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Health Care

In This Issue

A Good Way to Give Bad News: Recent Amendment to California's Breach Notification Statute

Julie Simer

We often hear stories of laptops containing credit card and social security numbers falling into the wrong hands or hospitals being fined for employees peeking into the medical records of a celebrity. With the sheer volume of electronic information available these days, it is not only likely, it is almost inevitable that a business will have the unfortunate duty of informing its customers of a security breach. When it happens, how do you break the bad news? Fortunately, a statute recently passed by the California legislature, SB 24, provides some much-needed clarity on the contents of the notice of breach.

In 2003, California became the first state to adopt a breach notification law, Civil Code section 1798.82 (Act). This law makes it mandatory for any person or business that owns or licenses computerized data to provide notice to any California resident whose unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person. "Personal information" is defined as the first name or first initial in combination with other identifying information such as a social security number, driver's license number, California identification card number, account number, credit or debit card number (in combination with any necessary security code, access

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Accountable Care Organizations: The Private Sector Will Lead

Mitchell J. Olejko

The Patient Protection and Affordable Care Act ("PPACA") became law on March 23, 2010. Since then, one of the provisions generating the most discussion and interest among health care providers is the Shared Saving Program ("SSP"). Fundamental to the SSP is development of so-called accountable care organizations ("ACOs"). These organizations would include independent health care providers and institutions involved in different aspects of an episode of care. ACOs are conceived of as systems of care that emulate the care delivery approaches of the participants in the Physician Group Practice Demonstration Project, including Geisinger Clinic, Marshfield Clinic and Park Nicollet Clinic, and other leading organizations, such as Mayo Clinic and Group Health Cooperative.

The term "Accountable Care Organization" is now used to refer to any arrangement, not just SSP organizations, where independent providers, working together, focus on bringing efficiency and quality to the delivery of health care services by decreasing mistakes and taking responsibility for the entire episode of care. A notable success in California is the collaboration involving Catholic Healthcare West, Blue Shield of California and Hill Physicians Medical Group for enrollees in the Sacramento area who receive health care benefits through the CalPERS.

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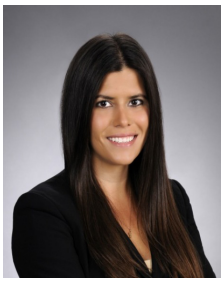

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Points from the President

RICK COHEN

The Firm is delighted to bring you this special issue of *Points and Authorities* focused on Health Care in celebration of our newly expanded Health Care Practice Group, chaired by Carol Lucas.

This issue also introduces our two newest Shareholders, Mitchell Olejko and Julie Simer, who have joined the firm in San Francisco and Orange County, respectively. Mitch and Julie bring additional expertise to the legal services and business-oriented counsel we currently provide to our clients in the health care industry, and broaden the Firm's capabilities across the North- and Southwest United States.

This issue covers the health care industry from a variety of angles. Mitch Olejko tackles new ACO regulations slated to go into effect in early 2012, pointing out some of its improvements and pitfalls. Julie Simer sheds light on California's new security-breach notification statute—the first of its kind in the health care space. Carol Lucas discusses the continued significance of a long-standing California law: the prohibition on the corporate practice of medicine. Paul Bressan addresses employment issues and Rick Darwin explains covenants-not-to-compete. Mary Rose writes about saving hospitals in bankruptcy, a highly complex and nuanced process. In a related vein, Randye Soref and Brian Harvey discuss the role of the Patient Care Ombudsman in monitoring the quality of patient care provided by health care businesses in bankruptcy.

As you can see, our health care attorneys cover the gamut of legal and business issues in the health care industry. This comes from the fact that we have represented providers, lenders and others in the health care industry for quite some time—among them nonprofit and for-profit health systems, hospitals, independent practice associations, medical groups, physicians, provider trade organizations, health care lenders, and drug and device companies. We invite you to communicate with us about the topics discussed here, or others that may be of concern to you.

Rick Cohen
President and Chief Executive Officer

California's Corporate Practice Ban: Still Vibrant After All These Years

Carol K. Lucas

California is one of several states that still prohibits the corporate practice of medicine. In its most basic form, the corporate practice ban prohibits lay entities from providing medical services to the public through the employment of physicians. The doctrine dates to the 1930's and was intended to preserve the traditional physician/patient relationship and keep physicians out of the control of lay corporations who are presumed to place commercial motives ahead of professional judgment. Through Medical Board pronouncements, Attorney General Opinions and court decisions, however, the corporate practice doctrine has been expanded from this simple core to affect numerous business relationships involving physicians, including the ability of "franchise" medical providers to operate in California, the requirements applicable to management service relationships, and the operation of med spas and convenience clinics in settings other than traditional medical offices. Further, California's prohibition on licensee fee-splitting makes work-arounds more complex to structure because it affects how a lay entity can legally be compensated by a professional entity.

