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HEALTH LAW PERSPECTIVES

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Onerous Hospital Bill Continues to Advance

Hospitals with out-of-network emergency utilization rates of 50 percent or more would receive no more than the Medicare rate for pre-stabilization emergency care from private payers, under proposed legislation that recently passed the Senate.

"While this bill targets out-of-network providers, if it passes, there are enormous implications for contracted hospitals as well," said HLB attorney Daron Tooch. "If health plans are permitted to limit out-of-network providers to substandard reimbursement amounts, it is only a matter of time before contracted hospitals will be similarly squeezed."

Under SB 1285 (Hernandez), this proposed new cap in non-contracted emergency department payments would apply to "major emergency department encounters," which are defined as encounters in which the billed charges exceed $2,000.

The proposed bill clarifies that the charges apply to hospital charges only, and not to emergency physicians, or to charges related to treatment for a workers' compensation injury. Further, the payment limitations do not apply to contracted services. A recent amendment added an exclusion for public hospitals and hospitals owned by the state, cities, counties, public universities and hospital and healthcare districts.

The bill defines out-of-network emergency utilization rate as "the percentage of all major emergency department encounters at a hospital during the course of a calendar year that are out-of-network for local, privately insured patients." The rate is calculated by dividing a hospital's total number of major emergency encounters during the most recently completed two calendar years that involved local, privately insured patients for whom the emergency services and care provided were out-of-network, by the hospital's total number of major emergency department encounters in the same two calendar years of local, privately insured patients.

"Hospitals should not ignore this legislation simply because it might not appear at first glance to currently affect them," Mr. Tooch said.

The bill also could have the perverse effect of reducing the number of in-network hospitals by incentivizing health plans to terminate contracts with facilities in order to force them into the new law. "This can happen whether the hospital is rural, urban or suburban," noted HLB Attorney Glenn Solomon. "Indeed, one or more health plans could try to game the new law against practically any hospital that receives a large number of its patients from just one or only a few plans."

In This Issue

SB 1285 passed the Assembly Health Committee on July 3 and will next be heard by the Assembly Appropriations Committee.

For additional information, please contact Daron Tooch, Lloyd Bookman or Glenn Solomon at 310.551.8111.

CMS Revises Conditions of Participation

By Amy Joseph

The Centers for Medicare & Medicaid Services (CMS) recently revised requirements for hospitals and critical access hospitals (CAHs) to participate in the Medicare and Medicaid programs. These revised Conditions of Participation (CoPs), effective on July 16, 2012, are intended to allow flexibility and reduce procedural burdens by modifying, removing, or streamlining current regulations that CMS has identified as excessively burdensome. CMS has estimated that these revisions will reduce the regulatory burden for hospitals and CAHs by almost $5 billion in the next five years.

Hospitals and CAHs, and their medical staffs should review existing medical staff bylaws, rules and regulations, and policies and procedures, and governing bodies should review their bylaws, to assure that these documents and the hospital's practices comply with these revised CoPs. Some of the revisions made by CMS are mandatory. Other revisions, although not required, could reduce time and expense, along with allowing more flexibility for providers. In some cases, the announced changes may be controversial. A summary of the major revisions are provided below.

CMS will permit one governing body to oversee a multi-hospital system. In the past, each hospital has been required to have its own governing body.

Hospitals are no longer required to notify CMS of certain restraint-related deaths. For deaths that occur while the patient is in soft, 2-point wrist restraints and no seclusion is used, or deaths that occur within 24 hours after such restraints are removed, hospitals must now maintain an internal log, made available to CMS immediately on request. For deaths involving all other restraints or the use of seclusion, hospitals are still required to notify CMS by the close of the next business day.

