

**HEALTHCARE ORGANIZATIONS  
FALL 2003  
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**TEXT**

**FURROW, GREANEY, JOHNSON, JOST, SCHWARTZ, HEALTH LAW & 2003  
SUPPLEMENT**

***What is Health Care Organizations?***

The field of health law might be broken up into three areas: financing, business/regulatory, and bioethics. This course focuses on the business/regulatory aspects of the health care industry, most frequently focusing on hospitals and managed care organizations, and their respective relationships with doctors.

This class will literally mimic the daily life of the general health attorney – exposing you to the various areas of law she encounters every day in practice – licensure, corporate, tax, fraud and abuse, employment and antitrust. Professor Jacobi/Greaney teaches the Health Care Financing Course, and Professor Coleman teaches the bioethics survey class.

***Do I need to have a health care background to do well in this class?***

No. This is a law class. It simply applies the law to a particular industry. It is my responsibility to ensure that you have the necessary knowledge about the industry to interpret the law.

You should look at the fact that there may be health care professionals in the class as an advantage – they can talk about their specific experiences, and enable you to learn even more.

***Are JD/MSJ/LLM students graded against each other?***

No. I use a separate curve for each degree program.

***Is this class primarily for students who are interested in health law as a career?***

No. Actually, it's a great course for any student who desires to begin integrating the various areas of law you are encountering. Health Law is essentially a business course that uses doctors and hospitals as its clients.

***Other interesting/necessary facts about this class:***

1. Attendance Policy. I adhere to the attendance policy.
2. Exam. The final exam will be a 24 hour self-scheduled take home exam that will be first made available on the first day of exams.
3. Handouts. I will post handouts on TWEN so that you can retrieve them at your convenience.

**Tentative Syllabus**

This is not a bar exam class. Consequently, there is not any driving force that compels us to rush through the material. That being said, I will try to pace the class according to your apparent interests, which means that we will go faster or slower depending upon how well you are prepared, and how much you participate (this means we go faster if you haven't read and/or don't talk).

**Aug. 25**

**Introductory class**

Although this is not a financing course, I use a very simplistic exercise in this class to give you a brief historical background on health care financing that will (a) enable you to understand why the industry functions as it does (b) what's going on with Medicare right now; and (c) ensure that everyone in the class is on a level playing field.

**Aug. 27**

**1-16**

This class should reinforce what happened in Monday's class. Further, it gives you some insight into the challenges of deciding what health insurance should pay for, irrespective of the reimbursement system we adopt in the United States.

**Sept. 1**

**No class – Labor Day**

**Sept. 3**

**17-64; Supplement 1-11**

Quality of the medical care we receive has been much in the news of late. From a legal/policy perspective, we'll need to decide whether achieving quality is best incentivized by adopting the "aviation" self-reporting model, the tort system, licensure, or institutional quality assurance (by hospitals and third party payors). This section gives you the medical/health services information you will need to make informed judgments about the legal/policy questions.

**Sept. 8**

**92-108; Supplement 18-21**

Whom should the state license and why? What is the state's goal in regulating individual practitioners – safety or quality or both? Should the state license all varieties of health care practitioner, irrespective of whether their methods are believed to be efficacious, or should the state limit licensure to individuals who offer proven treatment methods? Is there a bias by medicine against alternative healing approaches that makes it unfair (aka anticompetitive) to only recognize allopathic medicine (MDs, DOs, nurses)? When should the state take away someone's license?

**Sept. 10**

**Guest Speaker**

Representing either the licensing agency for physicians, in New Jersey, is the Board of Medical Examiners, which falls within the Division of Consumer Affairs requires knowledge of administrative law and practices. Deputy Attorneys General represent the licensing agency. Obviously, private practitioners who specialize in representing physicians appear before the board.

**Sept. 15**

**434-50; Supplement 53-60**

Another mechanism for achieving quality in the health care system is the Tort System. We do not cover the material that deals with physicians' individual liability. Rather, we focus on the various legal avenues for liability of institutions that are in a position to oversee physicians' practices.

**Sept. 17**

**451-469; Supplement 60-101**

Institutional tort liability affects how corporate attorneys structure various business deals and employment relationships. They must identify structures that achieve the client's business goals with maximum insulation from liability.

**Sept. 22**

**751-770; Supplement 158-65**

Consider whether the professions, which have a monopoly on their services through state licensure, have a special duty to serve the public, even at potential risk of personal harm or when the patient/client cannot pay for the services. In what circumstances do we want to make sure that everyone has access to professional services? Should the law enforce this moral obligation? Should there be a method of compensation or, at least, a means to spread the burden among all professionals?

**Sept. 24**

**770-92; Supplement 158-65**

What obligations should hospitals have to serve those who cannot pay – to what extent?

**Sept. 29-Oct. 8**

**795-840; Supplement 168-97**

Traditionally, physicians are not employed by hospitals, but obtain “medical staff membership” and “clinical privileges.” Further, interestingly, physicians have significant power over how the hospital is run, and can affect the hospital’s ability to generate revenue by how they practice. Frequently, despite the amount of power physicians wield over hospitals’ operations, their respective interests are not aligned. Much of current law and policy development has focused on this conundrum.

**Oct. 13, 15**

**841-61; Supplement 198-214**

Hospitals are overwhelmingly not-for-profit corporations, which is actually an oxymoron, because hospitals may and should generate profit. What the concept actually means is that they cannot distribute their profits to shareholders, but should reinvest them into patient care either by providing higher quality care, providing lower priced care, or serving the indigent and uninsured. Whether hospitals fulfill this expectation of charity is an oft-debated question. Since nfp hospitals do not have shareholders, oversight of nfp boards is a significant question, especially post-Enron.

**Oct. 20, 22**

**865-85; Supplement 215-16**

The Corporate Practice of Medicine is considered by many to be an historical anachronism. Lawyers spend much time working around it. What are the policy reasons for the doctrine, and should it be maintained?

**Oct. 27**

**886-898; Supplement 216-17**

Non-profit corporations are generally, though not always, exempt from state and/or federal taxes. An entity can be tax-exempt at the federal level, but not at the state level, because some states apply different philosophies and tests to the determination of exempt status. What is the rationale for tax exemption? What health care entities merit tax exemption? What are the tests, and do they make sense?

**Oct. 29 – Nov. 3**

**899-914; Supplement 217-18**

Why does the IRS treat managed care entities differently? Does it make sense?

**Nov. 5, 10**

**914-942; Supplement 218-26**

What are the clients in these cases up to? Why should the government allow nfp entities to joint venture with for-profit organizations? Who pays taxes and when?

**Nov. 12**

**943-966; Supplement 227-37**

What is the purpose of fraud laws as applied to health care providers?

**Nov. 17-19**

**966-988; Supplement 237-38**

What are the government's public policy goals for its application of the Anti-kickback Statute to providers? Are the kickback laws the appropriate mechanism for accomplishing these goals? Do the kickback laws stifle legitimate and important methods of doing business? Should the government be even more aggressive in pursuing "fraud and abuse"? Make sure that you pay attention to whether the particular statutes you are studying are civil or criminal, what the scienter requirement is, and who may pursue the claim. Familiarize yourself with the HHS OIG Web page, which is a "favorites" for all health attorneys.

**Nov. 24**

**984-1006; Supplement 238-246**

What legal authority do advisory opinions have?

**Dec. 1-4**

**1007-84; Supplement 247-66**