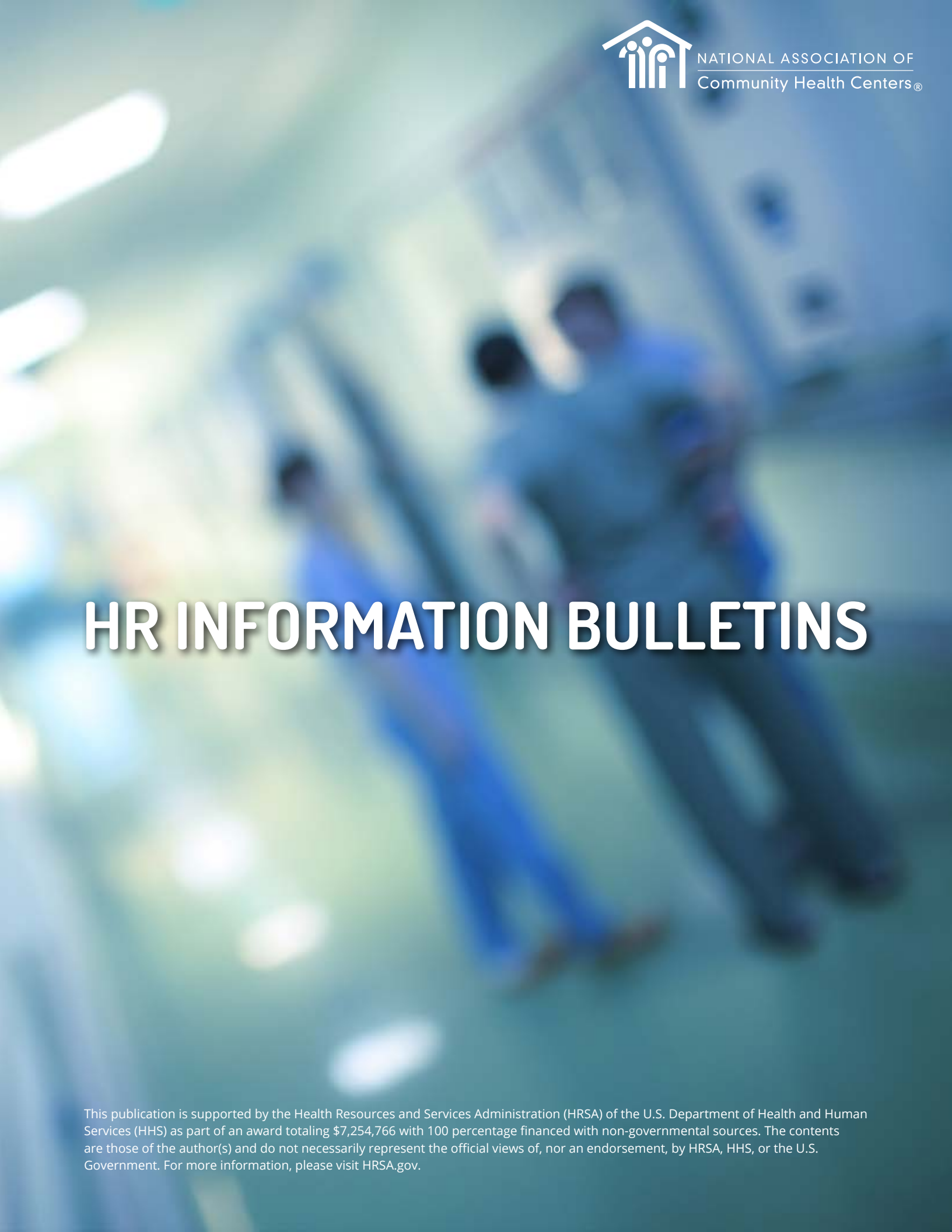

NATIONAL ASSOCIATION OF Community Health Centers®

HR INFORMATION BULLETINS

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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HR Information Bulletin #1

CONDUCTING EFFECTIVE JOB INTERVIEWS AND BACKGROUND CHECKS IN COMPLIANCE WITH FEDERAL EMPLOYMENT DISCRIMINATION LAWS

Employees who are knowledgeable, hardworking, and conscientious not only make a favorable impression on patients and others, but also help to ensure that the care and services provided by the health center comply with professional standards and legal requirements.

While on-the-job training and education play an important role in maintaining a competent and reliable staff, a health center would be well advised to make the most of its hiring process to minimize the risks associated with hiring an unqualified or careless employee.

This information bulletin provides an overview of the Federal employment discrimination laws that impact the vetting of prospective health center employees and offers tips on what to do and what not to do.[1] Specifically this bulletin:

- Addresses Federal employment discrimination laws, also known as equal employment opportunity laws, as they apply to the employee selection process. Laws such as **Title VII of the Civil Rights Act of 1964** ("Title VII"), the **Age Discrimination in Employment Act**, and the **Americans with Disabilities Act** ("ADA"), prohibit discrimination against certain groups of individuals, usually referred to as the "protected class." Consequently, the questions asked during a job interview should not relate to a job applicant's status as a member of a protected class. In addition, the **Genetic Information Nondiscrimination Act of 2008** ("GINA") prohibits employers from requesting or using genetic information, including among other things, an applicant's family medical history or information about the individual's genetic tests, in making hiring and other employment-related decisions.
- Contains examples of the types of questions that should be avoided in a job interview setting
- Outlines some proven interview strategies that will make an interviewer's task easier and help to ensure compliance with the law
- Explains how to lawfully use background checks and social media in the employee selection process.

This Bulletin is not intended to be a general discussion of employment discrimination law, nor is it intended to cover all the impermissible topics in the hiring process.

FEDERAL EMPLOYMENT DISCRIMINATION LAWS

There are numerous federal laws that prohibit discrimination in the hiring process. It is important to remember that, with only a few exceptions, these laws do not require employers to give preferential treatment to a job applicant simply because they belong to a protected class. Rather, they are intended to protect individuals from discrimination by prohibiting employers from taking protected characteristics, such as the applicant's religion, race, or national origin, into account in hiring and other job-related actions. Employment discrimination laws protect individuals against discriminatory employment practices in the pre-employment stage, when hiring decisions are made, as well as in subsequent employment situations when issues relating to compensation, job advancement, and termination will arise.

1 Because employment activities also are regulated on the state and local levels, health centers always should consult an attorney familiar with state and local employment laws to determine any additional legal requirements that may apply to the hiring process.

DISPARATE IMPACT DISCRIMINATION

As a health center reviews its employment interview policies and practices, it should keep in mind that pre-employment inquiries that relate to, or disproportionately screen out members of a protected class could be used as evidence of an intent to discriminate against members of that protected class, unless the questions asked can be justified by some legitimate business purpose. In other words, a health center could be in violation of one or more anti- discrimination laws if an interviewer asks a job candidate a question that, although it appears neutral, disproportionately affects members of a protected class. For example, if an interviewer asks an applicant about language skills when fluency in English, or in another language, is not required to perform the essential functions of the job, the question could tend to screen out applicants belonging to a protected group, such as people not born in the United States.

PERMISSIBLE QUESTIONS AFTER AN OFFER IS MADE

It also is important to remember that some questions that should not be asked during an interview are permissible *after* an offer of employment is made. For example, while an interviewer should never ask an applicant's birth date, because that could suggest an illegal age bias in hiring, a health center can legitimately obtain that information after the person is employed if it is relevant to the employment, such as insurance coverage or other employee benefits.

ILLEGAL INTERVIEW QUESTIONS AND COMMENTS

The job interview is an important tool available to a health center in the employee selection process. Used correctly, an interview can guide the center in making sound hiring decisions and help to promote the health center as a desirable and professional workplace. However, the interview process also can create problems for a health center if those who conduct employment interviews are not sufficiently familiar with the law or are otherwise ill prepared. A poorly conducted interview may well deter well qualified candidates from pursuing an opportunity to work at the health center. Conversely, applicants who do not secure a job offer may claim that an interviewer's questions or conduct during the interview are evidence of employment discrimination and could lead to a charge of discrimination being filed against the health center.

In today's competitive job market, health centers are likely to receive applications from many diverse candidates vying for the same job. It is important that centers be confident that interviewers are asking questions solely pertaining to a candidate's ability to perform the job, and that they are avoiding questions that could reveal a candidate's protected status under one or more federal or state employment discrimination laws. Even seemingly innocent questions that elicit information pertaining to the candidate's religion, national origin, or other protected characteristics may be taken as evidence of an improper motive and undermine the center's best efforts to hire the most qualified candidate for the job.

Topics to Avoid Under Federal Employment Discrimination Laws

- AGE
- GENDER
- GENDER IDENTITY
- MARITAL STATUS
- CHILD CARE OBLIGATIONS
- RELIGION
- RACE, ETHNICITY, NATIONAL ORIGIN
- PRESENCE OF A DISABILITY
- FAMILY MEDICAL HISTORY

DISCRIMINATION BASED ON AGE

The Age Discrimination in Employment Act (ADEA) protects individuals 40 years and older from discrimination in hiring and other terms and conditions of employment.[2]

Questions and Comments About an Applicant's Age

A candidate who is directly or indirectly asked about age in a job interview might later believe that age played a role in the center's decision to hire someone else. Even if the interviewer asked the question to clarify the candidate's education or employment history, an age-related question could be used against the center as evidence of discriminatory hiring practices.

- Sometimes, an interviewer will have to ask questions that relate, directly or indirectly, to a candidate's age. For example, it is permissible to ask applicants whether they are of legal age to work. Also, if a certain level of education is required to perform the job, questions about a candidate's educational background and degree, if any, are permissible. Health centers should, however, take care to pose the same questions to all candidates for the same position and to make sure that the requirement for a particular level of education is properly documented in the written job description for the position.
- Off-hand comments and the use of certain inappropriate terms also can suggest an age bias, and ought to be avoided. For example, interviewers should not suggest to a job candidate that the center wants to hire "a recent medical school graduate" or a "younger person."

Examples of inappropriate questions about an applicant's age are:

- **What is your date of birth?**
- **How old are you?**
- **When did you attend or complete primary and secondary school?**
- **Will you be uncomfortable working with a boss who may be younger than you?**

DISCRIMINATION BASED ON RACE, ETHNICITY, NATIONAL ORIGIN, SEX OR RELIGION

Title VII makes it unlawful for an employer with 15 or more employees "to fail or refuse to hire or to discharge any individual ... because of such individual's race, color, religion, sex, pregnancy or national origin."[3] Moreover, the United States Supreme Court has held that sex discrimination prohibited by Title VII includes discrimination based on sexual orientation and gender identity.

Executive Order 11246, which applies to employers with a Federal contract of $10,000 or more, similarly prohibits discrimination based on race, color, religion, sex, sexual orientation, gender identity, or national origin. Contractors (and subcontractors) with 50 or more employees and $50,000 or more in government contracts must take affirmative action to remedy any underutilization (as compared to their availability in the workforce) of women and minorities in their employ.[4]

It is important to note that Executive Order 11246 does not apply to federal grantees. It applies only to organizations that receive federal procurement contracts (or, in some cases, state contracts) or that are subcontractors under a federal procurement contract of $50,000 or more, and that employ 50 or more persons. Accordingly, Executive Order 11246 would not apply to a health center solely by virtue of its receipt of Section 330 funds (or other grant funds). However, if an eligible health center

2 29 U.S.C. § 621 et seq.

3 42 U.S.C. § 2000e-2(a)(1)

4 30 Fed. Reg. 12319

also enters into a federal procurement contract of $50,000 or more, the center would be required to comply with Executive Order 11246. Obligations under Executive Order 11246 typically are included directly, or by reference, in the applicable procurement contract. In those limited cases, it may be permissible to make inquiries concerning race to meet the contractor's affirmative hiring obligations.

Questions and Comments About an Applicant's Race, Color, or National Origin

As discussed above, it is unlawful for covered employers to discriminate in the hiring process on the grounds of race, color, or national origin. Questions or comments on the topic of race, ethnicity or national origin generally should be avoided.

- Interviewers should refrain from asking questions that might be regarded as being aimed at eliciting information about an applicant's race, ethnicity, or nationality, such as questions about the applicant's participation or membership in social or other non-professional organizations that draw membership from a particular nationality or ethnic group.
- Proficiency in English or another language may well be a bona fide requirement for certain jobs, in which case employers can ask questions about the candidate's proficiency or skills in the identified language. As with other specific job qualifications, language requirements should be stated expressly in the written job description for the position.
- It is permissible to pose questions regarding U.S. citizenship or other authorizations to work after a job offer has been extended. Indeed, such inquiry is required. Federal immigration law makes it illegal for an employer to knowingly hire anyone not authorized to work in the United States and requires employers to verify all new employees' authorization to work in the United States.[5]

Examples of inappropriate questions concerning an applicant's race, ethnicity, or national origin are:

- **Are you a U.S. citizen?**
- **Where are you from originally?**
- **What is the origin of your last name?**

Questions and Comments About an Applicant's Gender

Federal employment discrimination laws prohibit discrimination, intentional or otherwise, based on an applicant's gender.

- Generally speaking, any question that an interviewer asks of persons of one gender and not the other is likely to infer a discriminatory intent in the hiring process. For example, because questions should never be asked only of female applicants (and it may be awkward to ask those questions of male applicants as well), certain questions are best avoided entirely.
- A question asking the applicant's sex, or the candidate's preferred title, such as "Mr., Mrs., Ms., or Miss," or their preferred pronouns, e.g. "She," Her," "They" is not illegal if asked in good faith for a "non- discriminatory purpose."[6]
- Further, inquiries about a job candidate's gender are permitted when a particular gender is required as a legitimate business necessity, which in all likelihood, would not be the case for most health center employment situations. Under this very limited exception, an employer is permitted to discriminate in the hiring process and ask otherwise illegal questions about an applicant's gender when gender is a "bona fide occupational qualification" for the position. For example, a center may believe that it needs to hire a female nurse to assist a male provider performing OB/GYN procedures. To ensure compliance with Title VII and other applicable law, health centers

5 The Immigration Reform and Control Act, 8 U.S.C. §§ 1324a & 1324b

6 29 C.F.R. § 1604.7

should consult with a knowledgeable employment law attorney before recruiting for a position that specifies "men only" or "women only" among the requirements stated for the job.

- Note that federal law does not prohibit discrimination based on marital status, but many states and localities have laws that prohibit such discrimination.

Examples of inappropriate questions relating to gender are:

- **Are you married?**
- **Do you have a maiden name?**
- **Do you have plans to start a family?**
- **Are you pregnant?**

Questions and Comments About an Applicant's Religion

As indicated above, Title VII makes it unlawful for an employer to discriminate on account of religion. Thus, an employer may not consider an applicant's religious beliefs or the applicant's intention to observe religious holidays in hiring decisions. A limited exception exists for employers that are religious organizations, which may give preferential treatment to members of their religion if the work performed is related to the organization's religious activities.

- It is permissible to inquire whether the applicant is available to work the days and hours of the week needed to meet the position's posted job requirements, for example, Saturday office hours or scheduled Sunday call coverage.
- After an employer has hired someone, it also can inquire about an employee's religious beliefs and practices to determine if a religious accommodation is needed.
- Employers must accommodate the religious beliefs and practices of an employee unless doing so imposes an "undue hardship" on the conduct of the employer's business.

Examples of inappropriate questions on the topic of religion:

- Are you religious?
- Do you work on Saturdays?
- What holidays do you observe?

DISCRIMINATION BASED ON DISABILITY

The protections afforded individuals with a disability are largely derived from the ADA, which forbids employers with 15 or more employees from discriminating against qualified individuals with a disability when considering applicants for a job.[7] Section 504 of the Rehabilitation Act of 1973, applicable to health centers receiving federal financial assistance, has a similar disability discrimination prohibition.[8] Among other things, these laws aim to ensure that qualified individuals with a disability are considered for employment and are treated no differently in the hiring process than their counterparts who do not have a disability.

Questions or Comments About an Applicant's Disability

As a general matter, the ADA and Section 504 of the Rehabilitation Act prohibit pre-employment inquiries about the existence of a disability and pre- employment medical examinations so that a person with a disability is not screened out before their actual ability to do a job is evaluated. For example, an interviewer must avoid asking questions about a candidate's medical condition

7 42 U.S.C. §§ 12101 et seq.

8 29 U.S.C. § 794

or the presence of any disabilities.[9]

- While an employer may not ask about the presence of a disability or a condition that could imply that an applicant has a disability, the employer is permitted to ask questions to determine if an applicant can perform specific job functions. For example, an interviewer could show an applicant a written job description that lists specific job functions, or orally describe the required functions, and ask the applicant if they can perform those functions with or without an "accommodation."[10]
- If an applicant indicates that they can perform the required functions, but with an accommodation, the applicant may be asked how they would perform them and with what accommodations.

Examples of inappropriate questions concerning the presence of a disability:

- **Do you have any disabilities or impairments that may affect your job performance?**
- **Are you taking any prescribed drugs?**
- **Have you ever been treated for any mental health condition?**
- **Have you ever been treated for drug addiction or alcoholism?**
- **Have you ever been injured on the job?**
- **Have you ever filed a workers' compensation claim?**
- **Have you had or been treated for any [of the following] conditions or diseases?**
- **What conditions have you had or been treated for in the past [number of] years?**
- **How many days of work did you miss last year because of illness?**

Examples of PERMISSIBLE questions:

- **This job requires attendance from 9 a.m. to 5 p.m. Monday through Friday. Can you keep that schedule?**
- **Are you able to perform [described] job functions, with or without accommodation?**
- **How would you perform the [described] tasks?**
- **Did you have a good attendance record on your prior job?**

  [But NOT whether a poor attendance record was due to illness, accident or disability.]

9 In some circumstances, Federal contractors and subcontractors may have an affirmative obligation to employ and to advance in employment opportunities qualified individuals with a disability, e.g., Section 503 of the Rehabilitation Act of 1974 and the Vietnam Veterans' Readjustment Assistance Act of 1974. In these situations, an employer can legitimately inquire as to an applicant's disability in order to satisfy statutory requirements. However, these laws typically apply to procurement contracts for goods and to construction contracts, - but not to contracts for personal services. In the unlikely event that a health center has such a contract (as a prime contractor to the government or as a subcontractor), it should obtain guidance from the awarding government agency (or the prime contractor, if appropriate) as to its obligations.

10 Employers are required to provide a reasonable accommodation to the known physical or mental limitations of a person who otherwise is qualified to perform the essential functions of a particular job, provided that doing so would not impose an undue hardship on the employer. Reasonable accommodation is any modification or adjustment to a job, an employment practice, or the work environment that makes it possible for an individual with a disability to enjoy an equal employment opportunity. Some common examples of a reasonable accommodation include making an employer's facilities readily accessible to and usable by an individual with a disability, altering when or how an essential job function is performed, modifying equipment and devices, and modifying work schedules.

If an applicant has an obvious disability that might affect their ability to perform the job, an employer may ask the applicant to explain or to demonstrate how they would perform the job functions, even if other applicants are not asked to do so. If that same applicant were seeking a position where the known disability would not interfere with the performance of job functions, the applicant could not be required to demonstrate or describe how they would perform the job unless all applicants for the position were required to do so. In any case, the interviewer may not inquire as to the nature or severity of the disability, the prognosis for the underlying physical or mental condition, or whether the applicant will need treatment or time off from work on account of the disability.

In addition, employers may ask applicants if they require an accommodation during the hiring and interview process. An applicant may, for example, need special accommodation in completing the health center's written application form, or an applicant with an apparent disability may need an accommodation if the applicant opts to demonstrate (rather than explain) during the interview that they can perform the job's essential functions.

OTHER EXAMPLES OF ILLEGAL OR INAPPROPRIATE QUESTIONS AND COMMENTS

Genetic Information

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the use of genetic information in employment decisions and, except in very limited circumstances, [11]prohibits an employer from requesting, requiring, or purchasing genetic information. GINA defines "genetic information" to include information about an individual or a family member's genetic tests (the analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes) and, importantly, any family medical history (information about the manifestation of a disease or disorder in family members). GINA prohibits the acquiring of genetic information even if it is never used in an employment scenario.

According to the Equal Employment Opportunity Commission, which enforces the anti-discrimination provisions of the law, GINA is concerned primarily with protecting individuals who may be discriminated against because an employer thinks that they have an increased risk of acquiring a medical condition in the future. In short, according to the EEOC, an employer may never use genetic information to make an employment decision because genetic information is not relevant to an individual's current ability to work.

Other laws, such as the ADA, may protect an individual whose medical condition meets the definition of a "disability." Accordingly, while under the ADA an employer may conduct a medical examination after making a job offer (or during employment to the extent allowed by law), under GINA, the examination may not include the collection of family medical history because the history might reveal a predisposition to certain diseases. In short, making requests for information about an individual's current health status in a way that is likely to result in obtaining genetic information or requesting an applicant's family medical history should be "off limits" for interviewers.

Smoking

State or local law may protect job applicants from questions concerning tobacco use or other off-duty, lawful activities. Again, where those laws are in effect, interviewers should avoid asking such questions.

11 For example, an employer may request medical information to support an employee's request for reasonable accommodation under the ADA or to document the need for family or medical leave, provided that the request for documentation complies with applicable law.

MAKING THE MOST OF THE INTERVIEW OPPORTUNITY

The opportunity to meet a job applicant face-to-face is a critically important tool in the hiring process. Health centers should make the most of that opportunity. Being knowledgeable about the position and its requirements will help the interviewer to stay on course and not ask questions that may later cause problems for the health center.

- Prior to advertising a position, the health center should review the written job description for the position to make sure that it is current, and that it accurately describes the essential duties and requirements of the position and specific job functions.
- Develop a standard application form designed to elicit information about the job candidate's skills, personal qualities, and overall competence for the job. Make sure that the application contains only questions that are essential for determining if a person is qualified for the job, avoid inquiries about races, sex, national origin, age, and religion. Keep in mind that state or local laws may prohibit employment discrimination based on other protected characteristics, e.g. height, weight, etc.
- Carefully tailor standard interview questions for each vacant position so that the questions are specifically relevant to the position's essential duties and obligations. Using a standard set of questions for all candidates for a particular job facilitates the decision-making process by allowing the health center to compare more easily the strengths and weaknesses of each job applicant. Consequently, it leads to consistency and uniformity in the hiring process, which is strong evidence of a selection process that treats all applicants fairly and equally.
- Before each interview, the interviewer should take the time to learn as much as possible about the position so that they can describe the position, tailor questions to elicit relevant information, and answer any questions the candidate might have. If, for example, the position requires extensive patient contact, the center will want to be assured that the applicant has the necessary verbal communication skills, possesses the ability to be compassionate, and is adept at handling various situations, such as dealing with difficult patients.
- Determine whether the applicant has experience managing other employees if the position calls for supervising other members of the health center's staff.
- Learn how the applicant handled particularly difficult management situations in the past.

By utilizing a standardized hiring process and staying focused on the position's specific and essential job functions, an interviewer can more easily conduct an interview that serves the health center's objectives and complies with employment discrimination laws.

CONDUCTING LEGAL BACKGROUND CHECKS

Health centers may have a legitimate interest in the work history, education, criminal record, and financial history of applicants (or current employees) being considered for employment.

Except for medical history and genetic information, Federal law generally allows employers to inquire into an applicant's (or employee's) background or to conduct a background check.[12]

However, an employer must comply with the Federal anti-discrimination laws when it uses background information to make an employment decision, without regard to how the information was obtained. Similarly, when an employer uses a company that is in the business of compiling background information to conduct a background check, the employer must comply with the Fair Credit Reporting Act ("FCRA").

To that end, the EEOC, and the Federal Trade Commission ("FTC"), which enforces FCRA, have

12 Note that state or local laws may have different requirements regarding the collection and use of background information in making employment decisions

issued joint guidance on conducting lawful background checks.[13]

The key features of a lawful background check, according to the EEOC and the FTC are:

TREAT EVERYONE EQUALLY

- A decision to conduct a background check should not be based on an applicant's race, sex, national origin, etc.
- Apply the same standards to everyone when using background check information to make hiring decisions. For example, if the health center does not reject applicants of one ethnicity with certain financial histories, it should not reject applicants of other ethnicities because they have same or similar financial histories
- Take special care when basing employment decisions on background problems that may be more common among people of a certain race, color sex, etc. (any "protected class"). For example, employers should not use a policy or practice that excludes people with certain criminal records if the policy or practice significantly disadvantages individuals of a particular race, national origin or other protected characteristic and does not accurately predict who will be a responsible, reliable, and safe employee. Otherwise, the policy or practice may subject the employer to a charge of discrimination based on "disparate impact."

OBTAIN BACKGROUND INFORMATION

When obtaining background information (e.g. a credit report or a criminal background report) from a company in the business of compiling background information:

1. Inform the applicant in writing, but in a document separate from the job application, that the health center might use the information for employment decisions. If you also are asking for an "investigative report" – a report based on personal interviews concerning a person's character, general reputation, personal characteristics and lifestyle – the center must also inform the applicant of their right to a description of the nature and scope of the investigation.
2. Obtain the applicant's written permission to do the background check. While you can reject an employment application if the applicant does not give permission, it is extremely important that an employer apply this policy across the board and for all applicants. Otherwise, they are setting themselves up for a potential claim of employment discrimination.
3. Certify to the company conducting the background check that the center:

- Has notified the applicant and obtained written permission for the check;
- Has complied with all the FCRA requirements; and
- Will not discriminate against the applicant or otherwise misuse the information in violation of law.

WHEN TAKING AN ADVERSE ACTION

If the health center does not hire an applicant based on information obtained from a company in the business of compiling background information:

1. Give the applicant advance notice of the adverse action, including a copy of the consumer report relied on in making the decision, and a summary of the applicant's rights under the FCRA so that the applicant has an opportunity to review and explain any negative information.
2. Inform the applicant orally, in writing, or electronically:

- They were rejected on account of information in the report;
- The name, address, and phone number of the company that sold the report;
- The company that provided the report did not make the hiring decision and cannot give specific reasons for the hiring decision; and

13 *Background Checks: What Employers Need to Know* (201)

- They have the right to dispute the accuracy of the report and to obtain an additional free report from the reporting company within 60 days.

3. Observe retention and disposal requirements for background information.

REQUIRED RECORD RETENTION AND DESTRUCTION

The EEOC requires that an employer preserve all personnel or employment records – including all application forms and other records related to hiring regardless of whether the applicant was hired—for one year after the records was made or after a personnel action was taken, whichever comes later. Once the record retention period is satisfied, background information reports can be destroyed. However, FCRA requires that the records be disposed of securely including burning, pulverizing, or shredding of paper documents and disposing of electronic information in a manner that prevents reading or reconstruction.

USING SOCIAL MEDIA IN HIRING DECISIONS

Employers increasingly are using social media, such as Facebook, Twitter, as well as more generalized Google and other internet search engines, to obtain information in vetting prospective employees. The utility of social media in predicting employee behavior is a matter of debate, and the reliability of internet- sourced information is a concern. Separate from the question of the appropriate function of social media in the hiring process, there are legal "minefields" that should be recognized and avoided.

An employer may obtain information online that it is not permitted to consider in the hiring process, such as race, sex, disability. Once there is evidence that the employer obtained such information online, it is difficult to demonstrate that it did not use prohibited hiring information in making an employment decision.

GINA (discussed above) poses a particular social media risk. GINA prohibits an employer from requesting genetic information about both the individual and a family member of an individual. The regulations implementing GINA specifically define a "request" to include "conducting an internet search of an individual in a way that is likely to result in an [employer] obtaining genetic information." [14]Since the definition of "request" is so broad, an employer using social media to vet an applicant may inadvertently acquire protected "genetic information" such as an applicant tweets that their parent is recovering from cancer surgery.[15] A health center can effectively protect itself from this risk by retaining a third-party vendor to conduct the social media search, which will insulate the center from inadvertent access to protected information. Note, however, that the FCRA disclosure requirements discussed above will have to be made.

Accordingly, if a health center decides to review social media as part of its hiring process, it would be well advised to wait until after there has been a face- to-face meeting with the applicant. This will make it less likely to be accused of taking protected characteristics learned from a social network profile into consideration when making an employment decision.

Further, if a health center chooses to use social media, it should have a written policy describing exactly how it will conduct a search. The policy should:

- Establish a "firewall" between the person conducting the internet search and the person who makes the hiring decision to filter out any information that might reveal a protected characteristic.

- Identify which social media sites will be reviewed and what criteria will be used in assessing the information obtained. Such criteria should be relevant to an applicant's fitness for the job and, as with background checks, social media searches

14 29 C.F.R. § 1635.8(a)

15 There is a limited exception when the person conducting the social media search was given access permission by the creator of the profile, such as when both persons are "connected" on the social networking site.

should be used evenly with all applicants in a non-discriminatory manner.

- Provide that the applicant will be informed that a social media search will be conducted and prohibit asking the applicant for passwords or log-in credentials. Asking for passwords and other access to internet accounts is illegal in many states and may, in fact, discourage well-qualified candidates from pursuing employment on account of privacy concerns.

CONCLUSION

Hiring and maintaining a qualified, knowledgeable, hardworking, competent, and reliable staff is one of the most important components of a health center's operations. As such, preparation that focuses on the questions to ask a candidate and, equally importantly, the questions NOT to ask, is essential for a successful interview, which ultimately, should result in an effective hiring process.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

HR Information Bulletin #2

CLASSIFYING WORKERS AS EMPLOYEES OR AS INDEPENDENT CONTRACTORS: WHY IT MATTERS AND HOW TO DO IT CORRECTLY

A typical health center's workforce is comprised of a mix of clinical, administrative, technical, and support staff. While most staff are likely to be bona fide full- or part-time employees, a health center also may retain various individuals to provide services to the center or to the center's patients who are not considered to be regular employees of the health center, sometimes referred to as "consultants."

Such individuals may be brought on to perform a specific function, such as a grant writer or an information technology specialist, or to provide a specific service, such as a specialty physician or an occupational therapist. From a legal perspective, every person who is compensated for providing a service to or on behalf of the health center must be classified either as an "employee or as an "independent contractor."

As a general matter, an employer has significantly greater legal obligations with respect to an employee as opposed to an "independent contractor." However, there often is a significant financial incentive for an employer to classify a worker as an independent contractor as opposed to an employee. For example:

- An employer does not have to pay to the employer's share of Federal and state employment taxes and does not incur the administrative costs of withholding taxes from an employee's wages.
- Independent contractors typically are not covered by workers' compensation laws, are not entitled to overtime pay, are not covered by employer-sponsored health insurance and other employee benefit programs, which can easily increase compensation costs by 20% to 30%.
- Independent contractors do not have the legal protections offered by Federal and state employment discrimination laws which reduces the employer's potential liability for violations.
- Finally, workers sometimes prefer independent contractor status. The individual may be paid more than they would if they did the same work as an employee (on account of the employer's savings on employment taxes and employee benefits that must be paid for employees), and they may prefer not to have Federal and state taxes withheld from their pay.

Hiring a worker as an independent contractor can serve a legitimate business purpose for a health center. However, misclassifying an employee as an independent contractor can prove to be a costly error. Misclassification of workers for Federal and state tax purposes is the most common classification error, and can result in an employer being liable for significant tax penalties.

