BUSINESS ATTORNEYS ON THE FRONT LINE: HEALTH CARE CONSIDERATIONS IN BUSINESS LAW

THERESAMARIE MANTESE AND FATIMA M. BOLYEA[1]

AN ATTORNEY PRACTICING BUSINESS LAW WILL LIKELY REPRESENT A HEALTH CARE PROFESSIONAL AT SOME POINT IN HIS OR HER CAREER. PERHAPS THE HEALTH CARE PROFESSIONAL IS SEEKING A BUSINESS DIVORCE FROM HIS PARTNERS, OR IS EMBROILED IN A CONTRACT DISPUTE WITH A FORMER COLLEAGUE OR HEALTH CARE ENTITY.

Resolving a business dispute for a health care professional is not as simple as it may first appear. There are areas of health care compliance that must be carefully considered by any attorney representing a health care professional to ensure that the attorney has not inadvertently left a client unprotected. While there is a myriad of health care laws which may come into play in the context of representing health care professionals, this article specifically focuses on peer review committees and hearings, privilege, immunity, and reporting requirements under both federal and Missouri law. This article then applies those principles to practical issues that business attorneys may encounter when litigating, arbitrating, or settling a dispute for a health care client.

Federal Law: Reporting Requirements and Peer Review Under HCQIA

Peer Review Under HCQIA

Peer review is a process in which health care professionals examine and critique the standard of care provided to patients by other health care professionals. The goal of peer review is to ensure that health care professionals and entities provide the highest-level quality of care to patients, and that potential problems are identified and remedied quickly and effectively.

The Health Care Quality Improvement Act of 1986[2] ("HCQIA") was passed by Congress "to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior."[3] To guarantee patient safety and ensure consistency throughout the country, Congress found a need "to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance," and believed that this "nationwide problem [could] be remedied through effective professional peer review."[4]

To address these concerns, Title IV of HCQIA led to the establishment of the National Practitioner Data Bank ("NPDB"), an information clearinghouse that collects information regarding actions taken by professional review bodies against physicians and other health care professionals. This includes "medical malpractice payments, adverse licensure actions, exclusions from

Federal or State healthcare programs, and negative actions or reports made against practitioners by hospitals."[5] Health care entities are required to report this information to the National Board of Medical Examiners. This information is stored in the NPDB, with information regarding disciplinary action taken against physicians made available to health care entities, federal and state licensing authorities, and health care providers.

Reporting Requirements under HCQIA

Reportable Events Involving Physicians

The Health Care Quality Improvement Act requires health care entities to report certain "reportable events" involving physicians to the National Board of Medical Examiners. These reportable events include when a health care entity:

> (A) takes a professional review action that adversely affects the clinical privileges of a physician for longer than 30 days;
> (B) accepts the surrender of clinical privileges of a physician –
> (i) while the physician is under investigation by the entity relating to possible incompetence or improper professional conduct, or
> (ii) in return for not conducting such an investigation . . . ; or
> (C) in the case of a professional society, takes a professional review action which adversely affects the membership of a physician in the society.[6]

HCQIA defines "professional review action" as:

> an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients) and which affects (or may affect) adversely the clinical privileges … of the physician.[7]

This includes "a formal decision . . . **not** to take an action or make a recommendation…and also includes professional review activities relating to a professional review action."[8]

"Investigation" Defined

Although HCQIA mandates reporting of any event resulting in a physician's surrender of his or her privileges while under investigation by the entity, the statute does not define the term "investigation." Courts interpreting a term have determined that, because it is not defined in the statute, "the Court 'must presume that Congress intended to give the term its ordinary meaning.'"[9] In *Doe v. Rogers*, the court found that "[t]he term 'investigation' is ordinarily understood to mean a systematic examination[,]" and that such a systematic examination exists where the health care entity gathered documents, met with executive officials regarding the incident, interviewed physicians and witnesses involved in the situation, "report[ed] the incident to the state health department, and [formed] a team to conduct a Root Cause Analysis."[10] As noted by the *Rogers* court, a "reportable event is based on an 'investigation' as that term is contemplated by the statute, not as contemplated by a health care entity's individualized and internal governing documents."[11] In other words, a court might not give total credence to how "investigation" is defined by the health care entity's governing documents if that definition differs from what is contemplated by the statute.

