Department of Justice Imposes Significant Increase in False Claims Act Penalties

An interim final rule published by the Department of Justice (DOJ) on June 30, 2016, confirmed a massive increase in the amount of penalties violators are subject to under the False Claims Act (FCA). The increase comes as a result of the Bipartisan Budget Act of 2015 (BBA), which required federal agencies to update the amount of the civil monetary penalties to account for the impact of inflation since the level of each penalty was last set. The penalties, which ranged from $5,500 to $11,000 per violation since those benchmarks were set in 1999, have been increased to a minimum of $10,781 per violation and a maximum of $21,563 per violation. While the increased penalties go into effect on August 1, 2016, they apply to violations that occurred after November 2, 2015, the enactment date of the BBA. DOJ notes in the interim final rule, “Therefore, violations occurring on or before November 2, 2015, and assessments made prior to August 1, 2016, whose associated violations occurred after November 2, 2015, will continue to be subject to the civil monetary penalty amounts set forth in the Department’s existing regulations.”

The rule also imposes the framework for future penalty increases, which will be tied to the Consumer Price Index. The rule provides that future increases in penalties “will be determined by the difference in the Consumer Price Index between the October preceding the new adjustment and the October the year before.”

Although the prior per-claim FCA sanctions already provided health care providers with a strong incentive to settle FCA cases in order to avoid crippling penalties, the new penalties nearly double the potential penalty, further encouraging settlement. DOJ was authorized under the BBA to coordinate with the Office of Management and Budget to impose a lower penalty for FCA violators, but it appears to have declined to exercise that option. While the increase is alarming for health care providers, it was not completely unexpected, as the Railroad Retirement Board published a similar interim rule in May with identical increases for FCA violations. DOJ is providing a 60-day period for public comment on the increased penalties.

Supreme Court Rules on Implied Certification Theory of False Claims Act Liability

In one of the 2015-2016 term’s most consequential decisions for health care providers, the Supreme Court upheld the theory of implied false certification in its June 16 decision in Universal Health Services v. United States ex rel. Escobar. The case, which resolved a split among the lower federal courts, unanimously upheld the theory of implied false certification under the False Claims Act (FCA), while narrowing the application of the theory to claims that exhibit material noncompliance with the law.

The theory of implied false certification is premised on the principle that a provider implicitly certifies its compliance with all conditions of payment for services rendered through the act of submitting the claim to the government for payment. The Supreme Court explains the theory at the outset of its opinion, noting, “According to this theory, when a defendant submits a claim, it implies that it has satisfied all of the conditions of payment. If the defendant does not disclose a violation of a material statutory, regulatory, or contractual requirement, the theory goes, the defendant has made a misrepresentation that renders the claim ‘false or fraudulent’ under [the FCA].”

While the government and whistleblowers rely on this theory to demonstrate that any violation of a statute, regulation or contractual obligation violates the FCA irrespective of whether the defendant expressly attested to compliance with such statute, regulation or contractual
provision, defendants complain that the theory is overly expansive and inapplicable to requirements that are not expressly attested to on the face of a claim.

In its holding, the Court upheld the theory of implied false certification as a basis for liability where the following two circumstances are met: “[F]irst, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.” While upholding the theory of implied false certification was a clear victory for the government and whistleblowers, the Court did appear to account for the concerns of providers, which were highlighted in a number of amicus curiae briefs. Constricting the practical scope of the implied false certification theory, the Court held that FCA liability is triggered only if the statutory, regulatory or contractual noncompliance is “material.” The Court emphasized that the “materiality standard is demanding…. A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant's noncompliance. Materiality, in addition, cannot be found where noncompliance is minor or insubstantial.”

While some providers may view the decision as a loss due to the acceptance of the theory of implied false certification, the Court's holding does serve, in part, to protect providers through its imposition of a demanding materiality standard.

