No. S259364

IN THE SUPREME COURT

OF THE STATE OF CALIFORNIA

SUNDAR NATARAJAN, M.D.,

Petitioner and Appellant

vs.

DIGNITY HEALTH,

Respondent,

After a Decision of the Court of Appeal
Third Appellate District, No. C085906

San Joaquin County Superior Court
No. STK-CV-UWM-2-16-4821

REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF *AMICUS CURIAE* BRIEF OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE IN SUPPORT OF NEITHER PARTY

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REQUEST FOR JUDICIAL NOTICE

Pursuant to California Rules of Court ("CRC") rule 8.252, *Amicus Curiae* applicant the American the American Academy of Emergency Medicine ("AAEM") hereby requests judicial notice of the attached September 25, 2018, United States Department of Justice ("DOJ") News Release: Hospital Chain Will Pay Over $260 Million to Resolve False Billing and Kickback Allegations: One Subsidiary Agrees to Plead Guilty.

I. THE DOJ NEWS RELEASE IS ELIGIBLE FOR JUDICIAL NOTICE UNDER CRC RULE 8.252

Rule 8.252(a)(2) requires the moving party to state the following:

> (A) Why the matter to be noticed is relevant to the appeal;
>
> (B) Whether the matter to be noticed was presented to the trial court and, if so, whether judicial notice was taken by that court;
>
> (C) If judicial notice of the matter was not taken by the trial court, why the matter is subject to judicial notice under Evidence Code section 451, 452, or 453; and,
>
> (D) Whether the matter to be noticed relates to proceedings occurring after the order or judgment that is the subject of the appeal.

The DOJ News Release satisfies all the requirements for judicial notice.

A. The DOJ News Release is relevant because it exemplifies the AAEM's argument regarding a conflict between a physician's fiduciary duty to patients and the hospital's financial motivation

Under CRC rule 8.252(a)(2)(A) the matter to be judicially noticed must be relevant to the appeal.

As advanced in the AAEM's *amicus curiae* brief, a concern of the AAEM is the resulting downstream effect of a physician's fear of losing hospital privileges when a physician may recommend a course of action that is at odds with hospital administration. The DOJ article supports this argument in that it exhibits the ongoing conflict between a physician's fiduciary duty to patients and the hospital's profit motivation.

As such, the DOJ News Release is relevant to the appeal.

B. The DOJ News Release is subject to judicial notice under Evidence Code section 452(c) because it is an official act of the executive department of the United States, even though it was not presented to the trial court.

CRC Rule 8.252(a)(2)(B)-(C) requires the moving party to state whether the matter was presented to and judicially noticed by the trial court and, if not, to indicate why the matter is subject to judicial notice under the Evidence Code.

Here, the DOJ News Release was not presented to the trial court.

Evidence Code section 452(c) permits judicial notice of "[o]fficial acts of the legislative, executive, and judicial departments of the United States . . . ." The DOJ News Release is an official act of the United States Department of Justice, which is part of the "executive department." Evidence Code section 452(c).

Accordingly, the DOJ News Release is subject to judicial notice under Evidence Code section 452(c).

C. The matter to be noticed relates to proceedings occurring before and after the judgment that is the subject of the appeal.

CRC Rule 8.252(a)(2)(D) also requires the moving party to state whether the matter to be noticed relates to proceedings occurring after the order or judgment that is the subject of the appeal.

The DOJ News Release relates to proceedings that occurred both before and after the judgment that is the subject of the appeal.

The decision rendered in the trial court case occurred on or about September 11, 2017. The Court of Appeal in this action rendered an unpublished decision on October 22, 2019, and a published decision on November 20, 2019.

The DOJ published the attached News Release on September 25, 2018, which was after the trial court decision but

prior to the Court of Appeal decision that is the subject of the appeal.

II. CONCLUSION

For these reasons the AAEM respectfully requests that the Court judicially notice the DOJ News Release of September 25, 2018.

DATED: October 16, 2020.

Respectfully submitted,

By: */s/Marc J. Shrake*
Marc J. Shrake, Esq.

*Joseph P. Wood, Esq., M.D.
Pro Hac Vice application pending

Counsel for Amicus Curiae
The American Academy of Emergency Medicine

ORDER

The motion of the American Academy of Emergency Medicine requesting judicial notice of the attached News Release having been read and filed, and good cause appearing therefor,

IT IS HEREBY ORDERED that this Court takes judicial notice of the September 25, 2018, News Release published by the United States Department of Justice titled Hospital Chain Will Pay Over $260 Million to Resolve False Billing and Kickback Allegations: One Subsidiary Agrees to Plead Guilty, attached to this motion herein.

