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Patient Safety Work Product Privilege: Does It Still Exist?

By Sansan Lin and Katherine Markowski-Dru

In urging fellow members of the United States Senate to pass the Patient Safety and Quality Improvement Act of 2005 (PSQIA), the late Senator Edward Kennedy stated that "medical errors cause 98,000 deaths every year" and that the PSQIA stemmed from an effort to "encourage the development of a safer health care system."[1] Senator Kennedy explained that the PSQIA "implements this sensible recommendation by establishing patient safety organizations to analyze medical errors and recommend ways to avoid them in the future. The legislation also creates a legal privilege for information reported to the safety organizations, but still guaranteeing that original records, such as patients' charts will remain accessible to patients." The language of the PSQIA itself reflects the goal to "provide for the improvement of patient safety and to reduce the incidence of events that adversely [a]ffect patient safety." (PL 109–41, July 29, 2005, 119 Stat 424, codified at 42 U.S.C. § 299b-21 *et seq.*)

The PSQIA attempts to achieve this goal by establishing a voluntary reporting system for medical errors. Under the law, health care providers who choose to participate may voluntarily report medical errors through an in-house Patient Safety Evaluation System (PSES). Data collected through a provider's PSES is then submitted to a Patient Safety Organization ("PSO"), which de-identifies the data and provides it to "a network of patient safety databases" for analysis. 42 U.S.C. § 299b-23. Significantly for hospitals, the Affordable Care Act mandates that by January 1, 2017, qualified health plans in health insurance exchanges may not contract with a hospital of 50 beds or more unless that hospital has a PSES and reports to a PSO or "implements an evidence-based initiative to improve health care quality through the collection, management and analysis of patient safety events."[2] Thus, although reporting to a PSO started out as a voluntary procedure, either reporting to a PSO or implementing an evidence-based quality improvement initiative will soon be mandatory for most hospitals.

To encourage health care providers to voluntarily report medical errors through a PSES, the PSQIA provides—as Senator Kennedy described—a federal legal privilege and confidentiality protections for patient safety information that is considered Patient Safety Work Product (PSWP).

In This Issue

[1]. " Floor speech of Senator Edward Kennedy, July 21, 2005, Congressional Record—Senate at S8713, available online at https://www.congress.gov/crec/2005/07/21/CREC-2005-07-21-pt1-PgS8713-2.pdf.

[2] *See* Patient Protection and Affordable Care Act of 2010, P.L. 111-48 Sec. 1311(h)(1)(A), 1311(h)(2) (note that the January 1, 2015 deadline was thereafter extended to January 1, 2017) and 45 C.F.R. Sec. 156.1110(a)(2) (as amended March 8, 2016).

42 U.S.C. § 299b-22. PSWP "shall be confidential and shall not be disclosed" except as authorized by PSQIA. 42 U.S.C. § 299b-22(b); ***see also*** 42 C.F.R. § 3.206(b). Importantly data may only be classified as PSWP if they are **"assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety organization"** or "are developed by a patient safety organization for the conduct of patient safety activities." 42 U.S.C. § 299b-21(7)A)(i) (emphasis added). That is, information that exists for reasons other than reporting to a PSO, even if it relates to medical errors, is not PSWP.[3]

Although this may, at first glance, appear straightforward, there has been significant confusion in the courts over what to do when data relating to medical errors are "assembled or developed" both for the purpose of reporting to a PSO *and for some other purpose*, particularly state law requiring the development of such data. Does the federal statute preempt state law, or does the federal law not relate to information that is developed for such "dual purposes"? Although federal circuit courts have been split on this issue, providers should be aware of the impact of recent guidance by the United States Department of Health and Human Services (HHS) and of the United States Supreme Court's denial of a request to resolve the issue.

I. PSQIA's Privilege and Confidentiality Protections of PSWP

PSQIA defines PSWP as "any data, reports, records, memoranda, analyses (such as root causes analyses), or written or oral statements—

(i) which—

(I) are assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety organization; or

(II) are developed by a patient safety organization for the conduct of patient safety activities;

and which could result in improved patient safety, health care quality, or health care outcomes; or

(ii) which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.

42 U.S.C. § 299b-21(7)(A). However, a "clarification" explains that PSWP does *not* include "information that is **collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system.** Such separate information or a copy thereof reported to a patient safety organization shall not by reason of its reporting be considered patient safety work product." 42 U.S.C. § 299b-21(7)(B)(ii) (emphasis added).