Accordingly, this Information Bulletin:

- Addresses the importance of the legal and financial consequences of the "employee" and "independent contractor" classifications.
- Focuses on the tests used by the Internal Revenue Service ("IRS") for classifying workers as employees or independent contractors.
- Describes worker classification issues raised by other Federal and state employment laws, each of

which uses its own definition of "employee" versus "independent contractor."[1]

CLASSIFICATION BASICS

It is important to understand that proper worker classification reflects a legal conclusion that is based on the analysis of relevant factors in the relationship between a worker and an employer.[2] The fact that a worker has a written contract with an employer does not alone determine that the worker is an independent contractor. Many bona fide employees have employment contracts. Further, a contract provision that states that a worker is an independent contractor (as opposed to an employee), while relevant, does not determine the proper classification. All of the terms of the contract and, in particular, the control that an employer has over the worker under the contract must be considered. In other words, an employer and a worker cannot agree to treat the worker as an independent contractor if, based on all of the facts and circumstances of their relationship, the worker should be legally classified as an employee.

EMPLOYER'S CONTROL OF THE WORKER

Classification for IRS purposes, and for most other laws where classification is relevant, focuses on the employer's control over the worker, not only in terms of control of "what" the worker does, but also control of "how" the worker accomplishes the assigned task. The more control that an employer has with regard to the "means and methods" that are to be used in performing the assigned work, the more likely that the worker should be classified

as an employee. Moreover, the employer does not have to actually exercise the right to control the means and methods of performance, as long as it retains the right to do so.

CONTROL APPLIES TO ALL LEVELS OF WORKERS

It is important to understand that the "right to control" test applies to all categories of workers. Professionals, such as physicians and other clinicians, may be classified as employees even though they exercise independent medical judgment when carrying out their duties. The longstanding IRS position, supported by court decisions, is that physicians (and other clinicians) should be classified as employees if they are subject to the requisite degree of control and supervision with respect to services performed.[3]

Accordingly, it is a mistake to automatically treat physicians and other clinicians who are contracted to work for a health center from time to time as independent contractors. Their classification status should be evaluated under the same criteria applied to all workers. These criteria are discussed below in detail.

NO STANDARD CLASSIFICATION CRITERIA

If the employer's "right to control" how the worker performs assigned tasks is not explicitly spelled out (in an employment contract, through terms and conditions of employment, in personnel policies, etc.), the courts, the IRS, and agencies administering employment-related laws will look at numerous factors (as discussed below) to determine whether the worker should properly be classified as an employee or as an independent contractor. Usually, the classification is not based on one factor alone, but on all of the facts and circumstances of the employer-worker relationship. However, there is no uniform definition or test of "employee" and "independent contractor" status that applies across all applicable employment-related laws.

1 Employee classification also is relevant under federal health care fraud and abuse laws. Both the anti-kickback statute and the Stark II (regarding physician self-referrals) contain "safe harbors" for bona fide employees. Both statutes use the IRS classification standards, discussed below, to determine employee status.

2 Unless the context requires otherwise, the term "employer" is used throughout this Information Bulletin to denote a person or entity that compensates a person, i.e., a worker, for the provision of services, without regard to whether the worker is an employee or an independent contractor.

3 See, for example Rev. Rul. 61-178, C.B. 1961-2, 153; Jones v. Commissioner, 25 T.C. 1296 (1956).

WORKER CLASSIFICATION FOR FEDERAL TAX PURPOSES

If a worker is classified as an "employee" for federal tax purposes, an employer must:

1. Withhold the appropriate amount of federal income tax[4] and the worker's share of federal employment taxes from the employee's pay, such as Social Security and Medicare taxes payable under the Federal Insurance Contribution Act ("FICA"),
2. Forward the withheld amount to the IRS (within the time period established by the IRS) along with the health center's share of FICA taxes on an employee's wages, and
3. Provide minimum essential health care coverage under the Affordable Care Act if the employer has more than 50 full-time employees, or face stiff tax penalties.

These obligations do not exist if a worker is an independent contractor, in which case the independent contractor will have the responsibility for paying their FICA tax liability and for making quarterly estimated Federal income tax payments.

FEDERAL TAX CONSEQUENCES FOR MISCLASSIFYING EMPLOYEES

Incorrect classification of workers can have significant financial consequences. If an employee is misclassified as an independent contractor, the employer must pay:

- All of the FICA taxes it owes for the period that the worker was misclassified as an independent contractor.
- 20% of the FICA taxes that should have been withheld on behalf of the employee.
- A penalty equal to 1.5% of the wages paid to the employee, if the employer failed to withhold income taxes.
- If the employer also failed to properly report the compensation paid to the worker (by filing IRS Form 1099-MISC), the penalty increases to 40% of the FICA tax that should have been paid and up to 3% of the worker's earnings (for failure to withhold income tax). If the IRS can prove that there was a willful failure to withhold or to pay FICA taxes, the penalties increase dramatically. In that case, the employer is liable for a penalty equal to 100% of the taxes due and for interest on the income taxes not withheld.
- In addition, the IRS may impose the 100% penalty for a willful violation on anyone whom the IRS determines to be a "responsible party," such as any officer, board member, or employee of the health center who had the responsibility to withhold and remit taxes or otherwise had authority over the payment of wages. In short, that person can be held personally liable for their failure to fulfill that obligation.
- Although a worker it responsible for their individual tax liability, it is important to note that no penalties are assessed on a worker who is misclassified as an independent contractor. Thus, virtually the entire burden of ensuring proper classification falls on the employer, along with paying any penalties imposed by state and local tax authorities.[5]

4 Note that, even if a worker is properly classified as an independent contractor, an employer must withhold a minimum of 28% of the compensation due if the contractor does not provide, or provides an incorrect, Taxpayer Identification Number ("TIN").

5 An employer who misclassifies a worker may obtain relief from penalties under Section 530 of the Internal Revenue Act of 1978. Section 530 provides that the IRS may not assess tax penalties if the following conditions are met: (1) the employer always treated the affected worker as an independent contractor; (2) the employer filed all tax returns (including information returns) required with respect to the worker for all periods after 1978, and the returns were all consistent with independent contractor status; and (3) the employer had a reasonable basis for treating the worker as an independent contractor. A reasonable basis exists if the employer relied on any of the following: (1) judicial precedent, published IRS rulings, or IRS technical advice or letter ruling provided to the employer; (2) a prior IRS audit of the employer in which no assessment was made on account of misclassification of the affected worker; or (3) a long-standing, recognized practice of a significant segment of the industry in which the worker is employed to treat such workers as independent contractors.

IRS WORKER CLASSIFICATION TESTS

Historically, the IRS used the so-called "20-Factor Test" in classifying workers.[6] While the "20-Factor Test" remains relevant, the IRS now focuses on evidence in three functional categories (Behavioral, Financial, and Type of Relationship) that may (or may not) demonstrate that the employer retains the right to control.[7] The relevant "facts" for each category, as applied to health centers, can be summarized as follows.

Behavioral Control—Relevant Facts

Behavioral control refers to facts that show whether or not there is a right to direct or control how a worker does the work. Such factors include (1) types of instructions, (2) degree of instruction, (3) evaluation systems, and (4) training.

1. **Types of instructions that the health center gives the worker—**The more instruction that the health center gives to a worker, the more control it has over the worker and the more likely that the worker is an employee. For example, workers may instructed by the health center about such details as:

- When and where to perform work
- What tools or equipment to use
- Where to purchase supplies and services
- What workers will be hired to help with the work
- What work will be performed by which specific person
- What order or sequence to follow

2. **Degree of instruction—**The more detailed the instructions, the more control the employer exercises over the worker. The amount of instruction necessary to establish an employment relationship will vary among different jobs. However, even if no instructions are given, the fact that the health center has the right to control how the work is performed indicates that an employer-employee relationship exists. A health center may lack the knowledge to instruct highly specialized professionals or the task may require little or no instruction, but the key consideration is whether the health center has retained the right to control the details of a worker's performance.

3. **Evaluation system—**If there is an evaluation system to measure the details of how the work is performed, that also points to employee status. Conversely, an evaluation system that measures just the end result of the work can point to either an independent contractor or an employee relationship.

4. **Training—**A health center may train an employee to perform services in a particular manner and/or provide periodic or on-going training about procedures or methods. Both are strong evidence of an employment relationship. Independent contractors ordinarily use their own methods and receive less training.

Financial Control - Relevant Facts

Financial control refers to facts that indicate whether or not the employer has the right to control economic aspects of the worker's job. Such factors include: (1) unreimbursed expenses; (2) significant investment; (3) services available to the market; (4) method pf payment; and (5) opportunity for profit or loss.

1. **Unreimbursed business expenses—**Independent contractors are more likely to have unreimbursed business expenses than are employees. That a worker has fixed ongoing costs that are incurred regardless of whether work is currently being performed, such as equipment and space costs, is an especially important indicator of independent contractor status. However, it should be noted that at times employees may also incur unreimbursed expenses in connection with the services they perform.

6 The 20 Factors were outlined in Rev. Rul. 87-41, 1984-1 C.B. 296.

7 Internal Revenue Manual, 4.23.5.6.1 (12-10-2013).

2. Significant investment—An independent contractor often has a significant investment in the equipment they use in performing services unlike an employment situation where equipment, supplies, and the like typically are provided by the employer.

3. Services available to the market—An independent contractor generally is free to seek out other business opportunities in the relevant market and may advertise and maintain a visible business location. In contrast, employees typically are limited to providing services to one employer at a time.

4. Method of payment—An employee generally is guaranteed a regular wage for an hourly, weekly, or other period of time. An independent contractor usually is paid by a flat fee for the job, although in some professions, e.g. law, it is common to pay an hourly rate.

5. Opportunity for a profit or loss—An independent contractor expects to make a profit (and assumes the risk of losing money) on a particular engagement. The likelihood of profit or loss typically is not a consideration for an employee.

Type of Relationship—Relevant Facts

Type of relationship refers to facts that demonstrate how the employer and the worker view their relationship to one another. The relevant factors generally include: (1) written contracts; (2) employee benefits; (3) permanency of the relationship; and (4) services performed as a key activity of the employer's business.

1. Written contracts—While written agreements are relevant evidence of the nature of the relationship, the actual arrangements and conduct are the primary determinative factors, not what the parties think or say the relationship is. No matter what status the parties intended to create, the status they have actually created (taking into account all of the relevant factors) is what controls the classification.

2. Employee benefits—The provision of benefits typically available to employees, such as health insurance, a pension plan, vacation pay, sick pay, etc., is a strong indicator of an employer-employee relationship. However, because employers are not required to provide such benefits, their absence does not necessarily mean that the worker is an independent contractor.

3. The permanency of the relationship –Engaging a worker with the expectation that the relationship will continue indefinitely, rather than for a specific project, is considered evidence of intent to create an employer-employee relationship.

4. A key activity of the health center—If a worker provides services that are a key component of the health center's regular activity, it is more likely that the center will have the right to direct and control the worker's activities. For example, the center is likely to have the right to direct and control how clinical services are performed through treatment protocols, quality standards, etc. In contrast, it is less likely that the center will have the right to control non-core activities, such as repairing the roof.

OTHER EVIDENCE OF CONTROL

In reviewing whether a worker is properly classified as an employee or independent contractor, the IRS will review all evidence and information indicating control in the employer-worker relationship. Indeed, the IRS instructs its agents reviewing employer classification issues to remember four "very important" points which all employers also should keep in mind when classifying workers:

- There is no "magic number" of relevant evidentiary factors.
- Whatever is the number of factors used, they merely point to evidence to be used in evaluating the employer's right to direct and control the worker.
- All relevant information must be explored before answering the legal question of whether the right to direct and control associated with an employment relationship exists.
- Evidence supporting a worker's classification must

be factual and well documented and support the conclusion.

CLASSIFICATION PROCESS

For federal tax purposes, either the employer or a worker can ask the IRS to classify the worker as an employee or as an independent contractor. This is done by filing IRS Form SS-8, "Determination of Employee Work Status for Purposes of Federal Employment Taxes and Income Tax Withholding," with a description of the type of work being performed and information about the terms and conditions of the work sufficient to make the proper classification. The parties are bound by the IRS's decision, but only with regard to federal tax issues. Health centers also should keep in mind that the IRS strongly prefers that workers be treated as employees.

WORKER CLASSIFICATION UNDER OTHER FEDERAL EMPLOYMENT- RELATED LAWS

Worker classification is relevant under numerous other Federal laws that apply only to employees, not to independent contractors. These include:

- **Americans with Disabilities Act ("ADA")**
- **Age Discrimination Act ("ADEA")**
- **Title VII of the Civil Rights Act of 1964 ("Title VII")**
- **Employee Retirement Income Security Act ("ERISA")**
- **Group health plan coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA")**
- **Family Medical Leave Act ("FMLA")**
- **Fair Labor Standards Act ("FLSA")**
- **Equal Pay Act**
- **Genetic Information Nondiscrimination Act of 2008 ("GINA")**
- **National Labor Relations Act ("NLRA")**
- **Labor-Management Reporting and Disclosure Act ("LMRDA")**
- **Immigration and Nationality Act ("INA")**
- **Occupational Safety and Health Act ("OSHA")**
- **Uniformed Services Employment and Reemployment Rights Act ("USERRA")**

Under these employment-related statutes, worker classification typically determines whether the worker and the employer are covered by the statute at all. Moreover, certain federal employment-related statutes do not apply unless an employer employs a minimum number of employees (as defined for purposes of that statute). The table below indicates the minimum number of employees necessary for an employer to be covered by the applicable statute.

LAW OR ACT	NUMBER OF EMPLOYEES
FMLA	50
COBRA	20
ADEA	15
ADA	15
TITLE VII	15
GINA	15

As with the federal tax laws, the consequences of misclassification can be severe. For example, an employer that discovers that a worker it treated as an independent contractor is a "non-exempt" employee for purposes of the FLSA could find itself liable for significant overtime pay and penalties. Similarly, an employer that arbitrarily terminates an older worker believed to be an independent contractor could find itself involved in an age discrimination case.

As these statutes do not contain explicit definitions of "employee," the courts have frequently been called upon to distinguish individuals covered by the statutes from those who are not covered. In doing so, federal courts have tended to consider the common law "right to control" test along with numerous economic factors in order to assess the

relationship between the employer and the worker in its totality. The U.S. Supreme Court has noted that the following factors, in addition to the employer's right to control, are relevant in determining if the worker should be classified as an employee.[8]

- The skill required to perform the work
- Whether the worker supplies their own tools
- The location where the work is performed
- The duration of the relationship of the parties
- The employer's right (or lack thereof) to assign additional projects
- The worker's discretion over when and how long to work
- The method of payment
- The worker's role in hiring and paying assistants
- Whether the work is part of the employer's regular business
- Whether the worker is in business for themselves
- Whether "employee benefits" are provided to the worker
- How the worker is treated for tax purposes

In short, coverage under these statutes is highly dependent on individual circumstances and, if litigated, is subject to judicial interpretation. Accordingly, health centers should obtain legal counsel if a worker's status under these statutes is uncertain.

WORKER CLASSIFICATION UNDER STATE LAW

Classifying a worker as either an employee or as an independent contractor also is important under state laws, principally unemployment insurance, workers' compensation insurance, and state-based anti-discrimination laws. Although many states continue to use the traditional "20 factor" or similar tests in some form, an increasing number of states have adopted the so-called "A-B-C Test," either through court decisions or legislation. The A-B-C test makes it more difficult to classify a worker as an independent contractor, as opposed to an employee, because the worker is presumed to an employee unless the arrangement satisfies all three criteria of the test, namely:

A. The worker is free from control or direction in connection with the performance of the service.

B. The worker is performing services that are not part of the usual course of activities of the business and (in some states) outside of the customary places of business. For example, someone hired to paint the health center would not be performing work as part of the center's operations. A nurse most likely would be.

C. The worker is customarily engaged in an established trade, occupation, profession, or business of the same nature as the service being performed for the business.

In sum, if any one of the three elements of the A-B-C Test is missing the worker will be classified as an employee.

OTHER CONSIDERATIONS REGARDING WORKER CLASSIFICATION

"RULE OF THUMB" DETERMINATIONS

It is essential to remember in applying the relevant classification tests that outside of a strictly applied A-B-C Test, usually, no one factor is determinative of a worker's status. In close cases,

it will be necessary to carefully weigh all of the factors applicable to a particular classification issue. However, in many cases it may be possible to apply a "rule of thumb" to avoid a potential misclassification. Employment situations that do not readily fall into these categories should be analyzed further by applying the appropriate tests.

8 Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 316, 322 (1992).

Workers generally are considered to be independent contractors when they:

- Are sole proprietors of their own business
- Conduct their business thru a legally recognized business entity such as a corporation, limited liability company (LLC), etc.
- Work under a contract for hire, whether written, oral or implied
- Have the right to set the terms and conditions of their work and how they perform the assigned tasks
- Set a fixed fee or price for their work
- Set their own work schedule, subject only to agreed-upon deadlines

Workers generally are considered to be employees when they:

- Do not have the right to determine how they perform the assigned work
- Receive benefits typically reserved for employees, e.g., vacation, sick days, health insurance, life or disability insurance, etc.
- Perform the same services that otherwise are performed by bona fide employees, or that they previously performed for the employer as an employee, e.g., a "retired" employee providing "consulting" services
- Are subject to personnel policies applicable to employees such as drug testing, time and attendance, etc.
- Work for the health center exclusively
- Provide services that typically are management functions of the health center
- Perform work that does not require a high level of skill or expertise
- Perform services on the health center's premises using the health center's equipment and supplies

MONITORING COMPLIANCE WITH EMPLOYEE CLASSIFICATION REQUIREMENTS

It is a good practice for health centers, like all employers, to periodically review their policies and procedures for classifying workers for compliance with federal and state requirements. For example, it is possible for a worker in a state that applies the A-B-C test strictly to be classified as an employee for state purposes but not as an employee for all Federal purposes. Moreover, there is pressure at both the state and Federal levels for change in the classification rules, sometimes designed to promote the "gig" economy by making it easier to classify workers as independent contractors and sometimes by making it harder to classify as independent contractors so that workers will have protections afforded to employees. Accordingly, it is essential that health centers stay current on developments in the law.

TERMS AND CONDITIONS OF EMPLOYMENT/ INDEPENDENT CONTRACTOR ARRANGEMENTS

Obviously, the surest protection against the potential penalties that a health center might incur from misclassification is to classify the worker as an employee in the first instance. That would insure compliance with federal and state laws where worker classification is relevant. Note that many of the benefits typically provided to employees, such as paid vacation and/or holiday leave, paid sick leave, and severance pay are not regulated by federal (nor most state) law. Thus, a health center could treat workers as employees for the purposes regulated by law, but not necessarily for every other purpose.

However, before a health center takes that approach, it should make sure that the distinctions between, and the associated benefits provided to, its various types of employees are clearly spelled out in its personnel policies. Most importantly, the terms and conditions of employment should be clearly spelled out to the employee, preferably in a written employment letter, bearing in mind that a worker cannot agree to waive a requirement or benefit, such as tax withholding or overtime pay if the employer is legally required to comply with the

law or to provide the benefit. This is a particularly sensitive issue with regard to employee benefits subject to ERISA such as health and pension benefits and similar plans maintained by an employer for the benefit of its employees.

In instances when a health center prefers to engage an individual as an independent contractor, minimize risks by taking basic precautions:

1. Sign a written agreement with the independent contractor specifying the services to be provided, payment terms, deadlines, etc., but avoid language that gives the health center control over the "means and methods" of performing the services. The agreement should require the worker to comply with the tax obligations of an independent contractor.
2. Be consistent in using independent contractors. Do not engage an independent contractor to do the same kind of work provided by employees.
3. Allow the worker to determine where and how to accomplish the assigned tasks and work hours, without supervision.
4. Avoid giving the worker office space and access to the health center's equipment and supplies unless there is an agreement to "charge back" the costs to the worker.
5. Pay the worker on an invoice basis. Never pay independent contractors through the health center's regular payroll system.
6. Establish a file for each independent contractor and keep good records including contracts, invoices, and other information documenting that the worker is operating as an independent contractor, such as business cards, stationery, list of other businesses for which services are performed. Always keep independent contractor records separate from the health center's personnel files.
7. If the independent contractor will be paid with Federal funds, always follow (and document) required procurement procedures.
8. When possible, engage independent contractors that conduct their business through a legally recognized entity. In that case, the health center is hiring the company, not the individual. (Keep in mind, however, that the government takes the position that clinicians must contract individually, not through their professional corporation, in order to be covered under the Federal Tort Claims Act.)
9. Obtain taxpayer identification numbers for any unincorporated independent contractor to whom the health center pays more than $600.00 in a year, and file an IRS Form 1099.

CONCLUSION

Misclassification of health center workers may result in serious legal and/or financial consequences, under Federal tax law as well as other federal and state employment-related laws. As such, health centers should use caution when classifying workers, reviewing and utilizing various worker classification tests and seeking professional guidance when necessary. Taking appropriate precautions will substantially reduce the legal and financial risks, both to the health center and to the individual worker(s) involved.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

HR Information Bulletin #3

HUMAN RESOURCES RECORD KEEPING REQUIREMENTS FOR HEALTH CENTERS

Health centers create and maintain thousands of documents in the course of doing business. These documents include patient medical and billing records, as well as an array of financial, personnel, and corporate governance documents and related correspondence that are created by the health center in carrying out its business activities.

Personnel and payroll-related recordkeeping can present a particular challenge. There are numerous federal (and state) laws affecting the employment relationship where proper record maintenance is important, either because the law specifically requires certain records to be kept or the employer must have the appropriate records available in order to document its compliance with the law.

This Information Bulletin along with the attached Record Retention Table:

- Describe a quick self-audit of human resources record keeping and record retention policy (please see attached **Record Retention Table**)
- Identify elements of an effective human resources record retention policy

Assessing the center's human resources record retention policies and practices will help a health center to identify any gaps or weaknesses in its recordkeeping system and can identify opportunities for some organizational improvements, including reduced storage costs, greater efficiency in organizing and retrieving records, and improved management of the health center's legal risks.

It is important to understand that this Bulletin focuses on federal requirements. State law may require a health center to retain additional records or specify a retention period longer than the comparable federal requirement. Health centers should work with employment counsel or contact their State Attorney General's office for state record retention requirements.

In addition, health centers should keep in mind that a human resources records maintenance program is only one part of a health center-wide record retention program. There are numerous other documents and records outside the purview of human resources management that must be maintained, such as patient medical records, business records, grantrelated documents, corporate documents, corporate tax records, contracts, audits, and leases. Some of these documents also have legally mandated retention periods, such as records related to the expenditure of Federal grant funds.

HUMAN RESOURCES RECORDS REQUIRED UNDER FEDERAL LAW

There are recordkeeping requirements in three broad categories under federal law relating to "Human Resources." These are:

1. Federal employment laws – such as the **Americans with Disabilities Act ("ADA")** and the **Age Discrimination in Employment Act ("ADEA")**
2. Federal health and safety laws – such as the **Occupational Safety and Health Act ("OSHA")**
3. Federal tax and wage and hour laws – such as the Internal Revenue Code ("IRC") and **Fair Labor Standards Act ("FLSA")**

The Record Retention Table attached at the end of this bulletin details specific recordkeeping requirements from various Federal laws applicable to health centers that would be included under the categories above.

Obviously, it may be necessary to create and retain certain records in order to comply with several different statutory requirements. For example, date of hire, job classification or title, pay level, typically are required records. With a few exceptions, federal law does not mandate how (paper or electronic)[1] or where (in what department or record system)[2] records are maintained. It is not necessary, for example, to have an employee file containing records required for federal tax purposes and a separate employee file with records required under the ADEA. Moreover, many of the statutory recordkeeping requirements overlap, and duplicate information may be kept in different functional departments of a health center. For instance, the payroll department and personnel department both will have current salary information in health centers where those functions are separated.

Regardless of the form of the records or the manner in which they are retained, human resources-related records will be used to document a health center's compliance (or noncompliance) with applicable laws. It is important, therefore, that a health center have procedures in place to make sure it:

- Creates and maintains the required record(s),
- Can access the required record(s) when necessary, and
- Destroys record(s) that are no longer needed.

RECORD RETENTION PERIODS UNDER FEDERAL LAWS

RECORD RETENTION POLICIES

It is important to remember that the retention periods noted above are only minimum requirements.

- For ease of administration, a health center may want to retain all records pertinent to a particular human resources function for at least the longest period required for similar purposes.

  For example, all personnel-related records could be retained for three years. This would satisfy the **Family and Medical Leave Act (FMLA)** requirements as well as the requirements of the various Federal anti-discrimination statutes. Similarly, payroll-related records could be retained for four years, which would satisfy Federal tax and **Fair Labor Standards Act (FLSA)** requirements.

- Once the minimum statutory requirements are satisfied, employers are free to establish their own record retention periods that, of course, would have to take into account any particular state law requirements. In many cases, it may be advisable to retain records for longer periods than the legal minimum. For example, it may be wise to retain personnel records of current employees at least as long as they are employed by the health center, plus any required post-termination period.

- It also is important to keep in mind that human resources records also may be important to other functions of the health center. Time records may be necessary to document employee compensation costs charged to grant-funded programs. In short, it is important to consider all health center record requirements in developing a record retention policy.

- Records should not be retained beyond the period that they are useful to the health center. Doing so merely increases the costs of storage space (both physical and electronic) and creates administrative problems in managing unnecessary documents and files.

To promote and ensure efficient records management a health center should have a systematic approach to destroying records that it is not legally required to keep and that it no longer needs. An appropriate written record retention policy promotes efficiency and cost savings by

1 The IRS requires specific procedures for maintaining electronic records systems.

2 Under the ADA, an employer must maintain employee health records in a secure manner and separate from other employee records.

eliminating unnecessary records and documents. Further, it helps to ensure that necessary documents are not inadvertently destroyed and that records that are no longer required to be maintained under the law are not otherwise destroyed at the wrong time, such as when an audit, an investigation, or litigation in which the records are material is imminent or under way. Ill-timed destruction of documents can result in the imposition of fines and other sanctions and penalties.

ELEMENTS OF AN EFFECTIVE RECORDS RETENTION POLICY

Although this Information Bulletin addresses only human resource records, a record retention policy should cover all operations of the health center. An effective health center record retention policy should have the following features:

1. Be in writing, dated, and provided to all employees
2. Be written in simple, easy to understand language
3. Contain a schedule indicating the minimum and maximum period of time each covered record should be retained
4. Ensure that appropriate executive-level personnel oversee the destruction of health center documents, e.g., Human Resources Officer for personnel records, Chief Financial Officer for payroll and financial documents, etc.
5. Provide for regular audits or reviews of employees' compliance with the policy
6. Provide for review and destruction of records that no longer are required to be maintained at least annually
7. Include a procedure for notifying all employees promptly when records scheduled for destruction are to be retained, such as in the event of an audit, investigation, or litigation involving the records
8. Include a procedure for regular, period to review and revision of the policy

CONCLUSION

As part of their daily operations, health centers create and maintain thousands of documents, including, but not limited to, those related to the employment, safety, wages, and hours of their respective employees. However, the myriad of Federal laws impacting these records may result in particular challenges to health centers. As such, each health center should seek the advice of knowledgeable legal counsel in developing and implementing its record retention policies. This will assist the health center not only in assuring that it maintains the necessary records for the required period, but also in preventing the improper destruction of records, which could result in significant legal and/or financial liabilities in the future.

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HR Information Bulletin #4

THE DO'S AND DON'TS OF EMPLOYEE TERMINATIONS

Terminating an employee is an unpleasant, but sometimes necessary, part of managing a health center because the center's success depends on the skills, reliability, and trustworthiness of its employees. It may be necessary for a health center to terminate an employee for a host of reasons, including misconduct, poor performance, or budgetary constraints. This Information Bulletin addresses the thorny topic of how a health center can terminate an employee in a manner that minimizes the legal risk associated with such terminations.

Specifically, this Information Bulletin:

- Explains the two types of employer-employee relationships and what each relationship means in terms of a health center's obligations regarding termination:
  1. At-will employees - employees who can be terminated for any legal reason and without cause, and
  2. Contract employees – employees who have certain job protections under a written contract or a contract "implied by law."
- Discusses common types of actions that can result in wrongful discharge litigation; and
- Includes advice on how to terminate an employee legally, including, but not limited to:
  1. Implementing appropriate personnel policies or employee handbook provisions.
  2. Documenting misconduct and/or poor job performance.
  3. What to communicate when terminating an employee; and
  4. Negotiating and executing an employee separation agreement [1]

AN IMPORTANT DISTINCTION: AT-WILL VERSUS CONTRACT EMPLOYEES

Contract employees likely will have significantly different rights than "at-will" employees regarding termination and other terms and conditions of employment. Accordingly, it is critical that health centers, as employers, understand the difference between the two types of employees in order to recognize the health center's legal obligations when discharging the employee.

AT-WILL EMPLOYEES

In the absence of a written employment contract, in every state except Montana, employees are presumed to be engaged "at will." This means that the employee may resign at any time, for any reason or for no reason, and the employer may terminate the employee at any time, provided the reason for the termination is not unlawful, such as a violation of anti-discrimination laws or other laws that prohibit termination of an employee as a matter of public policy. For example, federal and state whistleblower protection laws make it unlawful to terminate an employee because they have reported alleged

1 Note that to the extent that a health center is a party to a collective bargaining agreement with a labor union, the collective bargaining agreement will govern personnel actions involving employees in the applicable bargaining unit. This Bulletin does not address disciplinary actions with respect to employees covered by a collective bargaining agreement.

wrongdoing to a regulatory or law enforcement body. [2]

CONTRACT EMPLOYEES

Written Contracts

If an employee signs an employment agreement that provides specific circumstances under which they can be terminated (e.g., for "cause" as spelled out in the agreement), unlike an "at-will" employee, that employee can be terminated only in accordance with the terms of the contract. For example, a typical employment contract will specify the duration of the employment (e.g., three years) and the grounds for terminating the contract prior to its end (e.g., substance abuse, gross misconduct, etc.). In short, the terms of employment are governed by the written agreement.

Implied Contracts

Even without a written contract, an employer may find that it is not able to terminate an employee "at will" as a result of an "implied contract." Simply put, this means that the employer has made certain representations to an employee or engaged in a course of conduct that, in effect, creates contractual obligations, just as they would if stated in a written employment contract.

A health center may find itself bound by an implied contract, usually inadvertently, on account of statements or practices that suggest that an employee is not subject to the center's "at-will" policy. Furthermore, a health center may expose itself to a wrongful discharge claim based on an alleged breach of the implied contract. For example:

- An implied contract may be deemed to exist if a supervisor or manager makes statements regarding the health center's disciplinary or termination procedures. For example, if a supervisor says to an at-will employee that "no one gets fired from this health center unless they really mess up," the employee could potentially argue that the supervisor's statement created an expectation that they have greater job protection than an "at will" employee.
- Employers sometimes require new employees to complete a "probationary period" often lasting a few weeks to several months. Although the employer does not intend to change an employee's at-will status once the employee completes the probationary period, there is some risk that successfully completing probation implies that the employee then has greater job protection. Consequently, to avoid creating false expectations on the part of employees, it is advisable to refer to the probationary period as an "introductory period" (perhaps warranting evaluation at its conclusion) and to notify employees that successful completion of the introductory period does not alter their at-will status.
- An implied contract may be deemed to exist due to an employee's reliance on language in the employee handbook or personal policies. For example, some courts have held that an employee following the requirements of a handbook creates a contractual obligation on the part of the employer to retain the employee, or that an employee's written acknowledgment of receipt of a handbook constitutes an employment contract. While the success of this claim varies widely from state to state, an employee is more likely to prevail if the handbook or personnel policies do not explicitly state that the document does not constitute an employment agreement and do not expressly reiterate the employer's "at-will" policy.