The following are some examples of how California's corporate practice prohibition has been interpreted and applied:

1. Management Services Organization ("MSO"). An MSO or other non-professional entity may provide administrative services (billing, purchasing, managed care contracting) to a physician or medical group under a management services agreement. However, if the MSO interferes with decisions regarding the practice of medicine, the MSO may be engaged in the corporate practice of medicine. The California Attorney General issued an opinion in 2000 that invalidated a proposed agreement in which an MSO would arrange for radiology diagnostic services for union members. Because the MSO had discretion to choose the radiology provider, the Attorney General deemed the service to require professional expertise and therefore to violate the corporate practice ban.

The California Medical Board has published guidance for physicians on the corporate practice ban. That guidance identifies a number of "business" or "management" decisions and activities that result in lay control over a physician's practice of medicine. The medical board unequivocally states that these decisions must be made by a licensed California physician and not by an unlicensed person or entity: ownership of a patient's medical records; selection, hiring and firing of allied health staff and medical assistants; setting the parameters under which the medical group will enter into managed care contracts; decisions regarding coding and billing procedures for patient care services; and approving the selection of medical equipment and medical supplies for the medical practice.

In addition, to the extent that an MSO "purchases" an existing medical practice, the acquisition transaction itself is shaped by the corporate practice ban. An unlicensed entity may not purchase any "professional" assets of the practice. Consequently, the MSO may not purchase medical charts or the goodwill of a practice, but only assets that may be owned by a lay entity.

2. Medical Foundation. The need for integration between a hospital and its medical staff when the hospital cannot employ physicians led to the enactment of Section 1206(l) of the California Health & Safety Code. Subsection 1206(l) was crafted by the legislature when the Medical Board forced two hospitals to terminate employment of a number of physicians. 1206(l) specifically allows a nonprofit corporation to contract with a medical group composed of at least 40 physicians, two-thirds of whom are full-time, which does research, and is composed of at least 10 specialties, to be exempt from clinic licensure. Often, nonprofit hospitals will use their nonprofit corporation to contract with medical groups that meet these requirements or create nonprofit subsidiaries for this purpose. The foundation is the business arrangement closest to a hospital's direct employment of physicians available in California.

Other arrangements between hospitals and physicians may be considered stops on the way to a full blown foundation. For example, many hospitals enter in "co-management" agreements pursuant to which a single specialty medical group manages a particular service line offered by the hospital. Such arrangements feature cooperation between the two in order to enhance a particular area of practice and to bind the medical group to the hospital. If successful, co-management may lead to participation in a foundation.

3. Friendly Professional Corporation. Often hospitals or other lay entities find "friendly" physicians to own all of the equity in a medical group as a way to jointly conduct business while complying with the corporate practice ban. Sometimes the agreement between the professional and the lay entity requires the friendly physician to transfer ownership of the group to another physician when his/her contract terminates. These arrangements must be carefully structured to avoid giving the hospital too much control over the professional corporation's practice, lest they violate the corporate practice ban.

4. Med-Spas. If a "med-spa" provides services that constitute the practice of medicine (i.e., "us[ing] drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings"), including laser services and cosmetic injectibles, care must be taken to assure that it is structured in a way that does not violate the corporate practice ban. The spa itself should either be owned and operated by a physician or the portion of the spa's business that constitutes the practice of medicine must actually be conducted by a physician or medical group. In the Matter of *The Accusation Against Joseph F. Basile, M.D.*, the California Medical Board found that a licensed physician aided and abetted the unlicensed practice of medicine when he permitted his unlicensed wife to provide laser services to patients in a cosmetic center that she owned, in some instances when he was not on the premises. In that case, Dr. Basile had agreed to act as Medical Director to the center, although the Medical Board found that he exercised insufficient supervision of the services rendered by unlicensed persons at the center.

5. Advertising of Medical Services. A corporation's advertising of medical services, their availability or even their location may be deemed to implicate the corporate practice laws, even where the corporation is not providing the medical services. The mere advertising by a corporation of the availability of medical services or advertising in a manner that seems to suggest that the services are being provided by a lay entity (such as a management company) may be deemed by the Medical Board to be a type of corporate practice violation. Many national practice management companies attempt to "brand" their services under their corporate umbrella. Websites that may be completely acceptable in non-corporate practice states, however, can provoke a cease and desist letter from the California Medical Board.