Similarly, the 1st Circuit Court of Appeals has held "that an 'investigation' ends only when a health care entity's decisionmaking [sic] authority either takes a final action or formally closes the investigation."[12] Pursuant to *Doe v. Leavitt*, an investigation includes "accepting a complaint, deciding to investigate, appointing an investigating committee, conducting fact-gathering, preparing to report, and so on and so forth, up to the point at which a professional review action is taken."[13]

Due to the broad nature of HCQIA, it has the potential to include numerous instances of alleged misconduct by physicians, even instances of misconduct which a physician may not realize could trigger the statute.[14] When a reportable event occurs, the "health care entity may report [the following information to the National] Board of Medical Examiners[:]" name of the practitioner; . . . "description of the acts or omissions or other reasons for the action" or surrender; and "such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate."[15] Due to the nationwide reach of the NPDB, a report to the databank can have far reaching and detrimental impacts on a physician's reputation and career.[16]

Non-Physician Health Care Practitioners

Physicians are not the only subset of health care practitioners covered under HCQIA. "A health care entity *may* [(but is not required to)] report . . . licensed health care practitioner[s] who [are] *not* physicians" to the Board of Medical Examiners in situations where the entity would be required to report physician practitioners.[17]

Missouri Law: Reportable Events and Peer Review

The Missouri Board of Registration for the Healing Arts (hereinafter, "the board") "administer[s] and execute[s] the statutes, rules, and regulations of the Healing Arts Practice Act."[18] The board's responsibilities include "promoting ethical standards, examination, licensure, regulation, investigation of complaints, and discipline of individuals practicing in the field."[19] Specifically, the board is responsible for making determinations regarding a licensee's ability to "practice his or her profession with reasonable skill and safety to the public."[20] The board may impose disciplinary actions upon licensees, which may lead to reporting to NPDB.

Reportable Events Under Missouri Law

Pursuant to Missouri law,

> . . . any entity that employs or contracts with licensed health care professionals to provide health care services to individuals *shall* report to the appropriate health care professional licensing authority any disciplinary action against any health care professional or the voluntary resignation of any health care professional against whom any complaints or reports have been made which might have led to disciplinary action.[21]

Missouri's definition of "health care professional" includes: a licensed physician or surgeon; a licensed dentist; a licensed podiatrist; a licensed pharmacist; a licensed psychologist; and a licensed nurse "while acting within their scope of practice."[22] Missouri's reporting statute encompasses more practitioners than just physicians; in this regard, the Missouri reporting statute is *broader* than HCQIA. In other words, while you may not be required to report a disciplinary action taken against a nurse or pharmacist under HCQIA, you *are* required to do so under Missouri law.

A "disciplinary action" is "any final action taken ... to reprimand, discipline or restrict the practice of a health care professional."[23] Importantly, only disciplinary actions which are "in response to activities which are also grounds for disciplinary actions according to the professional licensing law for that health care professional shall be considered disciplinary actions for purposes of [the statute]."[24] These disciplinary actions are discussed in the following section of this article. Importantly, HCQIA does not include such a limitation.

Reporting by the health care entity of a disciplinary action must occur "within fifteen days of the final disciplinary action."[25] The report must include *at least* the following information:

> (1) The name, address and telephone number of the person making the report;
> (2) The name, address and telephone number of the . . . subject of the report;
> (3) A description of the facts, including as much detail and information as possible, which gave rise to the issuance of the report . . . ; and
> (4) If court action is involved . . . , the identity of the court, . . . date of filing and the docket number.[26]

Missouri law is broader than HCQIA in this regard, as it requires significantly more information than HCQIA, including the contact information of the person making the report, and whether any court action is involved.

"[T]he licensing authority may, . . . [*u*]*pon request*, . . . furnish a report of any disciplinary action received by it" from the health care entity "to any [other health care] entity required to report under [§ 383.133]."[27] For example, a hospital considering granting privileges to a physician can request from the licensing authority a copy of a report filed by a different hospital regarding that physician. The "licensing authority may also furnish [a report], upon request, . . . to any other administrative or law enforcement agency."[28] However, "[n]either a report required to be filed under [the statute] nor the record of any proceeding [can] be used against a health care professional in any other administrative or judicial proceeding."[29]

Regarding potential causes of action against the licensing authority or the health care entity relating to reporting requirements, the Missouri statute provides that there shall be no liability on the part of any health care professional licensing authority, or any entity required to report, for any action taken in good faith and without malice in carrying out the provisions of § 383.133, RSMo 2010.