TYPES OF WRONGFUL DISCHARGE ACTIONS

It is important for health centers to understand the legal principles underlying the most common wrongful discharge claims in order to avoid behavior that may result in allegations that an employee has been unlawfully terminated and the resulting litigation. This section briefly describes various theories of wrongful termination. However, because many (but not all) of these legal theories

2 The employment "at-will" doctrine is established by court decisions and/or statutes in each state where it is followed. Accordingly, the scope and limits will vary from state to state. Health centers should consult with knowledgeable legal counsel with regard to their state's application of the doctrine

are grounded in state law it is advisable for health centers to consult qualified legal counsel with respect to the applicable requirements.

DISCRIMINATION

There are numerous federal laws that protect employees from discrimination. **Title VII of the Civil Rights Act of 1964** is particularly important. Under Title VII, an employer may not discipline, treat differently, or terminate an employee because of that individual's race, color, sex, religion, or national origin. Additionally, the **Americans with Disabilities Act** prohibits discrimination based on an individual's disability, and the Age Discrimination in Employment Act protects employees over age 40 from discriminatory conduct based on their age.

Most states and many municipalities also have enacted anti-discrimination statutes that provide similar and sometimes greater protections than those found in Federal law. For example, in some states it is illegal to discriminate against an employee, including but not limited to terminating employment, based on personal appearance, sexual orientation, family responsibilities, political affiliation, or veteran status.

BREACH OF CONTRACT

A second common grounds for an alleged wrongful termination is a breach of employment contract. A breach of contract claim generally arises in one of two ways.

Breach of a Written Contract

A breach of contract claim may be based on an explicit written employment contract between a health center and an employee. For example, an employee's written employment contract may state that the employee will be employed for a five-year term and can be fired before the end of that term only for certain specified reasons (e.g., "for cause" such as substance abuse on the job, gross insubordination, etc.). If, however, the health center fires the employee after two years of service for a reason not explicitly specified in the employment contract or in any other manner not in accordance with the employment contract, the health center may be accused of breaching their obligations under the contract, and the employee could bring a wrongful discharge claim against the center based on that legal theory.

Breach of Implied Contract

As previously discussed, under certain conditions, an employee may have rights that are not stated in a written contract but that are implied in law even if the employment is otherwise "at-will." While it is more difficult for an employee to prevail when there is no written contract, health centers should review their employment policies and practices for circumstances that could amount to an implied contact of employment

RETALIATORY DISCHARGE/ WHISTLEBLOWER CLAIMS/ VIOLATIONS OF PUBLIC POLICY

An employee who believes that the employer discharged them in retaliation for exercising a legal right may file a claim for wrongful discharge. Many federal and state statutes contain "whistle-blower" protections which prohibit employers from retaliating against an employee (e.g., disciplining, demoting, firing) who reports the employer to an authority (e.g., a federal or state agency/ commission) for violation of a particular law or regulation, or who participates in an audit or investigation involving the employer. For example, the **Occupational Safety and Health Administration** ("OSHA") administers the employee whistleblower provisions of fourteen federal statutes, which protect employees who report workplace safety and environmental/ occupational safety concerns to OSHA authorities. Similarly, the Federal False Claims Act contains an explicit whistleblower provision protecting employees who initiate or participate in a false claims investigation or lawsuit against the employer. Moreover, in many states, employees have won wrongful discharge lawsuits after being fired for filing a Worker's Compensation claim, serving on jury duty, and refusing to commit perjury.

CONSTRUCTIVE DISCHARGE

A constructive discharge can occur when an employee demonstrates that they were forced to resign due to actions or conditions so intolerable that any reasonable person in that employee's position would have resigned. In other words, the employee was, in effect, fired because, given the working conditions, no reasonable employee would have remained in the position. In many states, the employee must also demonstrate that their employer:

1) knew of the intolerable actions and conditions,
2) could have remedied the situation, but
3) did not take any remedial action.

TIPS FOR CONDUCTING A SUCCESSFUL TERMINATION

STARTING FROM THE BEGINNING: PERSONNEL POLICIES

A health center's personnel policies, which often are incorporated into an employee manual or employee handbook, form the foundation for a successful termination process. If the policies are well written and consistently followed, they may (if a health center is otherwise acting legally) provide the health center with a valid and successful defense against allegations of wrongful termination. Personnel policies will vary depending upon the health center's size and complexity, as well as its operational circumstances. Nevertheless, every health center's personnel policies should:

1. Clearly notify employees that, unless there is a written employment contract between the health center and an employee, the employee is considered at-will. Here is a sample provision establishing an at-will relationship:

   It is the Health Center's policy that all employees who do not have a written employment contract with the Health Center for a specific term of employment are employed at-will. The Health Center's personnel policies are not intended to create, nor do they create a contract of employment. These personnel policies do not confer contractual rights on the employee and do not create contractual obligations enforceable against the Health Center. Employment with the Health Center is for an indefinite length of time and either the employee or the Health Center may terminate employment at any time, for any lawful reason, or for no reason.

2. It is further advisable to include a disclaimer stating that no statements in the personnel policies (including in the employee manual/ handbook if applicable) or elsewhere, or the completion of any "introductory periods;' modify the at-will relationship. Here is a sample disclaimer regarding the modification of the at-will relationship:

   The statements contained in the Health Center's personnel policies and any other Health Center materials are not intended to modify the at-will relationship. Supervisory and management employees shall not make any statements or representations that alter the at-will employment relationship or imply that employees may only be terminated "for cause:' In any event, employees shall not rely on supervisory and management employee statements or representations that appear to alter the at-will employment relationship or imply that employees may only be terminated "for cause." Completion of the Introductory Period does not change an employee's status as an at-will employee, the Health Center's right to terminate an employee, or any other conditions of employment.

3. The personnel policies should also include a Code of Conduct for employees, disciplinary procedures (as discussed more fully below), procedures pertaining to the termination process (e.g., exit interview), and employees' rights upon discharge (e.g., payment for accrued leave, COBRA coverage, etc.).

4. Finally, in order to reduce exposure to potential implied contract claims, the health center should not include in the employee manual or applicable personnel policy handbook a welcome letter signed by the CEO/Executive Director or any other health center manager.

Before commencing work, all employees should sign a statement that they have received, read, and understand the health center's personnel policies. If a health center revises its personnel policies, employees should be given a new copy, with training regarding the contents of the new policies/procedures and should be required to sign an acknowledgement that they have received and understand the revised version. Note that an employee is acknowledging that they received and understand the personnel policies, not necessarily that they agree with those policies.

If an employee does not sign the acknowledgement, a supervisor should document that the employee received the policies. This is particularly important if there are changes made to the procedures relating to disciplinary matters, including the manner in which employees are terminated. If, for example, a discharged employee can demonstrate that they did not receive the new policy, they may have a valid claim that the old policy applies. If such employee is subsequently terminated for reasons addressed in the new (but not the old) policies, they can claim that the health center is failing to follow its own policies by their situation.

DISCIPLINARY POLICIES

It is strongly advised that all health centers include a disciplinary policy in their personnel policies, addressing employee misconduct and poor performance. The appropriate disciplinary action would, of course, depend upon the seriousness of the workplace infraction, but the personnel policies should outline various options, including termination, that the health center may exercise at its discretion. For example, oral warnings or written reprimands may be appropriate measures for certain instances of misconduct, but inadequate for others.

Progressive Discipline

Employers may adopt a so-called "progressive discipline" system. Although there are various permutations of this approach to disciplining employees, generally, the consequences for offenses become progressively more serious if the employee's behavior does not improve. For example, minor offenses such as slight tardiness might be first addressed through oral reprimands and informal meetings with the employee. Repetition of minor offenses or more serious first offenses might merit a written warning that the employee acknowledges and signs.

In theory, progressive discipline seems a logical and sound approach to addressing employee misconduct because it promotes a sense of fairness in the workplace - specifically, that the employer has tried to help the employee keep their job by explaining the employer's expectations and providing an opportunity for the employee to improve. It can also prevent a "surprise" termination if the employee is later fired for actions or behavior that they had already been warned is unacceptable.

In practice, however, formally adopting, and legally committing to, a progressive discipline system can create problems for employers and lead to burdensome litigation. If a health center commits to a progressive discipline approach but feels compelled in certain instances not to follow that policy and terminate an employee for a first-time infraction, the discharged employee could sue the health center for failure to adhere to its own policies and procedures (i.e., starting with less severe disciplinary action).

Proportional Discipline

Instead of adopting a progressive discipline approach, health centers should consider adopting a policy that, in practice, disciplines employees in proportion to their offenses but gives the health center flexibility to discipline as it determines is appropriate to the particular facts and circumstances of each situation.

Here is suggested disciplinary policy language for the personnel policies.

> *All Health Center employees are expected to comply with Health Center job performance standards, standards of conduct, and other rules and requirements. At the Health Center's sole discretion and in order to assist employees in improving their performance and conduct, disciplinary actions short of termination may be taken in some circumstances. This policy does not describe a progressive system of discipline, but rather provides examples of the various types of disciplinary options that the Health Center may exercise. The Health Center maintains the right to terminate employees for any lawful reason without first using any of the disciplinary measures described or to discipline an employee in ways other than those described herein.*

A LITTLE TRAINING GOES A LONG WAY

Once a health center has established sound personnel policies and procedures, the next step in protecting against wrongful termination claims is a good training program. Employers sometimes neglect this important step due to the press of business or limited resources. However, training can be extremely beneficial for several reasons.

1. Training employees on the health center's expectations lays the foundation for fairly disciplining employees if they fail to meet those expectations.
2. Training employees about the health center's anti-discrimination and non-harassment policies may prevent wrongful termination claims premised upon discrimination or harassment.
3. Training regarding the health center's grievance procedure, may help reduce the escalation of employee complaints and lead to successful resolution of conflicts that otherwise may result in a contentious termination proceeding.[3]
4. Finally, because employees often bring wrongful termination claims when they believe they have been treated unfairly, training employees regarding the health center's at-will policy and non-progressive disciplinary procedures may lessen employees' surprise and, therefore, decrease their propensity to sue the health center.

DOCUMENTATION, DOCUMENTATION, DOCUMENTATION

To properly defend itself against allegations of wrongful termination, it is of utmost importance for a health center to carefully document all workplace infractions, substandard performance, and the reason(s) for termination of any employee. Thorough documentation creates a written record of an employee's (mis)conduct and helps defend against allegations of discriminatory or arbitrary conduct on the health center's part.

Oral Reprimands

Documentation doesn't have to be a burdensome process. For minor offenses where the employee received an oral reprimand, an employer should sign and date a note to the employee's personnel file detailing the workplace rule violated and the fact that the employee was orally warned.

Written Reprimands

For more serious offenses, the employee should receive a formal written warning stating:

- The date, time, and place of the infraction;
- Factual details of the incident;
- Specifically, which rule or policy was violated;
- Remedial steps recommended (i.e., +, specific steps the employee should take to ensure the offense does not occur a second time); and

3 The regulations governing Section 330 grants to most health centers, 42 CF.R. 51c.§304(d)(3)(ii), require health centers to have in place Board of Directors' approved grievance procedures for employees (also see the Health Center Program Compliance Manual, Chapter 19). While a discussion of grievance procedures is beyond the scope of this Information Bulletin, in general, the procedures should be clearly written and consistently implemented.

- Consequence language (i.e., the repercussions if the employee commits the offense again).

It is advisable for written warnings to be signed by the supervisor (or the HR Director) and the employee (whether or not they agree) and copied into the employee's personnel file. If the employee refuses to sign the warning, the supervisor should note the employee's refusal on the warning, date and sign the document and include it in the employee's file.

Performance Appraisals

Honest performance appraisals are an added protection. Health centers should carefully document substandard performance in employees' performance reviews through the provision of low appraisal marks. It is very important never to inflate an employee's performance review. In other words, if an employee is performing well, but not above standard, simply indicate on the performance review that the employee meets expectations rather than rating such employee as "excellent" or "outstanding." Over-rating an employee creates a written record that performance was more than acceptable. If that same employee is later terminated and there is no documentation in their personnel file of substandard performance or specific incidents of misconduct the health center becomes more vulnerable to a wrongful termination claim.

Reasons for Termination

Finally, it is important to accurately document the reasons for terminating an employee. This is, in some respects, counter-intuitive given the fact that most employees are employed "at-will." However, it is important to document the reasons behind a termination in the event that the terminated employee sues the health center for wrongful termination. The contemporaneous documentation will allow the health center to demonstrate that the employee was not terminated for discriminatory or illegal reasons. The health center need only inform the employee that they were terminated in accordance with the health center's at-will.

BE CONSISTENT IN ENFORCING POLICIES

Terminating an employee for violating a policy that is not consistently enforced with respect to other employees can cause significant difficulties for an employer. Inconsistent application of workplace policies and procedures opens the door to allegations of wrongful termination, particularly claims of discrimination. For example, if a health center fires one employee for repeated tardiness but takes lesser disciplinary action against another employee who has a similar record of tardiness, the health center may be accused of discriminating in its enforcement of its policies. This is particularly problematic if the terminated employee is a member of a "protected class" (e.g., an older worker).

Although the health center may be able to defend its action based upon objective criteria (the terminated employee also had poor performance appraisals or violated other workplace conduct rules), the fact of inconsistent treatment will make defending against a legal claim more difficult. Additionally, consistent enforcement of policies creates predictability in the workplace and sends a message to workers that violations will not be tolerated.

REVIEWING THE FINAL DECISION TO TERMINATE AND INFORMING THE EMPLOYEE

Before making the decision to terminate an employee, one person at the health center (typically the HR Director[4]) should review the circumstances of the proposed termination and the relevant documentation. At a minimum, the HR Director should first determine whether the center followed its established policies, procedures, and practices.

4 Although the term "HR Director" is used throughout this Information Bulletin, it should be noted that this particular position may not exist at many health centers. While the CEO/Executive Director typically is responsible for all hiring's and firings, this responsibility can be delegated. Depending on the size and complexity of the health center and its particular circumstances, the CEO/Executive Director may appoint an HR Director, while others will have a Clinical Officer, Financial Officer, or other manager review employee disciplinary and termination decision.

Specifically, the HR Director should:

1. Review whether the health center applied its disciplinary policies consistently as compared to other similar situations. If it appears that the health center has deviated from the personnel policies or other applicable policies in any way, it should, before taking the termination action, document that such deviation was necessary in this particular employee's case. For example, if a health center has adopted a progressive discipline system but proposes to make an exception and terminate (rather than first impose less harsh measures), it should document in writing in the personnel file why lesser measures were inappropriate under the facts and circumstances of the employee's case.

2. Carefully review the employee's personnel file to ensure that the health center has sufficiently documented the reasons for the employee's termination and that their personnel file does not contradict the documentation (i.e., the proposed termination is for unsatisfactory performance while the file contains a record of exemplary performance appraisals

3. Communicate the termination message to the employee-often the most difficult aspect of firing an employee. There are a few practices that should be followed in communicating with the terminated employee.

    - Conduct a formal "exit interview" with at least two health center managers present, one of whom most likely would be the HR Director. The presence of two health center managers will help rebut allegations if the employee later disputes what was said or otherwise occurred during the exit conference. At the meeting, the HR Director should explain that the health center is terminating the employee and, under most circumstances, state the specific reasons for the termination. The quantity of information that a health center should communicate to a terminated employee varies significantly based upon the circumstances. For example, if the health center has clear, unequivocal reasons for terminating the employee, the center may choose to communicate this to the employee in hopes of preventing a wrongful discharge lawsuit. Conversely, if the grounds for termination are less clear or more intangible, the center may decide to inform the employee that it is simply exercising its at-will employment policy in terminating them.

    - At the exit meeting, the health center should also provide the terminated employee an opportunity to voice their disagreement and any other thoughts or concerns they have. Allowing the employee to speak about the situation may elicit information that the health center was not aware of prior to the meeting, provide the center with valuable insight into the operations and interpersonal relationships within the center and potential areas of improvement, and in extreme cases, may alert the center to a potential claim of wrongful termination, harassment, or a "whistleblower" suit. In some cases, these claims may be frivolous but, in others, the employee may have a legitimate claim that the health center can promptly correct, such as overturning an improper or inappropriate termination decision. Allowing the employee to speak freely and treating the employee with respect throughout the entire process may help avoid hard feelings, which, in turn, may help avoid a subsequent wrongful discharge claim.

4. Provide the employee with all information related to post-termination benefits (e.g., COBRA health care coverage). The HR Director should document that this information was provided to the employee. Information regarding the employee's final paycheck and/or other compensation (e.g., accrued unpaid vacation) also should be provided. Health centers should follow their personnel policies' guidelines on compensation (e.g., what day of the week a paycheck is issued) and consult their state's "wage and hour" law to determine the exact compensation due upon termination.

5. Require the terminated employee to return all health center property (e.g., keys, credit cards, computers, etc.).

6. Make sure that the employee signs a form stating that they have completed the exit interview. The signed form should be included in the employee's personnel file.

7. Assure that the terminated employee leaves the health center's premises immediately after the exit meeting. This may help avoid any potential theft, disruption, or other unpleasantness that unfortunately can result when discharging a disgruntled employee.

RELEASES/WAIVER OF LIABILITY FORMS AND SEPARATION AGREEMENTS.

Many employers require that discharged employees sign a "separation agreement" sometimes called a release or waiver of liability. This is a document that formally releases the employer from any legal liability related to its decision to terminate the employee. In other words, a valid separation agreement prevents an employee from suing the employer for wrongful termination. Though the content and enforceability of a separation agreement will vary from state to state, all separation agreements must contain four essential elements.

1. They must be in writing. Oral separation agreements are unenforceable in a court of law.

2. They must be signed by the employee.

3. They must be written in simple and clear language. The employee must "knowingly" and "voluntarily" enter into the agreement. To ensure that the process is knowing and voluntary, the language of a separation agreement should be simple and clear. The agreement should state that the employee has read and understands the provisions of the document and the consequences of signing it and recommend that the employee seek assistance from an attorney before signing it. Health centers should allow the employee a few days to consider the implications of signing the document, to seek legal counsel, and to ask any questions.[5]

4. They must be supported with "consideration," a legal term that means that the employer gives something of value to the employee above and beyond what the employer is already required to provide to the employee in exchange for the employee signing the release. The most common form of consideration for a separation agreement is a severance payment, such as two weeks' salary or extended health benefits, which are above and beyond what the employee already is entitled to.

Separation agreements may be appropriate on a case-by-case basis depending on the facts and circumstances of the termination. If a termination is particularly contentious, it may be in the health center's best interest to secure a separation agreement, if possible.

CONCLUSION

While terminating an employee may be an emotional and unpleasant experience, following the guidance in this Information Bulletin may reduce the chance of becoming involved in litigation with a former employee. Keep in mind, protecting the health center from wrongful termination claims (and potential liability) begins long before the actual decision to terminate an employee takes place. Health centers should:

- Establish and describe in their personnel policies the "at will" status of health center employees (where applicable), a code of conduct for all employees, and disciplinary and termination procedures.

- Consult legal counsel familiar with state employment law for assistance in developing termination policies and procedures and follow them consistently.

- Evaluate employees fairly and accurately and document instances of employee misconduct and/or poor performance. Consistent application of the health center's policies and thorough

5 The **Older Worker Benefit Protection Act** requires specific provisions be included in a separation agreement for an employee who is over the age of forty. For example, the employee must be given at least seven days to consider the agreement and have 21 days to revoke the agreement after it has been signed. Furthermore, as with all separation agreements, the employee must be counseled to seek legal assistance in deciding whether or not to sign the agreement.

documentation are the keys to successfully defending a wrongful discharge suit.

- Once the decision has been made to terminate an employee, treat the employee respectfully and, if possible, attempt to secure a valid separation agreement.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

HR Information Bulletin #5

LEGAL DEVELOPMENTS IN JOINT RECRUITMENT AND RETENTION EFFORTS BY HOSPITALS AND HEALTH CENTERS

A strategy used by some health centers to enhance physician recruitment and retention is to work with their area hospital(s) to combine resources for paying recruitment expenses and offering a strong compensation package. The purpose of this Information Bulletin is to:

- Present legal issues that arise in the context of hospital-funded recruitment and retention payment arrangements
- Suggest ways to appropriately address those issues. The bulletin examines:
    1. Stark Physician Self- Referral Law ("the Stark Law") exceptions for physician recruitment and retention payments;
    2. Federal Anti-Kickback safe harbor for certain physician recruitment arrangements, as well as the recent safe harbor for health center grantees; and
    3. Internal Revenue Service ("IRS") standards for tax-exempt organizations to hospital-funded recruitment and retention payments.

Although physician compensation is but one factor of a multi-faceted approach, it is a factor with legal ramifications if not done in compliance with applicable federal law and regulations. For example, in some communities, local hospitals have contributed funds to allow a health center to make payments to a physician or to guarantee a certain level of income for a physician in order to attract or retain a physician within a community.

Unless carefully structured, however, these hospital-funded recruitment or retention payments may be viewed by government regulators as disguised kickbacks to the physicians for referring patients to the funding hospitals and may raise potential violations under the Stark Law, the Anti-Kickback Statute, or both.[1] Such violations could expose both the health center and health center physician to liability.

FINDING THEM AND KEEPING THEM

Health centers are all too familiar with the challenges of attracting and retaining physicians on their staff. For one thing, health centers are located in medically underserved areas, and many (if not most) of those locations are also deemed to be geographical areas of the country with documented physician shortages. Small, isolated, rural towns and crowded, poor, inner cities often face challenges in finding and keeping clinical providers. With about 83 million people living in areas of the country that have a shortage of primary care physicians, those shortages have a dramatic impact on meeting the health care needs in many communities.

In recognition of the problem that physician shortages present for many Americans, the U.S. Department of Health and Human Services ("HHS") Health Resources and Services Administration's ("HRSA") National Health Service Corps ("NHSC") received $800 million in funding from the American Rescue Plan Act of 2021, the most recent COVID-19

1 The recruitment of a physician to the community can translate into financial benefits to the hospital. According to a 2019 survey, a primary care physician generates an average of $2,133,273 in revenue for hospitals per year. See **"2019 Physician Inpatient/ Outpatient Revenue Survey,"** conducted by physician search and consulting firm Merritt Hawkins.

relief package.[2] The NHSC provides financial, professional, and educational resources (such as loan repayment and scholarship awards) to medical, dental, and mental and behavioral health care providers practicing in areas of the country with limited access to care.

The Stark Law prohibits a physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity with which the physician (or an immediate family member) has a direct or indirect financial relationship.

THE STARK LAW

The Stark Law prohibits a physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity with which the physician (or an immediate family member) has a direct or indirect financial relationship.[3] Unless an exception applies, the physician cannot refer to the entity and the entity cannot bill for the referred services.

In other words, a financial relationship is established under the Stark Law when an entity, such as a hospital, pays recruitment or retention payments either directly to a physician, or indirectly to a health center that employs or contracts with a physician. If then, the physician makes a referral to the entity, such as the hospital, for services payable under Medicare or Medicaid, a violation occurs.

The Physician Recruitment Exception of the Stark Law

The Stark Law includes exceptions for employment relationships and personal services arrangements, thereby allowing hospitals to employ or contract with physicians.[4] However, those exceptions do not cover payments made by a hospital to a physician who is, or will be, employed or contracted by another entity, such as a health center.

The **Physician Recruitment Exception** applies to payments by a hospital (1) to a physician for the purpose of inducing the physician to relocate to the hospital's geographic area and become a member of the hospital's medical staff; and (2) to a physician, either indirectly through payments to a health

2 Pub. L. No. 117-2, Subtitle G, § 2602.

3 See 42 U.S.C. § 1395nn. Designated health services are defined to include:
- clinical laboratory services;
- physical, occupational, and speech therapy services;
- radiology and radiation therapy services;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment and supplies;
- prosthetics, orthotics, and prosthetic devices;
- home health services ;
- outpatient prescription drugs; or
- inpatient and outpatient hospital services.

4 See 42 U.S.C. § 1395nn(e)(2)-(3); 42 C.F.R. § 411.357(c)(d).

center, or directly to a physician employed by or contracted with a health center.[5]

REQUIRED CONDITIONS: HOSPITAL RECRUITMENT PAYMENTS TO HEALTH CENTER PHYSICIAN

In the context of health centers that employ or contract physicians, the Physician Recruitment Exception requires all nine of the following conditions[6] to be met in order to allow hospital-funded recruitment payments to a health center's employed or contracted physician:

1. The arrangement must be in writing, signed by the recruited physician and the hospital (and by the health center if payments are made to the health center and the health center does not pass all of the payments from the hospital to the physician;
2. The arrangement may not be conditioned on the recruited physician referring to the hospital;
3. The recruitment payment must not be based on the value or volume of referrals, or expected referrals, from the recruited physician or health center, or other business generated between the parties;
4. The recruited physician must be allowed to establish privileges at other hospitals and refer to other facilities;
5. All of the recruitment payment must remain with or pass through to the recruited physician except for the actual costs incurred by the health center in recruiting the new physician;
6. In the case of income guarantees, only the actual incremental costs attributable to the recruited physician may be allocated by the health center to the new physician;
7. Records of the costs, and passed through amounts, must be kept for five years, and made available to the HHS upon request;
8. The health center may not impose any additional practice restrictions on the recruited physician, other than those relating to quality of care;[7] and
9. The arrangement may not violate the Federal Anti-Kickback Statute, or any federal or state law or regulation governing billing or claims submission.

5 *See* 42 U.S.C. § 1395nn(e)(5); 42 C.F.R. § 411.357(e). A hospital's geographic area is defined as the lowest number of contiguous postal zip codes from which the hospital draws at least 75 percent of its inpatients. A physician will be deemed to have relocated to the hospital's geographic area if:
(i) the physician has relocated the site of his or her practice a minimum of 25 miles; or
(ii) at least 75 percent of the physician's revenues from services provided by the physician to patients (including services to hospital inpatients) are derived from services provided to new patients.

However, residents and physicians who have been in medical practice less than one year, as well as physicians employed on a full-time basis for at least two years immediately prior to the recruitment by (a) a Federal or State bureau of prisons (or similar entity operating at least one correctional facility) to serve a prison population, the Department of Defense or Department of Veterans Affairs to serve active or veteran military personnel and their families, or a facility of the Indian Health Service to serve patients receiving medical care exclusively through the Indian Health Service; and (b) did not maintain a private practice in addition to such full-time employment, will not be considered to have an established practice and will therefore be eligible under the physicians' recruitment exception regardless of whether the physician actually moved his or her practice location. When determining the geographic service area of rural hospitals, (1) zip codes may in some cases be noncontiguous and (2) at least 90 percent of inpatients must be drawn from this area.

The Secretary of the U.S. Department of Health and Human Services (HHS) may also issue an advisory opinion under 42 U.S.C. §1395nn(g)(6) deeming that the physician does not have an established medical practice that serves or could serve a significant number of patients who are or could become patients of the recruiting hospital, thereby exempting the recruited physician from the relocation requirement.

6 See 42 C.F.R. § 411.357(e).

7 A non-compete agreement would constitute a practice restriction while personnel policies, clinical policies, and record-keeping requirements probably would not. See 69 Fed. Reg. 16096-97 (Mar. 26, 2004).

If all of the above conditions have been met, then a hospital may:

- Make an indirect payment to a physician, by way of the health center passing payment from the hospital to the recruited physician, or
- Make a direct payment to a recruited physician who contracts with, or is employed by, a health center.

REQUIRED CONDITIONS: HEALTH CENTER RECRUITMENT PAYMENTS TO PHYSICIAN

The Physician Recruitment Exception includes a special provision for health centers that make recruitment payments.[8] Under this exception:

1. The Stark Law physician recruitment exception will apply to health centers on the same basis as it applies to hospitals for recruitment payments to physicians.
2. Health centers can make a payment to a physician to induce him or her to relocate to the community served by the health center without contracting or employing the physician. For example, a health center located in an area with a high prevalence of pediatric asthma may wish to make a recruitment payment to a pediatric specialist in order to recruit the physician to establish an independent practice in the community. As a result of the health center recruitment exception, the specialist (who will not be employed by or contracted to the health center) may make referrals to the health center's pharmacy for prescription drugs furnished to patients covered by Medicare or Medicaid, regardless of the recruitment payment from the health center to the physician.

The Physician Retention Exception of the Stark Law

To assist hospitals and other entities in certain rural and inner city areas in retaining sufficient numbers of qualified physicians in the community, the Stark Law regulations also include an exception for retention payments made by hospitals or health centers to physicians who practice in a rural area or Health Professional Shortage Area ("HPSA")[9] or where at least 75 percent of the physician's patients reside in a medically underserved area or are members of a medically underserved population.[10]

CONDITIONS: HOSPITAL OR HEALTH CENTER RETENTION PAYMENTS TO PHYSICIANS

To qualify for this exception, a physician must have a bona fide written recruitment or employment offer or must provide a written certification that they have received a bona fide opportunity for future employment, as explained below.

Bona Fide Written Offer—A physician must first have a bona fide firm written recruitment offer from another hospital, health center, rural health clinic, academic medical center, or physician organization. The offer must: (1) specify the amount of remuneration paid to the physician; and (2) require that the physician relocate from an area that is:

- At least 25 miles outside of the **geographic location served** by the hospital or health center that is making the retention payment AND
- Outside of the **geographic area serviced** by the hospital or health center that is making the retention payment.[11]

The retention payment is subject to the same obligations and restrictions on repayment or forgiveness as contained in the offer. Finally, the retention payment may not exceed the lower of (a)

8 See 42 C.F.R. § 411.357(e)(6).

9 Pursuant to 42 U.S.C. § 254e(a)(1), all FQHCs are automatically designated as having the designation of a health professional shortage area.

10 See 42 C.F.R. § 411.357(t).

11 The Secretary of HHS may waive the relocation requirement for payments made to physicians practicing in a HPSA or an area with demonstrated need for the physician through an advisory opinion issued in accordance with 42 U.S.C. § 1395nn(g)(6), if the retention payment arrangement otherwise complies with all of the otherwise required conditions.

the amount obtained by subtracting the physician's current income from the offer, or (b) the reasonable costs the hospital or health center would have to expend to recruit a new physician to replace the retained physician.

Written Certification from Physician— physician must provide a written certification of bona fide employment from another hospital, health center, rural health clinic, academic medical center, or physician organization that would require the physician to move their practice at least 25 miles and outside of the geographic area served by the hospital or health center that is making the retention payment.[12] The certification must contain the following information:

- Details regarding the steps taken by the physician to effectuate the opportunity;
- Details of the physician's employment opportunity, including the identity and location of the physician's future employer or employment location or both, and the anticipated income and benefits (or a range thereof);
- A statement that the future employer is not related to the hospital making the payment;
- The date on which the physician anticipates relocating their medical practice outside of the geographic area serviced by the hospital; and
- Information sufficient for the hospital to verify the information included in the written certification.

In addition, the hospital or health center must take reasonable steps to verify the physician's opportunity. Finally, the retention payment made by the hospital or health center may not exceed the lower of (a) 25 percent of the physician's current income,[13] or (b) the reasonable costs the hospital or health center would have to expend to recruit a new physician.

If the physician qualifies for a retention payment under this exception, the retention payment must meet the same first four requirements of the Physician Recruitment Exception, namely:

1. The retention payment arrangement must be in writing and signed by the parties;
2. The payment may not be conditioned on the retained physician referring to the hospital;
3. The payment may not be based on the value or volume of referrals; and
4. The retained physician must be allowed to establish privileges and refer to other hospitals.

