AHLA WEEKLY
3/6/2020

Compliance Considerations When Closing a Hospital

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Across the country, in both urban and rural areas, hospital closures have been occurring at an unprecedented pace, and it appears many more hospitals are susceptible to closure or to discontinuation of inpatient services. A recent report from the Chartis Center for Rural Health found over 450 rural hospitals as vulnerable to closure. And the highly publicized 2019 closure of Hahnemann University Medical Center—a teaching hospital serving as a safety net provider in Philadelphia—brought into high relief the adverse effect of urban hospital closures on medically underserved communities, the impact of teaching hospital closures on medical residency programs, and the reality that struggling hospitals may be controlled by for-profit investors rather than charitable organizations.[1]

For hospital and health system leadership, including the General Counsel, a hospital closure presents complex legal, regulatory, communications, and reputational challenges that must be anticipated and proactively managed to meet fiduciary obligations. A lack of good planning may slow the closure process, and very likely will increase legal exposure and generate adverse public attention.

Key Compliance Considerations

Hospital closures tend to be wildly unpopular events. Indeed, they frequently roil the local community and its elected officials due to concerns about access to care, disproportionate impact on medically underserved residents, and elimination of hospital jobs and related business activity. Emotions run high, as patients, physicians, and employees feel abandoned, and the larger community experiences the looming loss of an anchor institution. It is against this highly charged backdrop that hospital leadership must close the facility in a safe and compliant manner.

Overall, there are several compliance categories that should be considered:

Approval of Hospital Closure. While the particulars vary from state to state, in some jurisdictions a Certificate of Need board or other state agency has authority to approve or disapprove the plan for closing a hospital.[2] Moreover, the hospital licensing agency often will oversee the closure to monitor patient safety. If the hospital is a charitable organization, the state Attorney General's charitable trust division may oversee disposition of charitable assets.

A threshold risk for hospital leadership is that one or more of these government bodies will not approve the proposed closure on the terms proposed. This risk increases commensurate with the degree of resistance in the community to the closure. It is imperative to understand these approval requirements well in advance and to develop an integrated legal, communications, and advocacy strategy that culminates in a detailed closure plan that is sensitive to community concerns and is compliant with regulatory approval requirements. If resources permit, one element of this plan may offer a means for high priority non-hospital care to be placed in the community.

Legal and Regulatory Compliance. Once leadership has secured any necessary approval to close the hospital, the closure itself must be implemented in a legally compliant manner. This will require

timely notice of closure to numerous federal and state agencies, including Medicare and Medicaid, as well as to vendors and other contracting parties (such as payers).

From a staffing perspective, employees likely will be entitled to federal and state Worker Adjustment and Retraining Notification (WARN) Act protection.[3] A unionized workforce also may complicate the termination process. Aside from legal or contractual obligations, a hospital that communicates in a timely and respectful manner with employees about the closing, and facilitates the transition to new employment, likely will improve employee acceptance of the closing.

Similarly, constructive interface with the medical staff will be critically important. Hospital leadership also will need to determine how the medical staff will be dissolved, and how medical staff records will be maintained and accessed post-closing. With the announced closing, medical staff members may be inclined to refer patients to other area hospitals. To the extent possible, an open dialogue about this with key medical staff members may smooth the wind down of service lines and enhance patient safety.

Under Medicare voluntary termination requirements, CMS and the public must be notified of the imminent hospital closure.[4] State licensing law typically imposes a comparable obligation, along with a requirement to store medical records and afford patients a means to access them.

If the facility is a teaching hospital, it is advisable to take immediate measures to help assure that current residents are transitioned to another program. The recent closure of Hahnemann University Hospital brought this issue into high relief, as almost 600 medical residents experienced tremendous uncertainty as to their fate.[5] The rules around immediate transfer of residents and their funding are complex; the American Association of Medical Colleges (AAMC) has helpful resources and guidelines.[6]

Patient Safety. Maintaining patient safety can be very difficult in the time period between announcement of the closure and the closure itself. The longer this interim period, the more challenging patient safety becomes because key clinical and non-clinical staff, along with medical staff members, are likely to depart. It is essential to closely monitor patient care, with service line closures and patient transfers to occur as indicated. Because this can be complicated by any regulatory approvals needed before a service line can be discontinued, staying in close communication with state hospital licensing authorities may be beneficial. In any event, it is imperative to collaborate with other area hospitals that can accept transferred or diverted patients.

The emergency department merits special attention, because of the relatively high acuity of patients, especially those arriving by ambulance, and the possibility that women in active labor may present. Close coordination with emergency department staff should be a high priority. Among other things, a protocol should be implemented to assess if the hospital needs to go on ambulance bypass or to address any clinical concerns about the hospital's capacity to treat patients arriving in the emergency department.

