Exam ID # _______________

WIDENER UNIVERSITY SCHOOL OF LAW

HEALTH LAW II FINAL EXAM

Professor Pope **Spring 2009**

GENERAL INSTRUCTIONS:

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

2. **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.

3. **Exam Packet:** This exam consists of fifteen (15) pages, including this cover page. Please make sure that your exam is complete.

4. **Identification:** Write your exam number in these four places: **(i)** in the upper-right hand corner of this page, **(ii)** on the Scantron form that you use for Part One, **(ii)** on the cover of ***each*** Bluebook (or your ExamSoft file) that you use for Parts Two and Three, and **(iv)** on the outside of the exam envelope. In addition, on the Scantron form, fill in the ovals corresponding to your exam number.

5. **Anonymity:** The exams are graded anonymously. Do ***not*** put your name or anything else that may identify you (except for your student number) on any exam document. You must sign the Honor Code form, but that is submitted outside the exam envelope.

6. **Timing:** This is a three-hour exam. Time will commence after everyone has completed reviewing the instructions.

7. **Scoring:** There are 180 points on the exam, one per graded minute. Thus, you should allot a twenty (20) point question approximately twenty (20) minutes.

8. **Open Book:** This is an OPEN book exam. You may use ***any*** written materials, including, but not limited to: the Furrow casebook, other 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.

9. **Format:** The exam consists of three (3) parts which count toward your grade in proportion to the amount of time allocated.

PART ONE comprises fifteen (15) multiple choice questions worth three points each, for a ***combined*** total of 45 points. The suggested completion time is 45 minutes.

PART TWO comprises three (3) short essay questions worth thirty, ten, and thirty points respectively, for a ***combined*** total of 70 points. The suggested completion time is 70 minutes.

PART THREE comprises one (1) long essay question worth 65 points. The suggested completion time is 65 minutes.

10. **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 to a scaled score, based on the class curve. For example, if the highest raw score in the class were 120/180, then that student would typically receive an "A." I will post an explanatory memo and/or a model answer to TWEN a few weeks after the exam. L.L.M. and M.J. students are curved separately.

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

SPECIAL INSTRUCTIONS FOR PART ONE:

1. **Format:** There are fifteen multiple choice questions. Each one is worth three points.

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

3. **Fill in the Ovals on the Scantron:** With a No. 2 pencil, fill in the oval corresponding to the best answer choice for each question.

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 separate titled page in your Bluebook or ExamSoft file. Your objection must both **(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 answers in your Bluebook examination booklets or ExamSoft file. I will not read any material which appears only on scrap paper or this exam.

2. **Legibility:** If you are not typing, write legibly. Please write only on one side of the page. Leave a blank space/line between paragraphs. I will do my best to read your

handwriting, but must disregard (and not give you points for) writing that is too small or sloppy to read or otherwise illegible.

3. **Outlining Your Answer:** You are strongly encouraged to use one-fourth of the allotted time per essay 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:** ***Use headings and subheadings*** to separate chunks of text concerning a particular party, a particular legal theory, or a particular element of a legal theory (*e.g.* "Patient v. Doctor - ADA" and "ADA – Harm to others defense"). Use short single-idea paragraphs (leaving a space between paragraphs).

5. **Answer Content:** Answer all (but only) relevant issues that arise from the fact pattern. 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. It is sometimes helpful to the reader, especially where a comparison or contrast to the exam fact pattern might be fruitful. But do ***not*** cite case names as a substitute for stating the law. For example, do ***not*** write: "Plaintiff should be able to recover under *Bragdon.*" 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.* "the duty of defendant B is the same as defendant A, discussed above."). But be very clear and precise what you are referencing. Ambiguity is construed against the drafter.

8. **Balanced Argument:** Facts rarely fit rules of law perfectly. So, recognize key weaknesses in your position and make the argument on the other side. Do not make only slam-dunk arguments for a party. Make ***all*** plausible arguments implicated by the facts. If some of those are weak, say why.

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 (implied 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

15 questions worth three points each

1. **What does “community rating” and “experience rating” mean to insurance companies?**

   A. Insurance companies set premiums by either community rating or experience rating. In experience rating, the premiums are set based on the healthcare experience of each group in using health care services. On the other hand, in community rating, for a given health insurance policy all subscribers in a community pay the same premium. Without community rating, older and sicker groups became less and less able to afford health insurance.

   B. Community rating and experience rating are the same thing and is a method used by grievance committees at HMO's.

   C. Community rating and experience rating are the same thing and is a method used by grievance committees at PPOs.

   D. All of the above.

   E. None of the above.

2. **What is “utilization review”?**

   A. Utilization review is a systematic means for reviewing and controlling patients’ use of health services and providers’ use of health care resources.

