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ATTORNEYS

# Health Care Update

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## Charitable Care Requirements Proposed for Illinois Hospitals

On January 23, 2006 the Illinois Attorney General proposed the Tax-Exempt Hospital Responsibility Act. This proposed Act, if passed, would have significant implications for tax-exempt hospitals in Illinois.

Specifically, the Act sets forth charity care requirements for Illinois tax-exempt, non-profit hospitals and exempts only critical access hospitals. An Illinois tax-exempt hospital would need to provide charity care in an amount equal to eight percent (8%) of the hospital's total annual operating costs as reported each year in the hospital's most recent Medicare cost report. According to the Act, "charity care" is defined as medically necessary services provided at a reduced charge or no charge to patients who meet certain eligibility criteria. For example, free care (i.e., full charity care) must be provided to uninsured Illinois residents falling below one hundred fifty percent (150%) of the federal poverty level, and discounted care must be provided to those between one hundred fifty percent (150%) and two hundred fifty percent (250%) of the federal poverty level.

In addition to the mandate to provide a certain percentage of charity care, hospitals must also adopt certain fair billing and collection procedures. Hospitals would also be required to provide patient and community awareness by: (i) distributing to every patient, on or prior to the date of service or discharge, a written statement regarding charity care; (ii) posting signage; (iii) using standard forms and income verification/documentation; (iv) responding to applicants within fourteen (14) days after receipt of a completed charity care application; (v) implementing procedures to provide language assistance services; (vi) posting notice in a prominent place on the hospital's website; and (vii) publishing a notice on a quarterly basis in a newspaper of general circulation in the hospital's service area indicating that charity care is available and providing similar notice to all community medical centers located in the service area. Each hospital would be required to submit an annual report to the Illinois Attorney General.

In the event of violations of the proposed Act, hospitals could face a civil penalty of $10,000 per violation as well as risk revocation of the hospital's tax-exempt status. The Attorney General could also assess civil monetary penalties of $1,000 per day for failure to post notices or implement patient notification procedures and a court could order patient reimbursement for money paid contrary to the proposed Act.

Illinois hospitals are already facing estimated cutbacks of $2 billion as part of the proposed cost reductions in the Federal Medicare and Medicaid program. Such cuts would be especially painful given the Act's proposal to boost spending on indigent care. As a result, many hospitals could be forced to close, leading to devastating effects on Illinois' economy. Illinois non-profit hospitals employ approximately 142,347 full-time workers, have payrolls in excess of $8.9 billion a year, and spend $1.8 billion in capital improvements each year. Accordingly, these losses could be significant.

The Act comes in the wake of non-profit lawsuits alleging that hospitals have failed to provide sufficient charity care to justify their tax-exempt status, and the recent challenges to hospitals' property tax exemptions. Regardless of whether the Act, in its present form, eventually passes, clearly non-profit hospitals will continue to face considerable pressure to provide and document the charity care that they are providing.

**IN THIS ISSUE**

## Health Services Providers' Overtime and the FLSA

From time to time, the Wage and Hour Division of the U.S. Department of Labor issues opinions on the subject of whether the Fair Labor Standards Act (FLSA) requires payments to persons engaged in particular occupations for working overtime hours. Although many individuals assume that overtime payments are due only to hourly employees, the mere fact that an employer designates an employee as "salaried" versus "hourly" is not dispositive on the issue.

Section 213(a) of the FLSA (29 U.S.C. §213(a)) and regulations promulgated by the Secretary of Labor provide that workers "employed in a bona fide . . . professional capacity" are not covered by the FLSA. The meaning of the phrase "employed in a bona fide . . . professional capacity" is, however, far from clear. In order to establish that a worker is "employed in a bona fide professional capacity," the FLSA regulations require that there must be a showing that (a) the person is paid a substantial salary (at least $455 per week), (b) the work the employee performs involves "the consistent exercise of discretion and judgment as distinguished from performance of routine mental, manual, mechanical or physical work," and (c) the employee uses "advanced knowledge to analyze, interpret or make deductions from varying facts and circumstances." Advanced knowledge is defined as "knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction."

