No. S259364

IN THE SUPREME COURT

OF THE STATE OF CALIFORNIA

SUNDAR NATARAJAN, M.D.,

Petitioner and Appellant

vs.

DIGNITY HEALTH,

Respondent,

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

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

APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF AND *AMICUS CURIAE* BRIEF OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE IN SUPPORT OF NEITHER PARTY

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STATEMENT OF INTERESTED ENTITIES

There are no disclosures to be made under CRC rule 8.520(f)(4).

The American Academy of Emergency Medicine ("AAEM") is a nonprofit professional association of emergency medicine physicians. The AAEM represents the interests of more than 7,700 emergency physicians nationwide, including 730 physicians practicing in California. The AAEM supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes the physician's right to a fair process to maintain their hospital privileges.

DATED: October 16, 2020.

Respectfully submitted,

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

*Joseph P. Wood, Esq., M.D.
(*pro hac vice* application pending)

Counsel for Amicus Curiae
The American Academy of Emergency Medicine

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APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

Pursuant to rule 8.200(c) of the California Rules of Court ("CRC"), the American Academy of Emergency Medicine ("AAEM") hereby requests permission to file the attached *amicus curiae* brief in support of neither party in the above-captioned case.

There are no disclosures to be made under CRC rule 8.520(f)(4).

I. INTERESTS OF *AMICUS CURIAE* APPLICANT

The AAEM is a nonprofit professional association of emergency medicine physicians. The AAEM represents the interests of more than 7,700 emergency physicians nationwide, including 730 physicians practicing in California. The AAEM supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes the physician's right to a fair process to maintain their hospital privileges.

In the hospital setting, physicians have a duty to advocate for their patient's best interests even when doing so conflicts with the interests of the hospital. Physicians' primary protection against inappropriate privilege revocation is the requirement of a procedure that is fair in appearance as well as actuality. The threat of termination from a hospital medical staff without the right to a fair and unbiased procedure, would prevent most

physicians from advocating for their patients in an adversarial manner.

II. PURPOSE OF THE *AMICUS CURIAE* BRIEF

The AAEM believes its proposed *amicus curiae* brief will assist the Court in its analysis of the proper standard for disqualification of peer review hearing officers. This issue will impact all physicians practicing in California hospitals, and in turn, will impact hospital patients. As a matter of public policy, physicians must be free to advocate for their patients and practice free of corporate influence. The AAEM's proposed *amicus curiae* brief addresses the harm to patients and to the public generally if the physician's independent judgment is undermined by denial of a physician's rights to fair and impartial peer review and process.

For these reasons the AAEM respectfully requests that the Court accept and file the *amicus curiae* brief filed concurrently herewith.

DATED: October 16, 2020.

Respectfully submitted,

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

*Joseph P. Wood, Esq., M.D.
(*pro hac vice* application pending)

Counsel for Amicus Curiae
The American Academy of Emergency Medicine

ORDER

The application of the American Academy of Emergency Medicine for permission to file a brief as amicus curiae having been read and filed, and good cause appearing therefor,

IT IS HEREBY ORDERED that the American Academy of Emergency Medicine be, and hereby is, permitted to file the proposed brief attached to this application as amicus curiae herein; and

PERMISSION IS HEREBY GRANTED to any party to this appeal to serve and file an answering brief within _____ days thereafter.

Date:_____ _____

Presiding Judge

AMICUS CURIAE BRIEF

I. INTRODUCTION

Fundamental principles of fairness demand that any physician, whose career is at stake, shall have the right to disqualify a hearing officer in a proceeding for revocation of privileges, based on the hearing officer's apparent bias.

The American Academy of Emergency Medicine ("AAEM") files this *amicus curiae* brief primarily to emphasize the public policy reasons supporting the findings of the California Legislature: "Peer review that is not conducted fairly results in harm to both patients and healing arts practitioners by limiting access to care." Cal. Bus. & Prof. Code § 809(a)(4).

As an organization of emergency medicine specialists, our members interact regularly with most physicians on the hospital medical staff. We are sensitive to the need to discipline or revoke privileges of substandard physicians. However, our members have also witnessed abuse of the peer review and hearing process, where good physicians lost their privileges based on pretextual reasons.

As discussed more fully below, fundamental fairness is essential in hospital peer review for two reasons. First, the accused physician's career is on the line because revocation of privileges by any hospital makes it difficult, if not impossible, to gain privileges at another facility. Second, revocation processes that are perceived as unfair by the remaining members of the medical staff tend to discourage physicians from advocating for

vulnerable patients, or asserting criticism against the hospital for substandard hospital practices. Due to fear of losing hospital privileges, physicians will be less likely to compete with hospitals, even if they are able to offer patients more efficient and better services. As a matter of public policy, the peer review process must be fair both in actuality and in appearance.

