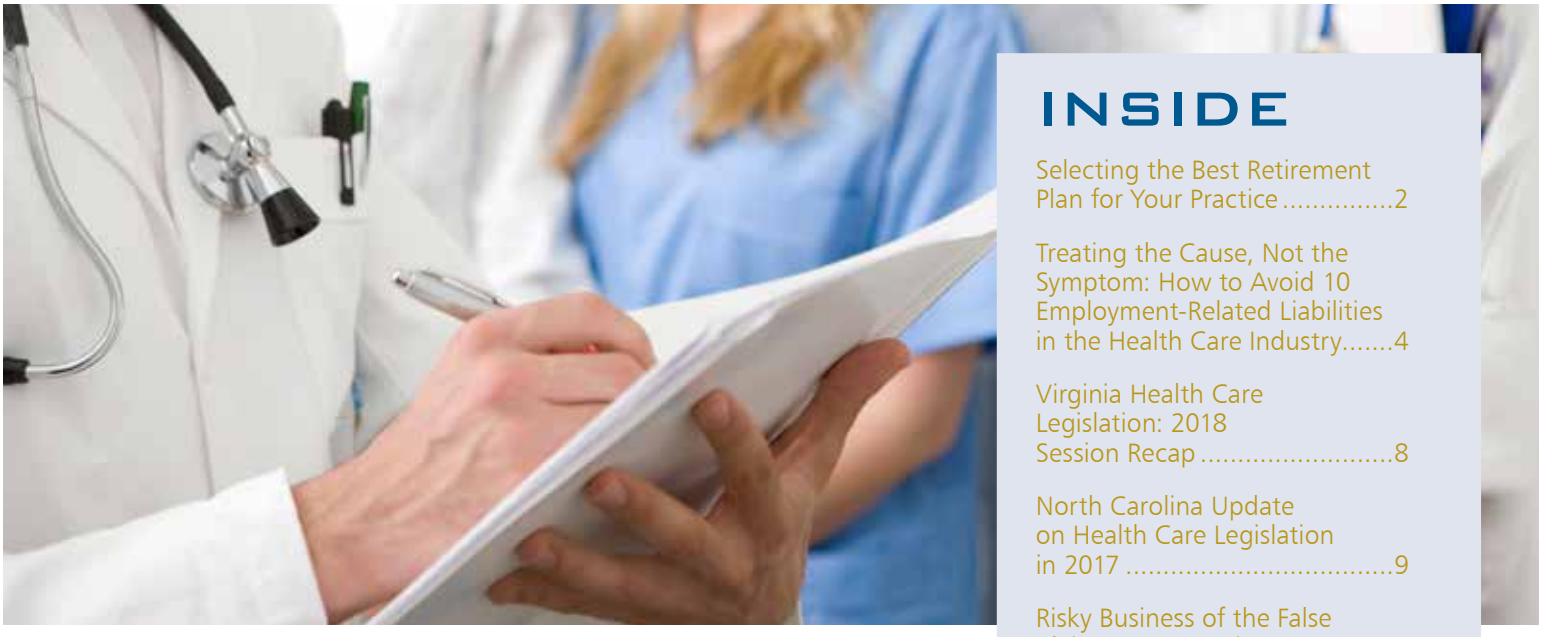
MAY 2018

WILLIAMS MULLEN ON CALL



INSIDE

Welcome to the fourth edition of *Williams Mullen On Call*. In this edition, we are pleased to provide timely interviews with two federally qualified health center (FQHC) executives -- Vincent A. Keane, the president and CEO of Unity Health Care in Washington D.C., and William Crumpton, the CEO of Caswell Family Medical Center in rural North Carolina. Mr. Keane and Mr. Crumpton discuss their organizations' mission in serving patients in their respective communities, as well as the various challenges and opportunities facing FQHCs in 2018.

Several of our team members also contributed informative articles for this edition. Ellie Clendenin presents an overview of retirement plan options for professional practices; Amanda Weaver and Aaron Siegrist explain how to avoid 10 employment-related liabilities in the health care industry workplace; Matt Cobb and Rick Zechini provide health care legislative updates for Virginia and North Carolina, respectively; and Tony Anikeeff goes in-depth on False Claims Act developments.

We invite you to let us know your thoughts about this publication and to identify any additional issues of interest to you. Thank you for joining us for this edition, and we look forward to presenting you with what we hope you will find to be insightful and practical information for years to come.

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SELECTING THE BEST RETIREMENT PLAN FOR YOUR PRACTICE

By Elinor H. Clendenin

An independent physician practice that does not have access to a hospital's retirement plans has several retirement plan options to consider. Doctors who are employed by hospitals will usually be able to participate in the hospital's retirement plan that is either an Internal Revenue Code (IRC) section 403(b) plan (if a nonprofit or governmental entity) or an IRC section 401(k) plan that allows employees to make pre-tax or Roth contributions. These plans will generally have some type of employer contribution either through a matching contribution or an employer contribution. Independent physician practices should also consider implementing a retirement plan for their owners and employees to help maximize retirement savings and lower taxable income. Below is an outline of plans that may be provided.

SIMPLE IRA

A small practice with under 100 employees may consider setting up a SIMPLE IRA. These plans are very simple to set up and involve little administrative oversight.

The SIMPLE IRA allows the employer to contribute to IRAs set up for employees and selected by the employer. Employees may contribute up to $12,500 to the IRA in 2018. The employer must contribute to all employees at least a 2% nonelective contribution or a 3% matching contribution. There is no nondiscrimination testing required, meaning that highly compensated employees would not be limited in their ability to defer pre-tax contributions as may occur with IRC section 401(k) plans.

Eligibility may be limited to employees with two years of service, with a year of service granted to an employee with $5,000 in earnings. There are no annual filings required. The downside to this plan is that the contribution limit is lower than a 401(k) plan, and an employer contribution must be made to all employees.

