Exam ID # _____

WIDENER UNIVERSITY SCHOOL OF LAW

HEALTH LAW II FINAL EXAM

Professor Pope **Spring 2011**

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 **fourteen (14) pages**, including this cover page. Please make sure that your exam is complete.

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

7 **Timing:** This exam must be completed within three hours.

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

9 **Open Book:** This is an OPEN book exam. You may use ***any*** written materials, including, but not limited to: any 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. You may use a "basic" calculator for computations such as HHI or COBRA.

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

PART ONE comprises 25 multiple choice questions worth three points each, for a ***combined*** total of 75 points. The suggested total completion time is **75 minutes**.

PART TWO comprises one essay question worth 30 points. The suggested completion time is **30 minutes**.

PART THREE comprises one essay question worth 75 points. The suggested completion time is **75 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 other students in the class. Your course letter grade is computed by summing the midterm, final, and quiz scores. Your total raw score will be converted into a scaled score, based on the class curve. There are two separate curves: one for M.J. students and one for J.D. and LL.M. students. The applicable mandatory curve in this class permits a maximum average grade of 3.40 for the J.D. students. I will post an explanatory memo and a model answer to TWEN a few weeks after the exam.

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

SPECIAL INSTRUCTIONS FOR PART ONE:

1. **Format:** This Part contains 25 multiple choice questions, worth three points each, for a combined total of 75 points. This part has a suggested completion time of 75 minutes. Please note that the questions vary in both length and complexity. You might answer some in 20 seconds and others in two minutes.

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

3. **Fill the Oval 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 that is otherwise illegible. ***I am serious; write neatly.***

3. **Outlining Your Answer:** I strongly encourage you to use ***at least*** 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.

   Do this 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 and are implicated by 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 complete substitute for legal analysis. 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 claim against C is identical to A's claim against C, because __." But be very 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 (reasonably implied by, suggested by, or at least consistent with, the fact pattern) that you believe to be necessary to answer the question.

STOP !

Do NOT turn this page until the proctor signals

PART ONE

25 questions worth three points each = 75 points
Suggested Time = 75 minutes

1. Both Medtronic and Boston Scientific manufacture pacemakers. Suppose the Medtronic and Boston Scientific executives made the following arrangement: Medtronic would be allowed to sell its pacemakers in New Jersey and Boston Scientific would be allowed to sell its pacemakers in Delaware, but Boston Scientific could not sell in New Jersey and Medtronic could not sell in Delaware. This arrangement would constitute:

A. A violation of the Clayton Act.
B. A violation of the Sherman Act.
C. A *per se* violation of the Sherman Act.
D. A violation of the False Claims Act.
E. None of the above.

2. The principle that lets private citizens bring a lawsuit on behalf of the government is known as:

A. Preemption.
B. *Qui tam.*
C. Pro se.
D. *Res ipsa loquitor*.
E. There is no such principle.

3. What is the main financial difference between a nonprofit and a for-profit hospital?

A. Nonprofit employees don't have to pay any taxes on their salary.
B. Nonprofits can only distribute 50% of their profits to owners or shareholders.
C. Nonprofits cannot distribute profits.
D. Nonprofits never have to report their revenue.

5. A hospital reviews a surgeon's professional competence and assigns a surgical proctor for 60 days. The surgeon cannot perform surgery without being granted approval by the surgical proctor. If the surgeon sues the hospital:

A. The hospital is immune from both injunctive relief and from damages under the HCQIA, so long as it reported the restriction to the NPDB.
B. The hospital is immune from damages under the HCQIA, so long as it reported the restriction to the NPDB.
C. The hospital is immune from damages under the HCQIA, even if it did not report the proctoring to the NPDB. Since this was not a "professional review action," a termination or denial of privileges, it did not need to be reported.
D. The hospital is categorically immune from credentialing lawsuits under the HCQIA.

