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CORPORATE TRANSACTIONS

Hospital Merger Did Not Qualify for Medicare Reimbursement When Transaction Lacked Reasonable Consideration and Selling Hospital Did Not Attempt to Obtain Fair Market Value.

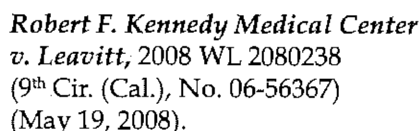
The Ninth Circuit Court of Appeals affirmed a district court summary judgment and upheld a decision by the Secretary of Health and Human Services ("HHS") denying Medicare reimbursement for depreciation losses resulting from disposal of assets, including buildings and equipment, through the statutory merger of two hospitals. The Court held that the merger did not qualify as a "bona fide sale" warranting reimbursement because the transaction lacked reasonable consideration and the selling hospital did not attempt to obtain fair market value for its assets.

Robert F. Kennedy Medical Center ("RFK") and St. Francis Medical Center ("St. Francis") were separate, non-profit hospitals. The hospitals negotiated a merger and agreed that RFK would merge into St. Francis. As the surviving corporation, St. Francis changed its name to Catholic Healthcare West Southern California ("CHW-SC"). RFK transferred assets with a value of approximately $50 million in exchange for $30.5 million in consideration from CHW-SC. RFK then filed a terminating cost report with Medicare's fiscal intermediary, claiming the merger resulted in a reimbursable loss from RFK's disposal of depreciable assets.

The fiscal intermediary audited RFK's cost report and denied the claim, the primary reason being that the merger was not a "bona fide sale" under 42 C.F.R section 413.134(f)(2). RFK appealed to the Provider Reimbursement Review Board ("PRRB"), which reversed the fiscal intermediary's decision. The PRRB concluded the merger qualified as a "bona fide sale" because RFK determined on its own initiative whether or not it should affiliate with another hospital and because RFK considered merger proposals from other parties. The CMS Administrator for HHS reversed the PRRB's decision, finding the $20 million disparity between asset value and purchase consideration reflected the lack of arm's length bargaining, and thus was not a "bona fide sale."

RFK appealed to the district court, which affirmed the HHS decision, deferring to HHS' interpretation of the Medicare regulations. RFK appealed. The Court of Appeal agreed with the district court, finding the HHS interpretation of a "bona fide sale" under the Medicare regulations was reasonable. The Court found that substantial evidence supported the HHS decision because: 1) the $20 million disparity showed the transaction lacked reasonable consideration; and 2) RFK did not attempt to obtain fair market value for its assets. The Court affirmed the district court decision.

Robert F. Kennedy Medical Center v. Leavitt, 2008 WL 2080238 (9th Cir. (Cal.), No. 06-56367) (May 19, 2008).



FALSE CLAIMS ACT

Claims for Whistleblower Retaliation and Wrongful Termination Under the False Claims Act Do Not Require the Heightened Pleading Requirements of Fraud.

The Ninth Circuit Court of Appeals reversed and remanded a district court order dismissing a lawsuit that alleged wrongful termination and whistleblower retaliation under the False Claims Act. The suit was brought by a nurse who was terminated from her position at Centinela Hospital Medical Center ("CHMC" or the "hospital"). The Court held that a claim for wrongful termination and whistleblower retaliation under the False Claims Act differs from a traditional fraud claim under the False Claims Act and, therefore, does not require the heightened pleading standard reserved for claims of fraud.

Plaintiff Marie Bernadette Mendiondo brought state and federal wrongful termination and whistleblower retaliation claims against CHMC when the hospital terminated her nursing position. Nurse Mendiondo, who claims she had previously informed hospital executives of several quality of care violations and false claims, alleged she was wrongfully terminated and retaliated against in violation of the federal False Claims Act ("FCA") (31 U.S.C. § 3730(h)), the California False Claims Act ("CFCA") (Govt. Code § 12653(b)), and California Health and Safety Code § 1278.5 (prohibiting retaliation for reporting unsafe patient care conditions).

The hospital moved to dismiss the complaint, arguing that a claim under the FCA necessarily involves fraud, and must therefore be plead with the heightened requirements of specifically identifying the fraud. The trial court agreed with the hospital and dismissed the complaint. Plaintiff appealed.

The Court of Appeal found that a traditional claim under the FCA must meet the heightened pleading requirements of fraud, but the Court distinguished a traditional FCA claim from a wrongful termination or whistleblower retaliation claim brought under the FCA. The elements differ for a traditional FCA claim and a FCA retaliation claim, the Court explained, and the latter does not require specific allegations of fraud. A plaintiff alleging a whistleblower retaliation claim under the FCA must show three elements, namely that : (1) the plaintiff engaged in activity protected under the statute; (2) the employer knew the plaintiff engaged in protected activity; and (3) the employer discriminated against the plaintiff because she engaged in protected activity.