**Senate Committee Proposes Stark Law Overhaul**

Acknowledging the obstacles to compliance with the Physician Self-Referral Law (Stark Law) in the rapidly changing health care landscape, the majority staff of the Senate Finance Committee (Majority Staff) on June 30 released a report calling for an overhaul of the law. The report, titled “Why Stark, Why Now? Suggestions to Improve the Stark Law to Encourage Innovative Payment Models,” organizes and summarizes the findings of a December 2015 roundtable. The roundtable engaged health care experts in a discussion regarding the compatibility of the Stark Law with a rapidly changing health care system, focusing, in particular, on the value-based reimbursement mechanisms enacted by the ACA and, most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The panelists surveyed for the report noted that the Stark Law has become an increasingly intractable obstacle to realizing a shift from a fee-for-service (FFS) payment system to alternative reimbursement mechanisms that focus on payment for performance. The report notes that the “strict liability regime, huge penalties, and the breadth, complexity, and ambiguities of the Stark law and its regulations have created what is often referred to as a minefield for the health care industry…. While many providers would like to move toward alternative payment models, most are reluctant to do so because they must contend with the tension between the Stark law and alternative payment models and the possibility of devastating penalties if they guess wrong.” The panelists view providers as being disincentivized from utilizing a payment system focused on efficiency by a regulatory structure that has the potential to inflict crippling punishments for a Stark Law violation.

The Majority Staff asked the participating panelists to suggest potential reforms of the Stark Law that would ease the movement of providers to alternative payment systems. The suggestions from panelists ranged from outright repeal of the Stark Law to the creation of new Stark Law exceptions (such as an exception enabling financial arrangements that involve risk-sharing and gainsharing in alternative payment models when appropriate safeguards are in place), the modification of existing exceptions (such as broadening the prepaid plan exception at 42 U.S.C. § 1395m(n)(b)(3)) and repealing the compensation arrangement requirements to limit the Stark law to ownership and investment interests.

Many commenters also argued that technical violations “should be subject to a separate set of sanctions that would not give rise to either FCA exposure or potentially ruinous repayment liability.” The report concluded by noting that although the Stark Law was intended to address risk in a FFS model, the “financial incentives that trigger overutilization concerns in an FFS payment model are largely or entirely eliminated in alternative payment models. Although the FFS payment model still exists, the comments show that the Stark law and its regulations have presented challenges to providers attempting to implement health care reform.”

While the report has yet to prompt any type of comprehensive legislation that is being seriously considered in Congress, it nonetheless provides recognition that the Stark Law has created a barrier to effective reform and highlights potential long-term solutions to reduce the law’s burden on providers.
Texas Loses Fight on Restrictive Abortion Law

In a decision being hailed as the most significant abortion rights ruling in decades, the Supreme Court on June 27 held unconstitutional a Texas law that rendered the operations of many abortion providers in that state illegal. In Whole Women’s Health v. Hellerstedt, the Court was asked to evaluate H.B. 2, a 2013 law that placed significant restrictions on Texas abortion providers, such as requiring abortion clinics to meet the standards of ambulatory surgery centers and mandating that physicians performing abortions have admitting privileges at a hospital within 30 miles of the clinic.

While supporters argued the law was necessary for patient safety, opponents, citing the 1992 Supreme Court case of Planned Parenthood of Southeastern Pennsylvania v. Casey, asserted that H.B. 2 impermissibly imposed an undue burden on a woman’s right to an abortion. In holding for the law’s challengers, Justice Breyer determined that the Texas law did in fact place an undue burden on women seeking an abortion and thus violated the 1992 decision in Casey. Breyer was joined by Justices Kennedy, Ginsburg, Sotomayor and Kagan.

Justice Alito authored the dissent, which argued on procedural grounds that the case shouldn’t have come to the Court. Justice Thomas, in a separate dissent, cited Casey and opined that the Court ruled incorrectly because the legislatures, and not courts, should determine medical necessity.