Causes for Disciplinary Action by the Board, and Reporting Requirements

A health care entity is required to report to the relevant licensing authority any disciplinary action responsive to "activities which are also grounds for disciplinary actions according to the professional licensing law for that health care professional."[30] Pursuant to § 334.100.1, "[t]he board may refuse to issue or renew any certificate of registration or authority, permit, or license" for any of the listed grounds.[31] Further, the board may file a complaint "with the administrative hearing commission . . . against any holder of any certificate of registration or authority, permit or license . . . or any person who has failed to renew" such certificate, permit, or license due to the grounds listed in § 334.100.2.[32]

The grounds listed in § 334.100.2 for disciplinary action are numerous. Indeed, the section includes more than 45 separately enumerated grounds for disciplinary action.[33] These include, for example:

> [u]se of any controlled substance . . . or alcoholic beverage to an extent that such use impairs a person's ability to perform . . . ; [u]se of fraud, deception, misrepresentation or bribery in securing any certificate[,][license, or permit]; "[m]isconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the [person's] functions or duties"; "attempting . . . by way of intimidation, coercion or deception, to obtain or retain a patient or discourage the use of a second opinion or consultation; . . . [w]illfully and continually performing inappropriate or unnecessary treatment"; and "[d]elegating professional responsibilities to a person who is not qualified . . . to perform such responsibilities."[34]

Publishing of Disciplinary Actions

While Missouri was, at one time, considered by some of its citizens and press outlets to be "secretive" about physician disciplinary hearings, the State has attempted to open up this information to the public.[35] For example, the board must now publish, at least quarterly, "a list of the names and addresses of all" licensees and "a list of all persons whose licenses have been suspended, revoked, surrendered, restricted, denied, or withheld."[36] Furthermore, "the board shall prepare and make available to the public a report [of] the disciplinary matters submitted to" the board that resulted in a recommendation by the board of "disciplinary action, *except* in [circumstances where the licensee] voluntarily enter[ed] treatment and monitoring programs for purposes of rehabilitation."[37] "Where the board does *not* recommend disciplinary action, [the board must prepare] a report stating that no action is recommended . . . and forward [that report] to the complaining party."[38]

Peer Review and Peer Review Committees

As discussed, there are specific reporting requirements that health care entities must follow under both Missouri and federal law. These reporting requirements take effect when a health care entity engages in disciplinary action against a health care professional. Generally, decisions on such disciplinary actions are considered and meted out by an entity's peer review committee. A "peer review committee" is defined as "a committee of health care professionals with the responsibility to evaluate, maintain, or

monitor the quality and utilization of health care services or to exercise any combination of such responsibilities."[39]

The peer review process will usually begin when a colleague of the licensee reports a complaint about the licensee to the health care entity. The health care entity may then refer the matter to its peer review committee, which will review the situation, possibly meet with the licensee, and vote on an action. At times, the peer review committee may recommend the creation of a subcommittee to conduct further meetings with the licensee and review patient records. The peer review committee might decide to approve conditional privileges, temporary suspensions, or other intermediate measures to monitor the licensee's actions and patient care. The specific makeup of peer review committees, and their processes, will usually be detailed in the health care entity's bylaws or peer review documents.

When Peer Review Collides with a Business Dispute

When a physician or other health care professional is involved in litigation, an attorney representing the professional must exercise caution, as there may be a health care issue lurking in the background that must be considered and addressed. For example, a health care professional may wish to split up the assets of a practice with his or her partners. However, if there is animosity remaining between the parties, and one party decides to go after the physician's license, this will trigger a new set of issues that neither you, nor your health care practitioner client, anticipated.

Settlement Agreements

When your health care client is facing a business dispute, settlement may be in the best interest of all parties involved. However, a settlement between two health care professionals, or between a health care professional and a health care entity, does not automatically protect your client from peer review actions, disciplinary actions, or reporting requirements. The parties to a settlement agreement *cannot* include in the agreement that neither party will report an otherwise mandatory reportable event or disciplinary action. Pursuant to state and federal law, if a reportable event occurs, the entity *must* report that event to the relevant licensing authority. Failure to do so can result in serious sanctions and repercussions against the health care entity, including loss of immunity under HCQIA, as discussed herein.

While parties to a settlement agreement cannot agree that they will refrain from reporting an otherwise reportable event, there are other ways parties can protect themselves during a negotiation. First, the parties may include mitigating language in the agreement that articulates the facts of the situation and each party's reasoning for settlement. This mitigating language should demonstrate to outside reviewers that peer review issues are simply not relevant to the situation. For example, if the settlement agreement involves the termination of your physician client, the language of the agreement should articulate facts that make clear that patient care was not an issue.

