

HLB

HOOPER, LUNDY & BOOKMAN, P.C.
HEALTH CARE LAWYERS



HEALTH LAW PERSPECTIVES

Newsletter
Volume 14, No. 1

February 2012

Providers May Sue Insurers for Double Damages if Coverage Denial is Based on Medicare Eligibility

By Daron Toooh

Health care providers can sue private insurers for double damages if the insurer denies coverage on the grounds that the individual is eligible for Medicare coverage, according to a federal Court of Appeals.

In a recent decision, a federal Court of Appeals held that a dialysis provider could sue an ERISA plan under the Medicare Secondary Payer (MSP) Act when the insurer ceased coverage for a woman after learning that she had become eligible for Medicare. (*Bio-Medical Applications of Tennessee, Inc. v. Central States Southeast and Southwest Areas Health and Welfare Fund*, 656 F.3d 277 (6th Cir. 2011)).

In *Bio-Medical*, the patient was diagnosed with end-stage renal disease (ESRD) and began receiving dialysis treatment at one of Bio-Medical's centers. The patient assigned her benefits to Bio-Medical. Three months after she was diagnosed with ESRD, she became entitled to Medicare benefits. When her insurer, Central States Southeast and Southwest Areas Health and Welfare Fund, discovered the patient was entitled to Medicare benefits, it immediately terminated her coverage.

In reaching its decision, the Court of Appeals addressed three questions. The first question was whether a "group health plan" can immediately deny coverage to one of its insureds simply because that person became eligible for Medicare. The court held that the payer violated the MSP Act in terminating the woman's coverage. The MSP Act provides that a group health plan cannot take into consideration an individual's eligibility for Medicare in determining coverage issues.

The second question addressed when a provider can

sue a payer for double damages. Under the MSP Act, Medicare may pay conditionally for an item or services if a primary plan that should pay the claim "cannot reasonably be expected" to pay "promptly." 42 U.S.C. section 1395y (b)(2)(B). Despite the convoluted language in the Act, the court held that a provider may bring suit against a primary plan if, as a result of the primary plan's failure to pay the claim, Medicare steps in and temporarily foots the bill.

Under the MSP Act, a primary plan must reimburse Medicare only if its responsibility to pay has been demonstrated through a judgment, settlement or "other means." 42 U.S.C. section 1395y(b)(2)(B) (ii). The court held that it is sufficient that a provider have a contract with the group health plan in order to "demonstrate responsibility" for payment of the claim. The Centers for Medicare and Medicaid Services has promulgated a regulation which defines "other means" to include a "contractual obligation." 42 C.F.R. sec-

IN THIS ISSUE

- **The Impact on PODs of Changes to WC Self-Referral Law**
- **Providers May Benefit in Suits Filed When Coverage Denial Based on Medicare Eligibility**
- **Medi-Cal Rate Litigation Update**

tion 411.22(b)(3).

The third question addressed by the court was the proper amount of damages under the Act's private cause of action. Should double damages equal twice the amount that Medicare conditionally paid the healthcare provider, or twice the amount that the healthcare provider would have received from the private insurer? The court noted that the purpose of the double damages provision is to punish private insurers who violate the Act, to deter such illegal conduct, and to incentivize private plaintiffs to bring claims against insurers who have shifted costs to Medicare. Because there was insufficient briefing on the issue, the Court of Appeal remanded the case to the district court to decide this issue.

This case is an important decision for providers who have been forced to accept Medicare reimbursement for claims that should have been paid by primary health plans. The decision makes it easier for providers to prevail in such actions and to recover double damages.

If you have any questions about this case, or similar issues, please contact Daron Tooch in Los Angeles at (310) 551-8192 or Jennifer Hansen in San Diego at 619.744.7300.

Medi-Cal Rate Litigation Update

By Katherine M. Markowski

Hooper, Lundy & Bookman, P.C. (HLB) is actively involved in ongoing Medi-Cal rate litigation that has serious ramifications for health care providers. Within the last month, federal district courts for the central and northern districts of California have issued four orders enjoining reductions to Medi-Cal reimbursement rates for various services. HLB anticipates that a fifth, similar order will be issued after a January 30, 2012 hearing on reductions to Medi-Cal reimbursement rates for additional groups of providers.