In a recent opinion, the Wage and Hour Division (Division) stated that medical coders do not qualify for the "learned professional" exemption from the FLSA. In this opinion, the Division described medical coders as persons who:

"*translate medical diagnoses and procedures into codes used for reimbursement from insurance companies. The coders analyze the patient's medical record to determine the appropriate code. The coders assign and report codes in accordance with national organizational standards. Coders must maintain knowledge of current medical and pharmaceutical terminology and attend ongoing continuing education courses in order to maintain their credentials and state board certifications. The coders must possess at least one state board certification.*"

The Division emphasized that while some medical coders possess a degree in Health Information Management, others have only a two-year college's associate degree or no college degree at all. Thus, according to the Division, although medical coders must be state certified, they do not qualify for an exemption from the FLSA because the medical coding field "is not generally recognized by colleges and universities as a bona fide academic discipline."

The Division's conclusion that medical coders are not exempt, based largely on their lack of required formal education, appears to be consistent with many other pronouncements by the Division relating to providers of health-related services. For example, as one would expect, the Division has held that licensed physicians and other practitioners "in the field of medical science and healing" qualify for exemption. Additionally, the Division has stated that interns and residents also qualify for exemption if they have earned the requisite degree for practicing their profession, regardless of whether such interns and residents have earned $455 or more per week. Certified physician assistants also qualify for exemption, according to the Division, if they have "successfully completed four academic years of pre-professional and professional study, including graduation from" an accredited physician assistant program.

Decisions regarding pharmacists' exemption are not, however, entirely consistent. Though pharmacists are eligible to qualify for exemption because of their "recognized professional status," relevant facts and circumstances may disqualify them. A recent court decision, for instance, held that pharmacists are exempt even if tasks collateral to their primary duties consume more than half of their time. Alternatively, a salaried pharmacist who was docked for fractions of a day for missing work was held by a federal appeals court not to be exempt. Also, 60 years ago, the highest court in New York held that a pharmacist who testified that (i) one-third of his day involved routine work, (ii) he was required to punch a time clock, and (iii) he was required to work a 40-hour week, was not exempt from the FLSA.

The Secretary of Labor's regulations state that registered nurses ordinarily qualify for exemption under the FLSA, but that licensed practical nurses and other similar health care employees do not qualify for exemption since possession of a specialized advanced academic degree is not a standard prerequisite for entry into such occupations. Similarly, a 1993 Seventh Circuit Court of Appeals decision held that a registered nurse who would otherwise have been exempt from the FLSA was not since her employer treated her as an hourly employee (e.g., docking her for each hour of an assigned shift that she missed and subjecting her to disciplinary suspension for minor infractions).

Registered or certified medical technologists meet the test for exemption if they "have successfully completed three academic years of pre-professional study in an accredited college or university plus a fourth year of professional course work in [an approved] school of medical technology." In 1976 a court ruled that uncertified medical technologists who exercise the same skills as certified technologists qualify for exemption, but hospital orderlies, aides, and x-ray technicians are not exempt. The Secretary of Labor's regulations also state that paramedics and emergency medical technicians are not "learned professionals" since "a specialized academic degree is not a standard prerequisite for employment in such occupations" and, therefore, they do not meet the "prolonged course of study" criterion. This interpretation is considered accurate even though paramedics and emergency medical technicians are required to complete hundreds of hours of training and clinical experience. Thus, an employee who had several duties one of which was driving an ambulance, but who was paid less than the minimum compensation set forth in the FSLA regulations, was held not to be exempt.

Similarly, a 2000 Wage and Hour Division opinion stated that despite the fact that ultrasound technologists earn substantially more than the minimum weekly salary, they are nevertheless not "learned professionals" because their skills are not "customarily acquired by a prolonged course of specialized intellectual instruction and study."

In sum, it is well established that exemptions from the FLSA are to be narrowly construed. The general principle seems to be that salaried health care workers will be deemed to be exempt only if they have had several years of specialized instruction, they perform tasks which involve the exercise of discretion and judgment, they are well paid, and they are treated differently from hourly employees.

## Classification and Compensation of Nurse Practitioners Under the Fair Labor Standards Act

The U.S. Department of Labor (DOL) enforces the Fair Labor Standards Act (FLSA). In a Wage and Hour Opinion Letter issued on August 19, 2005, the DOL responded to a hospital's inquiry concerning the classification and compensation of nurse practitioners. The hospital classifies regular, full-time, salaried nurse practitioners as exempt employees. However, the hospital also employs professional registered nurses (PRN) as needed (i.e. to cover for any salaried nurse practitioners who are absent and for busy periods). The PRNs are paid on an hourly basis.

The hospital had two questions. First, the hospital inquired whether its classifying the PRNs as non-exempt employees, who are entitled to an hourly wage plus overtime when applicable, would affect the full-time, salaried nurse practitioners' exempt status. The second question concerned the propriety of extra compensation, such as shift differentials for full-time, salaried nurse practitioners, and whether that could affect exempt status.