Such language is important because, if either party has settlor's remorse and seeks to report, for example, a physician's parting of ways with the health care entity, the mitigating language in the settlement agreement can provide powerful evidence that the reportable event was not a reportable event at all, but retaliation against your client. Many times, a settlement is between two health professionals in a group practice. If one party is unhappy with the settlement result, he or she might utilize the peer review process to retaliate against the opposing party. For example, the unhappy settling party may discuss his or her concerns with members of the hospital system, causing the hospital to scrutinize your client's records and performance, and leading to peer review on an unrelated matter. As such, the settlement agreement should make clear that there was nothing amiss with patient case, and include confidentiality and non-disparagement provisions.

If the settlement is between a health care professional and health care entity, the attorney for the professional should ask the health care entity whether it plans to engage in peer review or a disciplinary action. If the health care entity has not yet made this decision, the physician's attorney should consider waiting to complete a settlement until that decision had been made.

It is important for the attorney and his or her client to be aware that, pursuant to § 334.100, violation of a probation agreement, order, or other settlement agreement with the licensing board or other licensing agency can result in the board filing a complaint with the Administrative Hearing Commission and/or refusal to renew the professional's license. This can, of course, lead to a reportable event under HCQIA. As such, if

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each shareholder recognizes on the distribution. I.R.C. §§ 311(b), 1366, 1371. No additional gain would be recognized to the shareholders on receipt of the distribution as long as the fair market value of the distribution does not exceed the basis of the distributee shareholders in their stock, which will have been increased by the distribution, as mentioned above. I.R.C. §§ 1367, 1368.

50 I.R.C. §§ 743, 754.

51 I.R.C. § 338(h)(10).

52 I.R.C. § 704(b).

53 I.R.C. § 1361(b)(1)(D).

54 *See, e.g.*, Rev. Rul. 70-140, 1970-1 C.B. 73; Rev. Rul. 68-349, 1968-2 C.B. 143.

55 I.R.C. § 108.

56 I.R.C. § 108(a)(1)(B).

57 I.R.C. § 108(e)(7).

58 I.R.C. § 108(e)(6).

59 I.R.C. § 751.

60 Rev. Rul. 69-184, 1969-1 C.B. 256.

61 I.R.C. § 731.

62 A rare exception would be if the corporate transaction is able to meet all of the stringent requirements of a divisive reorganization under I.R.C. § 355.

63 21 percent of 100 percent (21 percent) plus 20 percent of 79 percent (100-21) (15.8 percent) plus 3.8 percent of 79 percent (100-21) (3 percent) = 39.8 percent.

64 This is comprised of the 20 percent capital gains tax under I.R.C. § 1(h) and the 3.8 percent net investment income tax under I.R.C. § 1411 and assumes a 12-month or greater holding period.

65 *See* I.R.C. § 1202.

66 This is comprised of the 20 percent capital gains tax under I.R.C. § 1(h) and the 3.8 percent net investment income tax under I.R.C. § 1411 and assumes a 12 month or greater holding period.

67 *See* I.R.C. § 705 (partnerships) and § 1367 (S corporations).

68 *See* I.R.C. § 751.

69 This is for the simple reason that the I.R.C. § 1202 exclusion from gain does not apply to sales of interests in pass through entities.

70 This would be by virtue of an I.R.C. § 754 election in the case of a partnership or an I.R.C. § 338(h)(10) election in the case of an S corporation.

71 I.R.C. §1202.

72 I.R.C. § 368.

73 I.R.C. § 751.

74 This would be by virtue of an I.R.C. § 754 election in the case of a partnership or an I.R.C. § 338(h)(10) election in the case of an S corporation.

75 *See* I.R.C. §§ 56(c)-(g) (1986) (as repealed by Pub. L. 115–97, 131 Stat. 2054, 2092-2094 (2017).

76 I.R.C. § 101(a)(2).

77 I.R.C. § 1411(c).

78 *See*, e.g., *Spicer Accounting, Inc. v. United States*, 918 F. 2d 90, 93 (9th Cir. 1990).

79 Rev. Rul. 69-184, 1961-1 C.B. 256.

80 Liquidation of the C corporation to convert to a partnership could cause a double tax and conversion of a C corporation to an S corporation could cause an S corporation level tax under I.R.C. §§ 1374 or1375, or cause a LIFO recapture tax under I.R.C. § 1363(d).

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your client enters into a settlement agreement with the board or a licensing agency, he or she must be sure to abide by its terms.

The attorney should also consider how a settlement that results in the practitioner parting ways with the health care entity will affect the practitioner's day-to-day practice. Does the health care entity provide software or online technology to practitioners with privileges to which the practitioner will lose access after the settlement? If so, the parties should consider whether they can come to an agreement in which the practitioner is permitted to use the software for a period, until he or she is able to transfer his or her files to a new system. Otherwise, the practitioner may be locked out of his or her record-keeping system or be forced to utilize an inefficient system.

