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CLIENT SPOTLIGHT

Francine Katz, Esq., General Counsel, St. Peter's University Hospital

By Susan J. Flynn-Hollander, Esq.

Mark your calendars for June 7, 2009 – the date of the North Jersey Lupus Walk at the Atlantic Health Jets Training Center in Florham Park, NJ. The fundraising effort is spearheaded by Francine Katz, General Counsel for St. Peter's University Hospital in New Brunswick – one of SPSK's hospital clients. Ms. Katz, co-chair of the New Jersey Walk With Us To Cure Lupus, will be leading the Walk with her tie-dye bedecked team of supporters who call themselves the "Katz Me If You Can" group. The Walk is co-sponsored (with the Jets organization) by another SPSK client, Atlantic Health. Members of Katz's team include her husband Bruce, sons Joshua (9) and Scott (5), brother Marc, and sister Suzanne. All three siblings have Lupus, and there is a cousin who is the recipient of a research grant from the Alliance for Lupus Research, the organization that receives the money raised by the Lupus Walks held throughout the country.

Ms. Katz was diagnosed with Lupus at the age of 15 and counts herself as fortunate that with regular visits to her physician and daily medication, she has few effects that would otherwise impact her everyday activities. She is quick however to point out that many others who suffer from the disease are not as lucky. It is for those individuals and the many others who have not yet been diagnosed that she passionately talks about the cause and encourages family, friends, co-workers, colleagues, and everyone with whom she comes in contact to support Lupus research to speed the process of finding a cure.

Team "Katz Me If You Can"

Ms. Katz has been General Counsel at St. Peter's for more than two years, served the hospital as outside counsel prior to accepting the in-house position, and proudly states that her favorite part of the job is "being able to provide support to our clinical staff, so that I have a hand in making our patients' lives better." St. Peter's motto is "Every patient, every time" and Francine is quick to note that "the hospital differentiates itself from

See "Francine Katz" on Pg. 10

DID YOU KNOW?

Blowing your nose to alleviate stuffiness may be second nature, but research shows it does no good, reversing the flow of mucus into the sinuses and slowing the drainage. Counterintuitive, perhaps, but research shows it to be true.

Most testing for the U.S. drug industry's late-stage human trials is now done at sites outside the country, where results often can be obtained cheaper and faster, according to a study published in the New England Journal of Medicine. The reason overseas trials are cheaper and faster is that patients in developing countries are often more willing to enroll in studies because of lack of alternative treatment options.

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Despite announcements by hospitals and clinics across the country of budget and job cuts, the overall healthcare employment outlook is still promising, according to an industry forecast. 17 percent of large healthcare employers indicated that they plan to increase the number of full-time employees in 2009.

The Environmental Protection Agency may act for the first time to regulate carbon dioxide and other greenhouse gases emitted by new coal-burning power plants, according to Obama administration officials. This expected move is the result of a Supreme Court order that caused EPA officials to reach a consensus about whether carbon dioxide is a pollutant that endangers public health and welfare.

Many state medical boards don't ask physicians about their clinical activity status, allowing license renewal even though a doctor may not have treated a patient in years, according to a report in the February Pediatrics.

Although sales of many consumer goods are dropping given the state of the economy, sales of condoms in the U.S. rose 5% in the fourth quarter of 2008, and 6% in January, The Nielsen Co. reports. The sales bump squares solidly with one of the nation's most common trends during any recession: nesting.

Healthcare spending in the United States is expected to have its largest single-year increase in 2009. According to a report by Medicare's Office of the Actuary, U.S. health spending is projected to top $2.5 trillion this year. That figure is up 5.5 percent from last year's estimated spending.

Low blood levels of vitamin D may be associated with an increased risk for dementia, a British study has found. Scientists measured blood levels of the vitamin in a representative sample of 1,766 people over 65 and assessed their mental functioning with a widely used questionnaire. About 12% were cognitively impaired, and the lower their vitamin D level, the more likely they were to be in that group. Compared with those in the highest one-quarter for serum vitamin D, those in the lowest were 2.3 times as likely to be impaired, even after statistically adjusting for age, sex, education and ethnicity.

Medtronic, a medical device maker, will start publicly disclosing its payments to doctors online, reporting anyone who receives payments of $5,000 or more a year in consulting and other fees. The action comes as some U.S. senators push for what they're calling a "physician payment sunshine act" that would require all companies to disclose their financial arrangement with doctors.

***See "Doctor-Health Thyself" at Page 5 of this newsletter.**

ARTICLES OF INTEREST

An Introduction to Trusts for the Benefit of Disabled Persons:

Understanding the Basic Differences Between Special Needs Trusts and Supplemental Benefits Trusts

By Gary Mazart, Esq. and Regina M. Spielberg, Esq.

A disabled individual often seeks public benefits to provide for basic necessities through programs such as Medicaid and Supplemental Security Income (SSI). Many of these public programs are "means-tested" and impose financial limitations for eligibility. A properly drafted trust, where assets are available to provide for the disabled beneficiary's special needs and to supplement public benefits, may result in an improved quality of life without jeopardizing public benefits. Two types of trusts are commonly used for this purpose: Special Needs Trust ("SNT") and Supplemental Benefits Trust ("SBT"). The distinction results from whether the assets funding the trust belong to the disabled person or a third party. A SBT is established and funded with the assets of a third party, usually a family member, either by testamentary trust or by *inter vivos* trust. A SNT is a self-settled trust funded with the assets of the disabled person, such as an inheritance or the proceeds of a personal injury action. In either instance, to avoid the beneficiary being disqualified from public benefits, the trustee's discretion to use trust assets for the disabled beneficiary must be sufficiently limited and the trustee must not use trust assets to purchase too many "countable resources" or provide the beneficiary with too much "income."

Special Needs Trusts

Under federal law a Special Needs Trust must be established by the disabled person's parent, grandparent, legal guardian or by a court. The law also requires (i) the beneficiary to be under age 65 when the trust is established and funded; (ii) the beneficiary to be disabled; and (iii) the trust to provide that upon the death of the beneficiary any state agency that has provided Medicaid benefits be reimbursed out of the trust up to the amount of the benefits provided during the existence of the trust. New Jersey regulations have additional requirements including trust language stating:

- it is for the sole benefit of the disabled person;
- the purpose of the trust is to supplement, not supplant, impair or diminish, any benefits or assistance of any federal, state or other governmental entity;
- the trustee will fully comply with all State laws, including the Prudent Investor Act[1];
- an annual formal or informal accounting of all expenditures made by the trust will be submitted to the appropriate public benefits agency;
- the State be given advance notice of any expenditure in excess of $5,000, and of any amount that would substantially deplete the principal of the trust; and
- additions to trust corpus must be reported to the appropriate public benefits agency.

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The SNT is a grantor trust, meaning that the income of the trust is generally taxed to the grantor but since the trust will be funded with the disabled beneficiary's assets, the IRS likely would characterize the parent, grandparent, legal guardian or court creating the trust as a "nominal grantor" and treat the disabled beneficiary as the true grantor for income tax purposes. Accordingly, the beneficiary would report all of the trust income on his or her individual income tax returns regardless of whether trust assets are actually distributed to or for his or her benefit.[1] For gift tax purposes, a transfer of the disabled beneficiary's assets to a SNT should not constitute a completed gift, and no gift tax should be imposed because during the trust's existence the assets held by it, along with the trust income, may be used only for the beneficiary's benefit.[1]

Supplemental Benefits Trusts

To avoid jeopardizing a disabled individual's public benefits, a Will or living trust of a parent, spouse or other third party can provide that the assets be held in a Supplemental Benefits Trust for the disabled individual's benefit. Since the trust would not be funded with assets of the beneficiary, most of the above described federal and New Jersey requirements with respect to SNTs do not apply. While the terms of a SBT are not mandated by law, the availability of trust assets to the disabled beneficiary will determine whether his or her eligibility for public benefits programs is compromised. Under the terms of a properly drafted SBT, the disabled individual has no control or access to the trust funds. As a result, the funds are not considered a resource available to the disabled individual for purposes of determining eligibility for Medicaid, SSI or Division of Developmental Disabilities residential services.[1] Anyone other than the disabled individual can continue to contribute funds to the trust. For example, relatives or friends of the disabled individual can make a gift by adding to the trust instead of making an outright gift to the individual.

