ARE CHARGE NURSES SUPERVISORS? SIXTH CIRCUIT DECISION IS CAUTIONARY TALE FOR EMPLOYERS

Over the past decade, the status of the charge nurse has been the subject of a great deal of uncertainty under the National Labor Relations Act (the Act). The key question has been whether a charge nurse is a "supervisor" under the Act, and thus does not have the right to engage in concerted activity under Section 7 of the Act.

This uncertainty has real consequences for healthcare employers. Some employers may be reluctant to invest charge nurses with any real authority due to concern that charge nurses may one day be part of a bargaining unit. This can affect operating efficiency -- and patient safety. Most importantly, these half-measures will not work. As a recent decision of the U.S. Court of Appeals makes clear, through their policies and practices, employers must definitely and affirmatively vest charge nurses with supervisory authority or not do so at all.

In Frenchtown Acquisition Company v. NLRB, 683 F.3d 298 (6th Cir. 2012), the Court of Appeals for the Sixth Circuit rejected the employer's claim that charge nurses at a long-term care and rehabilitation facility were supervisors. The court’s detailed decision reviewed eight separate supervisory actions related to discipline, hiring and giving work assignments. In each case, the court agreed with the National Labor Relations Board (NLRB) that the employer’s evidence was insufficient to prove supervisory status.

Under the express language of the Act, a supervisor must perform any of the following specifically enumerated duties:

- Hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward or discipline other employees;
- Responsibly direct other employees;
- Adjust employee grievances; or
- Effectively recommend any of these actions.

In addition, a supervisor must exercise the authority to perform these duties in the interest of the employer, and, most importantly, an employee claimed as a supervisor must use “independent judgment.” See 29 U.S.C. § 152 (11); NLRB v. Kentucky River Community Care, Inc., 532 U.S. 706, 712-612 (2001).

An employee exercises "independent judgment" when he or she may take or effectively recommend action "free from the control of others and form an opinion or evaluation by discerning and comparing data." In re Oakwood Healthcare, Inc., 348 NLRB 686, 692-693 (2006). Merely following company policies or rules, verbal instructions from a supervisor or other higher authority or a collective bargaining agreement will not suffice. Id.

The court’s analysis in Frenchtown should serve as a cautionary tale for long-term care and acute care facilities. First, job descriptions alone were inadequate to
establish supervisory status. The NLRB (and the court) delved into actual practice to determine what duties charge nurses actually performed.

The bottom line is that claimed supervisory authority must be backed up in writing and in practice. If, for example, an employer claims that charge nurses are dispensing discipline, then employee personnel files should contain written warnings or other notices of discipline signed by charge nurses.

Second, written policies (including collective bargaining agreements) or practices may negate claimed supervisory status. In Frenchtown, the employer argued that in-service counselings delivered by charge nurses were disciplinary in nature (or part of the discipline process). However, the collective bargaining agreement for nurse’s aides did not allow aides to have union representation with them when they received an in-service. The NLRB and the court concluded that this was evidence that in-services were educational and not disciplinary in nature.

Third, the supervisory duties must entail the exercise of independent judgment. Thus, in Frenchtown, transferring aides to ensure adequate staffing levels was not considered an exercise of independent judgment, even though the ability to transfer employees is one of the enumerated supervisory duties under the Act.

In the wake of Frenchtown, we encourage healthcare employers who consider charge nurses to be supervisors to examine their own policies and practices and evaluate how well they reflect the claimed supervisory status.

We also encourage healthcare employers to consider whether or how well they can manage the risk that charge nurses may not be deemed supervisors. At least one large healthcare provider in California -- the University of California -- avoids the issue altogether. In the UC system, “charge nurse” is not a job classification. Rather, it is a set of duties that may be assigned to nonsupervisory or supervisory nurses as needed. This practice has both operating and financial benefits. From an operating standpoint, nurses given charge assignments no longer occupy a “no man’s land,” where their supervisory status is unclear. From a financial standpoint, because a charge nurse is out of ratio for purposes of complying with California’s mandatory staffing ratios, the provider saves the additional expense of assigning another nurse to every shift.

Employers who have questions or concerns about how the Frenchtown case may affect their own businesses are invited to contact Ellen Shadur, eshadur@bakerlaw.com or 310.442.8816 or any member of Baker Hostetler Labor Relations Team.

