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Leveraging CIAs as a compliance tool: Analyzing trends to identify and mitigate hospital compliance risks

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This is the first in a series of articles reviewing corporate integrity agreements and related materials to identify trends in compliance risk. This article's focus is on hospitals. Future articles on this topic will focus on medical practices, individual healthcare practitioners, and other types of healthcare providers and suppliers.

Recent government enforcement activity serves as an excellent tool for identifying potential risk areas with respect to federal healthcare program compliance and devising strategies to assess and manage those potential risk areas.

Identifying, monitoring, and addressing potential risk areas is a critical component of an effective compliance program. Indeed, the U.S. Department of Health & Human Services Office of Inspector General (OIG) recommends that healthcare organizations participating in federal healthcare programs will, on at least an annual basis, conduct a risk assessment and internal review process pursuant to which the organization will (i) identify and prioritize risks, (ii) develop and implement internal audit work plans related to identified risk areas, and (iii) develop and implement corrective action plans in response to the results of any internal audits performed.[1]

To identify potential risk areas, healthcare organizations can and should consider a variety of sources. Common sources include internal compliance reports, quality evaluations and metrics, the OIG's annual work plans, and agency-directed audits and inquiries. A robust risk assessment also should include consideration of recent corporate integrity agreements (CIAs) imposed by the OIG, and related materials (e.g., settlement agreements, complaints, and news releases), as these sources provide a wealth of information regarding the agency's priorities, areas of focus, and compliance programming and performance expectations.[2]

By understanding the circumstances under which the OIG has imposed a CIA, members of the healthcare industry can better understand the agency's enforcement priorities and identify practices that may require closer scrutiny within their own organization. Unfortunately, while the OIG maintains a publicly available database of its active CIAs, which includes a list of the parties subject to the CIA, copies of each CIA, and, in most instances, corresponding news releases issued by the U.S. Department of Justice in instances where the CIA was part of a settlement,[3] the data is not organized in a way that easily allows for quantitative and qualitative analysis.

This article is the first in a series designed to equip healthcare organizations with actionable data on recent CIA enforcement activity, including identification of trends in the type of covered conduct and compliance activities that may be considered based on those trends. Because compliance risks and business priorities vary by provider type, each article in the series will focus on a particular type of provider or supplier. This article focuses on CIAs recently imposed on hospitals.

Trends among CIAs recently imposed on hospitals

During the period from January 1, 2020, through June 30, 2021, it appears that the OIG imposed six CIAs in which at least one of the parties was a hospital (each a hospital CIA and, collectively, the hospital CIAs).[4] All six hospital CIAs were imposed in connection with a settlement with the Department of Justice of one or more actions brought under the federal False Claims Act (FCA).[5] Notably, several of these settlements also include the state attorney general and/or other state authorities as parties in connection with a settlement of actions brought under the state equivalent of the FCA.

A study of the hospital CIAs noted above, as well as the corresponding settlement agreements and underlying complaints detailing the actions at issue, presents certain trends to the committed observer. In particular, and as detailed further below, the hospital CIAs provide insights into potential risks arising from (i) financial relationships between hospitals and specialty physician groups, (ii) services provided by inpatient psychiatric hospitals, and (iii) provider-based status. The specific allegations underlying these hospital CIAs, and the associated compliance obligations imposed through them, can be leveraged as valuable informational tools for hospitals when developing risk management and compliance strategies.

1. Alleged improper financial relationships between hospital and specialty physician group

For three of the hospital CIAs, the underlying FCA action(s) concerned allegations of an improper financial relationship between the hospital and a specialty physician practice that served as a potential referral source for the hospital.