Further, a hospital or health center providing the remuneration may not enter into a retention arrangement with a physician any more frequently than once every five years and the terms of the retention payment may not be altered during the term of the arrangement in any manner that takes into account the volume or value of referrals or other business generated by the physician for the hospital or health center. In addition, the arrangement may not violate the Federal Anti-Kickback Statute or any federal or state law or regulation governing billing or claims submission.

12 The Secretary of HHS may waive the relocation requirement for payments made to physicians practicing in a HPSA or an area with demonstrated need for the physician through an advisory opinion issued in accordance with 42 U.S.C. § 1395nn(g)(6), if the retention payment arrangement otherwise complies with all of the otherwise required conditions.

13 The amount must be measured over no more than a 24-month period using a reasonable and consistent methodology that is calculated uniformly.

THE FEDERAL ANTI-KICKBACK STATUTE

The Federal Anti-Kickback statute prohibits any person or entity from knowingly or willfully soliciting or receiving (or offering and paying) remuneration directly or indirectly, in cash or in kind, to induce patient referrals or the purchase or lease of equipment, goods or services, payable in whole or in part by a federal health care program.[14]

A hospital's offer to contribute to a recruitment or retention payment (i.e., remuneration) or a health center physician's acceptance of the hospital payment (directly or through the health center) could be viewed as an inducement by a hospital for a physician to refer patients to the hospital for services payable by Medicare or Medicaid. Consequently, these arrangements implicate the Anti-Kickback statute.

Congress and the Office of the Inspector General ("OIG") have created "safe harbors" to exempt certain business practices from constituting violations of the Anti-Kickback statute. Unlike the Stark Law which makes practices illegal if they do not fall with a specific exception, a practice that does not fall within a safe harbor of the Anti-Kickback statute is not necessarily illegal, but rather is subject to further legal analysis on the basis of the particular facts and circumstances, and on the parties' intent in entering into the proposed transaction or arrangement.

Practitioner Recruitment Safe Harbor

The OIG has established a narrow safe harbor for any payments or exchange of anything of value by an entity (e.g., a hospital) to induce a primary care practitioner (e.g., a physician) who has been practicing within their specialty for less than one year to locate, or to induce any other practitioner to relocate, their practice to a HPSA for their specialty that is served by the entity.

REQUIRED CONDITIONS: PAYMENTS TO INDUCE A PRACTITIONER TO RELOCATE

The Practitioner Recruitment Safe Harbor applies if all nine of the following conditions are met:

1. The arrangement is set forth in writing, specifying the benefits and obligations, and is signed by each of the parties;
2. If the recruited practitioner is leaving an existing practice, at least 75 percent of the revenues of the new practice (i.e., the health center) must be generated from new patients;
3. The period of agreement cannot exceed three years, and the terms of the agreement cannot be renegotiated during the three-year period;
4. The arrangement cannot require the recruited practitioner to make referrals to, or otherwise generate business for, the entity, although the entity may require the physician to maintain staff privileges;
5. The practitioner may not be restricted from establishing staff privileges at, from referring any patient to, or otherwise generating any business for any other entity;
6. The amount of benefits provided to the physician may not vary in any manner based on the volume or volume of any expected referrals to or business generated for the entity;
7. The practitioner must agree to treat patients receiving Medicare benefits or assistance from another Federal healthcare program in a nondiscriminatory manner;
8. At least 75% of the revenue from the new practice must be generated from patients who reside in a HPSA or a Medically Underserved Area ("MUA") or who are part of a Medically Underserved Population ("MUP"); and

14 See 42 U.S.C. § 1320a-7b(b).

9. The payment or exchange of anything of value does not benefit, directly or indirectly any person (except for the practitioner who is being recruited) or entity in a position to make or influence referrals of items or services payable by a federal health care program to the entity providing the recruitment benefits.[15]

Differences Between Stark Law and Anti-Kickback Law

Unlike the Stark recruitment exception (which applies solely to the recruitment of physicians), the Practitioner Recruitment Safe Harbor applies to health professionals beyond physicians. However, the safe harbor also is more restrictive than the Stark exception in that it applies only to practitioners who have been practicing for less than one year, who relocate to geographic areas designated as HPSAs, and for terms not greater than three years.

Health centers, in particular, may have difficulty in satisfying the following requirements:

1. The Practitioner Recruitment Safe Harbor requires at least 75 percent of the revenues of the new practice be generated from new patients. For two reasons, a practitioner recruited to work at an existing health center may not be able to satisfy this requirement:
    a. While moving to an existing health center may be viewed as a "new practice" from the perspective of the recruited practitioner, an existing health center may not be considered a "new practice" for purposes of satisfying the Stark requirement, and
    b. It is highly unlikely that 75% of the revenues generated by the recruited practitioner will be attributable to new patients of the health center.
2. The Practitioner Recruitment Safe Harbor prohibits the recruitment payment from benefiting, directly or indirectly, any person (except for the recruited practitioner) or entity in a position to make or influence referrals of items or services payable by a federal health care program to the entity providing the recruitment benefits. However, health centers that employ or contract practitioners who have received recruitment benefits from the health center's community-based partner (i.e., the local hospital) may receive an indirect "intrinsic" benefit from the recruitment payment in the form of good staff morale (and, therefore, more productive practitioners).
3. Lastly, the Practitioner Recruitment Safe Harbor does not address either retention or joint recruitment by a hospital and a group practice (e.g., a health center), a common practice among many health centers.

The safe harbor also is more restrictive than the Stark exception in that it applies only to practitioners who have been practicing for less than one year, who relocate to geographic areas designated as HPSAs, and for terms not greater than three years.

15 See 42 C.F.R. § 1001.952(n).

FEDERALLY QUALIFIED HEALTH CENTER SAFE HARBOR

Given the potential issues faced by health centers in satisfying the requirements of the Practitioner Recruitment Safe Harbor, it may be advisable for health centers to look towards the Health Center Safe Harbor to protect their practitioner recruitment (and retention) arrangements from prosecution under the Federal Anti-Kickback statute.

In December 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which, among other things, provides a safe harbor to health centers that receive grant funds under Section 330 of the Public Health Service Act ("health center grantee") for any remuneration offered and paid to health center grantees by any individual or entity so long as the arrangement contributes to the health center grantee's ability to maintain or increase the availability or quality of services provided to a MUP.[16]

The Health Center Safe Harbor regulations consist of nine standards.[17] As long as the following nine standards are met, remuneration does not include the transfer of goods, items, services, donations or loans (whether in cash or in-kind), or a combination thereof from an individual or entity to a health center grantee:

1. The transfer is made pursuant to an agreement that (a) is set out in writing; (b) is signed by the parties; and (c) covers, and specifies the amount of, all goods, items, services, donations, or loans to be provided by the individual or entity to the health center;[18]
2. The goods, items, services, donations, or loans are medical or clinical in nature or relate directly to services provided by the health center as part of the scope of the health center's section 330 grant;
3. The health center reasonably expects the arrangement to contribute meaningfully to the health center's ability to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, and the health center documents the basis for the reasonable expectation prior to entering the arrangement;
4. At reasonable intervals, but at least annually, the health center must re-evaluate the arrangement to ensure that the arrangement is expected to continue to satisfy the standard set forth in standard #3, and must document the re-evaluation contemporaneously;
5. The individual or entity does not require the health center (or its affiliated health care professionals) to (a) refer patients to a particular individual or entity, or (b) restrict the health center (or its affiliated health care professionals) from referring patients to any individual or entity;
6. Individuals and entities that offer to furnish goods, items, or services without charge or at a reduced charge to the health center must furnish such goods, items, or services to all patients from the health center who clinically qualify for the goods, items, or services, regardless of the patient's payor status or ability to pay;
7. The agreement must not restrict the health center's ability, if it chooses, to enter into agreements with other providers or suppliers of comparable goods, items, or

16 See Medicare Prescription Drug, Improvement. and Modernization Act of 2003, Pub. L. No. 108-173, §431(a), 117 Stat. 2150 (codified at 42 U.S.C. §1320a-7b(b)(3)(H).

17 42 C.F.R. § 1001.952(n).

18 The amount of goods, items, services, donations, or loans specified in the agreement may be a fixed sum, fixed percentage, or set forth by a fixed methodology. The amount may not be conditioned on the volume or value of Federal health care program business generated between the parties.

services, or with other lenders or donors;[19]

8. The health center must provide effective notification to patients of their freedom to choose any willing provider or supplier. In addition, the health center must disclose the existence and nature of an agreement (of the type described in standard #1) to any patient who inquires; and

9. The health center may, at its option, elect to require that an individual or entity charge a referred health center patient the same rate it charges other similarly situated patients not referred by the health center or that the individual or entity charge a referred health center patient a reduced rate (where the discount applies to the total charge and not just to the cost-sharing portion owed by an insured patient).

Traditionally, arrangements under which a hospital that receives referrals from a health center offers to assist a health center in recruiting practitioners to the health center's area by providing assistance such as payments for travel and moving expenses and salary guarantees have been subject to scrutiny under the Anti-Kickback Statute. These forms of assistance may be protected under the Health Center Safe Harbor provided that the assistance is given to the health center and not the individual practitioner (and the other requirements of the Safe Harbor are satisfied).

INTERNAL REVENUE CODE

Physician recruitment and retention payments are also subject to scrutiny by the Internal Revenue Service ("IRS"). The Internal Revenue Code ("IRC") prohibits tax-exempt organizations from establishing compensation arrangements that result in any part of the organization's net earnings inuring, in whole or part, to the benefit of private individuals. A recruitment or retention payment is a type of compensation arrangement that has to be structured with this prohibition in mind.

REVENUE RULING

In 1997, the IRS issued Revenue Ruling 97-21 ("the Ruling") that:

- Provides a framework for analyzing the legality of physician recruitment payments through five sample fact patterns;[20]
- Does not address whether a tax- exempt hospital could assist an existing medical practice, such as a health center, with the recruitment of a new physician to join the practice;
- Describes four requirements for a tax-exempt hospital providing recruitment payments to physicians who will provide services to members of the hospital's surrounding community, but not necessarily for or on behalf the hospital itself:

    1. The hospital may not engage in substantial activities that do not further the entity's exempt purposes or that do not bear a reasonable relationship to the accomplishment of those purposes.

    2. The hospital must not engage in activities that result in inurement of the hospital's net earnings to a private shareholder or individual.

    3. The hospital may not engage in substantial activities that cause the hospital to be operated for the benefit of a private interest rather than public interest.

    4. The hospital may not engage in substantial unlawful activities.

If a tax-exempt hospital indirectly makes a recruitment or retention payment to a physician through a direct payment to a health center, then the health center, also a tax-exempt entity, must

19 Where a health center has multiple individuals or entities willing to offer comparable remuneration, the health center must employ a reasonable methodology to determine which individuals or entities to select and must document its determination. In making these determinations, health centers should look to the procurement standards for recipients of Federal grants.

20 See Rev. Rul. 97-21, 1997-18 IRB 8.

ensure that its payment to the physician does not constitute private inurement or private benefit. In an Information Letter,[21] the IRS set forth twelve factors to consider in regard to compensation arrangements:

- The involvement of an independent board of directors (i.e., the health center board) or compensation committee to establish the arrangement
- Whether the total compensation is reasonable
- Whether there is an arm's length relationship between the organization and the physician
- Whether there is a ceiling or cap on compensation to protect against errors or windfalls
- The potential for the compensation arrangement to result in a reduction in charitable programs
- Whether the compensation arrangement takes into account data that measures quality of care and patient satisfaction
- If net revenue-based, whether the arrangement accomplishes the organization's charitable purposes
- Whether the arrangement transforms the organization's principal activity into a joint venture with the physician
- Whether the compensation arrangement is a device to distribute all or a portion of the health care organization's profits to persons who are in control of the organization
- Whether the compensation arrangement serves a real and discernable business purpose of the organization (e.g., achieving maximum operational efficiency without resulting in direct or indirect benefit to the organization's physicians)
- The presence of safeguards against abuse or unwarranted benefits, including unnecessary utilization
- Whether the compensation is based upon services which are personally performed by the physician

In determining whether any particular compensation arrangement is reasonable, health centers should ensure that any recruitment or retention payments are consistent with formal policies and procedures related to compensation, including standards of conduct and conflict of interest policies.

Health centers should also be aware of a court ruling on the tax implications of physician "loans", a commonly used recruitment mechanism. These loans often require a physician to work at the organization for a certain period of time in exchange for an advancement of funds; if the physician does not remain with the organization during that period of time, the physician must repay the advanced funds, typically with interest. However, a 2013 court ruling held that such funds are considered part of physicians' compensation packages, rather than loans.[22] The case involved a clinic that advanced funds to physicians, but did not withhold income or payroll taxes and did not report the payments as compensation on a Form W-2, but instead issued a Form 1099 when the physicians' "debts" were forgiven. The court cited a number of factors to consider when determining whether an advance should truly be considered a loan:

... a health center offering advance payments or loans to physicians for recruitment or retention purposes should carefully structure the arrangement to reflect whether the arrangement is a loan or compensation.

- Whether the promise to repay is evidenced by a note or other instrument
- Whether interest was charged
- Whether a fixed schedule for repayments was established
- Whether collateral was given to secure payment
- Whether repayments were made
- Whether the borrower had a reasonable prospect

21 See IRS Information Letter 2002- 0021 (Jan. 9, 2002).

22 *Vancouver Clinic, Inc. v. United States,* No. 3:12-cv-05016-RBL, 111 A.F.T.R.2d 2013-1571 (W.D. Wash. Apr. 8, 2013).

of repaying the loan and whether the lender had sufficient funds to advance the loan

- Whether the parties conducted themselves as if the transaction were a loan23

In sum, a health center offering advance payments or loans to physicians for recruitment or retention purposes should carefully structure the arrangement to reflect whether the arrangement is a loan or compensation. If a health center seeks to provide a loan to a provider, it should ensure that the above factors are met; if a health center intends the funds as an advance, it should consult with tax professionals to understand the tax implications.

In sum, a health center offering advance payments or loans to physicians for recruitment or retention purposes should carefully structure the arrangement to reflect whether the arrangement is a loan or compensation.

CONCLUSION

Recruitment and retention payments can be an effective tool to successfully recruit and retain physicians to practice within a geographic community served by a health center. However, when a hospital funds the recruitment or retention payment, it can raise legal issues under the Stark Law or Anti- Kickback statute. Moreover, when a hospital makes the recruitment or retention payment to a health center (which in turn makes a payment to a physician), it can raise legal issues under IRS standards for organizations that are tax-exempt.

As a guard against placing the hospital, health center, and/or physician in violation of applicable Federal laws and regulation, health centers should:

- Instruct legal counsel to review recruitment or retention payment arrangements for compliance with the Stark Law, Anti-Kickback statute, and IRS standards for tax-exempt organizations.
- Ensure that its recruitment and retention payments to physicians (in addition to other staff) are reasonable and comply with the health center's own compensation policies and procedures.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

23 *See Vancouver Clinic, Inc. v. United States,* No. 3:12-cv-05016-RBL, 111 A.F.T.R.2d 2013-1571 (W.D. Wash. Apr. 8, 2013), citing *Welch v. Comm'r,* 204 F.3d 1228, 1230 (9th Cir. 2000).

HR Information Bulletin #6

DEVELOPING PROVIDER INCENTIVE PROGRAMS THAT PASS MUSTER UNDER IRS AND OTHER REGULATORY STANDARDS

Health centers, like most other health care providers, face constant challenges from both the marketplace and regulators to improve their performance with respect to quality of care and patient satisfaction. At the same time, there are financial pressures to increase productivity and efficiency and to reduce costs. These pressures have led many health care providers, and, increasingly, health centers, to establish incentive compensation arrangements designed to encourage providers to work to achieve the organization's goals.

This Information Bulletin discusses the key legal requirements for provider performance incentive arrangements and provider recruitment and retention.[1] Specifically, the Bulletin:

- Describes rules under federal income tax exemption law for several common types of provider incentive arrangements;
- Explains federal cost principles that must be observed when federal grant funds are used to pay for provider incentives; and
- Clarifies limitations on incentive compensation arrangements imposed by federal fraud and abuse statutes.

PERFORMANCE INCENTIVES

ISSUES RELATED TO FEDERAL INCOME TAX EXEMPTION

Providing Reasonable Compensation

All provider incentive compensation arrangements of organizations that are exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code ("IRC"), including most health centers, must consider limitations on the organization's compensation practices contained in the IRC. It is, however, well established in Internal Revenue Service ("IRS") rulings and case law that a Section 501(c)(3) organization can pay "reasonable" compensation for services rendered to it.

No Private Inurement for Insiders—A Section 501(c)(3) organization must, as a condition of obtaining and maintaining tax exemption, ensure that its net earnings do not "inure" to the benefit of any private individual. In plain terms, this means that organizational "insiders," such as board members and key employees, may not take advantage of their position and use the organization's assets or income for their personal gain.

It is noteworthy that, at one time, the IRS took the position that all physicians were "insiders" subject to the prohibition on private inurement. However, the IRS now reviews all the facts and circumstances of a situation, just as it does with other persons affiliated with the organization, to determine if a physician is an "insider." The test is a functional one that looks at the reality of a physician's ability to exercise control over the organization's key financial decisions as opposed to a mere job title or their place on an organizational chart.

No Excess Benefits for Disqualified Persons—In addition, IRC Section 4958 imposes tax penalties

1 Health centers also may provide incentive compensation to executives and key administrators

on organizational insiders, referred to under that provision of the IRC as "disqualified persons," who derive an "excess benefit" from a Section 501(c)(3) organization. In addition, the law provides for tax penalties that can be imposed organization managers, such as board members and key executives, who knowingly approve an excess benefit transaction. Under Section 4958, a disqualified person receives an "excess benefit" if they receive an economic benefit from the organization, such as compensation, that is worth more than the value of the services provided to the organization in return for the compensation.

Generally speaking, "disqualified persons" are the same insiders who are subject to the prohibition on private inurement. Certain persons such as the CEO, CFO, and board members are automatically considered to be disqualified persons. Additionally, family members of a disqualified person and any individual in a position to exercise substantial control over the organization are disqualified persons subject to potential tax penalties. As with the inurement rule, a functional "control" test is applied, considering all the relevant facts and circumstances. Thus, a health center's Chief Medical Officer may well be a disqualified person.

In contrast, individual health center clinicians rarely (if ever) have the authority to use health center assets for personal gain or to make key financial decisions for the health center. Accordingly, most (if not all) of a health center's clinicians are neither insiders nor disqualified persons. There are, nevertheless, constraints on the compensation they can be paid. Section 501(c)(3) provides that an organization must operate exclusively for a tax-exempt purpose as opposed to conferring a private benefit on one or more persons. As a practical matter, anyone who is compensated for services provided to an exempt organization derives some degree of personal benefit. Thus, the IRS regulations permit an insubstantial private benefit.

In sum, any compensation arrangement between a Section 501(c)(3) organization and an employee or an independent contractor:

- Must not result in private inurement if that person is an insider (or if that person is a disqualified person, must not constitute an excess benefit transaction); and
- Must not confer an impermissible private benefit, whether that person is an insider or a disqualified person.

Failure to prevent private inurement or an excessive private benefit is grounds for revocation of tax exemption. At a minimum, an insider/disqualified person will be subject to the Section 4958 tax penalties.[2] Reasonable compensation, however, will not be treated as an excessive private benefit or as an excess benefit transaction subject to Section 4958 penalties.

Determining Reasonable Compensation

In determining the reasonableness of compensation, all compensation received must be considered including, for example:

- Base salary
- Incentive compensation and bonuses
- Fringe benefits
- Noncash benefits, such as personal use of a company car

In short, since incentive compensation is part of a provider's total compensation package, any incentive compensation arrangement must operate in a manner that ensures that total compensation paid remains within the bounds of reasonable compensation.

Whether a compensation package is reasonable is a question of fact determined by the circumstances of each individual case. There are numerous factors that should be considered in determining the reasonableness of a compensation arrangement. These include:

- The amount of compensation that similar organizations in the community pay for similar

2 Note that IRS regulations address circumstances under which excess benefit transactions, as defined in Section 4958, may be grounds for revocation of exemption. See 26 C.F.R. § 53.4958-8.

services provided by comparably qualified and experienced providers

- Compensation surveys published by the health care trade industry and professional organizations as well as specially commissioned studies produced by independent compensation consultants
- Compensation of employed providers paid by for-profit organizations, such as a private medical group practice
- Individual's background and experience, salary history, tenure with the organization, and knowledge of the organization and its operations
- Size and complexity of the organization
- Character and amount of responsibility undertaken
- Amount of time devoted to the job
- Individual's overall value to the organization

IRS rulings on reasonable compensation suggest two overarching principles:

1. First, compensation must be determined in an arm's length transaction. In short, the person receiving the compensation cannot participate in the decision setting the amount of compensation.
2. Second, there should be a positive correlation between the amount of compensation that the organization pays for services rendered and the benefit that the organization derives in return. In other words, compensation should be tied to performance that advances the organization's tax-exempt purposes.

There is no specific formula for determining the reasonableness of a compensation arrangement, and clearly some degree of judgment always will be involved. Therefore, it is extremely important to document the factors on which compensation decisions are made.

Types of Incentives

While all provider incentive arrangements must operate within the bounds of reasonable compensation, they can take many forms. Typical approaches include:

- Paying an end of year "bonus" based on the provider's performance and the financial performance of the organization
- Payments for exceeding a specified number of patient encounters
- Payments for generating more than a specified amount of patient billings
- Payments of a portion of patient revenue generated above a specified amount (also known as a revenue sharing transaction)
- Incentive arrangements with a combination of these features

As discussed below, revenue sharing transactions may well attract special IRS scrutiny. However, IRS rulings indicate that establishing a provider incentive compensation plan does not in and of itself result in private inurement (or a Section 4958 excess benefit transaction), or an excess private benefit, even where profits of the organization are considered in the formula for computing the incentive compensation.

It is extremely important that incentives promote the tax-exempt purposes of the organization. For example, the IRS does not favor productivity bonuses that merely reward the generation of revenue for an organization. The incentives should promote charitable purposes, such as improving quality or expanding services. Similarly, the incentive compensation arrangement should not result in a reduction in charitable services or benefits on account of the financial burden of the incentives on the organization. Maintaining or improving quality of care and promoting patient satisfaction should be factors in an incentive program, particularly one that uses productivity incentives.

Revenue Sharing Transactions

As previously noted, paying providers incentive compensation based on a portion of the health center's revenue is a "hot button" item with the IRS, in part because the statute specifically prohibits tax-exempt organizations from sharing net earnings with private persons. In addition, there is significant potential that such an arrangement will provide a "windfall" to the recipient, with payments at levels unrelated to the provider's actual contribution to the organization and exceeding reasonable comparables.

To reiterate, the most critical aspect of an incentive compensation arrangement that includes a revenue sharing feature is that the total compensation be "reasonable." The best way to ensure that result, and the approach favored by the IRS, is to "cap" incentives so that the total compensation paid remains reasonable under the traditional reasonable compensation analysis. Indeed, it is advisable to include a "cap" on any otherwise open-ended incentive, such as encounter-based incentives. This could be done, for example, either by capping the total amount of compensation that can be earned or the number of encounters that generate incentive pay.

Notwithstanding the IRS's wariness of revenue sharing transactions, IRS guidance suggests that an incentive compensation arrangement that includes revenue sharing is not per se improper. For example, in Revenue Ruling # 69-383, the IRS approved a tax-exempt hospital's payment of a fixed percentage of the radiology department's gross receipts to a radiologist for services rendered. In that case, the physician was a hospital employee (not an officer or other "insider"), the compensation arrangement was negotiated at arm's length, and the amount paid was documented to be reasonable under the circumstances. This ruling should protect incentive compensation arrangements with providers who are not "insiders" or disqualified persons provided, of course, that the requirements in the ruling are met. However, since the IRS evaluates all compensation arrangements based on the facts and circumstances of the case, a health center would be well-advised to have knowledgeable legal or tax counsel review any incentive program that includes a revenue sharing feature.

Issues Related to Federal Grant Cost Principles

In addition to raising tax exemption issues, incentive approaches must be reasonable from a federal grant perspective for any health center that receives Section 330 or other federal grant awards.

Using Federal Grant Funds

Federal grant funds may be used to pay incentive compensation, provided that the incentive payments meet the conditions set forth in the Federal Cost Principles[3]

1. First, the incentive must be premised on cost reduction, improving performance or efficiency, or provide some other discernible benefit to the grant-funded program such as suggestion or safety awards.

2. Second, the overall compensation paid, including the incentive, must be "reasonable" under the circumstances. Reasonableness is determined essentially in the same manner as it is for purposes of federal income tax exemption, with salary comparability being very important to establishing reasonableness.

3. Finally, under the Federal Cost Principles, incentive compensation must be paid (or accrued):

   - Pursuant to an agreement entered in good faith before the services generating the incentive were performed, or

   - Pursuant to an established plan followed by the organization so consistently as to imply, in effect, an agreement to make such payment.

Thus, the Federal Cost Principles require that an incentive compensation arrangement be in place, by contract or through well-established policies

3 See 45 CFR Part 75, Subpart E, Cost Principles

and procedures, before the services on which the incentive payment is based are performed.[4]

Using Non-Grant Revenues

The Federal Cost Principles do not apply to a Section 330-supported health center's non-grant revenue ("program income"), such as fee-for- service income and third-party insurance payments. Therefore, one could argue that the requirement to have an explicit agreement or a well-established practice of paying incentive compensation in place does not apply to the expenditure of program income. However, Section 330 of the Public Health Service Act, which authorizes the award of funds to health centers, requires all program income be used to further the purposes of the grant-funded program. Accordingly, in order to document the nature of the incentive arrangement not only for federal grant purposes but also for federal tax purposes, it is advisable to have:

- The terms under which incentive payments will be made to providers established in writing in advance, reflecting criteria that furthers program objectives (productivity and quality); and
- Prospective incentive payments included in the compensation line item of the budget.

Issues Related to the Federal Stark Law

Physician incentive compensation must comply with the requirements of the federal physician self-referral statute, also known as the "Stark Law." [5]The Stark Law is sweeping in scope and subject to numerous exceptions that must be precisely implemented to be effective. Accordingly, consultation with qualified legal counsel is advisable.

The Stark Law prohibits a physician from making a referral for certain "designated health services" (DHS)[6] payable by Medicare or Medicaid to an entity with which the physician (or an immediate family member) has a direct or indirect financial relationship.

The physician cannot refer a patient to an entity for a DHS, and, most importantly, the entity cannot bill for a DHS if the referral is prohibited by the Stark Law. Since a physician compensated by a health center obviously has a financial relationship with the center, the physician cannot send a patient to the health center's laboratory, pharmacy, or radiology department (or refer a patient for any other DHS) unless one of the "exceptions" to the Stark Law applies

Exceptions to the Stark Law

There are two exceptions to the Stark Law that permit physicians to receive compensation, including certain incentive compensation, from an entity such as a health center and to refer patients to the entity for a DHS.

1. The first covers a physician who is a bona fide employee of the entity.
2. The second covers a physician who is an independent contractor and who has a personal services contract with the entity.[7]

For either of these exceptions to apply:

- The services to be provided as an employee or as

4 Note that Congress may impose restrictions on the use of appropriated funds in compensating employees, for example, for Fiscal Year 2021 the maximum allowable salary that can be charged to a health center grant award is $199,300.00

5 The Stark Law defines a "physician "as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The Stark Law does not affect incentive compensation arrangements for other health care providers, such as nurses, nurse practitioners, and physician assistants.

6 See 42 U.S.C. § 1395nn. Designated health services include clinical laboratory services: physical, occupational, and speech therapy service: radiology and radiation therapy services; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services and supplies; outpatient prescription drugs; inpatient and outpatient hospital services.

7 Whether a physician is an employee or an independent contractor is determined by the "right to control" test. Thus is, if a health center has the right to control not only what a physician does but how the physician carries out their duties, the physician will be treated as an employee. This will depend on the facts and circumstances of a particular arrangement; the mere existence of a written contract, although an important consideration, would not necessarily control.

an independent contractor must be identified.

- The physician must be paid fair market value (including incentives) for the services provided; and
- The arrangement must be commercially reasonable even if the physician were not referring DHS to the entity.

Importantly:

- Incentive payments cannot be based on the volume or value of the physician's referrals of patients for DHS; but,
- The physician may receive incentive compensation for any services that the physician personally performs, even if the service is a DHS.

For example, an incentive compensation arrangement that rewards a physician employee or independent contractor under a personal services contract for every test that they order from a health center's laboratory would violate the Stark Law. Thus, the health center could not bill Medicare for those services.[8]

However, if the physician ordered a test and then personally performed the test, the physician could receive incentive compensation for the work that they personally performed, and the health center could bill for the DHS.

Independent Contract Physicians

In addition to the requirements above, there are four additional Stark Law requirements for an incentive compensation arrangement with an independent contractor physician working for a health center under a personal services agreement.

1. The agreement with the physician must be in writing, specify all the services to be provided, and be signed by the parties. (As a practical matter, it is good practice to have a written agreement with both employed and contracted physicians).
2. The aggregate services contracted for must not exceed those that are necessary for the legitimate business purposes of the parties.
3. The term of the agreement must be for at least one year.
4. Most importantly, the compensation to be paid over the term of the agreement must be set in advance and may not be set in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

Note that for purpose of the Stark Law, the actual total amount of the incentive compensation to be paid a physician does not have to be determined in advance and in most cases, will not be able to be determined in advance. Rather, the "set in advance" requirement simply means that the methodology for determining incentive compensation, such as a fixed sum for every encounter over a stated amount or a fixed percentage of revenue, must be set in advance. Thus, so long as the methodology for computing incentive payments does not change during the term of the agreement, the arrangement will not violate the Stark Law even if the total amount of the incentive payments varies.

ISSUES RELATED TO THE FEDERAL ANTI-KICKBACK STATUTE

The federal anti-kickback statute prohibits any person or entity from knowingly or willfully soliciting or receiving (or offering and paying) remuneration directly or indirectly, in cash or in kind, to induce patient referrals or the purchase or lease of equipment, goods or services, payable in whole or in part by a federal health care program. Violation of the statute is a criminal offense, and violators may also be subject to civil penalties and exclusion from the Medicare and Medicaid programs. Unlike the Stark Law, the anti-kickback statute applies to all types of providers (and anyone else), not just to physicians. Because a provider incentive arrangement clearly involves the payment of remuneration, it could be construed as

8 Although the Stark Law applies directly only to Medicare claims, many states have similar prohibitions on physician referrals for DHS covered by Medicaid.

an inducement to the receiving provider to refer business or otherwise to do business with the paying entity.

Employed Providers

Nevertheless, the anti-kickback statute has no practical effect on incentive compensation arrangements with employed providers because the statute contains a very broad exception for payments made to bona fide employees.

Independent Contractor Providers

The situation is not so simple with respect to performance incentive payments made to independent contractor providers. The statute provides a "safe harbor," i.e. protection from prosecution, for personal services contracts, including the requirement that the amount of total compensation to be paid be "set in advance." However, unlike the similar Stark Law exception, the anti-kickback safe harbor requires that the total aggregate compensation, in fact, be established in advance. In most cases it will not be possible to determine the total amount of compensation to be paid in advance if there is an encounter-based or percentage of revenue-based incentive plan. In short, many incentive compensation arrangements with independent contractor providers will not be protected by an anti-kickback safe harbor even though they are acceptable under the Stark Law.

