THREE KEY THINGS IN HEALTH CARE

HUNTON ANDREWS KURTH

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- **As healthcare businesses struggle to deal with the unprecedented challenge of COVID-19, another problem looms large—increased union organizing.**
  - Experts predict a surge in organizing activity as unions look to capitalize on the vulnerabilities the pandemic has exposed in some businesses.
  - This risk is especially acute in the healthcare industry, where many essential workers are being asked to risk their own health every day by treating infected patients. Some employees are wearing down—they are tired, frustrated, and above all, scared.
  - Unions are watching. They are seeking to fill the void through promises of a safer workplace, more pay, and a voice at the negotiating table. Now more than ever, healthcare businesses must be watchful and proactive in their union response strategy.
  - **Key takeaways:** Every healthcare business should be doing three things right now:
    - Talk to your Employees. A good employee engagement strategy is critical to maintaining positive relations and understanding the pulse of your workforce.
    - Identify and Mitigate Vulnerabilities. Businesses should be conducting regular assessments to identify particularly "at risk" locations and/or disaffected employee populations. It's too late to fix problems once a union files a petition to represent a group of your employees.
    - Have a Plan. Businesses should have a well-defined plan for responding to a union organizing campaign, including when a union seeks an election from the NLRB. Things move fast during a union election campaign, and employers that are prepared in advance typically fare better.

  It has been extraordinarily difficult for essential businesses to focus on anything other than pandemic response. Unions know this, and they are seeking to leverage the business community's distraction. Healthcare businesses are in the crosshairs, and need to react accordingly.

- **There is much confusion over the CARES Act requirement that providers submit quarterly reports regarding Provider Relief Fund (PRF) payments.**
  - Section 15011(b)(1) of the CARES Act[1] establishes a quarterly reporting requirement applicable to any "entity receiving more than $150,000 total in funds" under the various relief acts enacted by Congress.
  - Reports are due "[n]ot later than 10 days after the end of each calendar quarter," and must include (among other things) "the amount of funds received that were expended or obligated for []each project or activity," "a detailed list of all projects or activities for which large [sic] covered funds were expended or obligated," and jobs information.
  - The reporting requirement is reiterated in the Terms and Conditions for all eleven categories of PRF payments (available here), as well as an FAQ published May 6 that noted the reporting obligation "begins for the calendar quarter ending June 30."

[1] The Coronavirus Aid, Relief, and Economics Security Act (P.L. 116-136).

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- The May 6 FAQ disappeared on June 13. The replacement FAQ asks "*What do providers need to do in order to be in compliance with this [quarterly reporting] provision in the Terms and Conditions?*" The response seems to be "nothing," but there is scant support for that position.
  - HHS apparently is now relying on OMB Memo M-20-21 in an attempt to waive the recipient reporting obligation.
  - The OMB memo states that "[t]his guidance allows agencies and recipients to meet the CARES Act reporting requirements by utilizing, with minimal modifications, existing reporting requirements . . . . OMB does not expect that additional reporting by agencies or recipients should be necessary to meet the requirements of these sections of the statute."
  - Accordingly, HHS states in its FAQ response that "[r]ecipients of [PRF] payments do not need to submit a separate quarterly report" and that "HHS will develop a report containing all information necessary for recipients of [PRF] payments to comply with the reporting requirement."
  - How HHS will obtain "a detailed list of all projects or activities for which . . . funds were expended or obligated" by each provider is unknown.
  - Notwithstanding its stance on quarterly reporting, the replacement FAQ reflects that HHS intends to exercise its authority to impose reporting requirements apart from the quarterly reports ("HHS will be requiring recipients to submit future reports relating to the recipient's use of its PRF money. HHS will notify recipients of the content and due date(s) of such reports in the coming weeks").
- **Key takeaway:** By its terms, the statutory reporting requirement applies to the quarter ending June 30. The FAQs do not give any guidance to providers subject to the requirement, and HHS seems to think quarterly reports need not be submitted. Providers must watch carefully for further guidance on this issue. In the meantime, providers can proceed by gathering the required information so a quarterly report can be made if the requirement is revived.

- **Recent trends in Stark Law settlements are concerning, but anticipated final CMS Stark regulations provide reasons for optimism.**
  - Last year's Third Circuit decision in *United States ex rel. Bookwalter v. University of Pittsburgh Medical Center* was a poignant reminder of the ongoing risk that health systems face from qui tam actions under the False Claims Act (FCA) premised on violations of the Stark Law.
  - The continuing lack of clarity around the interpretation of certain Stark Law provisions, such as "taking into account the volume or value of referrals" (at issue in *Bookwalter*), leaves providers susceptible to unpredictable and potentially severe outcomes in litigation where qui tam relators seek to construe such provisions in a manner that implicates arrangements that were otherwise thought to be compliant.
  - The number and dollar amounts of Stark Law related FCA settlements have trended upwards since 2010, and while the last three years have seen lower amounts than the height of 2014-2015, the amount of settlements generally do not appear to be subsiding (with an average of $120 to $160 million per year for the past three years).
  - Some of this may be attributable to the increased success of qui tam relators in cases where DOJ has declined intervention – these historically accounted for less than 3% of total qui tam

settlement recoveries but have accounted for over 10% of total recoveries in the past three years.

- In contrast, there has been a positive trend in the amount of Stark Law Self-Referral Disclosure Protocol (SRDP) settlements, which have been steadily been decreasing from a height of 103 settlements in 2016 down to only 17 settlements in 2019.
- A potential significant contributor to this decrease in SRDP settlements was the November 16, 2015 Final Rule where CMS provided specific guidance that expanded the scope of documents that could be considered to meet the “written arrangement” requirement under various Stark Law exceptions.
- The October 17, 2019 Proposed Rule published by CMS to update and clarify the Stark Law regulations included some much-welcomed proposals to clarify certain ambiguities and misinterpretations by courts and others related to certain key provisions – including the “taking into account the volume or value of referrals” provision which was at issue in the *Bookwalter* case.
- **Key takeaway:** Health care systems continue to face significant risk and uncertainty with respect to qui tam actions seeking to capitalize on ambiguities or misinterpretations of the Stark Law. However, there is cause for optimism that this trend may begin to reverse if CMS finalizes much-needed clarifications addressed in its October 17, 2019 Proposed Rule.

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