Despite this statutory definition of PSWP, confusion concerning what information is considered PSWP often arises in medical malpractice disputes where a party requests that a provider produce information relating to an adverse event that the provider was required by state law to collect, but this same information has been collected through the provider's PSES system and reported to a PSO for quality improvement and analysis. Providers and the organizations representing them have taken the position that the PSWP privilege protects this type of information from disclosure, arguing that the federal privilege under PSQIA protects such documents from discovery and to find otherwise undermines the entire purpose of the PSQIA.

II. Case Law Reflects Differing Analysis in Various Jurisdictions

Courts have split on this issue, with some finding that "dual purpose" documents are privileged under the PSQIA and others finding that such documents are not. For example, the Kentucky Supreme Court held in *Tibbs v. Bunnell*, 448 S.W.3d 796, 801 (2014) ("Tibbs")—a medical malpractice case—that because Kentucky regulations require health care facilities to maintain administrative reports, including "incident investigation reports," such information could not be privileged from discovery under the clarification to the definition of PSWP set forth above, even if such incident reports were stored in the hospital's PSES. The hospital filed a petition with the United States Supreme Court for a writ of *certiorari* in this case, but the petition was denied on June 27, 2016, as discussed below.

On the other hand, a Florida appeals court held in *Charles v. Southern Baptist Hospital*, Case No. 1D15-0109 (Oct. 28, 2015)—also a medical malpractice case—that, even though Florida law purported to give patients the right to "any records made or received in the course of business by a health care facility or provider relating to any adverse incident," this law was preempted by the PSQIA to the extent that it included documents that "met the

[3] This means that if a hospital chooses to comply with the Affordable Care Act's requirements by "implement[ing] an evidence-based initiative to improve health care quality through the collection, management and analysis of patient safety events" rather than by reporting to a PSO, "the information involved in such initiatives would not be subject to the PSQIA's privilege and confidentiality protections." *See* Department of Health and Human Services *Final Rule on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters,* March 8, 2016, 81 F.R. 12203, 12315 at available online at *https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017.* However, systems can and should be designed to take advantage of state law protections for quality assurance and peer review processes.

definition of PSWP." *Id.* at 16. The Florida appeals court held that the patient's interpretation of the PSQIA—that is, that state law requiring the creation of the same information created for reporting to a PSO takes away PSWP protections from such reporting—"would render [the PSQIA] a 'dead letter' and is contrary to Congress's intent to cultivate a culture of safety to improve and better the healthcare community as a whole." *Id.* at 17. This case is currently on appeal to the Florida Supreme Court, with oral arguments scheduled for October of this year.

The question of whether incident information is, in fact, PSWP that is protected from discovery also has been heard by courts in Rhode Island, Illinois, and California, with each court using a slightly different analysis to reach a slightly different conclusion. In *Carron v. Newport Hospital*, R.I., No. 15-C.A. No. NC 2013-0479, the plaintiffs alleged that the negligence of a physician employed by the hospital during labor an emergency delivery caused the death of a newborn infant. Plaintiffs sought the production of two Medical Event Reporting System (MERS) reports relating to the event, which were prepared and submitted to a PSO, relying on Tibbs to argue that the reports were not privileged because they were required to be developed, collected and maintained by Rhode Island state law. The hospital distinguished *Tibbs* by noting that the MERS reports were not required by state law (Rhode Island state law did not require the preparation and/or maintenance of patient incident records) and that the hospital collected state-law mandated report in a different form. Following a motion to compel production of the MERS reports, the trial court, without written analyses, but appearing to rely on *Tibbs*, ruled in plaintiffs' favor. The hospital filed a petition for issuance of a writ of certiorari on June 29, 2015 that was granted by the Rhode Island Supreme Court on January 21, 2016. The parties are submitting briefs to the court.

