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Health Law UPDATE

June 2017

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FEDERAL UPDATE

Medicaid Fraud Control Units Recovered Nearly $1.9 Billion in 2016

On May 19, 2017, the Department of Health & Human Services, Office of the Inspector General (OIG), published the Fiscal Year 2016 Report on Medicaid Fraud Control Units (MFCUs), which investigate and prosecute Medicaid provider fraud and patient abuse or neglect.

The MFCUs reported criminal and civil recoveries of nearly $1.9 billion in 2016. The MFCUs spent $259 million in state and federal funds. Therefore, on average, the MFCUs recovered over seven dollars for each dollar spent.

MFCU investigations in 2016 also resulted in 1,564 convictions. Fraud cases accounted for 74% of the convictions and 35% of the convictions involved personal care services, such as home care aides and agency representatives. In one case, a home health aide was fined and sentenced to two years in prison for falsifying timesheets.

New Jersey reported 379 open fraud investigations, 21 fraud convictions and 13 civil settlements for 2016. The total recovery in this state was over $47.3 million.

The full report can be found on OIG's website: https://oig.hhs.gov/oei/reports/oei-09-17-00210.pdf

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Supreme Court Rules in Favor of Arbitration Agreements for Nursing Homes

On May 15, 2017, the U.S. Supreme Court ruled that a state court could not invalidate a nursing home resident's agreement to arbitrate disputes on the grounds that the resident's power of attorney document did not expressly mention arbitration agreements. The Supreme Court ruled that a contrary decision by the Kentucky Supreme Court violated the Federal Arbitration Act (FAA), by singling out arbitration agreements for disfavored treatment. The U.S. Supreme Court determined that the FAA establishes an equal treatment principle, i.e., that a court may invalidate an arbitration agreement based on generally applicable contract defenses, but not on legal rules that apply only to arbitration provisions. By requiring an explicit statement before an agent can relinquish his or her principal's right to go to court and receive a jury trial, the Kentucky court failed to put arbitration agreements on an equal plane with other contracts, which violates the FAA.

The case arose from two separate arbitration agreements signed by attorneys-in-fact for residents of a Kentucky nursing home. Upon the deaths of the residents, the estates of the residents brought personal injury/wrongful death actions against the nursing home. The nursing home moved to dismiss the cases, arguing that the arbitration agreements were enforceable. Ultimately, the Supreme Court agreed. The Supreme Court's decision is significant in that it strengthens the FAA, and specifically its application to nursing homes. The decision is *Kindred Nursing Centers, L.P. v. Clark, U.S., No. 16-32.*

In a related issue, the Trump administration is considering repealing a 2016 rule issued by the Centers for Medicare & Medicaid Services which bars nursing homes from receiving federal funding if the nursing home forces residents to sign arbitration agreements. Due to a federal court injunction, the rule has never gone into effect.

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DOJ Joins False Claims Act Suit Involving Medicare Advantage

The United States Department of Justice (DOJ) has intervened in a False Claims Act (FCA) suit against UnitedHealth Group, Inc. (UnitedHealth) filed in a California federal court on May 1, 2017. *U.S. ex rel. Swoben v. Secure Horizons*, Case No. 09-5013. The DOJ's intervention marks its first involvement in a whistleblower suit alleging fraud regarding the Medicare Advantage program. DOJ alleges that UnitedHealth, in bad faith, systematically ignored information in failing to investigate unsubstantiated diagnoses of patients to boost its "risk adjustment" payments. DOJ also alleges that

UnitedHealth conducted "one-sided" chart reviews that focused only on maximizing government payments, and neglected to correct errors that lead to overpayments.

In Medicare Advantage plans, the government pays health insurers, like UnitedHealth, a per-member, per-month payment for beneficiaries. A higher fee is provided for beneficiaries who have a higher risk score in anticipation of higher health care costs. Program rules require that information must be submitted in support of a patient's medical record to justify the higher fee. DOJ argues that UnitedHealth knew that a significant portion of the claims reported were invalid because the beneficiaries' medical records did not support the medical conditions.