"A Special Needs or Supplemental Benefits Trust can allow an incapacitated person to live with greater dignity by covering supplemental needs not met through government, charitable or other benefits."

Further, senior parents who are concerned about Medicaid or other means-tested public benefits to cover the future costs of their own custodial care, may transfer their assets to SBTs created for the sole benefit of their disabled child without affecting their own access Medicaid benefits. The trust must be drafted so that no individual except the disabled child can in any way benefit from the transferred assets.[1] Federal law provides that no transfer penalties will apply if a trust created for the sole benefit of a disabled child is "actuarially sound" or has a "payback provision." New Jersey regulations are more restrictive, however, requiring a "payback provision" naming New Jersey as the first remainder beneficiary, regardless of actuarial soundness.[1]

Also, a non-Medicaid spouse (including a domestic or civil union partner) of a disabled individual may wish to leave some or all of his or her estate in a testamentary SBT for the benefit of the Medicaid recipient spouse. If, however, the non-Medicaid spouse dies within five years of the receipt of assets from the Medicaid spouse which are then used to fund the testamentary SBT and the Medicaid spouse subsequently dies within five years of that original asset transfer to the non-Medicaid spouse, Medicaid is entitled to a recovery claim against a portion of the property held in the testamentary SBT.[1]

An *inter vivos* SBT may be drafted as a "grantor" trust so that the trust income will be reportable by and taxed to the grantor during his or her lifetime. Care must be taken, however, to ensure that the circumstances causing the trust to be treated as a grantor trust do not result in the inclusion of the trust property in the grantor's estate at his or her death. Following the death of the grantor, the *inter vivos* SBT will continue as a "non-grantor" trust (*i.e.,* the trust will report its income, deductions and credits on its own income tax returns). Similarly, a testamentary SBT will be taxed as a non-grantor trust.

Conclusion

A Special Needs or Supplemental Benefits Trust can allow an incapacitated person to live with greater dignity by covering supplemental needs not met through government, charitable or other benefits. Trustees and Grantors should understand that a properly drafted Trust is only the beginning of planning in this area. Ongoing administration requires diligence in the areas of funding, and distributions among others.

Doctor—Police Thyself

By Susan J. Flynn-Hollander, Esq.

The New York Times recently ran an article (April 28, 2009, Gardiner Harris) highlighting a "scolding report" in which the Institute of Medicine, a division of the National Academy of Sciences, scathingly chastised the many means by which pharmaceutical companies and device manufacturers provide cash, gifts, and free drug samples to doctors. The report concluded that "It is time for medical schools to end a number of long-accepted relationships and practices that create conflicts of interest, threaten the integrity of their missions and their reputations, and put public trust in jeopardy."

Only last year, the Association of American Medical Colleges proposed harsh new rules that attacked the current relationship between pharma and device companies and medical schools. Following the issuance of the Association's report, a number of medical schools and medical societies in the United States reviewed and revised their policies. This supports a growing acceptance that conflicts of interest will no longer be tolerated within the medical community.

The reform support from the Institute of Medicine, long considered the most respected and influential advisory group in medicine, is encouraging to many who have long advocated for change and transparency. Congress is finally responding to demands from reformers to pass legislation that would address many concerns and require drug companies and device makers to publicly disclose any kind of payment made to doctors, whether made in the form of money, in-kind, honorariums, free samples, free food, no-cost continuing medical education credits, and direct payments to doctors for marketing seminars. Senators Charles E. Grassley (R-Iowa) and Herb Kohl (D-Wisconsin) have co-sponsored bipartisan legislation that seeks to end all such activity by "holding the system accountable and building public confidence in medical research and practice."

Drug and device companies find themselves in a quandary since they spend billions of dollars each year building relationships and encouraging doctor loyalty to their brands and products. While many of the largest pharmaceutical companies have taken baby steps by ceasing to lavish doctor offices with pens, pads and other small value "gifts," other more costly practices have continued, with the companies contending that there is significant value for both doctors and patients. Meanwhile, the practice of dropping off box-loads of logo-emblazoned pens and offering free trips to doctors continues unabated in the world of biotech and medical device organizations.

> "… a 2007 survey showed that 75% of doctors accepted free drug samples…"

The NY Times article states that a 2007 survey showed that 75% of doctors accepted free drug samples, more than 33% accepted financial support for medical refresher courses and greater than 25% took payments for providing medical lectures and enrolling patients in clinical trials. Given these numbers, change will not come quickly in a culture that has willingly participated in these activities. While the argument can be made that few if any doctors would be unduly influenced by an attractive plastic pen or memo pad, the same cannot be true of payments of thousands of dollars each year for trips, lectures or clinical studies.

Industry financing, marketing tactics, systematic funding, and potential bias in medical "education" are inherently fraught with conflict, and doctors themselves are realizing that they must responsibly address these issues themselves or suffer the consequences of government doing it for them.

New Jersey Family Leave Insurance:
What New Jersey Employers Need to Know
By Edward W. Ahart, Esq. and Daniel O. Carroll, Esq.

On May 2, 2008, New Jersey Governor Jon Corzine signed into law a bill that will provide family leave insurance to eligible New Jersey employees. New Jersey became only the third State in the nation to enact legislation providing family leave insurance benefits for workers caring for newborn infants, newly-adopted children and seriously ill family members.

What is the purpose of the new law? The new law provides eligible employees with up to six weeks of family leave benefits in order to bond with a child or care for a family member with a serious health condition (such benefits are referred to hereafter as "Family Leave Insurance Benefits"). The law is designed to protect workers from losing income as a result of taking time off to care for family members who cannot take care of themselves.

When and under what circumstances may employees receive Family Leave Insurance Benefits? Beginning on July 1, 2009, covered employees of all private and government employers subject to the New Jersey Unemployment Compensation Law (N.J.S.A. 43:21-1 *et seq*.) may receive up to six (6) weeks of Family Leave Insurance Benefits in order to (a) bond with a child during the first twelve (12) months after the child's birth, if such employee or such employee's domestic partner or civil union partner is a biological parent of the child, (b) bond with a child during the first twelve (12) months after the placement of the child for adoption with the employee, or (c) care for a family member with a serious health condition as evidenced by a certification from a health care provider. *Note: Benefits may be paid for 3 weeks pending receipt of the medical certification from a health care provider.*

Who qualifies as a "family member"? The term "family member" means a child, spouse, domestic partner, civil union partner or parent of the individual claiming Family Leave Insurance Benefits. *Note: The term "child" includes a child of a covered individual, domestic partner of the covered individual or civil union partner of the covered individual*

See "Family Leave" on Page 11

Facebook...An Openbook?
By John P. Campbell, Esq.

The article below originally appeared in the DRI Newsletter, The Whisper, Volume 1, Issue 5 on February 13, 2009. It has been reprinted here because the explosive growth of Facebook has relevancy to the healthcare industry. Facebook users create status updates regarding their health and the health of their friends, children and family ("Jane is home with little Grace who has pinkeye this morning."). Users will post public comments regarding a friend's recent trip to the Emergency Room ("I heard you were in the ER…I can't believe you didn't get out of there until 6:30 a.m."). Hospitals, insurers, employers and others in the healthcare industry may gain useful information from Facebook surfing. Consider that while healthcare providers big and small spend inordinate amounts of time and money to strictly comply with HIPAA regulations – Facebook and other social networking vehicles freely dispense HIPAA type protected information at the rate of millions of "leaks" per day.

My father may call it "Facepage," but it is no longer used solely by the kids setting their alarms to make their 11:05 a.m. English class. The fastest growing population on Facebook is the 25 plus group. Doesn't that sound a lot like the same group of plaintiffs and witnesses we come across each day while we defend our clients? Tap into this resource and see what you can discover on Facebook and other popular social networking sites.

Facebook is a social networking site founded in 2004. The number of people actively using Facebook more than doubled in 2008. Facebook describes itself as a utility that helps people communicate more efficiently with their friends, family and coworkers. Many times, these communications are open for just about anyone to read. Facebook statistics regarding the number of communications on the site are staggering. It boasts more than 140 million active users. More than half of Facebook users are outside of college. The average user has more than 100 friends on the site.

