Medi-Cal Updates

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California Hospital Association
Medi-Cal Updates

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Agenda

• Quality Assurance Fee (QAF) Program
  o Implementation Timing
  o Initiatives and Legislation

• Medi-Cal APR-DRG Payment System
  o Changes Effective July 1
  o System Limitations

• 340B Drug Pricing Program
  o Proposed Omnibus Guidance
  o Pending Litigation
Quality Assurance Fee Program
QAF Program Overview

- Federal Medical Assistance Percentage (FMAP) is 50% in California
  - Varies based on state’s poverty level and unemployment rate
- General fund dollars draw down federal match
- CA in the bottom 10% of spending per capita for Medicaid = $7 billion annual shortfall
• Federal Upper Payment Limit (UPL)
  o Difference between Medicare allowable and Medicaid actual payments

• Federal requirements
  o Broad-based
  o Uniform
  o Doesn’t violate “hold harmless” provisions

• Winners and losers
QAF Program Overview (cont.)

- Private hospitals agree to be taxed by the state to raise non-federal share
- State collects taxes and draws down federal match
- State issues supplemental Medi-Cal fee-for-service (FFS) payment to hospitals
- State issues supplemental Medi-Cal managed care payments to health plans
- Health plans issue supplemental Medi-Cal managed care payments to hospitals
Feb. 2013: SB 239 Introduced

Sept. 2013: SB 239 Amended

Oct. 2013: SB 239 Signed by Governor

March 2014: DHCS Submits QAF FFS and Tax Structure to CMS

July/Aug 2013: QAF Workgroup Convened

2014 – 2016 QAF Implementation
Dec. 2014:
CMS Approves QAF FFS and Tax Structure

June 2015:
CMS Approves Managed Care Non-Expansion Rates for 1/1/14 – 6/30/14

March 2015:
FFS Cycles Begin

March 2016:
CMS Approves Managed Care Expansion Rates for 1/1/14 – 6/30/14

2014 – 2016 QAF Implementation (cont.)
2014 – 2016 QAF Projections

- Medi-Cal managed care rates for years beginning in 2015 must be approved by the CMS Office of the Actuary (OTA)
- Current review time is nine months; CMS is committed to reducing over time
- Non-expansion rates beginning 7/1/15 and expansion rates beginning 1/1/15 are subject to OTA review
July 2016: DHCS Submits Managed Care Non-Expansion and Expansion Rates for 7/1/14 – 6/30/15 to CMS for Review

Oct. 2016: CMS Approves Managed Care Non-Expansion Rates for 7/1/14 – 6/30/15 and Expansion Rates for 7/1/14 – 12/31/14

Dec. 2016: Hospitals Receive Managed Care Non-Expansion Payments for 7/1/14 – 6/30/15 and Expansion Payments for 7/1/14 – 12/31/14

2014 – 2016 QAF Projections (cont.)
2014 – 2016 QAF Projections (cont.)

Feb. 2017: DHCS Submits Managed Care Non-Expansion and Expansion Rates for 7/1/15 – 6/30/16 to CMS for Review

March 2017: CMS Approves Managed Care Expansion Rates for 1/1/15 – 6/30/15

Q3 CY17: CMS Approves Non-Expansion and Expansion Rates for 7/1/15 – 6/30/16
Ballot Initiatives

Two ballot initiatives could have an impact on the QAF program if passed by the voters on Nov. 8
Medi-Cal Funding & Accountability Act

July 2013
- CHA introduced initiative

Dec. 2013
- Initiative qualified for the ballot

Nov. 2016
- A vote of the people

If Passed
- Amends the California Constitution to make the QAF program “permanent”
To understand the initiative, you must understand the current law (SB 239, Hernandez):

- Establishes QAF program
- Prohibits the state from enacting cuts to hospitals’ Medi-Cal payments while a QAF is in place
- QAF must be the maximum size allowed under federal law (right sizes depending on federal laws and state funding availability)
Medi-Cal Funding & Accountability Act (cont.)