It is estimated that billions of dollars in unsupported risk adjustment payments are paid out each year. Earlier this year, DOJ disclosed that it currently has ongoing investigations regarding risk adjustment practices of other carriers, including Aetna and Cigna, suggesting a new trend in FCA litigation. In addition, DOJ indicated that it intends to intervene in another similar case filed by a former UnitedHealth executive alleging that UnitedHealth wrongly received at least $1 billion in risk adjustment payments.

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CHRONIC Care Act Passes Through Senate Finance Committee

On May 18, 2017, the Senate Finance Committee voted unanimously to approve the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act (S. 870). The bill is intended to improve care management, coordination and outcomes for Medicare beneficiaries with chronic health conditions.

The bill aims to achieve these improvements by increasing access to telehealth for Medicare beneficiaries with chronic illnesses as well as incentives for enrollees to receive care through accountable care organizations (ACOs). The bill also seeks to extend a demonstration program, known as "Independence at Home," which aims to keep people in their homes rather than hospitals, allows reimbursement for more non-health and social services and extends permanently Medicare Advantage Special Needs plans that target chronically ill beneficiaries.

A large number of ACOs have trouble keeping beneficiaries in-house, which makes it harder to coordinate beneficiary care. This bill attempts to limit that problem by reducing or eliminating a beneficiary's cost-sharing for a primary care service if the primary care doctor is in that ACO. This will only incentivize beneficiaries to the stay within the ACO for treatment and lower the beneficiary's cost to Centers for Medicare & Medicaid Services.

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STATE UPDATE

NJ Legislative Bills Seek to Protect Insurance Coverage for People with Preexisting Conditions

On May 8, 2017, the State Senate introduced a bill to bar health insurance companies from excluding coverage, imposing waiting periods or raising premiums for people with preexisting conditions (S 3158). On May 22, 2017, the State General Assembly introduced an identical bill. We will provide updates as more information becomes available.

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DOH Adopts Rules Implementing Health Care Professional Responsibility and Reporting Enhancement Act

The New Jersey Department of Health (DOH) recently adopted rules implementing portions of the Health Care Professional Responsibility and Reporting Enhancement Act. The law created a Health Care Professional Information Clearinghouse. The law also requires New Jersey licensed health care entities to report health care professionals employed by, under contract with or having clinical privileges with that entity to notify the Clearinghouse Coordinator regarding the professional's conduct relating to impairment, incompetence or professional misconduct which relates to patient safety. Further, the law requires the entity to notify the Clearinghouse coordinator of the actions the entity has taken against the offending professional. The new DOH rules are in addition to the rules regarding the law previously adopted by the New Jersey Division of Consumer Affairs (DCA).

Under the new rules, a health care facility must comply with the DCA rules on reporting to the Clearinghouse Coordinator, and must use the form of report adopted in the DCA regulations. A facility inquiring about a health care professional must use the inquiry form adopted in the new rules. Also, the new rules specify how facilities must respond to an inquiry. In addition, the new rules require health care facilities to maintain a record of all reportable events for a minimum of seven years. Finally, a facility may be subject to fines ranging between $250 and $1,000 for violations of the new rules.

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Petition Submitted to New Jersey Dental Board for Recognition and Advertisement of More Specialties

The American Board of Dental Associates (ABDS) recently submitted a petition for rulemaking to the State Board of Dentistry (Board) requesting that the Board amend existing N.J.A.C.

13:30-6.1 to formally recognize the ABDS-recognized certifying boards/areas of practice as specialties, and any future ABDS-recognized specialties. This would allow dentists certified by the ABDS boards to advertise as specialists in accordance with New Jersey rules. Currently, the rules allow such specialty recognition and advertisement decisions to be made only by the American Dental Association. The ABDS also requests that the following additional specialty areas of dentistry may be announced as specialty dental practices: oral implantology/implant dentistry; oral medicine; orofacial pain; dental anesthesiology; and any other area of dentistry recognized as a specialty by the American Dental Association or the ABDS as a specialty area. The Board referred this matter to its Rules and Regulations Committee for further deliberation. The rules are located at N.J.A.C. 13:30-6.1 and 6.2.