Lawyers are not the only ones reviewing Facebook for information.

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IRS Releases Final Report on Hospital Industry Compliance Check Audits

By Judy P. Chung, Esq.

On February 12, 2009, the Internal Revenue Service (IRS) released its "Final Report" on the results of its hospital industry compliance check audits conducted in 2006. The study was conducted so that the IRS and other stakeholders could better understand nonprofit hospitals and their community benefit and executive compensation practices and reporting.

The Final Report summarizes the reported community benefit and executive compensation data across various demographics. The four community types in the report are: i) high population hospitals (hospitals located in the 26 largest urban areas in the U.S.); ii) other urban and suburban hospitals (those hospitals located in urban and suburban hospitals other than the 26 largest urban areas); iii) critical access hospitals (rural hospitals designed as such under federal law); and iv) other rural hospitals (rural hospitals not designated as critical access hospitals).

The study also analyzed patient mix and excess revenues across these demographics. The results were based on five groupings of individual hospital's annual revenues: i) under $25 million; ii) $25 million to $100 million; iii) $100 million to $250 million; iv) $250 million to $500 million and v) over $500 million.

The Final Report focuses principally on two main topics: executive compensation and community benefits reporting.

With respect to executive compensation, the Final Report reveals high amounts of compensation, as well as broad reliance on the three-part "Rebuttable Presumption of Reasonableness" safe harbor. The average and median total compensation amounts reported as paid to the top management official were $490,000 and $377,000, respectively. Although many of the compensation amounts reported may appear high, nearly all examined were upheld as established pursuant to the rebuttable presumption process and within the range of reasonable compensation.

"With respect to executive compensation, the Final Report reveals high amounts of compensation…"

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STUDENT CORNER

What Price?

The High Cost of Medical Education

By Jose Almanzar **Edited by Cynthia Sladecek, Esq.**

The rising costs of college have certainly not gone unnoticed by parents and potential students and affordable education has graduated from an earmark project to an issue at the forefront of the recent Presidential campaign. Just as concerning are the increasingly exorbitant costs for graduate schools. The Association of American Medical Colleges data show that the median private medical school tuition and fees has increased by 50 percent between 1984 and 2004. Median public medical school tuition increased by 133 percent during the same time period. [1]

In the past, the high costs of medical school and law school were dismissed with the notion that doctors' and lawyers' salaries are commensurate with their outstanding loans. The earning potential alone was once worth the interest compounded on student loans. While the focus has been on initial affordability of college education, we must look beyond to the affordability of post-graduate education. What happens when medical school becomes too expensive even for the wealthiest of candidates? This is important, given that historically, 60% of medical students come from families in the top 20% of income earners. Primary Care Physician salaries are slowly dwindling down, so how can such a physician afford to pay off his or her student loans? What happens when medical students cannot afford to return to their communities and establish practices? Two young medical professionals provide an insider's view into the effects of excessive costs associated with medical educations, on the profession itself and on the health and vitality of local communities.

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American Physician Scientist Association:
Translation Research Frontiers
By Anton Kolomeyer, Shyam Patel, and Kedar Mahajan

The three medical schools of UMDNJ are proud to count among their respective student bodies a select group of scholars pursuing a joint degree program, earning them both MD and PhD degrees. This edition of The Benchmark features a Student Contribution from three aspiring physician-scientists from UMDNJ - New Jersey Medical School. SPSK is pleased to represent UMDNJ as Panel Counsel.

The annual New York Regional Meeting of the American Physician Scientist Association (APSA) was held recently at the Icahn Medical Institute, Mount Sinai School of Medicine. APSA is a national organization dedicated to addressing the needs of future physician scientists, either MDs with strong research backgrounds or MD/PhDs. The meeting objectives included training and career development, vertical and horizontal networking and mentoring as well as discussion of issues relating to retention and women physician scientists. In addition to small group sessions designed to explore all aspects of the clinician-scientist academic and personal lifestyle as well as the wine, chocolate, and cheese reception (including a chocolate fountain), the highlights of the meeting were the Keynote Lectures delivered by professors with very disparate research disciplines and perspectives. Three of these are highlighted below.

Can a single researcher develop drugs that evade bacterial resistance, treat T-cell lymphoma or rheumatoid arthritis, target tumor angiogenesis, or kill the malaria parasite? Vern Schramm, Ph.D., of Albert Einstein College of Medicine, explained how his research tackles these diverse challenges. Dr. Schramm creates inhibitors that mimic an enzyme's transition state (which exists for a fraction of a bond vibration – on the order of a femto second) using molecular electrostatic maps and substitution of individual atoms. The product of this quantum chemistry is an enzyme inhibitor with a

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OPINION: Demand Stronger Healthcare Reform
By Stephen Roberts

The proposed solutions of tax credits, mandates, and health exchanges may provide some short-term relief for individuals (at great financial expense) but do not address the underlying causes of our healthcare crisis and will exacerbate the problem in the long-run. Focusing exclusively on the 47 million uninsured will lead us to insufficient reform.

How good is your insurance coverage *really*? Out of the one million people filing for medically related bankruptcies each year, 75% have insurance at the onset of their medical condition. And these bankruptcies are just the tip of the iceberg: many more forego necessary medical treatment out of financial constraints, resulting in more costly, later-stage diseases and worse—thousands of needless deaths a year.

Mismanaged finances are at the heart of our crisis and research shows that the greatest amount of money is wasted through the for-profit, private insurance sector. There is an illusion that competition between private insurance companies creates quality plans. The reality is an inefficient beauracracy with $400 billion dollars a year of healthcare money going to administration rather than paying for actual healthcare.

In order to maximize profits an insurance company would need to selectively enroll those who don't need healthcare, deny everyone else coverage, minimize covered procedures, and minimize payments to doctors. Should we be surprised then that this almost

"How good is your insurance coverage *really*?"

exactly describes the trends in private insurance?

Healthcare profiteering is also largely responsible for the failing of Medicare, our public program. Senior citizens have more health problems and are therefore more costly to cover. When insurers stopped offering community ratings and began increasing their asking price for premiums, it became increasingly difficult for employers to honor their retiree healthcare benefits. Medicare was instituted in 1965 to offer coverage to

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NEWS ALERTS

In the Winter I edition of The Benchmark, one of our student contributors, Nicole McErlean, a Seton Hall Law School student, wrote a piece about the controversial vaccine, Gardasil. The following is an interesting update that appears to support many of the points made by Ms. McErlean.

In a front-page article, the Washington Post (3/26, A1, Stein) reports that three years ago, Gardasil entered our collective consciousnesses as a way to "protect girls against" the human papillomavirus (HPV), but it also led to a "debate [that] centered on one question: Would the shots make young girls more likely to have sex?" Now, as Merck aims "to get approval to sell the vaccine for boys...the debate is focusing on something else entirely: Is it worth the money, and is it safe and effective enough?" Alongside the apparent "double standards," the "shift in the discussion about Gardasil illustrates the complex interplay of political, economic, scientific, [and] regulatory...factors that increasingly influence decisions about new types of medical care." The vaccine may reduce women's cervical cancer risk, however, "for males, the vaccine is aimed at protecting against genital warts and less common malignancies that HPV can cause." But vaccinating males could prevent sexual transmission. Still, "this is a vaccine that principally benefits women's health," leading one expert to "wonder if it was the reverse, and there was a vaccine for women that helped prevent prostate cancer in men, this would be as much of an issue."

The New Jersey Legislature approved a final bill that would amend the State's existing physician self-referral statute in order to provide greater clarity in the area of ambulatory surgery center referrals.

Gov. Jon Corzine has signed a bill that authorizes physicians to refer patients to ambulatory surgical centers that they own. The bill, S-797/A-1933, spares New Jersey's 120 centers from a 2007 Bergen County trial court ruling that might have put them out of business. Superior Court Judge Robert Contillo, in *Garcia v. Health Net*, Ber-C-37-06, ruled that doctors who sent their own patients to the Wayne Surgical Center violated a 1992 law against self-referral. While the judge said the violations did not rise to a level of fraud that would allow insurers to deny claims, he implied thousands of doctors were acting illegally and could be subject to discipline. The new law, which retroactively makes previous referrals compliant, and stipulates that referring physicians must perform the surgery themselves and have a financial stake in the surgery center, but their compensation cannot be based on volume of referred patients.