In *Johnson v. Cook County*, No. 15 C 741, 2015 WL 5144365 at *1 (N.D. Ill. Aug. 31, 2015), plaintiff, the estate administrator of Rex Johnson, brought a Section 1983 action against Cook County for alleged constitutional violations relating to Johnson's death while he was a jailed inmate. *Id.* Plaintiff brought a motion to compel production of the Mortality and Morbidity Report (Report) prepared following Johnson's death. Cook County asserted that the Report was privileged under state law and PSQIA. *Id.* The trial court concluded that Cook County "ha[d] not met its burden of establishing that either statutory privilege applies." *Id.* at *2. First, the trial court concluded that Cook County had failed to demonstrate the Report was actually reported to a PSO. *Id.* at * 6. The trial court continued

HLB BRIEFS

HLB Northern California SuperLawyers® Announced

HLB is pleased to announce that four attorneys in our San Francisco Office have been recognized as Northern California SuperLawyers®: Ross Campbell, Craig Cannizzo, Mark Reagan and Paul Smith each received 2016 recognition. SuperLawyers recognizes attorneys who have attained a "high-degree of peer recognition and professional achievement." Their selection process involves peer nominations, independent research and peer evaluations.

Linda Kollar Pro Bono Work Recognized by AHLA

HLB is pleased to announce that Partner Linda Randlett Kollar of our Los Angeles Office has been recognized as a Pro Bono Champion by the American Health Lawyers Association for her "dedication to providing pro bono services in the health law field."Ms. Kollar was specifically recognized for her representation of a client that contracts with the HHS Office of Refugee Resettlement to provide mental health and other services to unaccompanied alien minors. The Office insisted that the entity was not covered by HIPAA, demanding the client send electronic reports containing sensitive health and other information to their offices without utilizing industry-standard security measures, such as data encryption. On behalf of the provider, Ms. Kollar provided a detailed memorandum to the Office, detailing the requirements of applicable state and federal health privacy laws. The Office has since amended its policy, requiring providers to encrypt electronic reports.

that, even if Cook County had adequately demonstrated the Report was functionally reported to a PSO, the Report would still not be privileged because "that information is privileged only if it is specifically generated or assembled for the purpose of reporting to a PSO or patient safety evaluation system," and Cook County had failed to show that "the Report was generated with a PSO or patient safety evaluation system in mind." *Id.* at *7.

In *Schlegel v. Kaiser Health Plan*, No. CIV 07-0520 MCE KJM, 2008 WL 4570619 at *1 (E.D. Cal. Oct. 14, 2008), the plaintiff brought suit against Kaiser Health Plan and other defendants "alleging claims for breach of the duty of good faith and fair dealing, breach of contract, negligence, fraud, negligent misrepresentation, and intentional and negligent infliction of emotional distress" with respect to Kaiser's kidney transplant program. The plaintiff sought to compel Kaiser to produce documents related to the "overall operation of Kaiser's transplant program, including documents relating to any investigation and audits of the transplant center by Kaiser, [California's Department of Managed Health Care ("DMHC"), the Federal Department of Health and Human Services Centers for Medicare and Medicaid Services ("CMS"), and the United Network for Organ Sharing (UNOS)]." *Id.* at *2. Defendants argued that these documents were protected from discovery under state law (California Evidence Code § 1157) and PSQIA. The United States District Court for the Eastern District of California held in *Schlegel* that ERISA preempted state law because the claims related to an employee benefit plan and thus the state law peer review protection did not apply. Id. With respect to PSIQIA, the court held that "the unique and narrow privilege created by the [PSQIA] was not intended to apply to the materials requested . . . . There is no indication that the investigations conducted by Kaiser, UNOS, CMS and DMHC were prepared for and reported to a patient safety organization. . . . Additionally, there is no indication that the 'mission and primary activity' of any of the relevant entities concerns the goal of patient safety as defined by the statute."

Given the varying state court decisions and interpretations of the PSWP privilege, HHS's recent guidance and the United States Supreme Court's denial of a request to weigh in on this issue, the confusion concerning the extent and application of the PSWP privilege continues.

III. HHS Sub-Regulatory Guidance

In May of this year, HHS issued guidance (the Guidance) for PSOs and providers that was intended to clarify what information qualifies as PSWP. 81 Fed. Reg. 32655 (May 24, 2016). This Guidance purports to "clarify" that records kept by providers for more than one purpose—*i.e., records* kept by a hospital both in its ordinary course of business or under a state law requirement and for purposes of reporting to a PSO—do not count as PSWP, and thus are not protected from discovery. The Guidance explained that "[t]he intent of the system established by the Patient Safety Act is to protect the **additional information created** through voluntary patient safety activities, not to protect records created through providers' mandatory information collection activities." 81 Fed. Reg. 32655, 32655 (emphasis added). Thus, according to HHS, the PSWP privilege applies only to records created solely for reporting to a PSO. Records collected or created for any other purpose are not PSWP.