CMS has broadened the meaning of "medical staff." Hospitals may include non-physician practitioners as eligible candidates for the medical staff, subject to State law. The medical staff must examine the credentials of all candidates and make recommendations for privileges and medical staff membership to the governing body. In addition, podiatrists are now eligible candidates for medical staff leadership positions. Historically, many states have limited medical staff membership to physicians and a select group of non-physician practitioners such as podiatrists, dentists and clinical psychologists. CMS is now responding to changes in States' laws and the growing responsibilities of other types of non-physician practitioners. Medical staffs and hospitals should, however, make certain that the staff responsibilities and privileges of each type of practitioner permitted to seek medical staff membership by the hospital and in the hospital's state are in line with the State's laws governing that type of non-physician practitioner. For example, in California medical staff membership is currently limited to physicians, podiatrists, dentists and clinical psychologists. Although CMS has broadened its definition of "medical staff," these new regulations do not require a change in California law.

Hospitals are no longer required to have a standalone nursing plan for each patient. Hospitals may opt to use a single interdisciplinary care plan that incorporates nursing services. This option is intended to provide flexibility for hospitals that believe a single interdisciplinary plan can better reflect coordination of care among various disciplines. Hospitals are still responsible for ensuring that a nursing care plan exists for each patient, but such a plan may now be included as part of a coordinated interdisciplinary care plan.

Hospitals may implement a program to allow patients or their support persons to administer appropriate medication. If a hospital opts to do so, it

HLB Again Achieves Top-Tier Ranking in Chambers Review of Leading Health Law Firms

Hooper, Lundy & Bookman, PC, has once again been named one of the top three health care law firms in California, according to the latest edition of Chambers USA. The directory is published by the prestigious Chambers & Partners, which produces law firm directories of top-rated law firms throughout the United States and Europe, ranking law firms primarily based on outside interviews with General Counsel, high-profile entrepreneurs and other significant purchasers of legal services.

In addition to the firm ranking, nine HLB attorneys were recognized as top performers in California, more than any other Chambers top-ranked firm. California Attorneys recognized included, Robert Lundy, Bradley Tully, John Hellow, Clark Stanton, Charles Oppenheim and Paul Smith. Three California attorneys – Lloyd Bookman, Steven Lipton and Patric Hooper – were all recognized as top performers in the country. In addition, Robert Roth was recognized as a top performer in Washington, D.C.

Following is the text of the firm's profile, reprinted with permission of Chambers & Partners, USA. We thank all of our clients and friends who contributed to the Chambers review.

THE FIRM Hooper Lundy & Bookman has served California's healthcare industry since 1987. It provides a wide range of legal services to a substantial and diversified client base, ranging from hospital systems to healthcare trade associations. The firm's regulatory arm has been described as a go-to resource for Medicare and Medicaid issues and is recognized throughout California for its expertise in Stark and anti-kick back laws. Healthcare organizations are also able to call upon the firm's multidisciplinary Health Reform group for assistance on all issues relating to federal healthcare legislation. The transactional group also maintains a steady flow of joint venture, M&A and general commercial work.

Sources say: *"An excellent boutique with a historical presence and knowledge to match." "They're very good in relation to reimbursement, regulatory work and litigation."*

KEY INDIVIDUALS

Lloyd Bookman is described by peers as an "institution" in healthcare law. He is recognized nationwide as an expert in Medicare and Medicaid, having served as lead counsel in some of the most significant cases in this field.

Patric Hooper is an "impressive and seasoned" litigator, specializing in actions against federal and state government. He also provides counsel to healthcare organizations on the nuances of regulated industry transactional law.

Steven Lipton is famed for his hospital representation practice, which includes hospital operations, contracting, M&A and advisory work. He is, in the words of one client, an "unquestionable superstar" in healthcare law.

Robert Lundy continues to be regarded as one of California's foremost healthcare attorneys. His broad practice is one of the best in the transactional space, where he comes particularly highly recommended. He is venerated as an "awesome legal talent" and is noted for his "strategic wisdom."

Robert Roth is held in high regard by sources for his deep expertise in Medicare and Medicaid matters. Clients attest to his strong reimbursement capabilities, and a recent highlight involved representing 80 hospitals in lawsuits aiming to retrospectively correct Medicare disproportionate share hospital payments.