   B. Utilization review usually involves data collection, review and/or authorization, especially for services such as specialist referrals and emergency room use, and particularly costly services such as hospitalization.

   C. Utilization Review ("UR") also known as Utilization Management is the process by which the health plan, payor or Utilization Review firm determine which services are medically appropriate and cost effective.

   D. Many insurance plans and all HMOs require that utilization review procedures are followed prior to all inpatient and some outpatient and emergency care or they will not pay for services rendered.

   E. All of the above.

3. **What is “Managed Care”?**

A. Managed care is defined as any system that integrates the financing and delivery of appropriate medical care by means of at least one of the following four features: (1) contracts with selected physicians and hospitals that furnish a comprehensive set of health care services to enrolled members, usually for a predetermined monthly premium; (2) utilization and quality controls that contracting providers agree to accept; (3) financial incentives for patients to use providers and facilities associated with the Managed Care Organization’s (MCO) plan; and (4) assumption of some financial risk by doctors.

B. Managed care is defined as any system that adds a middleman into the administration of the healthcare delivery process.

C. Managed care is defined as any system that is not the traditional health care insurance indemnity type of system.

D. Managed care is defined as any system that uses disease management and physician profiling tools.

E. None of the above.

4. **Which of the following are true?**

A. States may not force employers to purchase health insurance for their employees.

B. States may not require self-insured employers to cover mental health.

C. Both A and B.

D. Neither A nor B.

5. **What does Utilization Review aim to do?**

A. Utilization Review aims to encourage providers to use more inpatient services as much as possible.

B. Utilization Review aims to provide for effective pre-admission screening to avoid unnecessary admissions and provide early discharge planning to promote prompt placement once patient has reached a lower level of care.

C. Utilization Review aims to encourage the fee-for-service system.

D. ***More than*** one of the above.

6. The so-called "intermediate sanctions provision" of the Internal Revenue Code, 26 U.S.C. § 4948, which applies to all 501(c)(3) hospitals among other entities:

A. Shifts the sanctions associated with excess compensation and other benefits paid to non-profit insiders from the non-profit hospital to any individual who receives a substantial excess benefit from the non-profit hospital.

B. Permits the taxation of an organization manager who knowingly approves an excess benefit transaction with a person prohibited from receiving such a benefit.

C. Treats all officers, directors, and trustees of a non-profit as "disqualified persons" subject to the excess benefit provision.

D. A, B, and C are all correct.

E. None of the above is correct.

7. Dr. Friedman is an anesthesiologist whose application for staff privileges at Widener Hospital has been denied. The Credentials Committee of the medical staff reviewed her application, contacted all listed references, examined her residency personnel files, and looked over her medical-school transcript, among other peer-review activities. On the basis of its review of the paperwork, the Credentials Committee recommended to the Executive Committee of the medical staff that Dr. Friedman's application be denied.

When Dr. Friedman learned of the recommendation, she requested a hearing at which she or her counsel would be present, as well as an opportunity to introduce additional evidence into the record. Her requests were granted. The Executive Committee then recommended denial to the hospital's board of directors, which voted unanimously to deny the application.

Dr. Friedman is convinced that her application was turned down because the physicians who are currently in the Department of Anesthesiology do not want competition. Dr. Friedman has sued the medical staff, the hospital, and the board for violations of the federal antitrust laws and has requested *both* monetary damages *and* injunctive relief (*i.e.* a judgment ordering the hospital to admit her to the staff).

Choose the most correct statement:

A. The Health Care Quality Improvement Act probably provides a complete defense.

B. The Health Care Quality Improvement Act probably provides a partial defense.

C. The Health Care Quality Improvement Act probably provides a partial defense if the hospital did a search of the National Practitioner Data Bank.

D. None of the above. Private plaintiffs cannot sue under the Sherman Act.

8. Which of the following are true concerning Medicaid?

A. Medicaid is jointly financed by the federal and state governments.

B. Each state's participation in Medicaid is voluntary.

C. Eligibility requirements vary widely from state to state.

D. The share of the federal government's contribution varies from state to state.

E. All of the above.

9. ERISA preempts the imposition of state insurance reform laws to self-insured plans through:

A. Implied Preemption

B. The Deemer Clause

C. The Savings Clause

D. Federal Court Jurisdiction

10. Fyzur Drug Co. is a large, national, publicly-traded pharmaceutical firm. Among the products it manufactures and markets is a new fart-elimination drug that Fyzur plans to sell under the name StinkAway. The marketing department at Fyzur has developed the following marketing strategy for StinkAway. Physicians will be able to earn rollover minutes and free ringtones every time they fill out a questionnaire for a new patient placed on StinkAway. In addition, Fyzur will sponsor a "switchover" program under which cash payments will be made to pharmacists each time a pharmacist persuades a physician to change a prescription order from a competitor's fart elimination drug to StinkAway.