In response to the first question, the Wage and Hour Deputy Administrator of the DOL stated: "It is our opinion that having some employees within the same job classification who perform the same duties, but who are paid on a different (hourly) basis, does not affect the status of any other exempt employees paid on a salary basis. Exemptions under 29 C.F.R. Part 541 are not based upon a job title or job classification, but upon the salary and duties of each individual employee."

Responding to the second question, about whether it is permissible to pay exempt nurse practitioners a shift differential without affecting exempt status, the DOL advised that an exempt nurse practitioner's status does not change and is not affected by a shift differential. In fact, any additional compensation to such nurse practitioners for working extra hours is allowable and does not change an exempt employee's status, so long as the employee is paid on a salary basis. 29 C.F.R. § 541.604(a). Such additional compensation can be in the form of a bonus, straight time, overtime or any other method.

This opinion re-emphasizes several long standing principles applicable to wage and hour cases — job title alone does not signify whether an employee is exempt or non-exempt and employers must always analyze the actual job duties performed and the way in which the employee is compensated to determine whether an employee is exempt or non-exempt.

Given the increase in wage and hour litigation against health care institutions, it is prudent to conduct periodic audits of classification and payroll practices.

## National Practitioner Data Bank - A Failure?

Billed as the nation's central repository for hospital-based disciplinary actions against U.S. physicians, the medical community predicted that the National Practitioner Data Bank (NPDB) would receive 10,000 reports each year when it was launched in 1990. In reality, in its 15 years of existence the NPDB has only received a total of 10,800 reports through 2004, or roughly 720 reports a year. In 1991, for example, its first full year of operation, the NPDB received 915 reports of serious disciplinary action against doctors. This number dropped to 853 in 1992 and was at an all-time low of 645 by 1998. Although in 2004 there were 817 reports, an increase of 4.6% from 2003, the fact remains that most hospitals have never filed a report with the NPDB, even though they are required to do so whenever a doctor loses privileges or is suspended for more than 30 days.

Recently, the Health Resources and Services Administration (HRSA), which operates the NPDB, acknowledged that hospitals are not reporting as much as they should.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the main accrediting entity for hospitals, has also expressed concerns that the NPDB is not working. In February 2005, JCAHO called for the complete revamping of the NPDB citing that it simply is not accurate that only about 0.75% of all of the nation's physicians were subject to disciplinary actions by hospitals in 2004, or that only three out of every 10 hospitals ever disciplined one of their affiliated doctors severely enough to require a report to the NPDB.

According to JCAHO, the Federation of State Medical Boards (Federation), in its report of disciplinary measures taken against doctors by its members in April 2005, found that strict sanctions were up by almost 20% in 2004. The Federation also reported that 2,115 of these actions involved the loss of a physician's license, up 19% from 2003. Total medical board actions against doctors have jumped nearly 40% in the past five years. Thus, it is clear from these statistics that hospitals have been under-reporting to the NPDB.

Since its inception, consumer groups and lawmakers have tried without success to open the NPDB to public scrutiny. Most recently, Rep. Peter DeFazio (D-Ore.) introduced a bill last May 2005 that would make it easier for the public to view disciplinary reports and malpractice settlements, but thus far no action has been taken on this bill. This is not surprising given that the medical establishment has been extremely successful in thwarting similar types of legislation in the past. The AMA, for example, has repeatedly argued that malpractice settlements should not be disclosed in a society where litigation is increasingly routine.

At the same time that the NPDB is undergoing attack, some members of Congress are sponsoring legislation to expand the NPDB's coverage to all licensed health care practitioners, including nurses, pharmacists and respiratory therapists. In early 2004, New Jersey senators Jon Corzine (D-N.J.) and Frank Lautenberg (D-N.J.) co-sponsored legislation to expand the NPDB. Although this legislation stalled, the Safe Health Care Reporting Act of 2005, which contains an identical provision, was introduced last April by Rep. Frank Pallone (D-N.J.).

Although federal legislation is pending, many states have passed their own legislation addressing these issues. For example, many states have passed laws requiring medical facilities to provide information about formal disciplinary action against employees to prospective employers and requiring background checks on licensed health care workers. Many of these laws shield employers from liability if they provide the work histories of current or former employees in good faith.

Whether the NPDB will be overhauled or replaced is difficult to determine. Regardless, given the increased scrutiny of the lack of reporting, hospitals should review their current reporting practices to ensure that all required reports are being submitted to the NPDB.