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BUYING A DISTRESSED HOSPITAL OUT OF BANKRUPTCY

MARY H. ROSE

It is an immutable rule of economics that when business conditions change, someone gets hurt. This is as true in the health care industry as it is anywhere else, and the financial basis for the delivery of health care in the United States is experiencing more attention and regulatory revision than at any time since the introduction of Medicare in 1965. Regardless of whether the Supreme Court upholds the Patient Protection and Affordable Care Act, the ongoing regulatory changes to both public and private payment for patient care, as well as the budget restrictions facing governmental payors, will profoundly affect the financial operations of hospitals. Some hospitals, particularly those that are not well-managed, will inevitably suffer and will have no choice but to file for bankruptcy protection.

The financial woes of a hospital in bankruptcy can create an attractive acquisition opportunity. Due to its distressed financial condition, the hospital will typically sell for far less than a financially healthy hospital. Moreover, the bankruptcy process itself can help reposition the hospital for a brighter future.

Bankruptcy Sales. There are two ways a business can be sold in a bankruptcy case, under a plan of reorganization or as an asset sale under Bankruptcy Code § 363. Section 363 sales have become increasingly common in bankruptcy cases because they can be held at any time during the case. Whereas confirmation of a plan requires preparation, negotiation and approval of a full disclosure statement and plan for distributions to creditors, in accordance with lengthy statutory notice periods, an asset sale under Section 363 can be accomplished without resolution of most creditor claims and in a relatively short period of time pursuant to ordinary motion procedures.

The most significant attribute of a sale of assets in bankruptcy is that the sale is "free and clear" of liens, claims and encumbrances other than those that may be expressly provided for in the sale order. The assets are cleansed of the debts that overwhelmed the old company, and the buyer can rebuild the business starting with a clean slate. Moreover, bankruptcy sales enjoy a degree of finality not possible outside of bankruptcy. Pursuant to Bankruptcy Code § 363(m), a bankruptcy sale to a good faith purchaser cannot be reversed or modified on appeal unless there has been a court ordered stay of the sale pending appeal.

Contracts and Leases. Another important feature of bankruptcy sales is the ability of the buyer to "cherry pick" among the debtor's contracts and leases and leave unprofitable ones behind. Except for "personal service" contracts, such as medical director agreements, which can only be assigned with the consent of the counterparty to the contract, the buyer effectively has complete discretion as to which contracts and leases it chooses for assumption and assignment. The only requirements are that the buyer demonstrate "adequate assurance of future performance" under the contract or lease, and any monetary defaults are cured at the time of assignment. Notably, loan agreements are not assumable under bankruptcy law, and the buyer must either obtain new financing or make a deal with the existing lender for assumption of the obligation.

Among the most significant contracts in a hospital bankruptcy are the Medicare and Medicaid provider agreements, and a buyer must decide whether to assume the existing contracts or obtain new provider numbers and agreements. If the buyer decides to assume the existing contracts, it will be responsible for any overpayment claims by the government, whether or not known at the time of assignment. If the buyer does not assume the existing contracts, it must obtain new provider agreements, and until those agreements are in place, the buyer will not be paid for services to Medicare and Medicaid patients.

The Sale Process and Timing Issues. A hospital in bankruptcy that sells its assets will nearly always try to negotiate a sale agreement with a "stalking horse" bidder and then file a motion with the Bankruptcy Court for approval of the sale. The sale will be subject to "higher and better" offers at the time of sale, although the question of whether an offer is both higher and better in the hospital context can be affected by nonmonetary considerations such as the interests of the community or employees of the hospital. The advantages of being the stalking horse bidder are that the stalking horse can structure the terms of sale, will usually have a longer time period for conducting due diligence, and can typically negotiate a "break-up fee" (generally about 5% of the purchase price) payable in the event that another buyer is selected as the winning bid.

The sale of a hospital, even in a bankruptcy sale, requires compliance with applicable licensing and regulatory requirements, including state license transfer, change of ownership (CHOW) procedures for Medicare provider agreements, accreditation by the Joint Commission or other accreditation body, transfer of DEA registration, transfer of pharmacy permits, federal and local environmental compliance, compliance with regulations regarding radioactive materials and radiation machines, and compliance with any certificate of need (CON) laws. The sale of a nonprofit hospital to a for-profit entity also requires compliance with state law procedures regarding transfer of charitable assets, usually approval by the state attorney general.