- Creates “program periods”:
  - 1/1/14 – 12/31/16
  - 1/1/17 – 6/30/19
  - Future programs no more than three years duration

- Allows up to 24% of the net benefit as a contribution to the state general fund for children’s health coverage

- The statute “sunsets” Jan. 1, 2017
The initiative does the following:

- Removes the sunset date (thereby making the QAF program and all of the provisions “permanent”)

- Establishes rules for how the law can be changed
  - Requires two-thirds vote of the Legislature:
    - Non-substantive amendments
    - Provisions that further the purpose of the QAF to obtain or maintain federal approval
• Zero paid opposition to date

• Polling well in focus groups

• Over 900 members of coalition in support

www.keepagoodideaworking.com
What if the ballot initiative doesn’t pass?

- Budget trailer bill
- Extend sunset date by 12 months
- Reconvene hospital industry stakeholders to discuss next steps
Children’s Education & Healthcare Protection Act

- Current tax on the top 2% of earners is set to expire in 2018 (Proposition 30 from 2012)
- The Act extends the current tax through 2030
- Tax revenue is primarily allocated to:
  - Maintain funding for public schools and colleges
  - Increase funding into the rainy day fund
  - Increase funding to Medi-Cal (90% to hospitals)
Children’s Education & Healthcare Protection Act

- Modeling of the initiative projects approximately $1 billion in new Medi-Cal funding for hospitals
- Unknown how new Medi-Cal funds would be allocated amongst hospitals – methodology would need to be developed
- Reduces the size of the QAF – more general funds allocated to Medi-Cal means less taxes needed to draw down federal matching funds
Medi-Cal APR-DRG Updates
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Medi-Cal APR-DRG Changes Effective July 1

- Statewide ($6,320) or remote rural ($12,832) base rates applied to all hospitals
- Outlier thresholds increased by 4% to $46,801 and $150,801 for high-side tiers and $46,801 for the low-side tier
- Transition to V.33 of the APR-DRG grouper
Remittance Advice Detail (RAD) Code 0314: Recipient not eligible for the month of service billed

- Patient has no coverage upon admission but becomes eligible for Medi-Cal FFS during stay
- “Statement Covers Period” dates limited to the patient’s FFS eligibility dates
- Diagnosis and procedure codes only for treatment provided during FFS eligibility dates
Remittance Advice Detail (RAD) Code 0314: Recipient is not eligible for the month of service billed

- Services and supplies incurred only during patient’s FFS eligibility dates
- Remark statement “DRG claim that previously denied with RAD code 0314” required in box 80
- Delay reason code “10” (> 12 months late) or “11” (<12 months late) required in box 37
- Resubmission required by 10/16/16 to waive timeliness
Unresolved Billing Issues

• Appealed claims drop to paper claims, causing claims with more than 22 lines to process incorrectly

• Claims with charges of $1 million or more cannot be split billed

• If invalid revenue codes are billed, the entire claim is denied
Looking Ahead

- V.34 of Mapper released in September
- Emphasize DRG base payments over outliers
- Re-evaluate policy adjusters
- Detailed study of rehab per diem
- More focus on quality and outcomes, likely potentially preventable readmissions
Medi-Cal APR-DRG Updates (cont.)

- New Benefit Identification Cards
  - Newly-eligible recipients only
  - Recipients requesting replacement cards
340B Drug Pricing Program
Overview

• Requires drug manufacturers to provide outpatient drugs to eligible organizations at significantly reduced prices

• Hospital eligibility: children’s, critical access, sole community, free standing cancer and disproportionate share hospitals

• Proposed Omnibus Guidance issued Aug. 28

• Final guidance expected late 2016
Patient Definition

- Health care services must be provided by a provider who is either employed by the hospital or an independent contractor who the hospital may bill for services on behalf of the provider

- Simply having privileges or credentials at a hospital is not sufficient
Patient Definition