It is important to remember that the fact that a provider incentive compensation arrangement does not fit into an anti-kickback safe harbor does not mean that the arrangement is illegal. The arrangement is illegal only if the government can prove that the parties intended to induce referrals (or the doing of other health care business) by offering or paying remuneration. This underscores the importance of establishing, and documenting, that an incentive compensation arrangement is reasonable under the circumstances, that is, that the incentive was tied to the provider's performance as opposed to being merely a reward for referring patients or business.

CONCLUSION

Incentive compensation can be an effective method to motivate providers to perform productively and in accordance with quality measures, and to begin or to continue a relationship with a health center. However, as significant bodies of federal law and regulation impact the operation of incentive plans, they should be implemented carefully, with attention to applicable law, and preferably with the advice and assistance of qualified counsel.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

HR Information Bulletin #7

ACCOMMODATING EMPLOYEE LEAVE FOR FAMILY AND HEALTH-RELATED REASONS

Employees of health centers, like any other type of employer, request and take leave for a variety of reasons other than just for rest and revitalization. They may become ill, need to care for family members including children and aging parents, become injured on the job, need to care for injured family members who are or were military service members, or have exigent circumstances due to a family members' active duty in the military. Whatever the case may be, there are a number of options for health centers regarding leave policies that can accommodate an employee's need for leave from work, while still ensuring appropriate staffing patterns at the health center.

Health centers must comply with federal and state laws calling for employers to grant leave for family and medical reasons, but can provide greater employee benefits or protections for parental leave beyond what the law requires.[1]

This Information Bulletin:

- Provides an overview of the Federal Family Medical Leave Act ("FMLA") including benefits, employee rights, and health center rights
- Provides an overview of Title VII of the Civil Rights Act of 1964 ("Title VII") and the Pregnancy Discrimination Act ("PDA"), an amendment to Title VII
- Suggests ways in which health centers can respond effectively to leave requests for family and medical leave purposes
- Describes best practice considerations for health centers in adopting family and medical leave policies and reviewing employee requests for taking leave.

FEDERAL FAMILY AND MEDICAL LEAVE ACT

Most requests for family or medical leave likely will fall within the purview of the FMLA. The FMLA was enacted by Congress and signed by the President in 1993 to "balance the demands of the workplace with the needs of families." FMLA requires employers to provide eligible employees with up to 12 workweeks of unpaid leave in a 12-month period.

REASONS FOR REQUESTING LEAVE UNDER THE FMLA

The FMLA provides eligible employees with job security when they take time off from work for specified familial or medical purposes. Reasons for granting of leave under the FMLA include:

- The birth and subsequent care of a child.
- The placement with the employee of a child for adoption or foster care and subsequent care to bond with the child.
- The need to care for a spouse, son, daughter, or parent who has a serious health condition.

1 The FMLA is administered and enforced by the Wage and Hour Division of the U.S. Department of Labor. For a full discussion of the FMLA see *The Employer's Guide to The Family and Medical Leave Act* https://www.dol.gov/agencies/whd/fmla/employer-guide

- The employee's serious health condition that prevents the employee from performing the essential functions of their job, including incapacity due to pregnancy and for prenatal medical care.
- In addition, there are two types of military family leave available under the FMLA
  - Leave to care for a service member with a serious injury or illness if the service member is the spouse, child, parent or next of kin of the employee. In this case, an eligible employee may take up to 26 workweeks of unpaid leave as well as leave for any other type of FMLA-qualifying leave, provided that the combined total of leave for any FMLA-qualifying reasons may not exceed 26 workweeks during a single 12 month period.
  - Leave due a "qualifying exigency" when an employee's spouse, son, daughter, or parent who is a member of the Armed Forces (including the National Guard and Reserves) is on active duty deployed to a foreign country or has been notified of an impending call or order to active duty.

Under the FMLA, a serious health condition means "an illness, injury, impairment or physical or mental condition" that involves inpatient care or continuing treatment by a health care provider but includes, among other things, "any period of incapacity due to pregnancy, or for prenatal care." In contrast, the FMLA does not apply to routine medical examinations, or to common medical conditions, such as an upset stomach, unless there are complications. "Incapacity" means inability to work, including being unable to perform any one of the essential functions of the employee's position. For example, if an employee of the health center has pregnancy complications that would prohibit her from working (such as preterm labor when the treating physician requires the woman to be placed on bed rest with anti-contraction medications), the employee would be entitled to use FMLA unpaid leave during this period.

Bear in mind that employees may be entitled to FMLA leave for non-medical reasons such as the birth of a child and their subsequent care, or the placement with the employee of a child for adoption or foster care.

Additionally, many states and municipalities have their own family and medical leave laws, and the FMLA does not "trump" or supersede them. The FMLA is intended as a floor of protection, not a ceiling. In other words, it is possible for a state or local law to provide employees with greater leave rights than the FMLA. For example, some states provide a longer period of leave than the federal law. Health centers must follow the law that is most protective of the employee's rights and provides the employee with the greatest benefits. As such, health centers should be aware of the applicable requirements and should consult with qualified local counsel regarding relevant provisions of state and local with regard to which laws govern in particular instances.

Further, as the FMLA and similar state and local laws establish only the minimum requirements for leave. Health centers may have more liberal leave policies than what the law requires.

TO WHOM DOES THE FMLA APPLY?

The FMLA covers private-sector employers with 50 or more employees or public agency employers regardless of the number of employees. To qualify for FMLA coverage, employees must have worked for the employer for:

- At least 12 months total (not necessarily 12 consecutive months), and
- At least 1,250 hours during the 12-month period immediately preceding the date that the FMLA leave is to start.

If the employer has multiple locations, the employee must have worked at a location where the employer has at least 50 employees on the payroll within 75 miles of that location.

Based on the above, a part-time employee could qualify for FMLA leave. For example an employee who has been employed by a health center for 12 months and has worked 25 hours for each of 50 weeks (having taken two-weeks' vacation during

those 12 months) would also be eligible to take time off under the FMLA. Note that only time actually worked counts toward the hours of service requirement. Vacation time, sick leave, holidays, and any other kind of paid or unpaid time off is not counted.

FMLA BENEFITS

As noted, a health center with 50 or more employees must allow an eligible employee to take up to a total of 12 workweeks of unpaid leave in a 12-month period for the medical and familial reasons specified previously (and up to 26 workweeks for certain types of military family leave).

It is important to remember that the FMLA provides job protection, not compensated leave. This means that an employee using FMLA leave can rely on being able to return to their job in most circumstances, but wages/salary need not be paid to the employee while the employee is out on FMLA leave. However, under the FMLA, employees may choose to substitute (or the employer may require the employee to substitute) accrued paid leave—including vacation and/or personal leave—to run concurrently with unpaid FMLA leave. Additionally, employers must make it clear via written notice that such a substitution has taken place. The employee retains their right to reinstatement even if the employer requires them to use accrued paid leave for the FMLA-qualifying period.

While an employer may not entirely forbid an employee to substitute paid vacation and/or personal leave for unpaid leave, an employer may limit the substitution of paid sick leave in accordance with its policies on the use of such leave. For example, if an employee wanted to take time off to care for a sick child they could use their accrued paid sick instead of unpaid FMLA leave if the employer's sick leave policy permitted the employee to take sick leave to care for a child. Regardless of whether paid leave is substituted for unpaid FMLA leave, the employer need only provide a sum total of 12 workweeks leave (or 26 weeks for military family leave) for FMLA purposes.

In drafting an employee leave policy, health centers should address how the 12-month period in which an employee can exercise their FMLA rights will be calculated. If an employer neglects to specify a method of calculation, the employer must use the method that is most beneficial to the employee. There are several possible methods allowed under the law, including:

- The calendar year
- Any fixed 12-month period
- A 12-month period measured forward from the date an employee first takes FMLA leave. (The next 12-month period would begin the first time the employee takes FMLA leave after the completion of the first 12-month period).
- A "rolling" 12-month period measured backward from the date an employee uses any FMLA leave. (Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 workweeks not used during the immediately preceding 12 months).

The "rolling" 12-month period measured backward from the date an employee uses any FMLA leave. is the method most protective of an employer's interest in maintaining adequate staffing patterns and preserving workplace functions. Under this method of calculation, each time an employee takes FMLA leave, they are entitled to any balance of the 12 weeks that has not been used during the immediately preceding 12 months. For example, if an employee used 8 weeks of leave during the past 12 months, an additional 4 weeks of leave could be taken. If the employee used 8 weeks beginning January 30, 2021 and 4 weeks beginning July 30, 2021, the employee would not be entitled to any additional leave until January 30, 2022. However, beginning on January 30, 2022, the employee would be entitled to 8 weeks of leave and on July 30, 2022 would be entitled to an additional 4 weeks of leave.

Note that, state law may require a specific method for determining the leave period, in which case the employer must follow state law. Further, whichever FMLA method the employer uses, it

must apply it uniformly and consistently to all employees. An employer may change to a different 12-month period if it gives employees 60 days prior written notice of the change but must continue to make whichever period is most beneficial to the employees available during the transition.

EMPLOYEE RIGHTS UNDER THE FMLA

Job Reinstatement

With limited exceptions, employees are entitled to return to their job or an equivalent position at the end of a period of FMLA leave. While the employee need not necessarily be restored to the same job held prior to leave, the job must be one that is virtually identical to the original job in pay, benefits, and other terms and conditions of employment. In contrast, an employer is not required to reinstate certain "key" employees — those salaried, FMLA-eligible employees who are among the highest paid 10 percent of all persons employed by the organization— to an equivalent position if the employer has notified the employee in writing of their key employee status under the FMLA and the reasons for denying job restoration. In addition, the employer must demonstrate that reinstatement would cause "substantial and grievous economic injury" to its operations.

Written Notice

An employee is entitled to receive written notice from the employer when the leave they are about to take will be considered FMLA leave. This written notice, referred to as a "Designation Notice" is important because it lets the employee know that the leave will be counted against their annual FMLA leave allowance. This notice should inform the employee whether the employee is required to substitute paid leave for unpaid FMLA leave and whether the employee will be required to submit a fitness-for -duty certification to return to work.

Continuance of Health Benefits

An employee is entitled to continue to receive group health insurance coverage (including dependent coverage) on the same terms as if the employee had continued to work, if they received such coverage from the health center prior to requesting leave. If an employee pays some part of the group health insurance premium - typically deducted from their paycheck - when the FMLA leave is unpaid the employer can require the employee to pay their usual portion of the insurance premiums (without any mark-up or additional charge for administrative expense), and may terminate their health benefits if they do not do so. (See below under Health Centers' Rights, Termination of health benefits.)

Intermittent Leave

In certain cases an employee is entitled to take intermittent/reduced schedule leave for the employee's own serious health condition, to care for a spouse, parent, or child with a serious health condition, or to care for a covered service member with a serious injury or illness.

However, if an employee requests intermittent/ reduced schedule leave to take care of a healthy newborn or a newly placed adopted or foster care child, the health center has the right to approve the leave. Further, in situations where intermittent/ reduced schedule leave is based on planned medical treatment, and therefore is foreseeable, the employer is permitted to temporarily transfer the employee to an alternative job with equivalent pay and benefits if the job would accommodate recurring periods of leave better than the employee's usual job. Only time actually taken as intermittent leave can be charged against the employee's FMLA leave entitlement.

HEALTH CENTERS' RIGHTS UNDER THE FMLA

Advance Notice

An employer is entitled to 30 days' advance notice from the employee when the need for FMLA leave is foreseeable and it is possible and practical to provide that notice. If an employee fails to give 30 days' notice for a foreseeable leave with no reasonable excuse for the delay, and the employee knew of the FMLA notice requirements, the

employer may deny the taking of leave until at least 30 days after the employee provides notice.

For unforeseeable leave, such as leave necessary to care for a family member injured in an accident, notice must be given as soon as practical.

In the context of parental leave requests incident to a normal pregnancy or adoption, 30 days advance notice will usually be possible. However, a health center should be sensitive to the fact that births and adoption arrangements are not always predictable events and sometimes take place prematurely or on very short notice. Thus, health centers should take such extenuating circumstances into account when evaluating employee compliance with the reasonable notice requirement under the FMLA.

Medical Certification

If an employee requests leave for their own serious health condition (e.g., a heart attack) or the serious health condition of the employee's parent, spouse, or child, the employer can require a medical certification of the condition from a health care provider. (Importantly though, an employer may not request a medical certification for leave to bond with a newborn child or a child placed for adoption or foster care.) An employer may request recertification every 30 days in most situations involving medical conditions that have an uncertain duration, provided that the request is made in conjunction with an employee's actual absence from work. Only in situations where there is doubt as to the employee's reason for being absent, or if circumstances described in the previous certification have changed significantly, is an employer permitted to request medical recertification more frequently than once every 30 days. An employee is entitled to at least 15 calendar days to obtain the medical certification.

Clarification and Second Opinions

When an employee fails to provide adequate medical certification, that is, the certification is incomplete (lacking the information requested) or insufficient (the information provided is vague, ambiguous, or non-responsive) an employer may seek further clarification.

The employer must provide the employee with a written notice stating what information is necessary to make the certification complete and sufficient and give the employee 7 calendar days to cure the deficiency. If, after receiving a completed medical certification, the health center still questions the validity of the information on the form, the employer may require the employee to obtain a second, and in some cases a third, opinion at the employer's expense.

If the certifications and clarifications do not ultimately establish the employee's entitlement to FMLA leave, the employer may choose not to designate the leave as FMLA leave and treat the leave as paid or unpaid leave under the employer's established leave policies. In short, it is the employee's responsibility to provide the employee with a complete and sufficient information to establish their eligibility for FMLA leave.

Termination of Health Benefits

In very limited circumstances, an employer can terminate health benefits. If an employee on FMLA leave gives notice to the employer that they do not intend to return to work at the end of the FMLA leave period, or if the employee fails to return to work at the end of the FMLA period, the employer's obligation to continue providing group health benefits ceases. Further, if the employee is more than 30 days late in making required health insurance payments, the employer may terminate health benefits, provided that it gives at least 15 days advance written notice of the prospective termination date.

Non-Accrual of Other Benefits

Additionally, some employment benefits, such as seniority or paid leave, need not continue to accrue during FMLA unpaid leave if these types of benefits do not accrue for employees on other types of unpaid leave. Nonetheless, the employer and the employee may agree to continue other benefits, such as life insurance, during FMLA unpaid leave to ensure the employee will be eligible to be restored to the same benefits upon their return to work.

In these situations, the employer is entitled to be repaid by the employee for their share of non-health benefit insurance premiums upon return to work. A health center should have a clearly-written policy to this effect.

TITLE VII OF THE CIVIL RIGHTS ACT OF 1964

Title VII prohibits employers from discriminating against any person, either intentionally or in effect, with respect to the terms and conditions of their employment, on the basis of race, color, religion, sex (Including pregnancy), sexual orientation, gender identification, or national origin. For the purposes of accommodating parental leave requests, discrimination on the basis of pregnancy, childbirth, or a pregnancy-related condition constitutes unlawful sex discrimination under Title VII as amended by the Pregnancy Discrimination Act. Title VII applies to private employers with 15 or more employees, and, unlike the FMLA, employees are protected immediately upon employment.[2]

RIGHTS AND RESPONSIBILITIES UNDER TITLE VII

Granting of Leave

Under Title VII, requests for voluntary leave for parenting purposes, that is, pregnancy, childbirth, or a pregnancy-related condition, must be granted to employees to the same extent as an employer provides voluntary leave to employees for other reasons

Job Reinstatement

If a pregnant woman has taken leave because of a pregnancy-related condition (e.g., pre-eclampsia) and recovers, she must be allowed to return to work. Employers may not require a pregnant employee who has taken temporary leave to remain on leave until the child is born and may not have a policy prohibiting employees from returning to work for a specified amount of time after the birth of a child. Employers must hold open a job for an employee's pregnancy-related absence for the same length of time as jobs are held open for those on sick or disability leave. Title VII also requires employers to allow an employee on pregnancy leave to return to her job on the same basis as other employees returning to work from sick or disability leave. For example, an employee returning from pregnancy leave cannot be required to certify her ability to return to work unless such certification is required of all employees returning from comparable leaves.

Equivalent Treatment as Other Employees

Pregnant employees must be treated in the same fashion as other, nonpregnant employees with a similar ability or inability to work. For example, if a pregnant employee's attendance is suffering because of morning sickness, she must be treated the same as would any other employee with a temporary medical condition causing frequent tardiness or absence.

COMPLIANCE WITH TITLE VII

To ensure compliance with Title VII, a health center should have clearly written policies in place regarding voluntary leave. When developing these policies, health centers should consider issues such as:

- Whether the leave will be paid or unpaid
- The permitted duration of such leave
- The kind of notice that is required of the employee requesting leave.

It is important to make sure that these policies do not single out any medical condition or class of person. All health center Human Resource professionals should receive comprehensive and regular training in the proper application and implementation of these policies.

For an employee to claim successfully that a health center has discriminated against them, the employee must demonstrate that the health center:

- Intentionally discriminated against them (referred

2 *See Fact Sheet for Small Businesses: Pregnancy Discrimination.* **https://www.eeoc.gov/laws/guidance/fact-sheet-small-businesses-pregnancy-discrimination**

to as "disparate treatment") or

- Had a policy or procedure that resulted in discrimination, even if unintentional (referred to as "disparate impact") or
- Created or condoned a hostile work environment.

Although all three are important, health centers should be especially alert to the disparate impact issue, because even a policy seemingly neutral on its face could violate Title VII if it has a greater effect on one sex. For example, a policy granting only women time off to care for a child would have a disparate impact on men who wanted to take leave under the same circumstances.

Health centers not only should have clear leave policies in place, but they also should document their actions. carefully. Demonstrating consistent and comprehensive non-discriminatory practices will provide a substantial defense if an employee alleges discriminatory conduct.

COMPARISON OF PARENTAL LEAVE RIGHTS UNDER THE FMLA AND TITLE VII

Health centers must be aware of an employee's parental leave rights under both the FMLA (including any applicable state and local laws) and Title VII. The key provisions of the FMLA and Title VII about leave for parenting purposes are compared below.

GENERAL RIGHT TO LEAVE

FMLA: An eligible employee has a right to 12 workweeks of unpaid leave in a 12-month period for purposes relating to pregnancy, adoption or foster care, and to deal with their serious health condition or that of their child.

Title VII: Voluntary leave requests for pregnancy, childbirth, or parenting must be granted to the same extent as voluntary leaves are normally granted to employees for temporary or non-disability reasons.

PAID LEAVE

FMLA: FMLA does not mandate paid leave. Instead, employees may choose to use, or employers may require the employee to use, accrued paid leave, including vacation and/or personal leave, to cover some or all of the unpaid FMLA leave taken. The substitution of accrued sick leave is limited by the employer's policies on the use of such leave.

Title VII: Paid leave must be granted to employees requesting voluntary leave for parenting purposes to the same extent as paid leaves are normally provided to employees of the opposite sex.

MODIFIED OR PART-TIME SCHEDULES

FMLA: An eligible employee may take intermittent or part time leave for purposes relating to their serious health condition or the serious health condition of their child. When intermittent leave is requested for foreseeable medical treatment, the employer is permitted temporarily to transfer the employee to an alternative job with equivalent pay that suits the employee's need for recurring periods of leave better than the employee's usual job.

Title VII: Employers must treat employees requesting leave for pregnancy-related reasons the same as those requesting leave for other types of temporary disabilities.

MEDICAL CERTIFICATIONS AND INQUIRIES

FMLA: An employer may require that an employee submit a certification to support their need for FMLA leave. If an employee submits a medical certification form that the employer finds ambiguous or incomplete, the employer must give the employee an opportunity to correct the deficiencies. The employer may seek clarification of any ambiguities on the form from the employee's health care provider with the employee's consent. If these measures still do not alleviate the employer's concerns regarding the validity of the medical certification, the employer may seek a second (and in some cases a third) opinion at its expense. All communication(s) regarding the medical certification form must be between a health care provider or HR/benefits professional chosen by the health center and the employee's health care provider.

Title VII: A health center's policy regarding medical examinations and inquiries must be applied consistently across all employees, regardless of their specific medical condition.

REINSTATEMENT RIGHTS

FMLA: Typically, employees have the right to return to the same position or to an equivalent one at the end of FMLA leave. However, once an employee has exhausted their FMLA leave they no longer have the job reinstatement rights provided under FMLA even if they are unable to return to work. A "key" employee who was notified of their status in writing does not have to be reinstated if the employer can show that reinstatement would result in significant economic injury.

Title VII: Employers must allow an employee on parental leave to return to their job on the same basis as other employees returning to work from comparable types of leave.

CONTINUANCE OF HEALTH INSURANCE BENEFITS

FMLA: FMLA requires an employer to continue the employee's existing level of health insurance coverage during the leave period, provided the employee pays their share of the premiums. An employer must provide the employee with the same benefits on the same terms normally provided to an employee in the same leave status.

Title VII: An employer must continue an employee's health insurance benefits during their leave period only if it does so for other employees in a similar leave status.

STEPS FOR DETERMINING RIGHTS AND RESPONSIBILITIES REGARDING PARENTAL LEAVE REQUESTS

1. **Consider which laws apply to employees as a group.** The FMLA covers health centers with 50 or more employees, while Title VII applies to health centers with 15 or more employees. Thus, only those health centers with 50 or more employees are covered concurrently by the FMLA and Title VII.
2. **Verify the employee's benefits and/or entitlements under the relevant laws.**
3. **Remember—**when more than one law applies (e.g., state and local versions of the Federal FMLA and Title VII), employers must provide leave that is most protective of the employee's rights.
4. **Establish a plan for reinstatement, unless the employee would fall under an exception. If an exception applies, determine how the health center will handle it,** according to formal written policies, consistently applied. And make sure to document how and why the decision was made in accordance with those policies.

BEST PRACTICES FOR HEALTH CENTER LEAVE POLICIES AND PROCEDURES

- The health center should ensure that its family and health-related leave policies are easy to understand and that those in charge of implementing the policies appreciate the importance of uniform application. When formulating leave policies, health centers should address issues regarding reinstatement, duration of leave, notice requirements, use of vacation and/or sick leave as substitutes for unpaid leave, and disability benefits.
- The health center should address non-medical parental leave requests when drafting policies. Recall that parental leave requests under FMLA can be for reasons such as caring for a newborn, or bonding with a newly adopted or foster care child. Procedures for addressing these types of leave requests are clearly addressed in federal legislation and health centers must comply with them. Thus, health centers must incorporate such procedures (or more generous procedures) into their own policies.
- A health center should notify employees that written medical certification may be required for certain leave requests. Health centers should confirm that the medical certification requirements, including the time periods for required notices, and the consequences for failing

to submit certification forms, are clearly spelled out in the health center's policies. A health center should consider including on any leave of absence form a consent provision granting the employer's health care provider permission to contact the employee's health care provider for purposes of clarifying or authenticating information on medical certification forms.

- The health center should thoroughly document any disciplinary actions or communications regarding parental leave. If a claim does arise under FMLA or Title VII, having clear and detailed documentation will be critical to an adequate defense.

CONCLUSION

This Information Bulletin discusses laws that are intended to protect both health centers and their employees in the context of family and health-related leave. While compliance with the applicable laws may appear to be daunting, this need not be the case.

It is imperative that health centers remain conscious of the diverse contexts in which leave should be granted and make efforts to identify accurately and address all appropriate requests.

To ensure compliance with the laws governing leave:

1. Health center management should use common sense and ensure that all Human Resource personnel are properly educated about state and federal leave laws; and

2. Health centers should carefully draft and clarify their own policies regarding leave.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

HR Information Bulletin #8

THE GRAYING OF THE WORKFORCE AND IMPLICATIONS FOR HEALTH CENTERS

The leading edge of the baby boom generation began retiring in 2011, raising not only the well-known fiscal challenges to Social Security and Medicare, but also challenges for employers (including health centers).

In 1950, there were seven working people for every person age 65 and older in the U.S. By 2030, there will be fewer than three working people for every person age 65 and older in the U.S.[1] While the labor force is expected to increase by 8.0 million from 163.5 million in 2019 to 171.5 million in 2029, the participation rate is projected to decline from 63.1 percent in 2019 to 61.2 percent in 2029.[2] One of the main reasons for the decline in labor force participation is the aging of the baby-boom generation-- by 2029, all baby boomers will be at least 65 years old. The increasing percentage of people age 65 years and older also contributes to slower projected growth in the labor force, as well as a continued decline in the labor force participation rate, since older people are less likely to participate in the labor force.[3] At the same time, many workers are likely to remain in the work force longer for economic reasons. In particular, certain disincentives for continuing to work have been eliminated[4] and the retirement age for receiving Social Security has increased. There has also been a decrease in the benefit amount for each month a recipient retires at a younger than normal retirement age.[5] In fact, the projected median age of the workforce is projected to be 42.6 years in 2029, as compared to 41.9 years in 2019.[6]

Given the aforementioned, health centers are likely to find themselves challenged to find qualified workers as baby boomers retire and having to accommodate varying work schedules and levels of productivity for older workers who remain on the job. Further, health centers may find themselves having to ensure that older workers are not subject to illegal age-related discrimination in the terms and conditions of their employment.

This Information Bulletin:

- Examines some of the legal and practical challenges presented by the aging of the health center workforce and provides tips on how to address each of these challenges
- Explores the following issues that could arise in the context of an aging workforce:
  - Managing the impact of the impending labor shortage on health center capacity
  - Establishing employment practices and policies that minimize age discrimination-related liability

1 Committee for Economic Development, New Opportunities for Older Workers at **https://www.ced.org/pdf/New-Opportunities-for-Older-Workers.pdf** (Accessed 5/16/21).

2 Bureau of Labor Statistics, Employment Projections: 2019-2029 Summary at **https://www.bls.gov/news.release/ecopro.nr0.htm** (Accessed 5/16/21).

3 Id.

4 The Senior Citizens Freedom to Work Act did away with the earnings penalty which reduced Social Security benefits for workers aged 65-70 who earned wages, thereby eliminating a major disincentive to work.

5 For those born 1943-1954, the retirement age for Social Security is 66. For those born after 1960, the retirement age is 67.

6 Bureau of Labor Statistics, Employment Projections at **https://www.bls.gov/emp/tables/median-age-labor-force.htm** (Accessed 5/17/21).

- Accommodating leave requests and absences from work
- Avoiding discrimination against employees functioning as caregivers

MANAGING THE IMPACT OF THE IMPENDING LABOR SHORTAGE ON HEALTH CENTER CAPACITY

Health center boards of directors and senior management must take the retirement of baby boomers and fewer numbers of workers in the next generation into account as they consider how to fill key positions in the health center currently occupied by persons nearing retirement.

Health center managers are likely aware of the current labor shortages in certain segments of the health care industry, such as nursing. Moreover, the impending labor shortage is likely to place a premium on recruiting and retaining physicians, nurse practitioners, and physician assistants with knowledge and training in geriatrics, who will be in even greater demand as the population as a whole ages. Demand for geriatricians is projected to exceed supply, resulting in a national shortage of 26,980 FTEs in 2025.[7] While the supply of geriatricians is expected to increase from 3,590 FTEs to 6,230 FTEs (a 74 percent increase), the severity of the shortage predicted varies widely. For example, by 2025, the Northeast is projected to have a deficit of 2,890 FTE geriatricians while the West is projected to have a deficit of 14,530 geriatrician FTEs.

A health center should have a succession plan in place for identifying potential replacements, including utilizing appropriate external recruitment strategies, for managers who are approaching retirement. Without regard to the overall age of its workforce, a health center should, as part of its strategic planning process, assess the number and specific qualifications of the leaders that will be required for the next five years and adopt a plan to review skill sets against perceived needs, promote and/or recruit employees, and train successors.

ESTABLISHING A PHASED-IN RETIREMENT PROGRAM

Some employers, notably colleges and universities, have addressed the shortage of experienced workers by implementing phased-in retirement programs. These arrangements allow employees to tap into their pension plans while continuing to work part time. The purpose of phased-in retirement is to retain older workers who may be interested in working part time, while at the same time permitting them to access pension funds to make up the difference in compensation. This type of employment arrangement could be an excellent way for a health center to take advantage of the expertise that someone nearing retirement age might be able to provide, such as mentoring less experienced employees or strategic planning.

Historically, pension benefits could not be paid until an employee stopped working altogether. However, with economic pressures on retirees and potential labor shortages faced by employers, it has become increasingly desirable to make it economically feasible for older workers to work on a reduced schedule while supplementing their incomes from their employer sponsored retirement plan.

Beginning in 2007, the Pension Protection Act of 2006 allowed distribution of pension benefits from a qualified pension plan while an employee is still employed. The applicable Internal Revenue Service ("IRS") regulations[8] define what the "normal retirement age" is for the purpose of allowing the early payments.

- There is a "safe harbor" for plans in which the normal retirement age is 62 or older.
- The rules also allow early withdrawal from retirement plans in which the normal retirement age is 55, under certain conditions.

7 U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis, National and Regional Projections of Supply and Demand for Geriatricians: 2013-2025 at **https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/geriatrics-report-51817.pdf** (Accessed 5/16/21).

8 26 C.F.R §1.401(a)-1.

While a phased-in retirement plan can be beneficial both to the health center and employees, the Age Discrimination in Employment Act ("ADEA")[9], which is discussed later in this Bulletin, may affect how these plans are implemented. It is critical that health centers considering a phased-in retirement plan obtain the assistance of competent employee benefits counsel.

Additionally, the cost implications of part time employees must be considered. For example, employees who work part time may no longer be eligible for coverage under the health center's health benefits plan (depending on how the plan is structured) and, if under age 65, will not be eligible for Medicare. Obviously, health insurance will be an important consideration in retaining older workers on a part-time basis, but the health center's cost of providing health insurance to older, part-time employees could be high. Thus, it is important that a health center explore all options for continuing benefits to this group of employees.

HIRING "RETIRED" EMPLOYEES AS CONSULTANTS

Employers sometimes continue to use the services of "retired" employees by bringing them back as "consultants." This can save the employer money because, among other things, if a worker is an independent contractor as opposed to an employee, the employer does not have to pay federal and state employment taxes on the worker's wages and does not have to withhold income tax from wages paid.

Health centers should be very cautious if they retain a former employee as a "consultant." The legal test for whether a worker is an "employee," as opposed to an independent contractor depends essentially on whether the employer has the right to control how the worker does their job, not just what the worker does.[10] In short, the IRS will treat a worker as an employee – with adverse consequences for an employer who does not pay the requisite employment taxes and does not withhold income tax – based on how the worker performs the assigned tasks without regard to the label that a health center assigns to the worker.

Moreover, retaining a retired employee as a "consultant" to perform essentially the same duties as the person did as an employee is a "red flag" to the IRS. Those arrangements should be avoided entirely. Health centers should also be aware of state laws regarding the classification of employees vs. contractors as state laws can vary widely and be more stringent than the IRS definition (e.g., California law).[11]

On the other hand, a former employee would be more likely to be considered a contractor with the following characteristics:

- Establishes their own business to provide services such as auditing or bookkeeping to several clients
- Contracts with the health center
- Performs the work a few hours a month, but at no set time or day
- Purchases insurance for the business
- Bills the health center monthly for the services
- Is not reimbursed for business-related expenses
- Pays their own self-employment taxes

Useful Tips on Managing the Impact of the

9 29 U.S.C. § 621 et seq. See also EEOC ADEA Compliance Manual Chapter 3: Employee Benefits at http://www.eeoc.gov/policy/ docs/ benefits.html (Accessed 5/16/21).