On the same day that HHS released the Guidance, the United States Solicitor General filed an a*micus curiae* brief in the *Tibbs* case. Solicitor General recommended that the Supreme Court deny the petition for certiorari because HHS had clarified how PSQIA's privilege and confidentiality protections should be interpreted, and there was no issue to be decided by the Supreme Court. However, HHS's interpretation of what documents qualify as PSWP was at odds with *amicus curiae* briefs filed in support of the petition for writ of *certiorari* by the Joint Commission, the American Hospital Association, the Alliance for Quality Improvement and Safety, and various PSOs.

IV. U.S. Supreme Court Denies Review of Issue

Many providers and others in the health care industry waited in anticipation for the United States Supreme Court's decision as to whether it would weigh in on this issue by reviewing the Kentucky Supreme Court's decision in *Tibbs*.

Following the Kentucky Supreme Court's decision, the hospital petitioned the Supreme Court of the United States for a writ of certiorari to review the judgement of the Kentucky Supreme Court. The sole question presented was: Whether state law may nullify the federal "patient safety work product" privilege, or whether, instead the Kentucky Supreme Court erred by interpreting it not to protect information "normally contained in" documents subject to state reporting or recordkeeping requirements."

On June 27, 2016, Supreme Court denied the petition for a writ of certiorari. *Tibbs v. Bunnell*, 2016 WL 3461621 (U.S. June 27, 2016). The Supreme Court also declined to vacate and remand the case back to the Kentucky Supreme Court to take into consideration HHS's recent Guidance.

V. Issues Going Forward

As it stands, current and future discovery disputes and the conflict over the PSQIA's privilege and confidentiality protections will continue throughout the states on a state-by-state basis as there is no national binding authority or precedent.

Arguably, HHS's Guidance does not have the force and effect of law as it was not issued through the notice and public comment rulemaking process and thus can be con-

sidered only as an interpretive instrument. Further, pending state supreme court cases in Kentucky, Florida and Rhode Island could present a future opportunity for appeal to the United States Supreme Court. However, it is unclear given the Court's denial of *certiorari* in *Tibbs*, whether the high court ever will take up this issue.

Providers are now faced with the following choices:

- Maintain the status quo and wait for additional judicial developments or further regulatory guidance, which could mean that the existing PSES policies would generate data that arguably does not qualify as PSWP; or
- Comply with HHS's Guidance and determine whether any records, reports and/or other documents they have been collecting through their PSES system for reporting to a PSO still qualify as PSWP.

In light of this, there is some question as to whether the PSQIA can have any impact on the goal of reducing patient deaths due to error, given that the scope of privileged PSWP has been so narrowly defined such that the privilege only exists in very limited circumstances. Unless and until further guidance is issued by the United States Supreme Court, providers should be wary of relying on the PSQIA's protection for maintaining the confidentiality of their PSWP, at least to the extent that it consists of data assembled or developed for purpose other than reporting to a PSES.

For further guidance and information, please contact Sansan Lin or Katherine Dru in Los Angeles at 310.551.8111, Jennifer Hansen in San Diego at 619.744.7310, and Harry Shulman or Ross Campbell in San Francisco at 415.875.8500.

National Health Care Spending Trends and Implications

By Keith Fontenot

Three recent reports highlight the slower growth in health care costs in recent years and the implications of a likely return to higher growth rates for the Federal budget, the Medicare trust funds, and the share of the economy overall going to health care. The three reports are the Medicare Trustees' report, Congressional Budget Office projections, and National Health Expenditure forecasts from CMS. All projections beyond a few years are highly prone to error, but unfortunately it is often the specific projections that get the headlines. The most valuable thing about these reports are the trends and issues they highlight, such as the sustainability of last year's physician payment reform, aka MACRA, and productivity adjustments that were part of the Affordable Care Act. Also of note is the possibility that the Independent Payment Advisory Board's (IPAB) cost control mechanism for Medicare may trigger next year.