Although governmental authorities can expedite licensing and regulatory approvals, and may wish to do so in order to save a failing hospital, it can nevertheless be difficult to complete the process prior to the Bankruptcy Court hearing on the sale. One possible solution is for the buyer to enter into a management agreement for the hospital, with Bankruptcy Court approval, pending completion of the licensing and approval process. Alternatively, the buyer can opt for a delayed closing of the sale, with court-approved restrictions on operations of the hospital during the pre-closing period.

Although there is no one-size-fits-all template for buying a distressed hospital out of bankruptcy, the process is designed to be flexible and can be tailored to accommodate the needs of the particular hospital and buyer.

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Managing Effective Employment Terminations

Paul Bressan

Oftentimes, companies are compelled to terminate employees who are not performing up to the company's legitimate expectations, and terminated employees are more inclined to resort to wrongful discharge litigation. To minimize the risk of litigation for potential terminations down the road, companies should take the following steps from the inception of the employment relationship:

The Hiring Process
It all begins with the hiring process. If care is not taken at the beginning, mistakes could impact a later termination.

Applications. By now most companies are aware that direct questions asking an applicant's race or age are unlawful. However, other questions also may be seen to elicit similar improper information indirectly. For example, generally asking about membership in organizations, without limiting it to job-related organizations, could elicit information on race, sexual orientation, etc., and asking for dates of graduation could elicit information that correlates with age.

Interviews. Avoid chatting and asking personal questions. Asking a female applicant about her family or plans for children could be seen to suggest a gender/pregnancy bias. Asking about prior workers' compensation claims is unlawful, and might be seen as an indication of bias toward persons with disabilities.

At-Will Employment. If (as in most cases) a company does not want to provide guaranteed employment for a specific period of time or require "cause" for terminations, its applications, offer letters and Employment Agreements (if used) should contain express statements and an agreement by the applicant/employee that the employment is at-will.

Employee Handbook and Personnel Policies
These documents should clearly state that, with the exception of the at-will nature of the employment relationship (and an Arbitration Agreement, if applicable), they do not establish a contract, express or implied, but are meant as guidelines for the employment relationship. The company should weigh the pros and cons of an Arbitration Agreement. Performance evaluations must be honest and accurate, and must reflect the true value of the employee in each of the evaluation categories. Vacation policies must not have unlawful "use-it-or-lose-it" provisions.

Dealing with Employment Issues
Strong policies against discrimination and harassment (including sexual harassment), a complaint process where an employee can get an impartial and full investigation, with appropriate redress, and sexual harassment training (including the mandatory supervisory training, where applicable), are essential.

Companies must make sure that they have the proper wage/hour classifications in place. Treating a non-exempt employee as an exempt employee, or misclassifying an employee as an independent contractor, could have costly repercussions. If these claims do not arise during employment, you can be virtually certain that they will arise (perhaps on a class basis) when a disgruntled employee is terminated.

Leaves of absence deserve particular attention, particularly when they involve a medical condition, a workers' compensation injury or pregnancy. The interplay of various statutes in these types of leave creates a potential legal minefield. With respect to conditions that constitute statutory "disabilities" that impede the employee's ability to work, it is particularly important to engage in an "interactive process" with the employee to determine whether there is a reasonable accommodation that will enable the employee to perform the essential functions of the job without undue hardship to the company. The EEOC has been aggressive with respect to its stance that a company may not have a policy that automatically terminates a disabled employee after a specified leave period (e.g., a year), since this is contrary to the individualized assessment required by law.

Reductions in Force
Companies faced with the necessity of a staff reduction should ensure that they have an objective business reason for the RIF, and for each of the selections for termination in the RIF. Care must be taken to instruct decisionmakers on impermissible criteria in the selection process, such as age, race, national origin, sex, sexual orientation, religion, disability, medical leave status or internal complaints of discrimination or harassment. The company should establish appropriate selection criterion, such as job elimination, performance or seniority (i.e., retaining the more senior employees). Selections based on performance should be consistent with existing performance evaluations.

The company must determine whether there are notification requirements. Federal law (the WARN Act) requires 60 days notice in certain circumstances where 50 employees are affected in a 30- or 90-day period. Some states, including California, also impose notice requirements.

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A Good Way to Give Bad News: Recent Amendment to California's Breach Notification Statute

Julie Simer

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code, or password) , medical information, or health insurance information.

