HOOPER LUNDY & BOOKMAN, INC.
HEALTH LAW PERSPECTIVES

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Court Rules in Favor of Hospital Directors Charged in $10 Million Lawsuit

In a closely watched case in which the volunteer directors of a nonprofit hospital board were personally sued for the financial failure of a Los Angeles-area hospital, a U.S. District Court recently ruled that directors were entitled to summary judgment based on the "business judgment rule." The court also held that the directors were entitled to rely upon information and advice from the hospital's officers and outside counsel in discharging their fiduciary duties.

The case involved members of the board of directors of now-defunct Granada Hills Community Hospital, who were individually charged with negligence and breach of fiduciary duty in a $10 million lawsuit filed by David Gottlieb, Chapter 7 bankruptcy trustee, in June 2004 (*Gottlieb v Hicks*, Los Angeles County Superior Court, No. BC317818).

"This case highlights the potentially enormous personal liability that members of nonprofit boards of directors face," said HLB attorney Cary Miller who, along with HLB attorney Blake Jones, defended the Granada Hills directors. "Hopefully, this result will deter future lawsuits against well-meaning individuals who volunteer their time to serve on non-profit hospital boards."

The directors assumed their roles on the board in October 2002. Within a few weeks, the hospital was forced into Chapter 11 bankruptcy due to financial problems beyond the control of the new directors. Bankruptcy counsel recommended that the board retain a "turn-around company" to operate and manage the hospital during its reorganization. The board ultimately selected a Florida-based company, Healthcare Resource Specialists, Inc. (HCRS), which was approved by the bankruptcy court in January 2003. HCRS' representatives were installed as the Chief Executive Officer and Chief Financial Officer of the hospital. HCRS' responsibilities also included billings, collections and administration of accounts receivable.

The hospital initially did well under HCRS' management. However, the hospital's financial condition began to deteriorate in the spring of 2003 while the hospital's CEO was advising the directors that the hospital's financial condition was improving. Within six months of recommending the hiring of HCRS, the hospital converted from Chapter 11 bankruptcy to Chapter 7 when the directors discovered that $1.2 million in payroll taxes had not been paid and the hospital did not have sufficient cash to keep its doors open.

At the core of the trustee's lawsuit was the allegation that the directors failed in their responsibility to the hospital and its creditors, and specifically that the directors failed to make reasonable inquiries and investigation. Specifically, the directors were charged with negligence and breach of fiduciary duty by:

- Recommending and hiring HCRS without conducting reasonable due diligence.
- Delegating to HCRS the hospital's billing and collection activities despite the fact that HCRS had never

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done this work for this type of facility and lacked resources, equipment and expertise.

- Failing to ensure that HCRS obtained the systems and personnel to adequately perform the hospital's billing and collection.
- Allowing HCRS to be paid on an interim basis without verifying whether HCRS had generated sufficient revenue to warrant the payments.
- Allowing interim payments to be made to HCRS in lieu of obligations owed to critical vendors, payment of payroll taxes and payment of certain employee benefits.
- Continuing to allow HCRS to manage the hospital and administer its receivables despite substandard performance by HCRS.
- Failing to take reasonable and appropriate steps to stem the mounting cash flow and operating losses sustained by the hospital.

In its successful motion for summary judgment, HLB argued that the directors received regular reports including financial information and operational results from hospital officers and bankruptcy counsel. "Based on that information, the directors made decisions and took steps they believed were appropriate and in the hospital's best interests," Mr. Miller said. "In the absence of substantial evidence to the contrary, the directors' decisions were protected by the 'business judgment rule' which allowed the directors to rely on the information provided by the hospital's officers and bankruptcy counsel in making decisions."

The case continues against the hospital's officers. Trial is scheduled in December 2006.

For more information, please contact Mr. Miller or Mr. Jones in San Diego at 619.744.7300, Glenn Solomon in Los Angeles at 310.551.8179 or Scott Kiepen in San Francisco at 415.875.8510.