6. A tax-exempt hospital made loans for the personal benefit of its founder and his family members and friends, made research expenditures to advance his personal hobby, and purchased stock in a corporation owned by a friend of his. The tax-exempt status of the hospital:

A. Is jeopardized by private benefit.
B. Is jeopardized by private inurement.
C. Is jeopardized by excess benefit transactions in violation of section 4958 of the Internal Revenue Code.
D. Both A and C.
E. Both B and C.

7. In April 2011, it was discovered that heart device specialists at a Wilmington, Delaware practice started using Biotronik implants in nearly all their patients in 2009, after company documents showed they became consultants to the device maker, getting up to $5,000 a month in fees. Last year, at one Wilmington hospital where the cardiologists practiced, 95 percent of the Medicare patients, or 250 of the 263 people who got a pacemaker or defibrillator, got a Biotronik device. Does this arrangement violate the Anti-Kickback statute?

A. Yes, if one purpose of the consulting fees was to induce the physicians to use Biotronik devices.
B. Yes, if the Biotronik devices were not "medically necessary" for the patients who received them.
C. No, unless the implants were "designated health services."
D. No, unless the sole or primary purpose of the consulting fees was to induce the physicians to use Biotronik devices.
E. Yes, if both A and B are true.

8. What remuneration carries the MOST risk of Anti-Kickback Act liability?

A. A hospital gives free office space to a physician who has admitting privileges for her patients at that hospital.
B. A physician hires a billing service and agrees to pay them a percentage of the amount of Medicare reimbursement obtained from their billing on her behalf.
C. A hospital and a cardiology practice have a written agreement that the cardiologists will perform all EKG analysis for inpatients at the hospital, exclusively, and the hospital will send all its business to the cardiologists and provide equipment, staff, and space.
D. None of the above scenarios carries a risk of AKS liability.

9. How many days does a qualified beneficiary have to elect to continue COBRA?

A. 30 days from the date of the loss of coverage.
B. 45 days from the date of the loss of coverage.
C. 30 days from the later date of the loss of coverage or the date of notification.
D. 60 days from the later date of the loss of coverage or the date of notification.

10. What employers have to comply with COBRA?

A. All employers must comply with COBRA.
B. Any employer with at least 20 full time employees and a fully-insured group health plan.
C. Any employer with at least 20 full time employees and either a fully- or self-insured group health plan.
D. Any employer with at least 50 full time employees and a fully-insured group health plan.
E. Any employer with at least 50 full time employees and either a fully- or self-insured group health plan.

11. The new Health Care Reform Law contains provisions which:

A. Establish a link between violations of the False Claims Act and the Anti kickback statute (AKS).
B. Require that defendants must know that their actions willfully violated the AKS, not just that their conduct was unlawful.
C. Will make it harder for relators to bring frivolous *qui tam* suits.
D. Narrow the range of False Claims Act liability for Stark Law violations.
E. More than one of the above.

12. Two hospitals in the Harrisburg, PA area have proposed to consolidate. Apart from these two hospitals there is only one other hospital within the six county area. After the proposed consolidation, the resulting entity would have a market share of more than 85 percent. Which of the following would be an appropriate rationale for challenging the proposed transaction under the Clayton Act?

A. Adverse impacts on the quality and breadth of services, since competition between the two hospitals to increase the quality of patient care would be extinguished.
B. The new entity's ability and incentive to increase reimbursement rates for general acute-care hospital services charged to commercial health plans.
C. The impact of the escalation of prices charged to commercial health plans on the area's employers and their employees.
D. All of the above.
E. None of the above.

