Exam ID # _____

WIDENER UNIVERSITY SCHOOL OF LAW

HEALTH LAW II FINAL EXAM

Professor Pope **Spring 2010**

GENERAL INSTRUCTIONS:

1. **Read Instructions**: You may read these instructions (the first three pages of this exam packet) ***before*** the official time begins.

2. **Honor Code:** While you are taking this exam, you may not discuss it with anyone.

3. **Competence:** Accepting this examination is a certification that you are capable of completing the examination. Once you have accepted the examination, you will be held responsible for completing the examination.

4. **Exam Packet:** This exam consists of **16 pages**, including this cover page. Please make sure that your exam is complete.

5. **Identification:** Write your **exam number** in the following four places. (1) Write it in space provided in the upper-right-hand corner of this page. (2) Write it on the cover of each Bluebook (or your ExamSoft file) that you use for Parts Two and Three. (3) Write it (**and** fill in the corresponding ovals) on the Scantron form. (4) Write it on the upper-right-hand corner of your envelope.

6. **Anonymity:** The exams are graded anonymously. Do ***not*** put your name or anything else that may identify you (except for your student number) on the exam.

7 **Timing:** This exam is designed to be completed in less than three hours. But it is scored as a three-hour exam and you have **180 minutes** in which to complete it.

8 **Scoring:** There are 180 points on the exam, approximately one point per minute.

9 **Open Book:** This is an OPEN book exam. You may use ***any*** written materials, including, but not limited to: required and recommended materials, any handouts from class, PowerPoint slides, class notes, and your own personal or group outlines. You may not use a computer other than in its ExamSoft mode.

10 **Format:** The exam consists of three parts which count toward your grade in proportion to the amount of time allocated.

PART ONE comprises 30 multiple choice questions worth two points each, for a ***combined*** total of 60 points. The suggested total completion time is **60 minutes**.

PART TWO comprises one short essay question worth 50 points. The suggested total completion time is **50 minutes**.

PART THREE comprises one long essay question worth 70 points. The suggested completion time is **70 minutes**.

11 **Grading:** All exams will receive a raw score from zero to 180. The raw score is meaningful only relative to the raw score of the other students in the class. The raw score will be converted into a scaled score, based on the class curve. For example, if the highest raw score in the class were 120 of 180, then that student would typically receive an "A." A few days after the exam, I will post the exam itself, an explanatory memo, and a model answer both to TWEN and to the library exam database.

12 **Special Instructions:** Instructions specific to each exam section are printed immediately below.

SPECIAL INSTRUCTIONS FOR PART ONE:

1. **Format:** This Part contains 30 multiple choice questions, worth two points each, for a combined total of 60 points. This part has a suggested completion time of 60 minutes. Please note that the questions vary in both length and complexity. You might answer some in 30 seconds and others in three minutes.

2. **Identification:** Write your Student ID ***both*** on the first page of this exam booklet. ***and*** on the Scantron form. Fill in all the corresponding ovals.

3. **Fill the Ovals on the Scantron:** For each question***, fill in*** the oval on the Scantron corresponding to the best answer choice.

4. **Ambiguity:** If (and only if) you believe the question is ambiguous, such that there is not one obviously best answer, neatly explain why in a separately marked section of your Bluebook or ExamSoft file. Your objection must (i) identify the ambiguity or problem in the question and (ii) reveal what your answer would be for all possible resolutions of the ambiguity. I do ***not*** expect this to be necessary.

SPECIAL INSTRUCTIONS FOR PARTS TWO AND THREE:

1. **Submission:** Write your ***essay*** answers in your Bluebook examination booklets or ExamSoft file. I ***will not*** read any material which appears only on scrap paper.

2. **Legibility:** Write legibly. I will do my best to read your handwriting, but must disregard (and not give you points for) writing that is too small to read or otherwise illegible.

3. **Outlining Your Answer:** I strongly encourage you to use one-fourth of the allotted time per question to outline your answers on scrap paper ***before*** beginning to write in your exam booklet or ExamSoft file. Alternatively, you might draft your outline as a series of headings and sub-headings directly into your ExamSoft file, and then go back to fill-in the analysis with sentences and paragraphs.

   Outline your answer ***before*** writing because you will be graded not only on the substance of your answer but also on its clarity and conciseness. In other words, organization, precision, and brevity count. If you run out of insightful things to say about the issues raised by the exam question, stop writing until you think of something. Tedious repetition, regurgitations of law unrelated to the facts, or rambling about irrelevant issues ***will*** negatively affect your grade.

4. **Answer Format:** This is important. ***Use headings and subheadings***. Use short single-idea paragraphs (leaving a blank line between paragraphs).

5. **Answer Content:** Address ***all*** relevant issues that arise from the fact pattern and that are responsive to the "call" of the question. Do not just summarize all the facts or all the legal principles relevant to an issue. Instead, ***apply*** the law you see relevant to the facts you see relevant. Take the issues that you identify and organize them into a coherent structure. Then, within that structure, examine issues and ***argue*** for a conclusion.

6. **Citing Cases:** You are welcome but not required to cite cases. While it is sometimes helpful to the reader and a way to economize on words, do not cite case names as a substitute for stating the law. For example, do ***not*** write: "Plaintiff should be able to recover under *A v. B.*" Why? What is the rule in that case? What are the facts in the instant case that satisfy that rule?

7. **Cross-Referencing:** You may reference your own previous analysis (*e.g.* B's battery claim against C is identical to A's, above, because __." But be very explicit, clear, and precise what you are referencing. As in contract interpretation, ambiguity is construed against the drafter.

8. **Balanced Argument:** Facts rarely perfectly fit rules of law. So, recognize the key weaknesses in your position and make the argument on the other side.

9. **Additional Facts:** If you think that an exam question fairly raises an issue but cannot be answered without additional facts, state clearly those facts that you believe to be necessary to answer the question. Do not invent facts or issues that are not raised, implied, or suggested by the fact pattern.

STOP !

STOP !

DO NOT TURN THIS PAGE UNTIL THE PROCTOR SIGNALS

PART ONE

30 questions worth two points each = 60 points

Suggested Time = 60 minutes

1. The Medicare Program:

A. Is federally-funded, not state-funded.
B. Is limited to services for poor people.
C. Covers only citizens aged 65 and older.
D. Two of the above.
E. All of the above.

2. The _____ is a federal statute that establishes civil liability for any person who knowingly presents, or causes to be presented, a false or fraudulent claim to the U.S. government for payment.

A. Anti-kickback statute.
B. ERISA.
C. False Claims Act.
D. Sherman Act.
E. 501(c)(3).

3. Examples of Health Care Fraud include:

A. Physician billing for services provided by interns and residents.
B. Billing for services not medically indicated or necessary.
C. Giving health care providers inducements in exchange for referrals.
D. Billing for services not rendered.
E. All of the above.

4. Lawsuits filed by private individuals under the False Claims Act are referred to as _____ actions.

A. Whistleblower.
B. Qui tam.
C. Relator.
D. All of the above.

5. Which of the following entities investigate fraud and abuse:

A. Department of Health and Human Services (DHHS).
B. Department of Justice (DOJ).
C. Office of the Inspector General (OIG).
D. Medicaid Fraud Units.
E. All of the above.