401(K) PLAN

Perhaps the most well-known retirement plan is the 401(k) plan. Employees may defer up to $18,500 in 2018 plus $6,000 in catch-up contributions for employees who will be age 50 or older in 2018. The plan may be set up to allow employees to defer on a pre-tax basis or an after-tax basis known as Roth contributions.

An employer may choose to give an employer contribution either as a match or an employer profit-sharing contribution, but such contribution is not required. There is flexibility in the amount of the contribution, as it may change by year. Different groups of employees may receive varying employer contributions, though this design must pass nondiscrimination testing for treatment of non-highly compensated employees.

An owner of the practice group may contribute up to $55,000 a year for 2018 to his or her account as deferrals and the profit-sharing contribution. The contribution is tax-deductible to the owners of the practice as the employer.

Service for eligibility is based on hours rather than wages, and an employer may require that the employee complete 1,000 hours of service and be employed on the last day of the plan year to receive an employer contribution.

401(k) plans require more administrative oversight and expense than SIMPLE IRAs. Nondiscrimination testing and annual filings with the Department of Labor ("DOL") are required. High wage earners and owners may also be limited in their deferrals if non-highly compensated employees are not deferring enough. There are ways to avoid this problem, including adopting a safe harbor

contribution or adding automatic enrollment. There is also greater fiduciary liability for those overseeing a 401(k) plan, as they are responsible for selecting and maintaining investment options for the plan.

DEFINED BENEFIT PLANS

In recent years these plans have decreased in popularity due to strict funding requirements and expensive administration, but they provide for a high level of retirement savings and a guaranteed benefit. Under a defined benefit plan, the benefit is determined as a monthly amount payable at retirement age. The maximum annual benefit for an individual for 2018 is $220,000.

An employer must make an annual contribution to the plan. The limit on these contributions is higher than the $55,000 limit for 401(k) plans, allowing practice owners to save more for retirement. The owners of the practice will receive a tax deduction for the employer contributions to the plan. Employees are not able to direct their investments, and the funds are placed in a group trust to be managed by the employer.

These plans are expensive to maintain as the employer must hire an actuary to calculate the required funding amount for benefits and pay annual insurance premiums to the Pension Benefit Guaranty Corporation. An annual filing with the DOL is required. This plan may be offered along with a 401(k) plan.

CASH BALANCE PLAN

These hybrid plans are growing more popular with professional groups, including physician groups, because they allow for a large contribution amount. The plan

is a defined benefit plan but has individual accounts like a 401(k) plan described above. Similar to a defined benefit plan, participants are promised a certain amount at retirement age, which is stated as an account balance, but participants may not direct the investment of their accounts. The annual retirement benefit may be set as a flat dollar amount or a percentage of pay.

The employer makes an annual contribution. As with the defined benefit plan, the annual contributions can be substantially more than the $55,000 limit applicable to a 401(k) plan. The owners of a practice may work with an actuary to determine the annual contributions needed over an owner's working years to hit the maximum yearly benefit of $220,000 payable at normal retirement age over the participant's life. This will generally benefit employees who are closer to retirement, as they may make larger contributions over a condensed period. As with the plans discussed above, the owners may receive a tax deduction for the contributions to the plan.

The plan grows each year by being credited with interest credits. The interest rate must be a market rate of return, such as the 30-year Treasury bond rate or the rate of return on the assets of the plan. There are no employee contributions.

CONCLUSION

There are a variety of options available to independent professional practices to assist their owners and employees in preparing for retirement. If you have any questions regarding this article or establishing a plan, contact **Ellie Clendenin at eclendenin@williamsmullen.com or 804.420.6469.**

TREATING THE CAUSE, NOT THE SYMPTOM: HOW TO AVOID 10 EMPLOYMENT-RELATED LIABILITIES IN THE HEALTH CARE INDUSTRY

By Amanda M. Weaver & Aaron D. Siegrist

Companies of all shapes and sizes continually grapple with how to foster and maintain a productive, respectful work environment. Part and parcel of this objective is ensuring that the workplace complies with the various federal and state statutes that govern, among other things, how employees must be treated, how much they must be paid and how their complaints must be addressed. These laws often have particular implications for certain industries, and health care is no exception. In this article, we identify 10 employment-related concerns health care providers should be aware of, and how health care employers can minimize their risk of non-compliance.

DISABILITY ACCOMMODATION

The Americans with Disabilities Act of 1990 (ADA) is a watershed civil rights law that prohibits discrimination based on disability. Under the ADA, employers must provide reasonable accommodations to qualified employees with disabilities, unless doing so would pose an undue hardship. This includes providing on-the-job-accommodations (e.g. making facilities accessible, installing telecommunications for the deaf and allowing a training exam to be taken orally), as well as reasonable amounts of unpaid leave related to a disability. Failure to provide such an accommodation or failure to engage in an interactive process before denying an accommodation can expose an employer to liability. Supervisors should be aware of the obligation to provide reasonable accommodations and inform Human Resources (HR) if they believe an employee may need one. The maxim "better-safe-than-sorry" applies here. If, for example, an employee is frequently tardy but makes a comment to his or her supervisor that the tardiness may be related to a disability or health condition, the supervisor should inform HR, and HR should engage with the employee to determine if he or she needs an accommodation and, if so, if a reasonable and effective accommodation is available.

INTERACTION BETWEEN THE ADA AND FMLA

The Family and Medical Leave Act of 1993 (FMLA) requires certain employers to provide employees with up to 12 weeks of unpaid leave per year for qualified medical and family reasons, including pregnancy, adoption, personal or family illness. Some employers have what are known as "automatic termination" policies, providing for termination if an employee is not medically able to return to work at the end of this time period. These policies have

come under scrutiny and have been held to violate the ADA. The reason is that unpaid leave of a reasonably finite duration has been held to be a "reasonable accommodation" under the ADA, even if the leave is longer than 12 weeks (in some instances, up to a year or more). Whether an employee is entitled to such additional leave should be determined on an "individualized basis," based on factors such as the duration of the additional requested leave and whether the employee is reasonably expected to be able to perform the essential duties of his or her position at the conclusion of the additional leave. Any policy that provides for automatic termination after a set time period is, by definition, not individualized. Employers should, therefore, avoid such policies.