10 See IRS Publication 15-A (2021), Employer's Supplemental Tax Guide, for a summary of the relevant factors in classifying a worker as an employee versus independent contractor at **https://www.irs.gov/publications/p15a#en_US_2021_publink1000169466** (Accessed 5/16/21). Also see NACHC *HR Information Bulletin 2: Classifying Workers as Employees or as Independent Contractors: Why It Matters and how to do It Correctly.*

11 California Department of Industrial Relations, "Independent Contractor Versus Employee" at **https://www.dir.ca.gov/dlse/faq_independentcontractor.htm** (Accessed 5/16/21).

Impending Labor Shortage on Health Center Capacity

- **Take steps to implement a succession plan as part of the strategic planning process.**
- **Analyze, with the assistance of appropriate advisors, whether a phased-in retirement program might be feasible under the health center's retirement plan.**
- **Consider allowing flexible scheduling for older workers who want to continue in the work force but want to work fewer hours.**
- **Consider providing opportunities for older workers to serve as mentors for less experienced employees.**

ESTABLISHING EMPLOYMENT PRACTICES AND POLICIES THAT MINIMIZE AGE DISCRIMINATION-RELATED LIABILITY

The ADEA prohibits employers from discriminating against workers over age 40 with regard to recruitment, hiring, firing, promotion, and compensation. This includes limiting or segregating employees in any way that would deprive them of employment status, including with limited exceptions, enforcing a mandatory retirement age. Thus, as a health center's workforce ages, it is increasingly important to uncover and correct employment policies and practices that might be viewed as discriminating against older workers.

Bias against hiring older workers could be manifested in advertisements for job openings that contain phrases such as "recent graduates" or "young, energetic applicants" desired or in job descriptions that set forth significant physical requirements that are not necessary to the performance of the job. For example, a job description for a nursing assistant that includes the task of lifting patients onto an examining table could operate to exclude older workers who may not have the requisite strength if, in reality, it rarely is necessary for the employee to do so.

Discrimination against older workers also could be manifested in other, more subtle, ways. For example, no one in health center management should suggest that a worker over 40 "slow down", "think about retirement", or "take a break from the stress of the workplace," nor should comments such as "it is hard to keep up with technology at your age" be tolerated. These comments, however well intended, imply assumptions about the abilities of the worker that could be construed as a discriminatory bias against older workers.

Most health centers are understandably concerned about employee productivity; however, they should not let such concerns cloud managers' views of older workers' performance potential. In particular, stereotypes of older workers that suggest that they are not willing or able to work long hours, be productive during the hours they work, adapt to change, or remain creative and forward thinking, must be avoided. Indeed, not doing so could subject a health center to legal liability.

Moreover, the Supreme Court has held that the ADEA protects older workers not only from disparate treatment on account of age (e.g. promoting a younger worker over an older worker solely because of their age), but also protects workers against policies that have the effect of discriminating against older workers.[12] Employers instead need to be able to demonstrate that they are using "Reasonable Factors Other Than Age" or "RFOA" when establishing policies. An example might be a health center that instructed its Finance Department to evaluate its employees on productivity without

12 Smith v. City of Jackson, 544 U.S. 228 (2005); Meacham v. Knolls Atomic Power Lab., 554 U.S. 84 (2008)

any additional guidance on how to do so. Because of the lack of guidance, as a whole, older employees were disproportionately rated as least productive. The manner in which the evaluation process was established and implemented could be seen as unreasonable because the chance that older workers would be disadvantaged would be higher and the chance that the health center's underlying stated goal would not be achieved was greater. Furthermore, the health center did not establish that it had considered RFOA when making the policy.[13] In order to protect itself from a disparate treatment claim, the health center would have been better served to establish criteria for the evaluation that utilized RFOA. .

Useful Tips on Establishing Employment Practices and Policies that Minimize Age Discrimination-Related Liability

- **Review job opening announcements and advertisements to make sure that they contain objective wording that does not imply ageism.**
- **Periodically audit job descriptions to make sure they accurately reflect the requirements of the job.**
- **Incorporate training on how to avoid age stereotyping in diversity training for health center employees.**
- **Reward employees for performance and recognize older worker achievements on a par with other workers.**
- **Provide training opportunities for older workers.**

On the other hand, the ADEA does not require employers to treat older workers differently solely on account of their age. For example:

- An older worker may be expected to fulfill the requirements of their job and may be counseled or disciplined just as any other health center employee would be, in accordance with health center policies.
- If an older employee has difficulty taking instructions from a younger supervisor, then the older worker should be counseled or disciplined, as appropriate (just as a younger supervisor who overlooks older workers when it comes to promotions should be counseled).

ACCOMMODATING LEAVE REQUESTS AND ABSENCES FROM WORK

LEAVE POLICIES—IN GENERAL

Health centers should have understandable and comprehensive leave policies. Published policies that the health center consistently adheres to are important to give the health center some ability to predict and plan for when employees will not be available for work and to help ensure that leave is provided equitably. Leave policy is likely to become increasingly important in an aging workforce as workers request time off not only to take care of their own or a spouse's medical needs, but also to care for aging parents. As is the case with productivity and performance issues, leave policies

13 Equal Opportunity Commission, "Questions and Answers on EEOC Final Rule on Disparate Impact and "Reasonable Factors Other Than Age" Under the Age Discrimination in Employment Act of 1967 at https://www.eeoc.gov/regulations/questions-and-answers-eeoc-final-rule-disparate-impact-and-reasonable-factors-other-age# (Accessed 5/16/21)

and, importantly, the application of those policies, should be reviewed periodically to ensure that they do not discriminate against older workers (directly or indirectly) and otherwise are consistent with applicable federal and state laws.

LEAVE UNDER THE FEDERAL FAMILY AND MEDICAL LEAVE ACT

Health centers with 50 or more employees must comply with the Federal Family and Medical Leave Act ("FMLA")[14], which requires employers to provide up to 12 weeks of unpaid leave to an employee who has been employed for at least 12 months and has worked a minimum of 1250 hours in the previous 12 months (not necessarily consecutive months) for the employee's own serious medical condition and to care for the serious medical condition of a close relative.[15] Many states also have similar laws and, typically, the employer must provide leave under the law that provides the greater benefit to the employee. Accordingly, both FMLA and applicable state laws must be considered when crafting a leave policy.[16]

FMLA leave policies should address the following questions:

- **Concurrent leave —** Whether unpaid FMLA leave runs concurrently with available paid leave if permissible under state law.
- **Serious health condition —** The FMLA leave policy should stress that such leave is available only for a serious health condition of the employee or the employee's close family member. Under FMLA, a serious health condition involves overnight inpatient care at a hospital, hospice, residential medical care facility and subsequent recovery and treatment from the inpatient care, *or* care involving continuing treatment by a health care provider.[17] Moreover, as "caring for" a person implies presence with the person who needs care, an employee who requests FMLA leave to care for a seriously ill parent cannot use the leave, for example, to clean out and sell the parent's house.
- **Documentation of serious medical condition** — Employers may require the employee to provide medical documentation of the underlying serious health condition. FMLA leave policies should include a statement of the documentation required and, ideally, a form for the employee to use to provide the required information.

LEAVE UNDER THE AMERICANS WITH DISABILITIES ACT

An older employee who has a serious health condition (physical or mental) also may be protected under the Americans with Disabilities Act (ADA).[18] If an employee has a physical or mental impairment that substantially limits the employee's ability to perform a major life activity, such as working, the employer must provide a "reasonable accommodation" to the employee's disability, unless doing so would be an undue hardship to the employer. Importantly, the employee must be able to perform the essential duties of the job with or without the accommodation.[19]

A health center's leave policies should consider ADA requirements, as the "reasonable accommodation" that an employer has to make to an employee's disability may include, under appropriate circumstances, modifying the employee's work schedule, and providing intermittent breaks from work. The key to an employer's accommodation being deemed reasonable is to engage in an

14 29 U.S.C. 2601 et seq

15 According to the National Partnership for Women and Families, almost 15 million workers take FMLA leaves each year. **https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/key-facts-the-family-and-medical-leave-act.pdf** (Accessed 5/16/21)

16 FMLA and similar state laws also typically provide unpaid leave for the birth or adoption of a child. For a more extensive discussion of FMLA, see NACHC Human Resources Series Information Bulletin #7, *Accommodating Employee Leave for Parenting*

17 29 CFR § 825.113

18 42 U.S.C. 12101 et seq

19 For a detailed discussion of the ADA, see NACHC's Risk Management Series Information Bulletin #5 *The Americans with Disabilities Act.*

interactive, good faith discussion with the employee about:

- The cost of the requested accommodation
- The impact on patient care and safety
- Whether there are less expensive alternatives

For example, providing a worker with diabetes several breaks throughout the day as needed to check blood sugar or to have a snack, instead of the regularly scheduled breaks provided to other employees, may be reasonable accommodation to the diabetic employees.

Useful Tips on Establishing Appropriate Leave Policies

A written absence from work or leave policy should be part of the health center's employee handbook/written personnel policies and should, at a minimum, address the following issues consistent with applicable law:

- **Pay status during the leave**
- **Amount of leave available (paid and unpaid).**
- **Availability of health and other benefits during leave, and any conditions on continuing benefits (e.g., employee contributions)**
- **Accrual of leave (paid and unpaid) while on leave**
- **Employee notice requirements for taking leave**
- **Employer approval requirements (including person authorized to approve leave)**

It is very important that a health center maintain, for all types of leave, complete and accurate records of employee leave. Documentation should include start date, type of leave, date of return, notation of formal approval, and the presence or absence of medical certification.

AVOIDING DISCRIMINATION AGAINST EMPLOYEES FUNCTIONING AS CAREGIVERS

Health centers, like other employers, must be careful that that their employment policies and practices do not discriminate against caregivers. Litigation involving workers who claim they were treated differently on account of their having care giving responsibilities for a family member (e.g., being passed over for promotion, being the object of disparaging remarks, terminated) has increased dramatically, as have the recoveries awarded to employees subjected to discriminatory treatment.[20]

Although federal equal employment opportunity laws do not prohibit discrimination against caregivers as a protected class, the U. S. Equal Employment Opportunity Commission (EEOC) believes that there are circumstances under which discrimination against caregivers might constitute unlawful disparate treatment under Title VII of the Civil Rights Act of 1964 (with regard to discrimination based on sex) or the ADA (with regard to discrimination based on a worker's association with a person with a disability).

20 According to the Center for Work Life Law at Hastings College of the Law, the cases involving discrimination against workers for caregiving responsibilities have gone up 269% in the last decade. See **https://worklifelaw.org/publications/Caregivers-in-the-Workplace-FRD-update-2016.pdf** (Accessed 5/16/21).

According to the EEOC, common circumstances under which discrimination against a worker with caregiving responsibilities might constitute unlawful disparate treatment under federal law include:[21]

- Treating male caregivers more favorably than female caregivers
- Subjecting a worker to severe or pervasive harassment because their spouse has a disability
- Lowering subjective evaluations of work performance of a female employee because she became the primary caretaker of grandchildren, even though there has been no actual decline in performance (based solely on an assumption)

In particular, the EEOC warns against sex-based stereotyping about caregiving responsibilities. For example, women with care giving responsibilities may be perceived as being more committed to caregiving than to their jobs. Men may be subject to the opposite stereotype – namely, that they are poorly suited to caregiving, causing them to be denied leave or other considerations routinely afforded to their female counterparts.

Accordingly, supervisors should not make assumptions about where an employee's desires or loyalties lie merely because the employee also has family responsibilities. Likewise, caregivers should not be given poor performance evaluations, passed over for promotion, or denied participation in a high visibility project because of caregiving responsibilities. However, it also is important to keep in mind that caregiving responsibilities do not excuse unsatisfactory work. According to the EEOC, employment decisions that are based on an employee's actual work performance, rather than on assumptions and stereotypes, do not generally violate Title VII, even if the unsatisfactory work performance is attributable to caregiving.

In that regard, EEOC has identified certain employer "best practices" when dealing with employee-caregivers. These include, among others:

- Review workplace policies that limit employee flexibility in scheduling work, including posting work schedules as early as possible
- Provide reasonable personal or sick leave to allow employees to engage in caregiving
- Ensure that managers at all levels are aware of, and comply with, the organization's work-life policies
- Reassign job duties that employees are unable to perform on account of caregiving responsibilities

21 EEOC, Enforcement Guidance: Unlawful Disparate Treatment of Workers with Caregiving Responsibilities, May, 2007 at https://www.eeoc.gov/laws/guidance/enforcement-guidance-unlawful-disparate-treatment-workers-caregiving-responsibilities (Accessed 5/16/21).

Useful Tips on Avoiding Discrimination Claims Based on an Employee's Role as Caregiver

To minimize discrimination claims based on an employee functioning as a caregiver, the health centers should:

- **Add "family responsibility or caregiving" to the forms of discrimination prohibited in the health center's employee handbook or personnel policies and include the statement in notices and other places where nondiscrimination policies are posted**
- **Make sure that there is no bias in policy or in practice with respect to personnel granted leave to be caregivers, disciplined for attendance problems, or promoted**
- **Train supervisors not to make assumptions about workers with caregiving responsibilities**
- **Monitor the work assignments of employees who are working on alternative schedules because of caregiver responsibilities to be sure that they are receiving the assignments merited by their position as full time employees**
- **Audit employee files to make sure that capable, high performing workers are being given training and other opportunities for advancement, bonuses, and good performance reviews, regardless of care-giving responsibilities**
- **Provide information to employees about emergency and/or temporary resources for caregivers. For example, if your community has an elder care program or respite care, you could make brochures available or list caregivers in the employee handbook.**

CONCLUSION

By 2030, one in five Americans will be over the age of 65.[22] This phenomenon will significantly affect not only the services that health centers provide, but the makeup of the work force that provides those services. Health care spending is expected to rise from approximately $4 trillion a year to $6 trillion, or 19.4 percent of GDP, by 2027. By 2025, there is expected to be a health care shortage of about 500,000 home health aides, 100,000 nursing assistants, and 29,000 nurse practitioners. By 2032, there could be a national shortage of approximately 122,000 doctors.[23]

To be able to continue providing needed services to their communities, health centers must be able to retain valued older employees. That will be possible only if health centers begin now to address the challenges of the rapidly graying workforce, whether by developing approaches to manage the impact of impending labor shortages, establishing policies to minimize age-related discrimination (including discrimination based on an employee's responsibilities as a caregiver), establishing policies to accommodate employee leave requests, or, more than likely, a combination of all of these strategies.

22 United States Census Bureau, "Projections of the Size and Composition of the U.S. Population: 2014 to 2060" at **https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf (Accessed 5/16/21).**

23 The Week, "The Graying of America" (August 18, 2019) at **https://theweek.com/articles/859185/graying-america** (Accessed 5/16/21).

SUMMARY OF ACTION STEPS

1. **Implement a succession plan while embracing the older worker who wishes to continue to work, as long as they are performing the essential functions of the position.**
    a. In consultation with local employee benefits counsel, consider a phased-in retirement program.
    b. Classify employees and independent contractors correctly, applying IRS and state-specific criteria and act accordingly.
2. **Establish employment practice and policies that minimize age-related discrimination, including discrimination against employees who function as caregivers.**
    a. Review job announcements for discriminatory language.
    b. Review job descriptions to make sure they accurately describe the job's essential functions.
    c. Incorporate ageism training into diversity training – do not simply make assumptions about what workers can or cannot do, nor what they would prefer to do.
    d. Incorporate "family responsibility or caregiving" into anti-discrimination statements and policies.
    e. Audit files and employee complaints to make sure employees are given equal opportunity to receive interesting assignments and equal benefits.
    f. Recognize and reward all workers for their achievements and performance, not just tenure.
    g. Provide training opportunities for older employees.
    h. Do not be afraid to discipline a worker who is not performing or who is using leave excessively, regardless of age.
3. **Establish policies to accommodate employee leave requests.**
    a. Review employee leave policies to ensure consistency with applicable law, especially FMLA and similar state laws as well as ADA.
    b. Keep accurate records of employee leave.
    c. Don't be afraid to discuss a reasonable accommodation for an employee with a disability by engaging in an interactive discussion with them.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

HR Information Bulletin #9

THE DUTY TO DISCLOSE ADVERSE INFORMATION ABOUT HEALTH CENTER PRACTITIONERS

As part of the credentialing process, health centers are accustomed to querying the **National Practitioner Data Bank** ("NPDB") for information about a practitioner's licensure, professional society membership, medical malpractice payment history, and record of clinical privileges.[1]

This information allows health centers to assess the qualifications of applicants for clinical staff positions, as well as to fulfill deeming requirements for coverage under the Federal Tort Claims Act ("FTCA").[2]

Thereafter, if serious issues about the qualifications or impairment of existing practitioners arise, health centers may be required to report information back to the NPDB. For example, health centers must notify the NPDB when they restrict or withdraw a physician's privileges as part of a formal peer review process. Health centers must report clinical privileging actions taken against physicians and dentists, and medical malpractice payments made on behalf of all practitioners. Once an action is reported, it becomes available to licensing boards, hospitals and other eligible entities engaged in employment, affiliation, and licensure decision when they query the NPDB on that same practitioner.

Indeed, when a health center has determined that a physician's continued practice of medicine might endanger patients who are not patients of the health center, it may seek to notify the peer review committees of local hospitals in which the physician has privileges, or to disclose information to other health centers or potential employers who make credentialing inquiries. By reporting to the NPDB, that information becomes automatically accessible to eligible entities making those hiring and credentialing decisions.

To assist health centers with understanding their reporting obligations when they take adverse actions against health care practitioners as well as the pertinent legal considerations in making voluntary disclosures of such information, this Information Bulletin:

- Describes reporting duties to the National Practitioner Data Bank;
- Discusses legal considerations for making voluntary disclosures; and
- Describes reporting duties under the Patient Safety and Quality Improvement Act of 2005.

It should be noted that this Bulletin focuses on federal requirements. State law may impose more stringent requirements on health centers for reporting adverse privileging or medical events. Health centers are advised to contact local counsel in regard to state reporting requirements.

1 See **Health Resources and Services Administration, Bureau of Primary Health Care, *Health Center Program Compliance Manual*, "Chapter 5: Clinical Staffing" (August 20, 2018).**

2 42 U.S.C. § 233(h)(2).

THE NATIONAL PRACTITIONER DATA BANK: AN OVERVIEW

Established by the Health Care Quality Improvement Act of 1986,[3] the NPDB is intended to be a means of increasing the quality of care by restricting the ability of incompetent physicians and other practitioners to move from state to state without disclosure or discovery of previous medical malpractice payments, adverse actions involving licensure, clinical privileges, professional society memberships, health-related civil and criminal convictions, and exclusions from Medicare and Medicaid.

The Health Resources and Services Administration ("HRSA"), within the U.S. Department of Health and Human Services ("HHS") is the government agency responsible for the administration of the NPDB. The NPDB collects information on medical malpractice payments resulting from settlements and final judgments, as well as adverse licensure, clinical privileging, and professional society membership actions. The NPDB also contains information regarding practitioners who have been declared ineligible to participate in Medicare, Medicaid, and other health care programs. State licensing boards, hospitals, defined health care entities, professional societies, and certain federal and state agencies are some of the eligible entities with reporting responsibilities and access to information in the NPDB, though the extent of each entity's participation varies.

The federal requirements for disclosure and reporting information to the NPDB are set forth in Part 60 of Title 45 of the Code of Federal Regulations.[4] These regulations permit a health center to query the NPDB when entering an employment or affiliation relationship with physicians and mid-level providers (including, certified nurse midwives, physician assistants and nurse practitioners), as well as social workers, clinical psychologists, and a host of other types of practitioners who may comprise the health center's clinical staff, provided that the health center has a formal peer review process.[5] Given that checking adverse licensure action and professional liability claims history is a key element of the credentialing and privileging process, accessing practitioner information in the NPDB is an excellent resource for eligible health centers.

REPORTING DUTIES TO THE NATIONAL PRACTITIONER DATA BANK

Eligible health centers are required to report certain information about their practitioners to the NPDB in two circumstances: (1) the making of medical malpractice payments; and (2) the taking of adverse privilege actions. These reports help to ensure the information available in the NPDB for other potential health care employers is complete. The report must contain a narrative description of the reasons for the adverse privilege action. The narrative description should clearly describe the reportable action, use sufficient detail, and include a summary of the relevant findings and the basis for the reportable action. HRSA has published general guidance to assist providers with satisfying this requirement.

It is important to recognize that an eligible health center that fails to make a required report to the NPDB can lose the significant protection that normally immunizes peer review activity from liability

3 Pub. L. No. 99-660, Title IV § 402, 42 U.S.C. §§ 11101-11152.

4 45 C.F.R. Part 60.

5 A formal peer review process means the conduct of professional review activities (such as privileging) through formally adopted written procedures that provide a practitioner with adequate notice and an opportunity for hearings. The *FTCA Health Center Program Site Visit Protocol* assesses a health centers efforts to assess clinical competence through written peer review procedures or other mechanisms to assess clinical competence as well as results of such assessments during FTCA site visits. All health centers are expected to have formal privileging processes that meet the standards of national accrediting agencies such as the **Joint Commission** and the **Accreditation Association for Ambulatory Health Care, Inc.** (AAAHC). While not required by Chapter 5 of the Compliance Manual, certain accreditations many require the health center to have an appeal process for licensed independent practitioners (physicians, dentists, nurse practitioners, and nurse midwives) if a decision is made to discontinue or deny clinical privileges. An appeal process is also optional for other licensed or certified health care practitioners.

under state lawsuits.[6] This protection applies to liability under any federal or state law (e.g. antitrust or defamation actions) except for liability under state and federal civil rights laws. If HRSA determines that an eligible health center has substantially failed to report information to NPDB, then the health center will lose all of its liability protections for a period of three years from that date forward.[7]

MEDICAL MALPRACTICE PAYMENTS

An eligible health center must file a report with the NPDB when the health center (as opposed to insurance company or the federal government on behalf of a health center)[8] makes a medical malpractice payment (either a lump sum or the first of multiple payments but not a deductible) for the benefit of a physician, dentist, or other licensed or authorized health care practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or a judgment against the individual practitioner.[9]

For the purposes of determining whether a payment is reportable, it must be made on behalf of a practitioner who is both named in the complaint and the final judgment or settlement. However, an eligible health center does not need to report a medical malpractice payment if the payment results from a suit or claim made solely against the health center that does not identify an individual practitioner, or as a result of something other than a written complaint or claim demanding monetary payment for damages.

The health center must file a report to the NPDB within 30 days of the date a payment is made and simultaneously send a copy of the report to the appropriate licensing board.[10] Use of the NPDB's report-forwarding feature can automate this requirement, sending the report directly to the appropriate state licensing board as chosen by the reporting health center. These reports must contain certain information about the health care practitioner for whom payment was made, as well as information about the health center. The NPDB website provides a form for reporting medical malpractice payments, which health centers can use to gather the required information.[11]

A health center that fails to make a required report on a medical malpractice payment is subject to the imposition of civil money penalties by the Office of Inspector General ("OIG") of up to $23,331 (in 2020, and adjusted annually for inflation thereafter) for each payment involved.[12]

ADVERSE PRIVILEGE ACTIONS

An eligible health center must report to the NPDB when one of its physician's or dentist's privileges are reduced, restricted, suspended, revoked, or denied for a period of more than 30 days, as well as when it accepts a physician's or dentist's surrender or restriction of clinical privileges either:

1. While under investigation for possible professional incompetence or improper professional conduct; or

6 42 U.S.C. § 11111(a)(1)(D), (b).

7 The loss of liability protections for peer review actions does not affect a health center's FTCA coverage.

8 An insurance company directly files a report to the NPDB even if the health center pays a deductible towards the medical malpractice payment. Note, however, if a payment is made on an FTCA claim, then the claim is then reviewed by the Medical Claims Review Panel (MCRP) to determine whether the practitioner met the standard of care for purposes of reporting to the NPDB. See Health Resources and Services Administration, *Federal Tort Claims Act Health Center Policy Manual* (July 21, 2014). If the MCRP determines that the malpractice was a result of a "systems failure," as opposed to an individual practitioner's error(s), the MCRP will not report the payment to the NPDB. *Id.* at p.23.

9 A written complaint or claim can include, but is not limited to, the filing of a cause of action based on state tort law in any state or court or other adjudicative body, such as a claims arbitration board.

10 Health centers should also check state law to determine whether they must report directly to the state medical licensing board (e.g., independent of the copy of the NPDB report) since the state may require different information to be reported.

11 See also **U.S. Department of Health and Human Services, Health Resources and Services Administration. *NPDB Guidebook,* "Chapter E". Rockville, Maryland: U.S. Department of Health and Human Services, 2018.**

12 42 C.F.R. § 1003.800(a)(1).

2. In return for not conducting an investigation or professional review action.

Health centers may voluntarily report adverse actions that adversely affect the privileges of licensed health care practitioners other than physicians and dentists, such as mid-level providers, social workers, clinical psychologists, etc.

When required to report actions involving physicians or dentists to the NPDB, health centers must file the report within 30 days from the date the adverse action was taken or privileges were voluntarily surrendered. Each report submitted to the NPDB must be printed and mailed to the appropriate state licensing board for its use, along with the "Report Verification Document" the health center receives back from the NPDB documenting successful processing of the report. As with medical malpractice payments, the NPDB system is set up to electronically submit the report to licensing boards indicated by the reporting entity at the time the report is filed.

SUMMARY OF REPORTING DUTIES

NATIONAL PRACTITIONER DATA BANK	MANDATORY REPORTING TO THE NPDB	VOLUNTARY REPORTING TO THE NPDB	DATE REPORTABLE	REPORTING TO STATE LICENSING BOARDS
Medical Malpractice Payments (lump sum or the first of multiple payments)	Payments for the benefit of physicians, dentists, or other licensed or authorized practitioners	No	Within 30 days from date payment is made	Yes
Adverse Privilege Actions (reductions, restrictions, suspensions, revocations, or denials)	Actions affecting physicians or dentists	Actions affecting other licensed or authorized health care practitioners.	Within 30 days from date of adverse action	If reporting to NPDB is mandatory, then required within 30 days from date of adverse action.

LEGAL CONSIDERATIONS FOR MAKING VOLUNTARY DISCLOSURES

Traditionally, most employers have been counseled not to disclose unfavorable information about former employees due to potential risks of defamation actions or other types of liability. While this fear is understandable, several legal considerations should guide health centers to reconsider that policy, at least in regard to health practitioners, as a means of preventing unqualified or impaired practitioners from being re-employed by other health centers or providers.

DEFAMATION LAWSUITS

Although defending any defamation lawsuit will be time-consuming and expensive, health centers should recognize that the truth is always an absolute defense. This means that a disclosure (so long as it is truthful) is not illegal, even if it reflects unfavorably on the former employee (e.g., "Dr. Jones repeatedly missed work and failed to call in to alert their superior of their absence."). Accordingly, health centers should limit disclosures about former employees to factual statements to help minimize the risk of defamation liability.

HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

The Health Care Quality Improvement Act of 1986 (the same legislation which established the NPDB) provides broad immunity from state and federal liability to any person who provides information to a professional review body (such as a hospital's peer review committee) regarding the competence or professional conduct of a physician, unless the information is false, and the person providing such information knew it was false.[13] Additionally, many state peer review laws provide similar immunity to providers who share information with other entities in the credentialing process.

NEGLIGENT MISREPRESENTATION

A health center may face liability based on theories of intentional and negligent misrepresentation if it makes affirmative misrepresentations when providing a reference for an employee to another potential employer. In a 2008 case, the U.S. Court of Appeals for the 5th Circuit found that a physician's former partners were liable for writing misleading referral letters that described the physician, who, due to his negligence and addiction to narcotics, left a patient undergoing a routine tubal ligation in a permanent vegetative state, as "excellent". The Court reasoned that a party does not have an affirmative duty to disclose negative information; however, a party does have a duty to not make affirmative misrepresentations and may be held liable for doing so.[14] Interestingly, the 5th Circuit disagreed with the lower court's holding that the physician's place of employment had an affirmative duty to disclose the physician's negligence and drug-addiction.[15] Although this case is not binding on other courts, it may reflect how other courts would approach the issue.

RECOMMENDATIONS

In sum, a health center and its practitioners should carefully consider how they disclose adverse information about a practitioner in response to requests from hospital and health center credentialing committees, or in other circumstances when a practitioner's continued practice of medicine might endanger patients who are not patients of the health center.

Prior to making voluntary disclosures of adverse information, health centers should:

- Require practitioners, when seeking a reference for employment for another health care provider, to sign a release from any liability for providing true information about the practitioner's employment;
- Ensure that any disclosures are truthful and do not include statements of opinion, suspicion, conjecture, or outright misrepresentation; and
- Confirm that the requesting party is a professional review body making the request in connection with professional review activities.

REPORTING DUTIES UNDER PATIENT SAFETY AND QUALITY IMPROVEMENT ACT OF 2005

Enacted on July 29, 2005, the Patient Safety and Quality Improvement Act of 2005[16] ("Patient Safety Act") encourages health care providers to voluntarily report patient safety information, medical errors, and "near misses" to certified Patient Safety Organizations ("PSOs").[17] In order to facilitate such disclosure, the Patient Safety Act establishes certain legal privilege and confidentiality protections for any data developed

13 Pub. L. No. 99-660, Title IV, § 402, 42 U.S.C. § 11111. The Act also provides liability protections to health care entities that file reports with the NPDB and State licensing boards. 42 U.S.C. § 11137(c).

14 *See generally* Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs., No. Civ.A 04-0997, 2005 WL 1309153 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded,* 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

15 In the event that an employer discloses information that creates a "misapprehension" about qualifications, or if the disclosures *are* misleading, the 5th Circuit held that the employer has a duty to clarify the information provided.

16 Pub. L. No. 109-41, § 2(a)(5), 42 U.S.C. §§ 299b-21 to -26.

17 The implementing regulations may be found at 42 C.F.R. Part 3; see also 73 Fed. Reg. 70732 (Nov. 21, 2008).

by PSOs or prepared by health care providers and delivered to PSOs.

A PSO is a private entity certified by the HHS' Agency for Healthcare Research and Quality as having met certain criteria, allowing providers to participate in patient safety activities and share sensitive information relating to patient safety events without fear of legal discovery. PSOs are charged with analyzing patient safety data collected from providers, including health centers, and developing and disseminating recommendations, protocols, and best practices to providers on how to improve patient safety.

PSOs are intended to encourage a culture of safety among providers and provide feedback and assistance to effectively minimize patient risk. As such, while conducting its activities, PSOs must maintain procedures to preserve confidentiality with respect to patient safety data.

A PSO must disclose any potential conflict of interest, including any legal, financial, or contractual relationship it has with a provider. Because PSOs must have contracts with providers to receive and review patient safety data, health centers should ensure such contracts have been executed prior to reporting any data to them.

KEY TERMS UNDER THE PATIENT SAFETY ACT

Patient Safety Work Product ("PSWP")

PSWP is defined as any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) that:

(1) Could improve patient safety, health care quality, or h-.5ealth care outcomes; and either

a. are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; OR

b. are developed by a PSO for the conduct of patient safety activities;

OR

(2) Identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.[18]

However, PSWP does not include a patient's medical record, billing, and discharge information, or any other original patient or provider information. Importantly, the definition of PSWP explicitly excludes information that is collected, maintained, or developed separately from a patient safety evaluation system, even if it is reported to a PSO.