6. To prevent fraud against state governments (e.g. through Medicaid), some states have their own False Claims Acts.

A. True, and <u>all</u> these states can retain a percentage of recoveries under such acts that exceed the state's Medicaid share.
B. True, and <u>some</u> of these states can retain a percentage of recoveries under such acts that exceed the state's Medicaid share.
C. False.

<u>Both</u> questions 7 and 8 are based on the following facts:

In 2005, Dr. Kelso entered into a performance agreement with Delaware University Hospital's ("DUH") Medical Executive Committee (MEC) after a gynecologic surgery in which he severely perforated the patient's bowel. One performance-agreement condition was that Dr. Kelso could exercise his gynecologic-surgical privileges only if a board-certified physician monitor was present and assisted if certain procedures were undertaken. The performance agreement specified that any breach would result in his immediate suspension, pending termination, from the medical staff.

In 2010, Dr. Kelso's associate requested Dr. Kelso to assist him with a laparoscopic lysis of adhesions procedure. During the procedure, the patient's bowel was injured. Dr. Kelso participated in the bowel repair. Dr. Kelso did not call a monitor into the operating room (and by the express terms of the performance agreement, Dr. Kelso's associate could not serve as Dr. Kelso's monitor). The MEC heard about this and suspended his privileges.

A review panel sometime later concluded that the MEC acted in good faith, finding that "[t]he MEC's concerns regarding Dr. Kelso's judgment and performance were legitimate," that "[b]ased on the voluminous and extensive facts before it, the MEC had solid reason to believe that its failure to take action and suspend Dr. Kelso's privileges would place other patients at risk of imminent harm."

7. Dr. Kelso filed statutory and common law claims requested seeking reinstatement of his privileges.

A. If DUH has complied with the HCQIA, these claims should be dismissed.
B. DUH's compliance with the HCQIA is not grounds for dismissal of these claims.
C. Dr. Kelso has a valid claim under the Anti-Kickback statute.
D. More than one of the above.

8. Given the facts above, Dr. Kelso's best chance to show that DUH is <u>not</u> entitled to immunity under HCQIA is to argue that the suspension was not taken:

A. In the reasonable belief it was in furtherance of quality health care.
B. After a reasonable effort to obtain the facts of the matter.
C. After adequate notice and hearing procedures.
D. In the reasonable belief that the action was warranted by the known facts.

9. Dr. Butler is a neonatologist. Until February 2010, Dr. Butler was the Medical Director of the Neonatal Intensive Care Unit ("NICU") at DooPond Children's Hospital. Dr. Butler also enjoyed privileges at Community Medical Center ("Community"), the local teaching hospital. In December 2009, Community opened a new 65 bed NICU.

DooPond was concerned that Community was building a "flagship NICU" that would compete with DooPond's NICU. Consequently, DooPond closed its NICU to certain neonatologists. DooPond also told Dr. Butler (and other physicians in his private practice group) that if he did not agree to practice exclusively through DooPond, and in particular not at Community, then it would not renew his contract.

DooPond's actions create a risk of liability for itself under:

A. Clayton Act.
B. Sherman Act.
C. HCQIA.
D. ERISA.
E. Excess Benefits Transaction statute.

10. Ophelia was a full-time nurse at Brandywine Medical Center. Her employment was governed by the terms of a collective bargaining agreement (CBA) between Brandywine and the Delaware Nurses Association. In July 2009, Ophelia was transferred to the medical/surgical unit. Once there, she was ill-treated by the charge nurse and other staff who were of Filipino descent. They called Ophelia "garbage" and "stupid Chinese." Ophelia reported this to the human resources director. She also reported that she was being stalked by actor Christopher Walken. Because of this last comment, the HR director was concerned about Ophelia's mental fitness to work. She said that Ophelia would be terminated unless she got a medical clearance. Ophelia did not respond to this request, and was terminated.

Ophelia may have a wrongful termination claim:

A. If Brandywine violated the terms of the CBA.
B. If Brandywine violated Title VII prohibition against racial discrimination.
C. If Brandywine violated public policy principles in the Ethics Code of the Delaware Nurses Association.
D. 2 of the above.
E. All of the above.

11. As of April 1, 2010, a tax exempt hospital must do all of the following to maintain its 501(c)(3) tax exempt status EXCEPT:

A. Conduct a community health needs assessment.
B. Adopt an implementation strategy to meet the community health needs identified through such assessment.
C. Not charge uninsured patients for emergency medical services.
D. Establish a written financial assistance policy which includes eligibility criteria.
E. Not engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy.

12. New Castle Hospital is a nonprofit, tax-exempt hospital. Lelia, a hospital board member sells a building to the hospital for $700,000 whose fair market value at the time of sale was $400,000. This transaction presents tax problems <u>for the hospital</u> under:

A. 501(c)(3) prohibition of private inurement.
B. I.R.C. 4958.
C. Unrelated business income tax (UBIT).
D. All of the above.
E. A and B.

13. Kennett Circle Hospital is a for-profit hospital. It has two cafeterias. One is in the main hospital building. The other is in a nearby medical office building primarily serving the private patients of physicians. The hospital must:

A. Pay tax on the revenue of both hospitals.
B. Pay tax on the revenue of the off-site hospital.
C. Pay tax on the revenue of the off-site hospital. In addition, this is prohibited private benefit.
D. Pay tax on the revenue of neither hospital.

14. Penn Oaks Hospital is a non-profit hospital. It has two cafeterias. One is in the main hospital building. The other is in a nearby medical office building primarily serving the private patients of physicians. The hospital must:

A. Pay tax on the revenue of both hospitals.
B. Pay tax on the revenue of the off-site hospital.
C. Pay tax on the revenue of neither hospital.
D. Pay tax on the revenue of neither hospital. In addition, this is prohibited private benefit.

15. East Chester Hospital is a nonprofit, tax-exempt hospital. It pays its chief operating officer $600,000 when the compensation for persons in comparable positions in the same geographical area is $400,000. Under the Internal Revenue Code:

A. The hospital must pay a tax penalty of $200,000.
B. The COO must pay a tax penalty of $200,000.
C. The COO must pay a tax penalty of $50,000.
D. The hospital must pay a tax penalty of $50,000.
E. Both C and D.

16. The Chester, PA hospital market consists of four hospitals with the following market shares: H1: 30%, H2: 30%, H3: 20%, and H4: 20%. This market now has an HHI of 2600. If H1 and H2 merge, what will be the resulting market concentration as measured by HHI?

A. 3500
B. 3600
C. 3800
D. 4400
E. 5300

17. The Media, PA hospital market consists of six hospitals with the following market shares: H1: 25%, H2: 15%, H3: 15%, H4: 15%, H5: 15%, and H6: 15%. If H1 and H2 merge, will the resulting market concentration trigger FTC investigation?