With its recent release of Advisory Opinion 09-05, the OIG leaves hospitals and physicians who take call for uninsured Emergency Department patients with a bit of a quandary. The opinion addresses a hospital's Proposed Arrangement by which it plans to compensate some physicians for on-call services performed on behalf of the hospital's uninsured patients who present at the hospital's Emergency Department. The OIG concluded that while the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, the OIG would not impose administrative sanctions in connection with the arrangement as presented. You can read the opinion in its entirety at the OIG website: www.oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-05.pdf.

Hospital counsel and administrators who manage on-call programs will note that hospital-based physicians are excluded from participating in this program. Readers are left to ponder the reason for this distinction. It perhaps begs the question as to whether certain non-radiologist physician members of a Medical Staff may receive compensation under this scheme to provide call for certain non-exclusive radiology services while members of the hospital-based radiology group are charged with the same requirement to take call for the very same non-exclusive services, albeit without compensation.

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Beginning in March 2009, the Centers for Medicare & Medicaid Services ("CMS") plans to implement the permanent Medicare Recovery Audit Contractor ("RAC") program in phases. The successful six state pilot recoupment program implemented in New York, California, Florida, Arizona, South Carolina, and Massachusetts will be extended to a wider group of states divided into 4 regions, A, B, C, and D.

Under the program, the four RACs will contract with subcontractors to supplement their efforts. PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI in regions A, B and D. Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting in region C. CMS plans to have 4 RACs in place by 2010. Each RAC will be responsible for identifying overpayment and underpayments in approximately one fourth of the country.
The Contractors will be utilizing two levels of review, automated and complex. Automated review will occur when a RAC makes a claim determination at the system level without human review of the medical record. Alternatively, complex review will occur when a RAC makes a claim determination using human review of the medical record. A provider will have 45 days to respond to a medical records request. If a provider does not submit the requested medical records within 45 days, a RAC may deem a claim to be an overpayment.

Claims identified as overpayments will be subject to the Medicare appeals process. The Medicare appeals process will remain the same for physicians under Medicare Part B and for Medicare Part A non-inpatient claims. CMS reports that the only difference under Medicare Part A is for claims under the hospital inpatient prospective payment system. For such claims, the first level will go to the fiscal intermediary.

The stimulus package, the American Recovery and Reinvestment Act of 2009, provides many benefits and some new restrictions on physicians, hospitals, nursing facilities, educational institutions, business associates, and vendors.

"Francine Katz" from Page 1

other facilities with the level of compassionate care provided to each patient so that hospital stays are as enjoyable as possible."

Despite a busy professional and personal schedule, Ms. Katz also finds time to give back to Seton Hall Law School, and recently presented to a group of healthcare law students at the Newark campus. Francine's message to aspiring attorneys is to "gain experience through internships!" Not one to give this advice in theory only, Katz will have at least one Seton Hall law student interning at the office of the General Counsel at St. Peter's University Hospital this summer.

This Client Spotlight is as much about the upcoming June 7 event as it is about its co-chair. Francine has personally pledged to raise $18,000 this year with her team and with only days to go that goal has almost been reached. The North Jersey Walk website has posted total pledges close to $125,000 – but there is always more needed. Francine wants you to know that this year's walk begins at 9:00AM with check-in and Money Collection, at the Atlantic Health Jets Training Center in Florham Park. The 3 mile Walk (stride as much or as little as you choose) begins at 10:00AM and snacks and water will be provided. There will be Jets players in attendance, autograph opportunities, JetsFest activities, live music and food, a chance to see the new Jets facility, and fun for everyone. Benchmark readers are urged to participate by joining the Katz Me If You Can team, and/or making a donation to the Walk program. Learn more, join a team, make a pledge or get directions to the Walk at www.lupusresearch.org or call Sheri Kirkpatrick (NJ Fundraising Manager) at 732-842-1607.

When asked how winning the lottery might change her life, Katz quickly responds, "I would be in a position to significantly contribute money for lupus research to help speed along finding a cure." In the absence of a lottery win, we can still help fund research to find a cure. Won't you join Francine, the 102 members of the Katz Me If You Can team, the Atlantic Health team, and attorneys from SPSK's healthcare team, the Jets organization, the St. Peter's University Hospital team, and thousands of other participants walking on June 7th in support of this worthy cause? See you at 9AM-Atlantic Health Jets Training Center - rain or shine!

Alliance for Lupus Research

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who is younger than 19 years of age or 19 years of age and incapable of self-care.

What is a "serious health condition"? The term "serious health condition" means (i) an illness, injury, impairment or physical or mental condition which requires inpatient care in a hospital, hospice or residential medical care facility, or (ii) continuing medical treatment, or (iii) continuing supervision by a health care provider. *Note: The new law does not cover leave for an employee's own serious health condition.*

Who qualifies as a "health care provider"? The term "health care provider" means any person licensed to provide health care services or any other person who has been authorized to provide health care by a licensed health care provider.

Which employers are subject to this law? The new law applies to any employer that is subject to the New Jersey Unemployment Compensation Law. *Note: This is broader than the Federal Family Leave Act and the New Jersey Family Leave Act, which generally apply to employers with 50 or more workers and allow workers to take up to 12 weeks of unpaid leave for family or medical reasons. In addition, although governmental employers may choose not to elect coverage for temporary disability insurance benefits, they may not do so with respect to Family Leave Insurance Benefits.*

Who is eligible to file a claim for Family Leave Insurance Benefits? Individuals claiming benefits must have worked at least twenty (20) calendar weeks in covered New Jersey employment in which he or she earned at least $143 or individuals who have earned at least 1,000 times the New Jersey minimum wage during the fifty-two (52) weeks preceding leave (rounding up to the nearest $100, that amounts to $7,200). This means any employee of an employer that is subject to the New Jersey Unemployment Compensation Law. *Note: The new law is an extension of temporary disability insurance, so these requirements differ from the requirements for the Federal Family Leave Act and the New Jersey Family Leave Act.*

How much money are employees entitled to receive in the form of Family Leave Insurance Benefits? After a one-week waiting period, eligible employees are entitled to receive two-thirds of such employee's average weekly wage up to a maximum of $546 per week. No more than six weeks of benefits will be paid during any 12 month period. *Note: An employee can take Family Leave Insurance Benefits directly after recovering from a pregnancy-related disability and receiving temporary disability insurance benefits*.

Who pays for the Family Leave Insurance Benefits? In the case of an employer using the State administered plan, the benefits are paid entirely from employee contributions. As of January 1, 2009, such employers must withhold 0.09% from employees' taxable wages but are not required to contribute money to fund Family Leave Insurance Benefits. This amounts to an estimated payroll deduction of $0.64 per week or $33.00 per year for each employee. The withholding rate will increase to 0.12% in 2010. Importantly, these employee contributions are mandatory. In the case of an employer using an approved private plan, the employer does not transmit employee contributions to the State. *Note: Taxable wages subject to the New Jersey Family Leave Insurance Benefits program are reported and remitted together with other contributions due on the Employer Quarterly Report. A household employer will report and remit such contributions on the Employer Annual Report.*

"Facebook" from Page 6

According to a careerbuilder.com survey, approximately 20% of employers are reviewing social networking sites including Facebook to weed out job applicants as employers find interesting communications ranging from alcohol and drug abuse to tales of a recent arrest.

Our typical discovery demands may ask: "Have you or has any other person, to your knowledge, made any notes, memoranda, diary or journal entries of any information, data, conversations or factual summaries relevant to the subject matter of the within litigation?" "Are you in possession of photographs, videotapes or any tapes or other electronic recording relevant to the subject matter of the within litigation?"

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Instead of waiting 30 to 60 days for a reply, determine if this information is already available on Facebook. More than 13 million users update their statuses on Facebook at least once each day. In December 2008, participants posted a total of 900,000 status updates in a typical hour. A user updates his or her status on Facebook when answering the question: "What are you doing right now?" Users completing this task are creating online journals or diaries. Some of these status updates may be entirely benign ("Jane Smith is tired.") and it is unlikely that you will receive a confession ("Col. Nathan R. Jessep is ordering a code red."), but others may assist in painting a larger picture by reviewing other aspects of a user's page.