Date:_____

_____
Presiding Judge

ATTACHMENT

THE UNITED STATES DEPARTMENT of JUSTICE
STICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Tuesday, September 25, 2018

Hospital Chain Will Pay Over $260 Million to Resolve False Billing and Kickback Allegations; One Subsidiary Agrees to Plead Guilty

Health Management Associates, LLC (HMA), formerly a U.S. hospital chain headquartered in Naples, Florida, will pay over $260 million to resolve criminal charges and civil claims relating to a scheme to defraud the United States. The government alleged that HMA knowingly billed government health care programs for inpatient services that should have been billed as outpatient or observation services, paid remuneration to physicians in return for patient referrals, and submitted inflated claims for emergency department facility fees.

Assistant Attorney General Brian A. Benczkowski of the Justice Department's Criminal Division, Assistant Attorney General Joseph H. Hunt of the Justice Department's Civil Division, U.S. Attorney Maria Chapa Lopez for the Middle District of Florida, U.S. Attorney Ariana Fajardo Orshan for the Southern District of Florida, U.S. Attorney Charles E. Peeler for the Middle District of Georgia, U.S. Attorney John R. Lausch Jr. for the Northern District of Illinois, U.S. Attorney R. Andrew Murray for the Western District of North Carolina, U.S. Attorney William M. McSwain for the Eastern District of Pennsylvania, U.S. Attorney Sherri Lydon for the District of South Carolina, Assistant Director Robert Johnson of FBI's Criminal Investigative Division, and Acting Assistant Inspector General for Investigations Derrick L. Jackson for the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) made the announcement.

HMA was acquired by Community Health Systems Inc. (CHS), a major U.S. hospital chain, in January 2014, after the alleged conduct at HMA occurred. Since July 2014, HMA has been operating under a Corporate Integrity Agreement (CIA) between CHS and the HHS-OIG.

As part of the criminal resolution, HMA entered into a three-year Non-Prosecution Agreement (NPA) with the Criminal Division's Fraud Section in connection with a corporate-driven scheme to defraud Federal health care programs by unlawfully pressuring and inducing physicians serving HMA hospitals to increase the number of emergency department patient admissions without regard to whether the admissions were medically necessary. The scheme involved HMA hospitals billing and obtaining reimbursement for higher-paying inpatient hospital care, as opposed to observation or outpatient care, from Federal health care programs, increasing HMA's revenue. Under the terms of the NPA, HMA will pay a $35 million monetary penalty. Under the terms of the NPA, HMA and CHS, the current parent company, agreed to cooperate with the investigation, report allegations or evidence of violations of Federal health care offenses, and ensure that their compliance and ethics program satisfies the requirements of an amended and extended CIA between CHS and HHS-OIG.

In addition, an HMA subsidiary, Carlisle HMA, LLC, formerly doing business as Carlisle Regional Medical Center, has agreed to plead guilty to one count of conspiracy to commit health care fraud. The plea agreement remains subject to acceptance by the court. Up until 2017, Carlisle HMA, LLC owned and operated Carlisle Regional Medical Center, an acute care hospital located in Carlisle, Pennsylvania. Carlisle HMA, LLC was charged in a criminal information filed today in the District of Columbia with conspiracy to commit health care fraud.

According to admissions made in the resolution documents, HMA instituted a formal and aggressive plan to improperly increase overall emergency department inpatient admissions at all HMA hospitals, including at Carlisle Regional

Medical Center. As part of the plan, HMA set mandatory company-wide admission rate benchmarks for patients presenting to HMA hospital emergency departments – a range of 15 to 20 percent for all patients presenting to the emergency department, depending on the HMA hospital, and 50 percent for patients 65 and older (i.e. Medicare beneficiaries) - solely to increase HMA revenue. HMA executives and HMA hospital administrators executed the scheme by pressuring, coercing and inducing physicians and medical directors to meet the mandatory admission rate benchmarks and admit patients who did not need impatient admission through a variety of means, including by threatening to fire physicians and medical directors if they did not increase the number of patients admitted.

"HMA pressured emergency room physicians, including through threats of termination, to increase the number of inpatient admissions from emergency departments—even when those admissions were medically unnecessary," said Assistant Attorney General Benczkowski. "Hospital operators that improperly influence a physician's medical decision-making in pursuit of profits do so at their own peril. Where we find such conduct, the Criminal Division's Health Care Fraud Unit, together with our Civil Division and law enforcement colleagues, will aggressively prosecute those responsible to the fullest extent of the law."

HMA also agreed to pay $216 million as part of a related civil settlement. The civil settlement resolves HMA's liability for submitting false claims between 2008 and 2012 as part of its corporate-wide scheme to increase inpatient admissions of Medicare, Medicaid and the Department of Defense's (DOD) TRICARE program beneficiaries over the age of 65. The government alleged that the inpatient admission of these beneficiaries was not medically necessary, and that the care needed by, and provided to, these beneficiaries should have been provided in a less costly outpatient or observation setting. HMA agreed to pay $62.5 million to resolve these allegations with $61,839,718 being paid to the United States and $706,084 being paid to participating States.