A. Definitely. Such a merger would result in a "highly concentrated market."
B. Maybe. While not "highly concentrated," the merger would raise the HHI in a moderately concentrated market by over 100 points.
C. Probably not. Neither the premerger not post-merger markets were sufficiently concentrated.
D. Definitely not. The resulting market would still be considered "un-concentrated."

18. N-G is a medical practice that provides medical services to individuals enrolled in employer-sponsored healthcare plans operated and/or administered by Horizon Blue Cross Blue. N-G filed a complaint in the Superior Court of New Jersey to recover reimbursements for emergency services rendered to certain Horizon subscribers. Specifically, N-G alleges that Horizon violated New Jersey Emergency Services Reimbursement (NJESR) regulations that require payment of the physician's usual, customary and reasonable fee for emergency services. Assume that N-G can enforce (*e.g.* through assignment) any coverage rights of Horizon beneficiaries.

A. N-G's action is preempted by ERISA 502.
B. N-G's action is not preempted because the NJESR is an insurance regulation.
C. N-G's action is preempted by both ERISA 502 and 514.
D. N-G's action is preempted by neither ERISA 502 nor 514

19. Werner maintained health insurance through a policy issued by Group Health, which included both his wife and dependent child as beneficiaries under the policy. In July 2008, Werner's wife received pre-certification from an agent of Group Health for a costly medical procedure that she was to undergo the following month. Group Health paid at least two of the service providers involved in the medical procedure.

However, shortly thereafter, Group Health requested repayment for the bills it previously paid on Werner's wife's procedure. It refused to pay the remaining outstanding claims for said procedure, and refused to negotiate or settle any of the outstanding claims with Werner. Werner filed suit against Group Health in Delaware Superior Court, asserting breach of contract.

A. Werner's claim is probably preempted by 502.
B. Group Health can remove the claim to the U.S. District Court for the District of Delaware, even though Werner included no federal claims in his complaint.
C. Both A and B.
D. Werner's claim is probably NOT preempted by 502.

20. Christy, a respiratory technician, is an at-will employee of the Milwaukee Clinic. The Milwaukee Clinic:

A. May not terminate Christy for a reason that is arbitrary or irrational.
B. May not terminate Christy without providing her some meaningful opportunity to respond to the "charges" against her.
C. Both A and B.
D. None of the above.

21. Rachael is a dentist and a member of the Delaware Orthodontics Association. Membership in DOA is not legally required. But it is a practical necessity for a dentist who wishes to make a good living as an orthodontist. And it is a practical necessity to realize maximum potential achievement and recognition in the specialty. The DOA:

A. May not exclude Rachael for a reason that is arbitrary or irrational.
B. May not exclude Rachael without providing her some meaningful opportunity to respond to the "charges" against her.
C. Both A and B.
D. None of the above.

22. Dermatologists Dirk and Dan were removed from United Health's "preferred provider" lists. Five percent of all insured individuals in California participate in plans administered by United. These United-insured individuals could elect to be treated by nonparticipating providers. United Health:

A. May not delist Dirk and Dan for a reason that is arbitrary or irrational.
B. May not delist Dirk and Dan without providing them some meaningful opportunity to respond to the "charges" against them.
C. Both A and B.
D. None of the above.

23. A Philadelphia pulmonologist accepted tickets to Eagles football games and Phillies baseball games from a durable medical equipment supplier in exchange for patient referrals. This agreement:

A. Violates no federal laws because these tickets do not constitute "remuneration."
B. Violates no federal laws because even if these tickets constitute "remuneration," their value is *de minimus*.
C. Violates the Anti-Kickback statute.
D. Violates the Anti-Kickback statute as well as Stark, if the referrals were made.

24. During the first four months of 2010, thirty-three Wilmington, Delaware optometrists met on Monday mornings at the Pure Bread café to discuss fees. Starting in May 2010, these optometrists began charging the same fees. These optometrists may have some legal exposure under:

A. The Clayton Act.
B. The Sherman Act.
C. The Anti-Kickback statute.
D. The False Claims Act.
E. The National Labor Relations Act.

25. Martha has been an inpatient at the Witt Medical Center (in Philadelphia) since March 28, 2010. On May 3rd, Witt transferred Martha to the Saint Helen Hospice. Martha's daughters did not agree with this transfer. Do the daughters have an EMTALA claim against Witt?

A. The daughters may have a claim, if Martha's condition was not stabilized at the time of transfer.
B. The daughters may have a claim, if Witt is a Medicare-participating hospital.
C. Both A and B.
D. The daughters do not have an EMTALA claim.

26. Pete is taken by ambulance to St. Egregius Hospital. The hospital ED staff uniformly applies their standard screening procedure for patients with Pete's symptoms. Finding no emergency medical condtion, St. Egregius transfers Pete to County Memorial. Pete dies from an serious injury that St. Egregius failed to diagnose before transfer. Pete's wife probably:

A. Has an EMTALA claim against both the hospital and the ED physician.
B. Has an EMTALA claim against only the ED physician.
C Has an EMTALA claim against only the hospital.
D. Has an EMTALA claim against neither the hospital nor the ED physician.

27. On January 1, 2010, the Pennsylvania Department of Insurance promulgated a new regulation requiring all health insurers in the state to cover (1) diabetes supplies and education, and (2) morning after ("emergency") contraceptives. Harshee, a Pennsylvania employer, has a fully-insured plan that it purchased through premiums from CIGNA. Harshee employees who are beneficiaries of this plan are:

A. Not entitled to coverage under the Pennsylvania law, because the only way such rights could be enforced is through Section 502.
B. Entitled to coverage under the Pennsylvania law, because it does not "relate to" their plan.
C. Entitled to coverage under the Pennsylvania law, because of the "savings clause."
D. Not entitled to coverage under the Pennsylvania law, because of the "deemer clause."

28. On May 1, 2010, Pennsylvania enacted a law requiring all employers with 25 or more employees to spend 6.5% of their total wages on health insurance. This law is probably:

A. Preempted by ERISA 502.
B. Preempted by ERISA 514.
C. Preempted by both 502 and 514.
D. Preempted by neither 502 nor 514.

29. Jodi was a 19-year-old college student. Jodi's parents are self-employed bee honey sellers. They had a health policy that they purchased directly from CIGNA. The policy provided medical coverage to all dependents under 18. It provided some coverage to other dependents as follows: "to all dependents of the policyholder aged 19-24 enrolled as a full-time student in school." Other language specifies that "CIGNA retains full discretion to determine the meaning of the terms in this policy." While a sophomore at Kings College, Oxford (England), Jodi had an accident. CIGNA denied coverage, explaining that the dependent coverage was limited to full-time students studying in the United States. Jodi's parents sued for breach of contract in state court.

In determining the coverage dispute, the court will probably:

A. Side with the parents because the contract does not explicitly limit "students" to those studying in the United States.
B. Side with the parents because theirs is the best reading of the contract on a *de novo* review.
C. Side with the parents. Even if CIGNA's interpretation is not arbitrary and capricious, it suffers a conflict of interest such that its interpretation is entitled to less deference.
D. Side with CIGNA because its interpretation is not arbitrary and capricious.