For example, a user's friend may add journal information through wall posts. Facebook explains that the Wall is an open forum for users' fans or friends to leave comments, thoughts, and ideas about them on your Page or Profile. "This application makes it easy for people visiting your Page or Profile to say what's on their mind." In December 2008, people wrote 1.5 million wall posts in a typical hour. If it is relevant to the defense of your litigation, it may be interesting to know that Jane Smith's friend in Virgina was happy to see her over the Christmas holiday.

Moreover, over 2 million events are created each month where users invite one another to attend gatherings that range from a 5K run to a high school reunion. Users will decline or accept these events, adding to their online journal or diary. Users also take quizzes, play games, and otherwise occupy themselves on Facebook through thousands of applications. Once a user completes an application, a time/date stamp may result on his/her user profile and more information is added to the online journal or diary. If a plaintiff claims she experienced severe emotional distress relative to a hostile work environment one morning in September, but also completed a whimsical quiz entitled "Which 80s movie defines you?" that same morning, a worthwhile inquiry at deposition may become available.

Of course pictures and videos may tell us more about a person relevant to our litigation than Jane Smith's status update that she's having a glass of wine. More than 700 million photos are uploaded to the site each month. More than 4 million videos are uploaded each month. In December 2008, people updated over 1.6 million photos in a typical hour. It is unlikely you or your plaintiff will upload a video of your plaintiff disabling the safety device on the tractor which allegedly caused the target ankle injury, but a video of that same plaintiff dancing at Aunt Mary's wedding a month after the date of loss may be beneficial to your defense.

Facebook offers a potential treasure trove of information. To this end, Facebook warns its users that "…if you disclose personal information in your profile or when posting comments, messages, photos, videos, Marketplace listings or other items , this information may become publicly available." A user's communications may be available to review through his/her "network" designations. Facebook networks include schools, companies and regional networks including for example, Northern New Jersey. Facebook not only asks new users to join a network when initially joining the site, but the default setting is to have user information shared with members of the same network. Of course not all information is publicly available as many users will select privacy features to protect their communications, etc. from public viewing.

Therefore, it may be a good idea to consider reviewing other social networking sites to determine if a plaintiff or witness has made certain information publicly available. For example, MySpace was the most popular social networking website until Facebook exploded in 2008. In June 2008, MySpace hosted over 115 millions users. YouTube is another resource to consider. YouTube usernames and email addresses are often one and the same, so a search for a YouTube user by email address may result in many videos. LinkedIn is the business-oriented social networking site which now boasts approximately 30 million registered users. LinkedIn may be a particularly useful site in obtaining information relevant to expert witnesses. Blogspot or Blogger.com is another site to consider. The site's homepage says it all: "Your blog. Share your thoughts, photos, and more with your friends and the world."

In December 2008, an Australian court approved the use of Facebook to notify a couple that they lost their home after defaulting on a loan. The decision was made after several failed attempts to contact the couple at the house and by e-mail. The attorney found the couple's Facebook pages using personal details they had given the lender including birth dates and e-mail addresses. A Goggle search may be how you start your online research to see what you can discover regarding your new plaintiff or witness, but you should also consider Facebook and these other popular social networking sites.

"IRS" from Page 7

With respect to community benefit, the Final Report addresses three main issues: i) what are the leading types of community benefit provided by hospitals; ii) which types of hospitals reported spending the most on community benefit; and iii) what are the revenues and profits of the hospitals responding to the compliance check audit.

Uncompensated care was the largest reported community benefit expenditure. Overall, the average and median percentages of uncompensated care as a percentage of total revenues were 7% and 4% respectively. Uncompensated care accounted for 56% of aggregate community benefit expenditures reported by the hospitals in the study.

The average and median percentages of total revenues reported as spent on community benefit expenditures were 9% and 6% respectively. Among the community types, these percentages were lowest for rural hospitals and highest for high population hospitals. The percentage spent on reported community benefit expenditures generally increased with revenue size

The overall group of hospitals reported excess revenues of 5% of total revenues. Reported excess revenues varied across the community type and revenue size demographics, with large revenue size hospitals generally the most profitable and critical access hospitals the least profitable.

Although the reported data may not accurately represent the nonprofit hospital sector as a whole, it provides important information. The Final report is being released in the midst of a highly charged political environment, with heightened taxpayer expectations of regulatory scrutiny when tax revenues support a particular organization or industry sector. Accordingly, tax-exempt hospital boards are well advised to closely review the Final Report and evaluate the need for greater "common sense" focus on the process by which executive compensation is determined and on the manner in which community benefit is provided and reported.

"What Price" from Page 7

Jacob is a second year medical student in New York. Amelia is a second year physician at one of the largest hospitals in New York. Both Jacob and Amelia denounce the costs of medical education and believe that the high costs improperly influence students in their choice of medical careers. More particularly, the ever decreasing number of primary care physicians versus specialists is due, in large part, to the simple fact that specialists earn more money than primary care physicians. And that, of course, is because insurance companies and other payors skew reimbursement in that direction.

Jacob and Amelia both suggest that eliminating the debt associated with medical education will create a trifecta of benefits for both the medical academia and the medical profession: (1) Racially diverse and higher quality candidates (2) Monetary Disincentives: Candidates dedicated to the practice of medicine and helping their communities rather than a focus on earning potential; and (3) Equality amongst Primary Care Physicians and Specialists.

Amelia believes that the high expense of medical school deters even the most talented of college graduates. "A lot of these Biology and Life Sciences majors decide to be teachers instead. They can make an O.K. salary right out of college, they're eligible for pensions after only a few years, they get summers off, and they don't incur tons of debt. Not to say that we don't appreciate them as teachers but someone who wants to be a doctor and can't afford it shouldn't view 'teaching' as a fall-back." Jacob agrees and believes that this "fallback" of intelligent, would-be medical students "dilutes the teaching pool by inviting people who don't really want to be teachers to become teachers for all of the wrong reasons."

As for eliminating the monetary disincentives, both Amelia and Jacob pine for the days when doctors became doctors to help people - not to make money. They both believe that medical school should be affordable, if not entirely free, and a salary cap should be imposed for both primary care physicians and specialists. Amelia in particular feels that a cap would welcome candidates who truly want to be doctors and would deter those candidates who only have designs on becoming wealthy.

Interestingly, there exists a hierarchy in the medical profession, with the specialists at the top of the

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pyramid and the primary care physicians at the bottom. Amelia explains that "there are really two types of doctors: internal medicine doctors and specialists. It takes a few more years of training to become a *specialist*, but, in the end, the training is just training them in 'procedures'." Amelia, who works in internal medicine, believes she is a "thinking" doctor; she "gets paid to diagnose and recommend solutions." The specialists, however, clearly earn more money and students are motivated to put in the additional time and to incur debt for a few more years of residency and fellowship training, in hopes of eventually earning more money. Consequently, there are fewer and fewer primary care physicians and few of those who are willing to return to establish a practice in their home communities. Jacob and Amelia believe that eliminating the debt and capping the salaries of all doctors would inspire physicians to contribute to their communities and focus on improving the practice of medicine.

Jacob and Amelia have support for their beliefs. The high costs of medical education and the debt burdening graduates have implications for the racial and ethnic composition of the physician workforce. [1] The levels of minorities in medical schools are still well below 20%. [1] The primary reason for this differentiation is that minority students are likely to see the costs of medical education as an insurmountable deterrent.[1] Candidates from humble financial backgrounds are also likely deterred from medical school. Diverse medical practitioners create healthy relationships with patients who are similarly situated to them, whether in race or ethnic origin. In addition, minority doctors are more likely to return to their home communities and establish a primary care practice.[1]

While Jacob and Amelia's proposals to eliminate medical school costs entirely are admirable, it is not a viable solution for the immediate future. Perhaps a more achievable goal is to reduce medical school costs by increasing the amount and availability of grants, both from the schools themselves as well as the state and federal governments. Other authors have suggested that possible answers can be found in securing adequate funding for Title VII health professions programs, reauthorizing the Higher Education Act, expanding and protecting the National Health Service Corps Load Repayment Program, and broadening the tax-exempt status of medical scholarships.[1] As for state action, state legislatures could provide financial support to public medical schools to enable them to cap tuition and create new programs whereby new physicians can pay off loans in the form of state service. [1] These are just some of the several practical means of ameliorating or off-setting the high costs of medical school.