13. Lizzie worked at Morton Medical Center as an operating room nurse from April 1991 until June 2008, when her at-will employment was terminated. In July 2007, Lizzie learned that another nurse was ill with a staph infection. Lizzie administered antibiotics to that nurse as part of the nurse's treatment. Afterward, Lizzie was concerned about the risk of the infection spreading and spoke about it with her supervisors and, later, with the hospital's security manager. Lizzie was then terminated. A state statute protects and encourages reporting of a condition or practice that the individual has reasonable cause to believe would put at risk the health or safety of that employee or any other individual. If Lizzie sues the Morton Medical Center, she:

A. Will lose, because she was an at-will employee.
B. Will win, because she was engaged in activity protected by the state statute.
C. Will win, only if she can establish that she was terminated because she was engaging in the activity protected by the state statute.
D. Will win, because she was engaged in activity protected by the NLRA.
E. Will win, because she can establish that she was terminated because she was engaging in the activity protected by the NLRA.

14. What is "community rating"?

A. A method by which insurance companies set premiums and subscribers all pay the same premium.
B. A method by which insurance companies set premiums based on the healthcare experience of each group in using health care services.
C. A method by which insurance companies set premiums that causes older and sicker groups to become less and less able to afford health insurance.
D. More than one of the above.
E. None of the above.

15. Why would some doctors consider unions?

A. Doctors would never think of unionizing because it is illegal according to the National Labor Relations Act for doctors to unionize.
B. Only doctors who are self-employed would even consider unions to bargain collectively.
C. Some doctors are looking for solutions in dealing with managed care issues and other issues such as benefits, salaries, working conditions at the place they work.
D. None of the above.

16. To prevent private inurement and private benefit, tax-exempt health care organizations should do which of the following?

A. Avoid making loans to physicians.
B. Avoid entering into joint ventures or other arrangements with physicians.
C. Assure that the purchase price for a practice is based on what the practice would be worth to the health care organization.
D. Pay fair market value for all assets and services.

17. Which of the following statements regarding physician compensation arrangements would violate the rules against private inurement and impermissible private benefit?

A. A compensation arrangement that rewards the physician based on services actually performed.
B. A compensation arrangement where the health care organization and physician jointly benefit from net profits.
C. A compensation arrangement established by an independent board or compensation committee.
D. Compensation arrangements comparable to those in place at health care organizations that are similar sized and serve a similar market and volume.

18. Physician recruitment and incentive arrangements must comply with the Anti-Kickback statute. Which of the following arrangements designed to induce a physician to relocate to the geographic area served by a hospital would violate these statutes?

A. A portion of the compensation agreement is based on the volume or value of referrals by the physician.
B. The agreement is silent as to whether a physician may establish privileges at another entity.
C. The physician is allowed, but not required, to refer patients to the hospital.
D. The arrangement between the physician and hospital was agreed upon orally but later established in writing.

19. Which of the following would most obviously jeopardize a tax-exempt health care organization's tax exempt status?

A. Compensation paid to physicians.
B. Below market rate loans.
C. Competitive market place rental payments.
D. Assets sold at fair market value.
E. None of the above.

20. Suppose your for-profit client wanted to construct, develop, or establish a new health care facility, health care service, or home health agency. Or suppose your client wanted to make a capital expenditure of $2,500,000 or more in connection with a health service or health facility. What law would be the most likely hurdle or potential obstacle to these initiatives?

A. Clayton Act
B. Sherman Act
C. Certificate of Need
D. 501(c)(3)
E. HCQIA

21. Medicare is federally funded health insurance for:

A. Every resident of the United States aged 65 and over.
B. People aged 65 and over, only if they satisfy certain poverty guidelines.
C. People of any age with end-stage renal disease (ESRD).
D. People of any age, only if they satisfy certain poverty guidelines.
E. B and C.

22. Medicare Part A covers all of the following EXCEPT:

A. Inpatient care in hospitals.
B. Hospice care.
C. Doctors' services and outpatient care.
D. Post-hospital skilled nursing facilities.

23. Medicaid is paid for by:

A. The federal government only.
B. State governments only.
C. State governments with a federal match ranging from 1:1 to 4:1.
D. State governments with a dollar-per-dollar federal match, up to an annually determined limit.
E. State governments with the help of federal block grants.