The vice-president for marketing has submitted the plan to you, as general counsel, for a legal review. Assuming that some of the patients involved will be Medicare beneficiaries, which of the following statements is the most correct?

A. If both of the marketing strategies conform to industry standards for new-product marketing, they should be lawful under fraud & abuse laws.

B. The product-switchover program probably violates fraud & abuse laws, but not the rollover minutes and free ringtones program.

C. The rollover minutes and free ringtones program probably violates fraud & abuse laws, but not the product-switchover program.

D. Both marketing programs probably violate fraud & abuse laws.

11. A 501(c)(3) hospital operates an in-house industrial laundry. The CEO wants to market the excess capacity in the laundry (estimated to be about 4 percent of total capacity) by performing services for local nursing homes and hotels.

A. Such business activity would be unrelated to the hospital's charitable purpose and would proably jeopardize the hospital's tax-exempt status.

B. Such business activity exposes the hospital to possible sanctions because it might constitute an Excess Benefit Transaction.

C. Such business activity would probably *not* jeopardize the hospital's tax-exempt status, but the hospital would have to pay income tax on the revenue earned from this business activity.

D. Both A and B.

E. Both B and C.

12. Matthias works for Employer A and has been covered continuously under A's group health plan. Matthias's wife, Lisa, works for Employer B. B maintains a group health plan that imposes a 12-month preexisting condition exclusion on all new enrollees. Matthias enrolls in B's plan, but also stays covered under A's plan. Matthias presents B's plan with evidence of creditable coverage under A's plan.

A. B's plan must reduce the preexisting condition exclusion period that applies to Matthias by the number of days of coverage that Matthias had under A's plan, as of Matthias's enrollment date in B's plan.

B. Under COBRA, B's plan may not impose an exclusion for preexisting conditions.

C. Under HIPAA, B's plan may not impose an exclusion for preexisting conditions.

D. None of the above.

13. You work for a large nonprofit tax-exempt hospital system and are in charge of the monthly newsletter. Since the newsletter reaches a large targeted audience (40,000 people), various companies have expressed interest in advertising in your publication.

A. The revenue from the newsletter will probably ***not*** be significant enough to jeopardize the hospital's tax-exempt status.

B. There is no *de minimus* exception. The revenue from the newsletter probably is sufficient to jeopardize the hospital's tax-exempt status.

C. The hospital will have to pay federal income tax on the advertising revenue.

D. A and C.

E. B and C.

14. In a majority of states you must apply for a Certificate of Need in order to:

A. Establish a new facility or service

B. Change the patient capacity of an existing facility or service

C. Acquire or replace major medical equipment

D. All of the above

15. Three major managed care and health insurance companies in Delaware agreed not to contract with any Delaware pharmacy at above a certain reimbursement rate. If you represent a Delaware pharmacy:

A. You have a reasonable lawsuit against the managed care and health insurance companies under the Clayton Act.

B. You have a reasonable lawsuit against the managed care and health insurance companies under the Sherman Act.

C. You can probably establish a *per se* violation, and avoid the need to demonstrate market power or harm to competition

D. Both A and C.

E. Both B and C.

PART TWO

3 short essay question worth a *total combined* 70 points

Short Essay 1 - 10 points/minutes

Lisa and her husband both work as housecleaners in a motel on Route 202, for minimum wage and no health benefits. Lisa is pregnant but they are not sufficiently poor to qualify for Medicaid. Lisa is terrified of giving birth in the city's public hospital, and wants to have her baby at the Super Fabulous Birthing Center in nearby Wealthy Suburb Hospital. That hospital will not accept her, however, without evidence of health insurance.

What law can Lisa use to force Wealthy Suburb Hospital to admit her for the delivery of her baby? What must she do in order to take advantage of that law?

Short Essay 2 - 30 points/minutes

You represent Widener Hospital. Linda Bosse is the CEO and has sought your advice and counsel on several questions that have arisen at various stages in the development and creation of Widener Hospital. Widener Hospital is a recently constructed 175-bed full service hospital. Both the construction of Widener Hospital and the purchase of the equipment used within Widener Hospital were financed with tax exempt debt. Widener Hospital is a participating provider in Medicare.