In California Business and Professions Code § 809(a)[1], the Legislature used the word "fairly" three times in stating their legislative findings. § 809 (a)(3),(4),(5). Thus, the Legislature intended "fairness" to be an essential element of the peer review process. The issue in this case is: given the potential career ending consequence to the accused physician, and the potential harm to public health and safety when the peer review process appears to be unfair, what level of bias does § 809 et seq. permit in a hospital-appointed hearing officer.

II. DISCUSSION

A. Revoking Hospital Privileges Is Devastating to a Physician's Career

Most physicians need their hospital privileges to continue their practice and make a living. For physicians who primarily perform their services in the hospital setting, such as surgeons, emergency physicians, and hospitalist, the loss of privileges at a hospital "can have an immediate and devastating effect on a practitioner's career." *Mileikowsky v. West Hills Hospital &*

[1] Unless otherwise indicated, all statutory references are to the California Business and Professions Code.

Medical Ctr., (2009) 45 Cal.4th 1259,1268, *citing,* P. Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals* 38 U.S.F. L. Rev. 301, 302-303. This is because a physician whose privileges are revoked by a hospital will find it difficult or impossible to gain admittance to another hospital's medical staff. *Id.*

California hospitals are required to report revocation of a physician's clinical privileges to the California Medical Board. Bus. & Prof. Code § 805. The hospital's revocation of a physician's privileges also implicates federal law. The Healthcare Quality Improvement Act of 1986 (HCQIA) requires hospitals to report all physician disciplinary actions that remove or curtail privileges for more than 30 days, to the National Practitioner Data Bank (NPDB). 42 U.S.C. § 11133. The HCQIA also requires hospitals to obtain a report from the NPDB on all physicians applying for privileges. 42 U.S.C. § 11135. As some legal scholars have characterized it, a negative report in the NPDB results in a *de facto* blacklisting of that physician. K. Van Tassel, *Blacklisted: The Constitutionality of the Federal System for Publishing Reports of 'Bad' Doctors in the National Practitioner Data Bank* 33.5 Cardozo Law Rev. 2031, 2032 (2011)("Physicians are Blacklisted after being 'found' to have provided poor quality of care, through a highly subjective and oft-times summary, peer review process by private hospitals.")

The mandatory reports to the California Medical Board and the NPDB will impact any subsequent application for hospital privileges sought by a physician who has had her privileges

revoked by a private hospital. Blacklisting an incompetent or dangerous physician is consistent with legislative goals. See 42 U.S.C. § 11101 ("[t]here is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.") However, there is no utility, and great harm, in blacklisting a good physician whose revocation was motivated by anti-competitive desires or professional animus. The severe consequences of privilege revocation by a private hospital demands that physicians be given a fair and impartial peer review procedure.

B. Revocation Processes Lacking the Appearance of Fairness Will Reduce Quality of Care

Revoking a physician's hospital privileges through a process that is viewed as unfair by the medical staff has downstream effects that run counter to the goal of improving quality of care in hospitals. When the peer review process is perceived to be biased and unfair, the remaining physicians on the medical staff will understandably fear that their own privileges are at risk if they assert criticisms of substandard hospital practices or advocate for individual patients. A physician's fear of losing hospital privileges makes it difficult for the physician to order an appropriate but expensive test, or refer a patient to another hospital that has a better track record for a particular procedure, if doing so angers the hospital administration.

California courts have long recognized the importance of protecting a physician's clinical decisions from outside influence. The conflict between the physician's fiduciary duty of loyalty to the individual patient and the pecuniary interest of an employer corporation, including hospitals, is the key concern addressed by the California prohibition of the corporate practice of medicine (CPOM). *People v. Pacific Health Corp*. (1938) 12 Cal.2d 156, 160 ("the principal evils attendant upon corporate practice of medicine spring from the conflict between the professional standards and obligations of the doctors and the profit motive of the corporate employer….").

This conflict between a physician's fiduciary duty to patients and the hospital's profit motivation continues today even outside of the CPOM context. The AAEM regularly reviews member concerns about hospitals trying to improve its finances by influencing physician's clinical decisions. Recently, a private hospital association's attempts to pressure emergency physicians to admit patients to the hospital solely to increase hospital revenues was the subject of numerous whistle-blower lawsuits, and a Department of Justice lawsuit. On September 25, 2018, the Department of Justice announced a $260 Million settlement to resolve claims against Health Management Associates, LLC (HMA) for false billing and kickback allegations. Department of Justice Press Release. *See* Appendix (also attached to accompanying Request for Judicial Notice). According to the Department of Justice press release: "HMA instituted a formal and aggressive plan to improperly increase overall emergency

inpatient admissions at all HMA hospitals…." As part of the plan, "HMA set mandatory company-wide admission rate benchmarks for patients presenting to HMA hospital emergency departments – a range of 15 to 20 percent for all patients presenting to the emergency department, depending on the HMA hospital, and 50 percent for patients 65 or older (i.e. Medicare beneficiaries) – solely to increase HMA revenues." *Id.*