Key Take Aways from These Analyses

IPAB May Trigger in 2017

The Independent Payment Advisory Board (IPAB) statute creates a powerful, but untested, mechanism by which Medicare costs can be reduced if growth exceeds a specific target. The law specifies a method by which the Medicare Actuary calculates a target growth rate and compares that Medicare's growth rate to determine whether or not the cost control provisions of the law are triggered, and if they are, calculate a target savings amount. If the provision triggers, a process begins under which, under the statute, the Board makes recommendations, the President transmits those to Congress, and if Congress fails to act, the President is required to implement those provisions. At least that's the way it is supposed to work. The law also specifies a fallback procedure if the board fails to act – which appears to include situations such as the present where there is no board appointed. Under the fallback the Secretary of HHS would make recommendations to the President, who then transmits them to Congress, and if Congress fails to act to either implement or block those recommendations, then the Secretary would be required to implement those changes. The prospect that a new President could be in a position to make recommendations, and then in the event Congress does not act and implement those recommendations, could strongly influence the legislative/executive dynamics. Put another way, in the absence of Congressional action, the Executive would be empowered to rewrite the statute as if Congress had amended it, which is unprecedented. Such an event could give the President a powerful tool in negotiation with the Congress, as it could potentially require a veto of 2/3rd vote in both houses of Congress to override any effort to block Executive implementation.

The Actuary came very close to a determination that this provision would trigger in this year's report. The calculated target growth rate was 2.33 and the Medicare growth rate for this purpose was 2.21. Although the determination will not be made until next year when more data will be available, if current estimates were to hold true and Medicare growth is 2.82 and the target is 2.62, the IPAB process would be triggered. While the Actuary's estimates govern, it is worth noting that the non-partisan Congressional Budget Office (CBO) projects that the IPAB could trigger several times over the next decade, and estimates savings of about $8 billion dollars in its projections.

Sustainability of MACRA and Medicare Provider Productivity

As part of the Affordable Care Act, target productivity rates for fee for service providers were "baked in" and therefore are assumed in the projections of growth for the Medicare program. Notwithstanding this, the Medicare Actuary has, every year since 2011, published a separate memorandum that expresses his concerns about the long run impacts of the reduction in market basket payments for productivity in the national economy. His view is that because of the labor intensive nature of much of health care, productivity gains in the health sector over the long run are likely to be less than productivity growth in the national economy, and thus Medicare payments may not keep pace with cost growth over the long term. And, the productivity adjustment also affects Medicaid payments for certain classes of providers indirectly, through the Upper Payment Limits, which limit total payments for the class to what Medicare would have paid.

This year the actuary expanded on the memo to include concerns about the new physician payment changes in the Medicare and Chip Reauthorization Act (MACRA.) Although the enactment of MACRA avoided significant short run disruptions in physician payments, in the Actuary's view it is likely not sustainable over the long term. Payment updates for 2017-2019 are .5%, for 2020-2025 the updates are zero, and for 2026 and later there will be two rates -- .75% if the physician meets criteria for participating in the Alternative Payment Model program, and .25% if the provider is not. Bonuses of $500 million for the top quartile of those physicians not in the APM program, and 5% for those who are, expire in 2025. The Actuary concludes: "We anticipate that physician payment rates under current law will be lower than they would have been under the SGR formula by 2048 and will continue to worsen thereafter."

Growth in Medicare Advantage

By 2026, the Congressional Budget Office projects that 30 million out of 74 million Medicare beneficiaries will be in Medicare Advantage – about 40%. Actual data shows that in 2015, nearly a third of total Medicare payments were through private plans. This stands in stark contrast to the projections at the time the ACA was enacted, when both CBO and the Actuary projected significant declines. However, this growth is occurring at a time when payment reductions from the ACA are now all but fully implemented, and rising drug costs, and increasing consolidation are now rippling through the program.

Premium Increase/No Cola

General inflation is projected to be low, resulting in a cost-of-living adjustment in Social Security of about .2%. This will trigger the "hold harmless" provisions under which most Social Security checks are prohibited from decreasing. The hold harmless, however, can result in large premium increases for States (paying premiums for "dual eligibles,) and certain other categories of beneficiaries. In 2015, Congress acted to mitigate the resulting issues scheduled to take effect in 2016. It is quite possible that Congress will once again intervene to smooth out the premium increases likely in 2017. Such action would need to occur this fall, possibly in a "lame duck" session.

Slow growth in recent years and Implications of resurgence of growth.