Widener Hospital wants to enter into a seven year contract for management services with a for-profit company ("Manager"). The Manager will manage several units in the hospital, including the Intensive Care Unit and the Neonatal Intensive Care Unit. The Manager wants to be reimbursed for all of its expenses and, in addition, be paid a management fee equal to twenty percent (20%) of the hospital's revenues. The Manager also would like to be paid a bonus of $100,000 if Widener Hospital meets certain performance targets. The Manager is owned by several physicians who are members of the Widener Hospital medical staff and who routinely refer patients to Widener Hospital for inpatient and outpatient services.

Discuss the extent to which the proposed contract with the Manager will create risk to Widener hospital's tax exempt bonds, and what, if any, changes you would recommend be made to the contract to reduce or eliminate those risks.

Short Essay 3 - 30 points/minutes

West Chester Regional Hospital is a non-profit institution under state and federal law. The CEO, Max Mahlman, has handpicked Board members who never question his non-traditional decisions, including: outlandish parties, personal use of the helicopter, and huge salaries for management. Max has installed his wife, a convicted felon, in the hospital's billing department, where she earns a large commission on increases in West Chester's revenues. Max also secretly controls the only other health care facility in town. Max must be stopped.

Evaluate three (3) important causes of action that can be asserted against Max and/or the Hospital. Identify who the plaintiff could be for each.

PART THREE

1 long essay worth 65 points

You are an associate at a local law firm. Victoria, another associate, has started to draft a complaint, but she suddenly went into labor and is now on maternity leave. You must take over. Victoria has already reviewed the relevant documents and interviewed the clients. Based on that investigation, Victoria has drafted the factual allegations portion of the complaint. But she did not indicate what legal claims these factual allegations can support.

The senior partner has asked you to evaluate the legal theories that the client can pursue (and might include in the complaint). The partner has asked you to organize your memo by legal theory.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

The Parties

1. Plaintiff was employed for over sixteen years between 1992 and 2008, by defendant Concord Pike Clinic.

2. Defendant, the Concord Pike Clinic ("Clinic"), is a professional corporation qualified as an exempt organization pursuant to § 50l(c)(3) of the Internal Revenue Code. Clinic, at any given time, employs approximately 240 general and specialty physicians who provide services to Medicare and Medicaid beneficiaries. The majority of the Clinic employees are the owners and shareholders of the Clinic.

3. Defendant, Naamans Road ("Hospital"), is a non-profit corporation, approximately 250-bed acute health care facility, located at Wilmington, Delaware and qualified as an exempt organization pursuant to § 501(c)(3) of the Internal Revenue Code. All of the physicians with active staff privileges at Hospital are employed by the Clinic and routinely refer all of their patients to Defendant Hospital for inpatient and other services paid for by Medicare and Medicaid.

4. Defendant Clinic is not related to the Hospital, through common membership, governing bodies, trustees, officers, and the like.

Conduct of the Defendants

5. In fiscal year 2006-2007, Hospital provided Defendant Clinic with notes and other loans in principle amounts totaling more than $2.5 million, at no or below market interest rates, which notes and loans were in amounts and on such terms as Clinic could not obtain in commercial or private markets.

6. In fiscal year 2007-2008, Defendant Hospital provided Defendant Clinic with a line of credit totaling $10,000,000 at no or below market interest, which line of credit the Defendant Clinic could not obtain in such amounts and on such terms in the commercial or private markets.

7. In the fiscal year ending June 30, 2007, Defendant's Defendant Hospital transferred $7,290,671 directly to Defendant Clinic, which transfer did not represent and did not purport to represent the payment of fair market value for bona fide services rendered.

8. Defendant Hospital entered clinical director and department chair compensation contracts with physicians employed by defendant Clinic, priced at payment levels characterized in writing as "excessive" by both defendants.

9. At the time of the aforesaid loans and cash transfers, the Defendant had knowledge of public announcements and "appropriate practices" publications by authorized representatives of applicable agencies related to Medicare and Medicaid reimbursement, including the Office of Inspector General of the Department of Health and Human Services.

10. Coincident with the above-described conduct, Defendant Clinic engaged in a pattern and practice of referring large volumes of patients to the Defendant Hospital, who, in turn, billed Medicare, Medicaid and other government health care programs and received in excess of $800 Million dollars for the referred services.

11. Virtually all Clinical Laboratory and radiology services provided to federally insured patients by any provider affiliated with Defendant Hospital, are provided as a result of referrals from physicians within the employ of the Defendant Clinic.

12. Among the scores of physicians, medical clinics and medical and dental professional corporations within the region served by defendant Hospital, the only physicians or physician group that defendant Hospital, provided loans and other transfers is Defendant Clinic (and its physicians).