Reagan to Head AHCA Legal Subcommittee


Mark E. Reagan

HLB is pleased to announce that firm principal, Mark E. Reagan, has been appoint-ed Chair of the Legal Subcommittee for the American Health Care Association (AHCA).

AHCA is a non-profit federation of affiliated state health organizations, together representing more than 10,000 non-profit and for-profit assisted living, nursing facility, developmentally-disabled, and subacute care providers that care for more than 1.5 million elderly and disabled individuals nationally.

Mr. Reagan is the managing partner and a litigator in the firm's San Francisco office and he currently serves as General Counsel to the California Association of Health Facilities, the trade association primarily serving long-term care facilities in California.

His practice is devoted to counseling, litigation and trial and appellate work, before administrative agencies and all courts, with an emphasis on health care issues, including long-term care, managed care, health care fraud and elder abuse, licensing and certification, Medicare and Medicaid, false claims, anti-trust, unfair competition, workers' compensation reimbursement, risk management and corporate compliance. He frequently testifies before the California State Legislature on these and other health-related matters and assists clients with legislation and regulatory enactments.

Mr. Reagan may be contacted at 415.875.8501.

Emerging Medicare Part D Issues

By Felicia Sze

On January 1, 2006, Medicare Part D prescription began offering voluntary prescription drug insurance to Medicare beneficiaries. Beneficiaries who choose to participate will select either a qualified prescription drug plan (PDP), a Medicare Advantage or other Medicare health plan that offers drug coverage. A PDP is a drug-only insurance benefit offered by a private entity licensed to offer health insurance under state law that has a valid contract with the Centers for Medicare and Medicaid Services (CMS).

The following is a summary of some of the key issues that have arisen with the implementation of Medicare Part D:

The "Donut Hole"

Each PDP offers a different formulary of drugs with different costs and premiums, but each plan must meet certain minimum requirements (standard coverage): after a $250 deductible, the PDP must pay at least 75% of costs from $250 to $2,250, and then 95% of costs once a beneficiary has spent $3,600 out of pocket. The lack of coverage for drug spending between $2,251 and $5,100 is referred to as the "donut hole," where the beneficiary must cover all drug costs. Some PDPs offer enhanced alternative coverage which may consist of the coverage of drugs in all or part of the "donut hole." The PDPs' negotiated prices for covered drugs are available to the beneficiary regardless of whether the beneficiary pays for the drug directly.

Medicare Part A and/or B and Part D Coverage

Medicare Part D covers drugs which are available by prescription,

approved by the Food and Drug Administration, used and sold in the United States and prescribed for medically-accepted indications. Excluded from the Part D program are drugs that may be excluded under Medicaid and drugs for which coverage is available under Medicare Part A or Part B, as it is being prescribed and dispensed or administered.

Typically, the payment for drugs under Part A is bundled into the Part A payment to hospitals for inpatient stays or skilled nursing facilities. Exceptions are clotting factors for hospital inpatient stays and chemotherapy drugs and preventive injections at skilled nursing facilities which are paid separately by Part A.

If a beneficiary does not have Part A, if Part A coverage for the stay has run out or if a stay is non-covered, hospitals and skilled nursing facilities may be paid for most categories of Part B covered drugs. Generally, Part B covers drugs furnished incident to a physician's service, i.e., that are not usually self-administered (by more than 50% Medicare beneficiaries). Other categories of drugs covered by Part B are: separately billable ESRD drugs, separately billable drugs provided in hospital outpatient departments, durable medical equipment supply drugs, drugs covered as supplies, drugs used in immunosuppressive therapy, blood clotting factors, certain vaccines, antigens, parenteral nutrition, certain oral drugs used in cancer treatment, separately billable drugs provided in comprehensive outpatient rehabilitation facilities, and intravenous immune globulin provided in the home.