**BE CAREFUL OF THE COMPANY YOU KEEP -- CORPORATE ACTS LEAD TO EXECUTIVES’ EXCLUSIONS**

_D.C. Circuit affirms OIG’s broad, “circumstance-specific” approach to exclusions_

Purdue Frederick Company’s President, Executive Vice President and Chief Legal Officer and Vice President of Medical Affairs, who failed to prevent the company’s fraudulent marketing of OxyContin as less addictive than other pain medications, each pleaded guilty in May 2007 to misdemeanor misbranding of a drug under the Food, Drug & Cosmetic Act (FDCA).

The factual basis supporting the guilty pleas did not include any admission on the part of the executives that they acted with intent to defraud, much less any culpable state of mind. Indeed, the factual basis relied on the executives each being a "responsible corporate officer (RCO)" when the company’s sales representatives were misleading doctors about OxyContin’s abuse potential. Over the years, the government increasingly has targeted healthcare executives under the RCO doctrine, which authorizes misdemeanor charges against those in a position of authority who do not prevent or correct FDCA violations.
Shortly after the convictions, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) determined that the executives should be excluded from any participation in federal healthcare programs for 20 years. OIG exercised its exclusion authority on the basis that a conviction for misbranding of a drug constitutes a "misdemeanor relating to fraud" under 42 U.S.C. § 1320a-7(b). While the length of the exclusion was reduced to 12 years through the administrative appeals process, the executives subsequently appealed both the exclusion and its length of time to the U.S. Court of Appeals for the District of Columbia Circuit.

Categorical v. Circumstance-Specific Approach

In *Friedman v. Sebelius* (D.C. Cir., No. 11-5028, July 27, 2012), the executives argued that OIG did not have authority to exclude them for a "misdemeanor relating to fraud," when they neither were convicted of nor admitted to fraud or any other intentional misconduct. More specifically, the executives claimed that the charge of misbranding of a drug does not contain any element requiring evidence of fraud. The executives, therefore, argued that the court should adopt a categorical approach to exclusions that focuses around the crime of conviction. On the other hand, OIG maintained that the executives were appropriately excluded because the facts and circumstances underlying their convictions had a "factual nexus" or "relationship" to fraud – namely, the misleading conduct by Purdue Frederick’s sales representatives mentioned above.

In upholding the exclusions, the majority of the court held that the text, structure and purpose of the exclusion statute, viz., to protect federal healthcare programs from financial harm caused by untrustworthy providers, all indicated that OIG should consider the facts and circumstances underlying the conviction, rather than taking a categorical approach of simply looking at the crime of conviction. The court, not surprisingly, honed in on the phrase "relating to" in the exclusion statute and concluded that its inclusion in the statute was meant to be applied broadly for any conviction that has a "factual connection" to fraudulent conduct. However, a dissenting opinion filed in the case recommended that HHS define "relating to" in the exclusion statute to avoid the potential for arbitrary exclusion decisions. Additionally, while the executives lost the appeal on OIG's authority to exclude for their misbranding convictions, the court did reverse and remand on the basis that the 12-year exclusions imposed by OIG were "arbitrary and capricious" for want of a reasoned explanation for the length of the exclusions.

Conclusion

*Friedman* is instructive on at least two points affecting the healthcare industry. First, the government continues to use the RCO doctrine to prosecute healthcare executives, even though the executive may have not known about, or participated in, a particular offense under the FDCA. This highlights the government’s expectation that upper management be actively involved in ensuring corporate compliance with federal healthcare laws and regulations. Second, *Friedman* is a warning to both individual healthcare targets and defendants (and the lawyers advising them) that a guilty plea, regardless of the crime of conviction or supporting factual basis, could potentially result in exclusion if the OIG finds that there is a factual connection to fraud. While it generally is in a prosecutor’s best interest to efficiently resolve a case with a plea agreement, he or she is unlikely to interfere with OIG’s exclusion authority and insert language in the plea agreement seeking to prevent exclusion. Therefore, *Friedman* reminds us of the need to work proactively with OIG prior to accepting a guilty plea to better assess whether an exclusion proceeding may occur subsequent to conviction.