The remarkable story in Medicare has been, as the Administrator of CMS announced, that "Per-enrollee Medicare spending growth has been low, averaging 1.4 percent over the last five years, slower than GDP per capita (2.9 percent) and overall health expenditures per capita (3.4 percent)." However, the consensus of virtually all forecasters is that Medicare growth will accelerate somewhat over the coming years. There are two key elements: The first is estimates of the number of beneficiaries, which are generally reliable as key demographic trends are well known. The second is how much faster per capita costs grow than GDP, and that is highly, highly uncertain. In general, all forecasters assume that growth in Medicare will creep up from its current low levels to approximately GDP+1 per capita, which leads to a growing share of the budget going to Medicare.

The Budget and Total Health Spending and the Economy

Overall, total health spending in the US is projected to grow 1.3 percentage points faster than Gross Domestic Product (GDP) per year over 2015-2025 and thus the share of GDP associated with health would rise to 20.1 percent by 2025, up from 17.5 percent in 2014. Part of that overall growth is due to acceleration in per beneficiary costs particularly as the baby boomers age, and part is due to a growing number of beneficiaries.The CBO and the Trustees reports highlights the substantial and growing role that health programs play in the Federal budget. CBO projects high and rising levels of Federal debt under their forecasts, which would require large reductions in spending or increases in revenues to moderate. Looking out beyond this year, that bleak Federal fiscal picture will be a source of continued pressure for cost control in Federal health care programs

For more information, please contact Keith Fontenot or Marty Corry in Washington, D.C. at 202.580.7700.

CALENDAR

July 19	**CAHF & QCHF Institute & Summer Conference, Newport Beach, CA** Mark Johnson and Scott Kiepen co-presents *Recent Developments In Fraud and Abuse Investigation.* Mark Reagan will be co-presenting *Payroll-Based Journal Reporting Has Started: Don't Get Left Behind.* Mark Reagan will be co-presenting *Medical Decisions for the Unbefriended/Incapacitated.*
July 20	**HLB Managed Care Update 2016: Issues and Strategis for California Health Care Providers, Los Angeles, CA** Daron Tooch, Felicia Sze and Charles Oppenheim present.
July 21	**Beverly Hills Bar Association, Beverly Hills, CA:** *You May Be Healthy, But What About Your Provider? Dealing with Troubled Healthcare Providers.* Mark Johnson is a panelist.
July 21	**The Los Angeles County Medical Association - District 9 - Torrance/South Bay, Torrance, CA:** *An Overview and Update On MACRA* Charles Oppenheim presents**.**
July 26	**Women in Health Administration of Southern California and the Southern California, Northern California and San Diego-Imperial Chapters of HFMA: MACRA: The Next Step In Paying for Quality and Value.** Hooper, Lundy & Bookman will sponsors as host; Monica Mossaro and Charles Oppenheim present; Sandi Krul moderates.
August 3	**Strafford CLE Webinar: Medicaid Managed Care Final Rule: Calculating Medical Loss Ratio, Complying With Network Adequacy Standards and More** Felicia Sze co-presents.
September 12	**Association of Internal Healthcare Auditors Annual Conference, Atlanta, GA** **The 60 Day Rule: Reporting and Returning Overpayment** Lloyd Bookman presents.
September 15	**Heldman Simpson Partners Health Policy Conference, New York, NY** Keith Fontenot is a panelist**.**
September 16	**HFMA Northern California Fall Conference, Concord, CA:** *Medicaid Managed Care: New CMS Rule and More* Felicia Sze is a presenter.
September 20	**The Los Angeles Medical Group Management Association, Los Angeles, CA:** *MACRA Overview* Charles Oppenheim presents.
October 19	**CCH Webinar:** *Medicaid Managed Care Final Rule* Felicia Sze is a presenter.

2016 Edition of CHA Hospital Compliance Manual Includes Final 60-Day Rule and More…

The California Hospital Association (CHA) has released the 2016, 7th Edition of the California Hospital Compliance Manual.

The 2016 edition has been updated to reflect CMS' revised regulations of the 60-day requirement for reporting and returning overpayments, revisions to the federal self-referral (Stark) laws, modifications to CMS's "rare and unusual" exceptions to the "two midnight" rule, and more.

CHA's compliance manual is the only publication written for hospital compliance officers that integrates California with federal laws regarding high-risk compliance areas.

Written by Hooper, Lundy & Bookman, PC, attorneys and CHA, the manual focuses on key components of an effective compliance program. The manual features 700 pages of content including 16 chapters, a model hospital compliance plan, and an index.

To order the new manual or for more information, visit www.calhospital.org/compliance.

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