For example, one hospital CIA arose from a settlement involving alleged violations of the federal Anti-Kickback Statute and federal Physician Self-Referral Law (Stark Law) in connection with the acquisition by a Tennessee-based acute-care hospital of a physician practice specializing in cardiology.[6] Concurrent with the acquisition, the hospital entered into individual employment contracts with the cardiologists and a management services agreement with the cardiology practice. The United States and the State of Tennessee alleged that, through these arrangements, the hospital (i) paid remuneration to the cardiologists to induce referrals of Medicare and Medicaid patients to the hospital (in violation of the Anti-Kickback Statute), and (ii) directly or indirectly paid compensation to the cardiologists that was in excess of fair market value and/or took into account the volume or value of the cardiologists' referrals of designated health services to the hospital (in violation of the Stark Law). In the relator's complaint, the relator emphasized that (i) the cardiology practice operated at a substantial loss (e.g., around $5 million in fiscal year 2015), and (ii) the hospital's CEO explicitly justified these losses by stating (in meetings of the hospital finance committee) that the cardiology practice's losses were more than offset by downstream income from the cardiologists' referrals. Notably, the complaint also states that, on September 18, 2015 (almost two months prior to the date that the relator filed his complaint), the hospital's director of management operations was notified by Centers for Medicare & Medicaid Services that it was requesting a significant number of the cardiology practice's patient records for review, which may suggest that the government conducted its own investigation of the arrangement. This inference appears supported by the fact that the relator's complaint did not provide much detail regarding the arrangement between the hospital and the specific cardiology practice that was the subject of the settlement agreement; rather, the complaint focused on the hospital's relationships with other physician groups (which were not included in the settlement.)[7]

Similarly, a hospital CIA imposed on a California-based healthcare system arose from a settlement involving alleged violations of the Anti-Kickback Statute (and its California Medicaid equivalent) in connection with the acquisition of a cardiology practice and surgical center.[8] The CIA was imposed on the healthcare system's

directly and indirectly wholly owned subsidiaries that provide acute hospital inpatient services. This CIA also involved a settlement of allegations that services were provided and billed by a provider whose Medicare and Medi-Cal billing privileges had been revoked, although this issue was not addressed in the relator's complaint, and altering of invoices for medical devices, which allegedly inflated the reimbursement amount paid by Medi-Cal and certain other programs, not including Medicare. Notably, this CIA superseded and replaced a CIA entered into between a subset of the healthcare system's entities and the OIG on August 3, 2018.[9]

Specifically, an affiliate of the healthcare system acquired a cardiology practice and surgical center owned by a local cardiologist. According to the complaint, the practice and surgical center served as competitor of one of the healthcare system's hospitals.[10] In connection with this transaction, the cardiologist became an employee of the healthcare system affiliate.[11]

The following allegations appear to have been significant:

- The purchase price paid by the healthcare system affiliate for the cardiologist's practice and surgery center allegedly exceeded fair market value and was based on, or took into account, the volume and/or value of the cardiologist's referrals to the hospital. In his complaint, the relator alleged that the purchase price paid by the affiliate ($10 million to be paid over ten years) far exceeded the value of the assets purchased ($1.3 million, not taking into account liabilities), allegedly leading to the conclusion that most of the purchase price was payment to induce the cardiologist to refer his patients to the hospital.
- Immediately after the acquisition, the healthcare system affiliate shut down the surgery center (which competed with the hospital for cardiac procedures), despite the surgery center being a profitable business and a significant source of revenue for the affiliate. This appears to have caused the United States and the State of California to question the commercial reasonableness of the acquisition and surgery center closure.
- The salary ($1.2 million) paid to the cardiologist for his professional services allegedly was based on, or took into account, the volume and/or value of his referrals to the hospital. In his complaint, the relator alleged that the cardiologist was paid twice as much as his peers at the healthcare system, and that the cardiologist's salary was substantially above the 90th percentile compensation ($733,541) reported by the American Medical Group Association for cardiologists in 2017.[12]

Finally, a third hospital CIA arose from a settlement involving alleged violations of the Anti-Kickback Statute and Stark Law pertaining to various arrangements between an Oklahoma-based surgical hospital and a physician practice consisting of orthopedic surgeons. At the time, several of the physician practice's orthopedic surgeons were owners of the surgical hospital.[13] The United States and the State of Oklahoma found the following alleged arrangements to be problematic:

- The surgical hospital allegedly provided certain of the orthopedic surgeons with office space, employees, and supplies that were free or below fair market value.[14] For example, according to the relator's complaint, the surgical hospital allegedly paid the majority of the cost of personal medical assistants for two of the practice's orthopedic surgeons, who reportedly were significant referral sources for the hospital; in the ordinary course, these costs would have been borne directly by the orthopedic surgeons. The relator also alleged that the surgical hospital provided office space, at no charge, to one of the orthopedic surgeon's employees, who used the space to manage the orthopedic surgeon's personal business interests and personal affairs.
- The surgical hospital also allegedly paid compensation in excess of fair market value for the services

furnished by the physician practice and certain of its orthopedic surgeons. This allegation does not appear to have been addressed in the relator's complaint, and thus may have arisen from an investigation conducted by the government.