30. Which program covers most long-term (e.g. nursing home) care for individuals over age 65 in the United States?

A. Medicare
B. Medicaid
C. Neither of the above covers long-term care

---------- END OF PART ONE ----------

PART TWO

1 short essay question worth 50 points

Suggested time = 50 minutes

Until July 2009, Dr. Howzer worked for Eastman Medical Center in Los Angeles. At Eastman it was determined that in 39% of Dr. Howzer's cases, an intraoperative and/or postoperative complication had occurred. Accordingly, the medical executive committee at Eastman required that Dr. Howzer be assisted in all complicated and major surgeries. Dr. Howzer had also been named in seven civil lawsuits in California. All this information was a matter of public record in July 2009, when Dr. Howzer moved to Wilmington, Delaware.

Despite this extensive adverse information about Dr. Howzer, Talleyville Hospital (in Delaware) granted him general surgery, thoracic surgery, and vascular surgery privileges. Talleyville also permitted Dr. Howzer to perform angiography/arteriography procedures in its cath lab, even though he was not formally granted privileges for those types of procedures. A hospital administrator did the coding for Dr. Howzer's cath lab procedures, even though nurses would usually do the coding for all cath lab procedures.

A review of Dr. Howzer's background indicates that he lacks the training, skill, and experience to safely and effectively perform the procedures described above. Indeed, it was soon apparent that Dr. Howzer had a very high complication rate at Talleyville. And the nursing staff at Talleyville began to continuously and explicitly complain that he was a danger to his patients. For example, during February 2010, Dr. Howzer attempted a renal stent procedure on three patients. In each, he perforated the patient's renal artery, causing internal bleeding and ultimately the death of each patient. Moreover, these patients had only minimal stenosis and did not even require a renal stent procedure in the first place.

Still, the hospital took no action against Dr. Howzer, explaining that it did not have the power to limit or suspend his privileges. After all, the hospital had recently lost litigation involving the suspension of privileges of seven cardiologists. Indeed, the suspension of these other physicians' privileges cost Talleyville a great deal of money both in terms of damages, legal fees, and lost revenue from the Heart Center. It appeared that Talleyville attempted to recoup some of this shortfall by allowing Dr. Howzer to perform procedures in the Heart Center cath lab.

Finally, not only Talleyville but also Dr. Howzer himself was experiencing financial difficulty. Dr. Howzer filed for bankruptcy, seeking to discharge some $600,000 in debt (some of which was apparently due to purchases of controlled substances). He apparently was performing as many procedures as possible, whether or not the procedures were medically indicated and whether or not he was trained or competent to perform them.

Assess the government's False Claims Act case against Talleyville Hospital.

PART THREE

1 long essay question worth 70 points

Suggested time = 70 minutes

Brandywine Hospital is the only hospital in Concord, Pennsylvania. In January 2010, Penders Urological Center (PUC) built a freestanding ambulatory surgery center (ASC) near Concord. PUC constituted the first substantial competition that Brandywine would have for surgical services. While physicians are paid a professional fee ("professional component"), the hospital is paid a technical fee ("facility fee") for the use of its operating room, nurses and equipment. Brandywine was concerned about an imminent loss in surgical facility fees.

Brandywine began negotiating with local gastroenterologists. To inform its negotiations, Brandywine commissioned a study of gastroenterologist compensation in southeastern Pennsylvania. That study showed total compensation was typically less than 100% of a physician's net collections/billings. For example, low-billing physicians with net collections of $600,000 had total compensation of about $300,000. High-billing physicians with net collections of $1,000,000 had compensation of about $670,000.

In March 2010, Brandywine ultimately entered into part-time employment contracts that included the following three terms. (1) Brandywine promised to pay these physicians 130% of their net collections and asserted that this represented fair market value. (2) The contracts required the physicians to perform all outpatient surgeries at Brandywine. (3) The contracts also prohibited the physicians from performing outpatient surgeries at any other location, specifically at any ASC, within 30 miles of the nonprofit hospital. The contracts have been in force for about two months.

Identify and analyze all legal risks to which Brandywine Hospital has exposed itself by entering into these contracts with the gastroenterologists.

---------- END OF EXAM ----------

MEMORANDUM

TO: Health Law II class (Spring 2010)
FROM: Professor Pope
DATE: May 28, 2010
RE: Your Final Exam

Attached are the scoring sheets that I used to grade the May 6, 2010 final exam. There were a total of 180 earnable points on the exam. The exam scores ranged from 33 to 147 (MJ: 33-138, JD: 56-132, LLM: 84-147). The average total **exam** score was 88 (MJ: 67, JD: 101, LLM: 110). The average for the multiple choice section was 38 of 60 points. The average for the short essay was 23 of 50 points. The average for the long essay was 27 of 70 points.

In accordance with the course syllabus and the exam instructions, I used this scoring sheet only to determine a numeric score. GPA-relevant letter grades were determined based on the cumulative total of the quizzes (20% or 60/300 points), midterm (20% or 60/300 points), and final exam (60% or 180/300 points). The J.D., L.L.M., and S.J.D. students were curved together. I will post model exams separately. I am happy to provide you with a copy of your individual exam and exam scoring sheet. After you have reviewed these, I am happy to review your exam with you.

Cumulative **course** point totals ranged from 83 to 232. Total points were correlated to letter grades as follows, except that, not represented below, in both the M.J. and J.D. classes one B+ was bumped to an A- based on participation.

JD/LLM total	Grade		MJ total	Grade
229-232	A+ (2)		232	A+ (1)
223	A (2)		169-182	A- (2)
216	A- (1)		132-159	B+ (4)
204-207	B+ (5)		83-109	B (5)
174-189	B (6)			
134	B- (1)			

Short Essay

NOTE: This problem was adapted from *United States v. Azmat*, No. 5:07-CV-00092-LGW-JEG (S.D. Ga. Nov. 2007) (complaint). The "call" of the question asked you to "assess the government's False Claims Act case against Talleyville Hospital."