Clark Stanton has been singled out by his peers as a "go-to attorney" for medical staff and health information privacy matters. Clients praise his "responsiveness and understanding of a wide range of issues."

Bradley Tully provides "effective and solid" counsel to a range of healthcare providers on both the regulatory and transactional side. He possesses specialist knowledge of fraud and abuse, as well as anti-kickback and Stark issues.

John Hellow heads up the firm's "highly respected" regulatory department. He is widely renowned as a Medicare and Medicaid payment policy specialist and advises leading hospital groups, including American Hospitals.

Charles Oppenheim counts some of America's largest healthcare companies among his clients. He is known as a leading authority on anti-kickback and Stark Law issues. One client enthuses: *"He's the person I go to for California issues and for truly global visionary kinds of healthcare regulatory questions. If I have a question that's cutting edge, Charles will be the person I go to."*

Paul Smith has garnered praise as a "knowledgeable and skilled" healthcare attorney. He advises clients on corporate governance and transactional needs, in addition to reimbursement and regulatory compliance.

must have policies and procedures in place that adequately address safety, security, self-administration training and supervision, and documentation of self-administration in the patient's medical record. CMS believes that, with the proper precautions, such a program can reduce otherwise unnecessary lengths of stay and prevent some readmissions. If a hospital chooses to implement such a program, it will be imperative for nursing staff to communicate closely with physicians and other health care practitioners involved in a patient's treatment regarding the patient's capacity to self-administer medicine and to document the self-administration of medication.

CMS will no longer mandate that non-physician personnel are required to have special training to administer blood transfusions and intravenous medications. Rather, CMS is deferring to State law requirements. The revised regulations provide that such personnel must act in accordance with State law, along with medical staff policies and procedures regarding safe administration of blood transfusions and intravenous medications. The revised regulations provide that practitioners other than physicians may now prepare and administer drugs and biologicals, and may also document and sign orders for drugs and biologicals, in accordance with State law and hospital policy.

Hospitals will now have flexibility to use preprinted and electronic standing orders, order sets, and protocols. This change should help alleviate some of the more burdensome recordkeeping requirements applicable to practitioners and nursing staff. However, these orders and protocols must be approved by the medical staff and the hospital's nursing and pharmacy leadership, and must also be consistent with nationally recognized, evidence-based guidelines.

CMS will no longer require that verbal orders be authenticated within 48 hours. Instead, CMS will now defer to State law and hospital policy to establish the required timeframe for authentication. Various states may have stricter or more lenient requirements, as may accreditation agencies. California law applies the 48-hour timeframe for authentication of verbal orders.

All orders, including verbal orders, must be dated, timed, and authenticated by either the ordering practitioner or another practitioner who is responsible for the patient's care, in accordance with State law and hospital policy. This requirement was already in place as a temporary regulation, and CMS has now made this requirement permanent.

Hospitals are no longer required to maintain an infection control log. CMS has stated that such a requirement is redundant and unnecessary, as hospitals are also required to develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

Hospitals are no longer required to assign one individual as director of outpatient services to oversee all outpatient departments. Instead, hospitals may assign one or more individuals to be responsible for outpatient services, and may make personnel decisions based on the scope and complexity of outpatient services.

HLB Briefs

HLB is pleased to announce that attorneys David Hatch, Hope Levy-Biehl, Karl Schmitz and Devin Senelick have been selected as 2012 Southern California Rising Stars in Health Law. In addition, Felicia Sze has been selected as a 2012 Rising Star in Northern California. Attorneys are selected through a polling process conducted by *Law & Politics.*

An organ recovery team sent by a transplant center is no longer required to verify blood type and other vital data prior to organ recovery where the intended recipient is known. Because this safeguard is already required by the Conditions for Coverage for Organ Procurement Organizations, and other regulations also ensure multiple checks of blood type, CMS stated that the requirement is redundant and that its elimination will not affect patient safety.