The decision has had an immediate impact, resulting in the Supreme Court’s refusal to hear appeals from Wisconsin and Mississippi to restore laws restricting access to abortion. In the wake of the decision, Planned Parenthood launched a campaign seeking invalidation of similarly restrictive laws in a half-dozen other states.

NEW JERSEY

Christie Uses Line-Item Veto to Cut Charity Care, Nursing Facility Rates

The 2017 New Jersey state budget was signed into law on June 30, but not before Governor Christie wielded his veto pen to cut expenditures for charity care, nursing facilities and family planning services, among other items. The budget, effective July 1, reduces the charity care funding pool from $502 million to $302 million. Although the majority of the $200 million cut was included in the governor’s February funding proposal, $50 million of that sum fell victim to the governor’s line-item veto authority after legislators, prompted by hospital advocacy groups, had restored it to the final budget bill shortly before its passage.

Also vetoed from the final budget was $10.5 million for an increase in the per-diem rate for nursing facilities and $7.5 million for family planning services.

New Jersey’s teaching hospitals, however, fared better, with an increase in general education funding of $60.7 million, expanding the allotment from $127.3 million to $188 million.

Amended Version of Out-of-Network Bill Clears Assembly Committee

The Assembly Financial Institutions and Insurance Committee approved on June 20 legislation intended to protect consumers from surprise out-of-network medical bills. The bill, A1952, would require hospitals and doctors to disclose to patients before treatment whether they are participants in the patient’s insurance network. More controversially, the bill also would establish a state-regulated arbitration process to settle disputed bills to insured individuals who incur out-of-network charges during emergency or urgent procedures, or “inadvertently” during elective procedures.

When patients receive an emergency or elective procedure, they may encounter facilities, physicians or specialists that are not participants in their insurance network. At times, the patient receiving the services may not be aware of the identity of the out-of-network provider or facility until treatment is imminent or already under way. Currently, such out-of-network providers can balance bill the patient for all charges not reimbursed by the consumer’s insurance carrier.

The measure is the latest legislative attempt to address surprise medical bills, an effort that has been mired in gridlock for over eight years due, in part, to stiff opposition from the hospital and physician communities.

The primary source of misgivings is the proposed mandated arbitration mechanism, which would limit disputed reimbursement to a range between 90 percent and 200 percent of Medicare rates. This represents a departure from previous versions of the bill that permitted both providers and insurers to propose a
reimbursement amount and vested an arbitrator with the authority to determine the appropriate charge.

Mishael Azam of the Medical Society of New Jersey argued that Medicare is an inappropriate benchmark because Medicare rates are a “moving target, and federal law is changing as we speak ... into bundled payments and value payments.” Moreover, added Azam, Medicare rates always fall short of what it costs a doctor or a hospital to treat a patient.

John Azzariti, president of the New Jersey State Society of Anesthesiologists, voiced his concern that the bill would allow insurance companies to “dictate our reimbursement, much like Medicare.” Asserting, “It’s not sustainable to maintain a practice under those conditions,” Azzariti predicted the bill would force physicians to relocate their practices out of state.

On the other hand, the bill was praised by Maura Collinsgru of N.J. Citizen Action as a solution to “[s]urprise bills ... driving up the cost of insurance and unfairly penalizing New Jerseyans who do all the right things – buying insurance and using in-network providers.”

Horizon echoed this sentiment, stating, “Given that Horizon has the largest network of any provider and covers just under half the residents, doubling that number provides a reasonable estimate of what out-of-network providers charged all New Jerseyans in 2015. The roughly 80 percent of New Jersey physicians and 92 percent of hospitals that participate in Horizon's network are not the problem. The problem is the relatively small, but very expensive, group of providers choosing to remain out-of-network in order to exploit loopholes in the law and charge outrageous prices to patients who, very often, have no role in choosing that provider and no recourse once a bill arrives.”

With stakeholders at loggerheads, the bill’s future is uncertain. We will continue to monitor any developments over the coming months.
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