MISCLASSIFICATION OF EMPLOYEES AS "EXEMPT" UNDER THE FLSA

The Fair Labor Standards Act (FLSA) establishes a minimum wage, overtime pay and other standards for private sector and government employees. Employees are generally entitled to minimum wage for every hour worked and overtime pay for any time worked over 40 hours in a single workweek, unless one of the specific, enumerated exemptions to the FLSA applies. A common misconception among employers is that simply paying an employee on a salary basis makes them exempt. That is not the case. With few exceptions, to be exempt an employee must (a) be paid at least $23,600 per year ($455 per week), (b) be paid on a salary basis and (c) perform exempt job duties, which are enumerated in certain FLSA regulations. Typically, only employees functioning at a high level and with a significant amount of independent discretion will qualify for these exemptions.

Significantly, the FLSA also exempts certain health care professionals, regardless of how much they are paid or whether they are paid on a salary basis. Under this exemption, the employee must hold a valid license or certificate permitting the practice of medicine and actually be engaged in that practice. This would include physicians, surgeons and certain nursing professionals. For all other employees, employers must be careful to ensure that the employee meets the duties test for at least one exemption before treating the employee as exempt.

WAGE AND HOUR CLAIMS GENERALLY

As a corollary to the preceding section, employers should ensure that nonexempt employees are accurately reporting their time and being paid for all time worked. Work performed during breaks, checking emails at home, etc., can add up and expose the employer to liability for unpaid wages and overtime. Failing to pay such wages and overtime exposes an employer to liability, including the possibility of a class action. Lawsuits on this basis are common, and the subject of much commentary (for reference, see "Can You Sue the Boss for Making You Answer Late-Night Email?," published by the Wall Street Journal a few years ago). In order to avoid liability, employers should have clear policies for clocking in and out, reporting any requests to work off the clock and prohibiting off the clock work, such as unauthorized work from home.

SEXUAL HARASSMENT

In the climate of the #MeToo movement, employers face heightened pressure to respond swiftly (and strongly) to harassment complaints. Employers must ensure that they have in place a well-defined and easily understood process for employees to report harassment, and that this process is communicated to all employees. In addition, managers must know how to respond to receiving such reports or complaints and how to escalate a complaint to initiate an investigation. Finally, employers must ensure that their investigations and remedial actions are fair, appropriate and don't expose the employer to unexpected liability (for example, if an employer publicizes that an employee harassed someone and that turns out to be false, that could lead to a defamation claim). One proactive step employers can take is to conduct company-wide sexual harassment training. As the adage goes, an ounce of prevention is worth a pound of cure.

SOCIAL MEDIA POLICIES

Many employers have policies governing how their employees may use social media. These policies have come under scrutiny, and to the extent they attempt to prohibit employees from engaging in certain online conduct, some have been found unlawful under the National Labor Relations Act (NLRA). The NLRA protects employees' right to discuss the terms and conditions of their employment (including, but not limited to, wages, working conditions, safety issues, etc.) with co-workers, whether or not the employer is unionized. This includes discussions about working conditions using social media, such as an employee's Facebook post that is "liked" by other employees. The key question is whether a reasonable employee could interpret the social media policy as discouraging such activities. For example, a policy that prohibits

employees from disparaging their employer or their co-workers on social media would likely be held to violate the NLRA. Social media, and how it is used, is constantly evolving, and employers should regularly review the language of these policies to make sure they are keeping up. Employers should also be cautious when disciplining employees for social media conduct. Employers are advised to seek legal counsel in both endeavors.

INDEPENDENT CONTRACTOR MISCLASSIFICATION

Employee misclassification generates substantial losses to federal and state governments in the form of lower tax revenues and results in employees not receiving benefits to which they are entitled by law. As a result, the federal Department of Labor, IRS and certain state agencies have all increased enforcement efforts to weed out employees improperly classified as independent contractors. A common misconception is that paying a person as a "Form 1099" (the IRS tax form used to report payments to independent contractors) automatically makes that person an independent contractor for tax, wage or other purposes. To the contrary, whether an employee is an independent contractor is governed by the nature of the relationship in practice. Generally, independent contractors are individuals who are economically independent, operate their own businesses, are hired to perform a specific task and control how they perform it. For example, an individual who operates his or her own software design business and is hired by a physician group to design a new database, and who will stop working once that task is completed, is an independent contractor. By contrast, an individual who performs the same tasks as W-2 employees, but who works on a part-time basis or as a "consultant," is almost certainly an employee. Misclassification can expose an employer to liability for unpaid wages and overtime, unpaid payroll taxes and unpaid income taxes. Because the liability can be significant, employers are encouraged to consult legal counsel to assist in determining whether to treat an individual as an independent contractor.

BACKGROUND CHECKS

Understandably, many employers choose to consider criminal history and other background information when making employment decisions, such as hiring, retention, promotion and reassignment. This is especially true in the health care industry, where so-called "barrier crimes" can preclude employment in certain practice areas, and where employees are tasked with caring for patients and interacting with sensitive personal information on a daily basis. Except for certain restrictions on medical and genetic information, employers may generally run background checks on employees and applicants. There are, however, strict requirements under the federal Fair Credit Reporting Act (FCRA) related to any employer background check conducted through a third-party reporting agency. The FCRA mandates a very specific procedure for obtaining authorization prior to running the background check, for notifying the employee or applicant before and after making any adverse decision based on background information, and for making certain certifications to the third-party reporting agencies. Employers should ensure that any background checks comply with these requirements and consult legal counsel where necessary. In addition, employers should be careful to make sure that they are using criminal history information fairly and in compliance with applicable laws. For example, though certain licensing requirements may necessitate a blanket exclusion of candidates with felony convictions for certain positions in the health care industry, this does not apply to all positions. Employers should undertake an individualized assessment of each individual's criminal history as it pertains to the specific position.