CMS has eliminated the requirement that CAH staff directly furnish diagnostic and therapeutic services, laboratory services, radiology services, and emergency procedures. Instead, CAHs may provide these services under arrangement. This change should greatly increase a CAH's ability to provide a wider range of needed services, especially in areas where there may be a shortage of available personnel of a particular type.

In addition to these revisions, CMS also made "clarifying changes" to the CoPs. For example, a provision was added to clarify that drug administration errors, adverse drug reactions, and incompatibilities must be reported to the attending physician immediately. Such incidents must also be immediately reported to the hospital's quality assessment and performance improvement program, if appropriate.

CMS has also clarified that CAHs are not required to provide surgical services. While this is technically not a change, in the past, many CAHs have debated whether or not to provide surgical services and whether such services are required. In some cases, it has been difficult for CAHs to staff appropriately a surgical service on a full time basis, and this change may afford clarification of the degree of flexibility CAHs have to provide these services.

CMS originally included a requirement that at least one member of the governing body be a member of the medical staff of one of the hospitals in the system. However, since the Final Rule was issued CMS has received a number of questions and concerns related to this requirement. On June 15 CMS released a memo stating that it will reconsider this requirement in future rulemaking, and surveyors may not issue citations based on this specific provision. CMS also stated that although it is working to develop interpretive guidelines for all of the revised CoPs, the updated guidance may not be ready for release by July 16.

Because the revised CoPs take effect on July 16, hospitals and CAHs that have not already implemented needed changes to their bylaws, rules, policies and practices should consider doing so. HLB attorneys have extensive experience advising clients on compliance with CoPs and revisions of hospital and medical staff bylaws, rules and regulations, and policies and procedures.

For additional information, please contact: Laurence Getzoff, Jodi Berlin, or Amy Joseph in Los Angeles at 310.551.8111; or Clark Stanton or Harry Shulman in San Francisco at 415.875.8500.

California Supreme Court Clarifies Employer Obligations Relating to Rest and Meal Breaks for Employees

By Eugene Ngai

In a widely anticipated recent case decided by the California Supreme Court, *Brinker Restaurant Corp. v. Superior Court*, the Court clarified the requirements and obligations of employers relating to meal and rest breaks for their employees. California law requires that employers afford their nonexempt employees meal and rest periods during the workday, but there has been disagreement as to the application of these requirements, which are codified in the California Labor Code or set out in Industrial Wage Orders issued by the Industrial Welfare Commission (IWC). The IWC was created by the Legislature to respond to the problem of inadequate wages and poor working conditions. Many of the requirements applicable to nonexempt employees of healthcare providers are specified in Wage Orders No. 4 and 5, although the holdings of the California Supreme Court generally apply to all employers.

The general rule in California is that a nonexempt employee is entitled to a ten-minute rest break for every four hours worked, and an uninterrupted thirty-min-

ute meal break for every five hours worked. If an employer fails to allow an employee to take these required breaks, it is required to pay "premium wages", in the form of one-hour's pay per break missed, with a maximum of two hours of extra "premium wages" per day.

In *Brinker*, the Court first analyzed the requirements relating to rest breaks, and concluded that those nonexempt employees who work less than three and one-half hours per shift are not entitled to any rest breaks, those who work between three and one-half and six hours are entitled to a ten-minute break, those who work between six and ten hours are entitled to two ten-minute breaks, those who work between ten hours and fourteen hours are entitled to three ten-minute breaks, and so on.

The Court then analyzed the requirement that each rest break "insofar as practicable shall be in the middle of each work period." The Court concluded that contrary to plaintiffs' assertion, there is no uniform requirement that a rest break must precede a meal break. Thus, in the example used by the Court, during an eight-hour shift, although the opinion of the Division of Labor Standards Enforcement is that rest breaks will fall on either side of a meal break, there may be other factors that render such scheduling impracticable. The Court did not, however, provide examples or guidance on when such impracticability might arise.