- Drugs must be ordered or prescribed pursuant to a health care service classified as outpatient
  - Discharge drugs for inpatient stays
  - Drugs provided in the emergency or outpatient department prior to admission
- A patient receiving only infusion services would not be an eligible patient
Covered Outpatient Drugs

- Drugs paid under Medi-Cal as part of a bundle are excluded
- Hospitals could no longer categorically classify certain drugs as “covered outpatient drugs” because the status of such drugs will vary by payer
Contract Pharmacy Arrangements

- Hospitals must conduct oversight, including quarterly reviews and annual independent audits of *each* contract pharmacy location
- Any program violation should be disclosed to HRSA, not limited to those that rise to level of being “material”
Exceptions to Group Purchasing Organization (GPO) Prohibition

- An off-site outpatient facility of a 340B hospital which is not participating in the 340B program
- GPO drugs provided to an inpatient whose status is subsequently changed to outpatient by a third party
- Hospitals that cannot access a drug at the 340B price or at wholesale acquisition cost to prevent disruptions in patient care
Background

• AB x 4-5 (2009) added section 14105.46 to the Welfare and Institutions Code

• Prior to section 14105.46, 340B hospitals had the option of purchasing drugs dispensed to Medi-Cal beneficiaries through the 340B program or the open market

• Section 14105.46 requires 340B hospitals to dispense only 340B drugs to Medi-Cal beneficiaries
Background

• Prior to section 14105.46, hospitals who opted to purchase drugs at normal wholesale price could bill their usual and customary charge and be paid per the Medi-Cal fee schedule

• Section 14105.46 requires 340B hospitals to bill the actual acquisition cost of the drug plus a statutorily-set dispensing fee
Impact

• In many cases, 340B hospitals are reimbursed less than non-340B providers for dispensing the same drug to Medi-Cal beneficiaries

• Administratively burdensome for hospitals to bill actual acquisition cost plus dispensing fee due to structure of charge master
Lawsuit

- AHF filed a lawsuit in federal district court in 2009 challenging section 14105.46, stating that it unfairly discriminates against 340B hospitals
- May 2013 district court agreed with AHF and prohibited DHCS from enforcing 14105.46
- DHCS appealed to the Ninth Circuit Court of Appeals
- While the Ninth Circuit is reviewing the appeal, they granted DHCS authority to enforce 14105.46
AIDS Healthcare Foundation (AHF) vs. Department of Health Care Services (cont.)

Lawsuit

• Briefing was completed last month, waiting for Ninth Circuit to schedule oral arguments
• Decision not expected until early 2017
• Although DHCS has authority to enforce 14105.46, they have chosen not to while the appeal is pending
Medi-Cal Litigation Update

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Rate Litigation 2008-2011

• State enacted various Medi-Cal rate cuts in 2008 and 2009 affecting payments from 2008 through 2011
• Cuts affected inpatient hospital non-contract rates, hospital outpatient rates, DP/NF rates and subacute rates
• Generated substantial volume of litigation, resulting in some success
Settlement

- CHA and various other provider and beneficiary organizations have entered into a settlement agreement to resolve the 2008 to 2011 rate litigation
- Approved by the Court on September 22, 2014
- Approved by CMS
- Hospitals given the opportunity to opt out
- A group with separate litigation opted out, most hospitals did not
Settlement (cont.)

