BRACH | EICHLER LLC

Healthcare Law UPDATE

April 2020

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FEDERAL UPDATE

COVID-19 Legal Updates

We are striving to keep abreast of the numerous legal developments occurring during the nationwide novel coronavirus (COVID-19) public health emergency. Brach Eichler has created a COVID-19 Resource Center that consolidates our important client alerts and webinar series information in one place. Please visit the Resource Center for updates.

COVID-19 Fraud Alert

On March 23, 2020, the Department of Health & Human Services, Office of Inspector General (OIG) issued a Fraud Alert to make the public aware of fraud schemes related to COVID-19. The OIG discussed "scammers" and "fraudsters." COVID-19 scammers are offering COVID-19 tests to Medicare beneficiaries in exchange for personal information, including Medicare information. However, the OIG asserts "the services are unapproved and illegitimate." Fraudsters are targeting Medicare beneficiaries through telemarketing calls, social media platforms, and door-to-door visits. These bad actors may use the individual's information to commit medical identity theft and fraudulently bill Medicare or Medicaid, potentially leaving the victim responsible for denied claims. The OIG cautions Medicare beneficiaries to be mindful of unsolicited requests for their Medicare or Medicaid numbers, to be suspicious of unexpected calls or visitors offering COVID-19 tests or supplies, and to ignore offers or advertisements for COVID-19 testing or treatments on social media sites

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Office Manager of Substance Abuse Clinic is First Conviction Under EKRA Kickback Law

The office manager of a substance abuse clinic in Jackson, Kentucky pleaded guilty on January 10, 2020 to soliciting $4,000 in kickbacks from a toxicology laboratory in exchange for urine drug testing referrals. The 80-year-old woman was the first to be convicted under the federal statute, Eliminating Kickbacks in Recovery Act of 2018 (EKRA). Under EKRA, it is a federal crime to knowingly and willfully solicit or receive, or pay or offer, any remuneration (including any kickback, bribe, or rebate) in return for the referral of a patient to a recovery home, clinical treatment facility, or laboratory. Violations of EKRA may result in fines of no more than $200,000, imprisonment of no more than ten years, or both, for each occurrence. The statute was passed as part of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), which was enacted in 2018 to combat the opioid crisis.

While EKRA is similar to the federal Anti-Kickback Statute (AKS), EKRA differs in that it applies to all healthcare benefit program business, including private payors, while the AKS applies only to federal healthcare program business. Additionally, EKRA, like the AKS, includes several exceptions for certain arrangements, including employment arrangements, discounts, and waivers, but those exceptions differ from the AKS exceptions. For example, EKRA exempts remuneration paid to employees, but the exception is narrower than the AKS employment safe harbor. The AKS safe harbor protects all payments, including volume-based payments, to bona fide employees. The EKRA exception protects payments made to bona fide employees and independent contractors as long as the payment is not based on: 1) the number of individuals referred to a particular recovery home, clinical treatment facility, or laboratory; 2) the number of tests or procedures performed; or 3) the amount billed to or received from a healthcare benefit program from the individuals referred to a particular recovery home, clinical treatment facility, or laboratory. Therefore, a volume-based payment to a bona fide employee of a laboratory, for example, may be protected under the AKS but could be subject to criminal prosecution under EKRA.

It is also important to note that although the SUPPORT Act focuses on substance abuse facilities, the EKRA prohibition on kickbacks for patient referrals to laboratories applies not only to testing for substance abuse, but to all laboratory testing. Anyone in a position to solicit or receive, or pay or offer, any remuneration related to the referral of patients to recovery homes, clinical treatment facilities, or laboratories must ensure compliance with EKRA to avoid possible criminal penalties.