24. A claim for denial of benefits under ERISA:

A. Permits the recovery of pain & suffering damages demonstrably caused by the denial of benefits.
B. Permits the recovery of attorneys' fees if successful.
C. Permits the recovery of punitive damages, if the denial of benefits was willful, egregious, or wanton.
D. Can alternatively be brought as a state-law breach of contract claim.
E. None of the above is correct.

25. Which of the following are TRUE of the HCQIA?

A. It creates a private cause of action for physicians that are subject to a professional peer review.
B. It creates a presumptive statutory immunity from damages liability for those performing the professional peer review.
C. It creates liability for those performing the review, if they fail to follow HCQIA standards.
D. More than one of the above.
E. None of the above.

PART TWO

1 essay question worth 30 points

Suggested time = 30 minutes

Ruxing enrolled in a Jason-Select health insurance plan when he joined his employer, a Philadelphia law firm, in 2002. In February 2008, Ruxing was diagnosed with prostate cancer. His treating physician was Dr. Finn who recommended proton beam therapy ("PBT") for treatment instead of standard radiation therapy. Dr. Finn explained that PBT had a higher cure rate, lower complication rate, and a lower risk of radiation-caused malignancy.

On April 18, 2008, Jason-Select, acting as both plan administrator and insurer, denied Ruxing coverage for PBT. In its initial denial letter to Ruxing, Jason-Select stated: "This request is not approved for reimbursement because PBT to treat prostate cancer is considered to be experimental and investigational and as such is not eligible for coverage." The denial letter references the Plan's "specific limitations and exclusions." The Plan excludes "Procedures or treatments that WE conclude to be Experimental or Investigational." The term "Experimental or Investigational" is defined elsewhere in the Plan: "A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met: . . . Any health product or service that is subject to Investigational Review Board (lRB) review or approval . . . ."

IRBs are committees that have been formally designated to approve, monitor, and review medical research involving humans. Included in the denial letter is a three page document on "Proton Beam Therapy in Treatment of Prostate Cancer" that summarizes several ongoing medical studies regarding PBT. This document also demonstrates that each of the three studies is subject to the oversight of an "Institutional Review Board (IRB)."

After its initial denial of benefits, Jason-Select granted Ruxing a first level appeal. Dr. Finn submitted a letter for this appeal, which discusses PBT and states that PBT treatment is "medically necessary and essential" in treating Ruxing's prostate cancer. Ruxing also submitted the results of a clinical investigation conducted by physicians at the Pennsylvania University reporting favorable results from PBT treatment. Ruxing also noted that Jason-Select's document summarizing PBT studies demonstrated that those were subject to "investigational" not to "institutional" review boards. Jason-Select's committee met on June 3, 2008 and affirmed the denial the next day.

Despite his denial of coverage, Ruxing decided to undergo PBT treatments. He spent approximately $145,000 to undergo these treatments. Ruxing has come to you because he now wants to sue Jason-Select to recover his $145,000. Describe and assess Ruxing's best cause of action.

PART THREE

1 essay question worth 75 points

Suggested time = 75 minutes

Happy Hospice House ("HHH") is a non-profit provider of hospice services in fourteen states, including Delaware. HHH contracts with Medicare and Medicaid to provide such services. Approximately 93 percent of HHH's clients are enrolled in Medicare and approximately 4 percent of HHH's clients are enrolled in Medicaid.

In order for a patient to be admitted to hospice care and be eligible for hospice benefits, the patient must be certified as being terminally ill. "Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course." Pursuant to federal regulations, a hospice must obtain written certification of terminal illness for each of certain periods in which a patient is admitted to hospice care. In other words, a hospice must not only certify a patient's initial eligibility for hospice care, but also must regularly certify that patient's continued eligibility for hospice care.

In 2009, HHH undertook three new initiatives to increase its "census," the number of patients enrolled in its hospices. **First**, HHH told its employees to certify patients for hospice care who were not terminally ill. For example, HHH encouraged its employees to diagnose patients with Alzheimer's disease, dementia, or "failure to thrive." Since these are nebulous diagnoses, they allowed HHH employees to justify continued hospice care. If an employee or physician refused to certify a patient as terminally ill and therefore eligible for hospice care, HHH would turn to another employee or physician to do so. While several employees complained about these practices to their superiors, HHH terminated their employment.