EMPLOYEE EVALUATIONS AND RECORD RETENTION

One of the most common roadblocks to effectively defending against discrimination and retaliation claims is an employer's lack of documentation of an employee's poor performance. Failure to sufficiently document an employee's performance prior to termination can make it very difficult to defend against meritless discrimination and retaliation claims. Even if an employee was terminated for perfectly legitimate performance problems, the employer is at a disadvantage in defending a claim if it has little to no documentation of the supposed performance issues (or, worse, if the employee's evaluations were all positive). Employers must document performance issues and any steps taken to correct them, including any progressive discipline or counseling. Employers must ensure that evaluations are accurate and, whenever possible, should provide employees the opportunity to correct performance issues before implementing more severe forms of discipline, such as termination.

RETALIATION

Retaliation claims are especially costly to defend, because the employee's initial burden to state a retaliation claim (and survive dismissal) is much lower than other types of discrimination claims. Generally, to state a retaliation claim against an employer, an employee need only allege that he or she engaged in protected conduct, that he or she was treated adversely thereafter and that the adverse action was taken because of the protected activity. Protected conduct may include, but is not limited to, bringing a harassment complaint, requesting a disability accommodation or taking FMLA leave. Further, many types of actions may be deemed "adverse," not just formal discipline. Simply excluding the employee from meetings or giving him or her less favorable assignments may constitute adverse actions. Courts routinely refuse to dismiss retaliation claims at an early stage, because the mere fact that an adverse action occurs soon after a protected activity is enough for a court to "infer" causation. Therefore, employers should ensure that they have clear anti-retaliation policies that are communicated to employees and that they encourage employees to report suspected retaliation. Supervisors, in particular, should understand and acknowledge anti-retaliation policies and be mindful to document non-discriminatory reasons for adverse employment decisions.

If you have any questions about any of the topics or issues addressed in this article, please contact Amanda Weaver at aweaver@williamsmullen.com or (804) 420-6226, or Aaron Siegrist at asiegrist@williamsmullen.com or (804) 420-6307.

VA HEALTH CARE LEGISLATION: 2018 SESSION RECAP

By Matthew M. Cobb

To say the 2017 elections changed the dynamic of Virginia's General Assembly would be an understatement. The Democratic party swept all three statewide elected offices and trimmed the Republican majority in the House of Delegates to a razor-thin 51-49 split. Republicans were able to maintain control of the House of Delegates after one race ended in a tie, resulting in Delegate David Yancey (R) having his name pulled out of a bowl to secure Republican control of the House mere days before the start of the 60-day 2018 legislative session.

This changed dynamic resulted in a significant shift in the years-long debate regarding Medicaid expansion. After thwarting former Governor McAuliffe's efforts to expand Medicaid year after year, leading Republicans in the House of Delegates signaled a willingness to expand Medicaid if it included provisions such as a work requirement, hospital assessment to fund the state share of expansion and a "kill switch" if the federal government ever reduced its 90% match. While most Republicans in the House of Delegates still oppose expanding Medicaid, a coalition of Republicans and all the Democrats in the House provided enough support for Medicaid expansion to be included in its budget.

The Senate is controlled by a 21-19 Republican majority. While two Republican senators have expressed a willingness to consider expanding Medicaid, the Senate has refused to include Medicaid expansion in its budget.

Unable to reach a compromise on the state budget, the 2018 General Assembly session adjourned without enacting a budget. Governor Northam called a special session for the purpose of enacting a budget. At the time of publication, the House of Delegates passed a budget that includes Medicaid expansion and is nearly identical to the budget it voted for during the regular session. The Senate Finance Committee has not yet met to consider its budget. While all parties expect the General Assembly to enact a budget prior to July 1, it will not be a quick process this year.

While the topic of Medicaid expansion dominated the budget conversations, another controversial topic caused significant discussion during the session. Virginia's Certificate of Public Need program was back in the spotlight with over 30 bills introduced seeking to provide exceptions to the COPN requirements for specific projects, with the clear majority being for imaging services or ambulatory surgery centers. None of the exception bills ultimately became law, but a few of the COPN bills passed one chamber before failing. This has led Delegate Bobby Orrock (R), chairman of the House Health, Welfare & Institutions Committee, to convene a special workgroup of delegates to explore COPN reform during the summer and fall.

Many other bills impacting health care providers were debated or enacted during the General Assembly session, including House Bill 793 authorizing independent practice for nurse practitioners after five years of full-time clinical experience in their practice category. In addition, the General Assembly considered a variety of bills to expand health insurance options, including Senator Siobhan Dunnavant's (R) Senate Bill 934, which will permit a sponsoring association to create a benefits consortium to sell benefits plans to its members. The governor amended Senate Bill 934 to require it be re-enacted during the 2019 legislative session, but the General Assembly rejected his amendment.

While the regular General Assembly session has concluded, the special session to enact a budget continues. Every budget enacted by the General Assembly is consequential to Virginia's health care industry, but this year has the potential to alter Virginia's health care landscape for years to come.

If you have any questions concerning the legislation discussed above or other Virginia health care legislative initiatives, please contact Matt Cobb at mcobb@williamsmullen.com or (804) 420-6390.

NORTH CAROLINA UPDATE ON HEALTH CARE LEGISLATION IN 2017

By Richard A. Zechini

The North Carolina General Assembly considered several health care issues during the 2017 legislative session. Four of the more important of those issues are discussed below.

