Health Law Advisory

August 30, 2013 • Julie A. Knutson, Editor

Proposed Amendment to False Claims Act: Relief for Innocent Mistakes?

Health care providers and suppliers are well aware that they are living in a world of increased enforcement and that the Federal government has a growing arsenal of tools it uses to enforce the Federal health care laws and regulations. The Department of Justice, the Department of Health and Human Services, the Office of Inspector General, and other agencies have increasingly used a particular tool, the Federal False Claims Act, to recover billions of dollars paid to providers and suppliers as a result of health care fraud and abuse. The False Claims Act penalties of $5,000 to $11,500 per false claim plus treble damages, coupled with other enforcement mechanisms such as program exclusion, cannot be ignored. Given the number of recent False Claims Act settlements and the time and dollars it takes for a provider or supplier to investigate and settle a case, many in the industry are left wondering about innocent mistakes – those that are not the result of fraud - and whether there is any potential reprieve.

In response to concerns over innocent mistakes, the *Fairness in Health Care Claims, Guidance, and Investigations Act of 2013*, HR 2931, was introduced in Congress. The proposed bill would amend the False Claims Act to carve out unintentional billing mistakes and, as a result, not penalize health care providers and suppliers who submit erroneous claims that bear no relation to fraud.

First, the bill would require that, in order to launch an investigation, the U.S. Attorney General certify that the Federal agency investigating the potential health care fraud has reviewed its own rules and regulations, billing instructions, and communications with the alleged perpetrator to determine whether agency's guidelines were ambiguous. If all guidelines and communication were unambiguous, the False Claims action could proceed.

The bill would also require that the Federal government develop a "*de minimus*" threshold and only pursue claims of a "material" amount. The bill

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does not set a dollar amount, but states that the threshold should be based on a percentage of total dollars/reimbursement received from the Federal government. If the claims at issue exceed a set percentage, the False Claims Action could proceed.

The health care environment is changing rapidly and now, more than ever, health care providers and suppliers are required to keep abreast of new developments in Medicare and Medicaid regulations, manuals, billing instructions, and other guidelines.

Next, the bill would establish safe harbors and prohibit False Claims Act enforcement in limited circumstances. For example, enforcement would be prohibited where the provider or supplier acted in good faith and relied upon statements or audit findings from Federal agencies. The bill would also prohibit enforcement where the provider or supplier adopted and implemented a compliance program in accordance with the model compliance program guidance issued for providers and suppliers. Finally, the bill would raise the Federal government's burden of proof for health care false claims and require "clear and convincing evidence" of a violation.

The legislation is only *proposed* and it is difficult to predict the odds of the bill becoming law. The bill has received attention and support from many in the health care industry, including the American Hospital Association which notes that "conflicting and confusing regulations covering [Federal Health Care] programs can easily result in unintentional billing mistakes." The health care environment is changing rapidly and now, more than ever, health care providers and suppliers are required to keep abreast of new developments in Medicare and Medicaid regulations, manuals, billing instructions, and other guidelines. Most would agree that efforts are needed to pursue and deter intentional waste, fraud, and abuse in health care. However, for those providers and suppliers that have invested substantial time, money, and effort to develop robust compliance procedures in response to the ever-changing health care environment, the *Fairness in Health Care Claims, Guidance, and Investigations Act of 2013* would offer some relief and reduce the potential for costly investigations and litigation involving unintentional mistakes. ■

Michael W. Chase

OIG Report Revives Debate over Critical Access Status

On August 15th, the Office of Inspector General (OIG) released a report sure to add fuel to the continuing debate over Medicare payments to rural providers: "Most Critical Access Hospitals Would Not Meet the Location Requirements if Required to Reenroll in Medicare." After digitally plotting critical access hospital (CAH) and other hospital sites, the agency concluded that 64 percent of CAHs do not satisfy Medicare's current location requirements related to rural status and distance from nearest hospitals.

