On the Horizon in
HEALTH LAW

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INDUSTRY HOT TOPICS

Proposed Federal Budget for FY 2008 Would Increase Funds for Anti-Fraud Enforcement

The Bush administration recently released a proposed federal budget for Fiscal Year 2008 that would provide an additional $183 million of discretionary funds for Medicare and Medicaid fraud and abuse enforcement activities by several federal enforcement authorities, including the Office of Inspector General, the Department of Justice and the FBI.

The President's budget proposal stated that the funds would be used towards safeguarding the Part D program and Medicare Advantage plans against fraud and abuse, as well as improving financial management oversight in the Medicaid program.

If approved, the proposed budget would likely increase the already high level of federal fraud and abuse enforcement activity against health care providers. For example, in the first half of Fiscal Year 2006, the Office of Inspector General recovered over $1 billion from health care providers in 1,560 pending cases, and filed 595 new criminal cases.

In light of this increased enforcement activity, it is vital that health care providers such as hospitals, nursing homes and physicians be sure that they have appropriate corporate compliance programs in place to minimize the risk of violating the fraud and abuse laws, and know what steps to take in the event that they receive a subpoena from the federal government as part of a potential fraud and abuse investigation.

Department of Justice Revises Policies on Waiver of the Attorney-Client Privilege in Corporate Fraud Investigations

The Department of Justice ("DOJ") recently announced major changes to its guidelines governing when federal prosecutors can bring criminal charges against a corporation. The changes primarily focus on what factors the government can consider in determining if a company is cooperating with an investigation. Previously, DOJ policies provided that prosecutors could consider a company's willingness to waive the attorney-client and work-product privileges and whether the company seemed to be protecting culpable employees by advancing attorney's fees. Since their enactment in 2003, these policies have come under increasing criticism from both business and legal groups.

The recent policy changes are a response by the DOJ to these criticisms. The new policy revises corporate charging guidelines by requiring prosecutors to demonstrate a legitimate need for privileged information before requesting it from a company. A legitimate need depends on the likelihood and degree that such information would benefit the investigation, whether the information could be obtained alternatively in a timely fashion and in a manner that would not require the waiver, the completeness of the voluntary disclosure that has been provided

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to date and the collateral consequences of the wavier to the corporation. In addition, the approval process is now more rigorous and prosecutors must obtain approval from within the DOJ prior to requesting production of privileged investigative facts or legal advice.

The policy changes make clear that waiver of attorney-client and work-product protections is not a prerequisite to a finding that a company has cooperated in the government's investigation. Specifically, a company's decision not to waive privilege with respect to materials containing legal advice cannot be considered against a company, although acquiescence to such request can be considered favorably in a prosecutor's determination of whether a corporation has cooperated. Prosecutors may still consider the withholding of privileged investigative facts in determining whether to charge a company criminally. The policy also provided that prosecutors should not take into account whether a company advances attorneys' fees to employees under investigation, although in rare instances this may be considered when the circumstances show the advancement was intended to impede a criminal investigation.

In essence, these policy changes mean fewer privilege waiver requests and decreased pressure to cut off legal fees to targeted employees for companies involved in government investigations. At the same time, a strong incentive remains for companies to continue to waive their privileges as the DOJ will continue to reward such companies.

MEDICARE AND MEDICAID

OIG Says Hospital Can Provide Free Inpatient Dialysis

An acute care hospital serving a large indigent population may provide free inpatient dialysis services to Medicare and other government health program beneficiaries who are otherwise unable to obtain necessary dialysis services in the community, according to a January 25, 2007, advisory opinion by the Department of Health and Human Services, Office of the Inspector General (the "OIG").

The hospital requesting the advisory opinion was part of a large public health system that did not provide outpatient dialysis services. The hospital stated that many beneficiaries are unable to obtain needed dialysis in the community due to inability to pay, a shortage of openings at private clinics, inability to sit for the four to five hour treatment, and behavioral or psychiatric issues. The hospital also noted that many private clinics would not treat beneficiaries with pending Medicare and Medicaid applications. As a result, the hospital argued, these beneficiaries go without dialysis treatment only to later present at an emergency room with an urgent condition often requiring hospital admission, sometimes for several days. This situation then creates a shortage of acute care beds for other patients. To address these issues, the hospital sought to provide the free inpatient dialysis and then release the beneficiaries back into the community. The hospital confirmed that, in providing the free inpatient dialysis, it would not advertise the program or bill any third party payor for the services.