Patient Safety Evaluation Systems ("PSES")

A provider's PSES is the system by which an organization collects, manages, or analyzes information for reporting to a PSO. It is unique and specific to a provider. HHS does not require that organizations document their PSES, but notes that doing so would clearly establish when information would be considered PSWP. HHS "encourage[s]" providers to document their PSES as best practice.[19]

All activities engaged in by a PSO related to operating, and providing feedback to participants in a PSES constitute protected patient safety activities under the Patient Safety Act, including information about events, errors, near-misses, quality improvement data, and other patient safety data. Providers may voluntarily remove, and document the removal of, information from their PSES that has not yet been reported to a PSO, but by doing so, the information is no longer PSWP.

PRIVILEGE AND CONFIDENTIALITY PROTECTIONS

PSWP created by PSOs or shared with PSOs by providers is subject to confidentiality and privilege protections. A person who knowingly or recklessly

18 42 C.F.R. § 3.20 (emphasis added).

19 73 Fed. Reg. at 70738.

discloses identifiable PSWP in violation of the Patient Safety Act is subject to civil monetary penalties of up to $12,919 (in 2020, and adjusted annually for inflation thereafter) for each act constituting a violation.

Legal Privilege

Typically, PSWP is privileged and may not be:

(1) Subject to a federal, state, local, or tribal civil, criminal, or administrative subpoena or order, including in a federal, state, local, or tribal civil or administrative disciplinary proceeding against a provider;

(2) Subject to discovery in connection with a federal, state, local, or tribal civil, criminal, or administrative proceeding, including in a federal, state, local, or tribal civil or administrative disciplinary proceeding against a provider;

(3) Subject to disclosure pursuant to Freedom of Information Act (FOIA) or any other similar federal, state, local, or tribal law;

(4) Admitted as evidence in any federal, state, local, or tribal governmental civil proceeding, criminal proceeding, administrative rulemaking proceeding, or administrative adjudicatory proceeding, including any such proceeding against a provider; or

(5) Admitted in a professional disciplinary proceeding of a professional disciplinary body established or specifically authorized under state law;

Confidentiality

All PSWP is deemed confidential and may not be disclosed except as permitted below:

- Disclosure to carry out patient safety activities;
- Disclosure to conduct research, evaluations, or demonstration projects authorized by HHS (to the extent allowed by HIPAA);
- Disclosure by a provider to the FDA for an FDA-regulated product or activity;
- Disclosure by a provider to an accrediting body that accredits that the provider;
- Disclosure for business operations deemed necessary by HHS and which are consistent with the law;
- Disclosure to a law enforcement authority relating the commission of a crime (to the extent necessary);
- Disclosure to persons other than PSOs and the PSWP does not include materials that assess the quality of care of an identifiable provider or describe or pertain to one or more actions or failures to act by an identifiable provider.

Exceptions

The legal privilege and confidentiality protections do not apply to disclosure of relevant PSWP for in the following situations:

- Disclosure in criminal proceedings once a court has made a determination that the PSWP contains evidence of a criminal act, the PSWP is material to the proceeding, and the PSWP is not reasonably available from any other source;
- Disclosure to permit equitable relief for an individual to seek redress from retaliatory action taken against the individual for reporting information to a PSO;
- Disclosure authorized by each provider identified in the PSWP; and
- Disclosure of non-identifiable PSWP (as defined below).

NON-IDENTIFIABLE PSWP IS WORK PRODUCT THAT:

- Does not identify any provider that is a subject of the work product or providers that participate in activities that are a subject of the work product;
- Would not constitute individually identifiable health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] privacy standards); and
- Would not allow identification of an individual who reported information to a provider or PSO.

NON-RETALIATION

As referenced above, health centers are prohibited from taking action against employees who report in good faith relevant patient safety information to PSOs or to a provider with the intent of having that information reported to a PSO. Under the Patient Safety Act, reporters are protected from:

- Adverse employment actions, including an individual's loss of employment, denial of promotion, or denial of any employment benefit for which the individual would otherwise be eligible.
- Adverse evaluations or decisions made in relation to accreditation, certification, credentialing, or licensing of the individual.

Employees may seek equitable relief (e.g., reinstatement, back pay, and restoration of benefits) against employers that retaliate against them for reporting patient-safety information.

State Laws

Some states have mandatory reporting laws that may require a health center to report medical errors or patient safety information. Because reporting under the Patient Safety Act is voluntary, and not mandatory, the Act does not preempt or alter existing state reporting requirements. Consequently, a health center will continue to be subject to state reporting laws even if it chooses to voluntarily report data to a PSO.

C

CONCLUSION

Because state and reporting requirements regarding adverse actions are extremely varied, health centers should develop policies and procedures to establish a reporting system to ensure that mandated reports are timely made to the NPDB and state licensing boards. Ideally, the reporting system would identify:

- Which health care practitioners and events are subject to reporting;
- What events must be reported;
- What level of detail to report;
- What staff position is responsible for filing the report;
- To whom the report must be filed; and
- In what format the filing should be done.

To help avoid serious risks to patient safety, health centers should also consider making voluntary disclosures to professional review bodies about health care practitioners and adverse medical events. Prior to doing so, a health center should establish policies that govern what information will be disclosed, to whom it will be disclosed, and how it will be disclosed.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

HR Information Bulletin #10

DEVELOPING A HEALTH CENTER EMPLOYEE HANDBOOK

The number and complexity of laws, regulations and policies that apply to health care providers in general, and health centers and their employees in particular, can seem overwhelming. Developing a good resource to provide a health center's employees with appropriate guidance can significantly improve employee knowledge of management's expectations and obligations regarding the health center staff, and clarify each employee's responsibilities to the health center, other staff, and patients, as well as their rights as employees of the organization.

One way to provide each health center employee with access to specific policy guidance is by creating an employee handbook that contains the health center's current policies and procedures and reflects the health center's unique structure and scope of project. The content of an employee handbook will vary according to each health center's particular circumstances. There is no "one-size-fits-all" handbook – each must be tailored to the needs of an individual health center.

This Information Bulletin discusses the development and implementation of an employee handbook appropriate for your health center. Specifically, this Information Bulletin addresses:

- The reasons to develop an employee handbook, and its limitations.
- The roles of the board of directors and management in developing and implementing the employee handbook.
- Steps in developing or updating the employee handbook.
- Tips on implementing the employee handbook.
- Process to review and revise the employee handbook.

WHY EVERY HEALTH CENTER SHOULD DEVELOP AN EMPLOYEE HANDBOOK

INFORMATION MANAGEMENT

- The challenges posed by the demands of complying with applicable laws, rules, policies, and other guidance materials, and the need to keep employees informed of management expectations and governing board-approved policies and procedures, are common to all health centers. Yet each health center organization is unique, and employee guidance must be customized to adequately address the specific issues that affect a health center.
- The health center's operational policies and procedures should guide the efficient and productive operation of the health center, protect the rights of the patients and employees, help ensure that all employees understand the terms and conditions of their employment, and promote consistent and equitable treatment of patients and employees. Developing a means to provide health center employees with access to, and knowledge of, the many laws and rules that govern the terms of their employment and the performance of their duties requires planning and ongoing attention by the health center's governing board and management team. One resource that can provide such guidance is an employee handbook. Of course, the handbook's effectiveness will depend on its content and accessibility, as discussed further below.

EMPLOYEE HANDBOOK LIMITATIONS

A health center employee handbook cannot anticipate or address every situation or answer every question regarding health center operations. It should be drafted with the understanding that it is a starting place for employees seeking guidance, and should refer to specific health center rules and policies (and where they may be located). Of course no handbook will address every conceivable issue. Accordingly, the handbook should also:

- Advise employees to raise specific questions about the health center's personnel and other policies and procedures with their supervisors or with the Human Resources Director; and
- Request feedback from employees to help keep policies and guidance current.

BOARD AND MANAGEMENT ROLES

BOARD OF DIRECTORS' ROLE

A health center's Board of Directors is required to establish and as necessary update general policies that govern the conduct of the health center project (including but not limited to, personnel policies and procedures), in accordance with 42 C.F.R. 51c.304, the Health Center Program Compliance Manual and other policies issued by the Health Resources and Services Administration ("HRSA").[1] In particular, the board is responsible for establishing, reviewing and, as necessary, revising:

- Personnel policies, including those addressing selection and dismissal procedures; salary and benefit scales; employee grievance procedures; and equal opportunity practices;
- Financial management policies and practices and a system to assure accountability for health center resources, including periodic review of the financial status of the health center and the results of the annual audit to ensure appropriate follow-up actions are taken; approval of the annual budget, overall plan for the health center project and the health center's priorities; adopting a policy for eligibility for services, including criteria for partial payment schedules (the Sliding Fee Discount Program); and long-range financial planning;
- Health care policies, including scope and availability of services; location and hours of services; and quality-of-care audit procedures;
- Policies for evaluating health center activities, including service utilization patterns; productivity (efficiency and effectiveness) of the health center; patient satisfaction; and achievement of objectives; and
- Process for hearing and resolving patient grievances.

MANAGEMENT'S ROLE

The Executive Director/Chief Executive Officer is responsible for the implementation of these policies. Health center policies and procedures should be reviewed on a periodic basis by both the Board of Directors and the Executive Director/Chief Executive Officer, and updated as necessary, with input from key staff members. It is advisable to schedule such policy and guidance reviews as part of the Board of Directors' annual work plan to ensure that they are conducted on a timely basis, in accordance with the timelines set forth in the Compliance Manual as well as any changes in relevant laws, regulations, and policies that impact health center operations.

STEPS TO DEVELOP OR UPDATE AN EMPLOYEE HANDBOOK

Once a health center's Board of Directors and management team decide to create an employee handbook, or to update a handbook that already exists, the board should appoint a committee or working group of key staff members to gather

1 See Health Center Program Compliance Manual, Chapter 19: **https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html.** Note that there are exceptions for certain health centers operated by a "public entity or agency." Those exceptions are detailed in the Compliance Manual.

the relevant references and develop (or revise) the handbook's content. A board liaison may be appointed to facilitate communications between the Board of Directors and staff on any policy questions that arise. One staff member should be designated as a single point of contact to lead the committee/working group. The following steps can help guide the employee handbook development/revision process:

1. DETERMINE THE HEALTH CENTER'S NEEDS

The specific content of the health center's employee handbook should be tailored to meet the needs and resources of the organization. However, no matter the size of the employee handbook, or the amount of information it contains, it is essential that the contents are accurate, up-to-date, and easily accessible by each member of the health center workforce. Keep in mind that the health center's particular needs and resources typically change over time and the employee handbook should change along with them.

2. IDENTIFY APPLICABLE LAWS, REGULATIONS, AND POLICIES

As the next step, it is important to identify the specific laws, regulations, and policies applicable to the health center's operation.

A comprehensive discussion of all laws, regulations and policies that govern health center operations is beyond the scope of this Bulletin. NACHC strongly recommends health centers have their policies and employee handbooks reviewed by qualified legal counsel to ensure that all relevant issues are adequately addressed. Some of the more significant requirements to consider are contained in the following laws, rules, and policies:

- The Fair Labor Standards Act
- The Family and Medical Leave Act
- Non-discrimination laws, rules and requirements, including:
  - Presidential Executive Order 11246 (prohibiting discrimination in employment based on race, color, religion, sex, sexual orientation, gender identity, and national origin)
  - Title VII of the 1964 Civil Rights Act (prohibiting discrimination in employment based on race, color, sex, religion, and national origin)
  - Title VI of the 1964 Civil Rights Act (prohibiting discrimination in access to any program or activity receiving federal financial assistance based on race, color, or national origin including language proficiency)
  - The Equal Pay Act of 1963
  - The Age Discrimination in Employment Act
  - The Rehabilitation Act of 1973 (prohibiting discrimination by government contractors based on disability)
  - The Americans with Disabilities Act (ADA) (prohibiting discrimination by employers based on disability, and requires reasonable accommodations)
  - The Genetic Information Nondiscrimination Act of 2008 (prohibiting the use of genetic information in making employment decisions, including hiring, firing, promotion, compensation, and other terms and privileges of employment)
- The Employee Retirement Income Security Act
- The Uniform Services Employment and Reemployment Rights Act
- The Drug Free Workplace Act
- The Occupational Safety and Health Act
- State civil rights and employment laws and regulations
- The Health Insurance Portability and Accountability Act and state medical privacy laws and regulations

- The Federal Tort Claims Act ("FTCA") and its implementing regulations and policies as applied to health centers. [2]
- Internal Revenue Service guidance for tax exempt organizations
- Section 330 of the Public Health Service Act and implementing regulations[3]
- 45 C.F.R. Part 75 - Department of Health and Human Services ("DHHS") Administrative regulations for Federal grantees
- HRSA guidance, including the Health Center Program Compliance Manual[4] and other policies and program requirements[5]
- DHHS Office of Inspector General ("OIG") Compliance Program Guidance for Individual and Small Group Physician Practices[6]

3. IDENTIFY SPECIFIC CONTENT AREAS

Once the applicable requirements have been identified (or verified), the next step is to develop a list of subjects that will be covered (or added/revised) in the employee handbook. Suggested topics to address include:

General Policies

- Expected standards of conduct, ethics, and conflicts of interest policy
- Safe work environment issues
- Drug-free workplace
- Equal employment policy
- Policy against harassment
- Personal appearance and dress standards
- Hiring practices and immigration law compliance
- Confidential information policy
- Patient and public relations
- Solicitations and distributions (by employees and/or the public)
- Supplies and equipment
- Computer and information security
- Firearms and other weapons policy
- Smoking policy
- Keys/alarm system
- Submitting suggestions to management
- Patient complaint procedure
- Employee dispute resolution
- Emergency procedures

Employee Compensation and Benefits

- Employee classification
- Hours of operation
- Compensation
- Recruitment and hiring
- Promotion
- Payroll deductions
- Expenses
- Medical/dental benefits (including COBRA)
- Changes in benefits
- Termination

2 See 42 CFR part 6 and Federal Tort Claims Act Health Center Policy Manual and other related policies: **https://bphc.hrsa.gov/ftca/health-center-policies**

3 See 42 USC 254b; 42 CFR 51c.304 and 56.304

4 See **https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html**

5 See **https://bphc.hrsa.gov/programrequirements**

6 65 Fed. Reg. 59434 (October 5, 2000); **https://oig.hhs.gov/authorities/docs/physician.pdf**

- Retirement
- Paid time off
- Holidays
- Leaves of absence
- Work procedures
- Jury duty
- Military leave
- Sick leave
- Family/Medical leave
- Bereavement leave
- Workers' compensation
- Payroll records
- Disciplinary action
- Substance/alcohol abuse in the workplace

4. CHOOSE THE HANDBOOK FORMAT

Similar to the content, the format of the health center's employee handbook should be tailored to meet the needs and resources of the organization. When selecting the format that best meets the health center's structure and budget, consider how the handbook will be initially produced and made available to each employee, and how it will later be updated to keep it current. Format options to consider include:

1. A comprehensive manual containing in-depth discussion of regulations, policies, and procedures in a format that can be easily modified, such as a loose leaf binder;
2. An abbreviated handbook that can be inexpensively copied for each employee, and that references complete policies kept elsewhere;
3. An online handbook with links to policies and references; or
4. A combination of these formats.

5. PUT IT ALL TOGETHER

Although the development of the employee handbook should include input from various components of the health center, one individual should be assigned to lead a committee or working group (appointed as discussed above) in gathering references, drafting the employee handbook sections, and tracking the review and updating process. It may be helpful to:

- Appoint an editor or knowledge manager – someone who is familiar with the regulations, policies, and references that are specifically applicable to the organization.
- Develop a list of subject areas and identify individual subject matter experts to be responsible for the content of each section.
- Gather the health center's regulations, policies, and references in one central location.
- Schedule periodic review of the employee handbook as part of the annual board work plan.

A word of caution – "sample" handbooks can be helpful, but . . . While reviewing another organization's handbook as a "sample" or "template" may generate good ideas, simply putting your health center's name on someone else's employee handbook can lead to problems. Each health center must customize its handbook to the unique requirements that apply to its organizational structure, expectations, and requirements.

TIPS ON IMPLEMENTING THE EMPLOYEE HANDBOOK

No matter how comprehensive in content, an employee handbook is of no benefit if it is not kept current and/or if it goes unused. Once the health center employee handbook is created and approved (or updated/revised), the next step is to make sure each employee has ready access to it, and understands its contents (and any subsequent changes) by providing appropriate training. As with any policy or procedure, an employee handbook is effective only if it is used as a tool to guide employees in understanding the

terms and conditions of their employment and the organization's expectations of them. The following points can help guide the development of an effective implementation plan.

- Consider making the handbook available online.
- Incorporate its contents into the orientation procedures for new employees and use it regularly for training (both in-person training and online training).
- Provide supervisors with training tailored to help ensure consistent understanding and application of the health center's policies and procedures.
- Encourage employees, when in doubt, to ask their supervisor for clarification or additional information.

A PROCESS TO REVIEW AND REVISE THE EMPLOYEE HANDBOOK

As noted above, all health center policies and procedures, including an employee handbook, must be kept current.

- Board members and the health center management team should stay informed of changes in relevant law, rules, and policies through NACHC, HRSA, DHHS OIG and other resources.
- Health center board members, the Executive Director/Chief Executive Officer, and other key staff members should review the employee handbook at least annually and make revisions as needed.
- All employees should participate in training (online or in-person) regarding any updates.
- The health center should seek qualified legal advice regarding the center's employment practices.

CONCLUSION

A health center employee handbook can be an effective resource to help ensure that all health center personnel are familiar with relevant policies and procedures governing health center operations, and the terms and conditions of their employment. In order to develop a comprehensive and appropriate employee handbook, health centers should:

1. Consider their particular organization's structure and unique needs, requirements, and resources.
2. Include key staff members familiar with the various policies to be addressed in the employee handbook to ensure accuracy and relevance of the material.
3. Recognize that the creation of an employee handbook is only one tool in the process of improving staff awareness and compliance with applicable Federal and state laws, rules, and policies, as well as the health center's own policies.
4. Regularly review and update the handbook to stay current with the ever-changing regulations and policies that govern health center operations.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

HR Information Bulletin #11

USING AFFILIATIONS WITH RESIDENCY TRAINING PROGRAMS TO INCREASE YOUR HEALTH CENTER'S CLINICAL CAPACITY

Over the past 20 years, it has become increasing common for health centers to collaborate with teaching hospitals and freestanding medical residency programs nationwide.1 While these arrangements preceded the enactment of the Teaching Health Centers Graduate Medical Education ("THCGME") Program as part of the Affordable Care Act, the THCGME Program has resulted in accelerating this trend and diversifying the types of collaborations with health centers playing a more active role in the planning and administration of educational activities.

The THCGME Program established a mechanism to cover the direct and indirect expenses incurred by qualified Teaching Health Centers for new or expanded primary care residency programs.[2] Its continued reauthorization and expansion has resulted in the creation of many new primary care residencies in which health centers play a core role in the development and management of such programs, in collaboration with local hospitals and other providers.[3]

Given the ongoing concern regarding shortages of primary care physicians, this heightened level of collaboration is not surprising. The majority of these collaborations continue to involve the establishment of community-based residency rotations at new or established health center delivery sites or freestanding residency programs located in medically underserved areas exploring the possibility of converting into a health center. However, there continues to be a substantial increase in the number of health centers becoming Teaching Health Centers and establishing new residency programs for which they (or a related consortium) serve as the institutional sponsor.

This Information Bulletin provides information and guidance to health centers who are considering entering into an arrangement with residency programs and/or becoming a Teaching Health Center. Specifically, the Bulletin:

- Provides information on key considerations as they relate to collaborations on teaching/training activities and clinical service delivery activities.
- Summarizes federal Medicare Graduate Medical Education reimbursement principles, including an update of the key regulatory amendments since 2007 that are likely to have a direct impact on health center residency rotations;
- Summarizes the Federal THCGME Program; and
- Addresses the "upsides" and "downsides" of residency collaborations on health center operations.

1 Medical residency training programs provide new physicians an opportunity to develop their "hands-on" clinical skills and attain general competencies in a particular area of expertise after graduation from medical school. Residency programs are broadly distributed on a national basis, including both urban and rural settings. Most residency programs require residents to undertake clinical rotations in both an inpatient hospital environment, and outpatient/ambulatory care settings.

2 Section 340H of the Public Health Service Act, as added by Section 5508 of the Patient Protection and Affordable Care Act of 2010 (P. L. 111–148);

3 For updated information about the scope of the THCGME program, as well as new funding opportunities, visit https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education

KEY CONSIDERATIONS RELATED TO HEALTH CENTER—RESIDENCY PROGRAM COLLABORATION

Historically, several factors have encouraged collaborative arrangements between health centers and residency programs.

FROM THE RESIDENCY PROGRAM PERSPECTIVE—

- Programs have found it advantageous to offer residents the opportunity to develop their clinical and professional skills in primary care specialties in a community-based setting that serves a diverse and underserved patient population.
- In the competitive battle to attract highly qualified medical student graduates, residency programs report success in marketing this unique rotation opportunity to prospective residents who are seeking a well-rounded educational experience.
- An academic collaboration with a health center can create the foundation for a relationship that can be expanded to include collaborations in other areas of interest, such as clinical research.

FROM THE HEALTH CENTER'S PERSPECTIVE—

- The infusion of additional practitioners (both teaching faculty/preceptors and residents) into the health center has been a means of alleviating a shortage in physician capacity and/or increasing the scope and breadth of services offered to health center patients.
- The ability to familiarize residents with a health center's mission, clinical staff, and operations through resident training collaborations can have a positive and sustained impact as a physician recruitment strategy.
- Adding residents and academic faculty to the clinical team can create a dynamic environment within a health center, fostering the collegial exchange of information and enhancing the ability of the health center staff to keep abreast of emerging treatment regimens and technological advances, and their application in a community based setting.
- Collaboration with a well-recognized teaching hospital or residency program can serve to enhance the status of the health center to its staff, the community, and/or other third parties, just as the teaching hospital's reputation and credibility in the community may be enhanced by its linkage with the health center.

FROM AN ECONOMIC PERSPECTIVE—

- Hospitals or freestanding residency programs have incurred losses on their ambulatory care sites as a consequence of serving significant numbers of people without any compensation (or inadequate compensation).
- Health centers have received increases in grant funds under Section 330 of the Public Health Service Act to support services at new primary care access points and to expand medical capacity and services including oral health, behavioral health, and chronic care management.
- Health centers can qualify as Teaching Health Centers and receive direct and indirect Graduate Medical Education ("GME") reimbursement to cover residency program costs for new or expanded residency programs in which the health center is directly involved, including sponsoring, and establishing the rotations and other key aspects of such program.
- Changes in federal reimbursement rules for supporting Medicare GME helped promote the economic viability of establishing and maintaining health center-based residency rotations by allowing teaching hospitals that receive GME to count the time spent by residents at health center sites in GME reimbursement calculations. These rules also create the opportunity for a health center itself to seek Medicare GME reimbursement; however, there are limitations that may not make this an appealing option.
- As a result, health centers and teaching hospitals (and to a lesser extent, freestanding programs) have increasingly negotiated more complex arrangements. Many of these involve a health

center assuming ownership of clinical sites (such as family medicine centers) previously operated by the hospital (or freestanding program) and hosting the continued operation of the residency programs at such sites.[4] In addition, with the support of the THCGME Program, many health centers have created new residency programs whose ambulatory care rotations occur primarily (if not exclusively) at the health center's clinics.

ALLOCATION OF AUTHORITY—TEACHING/TRAINING VERSUS CLINICAL SERVICE DELIVERY

When a health center is not the institutional sponsor of a program and is incorporating a residency rotation into one or more of its clinical sites, it is critical that the health center and the residency program appropriately define their respective authorities for teaching/training activities versus clinical service delivery for purposes of accreditation, licensure, provision of services, billing, etc. Such allocation should be done as the parties establish the parameters of the collaborative arrangement and incorporated into the formal written agreement between the two.

RESIDENCY PROGRAM AUTHORITIES

- Accreditation Standards—The residency program must maintain authority and control over training activities as is necessary to meet applicable accreditation standards established by the Accreditation Council for Graduate Medical Education (or other applicable body).[5]
- Teaching/Training Activities—The residency program would typically retain primary responsibility and control (even in instances where health center-employed clinicians act as preceptors) of activities such as:
  - Classroom teaching.
  - Faculty appointment.
  - Orientation programs.
  - Faculty/program meetings.
  - Curriculum development.
  - Resident recruitment, selection, and evaluation.
  - General teaching program administration and evaluation.

HEALTH CENTER AUTHORITIES

Scope of Services—The health center must maintain responsibility for, and control over, activities related to clinical service delivery at health center sites, including decisions regarding the scope, location, and scheduling of services.6 This would include services provided at both existing health center sites as well as any former residency program facilities leased by or transitioned to the health center to furnish clinical operations, which would be included in the health center's approved scope of project.

- Service Delivery Activities—At the individual clinician level, characteristics of clinical service delivery activities typically include:
  - Diagnosis/treatment-related activities (i.e., medical history, examination, and medical decision-making) by the health center's employed and/or contracted clinical staff.
  - Direct patient involvement/interaction.
  - Generation of a bill for the services provided.
  - Quality improvement activities related to primary care clinical service delivery. Residents and preceptors providing services on the health

4 As part of these arrangements, it is common for a health center to secure some level of the clinical capacity for such sites through the physician preceptors, either by contract or by the transfer of physicians to the health center's workforce.

5 The particular allocation of authorities may vary, as each type of residency program (e.g., family practice, internal medicine, pediatrics, OB-GYN) may have unique programmatic requirements.

6 Health centers should periodically evaluate clinical operations to ensure that all off the services included in the health center's approved scope of project are readily available and reasonably accessible to all health center patients, regardless of whether the patient presents at a teaching site or a non-teaching site.

center's behalf should be required to reasonably participate in such activities.

For an in-depth analysis of the allocation principles applicable to these authorities, as well as the key terms for a written agreement to implement a health center-based residency rotation, see NACHC Issue Brief #26, Key Considerations in Developing Residency Training Program Collaborations, pp. 3–7.

ALLOCATION OF COSTS—TEACHING/ TRAINING VERSUS CLINICAL SERVICE DELIVERY

In addition to the need to appropriately allocate the authorities for teaching/training activities versus clinical service delivery, it is equally important that the health center and its residency program partner be able to distinguish between the costs of the teaching program versus the costs of clinical service delivery.[7]

- From the teaching/training perspective, this distinction is critical because federal Medicare GME reimbursement rules require a Medicare GME recipient to cover all or substantially all of the training costs.
- From the clinical service delivery perspective, this distinction is important to ensure that grant funds and third party payments for clinical services are not subsidizing teaching activities.

MEDICARE GME REIMBURSEMENT PRINCIPLES

Hospitals typically receive federal reimbursement for certain allowable costs incurred in conducting an accredited residency training program. To properly allocate costs and related payment obligations between a hospital (for teaching activities) and the health center (for clinical service delivery), it is important to understand the two kinds of federal GME reimbursement, which are paid through the Medicare program:

- **Direct GME** ("DME"); and
- **Indirect GME** ("IME").8

The Social Security Act authorizes hospitals to include the time a resident spends in patient care activities at a non-hospital setting in its direct and indirect GME full-time equivalency ("FTE") count if the hospital incurs all or substantially all of the costs of training at that non-hospital setting.[9]

Reimbursement for Direct Costs of Medical Education

The purpose of DME is to reimburse institutions, on a cost-basis, for the direct costs incurred by institutions involved in operating training programs.[10] Generally, in order to receive DME, the DME recipient must incur all or substantially all of such direct training costs.

Prior to passage of the Affordable Care Act ("ACA"), federal regulations generally required hospitals, as the GME recipient, to directly sustain (or reimburse health centers for) all or substantially all of the direct costs incurred by the health center rotations in order to include the residents' time at the health center in the hospital's GME reimbursement formula. Historically, the key costs to be reimbursed included salary and fringe benefits (including travel and lodging where applicable) of the residents; and the portion of the cost of health center employed teaching physicians' salaries and fringe benefits attributable to supervisory teaching activities. The ACA modified these rules to now require the hospital to incur only the salary and fringe benefits

7 This would apply whether the health center is a THCGME recipient and therefore must carefully allocate the costs of the residency program to the THCGME funding and otherwise avoid the double counting or charging of costs, or the parties execute a non-THCGME arrangement.

8 In order to receive GME reimbursement (whether DME or IME), the program must be an approved medical or dental residency program. 42 C.F.R. §413.75(a) (2); 42 C.F.R. §412.90(g).

9 See Sections 1886(d) (5) (B) (IV) and 1886(h) (4) (E) of the Social Security Act; 42 U.S.C. §1395ww. This policy is further clarified in the federal regulations at 42 C.F.R. §413.78 and 42 C.F.R. §412.105(f) (1) (ii).

10 42 C.F.R. §413.75(a)

of the residents at the health center rotation for GME reimbursement formula purposes.[11]

Reimbursement for Indirect Costs of Medical Education

IME reimbursement, which represents the far greater portion of Medicare's GME support, is meant to reimburse a hospital for the generally higher operating costs experienced by hospitals that sponsor/house residency training programs. These higher operating costs typically arise from increased resource utilization and clinical inefficiency due to the inclusion of an additional layer of less experienced staff involved in the delivery of patient care.[12]

Federal regulations do not require a hospital to reimburse a health center for its indirect costs (e.g., higher marginal costs due to lost productivity; inappropriate utilization or over-utilization of space, equipment and supply costs; inappropriate ordering of laboratory services) associated with the training program, even if the health center can document costs such as residents ordering more laboratory services. Nevertheless, many health centers do require hospital sponsors to cover some or all of these indirect costs as a condition of the collaboration.

Health Centers' Eligibility for Direct Medicare GME Reimbursement

- Eligible for DME—In 1998, health centers were added to the list of institutions eligible to receive DME reimbursement, regardless of whether the health center is the sponsoring institution of the residency program, provided that the health center incurs all or substantially all of the direct training costs at the health center site(s).
- Ineligible for IME—Unlike hospitals, however, health centers are not eligible to receive reimbursement for indirect costs.
- Low Reimbursement Payments—In addition to the exclusion of IME reimbursement, the methodology for determining health center DME reimbursement is not favorable for health centers. Payment is limited to the ratio of Medicare visits to the health center's total number of visits. For example, if Medicare represents 20% of a health center's payor mix, the DME reimbursement will equal only 20% of the allowable DME costs that the health center must incur.[13]

The lack of IME reimbursement, coupled with the unfavorable methodology for health center DME reimbursement, has effectively prevented health centers from seeking direct Medicare GME reimbursement under health center—residency program collaborations. Thus, hospitals have remained the GME recipient in the vast majority of these collaborations.

Additional Medicare GME Requirements

Historically, federal regulations have allowed the time spent by residents in non-hospital settings, such as health centers and physician offices, to be included by the hospital in its FTE count if: (1) the resident spent their time in patient care activities; and (2) the hospital and non-hospital site had a written agreement providing that the hospital would incur all training costs at the non-hospital site (including resident salaries and fringe benefits and the costs for supervisory teaching activities) and provide reasonable compensation for such costs to the non-hospital site.[14]

Since 2004, the statutory and regulatory requirements related to Medicare GME and non-

11 42 C.F.R. §413.75(b); 42 C.F.R. §413.78 (§413.78(g) for time periods after July 1, 2010).

12 IME is typically paid through a boosted inflated inpatient visit rate for applicable teaching hospitals through a complex formula based on the number resident FTEs and other site-specific factors (42 C.F. R. §412.90(g), §412.105).