This result is not necessarily surprising. Until 2006, Congress permitted states to designate hospitals that did not meet distance requirements but were located in health care shortage or high unemployment or poverty areas as "necessary provider" CAHs. Necessary providers must meet other Medicare Conditions of Participation (CoPs) for CAHs, but the Centers for Medicare & Medicaid Services (CMS) permanently exempts them from the CoP requiring CAHs to be located more than 35 miles (or more than 15 miles in an area of mountainous terrain or where only secondary roads are available) from other hospitals. Grandfathered necessary providers represent around 75 percent of all currently enrolled CAHs.

Favorable Medicare reimbursement rates for CAHs—101 percent of reasonable costs rather than on a prospective payment system or fee schedule

basis—is a frequent topic in the deficit reduction debate. Most recently, President Obama renewed his Administration's proposal to reduce CAH reimbursement to 100 percent of reasonable costs and eliminate CAH designation for facilities located less than 10 miles from another hospital in the 2014 fiscal year budget.

The OIG report describes how CMS could have saved approximately $268 million in 2011 if it had the authority to decertify necessary provider CAHs located 15 miles or less from the nearest hospital. The report also estimated that beneficiaries could have saved a total $181 million if CMS had decertified this group of necessary providers in 2011, given that beneficiary coinsurance amounts are calculated on hospital charges and not final costs, meaning that they may sometimes pay more to receive the same service at a CAH as opposed to an acute-care hospital.

OIG recommended that CMS:

1. Seek legislative authority to remove necessary provider CAHs' permanent exemption for the distance requirement;

2. Seek legislative authority to revise the CAH CoPs to include alternative location-related requirements (e.g. permitting CAHs to maintain certification despite not satisfying the location standards if they primarily serve uninsured or underinsured populations);

3. Periodically reassess compliance of all CAHs with location-related CoPs (CMS is currently evaluating CAH compliance with the distance requirements through recertification, but lacks statutory authority to survey grandfathered necessary providers for compliance with the same); and

4. Apply a uniform definition of "mountainous terrain" to all CAHs.

If CMS follows through with these suggestions, the repercussions extend beyond endangering the provider status of nearly 2/3 of all CAHs. In addition to decreased Medicare reimbursement, the loss of CAH designation could jeopardize participation in the federal 340B Drug-Pricing Program and impact Medicaid reimbursement.

While CMS concurred with the first, third, and fourth recommendations, it remains to be seen how or whether it will implement the OIG's suggestions. Last week, 20 lawmakers, among them Sens. Grassley and Harkin, argued against President Obama's proposed CAH cuts in a letter to the Senate Finance Committee, and groups like the National Rural Health Association continue to actively lobby against laws that would threaten CAH status and encourage their constituents to reach out to their lawmakers directly.

Readers can access the full report, OIG recommendations, and corresponding CMS responses at http://oig.hhs.gov/oei/reports/oei-05-12-00080.pdf. ■

Whitney C. West

OFCCP: "TRICARE Providers Are Subject to Affirmative Action Requirements"

For years, we have been tracking the Department of Labor's Office of Federal Contract Compliance Programs' ("OFCCP") efforts to expand its jurisdiction to health care employers. Generally, the OFCCP enforces regulations that require employers with at least 50 employees, who hold a single contract or subcontract of at least $50,000 to provide services to the federal government, to comply with certain affirmative action obligations, including maintaining an affirmative action program ("AAP").

Health Care Institutions As Federal Contractors/ Subcontractors

Many health care organizations have a direct contract with the federal government, and therefore have affirmative action obligations by nature of that contract. For instance, a hospital may be a covered contractor as a result of a contract with the Department of Veterans' Affairs or the Department of Defense, requiring the provision of medical services to active or retired military personnel.

On the other hand, an organization may have obligations if it has a "subcontract" to an entity with a federal contract. In relevant part, a "subcontract" is any agreement between a contractor and any person (1) for the purchase, sale, or use of non-personal services that in whole or in part, are necessary to the performance of any contract, or (2) under which

any portion of the contractor's obligation under any contract is performed, undertaken, or assumed. Whether a health care provider's subcontracts bring it under the OFCCP's jurisdiction is a difficult inquiry, as it depends upon the nature of the underlying prime contract and the terms of the subcontract. We have addressed the subcontractor issue in more detail in prior newsletters.