Lastly, the settlement agreement should resolve all pending and future claims between the parties. This is particularly true in a situation involving members of a practice group seeking to part ways. All issues should be resolved by the settlement agreement. For any issues that cannot be contemplated and remedied at the time the settlement agreement is signed, the parties should agree that if any such unintended situation arises (such as an audit), the parties will work in good faith to remedy the situation cooperatively.

Business Divorce

Health care practitioners regularly enter into business agreements with colleagues to open and jointly own and run health care practices. When relationships sour, and the practitioners seek a "business divorce," business attorneys must keep in mind the following issues.

Records. Hopefully, the divorcing partners will have implemented an organized filing system that permits the easy separation of records upon a splitting up of the practice. However, many times this is not the case. As such, the parties will have to determine how records will be divided and which practitioner retains which records. During this determination process, practitioners must ensure compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), which sets forth strict privacy requirements for patient health records and information. It is essential that the parties designate one of the practitioners to retain the records and be the "records custodian." This is important because, if peer review is triggered in the future based on an event that took place while the parties were in practice together, those records might ultimately be subpoenaed by a peer review group or health care entity. The practitioner should be familiar with the location of those records to ensure he or she can obtain access to them if necessary.

Business Operating Agreement. In dealing with a business divorce, the operating agreement can, of course, provide helpful insight and a potential roadmap to how the split will proceed. Among other things, the operating agreement may explain how assets will be divided, the process for handling patents and other intellectual property, and the division of business and patient records. While it would be helpful for health care professionals entering into practice together to have an operating agreement that covers all potential issues and outcomes, it is likely the parties may inadvertently leave out important subjects. Clients should be aware that the parties may amend the operating agreement or add an addendum to address any issues that were missed when the operating agreement was first drafted. Importantly, for purposes of peer review, some operating agreements may include a trigger clause, which requires the practitioner to exit the practice, sell his ownership

interest, or restrict his practice if disciplinary action is taken against the practitioner. Attorneys must keep this in mind when representing clients in disciplinary proceedings, and review all relevant business documents to determine repercussions for disciplinary action.

Physician Self-Referral Law (Stark)[40] and Anti-Kickback Act. As with any financial transaction involving physicians, a business divorce must always consider issues involving Stark and the Anti-Kickback Act of 1986. For example, if financial remuneration is going to pass between the parties, attorneys must be cognizant of the Stark law and Anti-Kickback Act to make sure any such payments are compliant with the statutes.

The Anti-Kickback Act provides that:

> (1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind –
>
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
>
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony.[41]

One way in which this may occur within a business divorce is where practitioners decide to split up the practice, but retain a shared space, shared employees, or close relationship, such as the one described in *United States ex rel. Cairns v. D.S. Medical LLC.*[42] During a business divorce, if practitioners wish to carry on business with each other in some form, they must be cautious not to run afoul of the Anti-Kickback Act.

In 1989, Congress passed the Omnibus Budget Reconciliation Act (Stark I), which prohibits financial relationships between physicians and clinical laboratories to which they refer patients.[43] In 1993, Congress passed the Omnibus Budget Reconciliation Act (Stark II), which expanded the 1989 act to prohibit referrals of "designated health services" to any entity with which the physician or immediate family member has a financial relationship.[44] This includes hospitals, clinical laboratories, or other entities providing health services.

The financial relationships prohibited under Stark include: "an ownership or investment interest in the entity, or . . . a compensation arrangement . . . between the physician (or an immediate family member of such physician) with an entity."[45] "An ownership or investment interest … may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service."[46] Stark provides several exceptions to both the ownership and compensation arrangement prohibitions.[47] As with the Anti-Kickback Act, practitioner partners seeking a business divorce must consider how their ongoing relationship will look, and the ongoing ownership structure of the practice.

Privilege and Immunity

Actions taken against a health care practitioner that target their credentials, privileges, and license can have long-lasting, devastating effects on the practitioner's career and reputation. Understandably, some physicians will seek to obtain redress for these actions through the court system. Can practitioners obtain damages and other relief from health care entities and licensing authorities that have engaged in peer review and/or disciplinary actions against them? What obstacles will these practitioners encounter? Which documents can a practitioner enter into evidence or obtain during discovery? Two important considerations that practitioners must factor into any decision whether to sue are: (1) privilege, and (2) immunity.