The Court also analyzed the requirements surrounding meal breaks and, siding with the employer's position, held that an employer does not have any affirmative duty to ensure that the employee stops all work during the thirty-minute meal break. Rather, the employer's duty is satisfied if the employee (1) has at least thirty minutes uninterrupted, (2) is free to leave the premises[1], and (3) is relieved of all duty for the entire period. The Court reasoned that if an employer mandated that an employee not work during the meal break, it would, ironically, be imposing duties on the employee, contrary to the requirements of the statute and Wage Order. Further, the Court held that "[p]roof an employer had knowledge of employees working through meal periods will not alone subject the employer to liability for premium pay." An employer may not undermine a formal policy of providing meal breaks by pressuring employees to perform their duties in ways that omit breaks. Therefore the employer cannot reprimand an employee for failing to work during a break, or discourage or impede an employee from stopping work during his or her meal break.

The Court then analyzed the issue of the timing of meal breaks, and concluded that the first meal break must occur no later than the start of the sixth hour of work, and second meal breaks must occur no later than the start of the eleventh hour of work. The Court specifically rejected the assertion that meal breaks must occur every five hours, even if the first meal break was taken only two hours into the shift; in such a case, the employer is only required to allow the employee to take a meal break before the start of the eleventh hour of work, not the seventh hour.

The Court noted that the health care industry secured from the IWC an exemption relating to meal breaks. Subdivision 11(D) of Wage Order 4 reads:

> [E]mployees in the health care industry who work shifts in excess of eight (8) total hours in a workday may voluntarily waive their right to one of their two meal periods. In order to be valid, any such waiver must be documented in a written agreement that is voluntarily signed by both the employee and the employer. The employee may revoke the waiver at any time by providing the employer at least one (1) day's written notice. The employee shall be fully compensated for all working time, including any on-the-job meal period, while such a waiver is in effect.

Employees in the health care industry may elect to have their second meal period only, waiving the first, which gives such employees the flexibility to eat, for example, after the sixth hour in a twelve-hour shift. Nevertheless, employers that employ individuals who would like to waive a meal period should be prepared to accommodate individuals who revoke such waivers, to avoid business disruption.

Against the backdrop of these requirements, the Court noted, in a concurring opinion, that employers "have an obligation both to relieve their employees for at least one meal period for shifts over five hours… and to record having done so…. If an employer's records show no meal period for a given shift over five hours, a rebuttable presumption arises that the employee was not relieved of duty and no meal period

was provided." Thus, employers should require employees to clock-out and clock-in when the employee takes the required meal break, and keep in mind that the employee should take his or her break before the start of the sixth and eleventh hours of work, lest the employer be required to pay premium wages.

For more information, please contact Eugene Ngai, Devin Senelick, or David Hatch in Los Angeles at 310.551.8111, Joseph LaMagna in San Diego at 619.744.7300, or Paul Deeringer in San Francisco at 415.875.8500.

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[1] *The Wage Orders also state that "[i]n all places of employment where employees are required to eat on the premises, a suitable place for that purpose shall be designated." The Court upheld a longstanding DLSE opinion stating that health care employers need not pay employees who are required to remain on-premises for the time spent on a duty-free meal break, but that if the employee were to respond to a page during the duty-free meal break, then the employer would be required to compensate the employee for the entire meal break period.*

Calendar

July 30-Aug. 1

ACI Conference: Healthcare Provider Disputes & Litigation, Chicago
Devin Senelick moderates a discussion on *In-House Think Tank on Provider Litigation Suits,* and presents on *Avoiding, Appealing and Arbitrating Claims/Denials*

CHA Hospital Compliance Manual, 2012 Edition is now Available

The *California Hospital Compliance Manual* is the only publication written for hospital compliance officiers that integrates California law and federal law on high-risk compliance areas. Written by Hooper, Lundy & Bookman, PC., and CHA, the 2012 edition has been updated to reflect changes through Jan.1, 2012 to Medicare and Medi-Cal reimbursemtnt requirements including physical supervision, three-day payment rule, partial hospitalization, observation status, ACOs and much more.

To order, or for additional information, please contact CHA at www.calhospital.org/compliance

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