TRICARE Network Participants

Many health care organizations do not have direct contracts or subcontracts with the federal government, but do participate in a TRICARE network. In 2010, an Administrative Law Judge ("ALJ") in *OFCCP v. Florida Hospital of Orlando*, held that a hospital that subcontracts to provide medical services to TRICARE beneficiaries was a federal subcontractor subject to affirmative action laws. In that case, Humana Military Healthcare Services, Inc. ("HMHS"), held a contract with TRICARE Management Activity of the Department of Defense ("TRICARE") to establish a healthcare provider network for beneficiaries under the program. Florida Hospital of Orlando ("Florida Hospital") was a "participating hospital" in that network. The ALJ concluded that TRICARE was a program to provide actual medical services, and the hospital was engaged to provide those services. Consequently, by providing medical services to TRICARE's beneficiaries, the hospital was deemed to be a subcontractor because its services were necessary to the performance of TRICARE's contract with HMHS.

In light of the *Florida Hospital* decision, most health care institutions were considered federal subcontractors because of their TRICARE subcontracts. On December 15, 2011, however, Congress passed Section 715 of the National Defense Authorization Act ("NDAA"), which provides, in relevant part:

> For the purpose of determining whether network providers under [TRICARE] provider network agreements are subcontractors for purposes of the Federal Acquisition Regulation or any other law, a TRICARE managed care support contract that includes the requirement to establish, manage, or maintain a network of providers may not be considered to be a contract for the performance of health care services or supplies on the basis of such requirement.

President Obama signed this legislation into law on December 31, 2011.

But wait!!!

Despite this legislation, the OFCCP persisted in asserting that it had jurisdiction over Florida Hospital. The Department of Labor's Administrative Review Board ("ARB") initially rejected the OFCCP's argument for jurisdiction, citing the NDAA legislation. The OFCCP, however, was not deterred, and asked the ARB to reconsider.

In a July 22, 2013 ruling, the ARB switched its position and ruled that Florida Hospital and other TRICARE providers *do meet* the definition of a federal subcontractor, despite the NDAA legislation.

The OFCCP claimed that in the definition of "subcontract," the two prongs are separated by an *or*, meaning that the prongs are read exclusively from one another. Under that interpretation, the first prong—that defines a subcontract as an agreement "for the purchase, sale, or use of non-personal services that in whole or in part, are necessary to the performance of any contract"—does apply to TRICARE network providers. In reaching this ruling, the ARB reviewed legislative history and determined that the NDAA "simply clarifies that a Medical Network Clause does not translate into a duty to perform healthcare services." In other words, the OFCCP argued that the NDAA only made the *second* prong of the "subcontract" definition ineffective, but that the first prong was still applicable.

The ARB therefore determined that Florida Hospital's TRICARE arrangement qualified as a purchase of non-personal services and that the purchase was necessary for the performance of the direct contract. In so ruling, it concluded that the OFCCP has jurisdiction over the hospital. (Notably, the two dissenting judges took the position that the NDAA plainly precludes jurisdiction under both prongs of the definition of subcontractor.)

Before you panic…

The decision leaves open the question of whether TRICARE payments could be considered federal financial assistance, which the OFCCP has conceded does *not* subject an organization to its jurisdiction. The ARB remanded the case for further inquiry into this issue, where Florida

Hospital will argue that TRICARE represents federal financial assistance similar to Medicare parts A and B.

Likewise, the ARB's decision will also likely be appealed.

Next Steps

Considering the OFCCP will undoubtedly use the ARB's decision as its "permission slip" to exert its jurisdiction over health care institutions, health care employers with only TRICARE arrangements (and no other federal contracts or subcontracts) are again faced with the quandary of deciding whether to go ahead and comply with affirmative action obligations when it is uncertain such obligations apply. We encourage employers uncertain about their status to seek legal counsel to discuss options in more detail. As is evident by the continued back and forth on this issue, it is even more clear that the OFCCP will not rest until it brings health care employers under its jurisdiction. ■

Kelli P. Lieurance
Labor, Employment and
Employee Benefits

North Dakota Supreme Court Reviews Negative Reference for Former Physician Employee

John Schmitt, M.D. was employed as a surgeon by Dakota Clinic from August 2002 through December 2004, when his contract was not renewed. He was subsequently employed by MeritCare Health from June 2005 until he terminated his employment effective July 2005. Dr. Schmitt contracted with a physician placement agency, which found a position for him at St. Joseph's Hospital in Dickinson, ND, subject to credentialing.