Peer Review Immunity Under Federal Law. "Congress believed that effective peer review would be furthered 'by granting limited immunity from suits for money damages to participants in professional peer review actions.'"[48] As such, HCQIA provides immunity to individuals participating in the peer review process. Specifically, "[i]f a professional review action . . . of a professional review body [satisfies] standards" set forth in § 11112(a), then

> (A) the professional review body,
> (B) any person acting as a member or staff to the body,
> (C) any person under a contract or other formal agreement with the body, and
> (D) any person who participates with or assists with the action, shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action."[49]

Further, no person acting as a witness to the professional review body, or

> providing information to a . . . review body, regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) *unless such information is false and the person providing it knew that such information was false.*[50]

HCQIA immunity is not limitless.

> [F]or there to be immunity . . ., the professional review action must be taken:
> (1) in the reasonable belief that the action was in furtherance of quality health care,
> (2) after a reasonable effort to obtain the facts of the matter,
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).[51]

HCQIA creates "a presumption that these requirements have been met unless the presumption is rebutted by a preponderance of the evidence."[52] The 8th Circuit has "held that the reasonableness requirements contained in section 11112(a) necessitate an objective inquiry."[53] Health care entities failing to substantially meet HCQIA's reporting requirements will lose the immunity provided by § 11111.

Peer Review Immunity Under Missouri Law. As with many other states, Missouri provides immunity to civil liability for members of, and those participating in, the peer review process. Pursuant to Missouri law, each member of a peer review committee and any person who testifies before, provides information to, or acts upon the recommendation of such a committee, "shall be immune from civil liability for such acts so long as the acts are performed in good faith, without malice and are reasonably related to the scope of inquiry of the peer review committee."[54]

Immunity statutes such as this permit health care professionals and those who assist them in the peer review process to provide information openly and honestly about the standard of care provided to patients by health care professionals, without fear of litigation or retaliation.[55]

Privilege and Confidentiality Under Missouri Law. Under Missouri law, documents and findings utilized, reviewed, or created by the peer review committee during its review process are privileged and confidential. Specifically, the

> interviews, memoranda, proceedings, findings, deliberations, reports, and minutes of peer review committees, *or the existence of the same*, concerning *the health care provided any patient* are privileged and . . . not subject to discovery, subpoena, or other means of legal compulsion . . . or be admissible into evidence in any judicial or administrative action for *failure to provide appropriate care*.[56]

A careful review of this provision is necessary, as there are a number of limiting situations.

First, the privilege applies only to documents and findings that concern the health care provided any patient. As such, the privilege does not apply or extend to "any judicial or administrative action brought by a peer review committee" that seeks to "deny, restrict or revoke the hospital staff privileges or license to practice of a physician or other health care providers," "or when a member, employee, or agent of the . . . committee or the legal entity which formed [the] committee" is sued by the physician or health care provider for "den[ial], restrict[ion] or revo[cation] [of the physician's] hospital staff privileges or license to practice."[57]

Next, "information otherwise discoverable or admissible from original sources is not be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before a peer review committee."[58] Further, a member of the committee, or "person appearing before it, [is not] prevented from testifying as to matters within his personal knowledge … but such witness cannot be questioned about testimony or other proceedings before any health care review committee or board or about opinions formed as a result of such committee hearings."[59] Lastly, the privilege does not extend to subpoenas for information sought by a health care licensing board of the state, even if that information would otherwise be confidential.[60]

Unlike Missouri, there is currently no federal peer review privilege statute providing for privilege or confidentiality of peer review information and documents. Thus, an attorney practicing in Missouri must be aware of the privilege under state law, and ways to work around it (if representing a physician) or enforce it (if representing the health care entity).

Application to Litigation. What does this mean for litigation? The immunity and privilege protections provided to health care entities by federal and state law create unique challenges for a health care professional seeking to sue a health care entity. Attorneys must determine whether the entity satisfied HCQIA's requirements for a professional review action. Was the physician provided adequate hearing and notice procedures? Did the health care entity act in the reasonable belief that the action was in furtherance of health care, and after a reasonable effort to obtain the facts? Lastly, did the entity act in the reasonable belief that the action was warranted? If the attorney can answer each of these questions in the affirmative, it is likely the health care entity will be immune from money damages.

Regarding privilege and confidentiality, an attorney representing a health care professional wishing to sue a health care entity should be familiar with the privilege and the various limitations and exceptions. For example, if the health care professional sues the health care entity for revocation of his or her staff privileges, then the privilege and confidentiality elements of Missouri law do not apply, as the privilege does not extend to any judicial action brought by the health care provider for denial, restriction, or revocation of the physician's hospital staff privileges or license to practice. This will be extremely helpful for a health care provider wishing to sue, as he or she will not be cut off from access to memoranda, documents, and notes drafted by the committee.