For more information, please contact Gregory S. Saikin, gsaikin@bakerlaw.com or 713.646.1399; or Robert M. Wolin, rwolin@bakerlaw.com or 713.646.1327.

ROUGH MONTH FOR PURPORTED DEFENDERS OF JUSTICE

Whistleblower’s Tax Relief Effort of 2012 Fails

James Alderson filed a whistleblower action alleging Medicare fraud by Quorum Health Group and several related entities, including the Hospital Corporation of America. The U.S. settled Alderson’s whistleblower action claims, and Alderson received over $100 million for his efforts (less counsel fees and taxes).

Alderson filed income tax returns reporting his reward as ordinary income. Later Alderson filed amended returns characterizing the whistleblower award as a capital gain and sought a refund. The Internal Revenue Service (IRS), clearly unappreciative of Alderson’s efforts, denied the refund claim. Alderson then filed suit for his refund.
Remarkably, whether a whistleblower’s award is ordinary income or capital gain is a question of first impression. The government contended that Alderson did not "sell" or "exchange" his information and, therefore, had no sale or exchange of an asset to qualify for capital gains treatment. Alderson contended he exchanged his documents, information and know-how and, in turn, received a whistleblower award, thus consummating a sale or exchange. The court found that Alderson did not "sell" or "exchange" his information and that the information was not a capital asset and that Alderson’s whistleblower award was ordinary income. Alderson et al., v. United States (9th Cir. July 18, 2012).

Sounds Like a Political Ad - Are You Lying Now or Did You Lie Then? -- Helpful Whistleblower’s Counsel in Hot Water

A whistleblower claimed she had been threatened, harassed and discriminated against as a result of filing a whistleblower action. Initially alleging that she had been directed to participate in her employer’s alleged Medicare fraud, the whistleblower’s complaint specifically referenced a letter in which she said that she would not lie to the Medicare authorities, would not help cover up violations.

The whistleblower’s story changed when asked in her deposition if she had ever been requested to lie to Medicare auditors or ever felt like it was a job requirement that she assist in fraud. She said no. After the deposition, her counsel submitted an errata sheet containing 101 corrections to the whistleblower’s testimony, some of which again changed her answers to match her original complaint allegations that her supervisors wanted her to lie to Medicare authorities.

At trial, the whistleblower’s story changed yet again. She testified that she had never been asked to lie and that her answers in her deposition had been accurate. She testified that her attorney had "literally word[ed]" some of the errata sheet changes and also had helped her write the July 3 letter referenced in her complaint.

Sensing bad faith, the district court concluded that counsel had helped the whistleblower push a meritless claim to trial. On this basis, the district court awarded the provider attorneys’ fees from the whistleblower’s counsel under 28 U.S.C. § 1927, which provides that any attorney who multiplies the proceedings in any case unreasonably and vexatiously may be required by the court to satisfy personally the excess costs, expenses and attorneys’ fees reasonably incurred because of such conduct. Gonzalez v. Fresenius Medical Care North America, (5th Cir. July 30, 2012).

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GAO RECOMMENDS IRS STEP UP ENFORCEMENT MEASURES FOR DENTISTS, DOCTORS AND OTHER MEDICAL SERVICES PROVIDERS WHO RECEIVE MEDICAID FUNDS

In a report issued July 27, 2012, the GAO recommended that the IRS "explore opportunities to enhance collection of unpaid taxes from Medicaid providers, including the use of continuous levies." The GAO reviewed Medicaid reimbursement information from the three states which received the most Medicaid funding under the American Recovery and Reinvestment Act of 2009. The GAO found that in 2009, doctors, dentists and other medical services providers who received $6.6 billion in Medicaid reimbursement owed the U.S. government $791 million in unpaid taxes from 2009 and earlier years. The GAO believes this estimate is low because it relies only on taxes that are self-reported and does not include amounts for which returns were not filed, underreported amounts or amounts reported under a different tax identification number. Over 40 percent of the unpaid taxes were identified as payroll taxes and over 30 percent of the unpaid taxes were identified as income taxes. The study points out that Medicaid reimbursements made to delinquent taxpayers are subject to one-time, rather than continuous, levies during the collection process. GAO concludes that if it were possible to continuously levy Medicaid reimbursements, collections would increase dramatically. Congress has proposed changing the law so that Medicaid reimbursements are subject to continuous levy. However, this measure has not become law.