	Issue	Points	Earned
Claims	While strongly implied, the fact pattern did not clearly state either (1) that any claims had been **submitted** or (2) that they were submitted to **federal payers**. These are necessary elements for establishing FCA liability. Consequently, you should have assumed these facts or noted that you need to confirm them.	**5**	
	Since the defendant is the hospital and not the individual physician, the submitted claims must be those **of the hospital.** The hospital billed separately for surgical procedures. Vicarious liability is possible, though not well-established under the FCA.	**5**	
False	**Worthless services** – This theory of falsity provides that the surgical services provided were of such very low quality that they were, effectively, equal to not really providing the services at all.	**5**	
	Here, the worthlessness is established with, among other facts: (1) the high error rate, (2) the physician's lack of training, (3) the physician's likely impairment.	**5**	
	Not medically necessary – This theory of falsity is established through **express false certification**. The claim form itself certifies medical necessity. So, signing and submitting the form when the services were actually not medically necessary makes that certification false.	**5**	
	Here, the lack of medical necessity is established with, at least, the fact that renal stent procedures were not indicated for those patients that received them. Those procedures were performed to generate revenue, not to address any illness or injury.	**5**	
	Upcoding – Both because coding was not done in the usual way and because the hospital was desperately seeking to replace lost revenue from this department, there is a strong implication that services were being upcoded.	**5**	
Knowingly	**Conscious motive –** If the hospital were upcoding, it appears that was deliberate. Facts that support this include (1) the switch in coding personnel and (2) the hospital's strong desire to replace lost revenue.	**5**	
	Actual knowledge – The hospital knew that the physician was providing worthless services because it knew he lacked the requisite skill to perform them. It knew this: (1) from his prior record, (2) from the nurses' complaints, and (3) from the high error rate.		
	Recklessness – Even if the hospital did not have actual knowledge that the services were worthless or lacked medical necessity, it certainly was on notice that it had created circumstances risking worthlessness and lack of medical necessity.	**5**	
	Helplessness – The hospital appears to argue that even if it knew of the risks of false claims, it could not stop them. Therefore, the argument might go, it was not "reckless" to permit them to continue. This argument fails because the premise is false. With the significant evidence in this case, the hospital could have built a case and achieved immunity under the HCQIA. The hospital chose not to do so, because the physician was earning revenue for the hospital.	**5**	
Total		**50**	

Long Essay

NOTE: This problem was adapted from *United States v. Tuomey Healthcare System*, No. 3:05-CV-2858-MJP (D.S.C. Dec. 2007) (complaint). The "call" of the question asked you to "identify and assess all legal risks to which Brandywine hospital has exposed itself by entering into these contracts with the gastroenterologists."

	Issue	Points	Earned
Stark	**Financial relationship** – The compensation arrangement meant that the gastroenterologists and the hospital were in a financial relationship.	**5**	
	Referral – The physicians made referrals to the hospital, and the hospital billed for services provided to the referred patients.	**5**	
	DHS – The referrals were for inpatient services, which are DHS.	**5**	
	No exception – The employment exception would require FMV. The compensation here appears to be very far above FMV.	**5**	
Anti-Kickback	**Remuneration** – Normal compensation was 50-70% of billings, but here it was 130%.	**5**	
	To induce – It looks like at least one purpose of the remuneration was to induce referrals (to compete against the ASC). Among other things, the contracts "locked-in" the gastroenterologists.	**5**	
	No exception – As with the Stark exception, the AKS employment exception would require FMV. The compensation here appears to be above FMV.	**5**	
	Knowing & Burden of proof – BH knew from its own study that the compensation was high. Still, liability would be more difficult to establish liability under AKS than under Stark because of the higher burden of proof in criminal law.	**5**	
False Claims Act	**Claims** -- Claims were probably submitted because the fact pattern states that the arrangement has been in place for "two months."	**5**	
	Falsity – The primary theory of falsity would be **implied false certification**. When the hospital submitted claims for services performed by the gastroenterologists, it impliedly certified that it complied with Stark and AKS. Both of those statutes condition payment on compliance. Since the hospital violated those statutes, the certification was false.	**5**	
	Knowing – The hospital did commission a study of compensation. But it ended up entering into contracts with much higher compensation than the figures in the study. The hospital either knew or was at least reckless with regard to Stark and AKS compliance.	**5**	
501(c)(3)	**Nonprofit tax exempt status** – The hospital is described as "nonprofit." Only hospitals that are tax exempt are concerned with the requirements for maintaining that status.	**5**	
	Private benefit – The revenue passing from the EO to the gastroenterologists exceeds FMV for services provided. It is unclear whether the gastroenterologists qualify as "insiders." But even if they do not, this transaction constitutes private benefit, which is specifically prohibited.	**5**	
	No EBT issue – Since the question asked you to assess risks to the hospital, you did not need to analyze EBT. EBT liability would be imposed on the gastroenterologists and perhaps the hospital manager that approved the contracts. In any case, note that the approval process may have earned safe harbor for the transaction.	**---**	**---**
Sherman Act	**Agreement** – The contract between the gastroenterologists and the hospital.	**5**	
	Unreasonable restraint of trade – The exclusive dealing provision looks like a trigger for *per* se or "quick look" analysis. But this would most likely be analyzed under the rule of reason.		
Total		**70**	

Health Law II Pope
Standard Item Analysis Report On Spring 10 Version A Version A

Course #:
Course Title: Health Law II
Day/Time:

Instructor: Professor Pope
Description: Final
Term/Year: Spring/10

Total Possible Points:	30.00	Median Score:	18.75	Highest Score:	26.00
Student in this group:	29	Mean Score:	18.59	Lowest Score:	12.00
Standard Deviation:	3.43	Reliability Coefficient (KR20):	0.58		