The Court found plaintiff's complaint met the pleading standard because: (1) it contained examples of potentially false billing and reimbursement practices and substandard patient care; (2) it indicated Nurse Mendiondo complained to the hospital's CEO and supervisor about these issues; and (3) it explained that the hospital terminated her because of these complaints. Such allegations, the Court found, sufficiently notified the hospital of the factual basis for each of Nurse Mendiondo's whistleblower retaliation and wrongful termination claims. The Court reversed and remanded the case to the trial court.

Mendiondo v. Centinela Hospital Medical Center, 521 F.3d 1097 (9th Cir. (Cal.), No. 06-55981) (April 1, 2008).

LABOR RELATIONS

Hospital's Ban on Nurse "Safe Staffing" Union Buttons Constituted Unfair Labor Practice.

The Ninth Circuit Court of Appeals granted a petition for review filed by a labor union, challenging a decision by the National Labor Relations Board ("NLRB"). The NLRB held that a hospital's ban on nurse "safe staffing" union buttons did not constitute an unfair labor practice. The hospital's ban, implemented during negotiations with a nurses union for a new collective bargaining agreement, prohibited nurses from wearing buttons that stated "RNs Demand Safe Staffing" in any areas where nurses might encounter patients. The hospital argued the buttons created a risk that patients would believe the hospital was understaffed and that the quality of care was substandard. The Court noted that the buttons had been worn for several months prior to the ban, without incident, and concluded the NLRB ruling was not supported by substantial evidence. The Court granted the petition and remanded the case to the NLRB.

Washington State Nurses Association v. National Labor Relations Board, 2008 WL 2096970 (9th Cir. (Wash.), No. 06-74917) (May 20, 2008).

MICRA

Unlicensed, But Registered, Social Worker is a Health Care Provider for Purposes of MICRA's Damages Cap.

The California Court of Appeal affirmed a trial court's summary judgment against a plaintiff who brought a negligence action against Sutter Health Central (the "hospital") and one of its employees, an unlicensed but registered social worker. The Court held that the social worker was a "health care provider" under the Medical Injury Compensation Reform Act ("MICRA"), even though she was not licensed. Thus, the social worker could avail herself of MICRA's cap on noneconomic damages.

Plaintiff's mentally ill father received treatment at the hospital. The hospital's social worker who cared for plaintiff's father was registered with the Board of Behavioral Science, but was not licensed (she was working toward licensure). After the hospital discharged plaintiff's father, he committed suicide. Plaintiff, along with her family members, filed suit alleging the hospital and its employed social worker were negligent in the care provided to her mentally ill father. Plaintiff claimed the hospital should not have discharged her father and also claimed the social worker was negligent in failing to disclose she was unlicensed. Plaintiff sought damages above the MICRA cap, arguing the unlicensed social worker did not qualify as a "health care provider" under MICRA. The hospital filed a motion for summary judgment, arguing that the MICRA cap applied. The trial court agreed with the hospital and entered summary judgment. Plaintiff appealed.

The Court of Appeal affirmed the trial court's decision. The Court ruled that an unlicensed social worker, registered with the appropriate agency and working toward licensure, is a "health care provider" rendering "professional services" under MICRA and, accordingly, the noneconomic damages cap applied. The social worker's failure to disclose this did not bring her outside the definition of "health care provider" under MICRA.

Prince v. Sutter Health Center, 161 Cal. App. 4th 971 (Cal. App. 3 Dist., No. C052530) (April 4, 2008).

REIMBURSEMENT

Teaching Hospital's Indirect Medical Expense Payment Based on Actual Number of Beds, Rather than Budgeted Beds.

The Ninth Circuit Court of Appeals affirmed a district court summary judgment and upheld a decision by the Secretary of Health and Human Services ("HHS") that used the actual number of beds at a teaching hospital, rather than the budgeted number, as the basis for calculating the hospital's additional, indirect costs of medical education payment ("IME adjustment"). The Court held that HHS' interpretation was reasonable and consistent with the purpose of the IME adjustment and the rules in the Provider Reimbursement Manual.

Under Medicare's prospective payment system ("PPS"), teaching hospitals are entitled to an IME adjustment payment to cover the added, indirect costs of medical education. The amount of the IME adjustment is based on a hospital's ratio of interns/residents to available beds. Simply stated, the higher the number of beds at a teaching hospital, the lower the eventual Medicare payment and vice versa.