The Impact of Staff and Community Resistance. As indicated at the outset, hospital closures are highly emotional events for the community, and for the elected officials who represent it. While vocal community resistance to the closure may be inevitable, certain measures may soften this response and open a dialogue about the community's most pressing health care needs going forward. Aside from scrupulous regulatory compliance and the concurrent development of a detailed closure plan, robust and timely communications with community leaders is important.

In contrast, community activism in opposition to hospital closure certainly can create adverse media attention and reputational harm. Beyond that, as has been seen in Hahnemann and beyond, it can be the cause of litigation or government opposition to the closure.

Leadership Role

In the face of a hospital closure, the governing board and executive leadership team must remain engaged and organized, regardless of the inherent difficulties in doing so. A detailed closure plan is advisable, with assigned responsibilities to assure that myriad regulatory, legal, financial, contractual, and other issues are addressed, and that clinical care is continuously monitored and remains safe.

While each situation is unique, hospital leadership should consider investing in external communications and government affairs support. Extensive interaction with patients, employees, medical staff members, community leaders, and elected officials will be needed as part of a tightly orchestrated rollout. As a general matter, leadership should err on the side of early and proactive communication. If applicable, detailed attention should be given to the questions and concerns of medical residents.

A few special leadership notes are in order. First, a closing hospital that is part of a larger health system should use system resources to its advantage. Nearby system facilities may be able to accept patient transfers, expand certain service lines, give closing hospital employees preferential access to open positions, streamline medical staff membership and clinical privileges for closing hospital clinicians, and house patient and medical staff records. More broadly, it is possible that the system can make a commitment for certain high priority non-hospital services to remain in, or be placed in, the local community. Second, a closing hospital that is in extreme financial distress will present special legal and fiduciary challenges. For example, it will be imperative to evaluate how malpractice tail insurance and employee benefits will be funded. If bankruptcy filing is a possibility, early consultation with bankruptcy counsel is critically important.

Finally, the governing board must assume ultimate oversight responsibility for the hospital's closure, working in close partnership with executive leadership. Board leadership may well be called upon to interface with the press and with local or state elected officials, and frequently have community ties that may open up constructive dialogue. While a "good" hospital closure is difficult to achieve, a key to successful implementation will be an integrated plan that recognizes both the complexity of the event and the profound effect it has on hospital constituents and the broader community.

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Endnotes

[1] Chartis Center for Rural Health, The Chartis Group, *The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability* (Feb. 2020) (Since 2010, 120 rural hospitals have closed across the country, including 19 hospital closures in 2019; an additional 453 rural hospitals are 'vulnerable' or 'most vulnerable' to closure); Joseph P. Williams, *Code Red: The Grim State of Urban Hospitals*, U.S. News & World Rpt. (July 10, 2019) (summarizing the then-impending closure of teaching and safety net Hahnemann University Hospital in Philadelphia) (hereinafter Code Red).

[2] *See, e.g.,* 20 Ill. Comp. Stat. 3960/6(b) (Illinois) (requiring Certificate of Need approval for discontinuation of a hospital facility or category of Service); N.J. Admin. Code § 8:33-3.2 (New Jersey) (closure of a general hospital requires full Certificate of Need review); Mass. Gen. Laws Title XVI, Ch. 111, § 51G, 105 Mass. Code Regs. 130.122 (Massachusetts) (department of public health must receive 90 days' advance notice prior to the closing of a hospital or discontinuation of any

hospital essential service; public hearing may be conducted; essential service closure notice to be sent to the Mass. Health Policy Commission, the Mass. Attorney General and certain other parties).

[3] 29 U.S.C. §§ 2101-2109 (generally requiring at least 60 days' notice to employees before a "plant closing" or "mass layoff"). State WARN Acts can have more stringent requirements than federal provisions.

[4] CMS State Operations Manual §§ 3-3046, 3-3046C.

[5] *See* Code Red, *supra* note 1; Kristina Fiore, *Hundreds of Trainees in Limbo as Philadelphia Hospital Closes,* Med Page Today, (July 15, 2019).

[6] *See, e.g.*, Gabrielle Redford, *What Happens when a Teaching Hospital Closes?*, Am. Ass'n of Med. Colleges (July 12, 2019). On a longer-term basis, the Centers for Medicare & Medicaid Services (CMS) has complex rules for moving residency slots to another qualified institution when a hospital closes. *See* 42 U.S.C. § 1995ww(h)(4)(H) (iv), as applied by detailed CMS guidelines.