SB 24 amended the Act and added the details of who must be notified, what the notice must say, and where it is to be distributed. Effective January 1, 2012, the notice of breach must be written in plain language and include:

1. The date of the notice;
2. The name and contact information of the reporting person or business;
3. A list of the types of personal information that were or are reasonably believed to have been the subject of a breach;
4. The date or estimated date of the breach or the date range within which the breach occurred;
5. Whether notification was delayed as a result of a law enforcement investigation;
6. A general description of the breach incident; and
7. The toll-free telephone numbers and addresses of the major credit reporting agencies, if the breach exposed a social security number, driver's license, or California identification card number.

At the discretion of the person or business providing the notice, the security breach notification may also include any of the following:

1. Information about what the person or business has done to protect individuals whose information has been breached.
2. Advice on steps that the person whose information has been breached may take to protect himself or herself.

When a single security breach affects more than 500 California residents, a sample notice (not including personal information) must be sent electronically to the Attorney General.

The statute requires the notice be sent in the most expedient time possible and without unreasonably delay. However, the time for sending notice must be consistent with the needs of law enforcement or any measures necessary to determine the scope of the breach and restore integrity to the system.

Notice may be given:

1. In writing;
2. Electronically (provided that the business complies with the "E-Sign Act");
3. By substitute notice (email notice, publication on the website, and notice to the media and the Office of Privacy Protection) if the cost to send the notice is greater than $250,000, the affected class exceeds 500,000 persons, or the business does not have sufficient contact information; or
4. Pursuant to notification procedures as part of the business' personal information security policy.

This statute does not replace other state and federal breach notification statutes. For example, Health and Safety Code section 1280.15 requires a California licensed clinic, health facility, home health agency, or hospice to notify the California Department of Public Health no later than five business days after discovery of a breach of patient information.

The Health Information Portability and Accountability Act of 1996 (HIPAA), as modified by the Health Infomation Technology for Economic and Clinical Health Act (HITECH Act), requires disclosure by a "covered entity" of a breach of unsecured "protected health information" to the affected individuals and to the Secretary of Health and Human Services. A notice that complies completely with the notice content requirements of the HITECH Act will meet the requirements of the Act. Financial institutions in the United States must comply with other federal requirements to develop a response plan and provide notice to consumers in the event of a security breach.

Encryption is one way a business can reduce the odds of a breach that requires notice. Establishing strict company policies on the use of portable devices and downloading is another. Every business should prepare an investigation checklist and designate those persons responsible for gathering information when a breach is suspected. The checklist should include all the information that would be necessary to provide in a notice. Then, executive management, with the assistance of legal counsel, should determine whether the notice is necessary and if so, strictly comply with state and federal law.

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Accountable Care Organizations: The Private Sector Will Lead

Mitchell J. Olejko

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Estimated savings were $15,000,000 over two years. The proposed SSP regulation was published on April 7, 2010. Proposed at the same time were rules and announcements setting the processes and procedures by which ACOs could receive some assurance that their new relationships would not violate antitrust laws, would not have a negative effect upon the tax-exempt status of nonprofit participants, and would not violate the federal anti-kickback and Stark statutes.

After wading through and assessing the proposed SSP regulation, the verdict was clear and was reflected in many of the over 1,200 comments received by the Centers for Medicare & Medicaid Services ("CMS"). Grave concerns were expressed about the complexity of the proposal, the difficulties inherent in the new processes to achieve compliance with other laws, the costs to develop systems that would permit successful participation in the SSP, and the amount of return to be received. Perhaps the most important issues were the freedom given to assigned beneficiaries to receive services from providers who were not members of the ACO and the retroactive assignment of beneficiaries to an ACO, making the ACO responsible for beneficiaries who chose to receive their most complex and expensive care outside of the ACO.

While PPACA requires the SSP to begin on January 1, 2012, the final SSP regulations were only made available on October 20, 2011, and only take effect 60 days after the date of publication of November 2, 2011. As expected, no ACO will begin operations under the SSP on January 1, 2012 and, unless CMS has made great strides in the final SSP regulation to improve the SSP, we believe that it will be of limited importance with few providers electing to participate, certainly not at the earliest possible time.

CMS's attempts to salvage the SSP from universal rejection was reflected in two recent demonstration projects announced by the Center for Medicare & Medicaid Innovation ("Innovation Center").