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CMS and ACHC Suspend Certain Survey Inspections

As of March 4, 2020, the Centers for Medicare & Medicaid (CMS) suspended non-emergency inspections of participating healthcare facilities in light of the spread of COVID-19. CMS suspended inspections to allow inspectors to focus on addressing the spread of the coronavirus. State Survey Agencies, Accrediting Organizations, and healthcare facilities are urged to maintain compliance with current CMS requirements and safety standards, specifically infection control procedures. Medicare/Medicaid-certified providers and suppliers are urged to monitor the COVID-19 CDC website and their state public health website and follow recommended guidelines and standards of practice.

The Accreditation Commission for Health Care (ACHC) postponed regular surveys in areas identified by the Centers for Disease Control and Prevention (CDC) as having more than 500 reported cases of COVID-19, as well as areas where residents were ordered to shelter in place by authorities. Limited surveys may be conducted for certain cases, like immediate jeopardy. ACHC has temporarily suspended all deemed recertification surveys for home health, hospice, and renal dialysis facilities. Additionally, ACHC suspended recertification surveys for durable medical equipment providers for 90 days. Postponed surveys will be rescheduled later and accreditation certification dates will be extended. ACHC is conducting some initial certification surveys for providers, when possible.

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Specialist Medical Providers Sue Cigna, Claiming Racketeering and ERISA Violations for OON Underpayments

Twenty-one plaintiffs, consisting of multiple healthcare providers ranging from gynecologists, to vascular specialists, to orthopedic groups, filed suit against Cigna Health and Life Insurance and Connecticut General Life Insurance Company. The case, filed in the U.S. District Court for the District of New Jersey, was brought by the plaintiffs to "…expose Cigna's brazen embezzlement and conversion schemes, through which it maximizes profits by defrauding patients, healthcare providers, and health plans of insurance out of tens of millions of dollars every year." *Advanced Gynecology and Laparoscopy of North Jersey, P.C. et al. v. Cigna Health and Life Insurance et al. Docket No.: 2:19-cv-22234-ES-MAH in the United States District Court for the District of New Jersey, Filed December 31, 2019.* A copy of the complaint may be found here.

Plaintiffs are out of network healthcare providers who provide medically necessary procedures to patients who are covered by the defendants' health insurance benefit plans. Plaintiffs allege the defendant insurers are significantly underpaying them for the medically necessary services they perform, thus committing several defrauding schemes, which include racketeering activities and multiple acts of embezzlement, theft, and unlawful conversion or abstraction of assets of the defendants' ERISA plans. *Id*. Through these alleged schemes, the plaintiffs allege the defendants improperly deprived the plaintiffs and the defendants' ERISA plans of funds and profits by embezzling the amounts alleged to be "discounted" to patients via the claims process. The plaintiffs allege the defendants carried out these alleged schemes via these steps: (1) defendants accepted the plaintiffs' claims at the full billed amount and defendants then requested the same amount from the patient's self-insured health plan; (2) the defendants then hired a repricing company, such as MARS, Multiplan, or Zelis Healthcare, to negotiate a reduced payment amount with the plaintiffs; (3) if a plaintiff refused to negotiate, the defendants would pay the claim at a substantially lower rate; (4) the defendants would then keep the difference between the full billed amount that was removed from the self-insured health plan and the amount that was ultimately paid to the plaintiffs (the "Discount").

The plaintiffs allege that evidence of the above can be seen in the different explanations of benefits (EOBs) that the plaintiffs and their patients would receive for the same procedure. The EOBs misrepresented to patients what their responsibility was for the medical services rendered and at the same time misrepresented to plaintiffs what amounts were not covered. Plaintiffs claim the defendants used the Discount to pay themselves and the repricing companies a "cost containment" administrative fee and, while a claim was being processed, the defendants would take the full billed amount from the self-insured plan and place these funds in an interest-bearing account until the "Discount" could be determined. Defendants profited while the plaintiffs attempted to negotiate sustainable rates for their medical services.

The plaintiffs are seeking damages, as well as the appointment of an independent fiduciary at Cigna's expense, to re-adjudicate all of the relevant claims processed by the insurance company.