Lastly, attorneys should consider the forum in which they wish to litigate, mediate, or arbitrate. Anything placed on the record in open court will, of course, be public record and easily discoverable in a later peer review action or litigation. Clients wishing to bring litigation against health care entities or health care professionals should consider the benefits of arbitration (which may provide more confidentiality and less publicity) or moving forward to an early mediation. Such decisions will depend on client goals and the particulars of the situation.

Conclusion

Health care is a complex area of the law, which changes with every passing day. Any business attorney seeking to represent physicians, health care entities, or health care practitioners must have at least a basic understanding of the statutes and issues discussed. Of course, this article cannot – and does not – address

every potential health care issue that may arise during a business dispute between health care professionals. Accordingly, a business attorney representing a client in the health care industry should strongly consider consulting with a skilled health care attorney to ensure he or she has not inadvertently missed a crucial issue. The failure to recognize and address such issues (particularly the ones discussed herein) can have devastating and long-lasting effects on a health care client.

Theresamarie Mantese

Fatima M. Bolyea

Endnotes

1 Theresamarie Mantese is a partner at Mantese Honigman, P.C. in Troy, Michigan. Ms. Mantese has over 34 years' experience as a business and health care attorney. She focuses her practice primarily on representing and advising health care providers and professionals in matters such as group practice and other business organizations, contracts, third party payer audits and reimbursement, fraud-and-abuse issues, professional license disciplinary actions, hospital staff privilege actions, legislative issues and joint ventures. Fatima M. Bolyea is an associate at Mantese Honigman, P.C. in Troy, Michigan. Ms. Bolyea specializes in complex commercial litigation, shareholder business disputes, and health care law.

2 Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784.

3 *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 911 (8th Cir. 1999).

4 42 U.S.C. § 11101(2)-(3).

5 *Walker v. Memorial Health System of E. Tex.*, 231 F.Supp.3d 210, 213 (E.D. Tex. 2017).

6 42 U.S.C. § 11133(a)(1).

7 42 U.S.C. § 11151(9).

8 *Id.* (emphasis added).

9 *Doe v. Rogers*, 139 F.Supp.3d 120, 137 (D. D.C. 2015).

10 139 F.Supp.3d at 137-38.

11 139 F.Supp.3d at 142.

12 *Doe v. Leavitt*, 552 F.3d 75, 86 (1st Cir. 2009).

13 552 F.3d at 84.

14 *See e.g., Murphy v. Goss*, 103 F. Supp. 3d 1234, 1237 (D. Or. 2015), *aff'd*, 693 F. App'x 636 (9th Cir. 2017) (physician, while on cardiac call, consumed wine; Oregon Medical Board found the plaintiff violated Oregon law by engaging in unprofessional conduct); *Moore v. Williamsburg Reg'l Hosp.*, 560 F.3d 166 (4th Cir. 2009) ("A physician's competence can be implicated by conduct outside a health care facility if there is a clear nexus between that conduct and . . . patient care.") *Id.* at 172; *Kolb v. Northside Hosp.*, 802 S.E.2d 413, 418-19 (Ga. Ct. App. 2017) (hospital satisfied presumption that it acted in the reasonable belief that suspension of physician was in furtherance of quality health care where physician told individuals she carried a gun on campus).

15 42 U.S.C. § 11133(a)(2)-(3) (emphasis added).

16 *Walker v. Mem'l Health System of E. Texas*, 231 F.Supp.3d 210 (E.D. Tex. 2017) ("An adverse report on the NPDB that deems a surgeon to have 'substandard or inadequate skill' is intrinsically harmful to that surgeon's practice, professional reputation and livelihood.") *Id.* at 216.

17 42 U.S.C. § 11133(a)(2).

18 *About the Board,* Missouri Board of Registration for the Healing Arts, https://pr.mo.gov/healingarts-about-the-board.asp (last visited June 11, 2018).

19 *Id.*

20 Section 334.099.1(1), RSMo 2016.

21 Section 383.133.1, RSMo 2016.

22 Section 383.130(2), RSMo 2016.

23 Section 383.130(1), RSMo 2016.

24 *Id.*

25 Section 383.133.2, RSMo 2016.

26 Section 383.133.2(1)-(4), RSMo 2016.

27 Section 383.133.3, RSMo 2016.

28 *Id.*

29 Section 383.133.5, RSMo 2016.

30 Section 383.130(1), RSMo 2016. These grounds for disciplinary actions are listed, in detail, for the various health care professionals throughout Chapter 334 of Vernon's Annotated Missouri Statutes. Section 334.100, RSMo 2016 covers health care licensees generally.