NC HEALTH AND HUMAN SERVICES BUDGET HIGHLIGHTS

- $7.5 million in community and rural health center grants.
- Serves 3,525 additional children in the North Carolina Pre-Kindergarten program through a combination of state and federal block grant dollars.
- $3.5 million to increase Smart Start funds to expand access to early literacy program known as Dolly Parton's Imagination Library.
- $8.7 million to help implement an improvement plan for state child welfare system after a recent critical federal review.
- $500,000 increase for smoking cessation programs and another $500,000 towards youth smoking prevention programs.
- $3 million to cover state laboratory budget deficit.
- $1.3 million in funds to Carolina Pregnancy Care Fellowship for related clinics to purchase medical equipment.
- $53.2 million reduction in funding for services for mental health, substance abuse and developmental disabilities.
- $2.5 million in legal fees for DHHS with anticipated or pending litigation over delays in construction of new Broughton mental hospital.
- $3.8 million provided for Medicaid funding to continue services at expected demands and use rates.
- $30 million to reinstate graduate medical education program within Division of Medical Assistance.

Senate Bill 257, PART XI pgs. 144-242 (https://www.ncleg.net/Sessions/2017/Bills/Senate/PDF/S257v9.pdf)

STOP ACT

Legislation designed to combat opioid abuse was enacted toward the end of the 2017 session. As background, opioid abuse was one of the most prominently discussed health care policy issues during the session with legislators, the attorney general and the governor all advocating for a state response to the epidemic. House Bill 243 restricts access to opioids and helps those who face addiction by doing the following:

Extending the statewide standing order for opioid antagonists to allow practitioners to prescribe an opioid antagonist to any governmental or nongovernmental agency. This provides access to medicine that can treat a patient who is overdosing.

Designating certain Schedule II and III drugs as "targeted controlled substances" and making changes to the laws governing the prescribing of those targeted controlled substances.

Requiring prescribers to check the Controlled Substance Reporting System before prescribing opioids to a patient.

STOP Act (https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v5.pdf)

OPTOMETRY SCOPE OF PRACTICE

A highly contentious battle between ophthalmologists and optometrists over the scope of optometry practice came to a halt two months before adjournment. House Bill 36, as originally drafted, would authorize optometrists to conduct certain surgical procedures, including two treatments for glaucoma patients that involve lasers. After extensive pushback from ophthalmologists, the House approved a new version of the bill

that replaces the substance of the bill with a study of the topic.

The amended legislation would require the North Carolina Institute of Medicine to study the pros and cons of expanding optometrists' scope of practice and then report its findings to the General Assembly in October of 2018. However, the bill stalled in the Senate Rules Committee and was not acted on by the Senate. The controversial nature of the bill mixed with legislators' desires to adjourn before late July resulted in the bill failing to progress in the Senate.

House Bill 36 (https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H36v2.pdf)

MEDICAID TRANSFORMATION

Legislation amending the 2015 Medicaid transformation bill stalled during the 2017 session. As background, the 2015 legislation established a framework for transitioning the state's Medicaid program from a fee for service model to a managed care model.

The 2017 effort primarily involved modifications to how the care for patients with behavioral health issues would be managed. North Carolina has utilized a managed care structure for this population for over five years through public nonprofit entities called local management entities/managed care organizations (LME/MCOs).

In general, House Bill 403 would provide for integrated care as follows:

- Medicaid patients with mild or moderate behavioral health issues would have their care managed by a commercial plan or provider-led organization (PLE). The commercial plan or PLE would manage the "whole person" but could subcontract with an LME/MCO for the management of behavioral health care. This arrangement is commonly referred to as a "standard plan."
- Medicaid patients with severe behavioral health issues would have their care managed, at least for the first five years of Medicaid transformation, by LME/MCOs. The LME/MCO would be responsible for the whole person but would be required to contract with a commercial plan or PLE for the management of physical health. This arrangement is called a "tailored plan."

In addition, the legislation would also provide greater detail regarding the operations and governance of LME/MCOs.

During a special session earlier in 2018 there was another attempt to reconcile the differences between the House and Senate on this legislation. While new drafts were prepared and stakeholders assembled to discuss the newer versions of the bill, ultimately the two chambers failed to agree to a compromise. The legislation is eligible for consideration during the short session that begins on May 16.

House Bill 403 (http://www.williamsmullen.com/sites/default/files/files/HB%20403.pdf)

Should you have any questions about the foregoing legislation or future NC health care legislative initiatives, please contact Rick Zechini at rzechini@williamsmullen.com or (919) 981-4074.

RISKY BUSINESS OF THE FALSE CLAIMS ACT: A BUSINESS PERSON'S GUIDE

By Anthony H. Anikeeff

Lance Armstrong, cycling through France on his many Tours de France, probably never gave a moment's thought to the False Claims Act (FCA). In that he is no different than many government contractors, subcontractors, grantees, health care providers, financial services providers or others that touch federal (or state) funds and are therefore subject to the FCA's terms (or a state equivalent). Armstrong and businesses primarily focus on achieving their immediate and long-term business goals, which infrequently include strategies for addressing what appears to be an unlikely occurrence. Today, however, Armstrong is embroiled in very expensive FCA litigation against the government and his former teammate turned qui tam relator. In that, he shares the experience of all too many who have been caught up by the ever-expanding efforts of the government pursuing traditional and innovative FCA theories and ever-more aggressive relators seeking their statutory FCA bounty.

One need not be expert in the FCA's details, but a prudent business person should appreciate why the FCA is important to one's business, know the FCA's parameters, know how one might reduce the likelihood and consequences of an encounter and know what to do if your company becomes exposed to the FCA. In coming articles, we will endeavor to provide a common-sense analysis of and answers to these topics. First, some context.