The civil settlement also resolves allegations that during the period from 2003 through 2011, two HMA hospitals in Florida, Charlotte Regional Medical Center and Peace River Medical Center, billed federal health care programs for services referred by physicians to whom HMA provided remuneration in return for patient referrals. To induce patient referrals, Charlotte Regional provided a local physician group with free office space and staff, as well as direct payments, which purportedly covered overhead and administrative costs incurred by the group for its management of a Charlotte Regional physician. HMA also provided another local physician with free rent and upgrades to his office space. HMA agreed to pay $93.5 million to resolve these civil allegations, with the United States receiving $87.96 million, and the State of Florida receiving $5.54 million.

Additional allegations that are resolved by the civil settlement are that between 2009 and 2012, two former HMA hospitals, Lancaster Regional Medical Center and Heart of Lancaster Medical Center in Pennsylvania, billed federal health care programs for services referred by physicians with whom the facilities had improper financial relationships. These relationships stemmed from HMA's excessive payments to (1) a large physician group in return for two businesses owned by the group and for services allegedly performed by the group, and (2) a local surgeon that exceeded the value of the services provided. The government alleged that these arrangements were structured in this manner to disguise payments intended to induce the referral of patients. HMA agreed to pay $55 million to the United States to resolve these civil allegations.

Finally, the civil settlement will also resolve claims that Crossgates Hospital, an HMA facility in Brandon, Mississippi, leased space to a local physician from Jan. 15, 2005 through Jan. 14, 2007, but required the physician to pay rent for only half of the space he was actually occupying, in return for patient referrals to Crossgates Hospital. HMA agreed to pay $425,000 to the United States to resolve these civil allegations.

Federal law, including the Anti-Kickback Statute and the Stark Law, prohibits hospitals from providing financial inducements to physicians for referrals. These provisions are designed to ensure that physician decision-making is not compromised by improper financial incentives.

"Billing for unnecessary hospital stays wastes federal dollars," said Assistant Attorney General Hunt. "In addition, offering financial incentives to physicians in return for patient referrals undermines the integrity of our health care system. Patients deserve the unfettered, independent judgment of their health care professionals."

"The payment of kickbacks in exchange for medical referrals undermines the integrity of our healthcare system," said U.S. Attorney Chapa Lopez. "Today's resolution should remind healthcare providers of their duty to comply with the law,

and the heavy price to be paid for corrupt practices committed by their executives. Our Civil Division will continue to invest itself in the pursuit of health care providers who violate the law for personal gain."

"Our office will continue to enforce prohibitions on improper financial relationships between health care providers and their referral sources, as these relationships can serve to corrupt physician judgment about a patient's true health needs," said U.S. Attorney Fajardo Orshan. "We will devote all necessary resources to ensure that those rendering medical care do so for the sole benefit of the patient and in compliance with the law."

"By manipulating patient status, HMA increased Medicare costs and pocketed taxpayer funds to which it was not entitled," said U.S. Attorney Peeler. "Our Medicare patients and our taxpayers deserve better, and I am proud that justice has been done. Nonetheless, we will continue to pursue those hospitals in our district that would seek to take advantage of the Medicare Program."

"Government healthcare programs are vital to the welfare of our communities," said U.S. Attorney Murray for the Western District of North Carolina, where two HMA hospitals were located. "We will aggressively pursue providers that fraudulently inflate charges to government programs and divert scarce resources from those in need into their own pockets."

"Our resolution of this matter and the significant recovery we have obtained show once again that no matter how complex the scheme is, we will find it, stop it, and punish it," said U.S. Attorney McSwain. "HMA covered up kickbacks for patient referrals with sham joint venture agreements, lease payments, and management agreements. These sorts of improper physician inducements are a form of 'pay to play' business practices that will not be tolerated. Healthcare institutions cannot pad their bottom line at the expense of the American taxpayers. And most importantly, this conduct must be rooted out because it gets in the way of providing top-notch patient care to American citizens."

"It is critically important to all of us that the patients' interest drive the physicians' decisions on care," said U.S. Attorney Lydon. "Unnecessary hospital admissions not only drive up costs but can cause damage to patients and cannot be tolerated."

The government further alleged that from September 2009 through December 2011, certain HMA hospitals submitted claims to Medicare and Medicaid seeking reimbursement for falsely inflated emergency department facility charges. HMA agreed to pay $12 million to resolve these civil allegations, with $11.028 million being paid to the United States and $972,000 being paid to participating States.

