ED Or 2015).

46. *Id*. at 1237.

47. 42 USC 11111(a)(1) (specifying immunity from damages only and not mentioning other relief); *Singh v Blue Cross/Blue Shield of Massachusetts, Inc*., 308 F3d 25, 35 (1st Cir 2002).

48. 42 USC 11112(a).

49. 42 USC 11112(b)(3)(D).

50. 394 P3d 581 (2017) (subject to rehearing).

51. *Id*.

52. 42 USC 11113 (2011). *See*, *Dunning v War Memorial Hosp*, No 12-2540, 2013 US App LEXIS 16504 (6th Cir Aug 6, 2013) (district court did not abuse its discretion by awarding fees and costs for its defense as to physician's claims that were subject to immunity under Health Care Quality Improvement Act).

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