- Settlement made permanent preliminary injunctions obtained against some of the rate cuts.
- Settlement prevented DHCS from implementing some of the rate cuts for three-month periods during 2011. Hospitals opting out did not get this benefit.
- Hospitals opting out could and have continued litigation to seek retroactive relief.
- Settlement was consistent with deal CHA struck in 2011 to eliminate inpatient cuts.
## Hospital Rate Cuts

### Outpatient Providers

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<thead>
<tr>
<th>Service</th>
<th>Effective Date</th>
<th>Reduction</th>
<th>Reduction Type</th>
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<tr>
<td>Hospital Departments</td>
<td>7/1/08 - 2/28/09</td>
<td>10%</td>
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</tr>
<tr>
<td></td>
<td>3/1/09 - 4/5/29</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/1/11 - 4/12/11*</td>
<td>1%</td>
<td></td>
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### LTC Providers

<table>
<thead>
<tr>
<th>Service</th>
<th>Effective Date</th>
<th>Reduction</th>
<th>Reduction Type</th>
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</thead>
<tbody>
<tr>
<td>District Part (DP - Level B)</td>
<td>7/1/08 - 2/28/09</td>
<td>10%</td>
<td>Frozen 0809 Rate</td>
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<tr>
<td></td>
<td>3/1/09 - 4/5/09</td>
<td>5%</td>
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<tr>
<td></td>
<td>8/1/09 - 2/23/10</td>
<td>Frozen 0809 Rate (Reduced by 5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3/1/11 - 5/31/11*</td>
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<tr>
<td>DP Subacute</td>
<td>7/1/08 - 2/28/09</td>
<td>10%</td>
<td>Frozen 0809 Rate</td>
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<tr>
<td></td>
<td>3/1/09 - 4/5/09</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8/1/09 - 2/23/10</td>
<td>Frozen 0809 Rate</td>
<td></td>
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**Notes:**
For dates not specifically listed, provider payment for that category is not subject to a reduction.
* Applied only to hospitals that opt out of settlement.
### Hospital Rate Cuts (cont.)

<table>
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<tr>
<th>Service</th>
<th>Effective Date</th>
<th>Reduction</th>
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</thead>
<tbody>
<tr>
<td>Non-Contract Hospitals (17 in Santa Rosa)</td>
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<tr>
<td></td>
<td>10/1/08 - 4/5/09</td>
<td>Lesser of 10% or average CMAC rate Minus 5%</td>
</tr>
<tr>
<td></td>
<td>4/6/09 - 11/17/09</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>1/1/11 - 4/12/11</td>
<td>Lesser of 10% or average CMAC rate Minus 5%</td>
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<tr>
<td>Non-Contract Hospitals (all others not contained in other categories)</td>
<td>7/1/08 - 9/30/08</td>
<td>10%</td>
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<tr>
<td></td>
<td>10/1/08 - 4/5/09</td>
<td>Lesser of 10% or average CMAC rate Minus 5%</td>
</tr>
<tr>
<td></td>
<td>4/6/09 – 4/12/11</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>1/1/11 - 4/12/11*</td>
<td>Lesser of 10% or average CMAC rate Minus 5%</td>
</tr>
<tr>
<td>Non-Contract Small &amp; Rural (Critical Access Hospitals &amp; Federal Rural Referral Centers)</td>
<td>7/1/08 - 10/31/08</td>
<td>10%</td>
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<tr>
<td>Non-Contract Small &amp; Rural Hospitals (non-CAH, non-Fed RRC)</td>
<td>7/1/08 - 10/31/08</td>
<td>10%</td>
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<tr>
<td></td>
<td>7/1/09 - 2/23/10</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>1/1/11 - 4/12/11*</td>
<td>10%</td>
</tr>
<tr>
<td>Non-Contract Hospitals in Open Areas with ≤ 2 Hospitals</td>
<td>7/1/08 - 4/12/11</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Notes:**
- For dates not specifically listed, provider payment for that category is not subject to a reduction.
- *Applies only to hospitals that opt out of the Settlement.
Reduced rates for many providers by 10% effective June 1, 2011

Limited DP/NF rates to those in 2008-09 rate year less 10% beginning June 1, 2011