As Americans, as lawyers, as consumers of the healthcare system in this country, and as participants, willing or unwilling, in the reform that is currently being shaped by the Obama Administration, it is important that we understand and challenge the medical education system to produce doctors unencumbered by massive school debt. Only in this way can we expect students to enter areas of practice they wish to pursue, rather than expend more time and money on additional training so that they might choose a field that enables them to comfortably pay off their loans but leaves patients without the primary care doctors who are already in such short supply. Ask yourself, are you and your family members more likely to seek the regular services of a pediatrician, family practitioner, internist OR a neurosurgeon, biochemical geneticist, congenital cardiac surgeon, reproductive endocrinologist, or pediatric otolaryngologist? Notwithstanding the complexities of revamping a well-entrenched system, without making it more attractive for medical school graduates to choose primary care medicine as part of the reform efforts, we are *all* going to share the price of those decisions in the years ahead.

"APSA" from Page 8

disassociation constant on the pico molar scale; pop a pill smaller than a baby aspirin, and you are good for a few weeks! Dr. Schramm works with physicians to identify targets with potential clinical value. For example, we need antibacterial drugs that do not select for resistant pathogens, and one possible drug target is against the "quorum-sensing" mechanism which will effectively leave the organism alive but blind to its environment. Dr. Schramm's lab is developing a transition-state inhibitor that selectively blocks quorum-sensing without affecting survival in *Vibrio cholerae*; hopefully this drug will give the host immune system time to respond without putting evolutionary pressure on the pathogen to develop resistance. While a magic bullet for these diseases may be far away, the mission is resolute - some of these inhibitors have already made their way into clinical trials for leukemia and autoimmune disorders.

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Dr. Katherine High from the Children's Hospital of Philadelphia, University of Pennsylvania, discussed the use of gene therapy for inherited disorders such as blood coagulopathies and select retinal degenerations. The focus of her talk was on Leber's Congenital Amaurosis (LCA), a rare inherited disease characterized by nystagmus (i.e., oscillating eye), abnormal pupillary response (i.e., delayed pupil constriction in response to light), and eventual blindness. Although eleven genes have been associated with this autosomal dominant disease, the Adeno-Associated Virus (AAV) gene therapy discussed was targeting LCA type 2 where the mutation is in RPE65, an enzyme involved in retinal phototransduction. Since adenoviruses are not incorporated into the host genome, the risk of mutagenesis is reduced in this "knock-in" therapy compared to gene therapy using retrovirus vectors. Ongoing clinical trials at University of Pennsylvania, University of Florida, Moorfields Eye Hospital, and University College of London showed that RPE65 gene transfer is stable, safe, and is able to improve vision in some patients. Factors affecting treatment outcomes included patient age, mutation type, extent of initial degeneration, degree of residual childhood vision, and injection site. Given that these initial clinical trials were short in duration and enrolled a small patient population, it is difficult to make any conclusive remarks regarding the long-term effects of these treatment outcomes. The principal investigators should be commended for pursuing this line of therapies; remember that in visual degeneration alone, over 200 gene mutations have been identified. Although we should all be optimistic about the potential application of gene-modifying therapies, the time when this technology is ready for wide-spread use is a long way off.

Many great strides have been made in the field of oncology and cancer research, and they were highlighted by Mark Ptashne, Ph.D., of Memorial Sloan-Kettering Cancer Center, who provided insight into the idea that cancer may be a reversal of evolution at the cellular level. Based on this theory, the loss of cellular specialization represents a reversion to a more primitive state, such as that seen in embryonic development. As evolution continues at the molecular level, interactions and affinities become very specific. Cancer, on the other hand, may be viewed as the loss of appropriate targeting specificity, ultimately leading to uncontrolled cell division if the appropriate molecules and genes are affected. In fact, high grade tumors, which tend to have worse prognoses, are named so because they are poorly differentiated. Dr. Ptashne's lecture fostered interdisciplinary perspectives and encouraged critical thinking as a means of studying cancer in the laboratory. These insights can help physician-scientists gear their current research in the appropriate directions that may eventually lead to better therapies in the field of cancer.

Since the physician-scientist training seeks to carry discoveries from the "bench" to the "bedside", the diversity of the talks at this conference ranging from basic science, translational, to clinical research was appropriate. By "thinking outside the box" and "fostering interdisciplinary perspectives" one would hope to further the understanding of characteristics and evolution of numerous diseases. The physician-scientist carries a unique obligation of relaying discoveries in both directions between the lab and the clinic. If you are interested in exploring basic and translational research done by physician scientists, please visit the APSA website at http://www.physicianscientists.org/.

"Opinion" from Page 8

seniors that were abandoned or never had plans. So the government picked up the bill that private insurers were unwilling to pay. Foreshadowing the modern economic crisis and associated bailouts, we privatized the profits and nationalized the financial losses.

Currently Medicare is tragically under-funded; the majority of money is directed toward private insurance companies through employers rather than to public programs through taxes. And yet 65-75% of healthcare service expenditures are paid for by publicly financed programs and out of patients' pockets. This is the story of Robin Hood in reverse: private insurance shifts costs onto the public, while withholding services and hoarding revenue.

Most Americans believe that the government should be involved in fixing the healthcare crisis to some degree but are concerned about the potential for waitlists, rationing of care, and the inability to choose one's own doctor.

In contrast to more socialized models of medicine, a publicly funded but privately delivered version of a single-

payer system limits the increased role of government to insurance risk-pooling. Patients would still have their choice in doctor and service providers could still be paid in a fee-for-service fashion—allowing for competition and innovation. Essentially, this reform would reclaim the $400 billion dollars wasted in the private insurance industry and re-direct it to Medicare. Research indicates that this would allow us to enroll everyone in the United States in the plan from their birth until their death and offer better benefits including dental, vision, and mental health. Furthermore, we could eliminate co-pays and deductibles (often seen as barriers to preventive medicine). Incredibly, all this could be done with a net surplus compared to current overall spending.

While this change wouldn't address every problem with healthcare it would address many of the most pressing ones. It covers everyone, improves the quality of insurance coverage, promotes primary care and preventive medicine, lowers medical malpractice premiums, drastically reduces the billing overhead and frustrations of doctors, and keeps Medicare sustainable.

Implementing this change will not be easy. Public awareness and insistence are necessary, and this issue must get enough attention so that our Congressional Representatives (perhaps begin by contacting them) will feel answerable to us, their constituents, rather than insurance lobbyists. We owe this to ourselves and to future patients.

HEALTHCARE DECISIONS/OPINIONS

In United States ex rel. Kosenske v. Carlisle HMA, Inc.,

2009 U.S. App. LEXIS 971

The Third Circuit Court of Appeals recently took the unusual step of interpreting the Stark regulations and held that Stark and Anti-Kickback violations may give rise to liability under the False Claims Act.

In 1992, BMAA, a group of anesthesiologists, entered an exclusive contract with Carlisle Hospital under which BMAA would provide all anesthesia services at the Hospital. While no pain management services were being performed by BMAA physicians at the Hospital in 1992, the contract also gave BMAA the exclusive right to provide pain management services in the future, with a right of first refusal to provide anesthesia and pain management services at any new Hospital facilities. Under the contract, the Hospital provided BMAA with free office space, equipment, supplies and personnel.

In 1998, the Hospital built a new facility with a Pain Clinic, located three miles from the Hospital. BMAA provided pain management services at the Pain Clinic on an exclusive basis, and the Hospital did not charge BMAA rent for space and equipment, or a fee for the support personnel at the Pain Clinic. BMAA billed Medicare for the professional fees at the Pain Clinic and the Hospital dropped a facility fee. Off-site pain management services were provided under the 1992 exclusive contract for hospital-based services, with no amendment to include the off-site services.

The District Court found that BMAA and the Hospital had a "compensation arrangement" and "financial relationship" implicating Stark but found that the arrangement met the personal services exception of Stark based on the existence of the 1992 exclusive contract. The Third Circuit did not agree that the parties had complied with Stark.