HOW DID WE GET WHERE WE ARE?

At a basic level, the FCA is the primary civil statute (among a suite of laws) by which the government seeks redress against those who would deceive it into paying out taxpayer dollars. The FCA's origins date to the civil war when Union troops discovered that contractors had delivered boxes of rocks and sand to the front lines instead of weapons and munitions. Unfortunately, the willingness of some to cheat the government has continued unabated since then as evidenced by characters like Armstrong and "Fat Leonard." Starting in the 1980s, the government increasingly opened the contracting doors to what are now hundreds of thousands of companies supplying every conceivable product and service across the globe, many of whom were and remain inadequately knowledgeable about doing business with the government. This has been matched by massive growth in the health care and financial serves industries. At the same time, in response to notable fraud scandals and pressure from government, and with little effective lobbying to resist, Congress has modified the FCA to make it ever easier to assert FCA claims, encouraged private parties to assert FCA claims as qui tam relators, and raised the penalties and damages for those found to have violated the law.

WHY IS THE FCA IMPORTANT TO A BUSINESS PERSON?

Company personnel, on occasion, make mistakes, take risks and exercise poor judgment. Almost every company encounters a disgruntled employee or one who may have hit on hard times. Many companies face a government audit. And every company eventually has competitors. The adage that those who do business with the government for long enough are likely to encounter a government investigation is not too far off the mark. That can occasionally involve a brush with the FCA. In the last three fiscal years, the Justice Department has recovered some $13.9 billion in FCA judgments and settlements. During that period, some 2,040 private party qui tam whistleblower suits launched by current or former employees, advisors, competitors and the like have led to the recovery of $9.7 billion. These actions have focused primarily on the health care, financial services and government contracts industries. And, these figures do not account for the many

investigations and qui tam actions that eventually are dropped, but at substantial cost to the target company and its personnel to extricate themselves.

As we will discuss, the government is entitled to recover up to treble the damages it suffers in an FCA matter. For culpable conduct after November 2015, the potential penalties have been essentially doubled for each claim. And, based upon Justice Department policy in the "Yates" memorandum, companies seeking favorable treatment in a settlement are expected to cooperate by, among other things, reporting those of its personnel who are responsible for the alleged wrongdoing. Separate from the civil exposure, those caught up in an FCA matter face the added administrative challenge of potential suspension/debarment and termination of one's contract. In relatively rare circumstances, one may face criminal exposure of some sort. In short, an FCA encounter is expensive, distracting, a drain on resources and potentially devastating to a company and/or some of its personnel caught up in the matter.

SO, WHAT'S TO BE DONE?

First, many companies do not become subject to an FCA case. That said, understanding the basics of the FCA as they pertain to one's business operations affords a company the opportunity to build protective measures into the company's overall compliance planning and crisis management efforts. Or, for those yet to develop a compliance plan or work towards developing a culture of compliance, it affords an incentive to start. The cost and effort of developing, implementing and maintaining such measures is generally far less than the costs and disruption of an FCA investigation, proceeding or settlement and should lead to a stronger and healthier company.

ADDITIONAL INFORMATION

Please see "Risky Business of the False Claims Act, Part II – What Your Business Needs to Know About the FCA & How You Might Encounter It." (http://www.williamsmullen.com/blog/risky-business-false-claims-act-part-ii-%E2%80%93-what-your-business-needs-know-about-fca-how-you-might).

Should you have any questions, please contact Tony Anikeeff at aanikeeff@williamsmullen.com or (703) 760-5206. Also, we invite you to visit the Government Contracts team's web page, http://www.williamsmullen.com/industry/government-contracts, where you will find a blog, a podcast and resource documents.

HEALTH CARE NEWSMAKERS

An Interview With Vincent A. Keane, President & CEO, Unity Health Care

Mr. Keane, could you please share with us a little bit about your background and about Unity Health Care, the organization you lead?

Unity Health Care is a §501(c)(3) federally qualified health center (FQHC) located in the District of Columbia. Unity Health Care originally started as a health care program for the homeless in 1985 and was funded by private grants. I began working as the CEO of Unity Health Care in 1990. In 1992, we were asked by the D.C. government to convert Unity to FQHC status and greatly expand the services we provided. We quickly expanded from a 50-employee center for the homeless with a $4,000,000 annual budget to now serving as a 1,000-employee center with 25 locations and a $100,000,000 budget.

My background is not entirely consistent with the position description for CEO of a large urban FQHC. I came to the United States from Ireland in 1969 as an ordained Catholic Priest. I was assigned to the Diocese of Richmond and worked mostly in the Northern Virginia area. In 1987, I left the priesthood, and married in 1988. I joined Unity two years later, and it has been a delightful run ever since.

Our programs care for the homeless, provide shelters, address school issues, provide 24-hour a day service to the D.C. prison system and facilitate health care and related programs for the underserved in the District.

As the largest federally qualified health plan in the District of Columbia, how do you work with other not-for-profit and other governmental agencies in the region to foster better access and care?

We are fortunate to have excellent partners who work with us in areas where they have greater focus and expertise. For example, we work with a number of agencies to address the severe housing problem which exists in the District. We provide access to pantries and shelters to those who leave a hospital with an injury, but we also work with housing "specialists" to attempt to locate affordable housing for working families whose hourly wages simply will not meet the cost of housing in the District. We also work with groups like Catholic Charities who complement the medical services which are our focus with the social and spiritual services which they are skilled at addressing.

While we are the largest of D.C.'s FQHCs by far, several of the smaller FQHCs provide focused services in a number of areas such as HIV treatment and prevention, immigrant centered issues, etc. We take advantage of those resources and that expertise where it will benefit the population we serve. Our constituents primarily are members of the underserved communities whose incomes are below the federal poverty line. They are often in fragile positions economically and socially. We care for all clients regardless of their ability to pay.