About a 23-25% reduction

Eliminated for rural or frontier DP/NFs September 1, 2013

Eliminated for all other DP/NFs October 1, 2013
• CHA sued and obtained preliminary injunction against DP/NF rate cuts
• Ninth Circuit reverses in May 2013 and vacates injunction
• Supreme Court declines review
• State notifies hospitals it will “claw back” DP/NF cuts stopped by preliminary injunction retroactive to June 2011
• After several years of intensive advocacy by CHA and affected facilities, Legislature eliminates the clawback (Section 14 of AB 1, signed March 1, 2016)
• Saves DP/NFs estimated $240 million
Future of Medi-Cal Hospital Rate Litigation

- Shift of Medi-Cal to managed care
  - Most provider disputes will be directly with the plans
    - Contract disputes
    - Payments for out-of-network services
  - Any disputes with DHCS over rates likely between the plans and DHCS
Future of Medi-Cal Hospital Rate Litigation (cont.)

- On the fee-for-service side, Medi-Cal pays hospitals at the federal upper payment limit due to the HQAF program—making litigation unlikely.
- Legal climate is more difficult:
  - Adverse Supreme Court case on ability of providers to sue
  - Adverse state and federal cases on meaning of key provision of the Medicaid Act and deference to CMS approvals
- Given the right facts, arbitrary rate cuts and impact on access and quality, litigation is still potentially viable. Most likely will see it for non-hospital providers.
Medi-Cal EHR Incentive Payment Audits
Medi-Cal EHR Incentive Payment Audits

- Hospital-specific data used in determining the EHR incentive payments
  - Total discharges
  - Medicaid inpatient days
  - Total inpatient days
  - Charges
  - Charity care
Medi-Cal EHR Incentive Payment Audits (cont.)

- Key factors are the discharges and the “Medicaid Share”
  - As discharges exceed 1,150 and 23,000 for a base year, so does the overall payment amount
  - Discharges can also affect the annual average growth rate, which is usually based on historical data
Medicaid Share

• Ratio, for 12-month period of (a) “estimated number of acute-care inpatient bed days” attributable to Medicaid fee-for-service and managed care individuals to (b) product of (i) estimated number of acute-care inpatient bed days for all payors and (ii) the estimated total amount the hospital’s eligible charges divided the hospital’s estimated total charges

\[(\text{Medi-Cal inpatient days/Total inpatient days}) \times (\text{Total hospital charges/eligible hospital charges})\]

• Higher Medicaid share means higher EHR incentive payments
Audits

- OIG is auditing states’ MU incentive payments, including California
- Hospitals are being made aware of hospital-specific OIG audit findings
- OIG audits are not consistent with DHCS reporting instructions
- Also, if OIG “corrects” data on audit, there is a question of whether this should have any effect on a specific provider since data was to be “estimates” submitted with the attestation without provision for audits and reconciliation
DHCS Audits

- DHCS is conducting its own audits
- Hospitals may have no findings from DHCS but have findings from the OIG
Final MCO Rule — Payments to Providers
Clarification on Plan Spending
(42 C.F.R. § 438.6)

State may only direct plan’s expenditures for:

• Adoption of a minimum or maximum fee schedule for particular services
• Provide a uniform increase for providers of particular services
• Value-based purchasing models such as P4P or bundled payments
• Participation in a multi-payer delivery system reform or performance improvement initiative
Class of Providers

• Can direct minimum payments, provide a uniform increase, provide value-based purchasing method, delivery system reform separately by class or provider, such as:
  o Public hospitals
  o Teaching hospitals
  o “Other classifications of providers”
“Minimum Fee Schedule” or “Uniform Increase” Approval

Methodology must be submitted to and approved by CMS:

- Must be based on the utilization and delivery of services;
- Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract;
- Expects to advance at least one of the goals and objectives in the quality strategy in § 438.340;
- Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy plan;
- Does not condition network provider participation in contract arrangements on the network provider entering into or adhering to intergovernmental transfer agreements; and
- May not be renewed automatically.
Additional Criteria for Approval of VBP or Delivery System Reform