- It also was alleged that two of the practice's orthopedic surgeons were provided with buyback provisions and payments in their equity in the surgical hospital that were above fair market value. In particular, the relator alleged that the orthopedic surgeons, as significant referral sources for the hospital, were given preferential buyout arrangements, pursuant to which they were allowed to sell, on an annual basis, a limited amount of their equity in the surgical hospital to one of the surgical hospital's corporate owners for a 6.5 multiple of earnings before interest, taxes, depreciation, and amortization; no other physician-owner of the hospital had this special buyout arrangement.

2. Alleged false claims for services provided by inpatient psychiatric hospitals

While three of the hospital CIAs arose from FCA actions largely predicated on alleged violations of federal healthcare program fraud and abuse laws, two other hospital CIAs arose from FCA actions predicated on false claims for services billed by inpatient psychiatric hospitals (as well as other behavioral health facilities).

One hospital CIA arose from multiple FCA actions alleging that a nationwide healthcare system and its numerous acute-care inpatient psychiatric hospitals and other behavioral health facilities submitted or caused to be submitted false claims for services provided to beneficiaries of Medicare and other federal health programs.[15] Specifically, the United States alleged that these claims were rendered false by the following alleged conduct:

- Admission of beneficiaries who were not eligible for inpatient or residential treatment (as applicable);
- Failure to properly discharge beneficiaries when they no longer met the applicable medical necessity criteria for the psychiatric treatment;
- Improper and excessive lengths of stay;
- Failure to provide adequate staffing, training, and/or supervision of staff;
- Billing for services not rendered;
- Improper use of physical and chemical restraints and seclusion; and
- Failure to provide inpatient acute or residential care in accordance with federal and state regulations, including, but not limited to, failure to develop and/or update individualized assessments and treatment plans, failure to provide adequate discharge planning, and failure to provide required individual and group therapy.

The healthcare system denied these allegations.

A second hospital CIA arose from allegations that two Ohio-based inpatient psychiatric hospitals and their corporate parent submitted or caused to be submitted false claims to Medicare for inpatient hospital stays for psychiatric services.[16] The United States alleged that these claims were false (among other allegations) because the underlying psychiatric services were medically unnecessary. As alleged in the relator's complaint, the inpatient psychiatric hospitals employed former patients, referred to as "marketers," to identify and entice indigent Medicare beneficiaries into voluntarily admitting themselves into the hospital's facilities with false promises of food, shelter, and/or treatment for drug addiction.[17] The relator further alleged that the inpatient psychiatric hospitals used threats of "judicial hospitalization" and coercion to keep admitted patients at the

facility.

3. Alleged false claims pertaining to provider-based status

The covered conduct underlying the sixth hospital CIA does not appear to share commonalities with the other five hospital CIAs discussed above. That said, one of the allegations—pertaining to the provider-based statute—is notable. Specifically, the United States and the State of Florida alleged that an academic healthcare system submitted false claims to Medicare and other federal healthcare programs because (among other reasons) its off-campus clinics submitted claims as if they were hospital-based (i.e., using site-of-service code 22 to attest that the service was hospital based) when they allegedly failed to comply with beneficiary notice requirements (pertaining to coinsurance liability) under Medicare provider-based rules located at 42 C.F.R. § 413.65 .[18] As set forth in one relator's complaint, while the healthcare system's clinics provided a notice to Medicare beneficiaries, the notice allegedly was deficient because it merely stated that the beneficiary "may" be seen in a provider-based clinic, but did not state (as required under 42 C.F.R. § 413.65(g)(7)) the amount of the beneficiary's potential financial liability or an explanation that the beneficiary "will" incur a coinsurance liability to the hospital that they would not incur if the facility were not provider based.

Potential compliance activities based on hospital CIAs

The hospital CIAs discussed above can be read to highlight key risk areas that hospitals may wish to consider and address as part of their annual risk assessments and related monitoring and auditing activities.