The first Innovation Center program is the Pioneer ACO Program. "Mature" ACOs may elect to participate in this demonstration project. The stated benefits are that this program is less complex and has greater potential upside returns and lower downside risks than the SSP. Only 30 health systems will be permitted to participate. CMS has not revealed the names of the applicants, although recent reports by Kaiser Health News and Politico Pro indicate that some of the more recognizable names in the industry (Mayo Clinic, Geisinger Clinic, etc.) have decided not to participate in the Pioneer ACO Program and, rather, will continue to participate in the Physician Group Practice Demonstration Project. It appears, however, that a number of notable and successful providers have applied to participate in the Pioneer ACO Program.

The second program announced by the Innovation Center is the Comprehensive Primary Care Initiative. This initiative invites health plans to participate in a demonstration whereby patients covered by private health insurance would participate along with Medicare beneficiaries. If a State Medicaid program participates in this initiative, then CMS would make up to 100 percent of the additional reimbursement available to the States.

This initiative addresses several of the negative reactions to the proposed SSP regulation. There does not appear to be a downside risk to the physicians. The initiative will make additional Medicare payments to participating primary care physicians expected to average $20 per Medicare beneficiary per month to be reduced in years three and four. Moreover, in years three and four, participating primary care physicians will share in a portion of the total Medicare savings in their marketplace.

The variety of private arrangements that are called ACOs is breathtaking and resemble, at first blush, the integrated delivery systems of the 1990s. ACOs, unlike their integrated delivery system precursors, have a greater chance to succeed. ACOs can deploy new systems and tools, including electronic health records, quality programs and best practice approaches, to the hard work of real clinical integration rather than mere structural changes.

Based on our experience, we expect continuing and increasing private activity led by local health care providers and payors who will use these new tools to increase quality and decrease costs, doing what is best for their communities in their marketplaces. We believe that Medicare programs will be effective only to the extent that they positively respond to these developments, as seen in the Innovation Center programs. While the recently announced initiatives by the Innovation Center demonstrate this flexibility, it is uncertain, until the 700 pages of preamble and regulations are fully considered, whether the recently announced final ACO regulations (to be published in the Federal Register on November 2, 2011) demonstrate such flexibility. While the changes touted by CMS certainly reflect responsiveness and flexibility—increased provider sharing of savings, no downside risk in one track, prospective assignment of beneficiaries, increased program focus by reduction of the number of quality measures, and elimination of the EHR requirement, among others—examination of the SSP components that CMS did not change from the proposed regulation, or did not tout, may undercut the initial favorable reviews. For example, CMS has continued its commitment to freedom of beneficiary choice, assigning beneficiaries to an ACO based on the use of primary care service but permitting beneficiaries to choose non-ACO providers for any non-primary care service. 42 CFR § 425.400(b). Despite this gap (and others), CMS may have done enough to entice participation in the SSP—at least by providers who were unwilling to take downside risk.

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To Penalize or Not to Penalize: When are Covenants Not To Compete Enforceable in California?

Richard C. Darwin and Carol K. Lucas

Owners of businesses, whether the businesses are organized as corporations, LLCs or partnerships, frequently agree that they will not compete with the business while they are owners and for a specified period after they cease to be owners. It is also common for the business's governing agreement, whether it be a shareholders' agreement, an operating agreement or a partnership agreement, to permit the forced repurchase of an owner's interest in the event that the covenant not to compete is violated. When the repurchase price represents the fair value of the membership interest, non-competes of this sort do not present a problem. However, where a business seeks to punish an owner by forcing him to sell the interest back at a penalty price, i.e., one that does not take goodwill into account, and simultaneously seeks to enforce a non-compete, it runs afoul of California law.

Non-compete agreements are void as a matter of public policy in California, but there are a few limited exceptions to the general rule. Generally, under §16601 of the Business and Professions Code, "any person who sells the goodwill of a business, or any owner of a business entity selling or otherwise disposing of all of his or her ownership interest in the business entity," may agree with the buyer to refrain from carrying on a similar business within a specified geographic area. The term "business entity" is defined to include a partnership, a limited liability company or a corporation.

In order for the covenant to be enforceable following repurchase of the interest, both the ownership and the sale must be bona fide. In *Hill Medical Corporation v. Wycoff* (2001) 86 Cal.App.4th 895, the Court of Appeal held that a covenant not to compete was unenforceable against a selling shareholder if the shareholder does not receive value for the goodwill that is attached to his shares. In *Hill v. Wycoff*, Dr. Wycoff was a shareholder in a radiology group in Pasadena that had fourteen shareholders. The shareholders were all party to a redemption agreement that required them to sell their shares back to the corporation at a price measured by tangible book value of the corporation (without goodwill). Dr. Wycoff left the group and sold his shares for book value. The group sought to enjoin him from competing within the 7.5 mile noncompete radius. The trial court held the restriction unenforceable. The Court of Appeal affirmed, holding that a sale that did not pay an owner the fair market value of the interest, including the value of the goodwill of the business, did not satisfy the exception in §16601, and was unenforceable.