Among our greatest resources are the "case managers" which we employ to coordinate care and social access among all of these systems and to help address our clients' culinary, educational, transportation, work force training or medical concerns.

Discuss briefly your financial success in caring for the underserved in the District of Columbia.

The District of Columbia has been very generous in its expansion of Medicaid coverage. As a result, over 96% of the D.C. population has some level of coverage. While we have weathered hard times in the

past, we are currently fiscally able to expand our services and improve access as a result of this increased funding and coverage.

However, our recent financial success is a mixed blessing. As a result of the improved economic climate for health care for the poor in the District, a number of other players, including hospitals and national firms, are attempting to enter the market. While we welcome healthy competition, we are concerned that the new entrants may be tempted to "cherry pick" the patients based on fiscal or ease of service considerations, and leave us at a fiscal disadvantage because of our commitment to serve everyone regardless of their circumstances. Still, we welcome the opportunity for competition, and we will "up our game" to become an even more value driven organization focused on excellent outcomes.

Describe briefly five of the most important components of the services you provide.

First, access to health care for our citizens is key. With 25 facilities, we try to facilitate access wherever possible, initially by being embedded in the very communities we serve.

Second, continuity of care is critical. You can buy some groceries on occasion at a 7-11, but you typically do not use a convenience store for your weekly household needs. We want to provide comprehensive care with the whole array of necessary items and services. We want to steer our patients seamlessly through the entire health care system. Soup to nuts. That is what I mean by continuity of care. We go beyond simply being an urgent care center. We provide everything from primary care to trying to address indirect social and health care needs that are a by-product of poverty.

Third, our practitioners focus on the diagnosis, treatment and resolution of specific diseases which appear in significantly greater numbers in the population which we serve. For example, diabetes, hypertension, HIV and Hepatitis C are all important focuses of our care.

Fourth, as I mentioned earlier, our commitment goes beyond direct health care. People in poverty do not just lack direct health care. They also have needs in areas which are sometimes referred to as the "social determinants of health." For example, we assist with transportation, language barriers (particularly for our Asian, Ethiopian and Hispanic populations), hunger and nutritional issues (addressing the "food deserts" which are common in the inner city), and other similar barriers.

Finally, we try to make accessing health care on a regular basis a priority for the people we serve. Some are suspicious of the health care industry, and we work hard to make it not just a "one off" service. We want them to come back and obtain follow up care. To do this successfully, compassion and trust are critical.

What changes in federal policy would be helpful to you in meeting your mission?

This is a very uncertain time with our federal government. We have been lucky so far. Uncertainty in funding and a lack of commitment at the federal level for basic things like the full range of prevention is of concern. At the federal level, they tend to focus on aspects of an overall problem which received the greatest attention in the media. For example, the new concern for the opioid crisis is very important, but you should not address that at the expense of continued growth in the treatment of mental health and substance abuse issues. We need to see more "linkage" among all relevant aspects of a health care problem.

We are also concerned, particularly from a Medicaid perspective, that the tendency seems to be moving towards state grants and competition which can lead to arbitrary budgets for care that did not meet the needs of the population. We are, however, amenable to exploring new compensation systems which reward outcomes rather than the number of procedures. If you can teach a patient not to smoke or drink, the value to the system is much greater than treating the patient with a series of visits to address the conditions that result from those bad habits.

We are also concerned about the "work requirements" being imposed on Medicaid. We are certainly in favor of everyone working who is capable of working. A problem with our population is that many are unable to work. The large incidence of mentally ill patients is an important consideration. Additionally, the high unemployment rate in urban areas such as DC is not primarily a function of people being lazy or wanting to take advantage of the system. Instead, there is simply a lack of meaningful entry-level jobs in an urban environment like much of the District. No one objects to Medicaid recipients working if they can; however, we should not create an arbitrary barrier simply because it may be politically expedient.

HEALTH CARE NEWSMAKERS

An Interview With William Crumpton, MBA, CEO, Caswell Family Medical Center

Mr. Crumpton can you describe briefly your background and the business of Caswell Family Medical Center?

Our organization, Caswell Family Medical Center (CFMC), is a federally qualified health center (FQHC). FQHCs were first introduced in the United States in 1975. They provide comprehensive primary and preventive care, including oral and mental health, to the underserved in the community and are a critical part of the health care safety net across the country. There are over 1,100 FQHCs in the United States in operation today, serving over 20 million patients a year. CFMC was formed as a §501(c)(3) organization in 1978. CFMC has a single location in Yanceyville, in Caswell County, North Carolina, a rural county with a population of around 24,000. We currently have a staff of 34 at CFMC.

Before coming to CFMC, I had the good fortune in 2001 to help start an FQHC in south central Virginia which grew from a staff of two in one location to a staff of 100 in five locations.

Could you please summarize the mission of your organization and the purpose of FQHCs generally?

CFMC is organized to ensure access to primary health care and other services for everyone in our community, including the uninsured and underinsured, and low-income individuals. We offer comprehensive primary care, urgent care and psychiatry and access to specialty services such as cardiology, mammography, nephrology, ob/gyn and behavioral health. We even arrange indirect health care services such as transportation. We are a "safety net" for those who cannot afford insurance and for those who have coverage but whose income level will not permit them to access care appropriately.

While there are other safety net providers in most communities such as those affiliated with State Health Departments and free clinics, most are at or above capacity and do not provide the full range of services which we are committed to making available. At the end of the day, if we are not there to serve this vulnerable population, hospital emergency rooms would serve as the venue of last resort.

Talk to us for a minute about the financial issues facing CFMC in North Carolina.

One concern is while North Carolina has not expanded Medicaid, it is embarking on a Medicaid managed care program where most of the administrative functions will be conducted by private carriers. Virginia, for example, has operated a Medicaid managed care plan for a number of years, so most of the administrative and payment concerns have been ironed out there. The North Carolina program is designed to begin in early 2019, and a number of the administrative aspects have not yet gone out for RFP. Our concerns primarily involve the cash flow issues which can arise from the implementation of a new process and the case management and pre-authorization protocols which may impact delivery and access.