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EEOC Sues Yale New Haven Hospital for Ageist Medical Staff Requirements

On February 11, 2020, the federal Equal Employment Opportunity Commission (EEOC) issued a press release in which it announced that the EEOC has sued Yale New Haven Hospital for ageist activities. Around March 2016, the hospital implemented a new policy whereby all physicians, dentists, and podiatrists over the age of 70 would be required to undergo a more thorough evaluation to receive or maintain clinical privileges. Particularly, each doctor over 70 years old would have to undergo both a neuropsychological and eye exam, in addition to satisfying the other requirements imposed upon members of the medical staff.

Due to an affiliation between the hospital and Yale University, all Yale Medical School faculty with appointments in the clinical departments must maintain clinical privileges with the hospital. As of April 2019, 145 individuals were subjected to the additional testing. Most of those tested have passed. Out of those eligible for these additional tests, seven have failed and five have refused testing by resigning or changing status.

In its lawsuit, the EEOC asserts that the doctors who have been subjected to the policy have been stigmatized and singled out. The EEOC further maintains that the policy deprives those 70 and older of both (1) equal opportunity employment by imposing an arbitrary age limit, and (2) the right to enjoy employment free from unlawful medical examinations in violation of the Americans with Disabilities Act. No rulings have been made yet as this case is still in its initial stages.

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STATE UPDATE

NJ COVID-19 Bills and Legislation

COVID-19 Specimen Collection Law – On March 20, 2020, Bill A3854 was enacted providing that, for the duration of the public health emergency declared in connection with COVID-19, all licensed healthcare facilities and clinical laboratories will be authorized to collect specimens for the purposes of testing for COVID-19. In addition, the new law expressly authorizes the Commissioner of Health, during a public health emergency, to waive mandatory staffing ratio requirements for healthcare facilities.

Law Enacted Requiring Insurance Coverage for COVID-19 Testing and Telemedicine – On March 20, 2020, Bill A3843 was enacted requiring health insurance carriers (health, hospital, and medical service corporations, health maintenance organizations, and insurance companies), as well as the state and School Employees' Health Benefits Programs and the State Medicaid program, to provide coverage for expenses incurred in: (1) the testing for COVID-19, provided that a licensed medical practitioner has issued a medical order for that testing; and (2) the delivery of healthcare services through telemedicine or telehealth in accordance with the provisions of the New Jersey telemedicine and telehealth laws. The requirements of the new law remain in effect during the duration of the public health emergency declared in connection with COVID-19.

New Law Addresses COVID-19 Telemedicine Requirements – On March 19, 2020, Bill A3860 was enacted establishing certain requirements to use telemedicine and telehealth to respond to COVID-19. The new law provides that, for the duration of the public health emergency declared in response to COVID-19, any healthcare practitioner will be authorized to provide and bill for services using telemedicine and telehealth, regardless of whether rules and regulations concerning the practice of telemedicine and telehealth have been adopted in New Jersey. The services authorized under the new Law will include the full range of services set forth in the definitions of telemedicine and telehealth under New Jersey law that are appropriate under the standard of care. In addition, the new Law provides that practitioners who are not licensed or certified to practice in New Jersey may provide healthcare services under the bill using telemedicine and telehealth if certain requirements are met.

New Law Enacted to Accelerate Professional and Occupational Licensure – On March 19, 2020, Bill A3862 was enacted permitting the director of the Division of Consumer Affairs in the Department of Law and Public Safety, with the approval of the Attorney General, to expedite the professional and occupational licensing process for out-of-state individuals when the New Jersey Governor has declared a state of emergency. The individual applying for a specific license, certificate of registration, or certification in New Jersey must have a corresponding license, certificate of registration, or certification in good standing from another jurisdiction.