"Compliance with government healthcare rules requires that patients only receive treatment they actually need," said HHS-OIG Acting Assistant Inspector General for Investigations Jackson. "Then government programs must be billed just for those services. No more, no less. Let there be no doubt, we will continue to protect federal healthcare programs and beneficiaries by holding provider organizations fully accountable."

"This settlement is a result of the FBI's hard work and dedication to hold companies accountable for their role in healthcare fraud and abuse," said FBI Assistant Director Johnson. "The FBI will not stand by when there are allegations that a company operates a corporate wide scheme to increase their financial gain at the expense of the U.S. government. We appreciate those who come forward with allegations of criminal misconduct and recognize the importance of the public's assistance in our work."

The allegations resolved by the settlement were originally brought in eight lawsuits filed under the *qui tam,* or whistleblower, provisions of the False Claims Act, which permit private parties to sue on behalf of the government for false claims and to receive a share of any recovery. The eight *qui tam* cases, which were filed in various districts and transferred to the U.S. District Court for the District of Columbia as part of a multi-district litigation presided over by the Honorable Reggie B. Walton, are captioned: *United States ex rel. Brummer v. HMA, Inc.*, 3-09-cv-135 (CDL) (M.D. Ga.); *United States ex rel. Williams v. HMA, Inc.*, 3:09-cv-130 (M.D. Ga.); *United States ex rel. Plantz v. HMA, Inc.*, 13-CV-1212 (N.D. Ill.); *United States ex rel. Miller v. HMA, Inc.*, 10-3007 (E.D. Pa.); *United States ex rel. Mason & Folstad v. HMA, Inc.*, 3:10-CV-472-GCM (W.D.N.C.); *United States ex rel. Nurkin v. HMA, Inc.*, 2:11-cv-14-FtM-29DNF (M.D. Fla.); *United States ex rel. Jacqueline Meyer & Cowling v. HMA, Inc.*, 0:11-cv-01713-JFA (D.S.C.); and *United States ex rel. Paul Meyer v. HMA, Inc.*, 11-62445 cv-Williams (S.D. Fla.).

The whistleblower in *United States ex rel. Nurkin* will receive approximately $15 million as a share of the recovery, and the whistleblowers in *United States ex rel. Miller* will receive approximately $12.4 million as their share of the recovery. The whistleblower shares to be awarded in the remaining cases have not yet been determined.

These matters were investigated by the Civil Division's Commercial Litigation Branch; the Health Care Fraud Unit of the Criminal Division's Fraud Section; the U.S. Attorneys' Offices for the Middle District of Florida, Southern District of Florida, Middle District of Georgia, Northern District of Illinois, Western District of North Carolina, Eastern District of Pennsylvania and the District of South Carolina, the FBI Healthcare Fraud Unit Major Provider Response Team, HHS-OIG and Defense Health Agency Program Integrity. On behalf of the States, an investigative/settlement team with members from North Carolina, Massachusetts, Virginia, Washington, and Florida assisted with the investigation and resolution of these matters.

The government's resolution of this matter illustrates the government's emphasis on combating healthcare fraud and marks another achievement for the Health Care Fraud and Enforcement Action Team (HEAT) initiative, a partnership between the Department of Justice and the Department of Health and Human Services to focus efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement, can be reported to the Department of Health and Human Services at 800-HHS-TIPS (800-447-8477).

Except for those facts admitted to in the guilty plea and in the Non-Prosecution Agreement, the claims resolved by the settlement are allegations only, and there has been no determination of liability.

If you believe you are a victim of this offense, please visit this website or call (888) 549-3945.

Attachment(s):
Download Health Management Associates, LLC Settlement Agreements
Download Health Management Associates, LLC NPA and Attachments
Download Carlisle HMA LLC Criminal Information

Topic(s):
False Claims Act

Component(s):
Civil Division
Criminal Division
Criminal - Criminal Fraud Section
Federal Bureau of Investigation (FBI)
USAO - Florida, Middle
USAO - Florida, Southern
USAO - Georgia, Middle
USAO - Illinois, Northern
USAO - North Carolina, Western
USAO - Pennsylvania, Eastern
USAO - South Carolina

Press Release Number:
18-1252

Updated February 13, 2019

CERTIFICATE OF SERVICE

I certify that I electronically filed the foregoing with the Clerk of the Court for the Supreme Court of The State of California by using the TrueFiling system. I further certify that all participants in the case are registered TrueFiling users and that service will be accomplished by the appellate TrueFiling system.

Executed on October 16, 2020, at Los Angeles, California.

_____/s/*Marc J. Shrake*_____
Marc J. Shrake

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **NATARAJAN v. DIGNITY HEALTH**
Case Number: **S259364**
Lower Court Case Number: **C085906**

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

10/16/2020

Date

/s/Marc J. Shrake

Signature

Shrake, Marc J. (219331)

Last Name, First Name (PNum)

Freeman Mathis & Gary, LLP

Law Firm