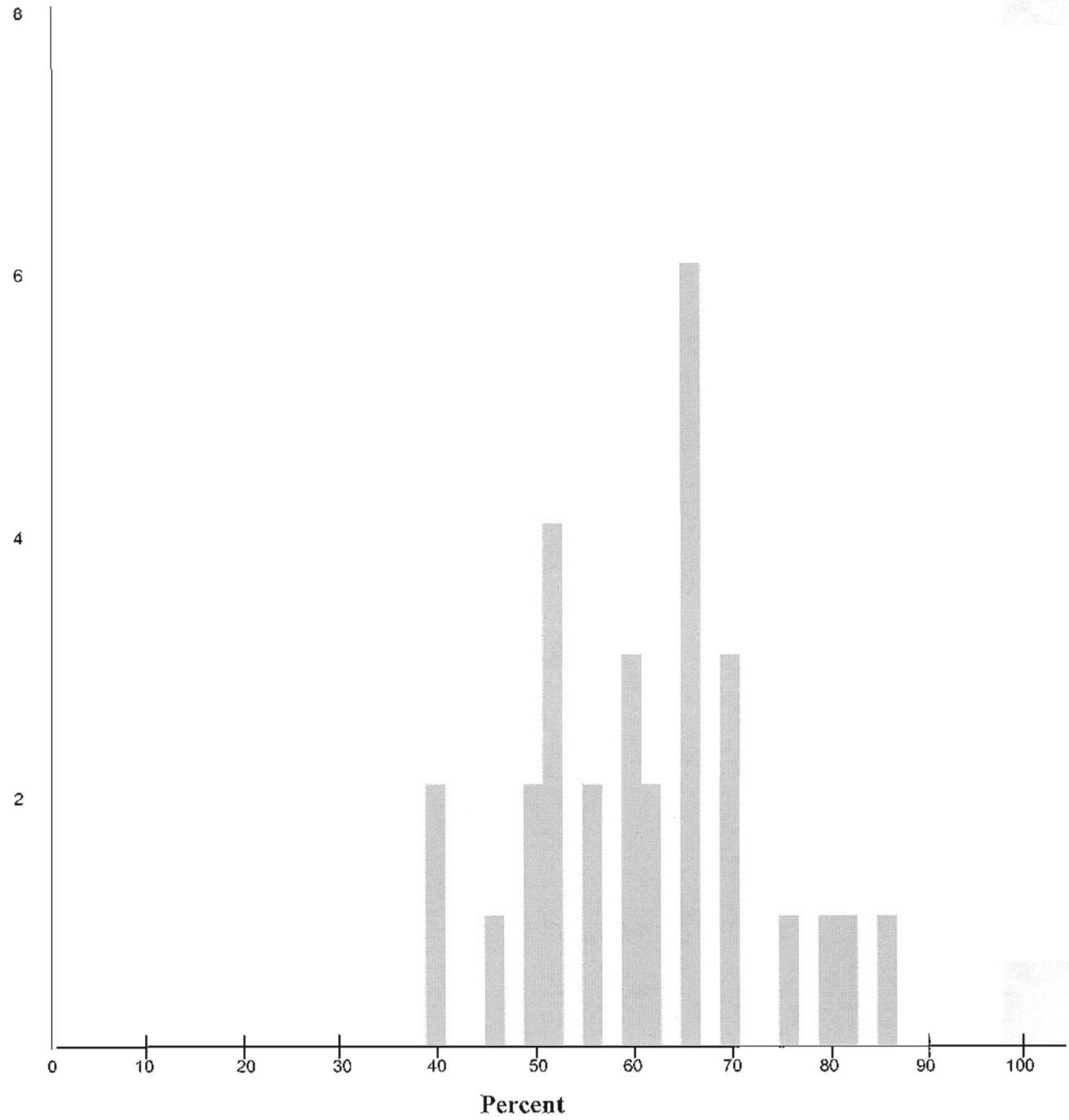
No.	Correct Group Responses			Point	Correct	Response Frequencies - * indicates correct answer										Non
	Total	Upper 27%	Lower 27%	Biserial	Answer	A	B	C	D	E						Distractor
1	37.93%	37.50%	25.00%	0.18	A	*11	0	0	18	0						BCE
2	100.00%	100.00%	100.00%	0.00	C	0	0	*29	0	0						ABDE
3	96.55%	87.50%	100.00%	-0.24	E	0	1	0	0	*28						ACD
4	72.41%	75.00%	75.00%	0.13	D	0	7	1	*21	0						AE
5	79.31%	75.00%	87.50%	-0.04	E	2	2	1	0	*23						D
6	27.59%	37.50%	25.00%	0.19	A	*8	14	6	0	1						D
7	34.48%	87.50%	12.50%	0.57	B	18	*10	0	1	0						CE
8	58.62%	75.00%	37.50%	0.29	C	6	2	*17	4	0						E
9	79.31%	75.00%	75.00%	0.09	B	3	*23	3	0	0						DE
10	37.93%	50.00%	37.50%	0.09	D	1	3	0	*11	14						C
11	68.97%	87.50%	50.00%	0.46	C	0	4	*20	3	2						A
12	13.79%	12.50%	12.50%	0.19	A	*4	1	0	4	20						C
13	86.21%	87.50%	75.00%	0.24	A	*25	0	2	2	0						BE
14	37.93%	75.00%	12.50%	0.45	B	4	*11	10	4	0						E
15	44.83%	87.50%	0.00%	0.63	C	3	3	*13	6	4						
16	72.41%	100.00%	12.50%	0.71	D	0	5	3	*21	0						AE
17	65.52%	62.50%	37.50%	0.38	A	*19	8	1	1	0						E
18	31.03%	25.00%	12.50%	0.10	A	*9	6	10	4	0						E
19	58.62%	75.00%	62.50%	0.04	C	0	2	*17	10	0						AE
20	93.10%	100.00%	87.50%	0.13	D	1	0	1	*27	0						BE
21	65.52%	100.00%	75.00%	0.23	C	2	1	*19	7	0						E
22	31.03%	87.50%	0.00%	0.56	D	1	3	16	*9	0						E
23	62.07%	75.00%	87.50%	-0.01	D	0	0	11	*18	0						ABE
24	93.10%	100.00%	75.00%	0.44	B	1	*27	0	0	1						CD
25	93.10%	100.00%	87.50%	0.09	D	0	0	2	*27	0						ABE
26	89.66%	100.00%	62.50%	0.42	D	0	1	2	*26	0						AE
27	82.76%	100.00%	62.50%	0.26	C	1	2	*24	2	0						E
28	51.72%	75.00%	12.50%	0.55	B	1	*15	4	9	0						E
29	37.93%	25.00%	25.00%	0.03	A	*11	2	9	6	0						E
30	55.17%	87.50%	25.00%	0.52	B	10	*16	3	0	0						DE

Health Law II Pope
Score Distribution Histogram Report On Spring

Course #:
Course Title: Health Law II
Day/Time:

Instructor: Professor Pope
Description: Final
Term/Year: Spring/10

Number of Students:	29	Total Possible Points:	30.00	Standard Deviation:	3.43
		Highest Score:	26.00	Mean Score:	18.59
		Lowest Score:	12.00	Median Score:	18.75



05/18/10

Health Law II Pope
Class Response Report On Spring 10 Version A

Course #:
Course Title: Health Law II
Day/Time:

Instructor: Professor Pope
Description: Final
Term/Year: Spring/10

Response Description

<dash>	correct response	<#>	multiple marks
<alphabet>	student's incorrect response	<*>	bonus test item

<space> no response

Test Items:	1-5	6-10	11-15	16-20	21-25	26-30				
Test Key:	A,C,E,D,E	A,B,C,B,D	C,A,A,B,C	D,A,A,C,D	C,D,D,B,D	D,C,B,A,B				