The *Wycoff* case involved a corporation, but the principle is equally applicable to LLCs and partnerships because they are included in the definition of the term "business entity." Similarly, its reach is not limited to medical practices. Most ambulatory surgery center governing documents, for example, require an owner to redeem his interest if he violates the covenant not to compete. Often, the price paid for interests purchased as a result of competition or other "adverse" events represents a discount from the price that would otherwise be payable, whether determined by an appraisal or the application of a formula. Under the rule of *Hill v. Wycoff*, there is significant question regarding whether such a transaction could support a noncompete under California law. For example, an ASC operating agreement may provide that upon termination of a membership interest, the interest is repurchased at a price equal to three times the ASC's trailing 12 month EBITDA, a price intended to represent the fair market value of the interest and to obviate a need for appraisal. The same operating agreement may prohibit ownership of another facility within 10 miles of the ASC, and may make such ownership an adverse terminating event. However, for members who compete, the price is fifty percent (50%) of the formula price. If four times EBITDA represents fair market value, then two times EBITDA cannot represent fair market value. Does the exception in §16601 apply in this instance? It should not. The analysis is even starker if the penalty price is based on book value (as it was in the *Wycoff* case) or on capital account balance, which is frequently nominal in mature surgery businesses.

These issues should be considered at the outset of a business, when the governing agreements are put into place. The question is which is more important: punishing a "rogue" owner or being able to enforce a covenant? Most remaining owners find it galling to pay a breaching owner the full fair market value of his interest, but if the covenant is important they must do so.

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Managing Effective Employment Terminations
Paul Bressan

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The company should consider providing severance packages to employees who are terminated in a staff reduction, in return for their execution of a Severance Agreement that contains a General Release. The costs of helping employees in their transition should be considered as a way of avoiding the higher costs of lawsuits from terminated employees.

The Termination Process

After progressing with care from the hiring process through the entire period of employment, a company should consider the following as it moves toward terminating an employee:

- Is termination warranted? Did the company follow progressive discipline? Did the company give the employee a chance to tell his or her side of the story, such as where the termination is for alleged misconduct?
- Does the company have proper documentation supporting the termination? Are the performance evaluations consistent with the termination? Are there documents that are inconsistent with the termination decision?
- Is termination consistent with the treatment of other employees?
- Should the company offer the employee a Severance Agreement?

When terminating an employee, the company should note and do the following:

- California law requires payment of wages due on the day of termination (within 72 hours for a resignation). This includes payment for accrued but unused vacation. Generally speaking, deductions (apart from the normal deductions) may not be made from the employee's final paycheck.
- Take steps to cut off the employee's access to the company's email and computer systems, and to retrieve any confidential information and equipment in the employee's possession. Conversely, make arrangements to return the employee's personal belongings.
- Conduct an Exit Interview where appropriate.
- Have a company policy in place for neutral references (i.e., dates of employment, position at termination, and confirmation of salary if requested in writing), and follow it.
- Treat the employee with dignity and respect in the termination process. It is not just what you do, but how you do it. For example, unless there is some special justification, do not have a security guard escort the employee out of the building in front of the other employees.

There is no sure-fire way to avoid employment litigation when terminating an employee, particularly in the litigious climate in California. However, following the steps outlined above will minimize the risk of litigation, and will put your company in the best position to defend itself if the terminated employee chooses the litigation path.

Paul Bressan is a Shareholder in the Los Angeles office, and Chair of the firm's Labor & Employment Practice Group. He can be reached at 213.891.5220 or pbressan@buchalter.com.

Buchalter Nemer welcomed two new Shareholders—Mitchell Olejko and Julie Simer—to its Health Care Practice Group last month. To better introduce our new Firm members, we sat down with them and asked about their practices.

MITCHELL J. OLEJKO
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Mitchell Olejko

BN: Where did you begin your practice?
Olejko: I started out in Seattle, WA as a tax lawyer representing foundations and nonprofits, doing a lot of tax-exempt organization work.