In granting the hospital's request to provide the free inpatient dialysis, the OIG stated that the program could implicate the OIG's civil monetary penalty authority and the Anti-Kickback Statute. Nevertheless, the OIG determined the program posed minimal risk to federal health care programs and provided significant benefits to underserved beneficiaries. In support of this conclusion, the OIG noted that the hospital did not provide any outpatient dialysis and would assist beneficiaries with locating that service in the community. The OIG also noted that the hospital would bear the costs of the program as part of an effort specifically designed to deter chronic dialysis beneficiaries from self-referring back to the hospital.

This advisory opinion, No. 07-01, can be obtained from the OIG's web site at www.oig.hhs.gov.

SETTLEMENTS

California Court Approves Settlement of Claims By Uninsured Patients Against Healthcare Company

A California Superior Court judge granted final approval to a settlement of a class action lawsuit in the case *Adrienne Dancer and Amber T. Howell v. Catholic Healthcare West and Does 1-50* on January 11, 2007. The plaintiffs alleged that defendant Catholic Healthcare West ("CHW") charged uninsured patients excessive, unfair and otherwise unlawful prices for medical products, services, and procedures performed by CHW and its affiliates.

This settlement resolves claims for over 780,000 uninsured patients who received services between July 1, 2001 and September 25, 2006 and who have an annual household income at or below $250,000. Pursuant to the settlement, these patients will be entitled to refunds or bill reductions of thirty-five percent.

CHW must now maintain an uninsured patient discount policy for four years, which essentially makes pricing for uninsured patients comparable to pricing for patients with private insurance. CHW also must continue to offer charity care as reflected in its Patient Payment Assistance Policy, make financial counseling available, and clearly notify its patients of CHW's discount pricing policies. In addition, CHW must make a good faith effort to resolve disputes before undertaking collection actions.

The settlement is expected to cost CHW approximately $423 million, assuming all of CHW's uninsured patients pay their bills in full.

LABOR AND EMPLOYMENT

California Court Upholds Termination of Physician for Over-Utilization of Resources

The California Court of Appeal, Second District, upheld the dismissal of Dr. George Sarka, a primary care physician at UCLA's (the "University") student health center on December 28, 2006. Dr. Sarka was terminated by the University after he refused to be "less wasteful of resources by relying less on diagnostic testing and more on optimal clinical judgment."

The controversy over Dr. Sarka's utilization of resources began in 2002, when Dr. Sarka was fired from the University after he failed to comply with orders to reduce his use of "very extensive, multiple tests" and office visits. Following this termination, Dr. Sarka filed a grievance with the University, alleging that his termination was, "clearly retaliatory for advocating appropriate patient care." The administrative hearing officer disagreed and upheld the University's termination, and Dr. Sarka subsequently filed a petition for administrative review in Los Angeles Superior Court, which was also denied. Dr. Sarka appealed, contending that the lower court failed to consider California Business and Professions Code Sec. 2056, which declares it a violation of public policy for employers to penalize physicians "principally for advocating for medically appropriate health care."

After reviewing Dr. Sarka's claims, the California Court of Appeal found that of the University had not violated Section 2056. The University's policies were substantiated by medical literature, generally accepted standards of primary care physicians at its health center, as well as the practices of other student health centers at University of California campuses and of other benchmark universities. Dr. Sarka failed to demonstrate that his advocacy was medically appropriate for primary care physicians in a large university's student health center and, therefore, his termination for insubordination was appropriate.

For the complete court opinion, see *Sarka v. The Regents of the Univ. of Cal.*, 146 Cal.App. 4th 261 (Cal. Ct. App. 2006).

ARBITRATION AGREEMENTS

North Carolina Court Upholds Arbitration Provision in Nursing Home Admissions Agreement

A North Carolina Court of Appeals granted a motion to compel arbitration, overturning a lower court ruling which found that the arbitration provision in a nursing home admissions agreement was unconscionable. The ruling stemmed from a complaint filed in 2004 by Melba Raper, executrix of the estate of Willard O. Raper, who died while living in the Oliver House nursing home. Ms. Raper filed the complaint against Oliver House alleging negligence, wrongful death, and punitive damages. Oliver House sought dismissal of the suit, or, alternatively, to compel arbitration based on an arbitration provision in its admissions agreement. The provision mandated the use of arbitration to resolve disputes stemming from the agreement, and Ms. Raper signed the admissions agreement on Mr. Raper's behalf.