13. Defendant Clinic used the substantial transfers of cash and loans described herein to fund, *inter alia*, individual physician compensation, bonuses, benefits, malpractice insurance, pension and benefit plans, and a physician profit sharing plan.

14. Defendant Clinic currently receives payments under Medicare for outpatient gastroenterology services. These services are provided almost exclusively by Defendant Clinic in its Ambulatory Surgery Center ("ASC") facility, pursuant to an agreement between the Defendants. The terms of this agreement require that Defendant Hospital forgoes virtually of all of the outpatient endoscopy services it would normally provide (and had been providing from 1992 thru 2001) but for the terms of the agreement allowing Defendant Clinic to provide these services instead.

-- END --

I enjoyed the class, and hope that you have an enjoyable summer!

EXAM ID ___________

Multiple Choice

1. A	4. C	7. C	10. D	13. D	
2. E	5. B	8. E	11. C	14. D	
3. A	6. D	9. B	12. A	15. E	Total ____ of 45 (3pt each)

Essay 1

EMTALA	--	
The hospital participates in Medicare and has an ED.	1	
If Lisa presents on hospital property, then she must be screened (in the standard way that such patients are screened)	2	
If she presents ***when*** in active labor, then when she is screened the hospital will find an EMC.	3	
The hospital must stabilize the EMC, which in the case of labor means delivery.	3	
It is unlikely that any of the transfer exceptions apply.	1	
ADA – This is not an option because Lisa has no disability	0	
Medicaid – This is not an option because the fact pattern states that she does not qualify.	0	
TOTAL	10	

Essay 2

501(c)(3)	--	
Private inurement	--	
The management company is likely an insider, given its control position.	10	
The management company was to be paid (both its fee and bonus) based on revenue. This looks like a dividend, like profits.	10	
Private benefit – Even if the management company weres not an insider, the payments would constitute private benefit because they are likely not FMV.	5	
Antikickback -- Since the management company is owned by staff docs, the payments could be a remuneration for referrals. Violation of AKS could jeopardize exempt status. (A similar analysis could be made under Stark because the owner docs may refer for DHS.)	5	
EBT – This is not relevant because it does not jeopardize the exempt status of the hospital.	0	
TOTAL	30	

Essay 3

501(c)(3)	--	
Max is an insider and uses hospital resources like the helicopter for non-exempt purposes. The huge salaries to management (insiders) are private inurement (or at least benefit). The wife earns a commission based on revenue. This is private inurement (or at least benefit).	10	
EBT	--	
Same grounds as private inurement because the managers are DQPs and payments are not FMV. But the penalties run against Max and the EBT recipients.	10	
AKS	--	
If the management includes doctors who make referrals, at least one purpose of the salaries may be to induce referrals.	10	
Stark	--	
If the management includes doctors who make referrals, those referrals are for DHS from an entity in which the doctors have a financial interest.	10	
False Claims Act	--	
If a claim has been made out under AKS or Stark, the the hospital's billing for such services will constitute implied false certification.	10	
The wife, given her incentives and her history, may be upcoding in order to increase commissions. But as in *Krizek,* the intent is not hers but Max's or the hospital's, since they are the defendants.	10	
Sherman Act	--	
"Secret" control of the only competitor implies a horizontal agreement for an illicit purpose. Any agreement may likely be analyzed under the per se rule, or at least quick look. (Some assumed that Max "owned" the other facilty, triggering Clayton. This is unstated but consistent with the facts.)	10	
TOTAL [Top 3 only]	30	

Long Essay

501(c)(3)		--	
	The chairperson contracts probably constitute private inurement.	7	
	The loans and payment to the clinic probably constiutes private inurement (or at least benefit).	7	
	The clinic (distinct from the hospital) cannot have shareholders.		
EBT		--	
	Same grounds as private inurement because the managers are DQPs and the payments are not FMV.	6	
AKS		--	
	Remuneration = the loan, line of credit, and other monies ¶¶ 5-7 The defendants had knowledge that this was wrong ¶ 9 Given the high volume of referrals (¶ 10), can infer the remuneration was to induce.	15	
Stark		--	
	The clinic doctors refer to the hospital in which they have a financial interest for DHS. The hospital billed for DHS.	10	
False Claims Act		--	
	Given the incentives here, it is possible that billed services were not "medically necessary." If a claim has been made out under AKS or Stark, the the hospital's billing for such services will constitute implied false certification.	10	
Sherman Act		--	
	The ASC and the hospital (horizontal competitors) have agreed to divide the market. This is a per se violation. (The agreement among clinic doctors is not a problem because they are all part of one economic entity.)	10	
TOTAL		65	

Final Exam Total _____ of 180