13 See 42 C.F.R. §405.2468(f)

14 This requirement originally codified at 42 C.F.R. §413.86(f) (4), has been re-codified in 42 C.F.R. §413.78 (c) through (g).

hospital settings have been updated periodically.[15] For cost reporting periods after July 1, 2010, the principal requirements for a hospital to include resident time at a non-provider site (e.g., FQHC) are:

- The hospital must incur the costs of the salaries and fringe benefits (including any relevant travel or lodging expenses) of the residents during the time the residents spend in the non-provider setting.
- The resident time can include time spent in either patient care activities or nonpatient care activities, such as didactic conferences and seminars (but excluding research not associated with the treatment or diagnosis of a particular patient).
- There must be a written agreement with the non-provider site addressing the hospital's coverage of the aforementioned resident costs, or in lieu of an agreement, the hospital is, in fact, incurring such costs by the end of each quarter in which such costs are incurred.

Application of Community Support and Redistribution of Costs Principles

In 2003, DHHS codified the two controversial principles of "community support" and "redistribution of costs" in the federal Medicare GME regulations.[16] These principles remained unaffected by the ACA for Medicare GME. In addition, they were effectively incorporated into the requirements established by the Health Resources and Services Administration ("HRSA") for the THCGME Program by limiting such reimbursement to covering only the costs of new resident FTEs in either a new or expanded residency program.

- Community support is defined as "funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including state and local government appropriations."[17] Thus, if a community has previously undertaken to bear the costs of medical education through community support, the costs supported by such support may not be considered GME costs to the hospital for purposes of Medicare payment.
- Redistribution of costs occurs when a hospital counts resident FTEs for GME cost purposes, even though the costs of the program had previously been incurred by an educational institution and financed through community support. The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital may not be considered GME costs for purposes of federal GME payments.[18]

The impetus for codifying these principles was the perceived exploitation by hospitals, and primarily dental schools, of a loophole involving the rules capping resident FTEs for GME reimbursement purposes—namely, the non-application of the cap to dental residents. In response, DHHS amended the rules to incorporate the "community support" and "redistribution of costs" principles.

DHHS also added a requirement that, in order for the hospital to count the FTE residents, it must continuously incur the direct GME costs of resident training in a particular program at a training site since the date the residents first began training in that program.[19]

Example of Community Support and Redistribution of Costs

The application of these principles on an existing residency rotation site can be best understood through example. Take the following scenario:

15 See 72 Fed. Reg. 26870 (May 11, 2007); Sections 5504 and 5505 of the ACA, with Federal regulations were subsequently modified to reflect the statutory changes at 78 FR 50968, Aug. 19, 2013, including the addition of 42 C.F.R. §413.78(g).

16 See 68 Fed. Reg. 45434; 42 C.F.R. §413.81

17 42 C.F.R. §413.75(b)

18 42 C.F. §413.75(b)

19 42 C.F.R. §413.81(b)

In 2015, a freestanding residency program begins training five residents through one precepting teaching physician at one site, at a cost of $100,000 annually, funded by state and local grants. No hospital seeks GME reimbursement for the residents' time at this site until 2018. In 2019, the site begins training ten residents through two precepting physicians at a cost of $200,000 funded entirely by federal GME reimbursement to a hospital that enters into an agreement with the residency program. For the period from 2015 through 2018, the state and local grant funding would be deemed "community support," as it was utilized to bear the costs of such pre-GME educational activities.

- Applying the "community support" principle, that $100,000 of costs could not ever be considered GME costs for Medicare payment purposes.
- Applying the "redistribution of costs" principle, the hospital's act of seeking GME reimbursement for the residents time at the site would be deemed to be an inappropriate redistribution of costs, as the costs of the program had previously been incurred by the residency program, i.e., through the community support.

The hospital would be eligible to retain GME reimbursement for the "new" $100,000 of costs represented by the addition of the five residents and one preceptor in 2019 because these costs were incurred by the hospital since the date those residents began training. However, because of the requirement that the hospital incur "all or substantially all" of the training costs at the site, the hospital must still incur the full costs of training, i.e., $200,000 for ten residents in order to receive GME reimbursement of $100,000 for those five residents.

The application of these principles depends on the unique history of each residency rotation site. In at least one instance, a health center that directly received GME reimbursement for operating a residency program that prior to the establishment of the health center was operated by a university and funded locally without federal GME, was barred from seeking future GME reimbursement.[20]

Accordingly, in instances where health centers agree to host or operate residency rotations, it is important to consider the funding history of the training program to determine eligibility for and/or level of GME reimbursement for training costs incurred at those sites (regardless of whether a teaching hospital or the health center is the direct GME recipient). For new residency programs and/or new training rotations, the lesson is clear: GME funding should be sought at the outset if this is assumed to be a long-term funding source to support the program and/or rotation.

THE TEACHING HEALTH CENTERS GRADUATE MEDICAL EDUCATION (THCGME) PROGRAM

The ACA's Teaching Health Center ("THC") legislation established an important new source of federal GME reimbursement (both direct and indirect) unrelated to Medicare GME.[21] The statutory definition of a THC is (1) a community-based, ambulatory patient care centers that (2) operates a primary care residency programs. Health centers, community mental health centers, and rural health clinics are among the entities specifically identified in the statute as potential THCs. As of the 2019–2020 academic year, the **THCGME program** was funding the training of 769 residents in 60 primary care residency programs, across 25 states.

In order to be eligible for THCGME, the applicant organization must be a community-based ambulatory patient care center that either (1) operates (sponsors) an eligible residency program, or (2) is part of a GME "consortium" where the consortium entity is the institutional sponsor and the community-based ambulatory patient

20 See 68 Fed Reg. 45454.

21 The initial 5-year, $230 million THCGME appropriation ended on September 30, 2015, and the Medicare Access and CHIP Reauthorization Act of 2015 provided $60 million in THCGME program funding for each of fiscal years (FYs) 2016 and 2017. The Bipartisan Budget Act of 2018 appropriated $126.5 million for the THCGME program for each of FYs 2018 and 2019. In 2021,continued funding of the THCGME program was reauthorized through 2023 as Section 2604 of the American Rescue Plan Act of 2021.

care center has an integral role in the academic, financial, and administrative operations of the residency. Eligible primary care residency programs under the THCGME program are family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, or geriatrics.

The THCGME payment formula for direct GME expenses is largely based on the methodology used for the Children's Hospital GME program (42 U.S.C. §256e) (rather than Medicare GME). Although HRSA was directed to establish a final methodology to implement the THCGME Program, as of January 1, 2020, HRSA has continued to maintain an interim rate of payment equal to $150,000 per resident FTE, which is intended to cover both direct and indirect cost. In determining the total resident FTE for funding purposes, only new resident FTEs in a newly-established program or new resident FTEs in a pre-existing residency program may be counted.

IMPACT OF RESIDENCY PROGRAM COLLABORATIONS ON HEALTH CENTER OPERATIONS

THE UPSIDES OF RESIDENCY PROGRAM COLLABORATIONS

The upsides of residency rotations are numerous, as demonstrated below.

- **Increased clinical capacity—**The establishment of a health center as a rotation site usually increases and enhances the health center's clinical capacity. In addition to expanding the number of physicians (both preceptors and residents) available to serve health center patients, such collaborations may enable a health center to increase the scope and breadth of services offered to its patients by accessing physicians with high levels of experience and expertise.
- **Recruitment and retention tool—**Residency collaborations have been seen as an important recruitment and retention tool. By exposing residents to community-based medicine during their training experience and by acquainting residents with the health center and its comprehensive clinical practice approach, residents will be motivated to join the health center's clinical workforce after graduation (or to at least stay to practice medicine in a medically underserved area). In fact, this is one of the underlying principles for the establishment of the THCGME Program. Residency program collaborations may also provide a tool for attracting (or retaining) experienced physicians to the health center. For experienced physicians, the opportunity to become part of a residency program's teaching faculty (or otherwise affiliate with such program) can serve as an attraction to join the health center's staff.
- **Enhanced staff morale—**Provider morale may be enhanced if health center clinicians are offered the opportunity to get involved in teaching activities. The infusion of energetic residents and faculty preceptors who may be contracted from a residency program can also serve to enhance staff morale and create a dynamic environment within the health center—fostering the collegial exchange of information and thereby enhancing a health center staff's ability to keep abreast of emerging treatment regimens and technological advances, and their application in a community-based setting.
- **Improved community relationships—**Residency collaborations may enhance the health center's status within the community, through both the health center's association with a well-recognized residency program as well as its ability to "tap into" a greater level of expertise / experience. Ultimately, this could result in improved community relationships, potentially providing access to services and partners previously unavailable to the health center, as well as additional opportunities with the residency program itself (e.g., clinical research).

THE "DOWNSIDES" OF RESIDENCY PROGRAM COLLABORATIONS

Conversely, collaboration with a residency program can have notable downsides if not anticipated and well-managed.

- **Decreased clinical productivity and reduced patient revenue—**The most prevalent shortcoming typically is a negative impact on clinical productivity caused by the fact that residents generally take longer to see patients. This problem can be exacerbated by a pattern of disruptions in staffing (clinical and support staff alike) due to last minute changes to resident or preceptor schedules. Further, decreased productivity often leads to reduced patient revenue due to decreases in number of patient visits.
- **Increased costs—**In addition, residents typically order more diagnostic tests than experienced clinicians and/or overuse supplies; the increased testing and supply use may be costly, as is the support staff needed to follow-up. Further, there may be additional costs related directly to decreased productivity, including the increased costs of overtime when residents "run over" the time needed to treat all patients scheduled for a particular day.
- **Disruption to effective operations—**A failure to sufficiently train and orient new residents/preceptors to the health center's policies and protocols and to appropriately introduce them to the health center's current staff (and vice versa!) can disrupt health center operations. If residency program staff and the health center's clinical or administrative staff have not had the opportunity to work closely prior to implementing the training program (i.e., during the planning process), personnel and/or clinical practice issues may emerge (e.g., clash of clinical cultures; health center staff may become insecure regarding stability of their jobs).

Fortunately, these problems can usually be addressed through careful planning before launching the collaboration and, thereafter, through continued meetings and timely action taken by a proactive, collaborative leadership focused on ensuring the mutual gains to be achieved by the collaboration.

CONCLUSION

Health center collaborations with residency programs (including becoming a sponsoring institution of such a program) present an excellent opportunity for extending clinical capacity and strengthening ties with local hospitals and other providers, to the benefit of all involved, including health center patients. In deciding to enter into such a collaboration, it is important that the health center understand the current federal funding framework associated with residency programs, as well as the possible benefits and downsides such a collaboration may entail. It is also important to have an understanding of the key terms for agreements needed to implement this kind of collaboration.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.

HR Information Bulletin #12

POLICIES AND PROTECTIONS RELATED TO EMPLOYEE HARASSMENT IN THE WORKPLACE AND WHISTLEBLOWER RETALIATION

Offensive behavior and inconsiderate treatment of colleagues can occur in any workplace. Although health centers are mission-driven organizations, they are not immune from the consequences, including financial liability, which can result from inappropriate behavior among employees, including bullying or harassment.

Harassment can come in many forms, including but not limited to offensive or derogatory jokes, racial or ethnic slurs, pressure for dates or sexual favors, unwelcome comments about a person's religion or religious garments, or offensive graffiti, cartoons or pictures. Activities that could be considered harassment include aggressive or violent behavior, intimidating actions, exclusion or isolation, other acts of degradation or humiliation, or threats of any of these.

If an employee complains of harassment and the health center somehow penalizes or takes inappropriate action against the complaining employee, it may expose itself to charges of retaliation. In addition, if appropriate action is not taken, the complainant may choose to report wrongdoing (whether substantiated or not) to external sources, such as regulators, law enforcement agencies or the media.

Harassment and retaliation can have significant negative effects on a health center. This Information Bulletin will:

- Give examples of conduct that may constitute harassment or whistleblower retaliation.
- Provide examples of the negative effects that can result from harassment and retaliation, including legal and other consequences.
- Recommend steps that a health center can take to minimize instances of harassment and whistleblower retaliation, and protect itself from potential liability.

HARASSING CONDUCT

HARASSMENT AS EMPLOYMENT DISCRIMINATION

Various federal laws, specifically **Title VII of the Civil Rights Act of 1964,** the **Age Discrimination in Employment Act,** and the **Americans With Disabilities Act,** prohibit unwelcome conduct based on race, color religion, sex (including pregnancy, sexual orientation, and gender identity), national origin, age (over 40), disability or genetic information. State and local laws often prohibit harassment based on not only those characteristics but additional ones such as familial/marital status, and appearance. The U.S. Equal Employment Opportunity Commission ("EEOC"), the federal agency responsible for enforcing the federal laws pertaining to discrimination in the workplace on the basis of age, disability, national origin, pregnancy, race/ color, religion, sex, and genetic information, has issued numerous guidance that further describe harassment.[1]

In general, harassment can be almost any type of unwelcome conduct. Importantly, the determination of whether an employee is being harassed is based on the reasonable perspective of the subject of the harassing conduct. The harasser could be the victim's supervisor, a supervisor in another area of the health center, a co-worker, or even a non-employee such as a patient. Moreover, anyone negatively affected by the offensive conduct may be a victim of harassment, not just the intended target.

The law does not prohibit simple teasing, offhand comments, or isolated incidents that are not very

1 See **https://www.eeoc.gov/harassment**

serious. Harassment is unlawful when enduring the offensive conduct becomes, in effect, a term and condition of employment (such as getting a promotion, avoiding a disciplinary action, etc.) or the conduct is so severe or pervasive as to create a work environment that a reasonable person would consider intimidating, hostile, or abusive.

Organizations may be held liable 1) where a supervisor or manager harasses an employee, or 2) where a supervisor or manager fails to act when they become aware of offensive conduct taking place in the health center. Thus, it is extremely important to:

- Encourage employees to report instances of alleged harassment to the appropriate health center staff, and
- Act promptly on complaints to demonstrate that the health center takes alleged harassment seriously.

Examples of these types of harassment include:

- Mocking someone about their appearance, whether verbally, in writing, by drawing or caricature, or otherwise.
- Unwanted comments about someone's religious beliefs.
- The exclusion of individuals of a certain race or ethnicity from group activities.
- Demeaning comments about a class of people—such as women or men—directed at a member of that group.
- Physical intimidation; and
- The circulation by email of off-color jokes and photographs.

NEGATIVE EFFECTS OF HARASSMENT ON A HEALTH CENTER

LOW MORALE AND LOSS OF PRODUCTIVITY

The loss of productivity that accompanies dissatisfaction in the workplace can often be observed in environments of harassment. People who do not feel comfortable at their jobs, whether they are the individual being harassed or simply a witness to such behavior, may respond with tardiness, absenteeism, or a drop-in performance generally.

NEGATIVE PUBLIC IMAGE

One of the more significant risks to an organization, especially for health centers, that may result from harassment is damage to the organization's public image. Harassment lawsuits, whistleblower suits, government investigations, and even gaining a reputation as an unpleasant place to work can lead to a negative public image for the organization. In the context of a health center, this can result in fewer patients, fewer volunteers, fewer providers, and fewer offers of financial support.

LAWSUITS

Litigation stemming from a harassment claim can lead to significant financial liability for a health center, accompanied by the damage to the health center's reputation. As noted, victims of harassment may bring lawsuits based on numerus federal or state employment discrimination laws.

Under federal law, an employer may be liable for the harassment in two ways.

Harassment—Tangible Employment Action

An employer always is liable for harassment by a supervisor that ends in a "tangible employment action" such as hiring, firing, promotion, demotion, an undesirable reassignment, or a significant change in benefits, compensation, and work assignments of the victim. Specifically, the employer may be liable to the employee for compensatory damages. These

damages can include out-of-pocket expenses such as costs associated with a search for a new job free from the harassing environment, medical expenses incurred in treating stress or other conditions resulting from the harassment, and compensation for any emotional harm suffered (such as mental anguish, inconvenience, or loss of enjoyment of life). Damages may also include lost pay and benefits if the victim was forced to terminate their employment on account of the hostile conditions in the workplace.

If the harassment did not lead to a tangible employment action, the employer will not be liable if the employer can prove that it exercised reasonable care to prevent and promptly correct any harassment *and* that the victim of the harassment unreasonably failed to complain to management or otherwise failed to take advantage of any preventive or corrective opportunities that the employer provides to avoid harm resulting from harassment.

In short, an employer has what is known as an "affirmative defense" to a discrimination claim based on harassment that did not result in a tangible employment action, but it must prove both elements of the defense, namely, that it took reasonable efforts to prevent and correct the conduct and that the alleged victim failed to complain or to take advantage of available corrective opportunities. Accordingly, it is very important for an employer to have effective anti-harassment policies and procedures in place in order to carry its burden of proof in these types of cases. Recommendations for such policies and procedure are addressed below.

Finally, it is important to understand that, according to the EEOC and U.S. Supreme Court decisions, an employer is automatically liable for unlawful harassment whenever the harasser is of sufficiently high rank in an organization (e.g. corporate officers, board members) such that they may be treated as the "proxy" or "alter ego" of the organization. In those cases, their conduct is automatically imputed to the organization and the employer cannot raise an affirmative defense (as described above) even if the harassment did not result in a tangible employment action. An example of this type of harassment is when a supervisor threatens to have a subordinate transferred to a lower paying job unless the subordinate agrees to go on a date with or provide sexual favors to the supervisor.

Note that this type of "sexual" harassment can occur in the context of a male supervisor and a female subordinate, a female supervisor and male subordinate, and same sex supervisor and subordinate. Also note that liability for harassment is not limited to conduct of a sexual nature. For example, a medical director may suddenly find fault with a physician's work performance and begin to threaten poor performance reviews because the physician ignored the medical director's overtures to participate in group prayers.

Harassment—Hostile Work Environment

An employer also can be liable for harassing conduct by other employees in the workplace or even non-employees over whom it has some control, such as vendors and patients, when that conduct unreasonably interferes with an individual's work performance or creates a severe or pervasive intimidating, hostile, or offensive work environment. For example, sexual harassment also can occur among peers, such as when one employee continually disrupts another employee's work with pornographic materials sent by email, interoffice mail, by hand, or otherwise.

As noted, a hostile work environment claim can be based on the conduct of non-employees. For example, a pharmaceutical manufacturer sales representative who frequently visits a health center to detail new products raises their voice and uses racial epithets to intimidate a receptionist into allowing them into the health center to meet with physicians. This interferes with the receptionist's ability to fulfill their job responsibilities and thereby creates a hostile work environment. If a health center manager is aware of this conduct but refuses to take action to prevent this from happening, claiming that the representative does not work for the health center and therefore cannot be told what to do, the health center may be held liable for the job-related consequences of the representative's actions.

Where an employer—through its managers—becomes aware of harassment that is severe and pervasive enough to create a hostile or offensive work environment and does not take corrective action that is likely to stop the recurrence of the harassment, both the harassing parties and the organization may be held liable, even if the harassed individual does not suffer any specific detrimental change in the terms and conditions of their employment. .

Enforcement and Remedies

Individuals who believe that they were harassed may bring charges under state or federal law against the organization and supervisors who failed to respond adequately. Before filing a federal lawsuit for harassment, a potential plaintiff must file an administrative complaint with the EEOC.

Where state laws apply to the claim, the EEOC frequently defers to state equal employment agencies that enforce state laws protecting these classes, allowing the state agency to address the complaints under state and local, rather than federal laws.

The EEOC has the authority to investigate charges of harassment against employers who are covered by federal non-discrimination laws and to resolve violations through settlement, mediation, or lawsuit. In investigating allegations of harassment, the EEOC looks at the entire record, including the nature of the conduct and the context in which the incidents alleged occurred. If the EEOC receives a charge of harassment that reveals a potential violation of law and cannot settle the charges, the EEOC may decide to file a claim in federal court or may decline to pursue the action further.

Where the EEOC does not identify a potential violation of law or chooses not to take further action, the EEOC will provide the individual who filed the charges with a "Notice-of-Right-to-Sue," which permits the individual to file suit in federal or state court.

RETALIATION

It is very important that health center managers do not retaliate or take actions that can be perceived as retaliation against an employee who files a claim of harassment or against anyone who reports alleged harassment, opposes employment practices that they reasonably believe constitute illegal harassment, or participate in any way in the investigation of or legal proceedings involving claims of harassment. The latter are sometimes referred to as "whistleblowers."

Retaliation not only exposes the health center to financial liabilities, including compensation of back pay and punitive damages to both the victim and whistleblowers, but it also reduces the likelihood that any health center employee would report other instances of wrongdoing.

Retaliation is prohibited by federal and state laws, which provide protections for whistleblowers in order to encourage the reporting of violations. **Title VII of the Civil Rights Act** includes whistleblower protection that prohibits employers from taking action that would deter a reasonable person from asserting rights guaranteed by Title VII. While discharge is perhaps the ultimate form of retaliation, other actions, such as demotion, suspension, removal of responsibilities, threats, isolation from regular employee activities, or any other manner of discrimination in the terms and conditions of the whistleblower's employment can be perceived as retaliatory action.

ALLOWABLE DISCIPLINARY ACTION

An employer can take disciplinary or remedial action against an employee who has reported wrongdoing, provided such action is a legitimate response to conduct unrelated to the harassment and not a penalty for having made a report against alleged wrongdoing. An employer may impose disciplinary actions against a whistleblower if they have violated the law or health center policies, or have poor job performance.

However, it is critical to have well documented reasons for such action so as not to leave the health

center open to a charge of retaliation. For example, if a health center terminated a whistleblowing employee for poor performance when that employee's recent performance evaluations were positive, the center could be at risk for a claim of retaliation.

Retaliation can lead to the development of a workplace culture that punishes the reporting of questionable conduct, which will surely inhibit an employer's ability to take corrective action before it is faced with potentially severe legal and financial consequences.

STEPS TO MINIMIZE HARASSMENT AND WHISTLEBLOWER RETALIATION

In order to reduce a health center's potential exposure for harassment and/or retaliation, the health center must take steps to deter such conduct and, if it occurs, to discover and address the conduct.

1. ADOPT A POLICY PROHIBITING HARASSMENT AND RETALIATION.

The first step a health center should take is to adopt a policy against harassment and retaliation that reflects the center's practices and procedures as well as state and local laws. See the following example for an anti-harassment and retaliation policy.

Example of an Anti-Harassment and Retaliation Policy

Ethics and integrity are the responsibility of everyone. Therefore, [insert health center name] requires that all employees, contractors, agents, officers, members of the board of directors, and other individuals doing business with or related to the business of [insert health center name] behave, at all times, in a professional and courteous manner.

Harassment of any individuals associated with [insert health center name], including, but not limited to employees, contractors, agents, officers, members of the board of director, patients, vendors or other visitors to [insert health center name] on the basis of race, color, national origin, religion, sex, gender, gender identification, genetic information including family medical history, sexual orientation, age, physical or mental disability, pregnancy, military status, or any other characteristic protected by law, including sexual harassment (all as defined and protected by applicable law) is unacceptable and will not be tolerated by [insert health center name].

Harassment includes, but is not limited to:

- Acceptance of improper conduct as a condition for not imposing a negative employment action, such as termination, demotion, writing a poor evaluation, or reduction of job responsibilities or pay.
- Offensive or unwelcome behavior, such as:
  - Jokes.
  - Racial or ethnic slurs.
  - Epithets or name or name calling.
  - Physical assaults or threats.
  - Unwelcome comments about a person's religion or religious garments.
  - Graffiti.
  - Cartoons or pictures.
  - Intimidation; and
  - Interference with work performance.

Furthermore, retaliation in any form against individuals who report or otherwise participate in efforts to address harassment or discrimination will not be tolerated. Retaliation includes any negative employment action or harassment directed at an individual in response to that individual's reporting of, or participation in efforts to address harassment, retaliation or other wrongdoing.

Individuals associated with [insert health center name] must report any harassment or discrimination promptly to their supervisor, who will notify the [Human Resources Director]. If the individual is uncomfortable discussing the issue with their supervisor, they may notify the [Human Resources Director, the CEO, Compliance Officer, or another member of senior management, who will notify the Human Resources Director]. [Insert health center name] will promptly conduct

a thorough and impartial investigation and will maintain confidentiality to the extent possible given [insert health center name]'s responsibility and duty to investigate any reports of harassment or discrimination. Individuals are encouraged to respond to questions or otherwise to participate in investigations alleged harassment. The identity of individuals who report harassment, alleged victims, witnesses, and alleged harassers will be kept confidential to the extent possible and as permitted by law and consistent with a thorough and partial investigation. [health center's name] will take immediate and proportionate corrective action if it determines that harassment has occurred.

Any individual associated with [insert health center name] who is found to have violated this [policy against harassment and retaliation] will be subject to disciplinary action, up to and including termination.

2. ESTABLISH AN INFRASTRUCTURE TO IMPLEMENT EXPECTATIONS AND PUBLICIZE CONSEQUENCES FOR VIOLATING EXPECTATIONS.

Once a policy against harassment and retaliation has been adopted a health center can establish an infrastructure to implement the health center's expectations for proper conduct (as set forth in the policy against harassment and retaliation) and to publicize the consequences for violating these expectations. This infrastructure should be coupled with the creation of a corporate culture that supports the infrastructure. Such corporate culture should:

- Assure that employees receive training on the center's non-harassment policies;
- Promote compliance with health center policies;
- Encourage the reporting of potential violations of such policies by making reporting a condition of employment; and
- Ensure that employees feel comfortable reporting harassment through a strong and explicit statement of non-retaliation.

More importantly, a health center should reinforce its policies by consistently taking swift and appropriate action to address harassment in accordance with its policies.

None of the steps taken by a health center to establish a culture of compliance will succeed if the tone of such culture is not set by health center leadership.

All the policies and procedures, as well as training requirements relating to harassment and retaliation that apply to health center employees, should apply equally to board members and senior management. Board members and managers who show no interest in enforcing or complying with the health center's policies against harassment and retaliation or who are not treated consistently in accordance with such policies because of their positions, can significantly limit the ability of the organization to deter and address harassment and retaliation.

3. INTEGRATE THE ANTI-HARASSMENT AND RETALIATION POLICY WITH THE CENTER'S COMPLIANCE PROGRAM.

An effective anti-harassment policy can be structured to include many of the elements of a health center compliance program or can be incorporated within the health center's general compliance program. In either case, to address harassment and retaliation issues, a health center compliance program should include at least the following elements, implemented as appropriate to meet the health center's specific needs.

Defining Hiring Practices

Well-defined, carefully considered hiring practices are an important first step in avoiding potential problems. An essential qualification of any health center position is the ability to maintain proper decorum and appropriate behavior, which includes not harassing others.

Providing New-Hire Orientation and Regular Training

A health center should provide new-hire orientation and training that includes the expectations of the health center for its employees. Providing regular "refresher training" for health center employees,

reminding them of key policies such as the non-harassment policy and disciplinary procedures, is critical.

Trainings should not only explain the non-harassment policy, but also give examples on how employees should and should not act within the workplace. Employees also should be informed of how to identify potential harassing conduct as well as how and to whom to report it. Health centers should train employees on where to get information should they have a question about the center's policies and procedures.

Supervisors must also be trained on how to treat employees with respect and in accordance with applicable non-discrimination laws and should be trained (with regular refreshers) on how to respond to allegations of harassment.

Reporting Mechanisms

Every health center should adopt a process by which employees can report concerns to management. Through training, employees should be taught to identify the types of behavior that are unacceptable and that should be reported. Additionally, health centers should encourage all individuals associated with the health center, including board members, employees, vendors, patients, and visitors, to report any apparent harassment that they observe to their supervisor or to other appropriate internal authorities, such as the compliance officer or another member of management. There also should be an alternative means of reporting for individuals who would otherwise be required to report to the individual who is harassing them or who are uncomfortable reporting to their supervisors for any reason. Each employee should know exactly where they can bring a complaint, not only for themselves, but also on the behalf of other employees.

Responding to Allegations

In order to reinforce the health center's message that harassment and other disruptive behavior will not be tolerated, the health center must appropriately respond to all allegations of potential violations of its policies and procedures. Failing to respond appropriately to alleged misbehavior can:

- Cause the individual making a report to question the health center's commitment to maintaining a harassment-free workplace.
- Render the health center's message regarding the importance of proper behavior meaningless; and/or
- Increase the likelihood that future whistleblowers, who, expecting an inadequate response if they were to report internally, might file a complaint with the EEOC or a state or local equal employment agency.

There is no established protocol that dictates how a health center should respond to a complaint, nor a specific timeframe for responding. Rather, a health center must determine, based on the facts and circumstances, how best to proceed in order to determine whether inappropriate conduct occurred and to promptly remediate the situation. However, it is critical that a center take complaints seriously and that they be investigated promptly and thoroughly.

Health centers, particularly those that are not accustomed to conducting investigations in response to alleged wrongdoing, should seek the advice of qualified legal counsel regarding appropriate steps that the health center should take to investigate whether harassment or retaliation occurred. Steps that counsel may recommend include, but are not limited to:

1. Conduct interviews of individuals with potential knowledge of the matter.
2. Review relevant documents.
3. Engage qualified legal counsel to conduct an investigation, so that communications with counsel may be protected by the attorney-client privilege. This "privilege" means that a third a party, such as government investigator or an opponent in litigation, cannot get access to a client's communications with an attorney when they are made for the purpose of obtaining legal advice.

The extent to which any communications and information developed during an investigation may be protected by the attorney-client privilege depends on the particular facts and circumstances and the applicable rules of evidence in a federal or state court. Any investigation in which a health center desires to protect communications under the attorney-client privilege should be undertaken only after consultation with qualified legal counsel and in accordance with direction provided by counsel.

If a health center determines, based on the investigation, that inappropriate conduct took place, appropriate disciplinary action should be imposed.

Taking Disciplinary Action

The consistent implementation of a disciplinary action policy is an essential aspect of proper response to identified harassment or other disruptive behavior. Failure to treat individuals in a consistent manner for offensive conduct can weaken the health center's message regarding the importance of proper behavior and can be tantamount to failure to respond at all.

The health center's response to a documented instance of harassment should be aimed at preventing the misconduct from recurring, including, in particular, taking appropriate disciplinary action against the responsible party or parties. Disciplinary action may include (as appropriate to the nature and seriousness of the offensive behavior):

- A verbal or written warning,
- Suspension from employment,
- Demotion, or
- Termination.

A disciplinary action policy should set forth firm guidelines for imposing disciplinary actions, while being flexible enough to allow for mitigating circumstances. While the policy should provide for disciplinary measures that can be tailored to the circumstances, the health center should have the authority under the policy to terminate an employee immediately, should the circumstances call for such action.

In addition, or as an alternative to taking disciplinary action, the health center could consider other remedial actions, such as requiring additional training on employer-employee relations and separating the harasser from the complainant in terms of workspace.

Documenting Actions and Efforts

Documentation of a health center's actions and efforts to prevent and remediate harassment and retaliation begins with the implementation of a policy against harassment and discrimination and other written standards, policies, and procedures, as described above. However, a health center also must document its efforts to put these written standards into practice. Health centers should proceed cautiously, with the advice of qualified legal counsel, in determining how much information to record throughout the process of deterring and addressing harassment.

CONCLUSION

Workplace harassment and retaliation may take several forms, all of which could have serious consequences for a health center. There are various steps for minimizing risk of harm to the health center resulting from such inappropriate conduct, but there is no one-size-fits-all solution to harassment and retaliation in the workplace. Establishing an infrastructure and culture that deter misbehavior, promote reporting of inappropriate conduct, and appropriately address any instances of harassment or retaliation will help a health center to successfully avoid the consequences of such conduct.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,254,766 with 100 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit **HRSA.gov**.