Second, both to encourage patients to enroll and to keep enrolled patients from revoking HHH enrollment, HHH offered them extra durable medical equipment supplies, extra nursing and staff visits, and other extra benefits. For example, patient L.B. received about $1,500 in assistance to pay for electric bills, groceries, and having his hot water heater fixed. L.B. later won a gift card from HHH in a contest for referring other patients to HHH.

Third, HHH ordered a set package of durable medical equipment for each patient who was enrolled. In other words, each time a patient was signed up with HHH, HHH would automatically order that patient a bedside commode, a bedside table, a walker, a wheelchair, oxygen, a hospital bed, and a specialized mattress, regardless of whether the patient needed all of this equipment. In return for ordering this equipment, HHH would receive bulk discounts from Med-Depot. HHH paid a discounted rate to Med-Depot for the supplies, in exchange for using Med-Depot as its exclusive medical supply vendor.

HHH has just hired you to serve as its compliance officer. Please assess the company's exposure to sanctions and/or other adverse action by the federal government.

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Pope – Health Law: Spring 2011 Final Exam Scoring Sheet

Multiple Choice Questions (3 points each)

Question	Correct	% class	Question	Correct	% class	Question	Correct	% class
1	C	73	10	C	79	19	B	83
2	B	97	11	A	21	20	C	86
3	C	93	12	D	76	21	C	21
4	A	97	13	C	90	22	C	90
5	B	66	14	A	55	23	C	73
6	B	35	15	C	83	24	B	4
7	A	76	16	D	79	25	B	62
8	A	31	17	B	83			
9	D	86	18	A	93			
TOTAL								

Score Distribution

Mean = 17.28 of 25
Median = 18.25 of 25
Highest = 21 of 25

Explanations

Q1 Some chose B. B is true but C is better because this is market division, a *per se* category.
Q5 Some chose C. But C is false because this is a PRA.
Q6 Many chose D or E. But these are both false. 4958 does not affect the EO itself.
Q7 Some chose E. But B is *not* an element of an AKS claim.
Q8 Some chose B. But the billing service is not itself making claims. C is possibly true but also consistent with a safe harbor. A is more likely a violation.
Q10 Some chose B. But the scope is not so limited, due to 514 for example, since this is a federal law.
Q11 Some chose E. But only A is true.
Q14 Some chose D or E. But only A is true.
Q21 Many chose A. But while generally true, it is not strictly true given the social security contribution requirement. C is more definitely true.
Q24 Many chose E. But only B is true. Some chose D but that is specifically what ERISA disallows.
Q25 Some chose D. But only B is true.

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Essay Question 1 (30 points)

NOTE: This problem was adapted from *Gardner v. Group Health Plan*, No.5:09-CV-00152-BO (E.D.N.C. Apr. 2, 2011) (order granting defendant summary judgment).

	Issue	P	E
ERISA 502 Preemption			
Preemption	While Ruxing might have a better chance of prevailing under a state contract law theory, that cause of action is preempted by ERISA 502 for the following reasons.	--	--
Employer-provided	Ruxing got his health insurance from his employer, a private law firm. Therefore, it is an employee benefit.	**3**	
Benefits owed	Ruxing's claim concerns the quantity of benefits owed: $145,000.	**3**	
Standard of Review			
Reservation of discretion	Jason-Select reserved discretion to itself to determine the meaning of "experimental" and "investigational." The plan excludes those treatments "that WE conclude to be Experimental or Investigational."	**5**	
	But for the COI discussed below, this reservation of discretion means that Jason-Select's determination would be reviewed under an arbitrary & capricious standard rather than the default *de novo* standard.	**1**	
Conflict of interest	Jason-Select has a COI, since it must pay claims with its own money. Ruxing's employer pays fixed premiums to Jason-Select. The financial risk is borne by Jason-Select.	**5**	
	Since Jason-Select has a COI, the court will grant less deference to its interpretation than a pure arbitrary and capricious standard.	**5**	
Merits of Claim			
IRB = IRB	If an "investigational review board" is the same as (interchangeable with) an "institutional review board," then Jason-Select's interpretation seems unassailable. But it is unclear whether they are the same thing.	**4**	
	Given the deferential standard of review, the court should affirm Jason-Select's interpretation unless it is a clear (or close to clear) abuse of discretion. In other words, unless there is a clear industry custom or standard that treats "investigational" and "institutional" differently, then Jason-Select's interpretation would seem reasonable.	**4**	
TOTAL		**30**	