Other NJ Bills

Bill Reintroduced to Revise Aspects of Out-of-Network Arbitration – On February 25, 2020, Bill A3526 was reintroduced in the New Jersey Assembly to revise certain aspects of the out-of-network arbitration process under the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the Act). A Senate version of the Bill was reintroduced on January 14, 2020. The Bill had previously been proposed in November 2018, but had not progressed past the committee level in either the Assembly or the Senate. The Bill removes the requirement that the difference between the carrier's and provider's final offer must be not less than $1,000 for the dispute to proceed to arbitration. The Bill also requires a carrier to pay the provider the billed amount, or pay at least the amount set by the 85th percentile of the FAIR Health Charge Benchmark database for the particular healthcare service performed by a provider in the same or similar specialty and provided in the same geographical area, which will be deemed the carrier's final offer for purposes of the Act.

Bills Reintroduced to Address Tiered Networks – Two Bills addressing tiered health benefits plan networks were recently reintroduced in the New Jersey legislature.

- Bill A3527/S1108, which had initially been proposed in January 2018, was reintroduced in the Senate on January 30, 2020 and the Assembly on February 25, 2020. The Bill amends the Health Care Quality Act by providing that a contract between a participating healthcare provider and a carrier which offers a managed care plan may not contain an "anti-tiering clause" which prohibits or limits a carrier's right to use a tiered-network plan in which healthcare providers are tiered and cost sharing for covered persons is determined by the tier placement of the provider.
- Bill S1944, which had initially been proposed in December 2015, was reintroduced in the Senate on February 25, 2020. The Bill supplements the Health Care Quality Act by requiring health insurance carriers to disclose selection standards for placement of healthcare providers in tiered health benefits plan networks and provides for the appointment of an oversight monitor to

review compliance with the Bill's requirements. In addition, the Bill provides guidelines and details as to how those standards must be calculated.

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Brach Eichler In The News

On March 30, Managing Member and Healthcare Law Chair John D. Fanburg was named to *NJBIZ*' Health Care Power 50, a list of the most influential leaders in healthcare in New Jersey.

John D. Fanburg shared his insight in this *NJBIZ* article about the challenges medical practices face as a result of COVID-19. (See page 6.)

Labor and Employment Chair Matthew M. Collins is quoted in this March 2 article about the issues employers should consider with regard to the use of medical cannabis.

According to *NJBIZ*' list of top law firms in New Jersey, Brach Eichler jumped up two notches to 18th in the state, compared to 20th last year.

HIPAA CORNER

Visit Brach Eichler's COVID-19 Resource Center for recent updates on HIPAA and COVID-19.

Healthcare Provider Pays $100,000 Settlement to OCR for Failing to Implement HIPAA Security Rule Requirements – On March 3rd, the U.S. Department of Health & Human Services (DHHS) issued a press release reporting that a solo provider medical practice has entered into an agreement with the DHHS Office for Civil Rights (OCR) in which it has agreed to pay $100,000 to settle a potential violation of the HIPAA Breach Notification and Privacy Rules. In addition, the practice will be undertaking a corrective action plan that includes two years of monitoring.

Although the practice proactively filed a breach report with OCR relating to a dispute with a business associate involving the blocking of access to the EHR system, the OCR found that the practice failed to implement certain HIPAA Security Rule requirements. OCR found that the practice had never conducted a risk analysis, as required by the HIPAA Security Rule, and failed to complete one after the breach incident. In addition, the practice failed to implement appropriate security measures to reduce risks and vulnerabilities, despite significant technical assistance from the OCR throughout its investigation.

OCR Director, Roger Severino, commented about this situation saying: "All healthcare providers, large and small, need to take their HIPAA obligations seriously. The failure to implement basic HIPAA requirements such as an accurate and thorough risk analysis and risk management plan, continues to be an unacceptable and disturbing trend within the health care industry."

If you would like assistance with your HIPAA privacy and security program, in managing a breach incident, or in business associate analysis and contracting, contact:

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