BN: How did you get into the health care field?
Olejko: When I began practice, hospitals were mostly nonprofit tax-exempt corporations, so it was a natural transition. My firm represented two of the major health care providers in the region. I was pulled in to serve as a tax advisor and later became Chair of the Health Care Practice Group the firm had formed to serve those clients. I did less and less tax exempt work and more corporate work. As health care became the highly regulated industry it is today, client's needs changed and my practice changed to meet that need.

BN: What came next?
Olejko: I became Senior Vice President and Chief Legal officer for Legacy Health System in Portland. I was there for six years.

BN: What brought you to San Francisco?
Olejko: There was a change in management at Legacy, so I decided to take the opportunity to do something new. I moved to Morrison & Foerster, then Ropes & Gray, doing transactional health care work.

BN: What do you like most about your health care practice?
Olejko: The clients I get to work with.

BN: Nice. What do you enjoy doing beyond the firm?
Olejko: I enjoy live music and literary events.

JULIE SIMER
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Julie Simer

BN: Where did you begin your practice?
Simer: I started out as a judicial law clerk for six trial court judges in Iowa. Following the clerkship, I moved to Arizona and joined the Maricipopa County Attorney's Office in the Narcotics and Organized Crime Unit. Then, I became an Assistant Attorney General in the Arizona Attorney General's licensing division. This regulatory and statutory enforcement experience has been invaluable in the practice of health law, a highly-regulated industry.

BN: Tell us about your transition to health care law.
Simer: I moved to a civil practice and became a named partner at the Phoenix law firm of Kahn Freeman & Laforge, LLP. My last name at the time was LaForge. The firm handled civil litigation and bankruptcy. When one of my partners retired, the remaining partner and I severed the bankruptcy and collection practices; and I operated the collection practice as a sole practitioner in Arizona until 2002.

BN: What brought you to California?
Simer: I was doing a large volume of work for Syndicated Office Systems (SOS), a subsidiary of Tenet Health Systems. At the time, Tenet was the second-largest private hospital system in the United States. I handled self-pay litigation for Tenet hospitals in Arizona, and SOS asked me to obtain a California license to do the same work for their California hospitals. Eventually, I accepted a position in the managed care litigation department of Tenet Health System and moved to California to work in the Santa Ana, California office. I left Tenet in 2004 to return to private practice. Since then, I became a partner at the Enterprise Counsel Group in Irvine, California, and have concentrated on health care issues for providers. I continue to represent clients in Arizona and California, particularly with respect to fraud & abuse regulations, privacy issues, and managed care contracting.

BN: What do you enjoy most about your practice?
Simer: My ability to troubleshoot. My clients need solutions that are both legally sound and make good business sense. My combination of skills, having been a litigator and having worked on the inside in a corporate legal department, helps me see things from the client's perspective. They appreciate that I'm able to offer a practical business solution to their legal problems.

BN: What do you enjoy doing beyond the firm?
Simer: I'm an outdoors person, so I love living in California. I enjoy sailing, and both mountain and road biking. I also enjoy photography, and I have exhibited my photographs as part of local arts programs.

BN: Anything you want to add?
Simer: Two of our Practice Group's Shareholders, Carol Lucas and Mitch Olejko, are past chairs of the Health Law Committee of the CA State Bar Business Law Section, and I am the current chair. I think it is a great honor serve in this important leadership role, and I look forward to an exciting year with health care at the forefront of national attention.

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SIDEBAR

PATIENT CARE OMBUDSMAN: A NEW ROLE IN HEALTH CARE BANKRUPTCY CASES

RANDYE SOREF AND BRIAN HARVEY

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 implemented certain amendments to the Bankruptcy Code that govern the operation of health care businesses while in bankruptcy. One significant modification is the creation of a Patient Care Ombudsman ("PCO"). The PCO is an independent professional appointed by the U.S. Trustee, who is charged with the duty to monitor the quality of patient care provided by debtor health care businesses.

There are a number of requirements the PCO must follow once appointed, making it is advisable for a PCO to retain bankruptcy counsel to help navigate the procedural complexities. For instance, the PCO must formally report findings regarding the quality of patient care to the Bankruptcy Court every 60 days, and if the PCO finds that the quality of patient care is "declining significantly," the PCO must immediately report such a decline in writing. Despite this directive, the Bankruptcy Code does not automatically grant the PCO authority to review patient records. Rather, upon appointment the PCO must petition the Bankruptcy Court for authority to review patient records. In granting such authority, the judge is required to impose restrictions on the PCO to ensure patient confidentiality.

The law governing the appointment of a PCO is new and evolving. As more healthcare business bankruptcy cases are filed, it is anticipated that the PCO's role will grow and become better defined.

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