For more information, please contact Jenifer Benda, jbenda@bakerlaw.com or 303.764.4025.

PROVIDERS NOW PERMITTED TO MAKE GIFTS AND DONATIONS TO OHIO POLITICIANS

An Ohio statute prohibited Medicaid providers and their owners from making campaign contributions to candidates for state attorney general or county prosecutor. Physician constitutional defenders claimed that the ban on contributions restricted their First Amendment interests and was more restrictive than necessary to achieve its goal of preventing

For more information, please contact Robert M. Wolin, rwolin@bakerlaw.com or 713.646.1327; or Richard W. Siehl at rsiehl@bakerlaw.com or 614.462.2639.

**SUSAN FEIGIN HARRIS DISCUSSES CONSIDERATIONS FOR HOSPITALS IN AFTERMATH OF PPACA DECISION IN BECKER’S HOSPITAL REVIEW**

The Supreme Court’s decision to uphold the Patient Protection and Affordable Care Act (PPACA) let the individual mandate stand, but limited lawmakers’ ability to withhold funding from states that choose to opt out of Medicaid expansion. A July 27 article in *Becker’s Hospital Review* notes that if states do not take more money from the federal government to expand Medicaid coverage, they may be left with hundreds of thousands of uncovered individuals. That would mean hospitals and health systems would not receive the added reimbursements anticipated from the Medicaid expansion in their state.

"For providers, this calls into question the potential success of the PPACA’s intent to eliminate a large chunk of the uninsured -- some 16 million Americans. If a provider's state chooses to forgo the expansion, a provider could still be faced with significant numbers of uninsured patients and experience Medicaid payment shortfalls," said Houston business partner Susan Feigin Harris in the article "10 Considerations for Hospitals in the Aftermath of Supreme Court's PPACA Decision."

Harris warned that Medicaid cuts to safety net hospitals will have a widespread effect. "There are a lot of components in our healthcare system that are extremely important and feeding each other, and there's a domino effect if we take away money from safety net hospitals," Harris said.

Harris, who counsels a number of children's hospitals, said that the Health and Human Services secretary has a fair amount of discretion in how disproportionate share hospital (DSH) cuts are dispersed, but that executives at DSHs and other hospital leaders have important questions to ask, including:

- If your state will not expand Medicaid, how much pressure will your hospital or system bring to bear on the state legislature to potentially change the position of the governor?
- Do you have any impact with respect to DSH reductions? How can you make the argument that in a state without expansion you should not have reductions?
- What impact will belt tightening in both state and federal government budgets have on provider rate cuts?

**EVENTS CALENDAR**

**September 21**

Houston partner Susan Feigin Harris will speak on "Review of the Supreme Court Decision and Aftermath" at the September meeting of the Healthcare Financial Management Association – Texas Gulf Coast Chapter in Houston, Texas.

**October 9**

Houston counsel Lynn Sessions will speak on "All Hands on Deck: An ERM Approach to Creating Collaboration Between Compliance, Risk & Legal" at the annual meeting of the American Society for Healthcare Risk Management in Washington, D.C.

**October 11**

Houston counsel Greg S. Saikin will speak on "Criminal Health Care Fraud Enforcement Update: From Audit to Appeal" at the U.S. Attorney's Office Health Care Fraud Working Group in Tyler, Texas.

**October 15-16**

Houston partner Donna S. Clark will speak on "Preventing Fraud and Abuse in Your Practice" at the 2012 Texas Health Law Conference sponsored by the Texas Hospital Association in Austin, Texas.
Houston partner Susan Feigin Harris will speak on "Out of Network: Exclusion of Providers Based on Referral Patterns and Network Adequacy" at the 2012 Texas Health Law Conference sponsored by the Texas Hospital Association in Austin, Texas.

October 23

Columbus partner Richard W. Siehl will speak on implementation of the Accountable Care Act to the Board of Directors and Faculty of the Robert C. Byrd Clinic at the West Virginia School of Osteopathic Medicine in Lewisburg, West Virginia.

October 30

Houston counsel Lynn Sessions will speak on "Lessons From Cutting Edge Transactions in Health Care and Life Sciences - HIPAA/HITECH Compliance" at the Current Issues in IP Contracting conference in Houston, Texas.