Dr. Schmitt's application for employment by St. Joseph's included a release from liability for "any and all individuals, entities, or organizations who provide [St. Joseph's] in good faith and without malice, information concerning [Dr. Schmitt's] professional competence, ethics, character, health status, other qualifications and ability to work cooperatively with others."

Dakota Clinic apparently responded "Do not recommend" to a credentialing questionnaire from St. Joseph's. MeritCare insisted that Dr. Schmitt sign a separate authorization, granting MeritCare immunity from liability, and agreeing not to sue MeritCare. Dr. Schmitt initially refused to sign the MeritCare release, but gave in after he learned that St. Joseph's had rescinded its employment offer to him. He felt that he signed this authorization under duress.

MeritCare then completed a preprinted questionnaire, stating that during employment by MeritCare, Dr. Schmitt's appointment at MeritCare had never been denied or voluntarily revoked, he had not voluntarily or involuntarily changed medical staff membership or surrendered clinical privileges, his practice had not been investigated or monitored as a result of quality determinations, he had not been named in a professional liability case and he had not been a defendant in a felony criminal matter. In response to a request for a recommendation, MeritCare checked a box that it "Would recommend" with a handwritten note stating "with reservation." MeritCare also answered "yes" to the question whether Dr. Schmitt had any disciplinary actions at MeritCare: "Dr. Schmitt was presented with an action plan based on episodes of insensitive comments and irritability with others. He submitted his resignation before completing the action plan. No restriction or limitation of privileges was suggested by the action plan."

After MeritCare's response, St. Joseph did not re-offer employment to Dr. Schmitt, and he was unable to secure employment at other North Dakota and Minnesota medical facilities.

Dr. Schmitt sued MeritCare and Dakota Clinic, claiming defamation, tortious interference with a prospective business advantage, and violation of state antitrust laws. The district court granted MeritCare summary judgment, finding that MeritCare's recommendation with reservation was based on truthful, nondefamatory facts disclosed

in the questionnaire and were not susceptible of a defamatory meaning in view of Dr. Schmitt's admission the statements were "technically true."

In an opinion dated July 22, 2013, the North Dakota Supreme Court analyzed Dr. Schmitt's claim of defamation and libel under North Dakota statutory and case law, finding that MeritCare's answers to the questionnaire were not fairly susceptible of a defamatory meaning, and affirmed the district court's grant of summary judgment. Based on a nuance peculiar to North Dakota defamation law, Dr. Schmitt argued that although the responses were technically true, they still constituted defamation by implication because they used innuendo, insinuation, or sarcasm to convey an untrue and defamatory meaning. He also argued that MeritCare's delayed response to the questionnaire was an implied defamatory assertion. The Court rejected both arguments, finding as a matter of law that MeritCare's responses, in context were not fairly susceptible of a defamatory meaning. The Court quoted a 2006 Indiana decision, stating that "It would be an odd use of the defamation doctrine to hold that silence constitutes actionable speech." Finally, the Court rejected Dr. Schmitt's allegation that Dakota Clinic and MeritCare had colluded, contracted or otherwise combined against Dr. Schmitt in violation of the state antitrust laws. There was simply no evidence of such activity presented.

Because the Court's decision was so dependent upon state law, readers in Iowa and Nebraska cannot be assured of precisely the same result under their state laws. However, there are a number of observations concerning MeritCare's approach that can be adopted by physician employers in any state to reduce potential liability when responding to requests for references concerning disruptive physicians:

1. Make sure that the physician's authorization of the former employer's response to credentialing inquiries is sufficiently broad to protect the former employer and its employees, owners, officers, directors and other agents. Consider an authorization that goes so far as to obtain the physician's covenant not to sue on the basis of the former employer's response.