31 Section 334.100.1, RSMo 2016.

32 Section 334.100.2, RSMo 2016.The Administrative Hearing Commission is an administrative body consisting of no more than five appointed commissioners (attorneys who shall not practice law during their term of office). Section 621.015, RSMo 2016. The Administrative Hearing Commission is tasked with "conduct[ing] hearings and mak[ing] findings of fact and conclusions of law in those case when, under the law, a license issued by any of the [listed] agencies may be revoked or suspended or when the licensee may be placed on probation." Section 621.045, RSMo 2016.

33 *See* § 334.100.2(1)-(27), RSMo 2016, and all subparts.

34 Section 334.100.2(1)-(4), RSMo 2016.

35 Jeremy Kohler, *Missouri Secretive, Lax on Doctor Discipline*, ST. LOUIS POST-DISPATCH (Dec. 12, 2010), http://www.stltoday.com/news/local/metro/missouri-secretive-lax-on-doctor-discipline/article_5cc342ba-dd6c-5428-b25e-99f8faeca638.html; Jeremy Kohler, *Missouri Patients Can Now Find Out More About Their Doctors*, ST. LOUIS POST-DISPATCH (Sep. 9, 2011), http://www.stltoday.com/news/local/metro/missouri-patients-can-now-find-out-more-about-their-doctors/article_67f7de3c-27ec-5e80-a900-a302d83a9b65.html.

36 Section 334.101.1, RSMo 2016.

37 Section 334.101.2, RSMo 2016 (emphasis added).

38 *Id.* (emphasis added).

39 Section 537.035(2), RSMo 2016.

40 42 U.S.C. § 1395nn; commonly referred to as the Stark law.

41 42 U.S.C. 1320a-7b(b)(1).

42 *United States ex rel. Cairns v. D.S. Med. LLC*, No. 1:12CV00004 AGF, 2015 WL 590325 (E.D. Mo. Feb. 11, 2015) (physician and distributor of spinal implant devices accused of violating False Claims Act and Anti-Kickback Act where physician's company "rented space from" distributor's company; "shared employees and contractors"; and where physician used distributor's company as "'virtually exclusive source' of spinal implant devices"). *Id.* at *1.

43 Omnibus Budget Reconciliation Act of 1989, Pub.L. No. 101-239 § 6204, 103 Stat. 2106, 2236-2244.

44 Omnibus Budget Reconciliation Act of 1993, Pub.L. No. 103-66 § 13562, 107 Stat. 312, 596-605.

45 42 U.S.C. § 1395nn(a)(2).

46 *Id.*

47 These exceptions can be found in 42 U.S.C. § 1395nn.

48 *Sugarbaker*, 190 F.3d at 911.

49 42 U.S.C. § 11111(a)(1).

50 42 U.S.C. § 11111(a)(2) (emphasis added).

51 *Sugarbaker*, 190 F.3d at 912 (quoting 42 U.S.C. § 11112(a)).

52 *Wayne v. Genesis Med. Ctr.*, 140 F.3d 1145, 1148 (8th Cir. 1998).

53 *Sugarbaker*, 190 F.3d at 912. *See Lee v. Trinity Lutheran Hosp.*, 408 F.3d 1064 (8th Cir. 2005) ("hospital acted in a 'reasonable belief that [revoking physician's privileges] was in furtherance of health care'" where hospital confirmed its concerns with plaintiff's mixing prescribed drugs to patients; other physicians "believed that Dr. Lee had not conducted an adequate work-up" for a different patient; and the Peer Review Committee had noted problems in other patient charts.) *Id.* at 1071; *Johnson v. SSM Healthcare System*, 988 F.Supp.2d 1080, 1088 (E.D. Mo. 2013), *aff'd*, 583 F. App'x 591 (8th Cir. 2014) (unpublished) (termination of physician's staff privileges qualified for immunity under HCQIA; on summary judgment motion, the court "must determine whether the physician satisfied his or her burden of producing evidence that would allow a reasonable jury to conclude that the hospital's peer review process failed to meet the standards of the HCQIA.").

54 Section 537.035(3), RSMo 2016.

55 *See State ex rel. Lester E. Cox Med. Ctrs. v. Darnold*, 944 S.W.2d 213, 215 (Mo. banc 1997) (The Missouri peer review statute was enacted "to encourage health care professionals to engage in candid, critical analysis of their peers' performance by shielding participants from liability for their comments during peer review."). *Id.*

56 Section 537.035(4), RSMo 2016 (emphasis added).

57 Section 537.035(5), RSMo 2016.

58 Section 537.035(4), RSMo 2016.

59 *Id.*

60 Section 537.035(6), RSMo 2016.