Score Distribution

Mean = 17.9 of 30
Highest = 28 of 30

Exam ID _____

Essay Question 2 (75 points)

NOTE: This problem was adapted from *Hall v. VISTA Hospice Care*, No. 3-07-CV-0604-M (N.D. Tex. Sept. 29, 2009) (complaint filed), 2011 WL 816632 (Mar. 9, 2011) (granting partial motion to dismiss).

	Issue	P	E
False Claims Act			
Claims	HHH submitted claims for payment by federal payers Medicare and Medicaid.	**4**	
Factual Falsity	HHH certified patients as needing medical equipment (from Med-Depot) that they did not actually need.	**5**	
Legal falsity: implied false certification	Medicare regulations disallow payment for hospice services unless the patient is terminally ill. HHH submitted claims for hospice services impliedly certifying compliance with these regulations, a condition to government payment.	**5**	
Legal falsity: AKS	HHH submitted claims in violation of the AKS (see two theories below). Under the ACA-amended FCA, this is automatically a violation of the FCA.	**5**	
	Under the pre-ACA version of the FCA, claims submitted in violation of the AKS would be implied false certification.	**2**	
Knowingly	HHH engaged in these activities with *at least* actual knowledge of their falsity. HHH actually ordered its employees to "adjust" medical records.	**5**	
Anti-Kickback 1			
Remuneration	HHH gave patients goods and services (DME, extra nursing, other) that were outside the scope of the hospice benefit. These constitute remuneration.	**5**	
To induce	This remuneration was intended to induce the patients: (1) to enroll in hospice, (2) to stay enrolled in hospice, and (3) to encourage others to enroll in hospice.	**5**	
Knowingly	HHH paid the remuneration with the express purpose to induce. It was part of a conscious and deliberate plan.	**5**	
Anti-Kickback 2			
Remuneration	Med-Depot discounted medical supplies for HHH. This is remuneration.	**5**	
To induce	The discount was intended to induce HHH to order medical supplies. Indeed, HHH ordered (even over-ordered) medical equipment for its patients.	**5**	
Knowingly	HHH knew or should have known that the discount was illegal. It is sufficient to establish that HHH knew this conduct was generally illegal.	**5**	
501(c)(3)			
Tax exempt	HHH is a non-profit (and probably) tax-exempt entity.	**2**	
Private Benefit	By paying the remuneration (see AKS 1), HHH was providing a "private benefit" to its patients at a higher than *de minimum* level. This is specifically prohibited.	**5**	
Sherman Act			
Contract	There was a contract between HHH and Med-Depot.	**2**	
Exclusive dealing	This is a contract in restraint of trade. Exclusive dealing is sometimes a *per se* category, but it is unclear that it is in this context.	**5**	
Wrongful termination			
Termination	Healthcare providers who challenged the suspect practices were terminated.	--	--
Public Policy	These terminations were arguably in violation of public policy, as the conduct for which the employees were apparently terminated was challenging illegal practices.	--	--
	But the call of the question asked about action taken BY the federal government. Wrongful termination would be a private action by the terminated employees.	--	--
Global Organization			
Organization	These are points reserved for the overall presentation of the analysis.	**5**	
TOTAL		**75**	