Not all conflicts between physicians and hospitals are as dramatic or far reaching as seen in the suits against HMA. However, such cases illustrate that conflicts between physicians' fiduciary duties to patients and a hospital's profit motivation are ongoing. Emergency physicians and other physicians practicing in the hospital setting require the protection of a fair and impartial peer review process in order to freely advocate for vulnerable patients and assert criticism against hospitals for improper and even dangerous practices.

Courts have recognized that hospitals may sometimes give pretextual reasons in wielding their power over a physician's privileges. *See Rosner v. Eden Township Hospital District* (1962) 58 Cal.2d 592, 596. In *Rosner*, the physician was denied privileges based on the hospital's assessment of his temperament and inability to get along with other staff. The Court noted that the real reason Rosner's staff application was denied was his public criticisms of other doctors and some hospital practices. *Rosner, supra*, 58 Cal.2d at 598. In *Rosner*, the Court observed: "[t]he goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel

that treatment of patients is improper or that negligent hospital practices are being followed." *Id.*

In *El-Attar v. Hollywood Presbyterian Med. Ctr.* (2013) 56 Cal.4th 976, the California Supreme Court recognized the reality that hospitals might attempt to revoke a physician's privileges for motives unrelated to improving quality of care. The Court observed that "[a] hospital's governing body could undoubtedly seek to select hearing officers and panel members biased against the physician. It might even do so because it wishes to remove a physician from a hospital staff for reasons having no bearing on quality of care." *El-Attar, supra*, 56 Cal.4th at 995 (citations omitted). In light of a hospital's significant power over a physician's privileges, and indeed, the physician's career, it is essential that the peer review process be fair in actuality and appearance.

C. Peer Review and Revocation Hearings Must Meet Prevailing Standards of Impartiality

California law protects competent physicians from loss of their hospital privileges by requiring a fair peer review process. Bus. & Prof. Code § 809.2(a)-(h). In *Mileikowsky,* the Court stated: "Peer review that is not conducted fairly and results in the unwarranted loss of a qualified physician's right or privilege to use a hospital's facilities deprives the physician of a property interest directly connected to the physician's livelihood." *Mileikowsky*, *supra*, 45 Cal.4th at 1267. This Court has recognized that physicians in both public and private hospitals

are entitled to peer review procedures that comport with the minimum common law requirements of due process. *See Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802. In *Anton*, the Court recognized that "a physician may neither be refused admission to, nor expelled from, the staff of a hospital, whether public or private, in the absence of a procedure comporting with the minimum common law requirements of due process." *Anton, supra*, 19 Cal.3d 802 at 815. Although there are no fixed or rigid procedures for the protection of fair procedure rights, as a general principle, "it is inconceivable…that such rights would not include impartiality of the adjudicators." *Applebaum v. Board of Directors* (1980) 104 Cal. App. 3d 648, 658.

Pursuant to California Business and Professions Code §809.2(b), certain minimal requirements are set forth for the selection of a hearing officer: "the hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote." Additionally, the statute provides that an accused physician "shall have the right to a reasonable opportunity to voir dire the panel members and any hearing officer, and the right to challenge the impartiality of any member or hearing officer." § 809.2(c).

Physicians recognize the influential role an attorney hearing officer serves in the peer review process. While the hearing officer may not have a vote in the peer review proceedings, hearing officers control the discovery process and

"rule upon any request for access to information." § 809.2(d); hearing officers are authorized to rule on challenges to their own impartiality and the impartiality of any member of the panel. § 809.2(c); hearing officers are authorized to grant or deny a request for continuance. § 809.2(g). Additionally, courts have found that "[a]n administrative hearing officer, much like a court may change his or her mind about the production of documents, or decide to tailor the admission of evidence in light of earlier discovery-type orders to ensure fairness." *Unnamed Physician v. Board of Trustees*, (2001) 93 Cal.App.4th 607, 620. Thus, hearing officers are empowered to exercise significant influence over the outcome of the peer review process.