Los Angeles County/University of Southern California Medical Center (the "hospital") had used budgeted beds when calculating its IME payment since 1986. In 1994, its Medicare intermediary, Blue Cross and Blue Shield Association ("Blue Cross"), determined the cost report understated the number of beds physically available in the hospital and increased the count by 123 beds. The hospital appealed the decision to the Provider Reimbursement Review Board ("PRRB"), which concluded that Blue Cross' decision was proper in light of the Medicare regulations. The PRRB found the number of budgeted beds was not an absolute maximum for the hospital because, with 123 additional actual beds, more patients (than the number of budgeted beds) could be treated on any given day. The hospital appealed to the Secretary of Health and Human Services ("HHS"), which denied review and accepted the PRRB decision as a final ruling. The hospital sought review in district court, which granted summary judgment in favor of HHS. The hospital then appealed to the Ninth Circuit Court of Appeals.

On appeal, the hospital argued: 1) it was arbitrary and capricious for HHS to move from using budgeted beds to using physical beds without explanation; and 2) it was arbitrary and capricious for HHS to reject budgeted beds in favor of a physical bed count. The Court of Appeal noted the parties' disagreement boiled down to whether the IME calculation should be staff-driven or size-driven. Put another way, the dispute turned on whether beds are a proxy for the number of patients (as argued by the hospital) or whether beds are a proxy for the number of physicians. HHS argued that a hospital's size is what relates most to its teaching load and, therefore, the best measure of size is the actual number of beds maintained for patient use. The Court found HHS' interpretation was reasonable and consistent with the purpose of the IME adjustment and the rules in the Provider Reimbursement Manual. The Court affirmed the district court decision.

County of Los Angeles v. Leavitt, 521 F.3d 1073 (9th Cir. (Cal.), No. 06-55222) (March 31, 2008).

CMS Hospital Funding Rule Vacated and Remanded Because It Was Issued in Violation of Congressional Prohibition.

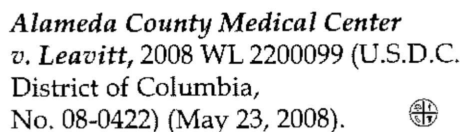
A coalition of hospital groups, led by the National Association of Public Hospitals and Health Systems ("NAPH"), the American Hospital Association ("AHA") and the Association of American Medical Colleges ("AAMC") filed suit in federal court, seeking to prevent the implementation of a proposed Centers for Medicare and Medicaid Services ("CMS") rule that would cut funding for public hospitals by $5 billion over five years (CMS 2258-FC, "Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership"). The District Court found that the Department of Health and Human Services ("HHS") issued the CMS rule despite clear Congressional intent prohibiting the rule.

Originally proposed on January 18, 2007, and released on May 25, 2007, (published May 29, 2007 in 72 Fed. Reg. 29748) as a final rule with a comment period, the rule narrows the definition of a "public health care provider" and limits reimbursement to the cost of treating Medicaid patients. The final rule was slated for a July 30, 2007 effective date. However, Congress prevented the rule from going into effect with a one-year legislative moratorium, which expired on May 25, 2008. Despite Congress' action, during the moratorium period, HHS prioritized the CMS rule, proposed it for consideration, solicited comments on the rule, and issued a final version the day the moratorium expired.

Seeking an injunction to prohibit HHS from implementing the rule, the hospital groups challenged the rule on three grounds: (1) the rule defines "units of government" far more narrowly than is permitted under current law and severely restricts options for states to finance the non-federal share of their Medicaid program expenditures; (2) HHS lacks authority to limit Medicaid payments to public providers to cost-based only while continuing to allow private providers to be paid under a different methodology because a cost limit imposed solely on governmental hospitals is counter to clear Congressional intent; and (3) the Congressional moratorium signed by the President on May 25, 2007, effectively prevented HHS from issuing a final rule the same day.

The Court declined to rule on the first two substantive arguments and instead hung the decision on the third. The Court characterized HHS' procedural violation as "a maneuver by the Executive Branch deliberately designed to outfox a clear directive by Congress." The Court found that HHS violated the Congressional one-year moratorium when HHS published the draft rule and solicited comments. The remedy when a rule has been improperly promulgated, noted the Court, is to vacate the rule and remand the matter to the agency. Thus, the Court vacated and remanded the rule to CMS. CMS released a statement that it is reviewing the decision, but stressed the Court did not rule on plaintiffs' substantive arguments against the CMS rule.

Alameda County Medical Center v. Leavitt, 2008 WL 2200099 (U.S.D.C. District of Columbia, No. 08-0422) (May 23, 2008).



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