For example, the first three hospital CIAs suggest that compliance with the Anti-Kickback Statute and the Stark Law remains a top enforcement priority for the OIG. As such, hospitals may wish to review the systems they have in place to ensure compliance with these laws and to assess whether additional measures are warranted. Further, the CIAs imposed a variety of compliance obligations on these hospitals, providing a clear indication of the government's expectations for compliance programming. Hospitals may wish to consider implementing these compliance activities to mitigate potential Anti-Kickback Statute and Stark Law risk.

Specifically, in all three cases, the OIG imposed a "focus arrangements" CIA on the hospital parties (i.e., CIAs that impose numerous compliance program requirements specifically aimed at ensuring that the hospital's arrangements with actual or potential referral sources do not violate the Stark Law and/or the Anti-Kickback Statute). These compliance activities include, without limitation, the following:

- Implementing policies pertaining to arrangements with potential and actual referral sources (e.g., policies pertaining to (i) tracking new and existing arrangements with referral sources, (ii) tracking all remuneration to and from referral sources to ensure compliance with the arrangement terms, (iii) evaluating arrangement documentation to ensure that threshold requirements are met, and (iv) establishing an internal review process for such arrangements).
- Training specifically targeted at Anti-Kickback Statute and Stark Law compliance (including regulatory requirements and compliance safeguards implemented by the organization to better ensure compliance).
- Creating a centralized tracking system for arrangements with both potential and actual referral sources.
- Implementing a review and approval process for all arrangements with potential and actual referral sources, which may include, for example, review by legal and/or compliance personnel, documentation of business need, and a process for determining and documenting fair market value.

To the extent a hospital already has the above policies and processes in place, the hospital may wish to consider,

as part of its monitoring and auditing activities, assessing the organization's compliance with those policies and processes and evaluating whether additional safeguards are needed.

The two hospital CIAs involving inpatient psychiatric hospitals suggest that the OIG is concerned with the medical necessity and quality of services provided in the behavior health space. To address that concern, inpatient psychiatric hospitals, as well as acute care hospitals that provide psychiatric services, may wish to consider, as part of their annual risk assessment, adding a pre-bill review of a sample of cases involving inpatient psychiatric services. Such a review may examine whether admission criteria were met, whether length of stay was supported by the medical record, and/or whether specific regulatory requirements (e.g., pertaining to individualized assessments and treatment plans) were met. These hospitals also may wish to consider training for clinicians aimed at addressing the applicable legal and regulatory requirements as well as the operational tools and resources available to service patients in a compliant manner.

Finally, taking into consideration the sixth hospital CIA discussed above, hospitals may wish to include, as part of their risk assessment activities, evaluating their beneficiary notices for off-campus departments (to ensure compliance with 42 C.F.R. § 413.65(g)(7)), educating or reeducating coders on the importance and purpose of each site-of-service code, and/or conducting a pre-bill review of a sample of claims for off-campus departments and clinics to ensure that the appropriate site-of-service code is appended.

Conclusion

As reflected above, CIAs can serve as a useful tool for identifying potential risks and developing compliance measures to mitigate those risks. While the specific risks addressed by a hospital compliance program will ultimately depend on a variety of factors, including resource constraints and competing compliance and business priorities, consideration of CIA enforcement should better equip hospitals to identify and prioritize risk areas that may be applicable to their organization.

Takeaways

- Identifying, monitoring, and addressing potential risk areas is a critical component of an effective compliance program.
- Corporate integrity agreement (CIA) enforcement serves as a useful risk assessment and compliance planning tool.
- CIAs recently imposed on hospitals suggest that compliance with the Anti-Kickback Statute and the Stark Law remain an enforcement priority.
- CIAs recently imposed on hospitals reflect a continued concern with clinical eligibility, medical necessity, and quality of behavioral health services.
- To address these potential risks, hospitals should consider review of existing policies and processes (and development of new policies and procedures when needed); targeted training programs for clinical and allied professional personnel, contractors, and agents; and targeted pre-bill reviews pertaining to these trending topics.

1 OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4,858, 4,859, 4,875, 4,876 (January 31, 2005) , https://bit.ly/2Xbbb0m. *See also* HCCA-OIG Compliance Effectiveness Roundtable, *Measuring Compliance Program Effectiveness: A Resource Guide*, March 27, 2017, https://bit.ly/3BOA1lK.
2 *See* Publication of the OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,994 (February 23,

1998) ; OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4,858, 4,875 (January 31, 2005) ; The Office of Inspector General of the U.S. Department of Health & Human Services and The American Health Lawyers Association, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors*, accessed September 14, 2021, https://bit.ly/39575td.