No.	Student ID	Exam #										
1	562203	0	-,-,-,-,-	B,A,A,-,-	-,-,D,C,A	C,-,C,D,-	-,C,-,-,-	C,D,D,C,-				
2	563740	0	D,-,-,-,C	C,A,-,-,-	-,D,-,C,B	-,-,B,-,-	-,C,-,-,-	-,B,D,-,A				
3	563745	0	-,-,-,B,-	B,-,-,-,E	-,E,-,-,-	-,-,C,-,-	-,-,-,-,-	-,-,-,-,-				
4	563748	0	D,-,-,-,	E,A,-,-,E	E,D,-,-,A	B,B,-,D,-	-,A,-,E,-	-,-,C,D,A				
5	563750	0	-,-,-,-,-	B,D,A,-,E	-,-,-,-,D	-,-,D,D,-	-,C,C,-,-	-,-,D,C,-				
6	563795	0	-,-,-,B,-	B,A,-,C,E	B,E,-,C,D	-,-,C,-,-	A,-,C,-,-	-,-,C,-,A				
7	563811	0	D,-,-,-,-	B,-,-,C,-	-,E,-,-,-	-,-,D,-,-	-,-,-,-,-	-,-,-,D,-				
8	563824	0	D,-,-,-,-	B,A,-,-,B	E,B,-,-,D	-,-,-,-,-	B,C,-,-,-	-,-,-,D,A				
9	563851	0	-,-,-,-,-	-,A,-,-,E	-,E,-,A,E	B,B,C,D,C	D,C,-,-,-	-,B,-,-,C				
10	563947	0	D,-,-,-,-	B,A,-,-,E	-,E,-,C,-	-,-,-,D,-	D,B,C,-,-	-,-,-,-,-				
11	564029	0	-,-,-,-,B	C,-,B,-,-	-,E,-,C,-	-,B,-,B,-	-,C,-,-,-	-,-,A,-,A				
12	564078	0	D,-,-,B,-	B,A,A,A,E	D,E,-,D,D	C,B,B,-,-	-,C,-,A,-	-,-,D,B,-				
13	564087	0	D,-,-,-,-	-,A,A,-,E	-,D,-,A,E	-,-,C,-,-	-,C,C,-,-	-,D,D,C,A				
14	564089	0	-,-,-,-,-	-,A,D,-,E	-,E,-,C,A	-,-,C,D,-	D,C,-,-,-	-,-,-,-,-				
15	564188	0	D,-,-,B,-	-,-,-,-,A	-,E,-,-,D	-,-,D,-,-	-,-,C,-,-	-,-,D,D,-				
16	564241	0	D,-,-,-,-	B,A,D,-,E	B,E,-,A,-	-,-,D,D,-	D,-,C,-,-	-,-,-,-,A				
17	564259	0	D,-,-,-,-	B,A,-,A,E	B,E,-,-,-	-,-,C,D,-	-,C,-,-,-	-,-,C,C,-				
18	564262	0	-,-,-,B,A	B,-,-,-,-	-,D,-,-,D	B,B,-,-,-	D,B,C,-,-	-,A,-,C,A				
19	564286	0	D,-,-,-,-	B,A,A,-,E	-,E,C,C,-	-,-,-,-,A	A,C,C,-,-	-,-,-,-,-				
20	564359	0	-,-,-,C,-	-,A,-,-,-	-,-,-,C,-	-,-,C,D,-	D,C,C,-,C	-,-,-, ,-				
21	564569	0	-,-,B,-,A	-,-,-,C,B	B,E,-,-,-	-,-,-,-,-	-,-,-,-,-	-,-,-,C,-				
22	564593	0	D,-,-,B,-	-,A,-,-,E	-,E,-,A,E	-,-,-,-,-	-,C,C,-,-	-,-,-,C,-				
23	565069	0	-,-,-,-,B	C,-,B,-,-	-,E,-,C,-	-,B,-,B,-	-,C,-,-,-	-,-,-,D,-				
24	565161	0	D,-,-,-,-	-,-,-,-,B	-,E,-,C,-	-,C,C,-,-	-,-,C,-,-	-,-,D,-,A				
25	565250	0	D,-,-,-,-	C,-,A,-,-	-,E,-,D,E	C,B,B,-,-	-,B,-,-,C	B,-,D,B,C				
26	572246	0	D,-,-,-,-	B,A,D,A,E	D,E,-,D,B	B,-,C,-,-	-,C,-,-,-	-,-,C,-,A				
27	573141	0	D,-,-,-,-	C,A,D,-,-	-,E,D,-,-	-,B,B,D,-	-,-,-,-,-	-,-,-,C,-				
28	573846	0	D,-,-,-,-	C,-,-,-,-	-,-,-,-,-	-,-,B,-,-	-,-,-,-,-	-,-,-,C,-				
29	629341	0	D,-,-,B,-	B,A,-,-,-	D,E,C,D,B	B,D,B,-,-	D,C,-,-,-	C,-,D,D,C				

ID: [redacted] HealthLawII_(Pope)-10SP Pope

Model answer Final EXAM

1)

1) Short Essay

False Claims Act Libaility Against Talleyville Hospital

The government may have a strong case for False Claims Act liability agaisnt Talleyville Hospital. For a hospital to be liable under the False Claims Act it must: 1) submit claims to the federal government; 2) the claim must be false or fraudulent; and 3) the hospital had to 'know' that the claims were false or fraudulent.

Claims submitted to the federal government

The False Claims Act (FCA) applies to all claims submitted to the federal government. If Talleyville Hospital (Talleyville) does not submit any claims to the federal government, then it cannot be held liable under the FCA. However, most hospitals do submit claims to the federal government. Roughly 65% of all medical care in the United States is paid for by Medicare or Medicaid. As such, a majority of hospitals participate in the Medicare and Medicaid programs by accepting and providing care to patients insured under Medicare and Medicaid. Thus, it is more likely than not that Talleyville participates in the Medicare and Medicaid systems and thus it most likely submits *claims* for payment to those systems.

Claim false or fraudulent

The second element of the FCA requires that the claims submitted to the federal government be false or fraudulent. A claim can be false or fraudulent in many ways. For starters, a claim will be considered false or fraudulent if: a) the services provided were not medically necessary; b) if the quality of service was so low that it amounted to no service at all, or; c) if the services were not compliant with the requirements set forth by the Centers for Medicare and Medicaid (CMS).

In this case, Dr. Howzer performed services on patients "whether or not the procedures were medically indicated," such as the renal stent procedures performed during February 2010. Under the doctrine of *express false certification*, if a Dr. signs a certification stating that services were medically necessary when they were not , the claim will be considered 'false or fraudulent' for the purposes of FCA. If Talleyville submitted any claims to the federal government for 'medically unnecessary' services provided by Dr. Howzer, it committed express false certification and thus submitted a 'false or fraudulent' claim to the federal government.

In addition, when the quality of services are lower than expected by the Department of Health and Human Service (HHS), the government analogizes the services to 'no service rendered.' Billing the federal government when 'no service' was rendered is a type of false claim. Most of Dr. Howzer's services likely fell well below the quality threshold established by HHS. Dr. Howzer had "a very high complication rate" for patients he served at Talleyville, and this fact is exemplified by the deaths of the three renal stent patients in February 2010. Moreover, Dr. Howzer performed many services "whether or not he was trained or competent to perform

them." As such, the quality of services performed by Dr. Howzer likely fell well below the quality expected by HHS. If Talleyville Hospital billed the federal government for any of the services provided to these patients, the claim submitted was false or fraudulent.

Lastly, when services provided are not compliant with regulations established by CMS, claims submitted for those services are also considered false or fraudulent. Under the doctrine of *implied false certification*, a false claim has been submitted if a statute explicitly mandates that payment for a service is conditioned upon adherence to the statue. Dr. Howzer was not qualified to perform many of the services he provided at Talleyville Hospital, frequently taking on cases "whether or not he was trained or competent to perform them." CMS regulations generally mandate that only qualified medical personnel perform services, and Dr. Howzar clearly was not qualified. Talleyville is implicated here for one primary reason: a hosptial administrator did the coding for Dr. Howzer's cath law procedures. If Talleyville submitted any claims to the federal government for Dr. Howzer's services that were not compliant with CMS regulations, they submitted a false or fraudulent claim.

Entity 'knew' the claim was false

The last element of the FCA requires that the person or entity billing the federal government know that the claim submitted was false or fraudulent. The FCA defines 'knowingly' three different ways: a) actual knowledge; b) reckless disregard, and; c) deliberate ignorance. In this case, Talleyville Hospital likely satisfied the 'acual knowledge' provision of the 'knowing'

requirement of the FCA.