Generally, when a Part D plan is billed for a drug covered by Part A or Part B, the Part D plan should not deny payment based upon coverage under Part A or Part B. A Part D plan also cannot require that coverage be denied under Part A or Part B before making payment under Part D, subject to some exceptions. However, if the drug is actually covered under Part A or Part B and the Part D plan has paid for the drug, the Part D plan will seek recovery from the billing entity, which should bill Part A or B instead.

Dual Eligible Beneficiaries

The transition to Medicare Part D has been less than smooth. Medicare Part D covers the cost of prescription drugs for dual eligible Medicare/Medicaid (Medi-Cal in California) beneficiaries. When some dual eligible beneficiaries failed to sign up for PDPs, they were automatically assigned to PDPs. Some dual eligibles were not listed in computer databases when they attempted to purchase their drugs while others were told that they would have to pay amounts for drugs that they could not afford. Still others found that their formularies would not cover certain procedures or that their neighborhood pharmacists had not contracted with their assigned PDP. In response to issues that dual eligibles faced, over twenty states, including California, have agreed to temporarily resume paying for prescription drugs for dual eligibles on an emergency basis. CMS announced on January 24, 2006, that it would reimburse states that pay for prescription drugs that should have been covered under Part D.

The maintenance of effort provision (the "claw-back" provision) requires states to pay the federal government a substantial portion of the calculated savings that the state is expected to realize for no longer providing a pharmacy benefit under Medicaid for dual eligibles. This is the first time states will be required to help finance a Medicare benefit. For 2006, this "claw-back" is estimated to cost California an extra $70 million annually.

Issues for Long Term Care Facilities

Long term care (LTC) pharmacies can only be reimbursed by Part D for prescription drugs if they contract with a Part D plan. Part D plans are required to contract with any pharmacy willing to participate in its LTC pharmacy network so long as the pharmacy is capable of meeting certain minimum performance and service criteria (and relevant state laws governing the practice of pharmacy in the LTC setting) and any other standard terms and conditions established by the plan for its network pharmacies. If, however, a resident has not selected a Part D plan that contracts with a LTC facility's pharmacy, that pharmacy cannot be reimbursed by Part D for drugs provided to that resident. LTC facilities should provide assistance (provision of objective information) to residents if the residents need assistance, but they are prohibited from actively steering residents' selection of plans.

Obviously the Medicare Part D Drug Program implementation is complicated and rocky. Providers may find they are not being paid timely or properly. If you have any questions or need additional information about Part D, please contact Felicia Sze at 415.875.8503.

HLB Attorneys Named Super Lawyers

Eight HLB attorneys have been 2006 Super Lawyers in the January edition of *LA Magazine.* Attorneys are selected through a polling process conducted by *Law & Politics.* This year's honorees include Robert Lundy, Patric Hooper, Lloyd Bookman, John Hellow, Bradley Tully, Byron Gross, Cary Miller, and Linda Kollar.

CALENDAR

March 8 **California Hospice Foundation 2006 Spring Conference, Berkeley.** HLB Attorney Jodi Berlin presents *Preparing for Medicare Audits: Tips to Avoiding Disaster.*

March 22-24 **AHLA Annual Medicare and Medicaid Payment Institute, Baltimore.** HLB Attorney Jon Neustadter presents Bad Debt and Waiver of Copayments; HLB Attorney John Hellow presents a Medicare Litigation Update. HLB Attorney Lloyd Bookman moderates a PRRB panel discussion.

April 23-26 **HCCA 10th Annual Compliance Institute,** Las Vegas. HLB Attorney Elspeth Delaney co-presents *Sarbanes-Oxley: Best Practices for Private and Nonprofit Health Care Entities;* HLB Attorney Mark Hardiman presents *Current OIG Enforcement Initiatives: A Road Map for High Risk Compliance Areas.*

April 25 **Meds/PDN.** HLB Attorney Linda Randlett Kollar co-presents *Behavioral Health and the Law,* San Francisco.

May 7 **California Society of Healthcare Attorneys Spring Seminar.** HLB Attorney Elizabeth Saviano speaks on *Primary Care Access for Vulnurable Populations.*

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