3 "Corporate Integrity Agreement Documents," Office of Inspector General, U.S. Department of Health & Human Services, updated September 14, 2021, https://bit.ly/3tHRdX1.

4 Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Cookeville Regional Medical Center Authority, https://bit.ly/3aGoFVi, (related to United States ex rel. Seabury v. Cookeville Regional Medical Center Authority, d/b/a Cookeville Regional Medical Center, d/b/a Cookeville Regional Medical Group, Inc., f/k/a CRMC MSO, Inc., d/b/a CRMC MSO Sub-1, Inc., d/b/a Tennessee Heart, Civ. Action No. 2:15-cv-00065 (M.D. Tenn., Nov. 10, 2015)); Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Universal Health Services, Inc. and UHS of Delaware, https://bit.ly/3AN9OCV (related to United States ex rel. McLauchlin, et al. v. Havenwyck Holdings, Inc., et al., No. 2:19-cv-10832 (E.D. Mich., Jun. 21, 2019) (also settling 17 other complaints)); Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Southwest Orthopaedic Specialists PLLC, https://bit.ly/3aEwvP1 (related to United States ex rel. Allison v. Southwest Orthopaedic Specialists, PLLC, et al., No. CIV-16-569 (W.D. Okla., May 27, 2016, amended Dec. 8, 2016, and May 22, 2018)); Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Oglethorpe Inc., https://bit.ly/3vjDXsj (related to United States ex rel. Baker v. Oglethorpe, Inc., et al, No. 2:16-cv-1040 (S.D. Ohio, Oct. 28, 2016)); Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and University of Miami, https://bit.ly/30wgfhi (related to United States ex rel. Jonathan Lord, M.D. v. University of Miami, No. 13-22500-Civ-Altonga (S.D. Fla., Jul. 12, 2013, amended Dec. 3, 2013, and June 15, 2016); United States ex rel. Philip Chen, M.D. and Joshua Yelen v. University of Miami and Miami-Dade Public Health Trust, No. 13-24320-Civ-Altonaga (S.D. Fla., Nov. 27, 2013); United States ex rel. Mitchell Wallace v. University of Miami and Miami-Dade Public Health Trust, No. 14-cv-21206-Altonga (S.D. Fla., May 12, 2014)); First Amended Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Prime Healthcare Services Inc. et al., https://bit.ly/3DJmGf7 (related to United States and the State of California ex rel. Martin Mansukhani v. Prime Healthcare Services, Inc., et al., Civil Action No. 5-18-cv-00371-RGK (C.D. Cal., Feb. 21, 2018, amended (i.e., Second Amended Complaint) April 24, 2020); United States and the State of California ex rel. John Doe Number One and John Doe Number Two v. Prime Healthcare Services, Inc., et al., Case No. LACV 18-02124-FMO (AFMx) (C.D. Cal., April 14, 2018) (subsequently transferred to LACV 18-02124-FLA (AFMx)).

5 *See* Department of Justice, "Cookeville Hospital Settles False Claims Act Allegations," news release, February 14, 2020, https://bit.ly/3aIryF4; Department of Justice, "Universal Health Services, Inc. And Related Entities To Pay $122 Million To Settle False Claims Act Allegations Relating To Medically Unnecessary Inpatient Behavioral Health Services And Illegal Kickbacks," news release, July 10, 2020, https://bit.ly/3AEE4Qo; Department of Justice, "Oklahoma City Hospital, Management Company, And Physician Group To Pay $72.3 Million To Settle Federal And State False Claims Act Allegations Arising From Improper Payments To Referring Physicians," news release, July 8, 2020, https://bit.ly/2YNdwPE; Department of Justice, "Ohio Treatment Facilities and Corporate Parent Agree to Pay $10.25 Million to Resolve False Claims Act Allegations of Kickbacks to Patients and Unnecessary Admissions," news release, March 5, 2021, https://bit.ly/3p7ly10; Department of Justice, "University of Miami to Pay $22 Million to Settle Claims Involving Medically Unnecessary Laboratory Tests and Fraudulent Billing Practices," news release, May 10, 2021, https://bit.ly/3aGcpUB; Department of Justice, "Prime Healthcare Services and Two Doctors Agree to Pay $37.5 Million to Settle Allegations of Kickbacks, Billing for a Suspended Doctor, and False Claims for Implantable Medical Hardware," news release, July 19, 2021, https://bit.ly/3BKEXbj.