2. Avoid discussions with other former employers, local hospital medical staff officers and administrators, that could be construed as collusion to boycott or otherwise exclude the physician from practice.

3. In responding to credentialing inquiries, do not feel compelled to adhere strictly to the answers offered by the pre-printed form, or even to respond to all of the questions.

4. Respond to credentialing inquiries as factually as possible. Avoid asserting opinions. If you provide information of historic disciplinary action, it may be unnecessary to respond to the question of whether you recommend the physician or not.

5. While the physician is still employed, take formal action in response to disruptive conduct. In this manner you will have "facts" to refer to when later asked to provide a reference for the physician. For example, MeritCare was able to describe an unfulfilled action plan that had been required of Dr. Schmitt.

The refreshing thing about the decision in Schmitt v. MeritCare, is that the summary judgment in favor of the former employer suggests that it can be safe to provide an honest reference with regard to a disruptive physician. All employers of physicians and credentialing health care facilities find themselves in the position of depending upon others for credentialing references. Yet, when faced with providing a negative reference for a disruptive physician, these employers and facilities invariably have to wonder what kind of litigation will result from their candid response to an inquiry. While MeritCare certainly became embroiled in litigation as a result of its honest response, at least it was able to resolve the matter relatively promptly through summary judgment. ■

Barbara E. Person

OFCCP Issues Final Rules Regarding the Employment of Vets and Disabled Workers

On August 27, 2013, the U.S. Department of Labor's Office of Federal Contract Compliance Programs announced Final Rules that make changes to the regulations implementing Section 503 of the Rehabilitation Act of 1973 ("Section 503"), and the Vietnam Era Veterans' Readjustment Assistance Act ("VEVRAA"). This is a huge change for federal contractors, as previously, contractors did not have to perform statistical analyses of their employment practices related to veterans and individuals with disabilities. The Final Rules change that.

Section 503

Section 503 prohibits federal contractors and subcontractors from discriminating in employment against individuals with disabilities ("IWDs"), and requires contractors to take affirmative action to recruit, hire, promote, and retain such individuals. The following are some of the highlights of the Final Rules:

- Utilization Goals: The Final Rules establish a nationwide 7% utilization goal for qualified IWDs. Contractors with more than 100 employees must apply the goal to each of their job groups. Contractors with fewer than 100 employees must apply the goal to the entire workforce.

  Contractors must also conduct an annual utilization analysis and assessment of problem areas, and establish specific action-oriented programs to address any identified problems. The OFCCP claims that such goals are different than "goals" used under E.O. 11246 because the Section 503 goal focuses on the entire workforce, as opposed to those employees newly placed into a position.

This is a huge change for federal contractors, as previously, contractors did not have to perform statistical analyses of their employment practices related to veterans and individuals with disabilities.

  According to the OFCCP, failure to meet the goal will not lead to a fine, penalty or sanction; rather, it appears that the OFCCP will evaluate the contractor's outreach efforts to meet the goal and use such considerations when determining overall compliance.

- Applicant/Hire Data Collection: The Final Rules require that contractors document and update annually several quantitative comparisons for the number of IWDs who apply for jobs and the number of IWDs they hire. Such data is to be used to measure the effectiveness of the contractor's outreach and recruitment efforts. The data must be maintained for three years in order to "spot trends."

- Invitation to Self-Identify: The Final Rules require that contractors invite applicants to self-identify as IWDs at both the pre-offer and post-offer phases of the application process, using language prescribed by the OFCCP. The Final Rules also require that contractors invite their current employees to self-identify as IWDs every five years, using the prescribed language. This language will be posted on the OFCCP website in the near future.

- Incorporation of the EO Clause: The Final Rules require that specific language be used when incorporating the equal opportunity clause into a subcontract by reference.

- Records Access: The Final Rules clarify that contractors must allow the OFCCP to review documents related to a compliance check or focused review, either on-site or off-site, at the OFCCP's option. In addition, the Final Rules require contractors, upon request, to inform the OFCCP of all formats in which it maintains its records and provide them to OFCCP in whichever of those formats OFCCP requests.