• Contract arrangements must also demonstrate the arrangement:
  o Must make participation available, using the same terms of performance, to a class of providers providing services under the contract related to the reform or improvement initiative;
  o Must use a common set of performance measures across all of the payers and providers;
  o May not set the amount or frequency of the expenditures; and
  o Does not allow the State to recoup any unspent funds from the MCO, PIHP, or PAHP.
Pass-Through Payment Transition

Defines “pass-through” payments as any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for:

- Specific service or benefit provided to a specific enrollee
- Permitted provider payment methodology previously discussed
- A subcapitated payment arrangement for specific set of services and enrollees
- GME payments
- FQHC/RHC wraparound payments
Pass-Through Payment Transition: Hospitals

- Pass-through payments permitted, but phased out over 10-years beginning with contracts starting on or after July 1, 2017
- Maximum pass-through payments for each year equal to a percentage of a “base amount;” starts at 100% and decreases by 10% each year
- Base amount based on aggregate difference between the amount Medicare FFS would have paid for those hospital services for 12-month period two years prior to the rating period and the amount the plans would have paid without pass-through payments
HQAF Program and CHOWs
The Statute

• A “new hospital” does not receive supplemental payments and does not pay the QAF fee
• A new hospital is a hospital that does not have a “days data source”, or has a “days data source” from a prior owner, but does not agree to be financially responsible for the prior owner’s outstanding Medi-Cal obligations
The Statute (cont.)

• Days data source is the OSHPD financial disclosure report used to determine the QAF fee
• Currently, it is the OSHPD report for the hospital’s fiscal year ending during calendar year 2010
• Statute requires DHCS to develop a process for new owners to agree to be financially responsible for prior owner’s Medi-Cal obligations
• DHCS issues bulletin on August 26, 2014 establishing process for new owner to agree to financial responsibility
• Required at least 60 days notice to DHCS prior to the CHOW
• Required new owner to submit a Public Records Act request regarding old owner’s Medi-Cal obligations at least 60 days prior to the CHOW
• Required new owner to enter into a “Financial Responsibility Agreement” with DHCS
May 13, 2016 Bulletin

• DHCS issues new bulletin on May 13, 2016
• Supersedes prior bulletin
• Very important to any hospital that has undergone a change of ownership since its fiscal year ending in 2010 or to any new change of ownership
• Establishes separate processes to avoid becoming a new hospital and to be treated as a new hospital
• Eliminates 60-day prior notice and PRA request requirements to assuming financial responsibility for prior owner’s Medi-Cal obligations
• Must submit a complete and correct signed Financial Responsibility Agreement to DHCS within 30 days of date of letter from DHCS notifying new owner of Medi-Cal certification
• Failure to timely submit a financial responsibility agreement
  o HQAF payments will be made only for periods beginning the day a complete and correct agreement is submitted
  o New owner will still be liable for the QAF fees beginning when the CHOW is effective
• If your hospital has undergone a CHOW on or after the prior owner’s fiscal year ending in 2010 and the current owner participates in the QAF program the current owner has until September 30, 2016 to submit a complete and correct financial responsibility agreement

• Failure to do so may result in recoupment and cessation of QAF supplemental payments, but hospital will still be liable for the QAF fees
Hospitals that are using a days data source in the current HQAF Program from a prior owner and have not submitted a financial responsibility agreement to DHCS have until September 30, 2016 to do so to avoid being treated as a new hospital and putting QAF supplemental payments at risk of being recouped for the entire current program — January 1, 2014 through December 31, 2016
• Non-Assumption Attestation
  ◦ A hospital undergoes a CHOW and wants to be a “new hospital” under the HQAF program, must submit to DHCS an attestation signed by the CEO under penalty of perjury that the hospital meets the statutory requirements to be a new hospital, along with other material
  ◦ Due 30 days after the date of letter notifying new owner of Medi-Cal certification
New hospital will not have to pay the QAF fees and will not receive QAF supplemental payments.