For starters, before Dr. Howzer began working at Talleyville the information from his stint at Eastman Medical Center was publically available . If Talleyville had performed a search prior to hiring Dr. Howzer, it would have seen that 39% of his surgeries had resulted in complications and that he had been named in seven civil lawsuits in California. If Talleyville conducted a search and was aware of this information, it may have satisfifed the 'knowing' requirement of the FCA. However, even if Talleyville did not condcut such a search, but refrained from searching so as to deliberately avoid learning of Dr. Howzer's poor service record, they demonstrated 'deliberate ignorance' of his credentials and thus satisfy the 'knowing' requirement.

Most importantly, during Dr. Howzer's time at Talleyville the nursing staff "continuously and explicitly complain[ed] that [Dr. Howzer] was a danger to his patients." This information was made known to the hospital, and Talleyville demonstrated that they knew of Dr. Howzer's poor performance by explaining that it did not have the power to limit or suspend his privileges. As such, the hospital was well aware of Dr. Howzar's poor performance record and thus had 'actual knowlege' that they claims they were submitted were 'false or fraudulent.'

In sum, if Talleyville submitted claims to the federal government for the services provided by Dr. Howzar, it violated the False Claims Act.

Short Essay / **Example of what NOT to do**

Issues

The standard of prof in a false Claims Act case is "preponderance of the evidence". The claim is more likely true than not. This is the same burden of proof ordinarily applicable in most civil cases and is easier to meet than the "beyond a reasonable doubt" standard use in a criminal case.

This is fine law

The false Claim Act may take many forms overcharging, failing to perform a service delivering less than the promised amount of goods or services, underpaying money owed to the Government, providing inferior products failing to comply with proper restricted charges for one thing but delivering another and violating Government regulation

The legal definition of a FCA can be found in Section §3729 of the Act

Short Essay

Facts Dr. Howzer worked for Eastman Medical Center in LA until 7/2009. It had been determined that in about 39% of Howzer's cases post operative complications occured. Howzer had been named in 7 civil lawsuits when in California. All information was a matter of public record. Despite this extensive adverse information Howzer Talleyville Hospital granted him general surgical, thoracic and vascular surgical privileges. Talleyville also permitted Dr. Howzer to perform angiography/ arteriography procedures in its cath lab, even though he was not formally granted privileges for those type of proadures.

The hospital admitted the coding for Howzers cath lab procedures, even though nurses usually do the coding for ALL cath lab procedures.

During a review of Howzer's background indicated that he lacks the training, skill and experience to safely + effectively perform those procedures.

After the Nursing Staff began to complain that he was a danger to his patients Talleyville

This is pure facts

took no action against him. Dr Houzer felt the hospital did not have the power to limit a suspend his privileges, due to a recent lost litigation involving the suspension of privileges of 7 cardiologists. The suspension of these cardiologists cost Tallyville a great deal of money, both in fees of damages legal expenses privileges and a great deal of lost revenue for the Heart Center.

Facts

Tallyville was attempting to make up for lost funds by allowing Houzer to practice medicine at the Cath Lab, although he was not qualified.

Both Tallyville and the good doctor were experiencing financial difficulties. Houzer filed for bankruptcy, seeking to discharge 600,000 of dept. He was performing as many procedures as he possibly could but he was not qualified trained or competent to perform the procedures.

Rule

False Claim act

The law of false claims is designed to protect the government from paying for goods or services that have not been provided or were not provided in accordance with government

Core law

regulations The False claims act, permits the federal gaumnet to recover from individuals who knowingly submit false claims (can obtain treble damages for each claims) Private "qui tam" actions enable private individuals to bring action to enforce the False Claim Act.

False Claim act imposes civil and criminal penalties while Stark imposes civil penalties.

Government Enforcement

Very little analysis

Houzer The (D) could be charged with aggravated form of gross negligence, a disregard because (D) performed procedures that he was not qualified to do. The FCA requires a level of scienter of - (1) actual knowledge (2) deliberate ignorance, a act in (2) reckless disregard for pt safety. The court could find that (D) acted with disregard to laws and is guilty of an aggravated form of gross negligence a "gross negligence plus", was equivalent to reckless disregad, and thus the appropriate level of scienter to apply in False Claim act action, Houzer performed procedures that were medically necessary, however he lacked the proper credentials to perform those

procedures he will be found liable for his acts. if he -

① Knowingly presents a causes to be presented a false a fraudulent claim for payment approval -

② Knowingly makes, uses, or causes to be made used, a false record a statemet material to a false a fraudulent claim

③ Conspires to commit a violation of sub paragraph (A)(B)(D)(E)(F) a (G)

Houzer is guilty of knowingly presenting a claim for services rendered, however in order for that Claim to be legal the person providing the services must meet all standards of necessary care, and be in agreement with all rules and regulations set forth by the FLA -

End

Example of What NOT to do.

Long Essay.

Brandywine Hospital ("hospital") would violate Anit Kikkba Statute if the government show that.

AKS

Can it? Why?

- The Payment of 130% to Physician, if it Not the fair Marke Value, it would be illegal remuneration
- the hospital offer this remuneration to induce doctors to reffer thier Patient to the hospital, and the services that Perfurmed by these doctors are billed to the governme through Medicar or Medicaid.
- the hospital Willfuly and knowingly agreed with the gastroenterologists to give them more money So the refer more Patient, Medicare and Medicaid Patients, to hospital.

Stark the government has to show the following to claim the hospita violate Stark.

Can it? Why?

1. Physician hospital has an agreement with doctors
2. Make referal to disignated health service (DHS) government has to shew that doctors made referral to a DHs, and doctors made referals, according to agreement to out Patient hospital Services which is one of the DHs.
3. Patient recived DHs, Government has to show that not only doctors mad a referal to DHs but also Patient received a service from DHs.

cont

4- hospital has to bill this service to the government through Medicare or Medicaid

5- doctors have a financial relation with DHS provider, doctor has this interst because hospital will give them high compensation for each referal and ~~the~~ compensation is a financial relation

6- No exeption applies, the exeption that might apply here is the professional services exeption, government could argue that hospital agreement did not meet the exeption because the compensation is not a fair Market value

501(c)(3) Brandywine as nonprofit hospital could lose thier status because they violated 501(c)(3) requirment, hospital alone that by allowing private benefit from their income goes to doctor ~~the high compensation for doctor exceeded~~ doctors as a third party outsider NOT allowed to get benefit from a nonprofit income but hospital allowed them to get this benefit by offering the high compensation.

[redacted]

false claim Act if the government succeed on their AKs, Stark, and 501(c)(3) they could argue that doctor might refer to hospital who billed government for false or fraudulet claim that paid by the government to hospital. The hospital billing for those services constitute implied false certification

Shermon the exclusive dealing between hospital and doctors Act. is a per se violation, hospital can argue that ~~doctor~~ the agreement is not horizontal because doctors are not competitors, but government can show this is a horizontal agreement because if the local doctors are not exclusvly make referal to hospital they would be competitors.