The Court ruled that the 1992 contract could not apply to services at a facility that were not being provided at the time of the contract at a facility that did not even exist at the time the contract was negotiated. Accordingly, the contract did not reflect the actual operating arrangement between the parties because of the change in the

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relationship over the years. Even if it did, the contract said nothing about the consideration that BMAA was receiving for its services and there were no arm's length negotiations as to the fair market value of the services.

The Court stated that, by definition, a negotiated agreement between parties where one is in a position to generate referrals for the other does not reflect fair market value because of the incentive to mask the payment of non-fair market value compensation. Because physicians in an outpatient facility are in a position to generate substantial referrals for a hospital, any relationship between a hospital and such physicians must be structured and accurately documented in a way that complies with the personal service exception to Stark. Therefore, the Third Circuit ruled that falsely certifying compliance with Stark and the Anti-Kickback regulations in connection with claims submitted to Medicare is actionable under the False Claims Act.

United States ex rel Fry v. The Health Alliance of Greater Cincinnati, et al.

2008 U.S. Dist. LEXIS 102411

The District Court for the Southern District of Ohio issued a published opinion on December 18, 2008 in which it concluded that the plaintiff had adequately alleged defendants operated a cross-referral scheme to cause the government to pay out sums of money and denied defendants' joint motion to dismiss.

Plaintiff challenged the system by which defendants, the Christ Hospital ("TCH") and the Health Alliance of Greater Cincinnati ("THA"), assigned time to cardiologists in the hospital's heart station in proportion to the volume of referral of cardiac procedures made by cardiologists to TCH.

In Count I, plaintiff alleged defendants knowingly presented or caused to be presented false claims, including Medicare claims, for reimbursement for services rendered to patients referred to TCH under defendants' system, in violation of the False Claims Act ("FCA"). In Count II, plaintiff alleged another FCA violation under the theory that defendants made or used false records or statements to cause claims to be paid when defendants submitted false certifications and incorrect data in Medicare and Medicaid cost reports.

Defendants filed their motion to dismiss arguing that the complaint failed to state a claim under the FCA. Defendants argued first that plaintiff's complaint failed to allege facts showing that a benefit flowed to the doctors constituting remuneration within the meaning of the Anti-Kickback statute. Defendants argued that the dictionary definition of remuneration, as well as the legislative history of the Anti-Kickback statute, showed that the term remuneration is meant to include cash and in kind benefits, but not staff privileges or scheduling.

The court concluded that the government had pleaded facts showing that time in the heart station was essentially money, and further, that defendants' system excluded cardiologists from the benefit of heart station time when their referral levels did not qualify them for such time. The Anti-Kickback statute uses the term "any remuneration," which suggests an expansive reading of the form of any kickback directly or indirectly, as opposed to a narrow reading that would exclude the benefit of heart station time.

Defendants' second principal argument was that they lacked the requisite *mens rea* to violate the FCA. They contended that because it is an open question whether allowing a doctor to serve in the heart station constitutes remuneration, it was objectively reasonable for defendants to think their conduct was legal and therefore as a matter of law the complaint had to be dismissed. Defendants based their argument on the Supreme Court's decision in Safeco Ins. Co. of Am. v. Burr in which the Supreme Court found that companies did not violate the Fair Credit Reporting Act where their reading of the statute was objectively reasonable. 127 S.Ct 2201 (2007).

The Court was not convinced that Safeco applied in the FCA context but agreed that even if it did impose the requirement for the Court to make the legal determination whether defendants' conduct was objectively reasonable, the conduct at question simply did not pass the smell test. The allegations showed benefits were accruing to doctors in exchange for referrals, that the system was challenged by those doctors being shut out, and it has been common knowledge since 1972 that remuneration for referrals is illegal. The Court rejected the argument that defendants' conduct fell within such an ambiguous area of the law that the Complaint against them

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merited dismissal.

The Court concluded that the Supreme Court has given the False Claim Act "an expansive reading," and observed that it reaches all fraudulent attempts to cause the government to pay out sums of money. Plaintiff's complaint pleaded enough facts to state a claim to relief that is plausible on its face and such conclusion comports with the Supreme Court's expansive reading of the statute.

MEET THE AUTHORS FROM SCHENCK PRICE SMITH & KING, LLP

Edward W. Ahart is a partner with Schenck, Price, Smith & King's Business Law Department, and has chaired both the Department and the Corporate Practice Group. Mr. Ahart has extensive experience in the purchase, sale and financing of businesses and related commercial transactions, including the structuring and restructuring, negotiating and closing of complex asset and stock sales and acquisitions. He is a frequent speaker on corporate governance, transactional and financing matters and is an active participant in the Rothman Institute of Entrepreneurial Studies at Fairleigh Dickenson University. After receiving an undergraduate degree with honors from Lafayette College in 1969, Mr. Ahart attended the Cornell Law School where he was graduated in 1972. Prior to joining Schenck, Price, Smith & King, LLP in 1973, he served as Law Secretary to the Honorable Joseph Halpern, Superior Court of New Jersey, Appellate Division. Mr. Ahart may be reached at ewa@spsk.com

Gary Mazart is a partner with Schenck, Price, Smith & King, LLP, chairing the firm's Tax, Trust and Estate Department and co-chairing its Elder Law/Disability Law Practice Group. Mr. Mazart is the editor of and contributing author to New Jersey Elder and Disability Law Practice published by the New Jersey Institute of Continuing Legal Education. He also has authored "Lifetime Planning" and "Protecting the Home in Government Benefits Planning," and co-authored "Transfer Tax Planning for Incapacitated Persons by Guardians," and "Matrimonial Settlements – A Public Benefits Conundrum" all published in New Jersey Lawyer Magazine by the New Jersey Bar Association. Most recently, Mr. Mazart co-authored an article for Estate Planning, Volume 36, entitled "The Revival of the Income-Only Trust in Medicaid Planning", and an article for the February 2009 edition of New Jersey Lawyer Magazine entitled, "Trusts for the Benefit of Disabled Persons: Understanding the Differences Between Special Needs Trusts and Supplemental Benefits Trusts." Mr. Mazart may be reached at gm@spsk.com

Regina M. Spielberg is a partner with Schenck, Price, Smith & King, LLP and a member of the firm's Tax, Trust and Estate Department and is one of only 39 New Jersey attorneys certified nationally as an Elder Law Attorney by the ABA Accredited National Elder Law Foundation. She has co-authored articles for Estate Planning, Volume 36, entitled "The Revival of the Income-Only Trust in Medicaid Planning" as well as "Matrimonial Settlements – A Public Benefits Conundrum", "Trusts for the Benefit of Disabled Persons: Understanding the Differences between Special Needs Trust and Supplemental Benefits Trusts" for New Jersey Lawyer Magazine. Ms. Spielberg received her undergraduate degree from Montclair State College, her M.B.A. in Finance from Long Island University, and her J.D. from Rutgers University Law School, Newark. Ms. Spielberg may be reached at rms@spsk.com

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John P. Campbell is an associate with Schenck, Price, Smith & King, LLP and a member of the firm's Litigation Department. Mr. Campbell is an active member of DRI, the national organization of defense trial lawyers and corporate counsel. His published articles have appeared in DRI's November 2005 Technology Committee Newsletter, eNews; July 2006 Commercial Litigation Committee Newsletter, the Business Suit; and August 2006 Young Lawyer's Committee Newsletter, The Whisper. Mr. Campbell earned his undergraduate degree from James Madison University in 1997 and earned his law degree from Seton Hall University School of Law in 2001. Mr. Campbell may be reached at jpc@spsk.com Mr. Campbell is an avid cyclist and integral member of the SPSK Softball Team.

Daniel O. Carroll is an associate with Schenck, Price, Smith & King, LLP, and a member of the firm's Business Law Department and its Business Transactions and Corporate Governance Practice Groups. He was first employed by the firm as a summer law clerk in 2000 and joined the firm as an associate in 2001 after graduating from law school. Mr. Carroll attended Tulane Law School where he was a member of the Tulane Journal of International and Comparative Law. In 2001, Mr. Carroll graduated cum laude from Tulane and was admitted to practice law in New Jersey later that year. Mr. Carroll was also admitted to practice law in New York in 2002. Ms. Carroll may be reached at doc@spsk.com Mr. Carroll and his wife Eileen are proud new parents of baby Jack.