New owner will be liable for fees and not receive supplemental payments if complete, correct and acceptable attestation is not submitted timely until one is submitted.
• One-time ability to submit attestation on or before September 30, 2016
• Any hospital that wants to be treated as a new hospital and not pay the QAF fees for the current QAF program must submit an attestation to DHCS by September 30, 2016
• Otherwise, the hospital will be liable for the QAF fees regardless of whether it has received or may retain the QAF supplemental payments
• Submission of the Attestation is effective only for the current QAF program period, through December 31, 2016
• There presumably will be a new bulletin describing the process for being considered a new hospital for the next program period
May 13, 2016 Bulletin — Last Thought

If your hospital has undergone a CHOW in 2010 or later you should carefully review the May 13, 2016 bulletin and probably must take an action described in that bulletin to avoid adverse and unforeseen consequences.
UHS v. Escobar

• Important False Claims Act (FCA) case
• Issued June 16, 2016
• Upholds “implied certification” theory of liability under the FCA
• Imposes Materiality Constraints
• Unanimous decision
Factual Allegations

• Teenage Medicaid beneficiary, Ms. Rivera, treated by an outpatient mental health facility for five years
• Diagnosed with bipolar disorder
• Adverse reaction to drugs prescribed by the facility’s personnel
• Suffered a seizure and was hospitalized
• Suffered a second seizure and died
Factual Allegations

- Only one of five professionals who treated the patient was properly licensed
- Person who diagnosed Ms. Rivera as bipolar identified herself as a Ph.D. psychologist, but failed to mention that degree came from an unaccredited internet college and that Massachusetts had rejected her license application
- Practitioner who prescribed medication was held out as a psychiatrist, but was a nurse without authority to prescribe absent supervision
- 23 facility employees lacked licenses but counseled patients and prescribed drugs without supervision
Allegations

• Massachusetts determined that facility violated more than a dozen state Medicaid regulations governing staff qualifications and supervision
• Facility agreed to a corrective action plan
Medicaid Billing — Allegations

- Facility billed Medicaid for the services
- Used billing codes for individual and family therapy
- Staff member misrepresented qualifications and licensing status to the federal government to obtain national provider identifiers (NPIs)
Qui Tam Filing

• Plaintiffs file a whistleblower lawsuit alleging submission of false claims to Medicaid
• Allege state requires facilities to have specific type of clinicians on staff with particular licensing requirements, but that the facility violated these requirements
• Allege facilities submitted Medicaid claims without advising state of licensing violations
• Allege that state would not have paid if aware of violations
• US declines to intervene
Implied Certification

- Supreme Court holds that the omission in submitting a claim of statutory, regulatory, or contractual violations can be a basis for FCA liability if they render the claimant’s “representations misleading with respect to the goods or service provided”
- Does not have to be an express misrepresentation for liability
- Statute, regulation, or contractual provision violated does not have to be an express condition of payment to be a basis for liability
Implied Certification (cont.)

• Implied Certification can be a basis for liability where:
  • The claim makes specific representations about the good or service provided
  • The defendant fails to disclose noncompliance with material statutory, regulatory, or contractual requirements which makes the representations half-truths
Misrepresentations

- Held that by submitting claims with codes for specific services without complying with the law it had misrepresented the services.
- Held that submitting claim using NPIs corresponding to specific job titles were clearly misleading in context.
Materiality

- Misrepresentation must be “material” for FCA liability
- Does not clearly define materiality in the FCA context
- Appears to mean whether omission would have affected the government’s payment determination
Materiality (cont.)

- Not sufficient that government designates compliance with a provision as a condition of payment or that the government would have the option to declined to pay if it knew of the noncompliance
- Not material if noncompliance is minor or insubstantial
Materiality (cont.)

- Government’s designation of a provision as a condition of payment is relevant, but not dispositive
- Proof of materiality can include evidence that the Government consistently failed to pay claims based on noncompliance
- Proof of immateriality where government has paid a particular claim despite knowledge of noncompliance or regularly pays a type of claim despite actual knowledge of noncompliance
Questions?
Thank you

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