CHAINS » *Vince Galloro*

Tug of war

Community raises offer as Tenet proceeds with suit

The corporate control battle between Community Health Systems and Tenet Healthcare Corp. took an unexpected step toward its conclusion last week. But Community's legal troubles, including the lawsuit Tenet filed against the company last month, show no sign of abating just yet.

Community raised its offer to $7.25 a share, according to a May 2 news release. The offer's total value, including assumed debt, is $8.1 billion. The Franklin, Tenn., company also set a deadline of 6 p.m. Eastern time May 9 for Tenet to "begin good-faith discussions," or else Community will withdraw the offer and its slate of nominees for election to Tenet's board of directors at its Nov. 3 annual shareholders meeting. Appearing at the Deutsche Bank healthcare investors conference in Boston on May 2, Larry Cash, executive vice president and CFO, defined "good-faith discussions" as an offer from Tenet to begin planning due diligence toward negotiating a definitive agreement.

On the same day, however, Dallas-based Tenet filed a motion to begin discovery in its federal lawsuit against Community, outlining the documents that Tenet contends shareholders need to see in order to make a decision on Community's bid to buy Tenet, according to a securities filing.

Tenet's court filing, made in the case it filed April 11 in U.S. District Court in Dallas, seeks a broad range of documents from Community. These include documents related to: Community's admissions criteria

LEGAL » *Joe Carlson*

Settlement holdout

Whistle-blower in WellCare case refuses deal

Federal litigators, attorneys with nine state governments and three corporate whistle-blowers have all agreed to accept a $137 million legal settlement with Florida's WellCare Health Plans over allegations of pervasive Medicaid fraud.

A fourth whistle-blower, however, refused to sign off on the nine-figure settlement because he believes it to be too low, which may torpedo the deal.

"We think they stole at least $400 million to $600 million, and they're paying back $137 million," said attorney Barry Cohen, of Tampa, Fla., who represents the holdout whistle-blower, Sean Hellein. "I think that there's something wrong with the system when you can commit a crime like this, and then you can say, 'I spent all the money and I don't have the ability to pay you back.' "

Hellein's resistance will force a fairness hearing in U.S. District Court, where a federal judge will hear evidence and then determine whether the settlement is appropriate. An answer in the negative could scuttle the deal, Cohen said.

WellCare spokeswoman Amy Knapp would say only that the firm is looking forward to resolving the False Claims Act lawsuit with federal investigators and attorneys general in Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio.

"After careful assessment of the factual allegations and legal claims, the federal and relevant state governments concluded that the settlement amount is appropriate, and we agree," Knapp said. "The events at issue occurred well over three years ago, and since then, WellCare has been transformed."

Sean Hellein, one of four whistle-blowers, says he thinks WellCare's settlement offer is too low.

DANIEL WALLACE PHOTO

WellCare, a publicly traded contractor that manages state Medicaid programs, was accused of numerous illegal accounting activities, such as inflating claims in order to meet state-mandated medical-loss ratios and overpaying a reinsurance captive in the Cayman Islands as a way to conceal profits.

Since 2006, when the allegations first came to light, WellCare has entered a deferred prosecution agreement with state and federal prosecutors that included an $80 million fine, as well as a $10 million settlement with the Securities and Exchange Commission. On May 4, the company also received final approval to settle a class-action lawsuit that will pay shareholders a total of $88 million in cash and $113 million in stock.

Those settlements and the proposed whistle-blower payments would put WellCare's total legal payouts at more than $428 million in cash and stock.

Separately, WellCare has sued three former executives who are accused of mismanaging the company until 2007, though that litigation was put on indefinite hold in March after the executives—former CEO Todd Farha, former general counsel Thaddeus Bereday, and former chief financial officer Paul Behrens—were indicted criminally by a federal grand jury in Florida.

"The criminal trial will result in a developed factual record that will provide the parties with substantial evidence that may be able to be utilized in this case," attorneys for both WellCare and the executives wrote in their joint motion for a stay in the lawsuit pending the outcome of the criminal case.

In a May 6 earnings report, WellCare said it booked net income of $21.6 million in the quarter ended March 31, compared with $6.4 million in the same quarter a year ago. «

handbook, known as the Blue Book; its use of software by Pro-MED Clinical Systems; agendas or reports of weekly divisional conference calls that referenced rates of admissions, especially admissions from the emergency department, from 2006 onward; more information on various government investigations; and Community's communications with the U.S. Securities and Exchange Commission, investors and journalists related to the offer to buy Tenet.

Stock analysts suggested that if Tenet's board had any interest in a transaction, then the offer should get them to the table. Absent that interest, the deadline would serve as an exit strategy for Community, allowing management to focus on the investigations and other acquisition opportunities.

Even if the deal falls through, the central question of Tenet's lawsuit—whether Community's hospitals are billing for inpatient admissions when the patients should be billed as observation visits—will remain, as the lawsuit has heightened the scrutiny of one-day stays.

L. Greg Cunningham, founder and CEO of the American Case Management Association, said the inpatient-vs.-observation question dates to well before Medicare's Recovery Audit Contractor program. Medicare fiscal intermediaries had varying interpretations of the observation visit criteria as far back as the late 1980s, Cunningham said.

Case managers have to be diplomatic to sell their decisions to physicians, clinical nurses and even patients' families, Cunningham said. "One of the phrases that I use when I'm teaching to hospital administrators in particular is that you're asking a group of people to do a huge amount of decision making with zero authority," Cunningham said, adding, "It's still the physician's decision, ultimately."

Dr. Michael Ross is director of the observation medicine program at Atlanta-based Emory Healthcare and a former chair of the observation medicine section for the American College of Emergency Physicians. Physicians can't be expected to know the lengthy, ever-changing admissions criteria, such as the InterQual set that is most widely used, Ross said.

Unfortunately, Ross said, patients who would be best served in observation are stuck in a healthcare financial world that sees only black and white. "We keep trying to shoehorn them into either outpatient or inpatient," he said. "The dichotomy works fine for 90% of patients, but not this group."

In addition to the unique circumstances of each patient, the decision is further complicated by the different resources available at each hospital, said Dr. Chris Baugh, an attending physician in the emergency department at Brigham and Women's Hospital in Boston. According to the National Hospital Ambulatory Medical Care Survey by the Centers for Disease Control and Prevention, only about half of hospitals that had 50,000 or more emergency visits in 2007 had a separate observation unit, Baugh said. Only a third of hospitals with 20,000 to 50,000 visits had such a unit, and specialist physician coverage varies widely, too, he added.

"You could argue that observation is not an available option, at least as a unit, in more places than not," Baugh said. "You could still use observation in the emergency department, but that hurts capacity, and that's not a viable option always for hospitals that need the emergency space." ‹‹

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