As a FQHC, we are reimbursed by the federal programs under a "cost-based" system, much the way most hospital providers were a couple decades ago. This favorable reimbursement system provides us with the fiscal capacity to perform a number of functions which are not reimbursed and which otherwise could not be provided. Under the new Medicaid managed care system, we would be reimbursed

by the private carrier contracting with North Carolina based on a negotiated rate, and then we would make a filing with the North Carolina Medicaid program to be reimbursed the difference between the private carrier payment and the cost-based reimbursement we historically received. Our concern is not whether the reimbursement will be forthcoming; it is the timing of the reimbursement and the impact of the time value of money. Our margins are very thin, and any interruption to our cash flow can affect our ability to serve our population and to achieve our mission.

What are some fiscal challenges you face from a federal perspective?

As a FQHC, we are obviously dependent on federal funding and are subject to detailed regulations concerning the services we are required to provide. In recent years, we have faced a "funding cliff" where we suddenly face a significant risk of reductions or elimination of federal resources based on the results of spending bills and threats of government shutdowns. The recently approved bill appears to hold harmless the FQHCs for the time being; however, this uncertainty makes it very difficult for us to plan how to budget our resources over the coming year and to make appropriate hiring and program decisions. It also makes it problematic to recruit and retain talented practitioners who are concerned about job stability.

Talk for a minute about the demographics of the population that you serve.

As I mentioned earlier, Caswell County has a population of around 24,000, although our catchment area is somewhat broader than the County line. We are a rural area, and jobs unfortunately are not as plentiful as we would prefer.

In Caswell County, the individuals we serve tend to be the working poor. They also tend to be elderly. They are our neighbors and friends and people we know. Indeed, as with all FQHCs, 51% of our Board of Directors are patients of our program.

Most of our constituents have some coverage, but they lack resources to access health care. As such, in addition to traditional health care, we help facilitate transportation to CFMC and to other health care resources.

From a clinical perspective, we focus on providing our clients with a needs assessment. We offer a full range of primary care services, including ob/gyn. We also provide important screening exams for breast, colorectal and other cancers. Lab and radiology services are also an important component. Finally, opioid and mental health treatment are particularly important in this environment, although we are fortunate to have a smaller opioid problem in Caswell County than in many other rural areas.

What would you like to see from a legislative perspective at the federal and state level?

At the federal level, we would hope for a renewed commitment to positioning all FQHCs for success. A permanent solution for federal funding is extremely important in that regard. Having to face a fiscal cliff every few years is not an acceptable approach for planning or recruitment, and there are not adequate substitutes for us in the community if we are forced to reduce the level of care and access which we provide.

At the state level, I simply cannot say enough good things about the efforts we see from the new Secretary of Health and Human Services, Mandy Cohen, MD, MPH. Secretary Cohen seems to have a very clear focus on the issues faced by the population we serve, particularly the behavioral health issues. I understand that she served as COO and Chief of Staff at CMS and helped it implement a number of marketplace policies. We are optimistic that she will lead the new North Carolina Medicaid managed care program to success.

HEALTH CARE TEAM SPOTLIGHT: MAGGIE S. KRANTZ

By Patrick C. Devine, Jr.

Have you noticed that our team seems to be eating a lot more German chocolate lately? Or that you see some emails sent at very early hours? We have Maggie Krantz to thank for those. Maggie, a long-time member of our Health Care team, has moved to Kaiserslautern, Germany, for a few years thanks to her husband's career. And thanks to the magic of technology, she continues to be part of our team.

Maggie is a native of Poland who moved to Germany as a child. She married a U.S. serviceman and moved to the United States, earning her JD at the University of Virginia School of Law just a few years after moving here. She practiced health care law with several members of our team before moving back to Germany in 2009. While in Germany, she served as a health care specialist to the U.S. Army Medical Department Activity Bavaria, the largest footprint in the U.S. Army Medical Command, with seven geographically dispersed outpatient clinics and approximately 400 providers and 40,000 beneficiaries. while also working on a contract basis with Jamie Baskerville Martin, Dominic Madigan and Jeremy Ball. The team was thrilled when she moved back to the Richmond area in 2014, and she quickly reintegrated with the group. But in late 2017, Germany beckoned again. "There was no question that we wanted Maggie to continue on our team," said Jamie Baskerville Martin, chair of Williams Mullen's Health Care practice. "Maggie is an extraordinary lawyer with great experience in Certificate of Public Need (COPN) and both state and federal regulatory matters. Her institutional knowledge of our clients is irreplaceable." So, with a laptop, some office supplies, and an internet connection, we were in business. Maggie's new "office" is a charming 200-year-old farmhouse in Kaiserslautern, Germany, and she starts her day right when the night owls here are heading to bed. As always, Maggie can still be reached at (804) 420-6420 or mkrantz@williamsmullen.com.

"The time difference has worked to our advantage," said Martin. "We toggle projects back-and-forth all the time, but with Maggie working in Germany, it's as if we have an overnight law office. It's great to wake up in the morning and be greeted by work that has magically progressed overnight!"

"It's been a wonderful way to balance both family needs and my career," said Krantz. Martin, a member of Williams Mullen's Women's Initiative Network Steering Committee, agrees. "Too often, the traditional structure of law practice is not compatible with two-career families. Some flexibility can go a long way toward helping us retain, and our clients benefit from, the knowledge of experienced lawyers."

And if you show up on a day when Maggie has sent a 20-pound box of German chocolate, Guten Appetit. Per many requests, we are diligently researching the legality of shipping some of Germany's finest beers here, too.

Meet Our Health Care Team

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