## Employer Violated FMLA by Requiring Two-Week Notice for Employees Using Paid Vacation Time.

An employer's leave policy that required employees to give two weeks' notice before taking paid vacation leave violated the Family Medical Leave Act (FMLA) because it discouraged employees from taking medical leave. In *Solovey v. Wyoming Valley Health Care Sys. Hosp*., the plaintiff was a nurse at the defendant hospital and a member of the union that represented all the nurses. The union and the hospital were parties to a collective bargaining agreement (CBA) that required two weeks' notice before an employee could take paid vacation. When the nurse's father became ill suddenly, she left work for a week to care for him. Although the nurse was granted FMLA leave to cover her absences, the hospital denied her the chance to substitute paid vacation leave for unpaid FMLA leave because she had not given two weeks' notice.

The court held that the policy violated the FMLA. According to the *Solovey* court, if employees are allowed to take paid vacation leave at all, it is unlawful for an employer (or union) to place limits on the way such vacation leave is used. By requiring two weeks' notice to use paid leave, employees with family medical emergencies might be discouraged from taking FMLA leave, because it would have to be on an unpaid basis. Thus, the *Solovey* court concluded that the CBA could not put such a limit on employees' FMLA rights.

This case should alert employers of the need to examine their employment leave policies, whether or not they are contained in a CBA. Since the FMLA gives employees the right to substitute paid vacation leave for unpaid FMLA leave, any limitation on that right may violate the law.

## AMA and Physicians Craft Outline for P4P Initiatives

The American Medical Association (AMA) and nearly 70 physician groups have crafted a legislative outline for a Medicare pay-for-performance (P4P) initiative, beginning in 2007, that includes a physician pay boost.

Among the physician groups collaborating with the AMA on this legislation are the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American Medical Group Association, the American College of Surgeons, the American Society of Anesthesiologists, the Medical Group Management Association, the American Urological Association and the American Academy of Family Physicians.

The initiative also proposes the eventual repeal of the "sustainable growth rate" (SGR) methodology currently used to pay doctors under Medicare. Under the current Medicare physician payment schedule, doctors' pay would be reduced about 5% annually over the next 7 years. These pay cuts are called for in the SGR formula and are triggered if physician spending exceeds the SGR target. The AMA and the physician groups have stated that modernizing the way Medicare pays physicians in order to promote increased quality care will not work under the existing SGR formula since P4P and SGR, the AMA contends, are inconsistent concepts. Specifically, the AMA argues that if P4P is implemented along with the current SGR formula it will further penalize physicians for providing the care necessary to keep patients healthy and out of the hospital.

Eliminating the SGR would cost between $154 billion to $183 billion. Given these costs, there does not appear to be much congressional support for a such a repeal.

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The AMA/Physician legislation incorporates P4P into Medicare beginning in 2007 through the use of pay-for-reporting. Under pay-for-reporting physicians would be paid extra to report basic quality information such as participation in patient safety programs. In 2008 and 2009 pay-for-reporting would be expanded via a transition to more advanced quality improvement programs and reporting of evidence-based quality measures.

During this period quality performance data would be transmitted back to physicians for internal quality improvement purposes and tests of the feasibility of collecting data and accurately measuring physician performance in preparation for P4P.

In 2010, P4P provisions would be fully implemented, contingent on a repeal of the SGR formula. During the initial stage of P4P adoption the physician fee schedule would be fixed by allocating additional dollars to the SGR at least equal to the amount required to provide a fee schedule update equal to the increase in the Medicare Economic Index. All doctors would be guaranteed a payment "floor" of positive payment updates.

Under the fully implemented P4P program, a percentage of Medicare payments to all physicians would be set aside to reimburse doctors based on their quality performance, with a focus on continuous quality improvement. Doctors' performance would be measured with evidence-based indicators or process and/or patient outcomes, and any efficiency measures used would be transparent, evidence-based and focused on clinical quality improvement.

Under the AMA/Physician legislation, public reporting of a physician's quality information would only be allowed after adequate safeguards are put into place to prevent unintended consequences such as patient de-selection.

P4P programs for physicians under Medicare may prevent or shorten hospitalizations under Medicare Part A, but that means more care will be delivered in physicians' offices, raising physician spending and resulting in further cuts in physician payment under the SGR. At this point it appears that P4P will be a reality for physicians at some point, however, exactly how P4P programs will be implemented is still unclear.