Cynthia L. Sladecek is an associate with Schenck, Price, Smith & King, LLP and a member of the Litigation Department. Ms. Sladecek served as Law Clerk to The Honorable John B. Dangler, J.S.C. in Morris County and completed a judicial clerkship with The Honorable Arthur D. Spatt, U.S. District Court, Eastern District of New York. A current member of the Worrall F. Mountain Inn of Court, Ms. Sladecek also completed an internship with the U.S. Attorney's Office, Eastern District of New York. Ms. Sladecek graduated from Fairleigh Dickinson University in 2000 and received her J.D. from New York Law School in 2003. Ms. Sladecek may be reached at cls@spsk.com Cindy is the newest addition to The Benchmark Editorial Staff and her enthusiastic assistance is gratefully acknowledged along with recognition of outstanding achievements on the SPSK Softball Team, and Young Alum support of her alma mater, NYLS. Ms. Sladecek and husband Ed Flanagan celebrated in style a few weeks ago at their destination wedding in Charleston, S.C.

Susan J. Flynn-Hollander is Of Counsel to SPSK, Editor-in Chief of the firm's newsletter, The Benchmark, and is a member of the Business Law Department and Health Care Law Practice Group focusing exclusively on health care related matters. Ms. Flynn-Hollander has a diverse business, insurance and consulting background and has held executive management positions including, Legal Counsel, Senior VP and Chief Operating Office for Terence Cardinal Cooke Health Care Center in NYC, NY and VP Administration and General Counsel of Bayonne Medical Center, Bayonne, NJ. A graduate of Douglass College and New York Law School, Susan was Book Editor for the NYLS Journal of International and Comparative Law. Ms. Flynn-Hollander chairs a number of student mentoring and community service events and serves as Treasurer and member of the Executive Committee for the Foundation of UMDNJ, the Healthcare Foundation of New Jersey, the Foundation Venture Capital Group, and is a Member/Trustee for the Women's Health Institute and the New York Law School Alumni Board.

SPECIAL CONTRIBUTOR

Judy Pak Chung, a former associate at SPSK, served as assistant editor for "The Bruin," the college newspaper of her alma mater, the University of California, Los Angeles. A graduate of Seton Hall Law School, Ms. Chung was a member of the Legislative Journal and an intern with the Immigration Department. Ms. Chung manages to maintain personal and professional ties on both coasts, and has volunteered with the Asian American Legal Defense and Education Fund. No stranger to healthcare issues, Judy and dentist-husband Christian are proud parents of their son Ethan, and look forward to the arrival of a family addition later this year. The Editorial staff of The Benchmark thank Judy for her many contributions to the newsletter.

MEET OUR STUDENT CONTRIBUTORS

Stephen Roberts entered medical school thinking about a future career in neurology/neurosurgery. While still considering several fields he is gravitating more toward a Family Medicine practice. A UMDNJ – NJMS student, Steve is active with Physicians for a National Health Program - a single issue organization advocating a universal, comprehensive single-payer national health program; PNHP has more than 16,000 members and chapters across the United States. In addition Steve and a few of his fellow students have organized a non-credit elective in the medical school focusing on healthcare reform. The group also travels to NJ colleges, most recently Rutgers and TCNJ, to speak on the topic, and uses a grassroots approach to educate politicians and the public about the subject of healthcare reform in this country.

Jose Almanzar just completed his 1L year at New York Law School. He graduated from Binghamton University where he received a B.A. in Environmental Studies. Jose hails from the Dominican Republic but is a New Yorker at heart, and has been living in NYC since 1990. Jose was recently elected Vice President of the NYLS Student Bar Association and is a summer law intern with the Department of Environmental Protection.

Anton Kolomeyer was born in Moscow, Russia in 1982 and moved to the United States in 1994. He graduated from Rutgers University with Honors (majoring in Molecular Biology and Biochemistry) in 2003. In 2005, Anton entered the UMDNJ-New Jersey Medical School 7-year MD/PhD program. The focus of his PhD thesis is Age-related Macular Degeneration, the number one leading cause of blindness in the industrial world in persons over the age of 55. Anton is a member of a number of organizations, including Sigma Xi (Honors Research Society) and the New York Academy of Sciences. Since 2006, he has received eight scholarships for academic performance and community service, three research fellowships, and two travel grants. His medical school activities include participation in the student health family care center where students provide free-of-charge services to the uninsured population, publishing in The Plexus – NJMS's newspaper, tutoring for CALM (Collaborative Approach to Learning Medicine) – a student organization helping students review for exams, and participating in a vision screening program in underprivileged areas of Newark and Jersey City. Upon completion of his PhD, Anton will return to medical school and will eventually pursue a residency in Ophthalmology.

Shyam A. Patel graduated from Drexel University in 2006 with a B.S. in Biological Sciences. Currently, he is a rising 4th-year MD/PhD student at UMDNJ- New Jersey Medical School. His PhD thesis work focuses on cellular mechanisms of resistance of breast cancer to chemotherapy and radiation treatment. In particular, his associated laboratory suspects that resistant breast cancer cells harbor stem cell characteristics, which confer resilient properties to them and may account for resurgence of cancer after years of disease-free survival. Shyam has a strong passion for cancer research and would like to pursue an academic career in the field of oncology. He believes that physician-scientist training paths across the country are truly beginning to define the future of medicine, as translational research is critical for the advancement of science and healthcare.

Kedar Mahajan started developing an interest in research during his junior year at Rowan University where he graduated with a B.S. in Biochemistry in 2005. This led Kedar to join the MD/PhD program at NJ Medical School where he could combine his interest for patient care along with basic scienceresearch. Kedar will be starting his 5th year of the MD/PhD program with his thesis project in neuroscience focusing on oligodendrocyte biology and myelination. Understanding cellular pathways to determine how these cells function will help develop targeted therapy for central nervous system disorders such as spinal cord injury, multiple sclerosis, and traumatic brain injury. Kedar looks forward to his continued training as a physician-scientist and the challenges that await!

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[3] Treas. Reg. 25.2511-2(b)
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[1] Medical Student Debt, American Medical Association, March 12, 2009. www.ama-assn.org

[2]Andere Herstein, Making Med Schools More Diverse, May 6, 2008.

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[6] Gail Morrison, M.D., Mortgaging Our Future- The Cost of Medical Education, Vol. 352:117-119, No. 2, New England Journal of Medicine 2005.

[7] Morrison at page 3.

Special thanks to **M. Sheilah O'Halloran, Esq.** for Editorial Assistance. Ms. O'Halloran is a Partner with SPSK's Business Law Department, also serves as Chair of the Health Law Practice Group, is a Member of the firm's Management Committee, heads its Associate Evaluation Committee, and serves as outside Assistant General Counsel for Atlantic Health, Morristown, NJ. Ms. O'Halloran graduated from Seton Hall Law School with Honors and was a Member and Survey Editor of the Law Review and Member of the National Appellate Moot Court Team. A French Major in college at Montclair State University and public translator, Sheilah holds a Master's Degree from the School of Translation, The University of Montreal, where she also taught as an adjunct professor. Sheilah hold leadership positions in a number of professional associations, serves on the Board of Trustees of the Westfield Area Y and the UCPC Behaviorial Healthcare in Plainfield, NJ, and is an active volunteer with the Interfaith Council for the Homeless.

FOR HOSPITALS NEGOTIATING/RENEWING IOM (INTRAOPERATIVE MONITORING) AGREEMENTS – DO YOU KNOW THE REIMBURSEMENT PROVISIONS TO INCLUDE TO REMAIN COMPLIANT WITH RECENT CMS GUIDELINES? IN ADDITION TO PROVIDING ASSISTANCE WITH IOM AGREEMENTS, THE SPSK HEALTH LAW PRACTICE GROUP HAS EXPERTISE WITH MANAGED CARE AGREEMENTS AND APPEALS, AND CAN COUNSEL PHYSICIANS AND HOSPITALS FACING "RAC" REVIEWS. (See Page 10.)

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