The lower court denied Oliver House's motion, stating that the arbitration provision was unconscionable. The lower court reasoned that: (i) the arbitration provision was part of a standard form contract used by Oliver House; (ii) there was no independent negotiation between the parties regarding the contract or the arbitration provision; (iii) there was an inequality of bargaining power between the parties; and (iv) the contract dealt with a matter of substantial public interest, *i.e.*, long term care for the elderly. The lower court also found that the admissions agreement, as a whole, was unclear and ambiguous.

In its ruling, the Court of Appeals first noted the strong public policy in North Carolina favoring arbitration. It then held that in order to find a contract unconscionable, a court must find both substantive and procedural unconscionability; in other words, unconscionability requires "an absence of meaningful choice on part of one of the parties *together with* contract terms which are unreasonably favorable to the other." The Court of Appeals found the argument of procedural unconscionability lacking, in part because Ms. Raper admitted she signed the contract voluntarily. Further, the Oliver House contract clearly disclosed the existence of the arbitration provision as it appeared in boldface type directly above the signature lines.

The Court of Appeals found a lack of any other evidence to support the procedural unconscionability claim. Similarly, there was no evidence supporting a finding that the arbitration provision was substantively unconscionable because the provision was mutual and applied to both parties. In addition, the lower court also found that the fact that the provision related to a matter of substantial public interest--long term elderly care--was not enough by itself to overcome North Carolina's strong public policy in favor of arbitration. The lower court's assertion that the admissions agreement as a whole was ambiguous and unclear was irrelevant to the debate over unconscionability.

For the complete court opinion, see *Raper v. Oliver House, LLC*, 637 S.E.2d 551 (N.C. Ct. App. 2006).

Ohio Court Upholds Arbitration Provision Despite Procedural Unconscionability

The Ohio Appellate Court, Eleventh District, recently upheld a contract requiring a nursing home patient to arbitrate any claims. The estate of Patricia Manley filed a lawsuit against Lake Med Nursing and Rehabilitation Center, owned by Personacare of Ohio, alleging that the nursing home's poor treatment of Ms. Manley led to her death. The Appellate Court ruled that the arbitration provision was enforceable because,

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while the provision was procedurally unconscionable, it was not substantively unconscionable. The Court stated, "unconscionability is generally recognized to include an absence of meaningful choice on the part of one of the parties to a contract, combined with contract terms that are unreasonably favorable to the other party." To have a successful unconscionability claim, both procedural and substantive unconscionability must be present.

Procedural unconscionability involves the relative bargaining power of the parties, including the age, intelligence, business acumen and relative positions of the parties. In this case, some evidence weighed against a finding of procedural unconscionability. Ms. Manley was alert, asked questions, was provided a pamphlet that explained the arbitration agreement and was given a further explanation of the agreement by way of a hypothetical example. However, these factors were outweighed by evidence supporting unconscionability. Ms. Manley was 66 years old, fearful from a recent attack, under considerable stress from entering a nursing home with neither a family nor friends to assist her, had no legal expertise, suffered bouts of confusion and had a mild cognitive impairment. Due to these factors, the Court found the agreement procedurally unconscionable.

The Court also examined whether the agreement was substantively unconscionable. This analysis focused on whether the terms of the contract were commercially reasonable. The agreement clearly stated that admission to the nursing home was not contingent on signing the arbitration agreement. It set forth in bold print that this agreement was a waiver of a jury trial, it gave Ms. Manley thirty (30) days to reject the provision, and did not require the payment of attorneys' or mediation fees by the losing party. The Court found the substance of the agreement to be reasonable.

As the arbitration agreement was not substantively unconscionable, the Court upheld the agreement. In dissent, Judge O'Toole argued that the arbitration agreement was substantively unconscionable because all arbitration rights benefited Personacare, not Ms. Manley. In addition, Judge O'Toole argued that, according to industry standards, the arbitration clauses should not be used in such situations, and that the agreement was overbroad and vague.

For the complete court opinion, see *Manley v. Personacare,* 11th Dist. No. 2005-L-174, 2007-Ohio-343.

Learn More!

To contact a member of the Vorys, Sater, Seymour and Pease LLP Health Care Group, please contact any of our offices and simply ask to speak to an attorney member of the VSSP Health Care Group.

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