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New Jersey Board of Nursing Adopts Rules Amendment for Dispensing Medication

The New Jersey Board of Nursing has amended its rules governing dispensing of medications. The rule now requires advanced practice nurses who dispense pharmaceutical samples to patients to label such samples with the following: (i) the complete name of the medication dispensed; (ii) the strength and quantity of the medication dispensed; (iii) instructions as to the frequency of use; (iv) any special precautions; and (v) the expiration date of the medication. All of this information must be included on each label placed on a sample. Advanced practice nurses are not required to label samples when manufacturers have already included this information. However, if any of the required information is missing on a sample, the nurse must supplement the sample with the necessary information. The regulation is located at N.J.A.C. 13:37-7.10.

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Legislative Update

Alternative Payment Models—On May 25, 2017, the NJ Senate passed A4334 which permits health care practitioners to refer patients to a health care service in which the practitioner has a beneficial interest, provided that the referral is related to an alternative payment model. As defined in the bill, alternative payment models, operated by Medicaid, Medicare or a health insurance carrier, provide payments to health care practitioners and health care services based on their performance in meeting certain quality measures linked to patient safety and operational performance, which may include institution-specific and specialty-specific goals.

Property Tax Exemptions for Nonprofit Hospitals—On May 25, 2017, Senate Bill 3243 was introduced to restore the property tax exemption for nonprofit hospitals with for-profit medical providers onsite. The bill would require these hospitals to pay community service contributions to host municipalities and also establishes a Nonprofit Hospital Community Service Contribution Study Commission.

Licensing of Radiologist Assistants—On May 25, 2017, Senate Bill 3234 was introduced which provides for the licensing of radiologist assistants. The radiologist assistant would need to be certified and registered with the American Registry of Radiologic Technologists and credentialed to provide primary advanced-level radiology health care under the supervision of a licensed radiologist.

Out-of-Network Benefits—On June 12, 2017, State Senator Paul Sarlo introduced a bill (S3299) regarding out-of-network benefits. The bill would require providers, insurers and employers to make certain disclosures regarding out of network healthcare costs and allows the State Health Benefits Plan, which covers public workers, to negotiate directly with hospitals in certain circumstances. Another bill (S1285) related out-of-network benefits, introduced by State Senator Joe Vitale, has stalled in the Senate Budget Committee, chaired by Senator Sarlo.

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Brach Eichler In The News

John D. Fanburg, Mark Manigan and **Keith Roberts** spoke at the NJAASC 7th Annual Ambulatory Surgery Conference on June 14th, on the topic "Politics, Legislation and Regulations that Affect the ASC Industry." For more information, visit *http://www.bracheichler.com/C3F493/assets/files/News/Legal%20Report%20-%20NJAASC%20June%2014,%202017.pdf*

Lani M. Dornfeld and **Cheryll Calderon** will speak at the Home Care & Hospice Association of New Jersey annual meeting on June 22nd on the topic "Preferred Provider Arrangements: Compliant Partnering to Enhance Quality of Care." For more information, visit: *www.homecarenj.org/2017-annual-conference*

HIPAA CORNER

OCR Issues Quick Response Cyber Attack Checklist and Graphic

The U.S. Department of Health & Human Services (HHS), Office for Civil Rights (OCR) has developed and published a checklist and a corresponding infographic that explains the steps for a HIPAA covered entity or its business associate to take in response to a cyber-related security incident.

The checklist is available at: *https://www.hhs.gov/sites/default/files/cyber-attack-checklist-06-2017.pdf*

The infographic may be found at: *https://www.hhs.gov/sites/default/files/cyber-attack-quick-response-infographic.gif*

Covered entities and business associates are encouraged to review the recommended steps, including executing response and mitigation procedures and contingency plans, reporting the crime to law enforcement agencies, reporting cyber threat indicators to the appropriate federal and information-sharing and analysis organizations (ISAOs) and reporting the breach to the OCR and to affected individuals. In the publication, the OCR stated that it will consider all mitigation efforts taken by the affected entity during a breach investigation, including the sharing of non-protected breach-related information with law enforcement and other federal and analysis organizations.