6 United States ex rel. Seabury v. Cookeville Regional Medical Center Authority, Civ. Action No. 2:15-cv-00065 (M.D. Tenn., November 10, 2015), https://bit.ly/3oZ5ZIz.
7 United States ex rel. Seabury v. Cookeville Regional Medical Center Authority, d/b/a Cookeville Regional Medical Center, d/b/a Cookeville Regional Medical Group, Inc., f/k/a CRMC MSO, Inc., d/b/a CRMC MSO Sub-1, Inc., d/b/a Tennessee Heart, Civ. Action No. 2:15-cv-00065 (M.D. Tenn., Nov. 10, 2015). *See also* Settlement Agreement (Feb. 10, 2020); United States ex rel. Seabury v. Cookeville Regional Medical Center Authority, d/b/a Cookeville Regional Medical Center, d/b/a Cookeville Regional Medical Group, Inc., f/k/a CRMC MSO, Inc., d/b/a CRMC MSO Sub-1, Inc., d/b/a Tennessee Heart, Civ. Action No. 2:15-cv-00065 (M.D. Tenn., Nov. 10, 2015).
8 Department of Justice, "Prime Healthcare Services and Two Doctors Agree to Pay $37.5 Million to Settle Allegations of Kickbacks, Billing for a Suspended Doctor, and False Claims for Implantable Medical Hardware," news release, July 19, 2021, https://bit.ly/3hQAuMR.
9 United States Department of Health & Human Services Office of Inspector General and Prime Healthcare Services, Inc., corporate integrity agreement, June 1, 2021, 1–2, https://bit.ly/3axS1EW.
10 United States and the State of California ex rel. Martin Mansukhani v. Prime Healthcare Services, Inc., et al., Civil Action No. 5-18-cv-00371-RGK (C.D. Cal., Feb. 21, 2018, amended [i.e., Second Amended Complaint] April 24, 2020), https://bit.ly/3zlovg0.
11 United States and the State of California v. Prime Healthcare Services, Inc., et al., settlement agreement, June 1, 2021, https://bit.ly/3eNUEFr.
12 United States and the State of California ex rel. Martin Mansukhani v. Prime Healthcare Services, Inc., et al.
13 United States ex rel. Allison v. Southwest Orthopaedic Specialists, PLLC, et al., No. CIV-16-569 (W.D. Okla., May 22, 2018).
14 Settlement Agreement (July 2, 2020); United States ex rel. Allison v. Southwest Orthopaedic Specialists, PLLC, et al., No. CIV-16-569 (W.D. Okla., May 27, 2016, amended Dec. 8, 2016, and May 22, 2018) ¶ D.
15 Settlement Agreement (July 6, 2020); United States ex rel. McLauchlin, et al. v. Havenwyck Holdings, Inc., et al., No. 2:19-cv-10832 (E.D. Mich., Jun. 21, 2019) (also settling 17 other Complaints) ¶¶ A-D.
16 United States v. Oglethorpe, settlement agreement, January 28, 2021, https://bit.ly/3vaJ6De.
17 United States ex rel. Baker v. Oglethorpe, Inc., et al, No. 2:16-cv-1040 (S.D. Ohio, Oct. 28, 2016).
18 United States ex rel. Jonathan Lord, M.D. v. University of Miami, Civ. No. 13-22500 (S.D. Fla., June 15, 2016). *See also* Settlement Agreement (April 9, 2021); United States ex rel. Jonathan Lord, M.D. v. University of Miami, No. 13-22500-Civ-Altonga (S.D. Fla., Jul. 12, 2013, amended Dec. 3, 2013, and June 15, 2016); United States ex rel. Philip Chen, M.D. and Joshua Yelen v. University of Miami and Miami-Dade Public Health Trust, No. 13-24320-Civ-Altonaga (S.D. Fla., Nov. 27, 2013); United States ex rel. Mitchell Wallace v. University of Miami and Miami-Dade Public Health Trust, No. 14-cv-21206-Altonga (S.D. Fla., May 12, 2014).