When the hearing officer's future potential income from judging depends on the goodwill of the hospital, as in the present case, principles of fair procedure demand that the accused physician shall have the right to disqualify the hearing officer, based on apparent bias due to a financial conflict of interest. *See Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017. In *Haas*, the Court found that an administrative hearing officer's pecuniary interest disqualified her from presiding over a matter involving the revocation of a business license. The Court observed that of all the types of bias that can affect adjudication, "pecuniary interest has long received the most unequivocal condemnation and the least forgiving scrutiny." *Haas, supra*, 27 Cal.4th at 1025. When an adjudicator is challenged for financial interest, the reviewing court is not required to decide whether in fact the adjudicator was actually influenced, "but only whether

sitting on the case would offer a possible temptation to the average judge to lead him not to hold the balance nice, clear, and true." *Id.* (citations omitted). "The requirements of due process are flexible, especially where administrative procedure is concerned, but they are strict in condemning the risk of bias that arises when an adjudicator's future income from judging depends on the goodwill of frequent litigants who pay the adjudicator's fee." *Haas, supra*, 27 Cal.4th at 1037.

In *Yaqub v. Salinas Valley Memorial Healthcare System,* (2004) 122 Cal.App.4th 474, the court applied *Haas* to circumstances involving a physician's revocation of privileges. The *Yaqub* court found that the hearing officer was disqualified due to apparent bias caused by a potential financial conflict of interest. *Yaqub, supra*, 122 Cal. App.4th at 485-487. In reaching this decision, the court found guidance from principles applicable to judicial officers in court proceedings. *Yaqub, supra*, 122 Cal. App.4th at 486. The *Yaqub* court observed that canon 2 of the California Code of Judicial Ethics states that a judge "shall avoid impropriety and the *appearance* of impropriety in all of the judge's activities." *Id.* The court explained that the "commentary to this canon provides an objective test for the appearance of impropriety: The question is not whether the judge is actually biased, but 'whether a person aware of the facts might reasonably entertain a doubt that the judge would be able to act with integrity, impartiality, and competence.'" *Id.* (citations omitted).

Whether a revocation process occurs in a public hospital or a private hospital, it is essential that the process be objectively

fair and unbiased. Physicians, like most people, simply will not view a proceeding as "fair" when there is the appearance of bias arising from financial circumstances that would offer a possible temptation to the average person as a hearing officer. In *Haas*, and *Yaqu*b, the courts recognized that holding out an opportunity of future employment to the hearing officer, even implicitly, in exchange for favorable decisions creates an impermissible appearance of bias. *Haas, supra*, 27 Cal.4th at 1037; *Yaqub, supra*, 122 Cal.App.4th at 487.

III. CONCLUSION

If the peer review process is flawed, there is an increased likelihood of an error that derails a good physician's career. Additionally, a hospital's revocation of a physician's privileges through an unfair process will engender fear among the remaining medical staff members. As most physicians can't risk losing hospital privileges, this fear stifles competition, diminishes a physician's ability to advocate on behalf of vulnerable patients, and engenders a culture of silence among the very physicians who are best placed to identify substandard hospital practices. Therefore, the purposes of improving quality of care, by revoking the privileges of physicians who provide substandard care, while protecting the privileges of competent physicians, are best served by a fair process that allows an accused physician to disqualify a hearing officer based on the appearance of bias.

DATED: October 16, 2020.

Respectfully submitted,

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

*Joseph P. Wood, Esq., M.D.
(*pro hac vice* application pending)

Counsel for Amicus Curiae
The American Academy of Emergency Medicine

CERTIFICATE OF COMPLIANCE
WITH RULES OF COURT,
RULE 8.204(C)(1)

I, the undersigned Marc J. Shrake, declare that:

I am a partner in the law firm of Freeman Mathis & Gary, LLP, counsel for the American Academy of Emergency Medicine.

This certificate of Compliance is submitted in accordance with Rule 8.204(c)(1) of the California Rules of Court.

This Brief was produced with a computer. It is proportionately spaced in 13-point Century Schoolboy typeface. The brief contains approximately 3,095 words, including footnotes, based on Word's wordcount function.

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

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

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

CERTIFICATE OF SERVICE

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

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

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

APPENDIX

THE UNITED STATES DEPARTMENT of JUSTICE
STICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Tuesday, September 25, 2018

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Topic(s):
False Claims Act

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

Press Release Number:
18-1252

Updated February 13, 2019

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

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

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **MShrake@fmglaw.com**

3. I served by email a copy of the following document(s) indicated below:

Title(s) of papers e-served:

Filing Type	Document Title
APPLICATION	AAEM Amicus Curiae Application and Brief FINAL
REQUEST FOR JUDICIAL NOTICE	AAEM Judicial Notice FINAL
MOTION	Pro Hac Vice Application and Motion re Joseph Wood FINAL

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

10/16/2020

Date

/s/Marc J. Shrake

Signature

Shrake, Marc J. (219331)

Last Name, First Name (PNum)

Freeman Mathis & Gary, LLP

Law Firm