Background

As part of California Governor Jerry Brown's attempts to fill gaps in the State's budget, in March of 2011 the Governor signed into law a bill affecting payments for health care services provided to recipients of Medi-Cal, California's Medicaid program. Assembly Bill 97 (AB 97) authorized severe Medi-Cal rate reductions for various types of health-

care services, including \$14 billion in cuts, a ten percent reduction in Medi-Cal provider rates, mandatory Medi-Cal copayments, and a coverage cap of seven physician office visits per year.

The California Department of Health Care Services (DHCS) submitted several proposed State Plan Amendments (the SPAs) incorporating AB 97's cuts for federal approval in July of 2011. The Centers for Medicare and Medicaid Services ("CMS"), on behalf of the federal government, approved the proposed rate reductions in October of 2011, notwithstanding state and federal court rulings finding that similar cuts violated federal Medicaid law, and despite the State's failure to prove that the rate cuts will not adversely affect access to health care services for Medi-Cal beneficiaries. In response, health care providers and Medi-Cal beneficiaries have sought protection from the courts to prevent the harsh impact of the SPAs cuts.

Court Action

Entities that have sought legal protection from the Medi-Cal rate reductions include State trade associations on behalf of hospitals providing skilled nursing care services to Medi-Cal beneficiaries; pharmacies participating in the Medi-Cal fee-for-service program; non-emergency medical transportation providers participating in Medi-Cal; the California Disability Community Action Network, on behalf of In-Home Health Services recipients; and on behalf of physicians, dentists, pharmacists, emergency medical transportation providers, and durable medical equipment providers.

In December of 2011, Judge Christina Snyder of the United States District Court for the Central District of California issued preliminary injunctions prohibiting the State from implementing AB 97's Medi-Cal rate reductions for providers of pharmacy services and for skilled nursing services rendered by distinct part hospital units. A preliminary injunction is issued before a full trial on a matter, and may be ordered upon a finding by the judge that these providers have a strong likelihood of succeeding on the merits of these lawsuits once a full trial is had.

In her rulings, Judge Snyder cited several reasons why AB 97's cuts violated federal law, including:

- CMS's failure to consider whether, in formulating the reductions, the State relied on responsible cost studies and developed rates reasonably related to provider costs. CMS's failure to do so likely was arbitrary and capricious, and thus a violation of federal law.

- CMS's approval of the SPA, despite facts indicating that SPA rate reductions would have an adverse impact on access to services, was also likely arbitrary and capricious, and thus a violation of federal law.
- CMS's acceptance of the State's monitoring plan for ensuring quality of care, despite the fact that no consideration of the impact of the rate reductions on quality of care by DHCS was shown, was likely arbitrary and capricious, and thus a violation of federal law.

In addition, Judge Snyder held that the Ninth Circuit Court of Appeals has permitted private enforcement of the federal Medicaid Act under the Supremacy Clause by providers like those seeking the injunctions. Furthermore, in the case of hospitals providing skilled nursing care services to Medi-Cal beneficiaries, Judge Snyder held that the SPAs' cuts likely amounted to an unconstitutional "taking" under the Fifth Amendment to the U.S. Constitution. Because these hospitals legally are unable to withdraw from Medi-Cal until certain conditions are met, they must continue to treat Medi-Cal patients regardless of the level of Medi-Cal rates. Thus, implementing rate cuts on these facilities would likely amount to a violation of the Fifth Amendment's prohibition on the government taking property without just compensation.

Judge Snyder found in both cases a strong risk of irreparable injury should the SPAs' rate reductions be implemented, as many providers would as a result be forced to eliminate services, lay off employees, and perhaps even cease operations. These reductions in services and employees would negatively impact the availability of health care services to many already-underserved communities. Previous

case law in the Ninth Circuit has held that irreparable injury may be proven by evidence showing that at least some Medi-Cal beneficiaries might lose services as a result of a rate reduction, and Judge Snyder agreed that this level of risk was shown in these cases. Additionally, because the federal Constitution prohibits providers from bringing any legal action in federal court against the State to later recover unlawfully withheld Medicaid payments, providers would have no way to recover payments withheld by the State should the SPAs' rate cuts later be found illegal.