- ADAAA: The Final Rules implement changes necessitated by the passage of the ADA Amendments Act (ADAAA) of 2008 by revising the definition of "disability" and certain nondiscrimination provisions of the implementing regulations.

VEVRAA

VEVRAA prohibits federal contractors and subcontractors from discriminating in employment against protected veterans, and requires these employers to take affirmative action to recruit, hire, promote, and retain these veterans. The following summarizes some of the key changes:

- Hiring Benchmarks: The Final Rules require that contractors establish annual hiring benchmarks for protected veterans. Contractors must use one of two methods to establish their benchmarks. First, contractors may choose to establish a benchmark equal to the national percentage of veterans in the civilian labor force, which will be published and updated annually by the OFCCP (currently 8%). Alternatively, contractors may establish their own benchmarks using certain data from the Bureau of Labor Statistics ("BLS") and Veterans' Employment and Training Service/Employment and Training Administration ("VETS/ETA") that will also be published by the OFCCP, as well other factors that reflect the contractor's unique hiring circumstances. The data will be posted in the Benchmark Database in the near future.

  The OFCCP claims that such benchmarks are different than "goals" used under E.O. 11246; the benchmarks are to be used only as a barometer to gauge the success of recruitment efforts.

- Data Collection: The Final Rules require that contractors document and update annually several quantitative comparisons for the number of veterans who apply for jobs and the number of veterans they hire. The goal is to measure the effectiveness of outreach and recruitment efforts. The data must be maintained for three years.

- Invitation to Self-Identify: The Final Rules require that contractors invite applicants to self-identify as protected veterans at both the pre-offer and post-offer phases of the application process. The Final Rules include sample invitations to self-identify that contractors may use at each phase.

- Incorporation of the EO Clause: The Final Rules require that specific language be used when incorporating the equal opportunity clause into a subcontract by reference.

- Job Listings: The Final Rules clarify that when listing job openings, contractors must provide that information in a manner and format permitted by the appropriate State or local job service, so that it can access and use the information to make the job listings available to job seekers.

- Records Access: The Final Rules clarify that contractors must allow the OFCCP to review documents related to a compliance check or focused review, either on-site or off-site, at the OFCCP's option. In addition, the Final Rules require contractors, upon request, to inform the OFCCP of all formats in which it maintains its records and provide them to the OFCCP in whichever of those formats OFCCP requests.

Current contractors with a written affirmative action program ("AAP") already in place on the effective date have additional time to come into compliance with some of the newer AAP requirements.

What do you do now?

The Final Rules will be published in the Federal Register shortly (likely in the next two weeks) and are effective 180 days after its publication. However, current contractors with a written affirmative action program ("AAP") already in place on the effective date have additional time to come into compliance with some of the newer AAP requirements.

We will continue to review each of the Final Rules in their entirety and provide additional guidance related to complying with these new obligations. Stay tuned! ■

Kelli P. Lieurance
Labor, Employment and Employee Benefits

Upcoming Speaking Engagements

On September 5, 2013, Vickie B. Ahlers will speak at the MidAmerica Information Summit hosted by the Iowa Hospital Association. She will discuss the implications of the Final Rule for hospital associations.

On September 17, 2013, Michael W. Chase and Andrew D. Kloeckner will present "Best Practices for Preparing Your Organization for Investigations and Audits" at the Nebraska Health Care Association Fall Convention at the La Vista Conference Center. Their presentation will begin at 3:00 p.m.

Julie A. Knutson and Michael W. Chase will speak at the LeadingAge Nebraska Fall Conference in Omaha on October 2, 2013. They will present "Ten Mistakes You Don't Want to Make in Implementing Your Compliance Program."

On October 9, 2012, Julie A. Knutson will present "Living with a Corporate Integrity Agreement: a Word to the Wise About Nursing Facility Compliance" at the LeadingAge Iowa Fall Conference in Des Moines. She will co-present with Mike Van Sickle, Gary Jones and Todd Muckey.

On October 21-22, 2013, John Holdenried will be co-presenting at the American Health Lawyers Association Tax Program in Arlington, Virginia on the topic: "ACOs and Other Models of Care: From Formation to Operation—Tax Considerations and More." ■

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