The HHS also has published a ransomware fact sheet, that may be found at: *https://www.hhs.gov/sites/default/files/RansomwareFactSheet.pdf*

If you would like assistance in reviewing and updating your HIPAA policies and procedures, including your Breach Notification Rule policy, feel free to contact:

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Texas Health System Agrees to Pay $2.4 Million Settlement for Alleged HIPAA Violations

Memorial Hermann Health System (MHHS), a not-for-profit health system based in Houston, Texas, has entered into a resolution agreement with the Department of Health and Human Services, Office of Civil Rights, to pay $2.4 million for alleged violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. In 2015, MHHS reported a patient to appropriate authorities for use of a fraudulent identification card. Although this was a permitted disclosure under HIPAA, MHHS impermissibly disclosed protected health information (PHI) by issuing press releases with the patient's name, disclosing PHI in meetings with the media and public officials and in a statement on their website. In addition to the payment, MHHS agreed to a corrective action plan that requires MHHS to update its policies and procedures and appropriately train staff regarding disclosure of PHI.

This matter illustrates that a health care entity may properly cooperate with law enforcement, but must remain vigilant to not disclose PHI in impermissible ways.

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HEALTH LAW ALERT

JUNE 2017

New Jersey Supreme Court Rejects Sham Physician Ownership of Multidisciplinary Medical Practices

On May 4, 2017, the New Jersey Supreme Court imposed liability under the New Jersey Insurance Fraud Prevention Act (IFPA) on a chiropractor and an attorney for knowingly assisting a chiropractor to create an unlawful multidisciplinary practice in violation of rules governing the supervision and ownership of a medical practice. In the case, *Allstate Insurance Company v. Northfield Medical Center, P.C.*, 2017 WL 1739692, Allstate alleged that the defendants knowingly assisted and encouraged an investing chiropractor to retain control of the finances of a medical practice. Allstate claimed this violated a state rule, N.J.A.C. 13:35-6-16, which provides that a medical doctor may not be employed by a licensee with a more limited scope of practice, such as a chiropractor.

The Use of Management Companies

The use of management companies and management services agreements is an acceptable way to manage the business aspects of a medical practice, as long as they do not have a fundamental impact on the delivery of health care services. State regulations do not preclude administrative services agreements between a management company and a professional medical practice and New Jersey courts have approved such a relationship. However, the rules and court decisions make clear that medical doctors must always maintain and exercise professional judgment in rendering professional services and must not be subject to undue influence or control by others.

What Went Wrong in This Case?

In this case, the court agreed with Allstate that the defendants – including a chiropractor and an attorney – intentionally promoted what they knew was a "lie" – a business model that appeared to have medical doctors supervising and controlling a medical practice, but that actually placed control in the hands of a chiropractor through deceptive efforts at "shielding the true controller." These tactics included listing medical doctors as the "owners" but who never treated patients of the practice. The "owners" also were required to sign agreements allowing the chiropractor to remove the doctor-owners from their positions. In addition, insurance fraud was involved because the illegal

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practice structure caused the claims to insurance companies to be ineligible for payment, and fraudulent. The court found that the defendants knew they were violating legal rules on medical practice ownership and supervision, and committed fraud by trying to hide their actions from detection.

Takeaways

The decision in this case is important for several reasons. First, courts will enforce the rule that medical practices must be owned and controlled by fully licensed medical doctors, not just on paper but in reality. Second, any person, including a health care or business professional, who knowingly attempts to violate rules concerning New Jersey ownership and operation of medical practices, is subject to liability for fraud. Insurance companies such as Allstate are ready to file fraud suits in such cases. Since violations of the IFPA result in triple damages and awards of attorneys fees to insurance companies, medical professionals should carefully review their practice structures and management agreements.

If you need assistance in reviewing your practice structure, management services agreement or other agreements or arrangements, feel free to contact any member of our Health Law Practice Group below.

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