Finally, Judge Snyder held that "[a]lthough keenly aware of the State's fiscal difficulties, the Court believes that the balance of the equities and the public interest strongly favor the issuance of an injunction," because "the State's fiscal crisis does not outweigh the serious irreparable injury [providers and Medi-Cal beneficiaries] would suffer absent the issuance of an injunction."

In January of 2012, Judge Snyder issued a substantially similar opinion and preliminary injunction in the action brought by non-emergency medical transportation providers participating in Medi-Cal. The Northern District of California also issued this month a substantially similar opinion and preliminary injunction in the action brought by recipients of In-Home Supportive Services.

The federal courts thus have issued four injunctions within the past month prohibiting the State from enacting the SPAs' Medi-cal rate cuts. These injunctions mean that the cuts cannot be implemented—if at all—until a final decision is reached after trial in these cases, and indicate that the courts believe that the State will not be able to prove at trial that the rate cuts are legal and permissible.

HLB Briefs

HLB Announces New Senior Counsel Appointments: HLB is pleased to announce that Karl Schmitz in Los Angeles and Matthew Clark in San Francisco have been named Senior Counsel of the firm.

2012 Southern California Super Lawyers: HLB is pleased to announce that Robert Lundy, Lloyd Bookman, Patric Hooper, Charles Oppenheim and Bradley Tully have been selected as 2012 Southern California Super Lawyers.

Future Action

On January 30, 2012, HLB presented oral argument before Judge Snyder of the Central District Court in the action brought by multiple State trade associations on behalf of physicians, dentists, pharmacists, emergency medical transportation providers, and durable medical equipment providers. At the January 30th hearing, Judge Snyder issued a 25-page tentative decision finding that plaintiffs are likely to prevail on the merits and that an injunctive order should issue to prevent the State's implementation of the proposed Medi-Cal outpatient rate cuts. It is likely that Judge Snyder will issue a final injunctive order mirroring her tentative decision within the week.

The State, but not CMS, has appealed from the three injunctions thus far issued by Judge Snyder arising from AB 97, and intends to appeal from the injunction issued by the Northern District of California court. In addition, the State has filed an emergency motion with the Ninth Circuit Court of Appeals, requesting that the appellate court stay the lower courts' preliminary injunctions pending resolution of the appeals. The Ninth Circuit denied the State's stay motions on the grounds that the State was first required to seek a stay from the district courts that issued the injunction orders.

HLB will continue to follow the progress of these cases and their impact on providers and Medi-Cal recipients.

For more information, contact Lloyd Bookman or Jordan Keville in Los Angeles at 310.551.8111; or Craig Cannizzo, Mark Reagan or Felicia Sze in San Francisco at 415.875.8500.

Drugs and Devices Added to California Workers' Compensation Self-Referral Law: Does This Impact Physician-Owned Device Companies?

Effective January 1, 2012, California's workers' compensation self-referral law was expanded to apply to pharmacy goods, defined to include any dangerous drug or device. As a result, implantable medical devices requiring a physician's order, are now covered by the law, and questions have arisen regarding the impact this might have on physician owners of a medical

device company who perform surgeries on California workers' compensation patients.

When enacting this change in the law, the Legislature made clear that it intended to address arrangements in which physicians provide prescription medical foods for their patients. There is no indication the Legislature gave any consideration to physician-owned device companies. Nevertheless, as amended, the law would now prohibit a physician from referring a patient for implants to a company that the physician owns or has a financial relationship with, unless an exception were available.

However, it does not appear that patients would be viewed as being "referred" to a medical device distributor, within the meaning of California's self-referral law. Therefore, ***this law does not appear to have any impact on physician-owned device companies.*** Although the term "referral" is not defined in the statute, the California Attorney General, for many years, has relied on the standard dictionary definition of a referral for purposes of California's closely related anti-kickback statute as follows:

The verb 'refer' is defined as 'to send or direct for treatment, aid, information, decision' (Webster's Third New Internat. Dict. (1971 ed.) at p. 1907, def. (2a)) and a 'referral' as 'the process of directing. . . a patient . . . to an appropriate specialist or agency for definitive treatment' (id., at p. 1908, def (1b)). The phrase 'referral of patients' . . . may thus be thought of as the process whereby a third party independent entity who initially has contact with a person in need of health care first selects a professional to render the same and then in turn places the prospective patient in contact with that professional for the receipt of treatment. (65 Ops. Cal.Atty.Gen. 252, 254 (1982).)

Accordingly, instead of the physician referring a patient to device distributor, the physician is referring the patient to a hospital or surgery center, and the hospital (or surgery center), upon the physician's order, purchases the implant from the distributor. The patient's relationship is with the hospital or surgery center where the patient receives care. There is no financial relationship or physical encounter between the

patient and the distributor, and the distributor has no direct relationship with the patient. Under these circumstances, although the distributor sells an implant to the hospital upon a physician's order, we do not believe that there would be any prohibited referral of a patient to distributor by its physician owners.

There would, however, still need to be an exception allowing the physician to refer the patient to the hospital (because, through the distributor, the physician would have an indirect financial relationship with the hospital). However, as before, the law contains an

exception allowing a physician to refer a patient to a hospital, so long as the physician is not paid for that patient referral (and any equipment lease between the parties meets certain requirements). This exception would continue to apply. For ambulatory surgery centers, the analysis is the same, because a similar exception applies for these referrals.

For additional information, please contact Charles Oppenheim, Bradley Tully, David Hatch, Karl Schmitz, or Eugene Ngai in Los Angeles at 310.551.8111; or Stephen Phillips in San Francisco at 415.875.8500.

CALENDAR

January	17	Hospital Council of Northern & Central California, Central Valley Region Program Steven Lipton Presents <i>EMTALA and California Involuntary Detention Laws</i> .
	19	Progressive Audio Conference Charles Oppenheim presents: <i>Stark Law Update: Stay Compliant in the Face of Increased Audits</i>
February	2,8	CHA Annual Hospital Compliance Seminar, Sacramento, Glendale HLB Attorneys are lead faculty for this program. Charles Oppenheim speaks on <i>Integrated Delivery Models</i> ; John Hellow speaks on <i>Impacts of Quality on Compliance</i> ; Lloyd Bookman speaks on <i>Compliance Audits</i> ; and Patric Hooper speaks on <i>The OIG Work Plan</i> .
	14	BIOCOM Reimbursement Educational Seminar: Navigating the Changing Payor Provider Landscape Kitty Juniper participates on two panels: <i>Integrated Healthcare Delivery and Care Management Panel Discussions</i> .
	22-25	ABA 13th Annual Conference on Emerging Issues in Healthcare Law, San Diego Patric Hooper speaks on <i>Medicaid Fraud Enforcement: What the State and Doing and How Providers are Responding</i> ; Mark Hardiman speaks on <i>Ethical Issues for Healthcare Attorneys in the Land of Overpayment Disclosures, Provider Financial Relationships and HIPAA Violations</i> ; John Hellow speaks on <i>Provider, Physician and Supplier Obligations to Report and Return Overpayments</i> .
	29	Hospital Council of Northern & Central California Scott Kiepen and Felicia Sze present a webinar; <i>Elder Abuse Laws: The Law, The Facts and Risk Management Strategies for General Acute Care Hospitals</i>
May	12	ABA White Collar Crime Section Annual Meeting on Health Care issues, Las Vegas. Patric Hooper speaks on <i>The Fundamentals of Health Care Law</i>

Copyright 2012 by Hooper, Lundy & Bookman, PC. Reproduction with attribution is permitted. To request addition to or removal from our mailing list contact Baron Kishimoto at Hooper, Lundy & Bookman, PC, 1875 Century Park East, Suite 1600, Los Angeles, CA 90067, phone (310) 551-8152. *Health Law Perspective* is produced monthly, 10 times per year and is provided as an educational service only to assist readers in recognizing potential problems in their health care matters. It does not attempt to offer solutions to individual problems but rather to provide information about current developments in California and federal health care law. Readers in need of legal assistance should retain the services of competent counsel. Los Angeles: 310.551.8111; San Francisco: 415.875.8500; San Diego: 619.744.7300; Washington, D.C. 202.587.2590