



HEALTH LAW PERSPECTIVES

Newsletter
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CHA and CMA Join Class Action Complaint Challenging Blue Cross Rescission Policy

HLB has filed an amended complaint as the next step in the quest by California health care providers to stop Blue Cross of California and its affiliates and parent from denying health care claims by attempting to rescind the patients' insurance coverage after the services have been provided to the patients.

The amended complaint includes the California Hospital Association and the California Medical Association as additional plaintiffs to join the class action complaint that was filed in October 2006, by Coast Plaza Doctors Hospital, against Blue Cross of California, Blue Cross Life and Health, and their parent company, Wellpoint, Inc.

"The decision by CHA and CMA to join in the class action indicates the broad scope of the problem being caused by Blue Cross' rescission practices. We believe that Blue Cross has failed to pay claims worth hundreds of millions of dollars based on its illegal practices," said Daron Toooh, one of the lead attorneys in this case. "Blue Cross' rescissions appear calculated to push providers to bill and collect from their patients what Blue Cross itself has an obligation to pay," explained Mr. Toooh. "This conduct by Blue Cross is precisely what California law is intended to prevent."

The Department of Managed Health Care recently determined that Blue Cross' rescission practices violated the Knox-Keene Act, and the DMHC levied a \$1 million dollar fine against Blue Cross.

The Complaint seeks to protect patients, hospitals, and physicians from Blue Cross' illegal practice of retroactively rescinding insurance policy coverage

for patients after the health care services have been rendered by the providers. The complaint explains that California law prohibits Blue Cross from retroactively denying payment after the services have been provided in good faith. The class action and amended complaint follow lawsuits that were filed by Hooper, Lundy & Bookman in May 2006, on behalf of a number of specific hospital clients, challenging these types of retroactive policy rescissions.

"Unfortunately, it appears that Blue Cross' rescission practices are not isolated to particular providers, but reflect a systematic practice by Blue Cross to avoid paying for these claims," explained Glenn Solomon, another one of the lead attorneys for the lawsuit.

Blue Cross has been the subject of dozens of lawsuits by patients alleging that Blue Cross routinely looks for after-the-fact reasons to cancel policies by reviewing previously approved applications. The rescissions directly impact the hospitals and physicians, because they are not being paid for their services, and instead are being directed by Blue Cross to collect from the patients.

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“The entire health care system is at jeopardy when insurers do not pay valid claims based on improper rescissions,” noted Mr. Solomon. “Not only do patients and providers suffer when valid claims go unpaid, but also rescinded patients are pushed onto the rolls of the uninsured, which strains limited public resources.”

For additional information, please contact Mr. Solomon or Mr. Tooch at 310.551.8111. ■

Anti-Trust Challenge to PPOs Defeated

The California State Court of Appeal (Second Appellate District) recently issued an opinion in an anti-trust matter which strongly endorses the legality of selective contracting, the creation of provider networks, and PPO’s.

This is the first appellate decision expressly addressing these issues in California. The Opinion affirmed a trial court judgment based on an Order granting a motion for judgment on the pleadings. Jay Hartz of Hooper, Lundy & Bookman, Inc. represented the defendant network, which successfully defeated plaintiff’s claim.

The defendants were Blue Cross, and PTPN, Inc., which is recognized as the nation’s first and largest network of independent rehab therapists in private practice. PTPN had a contract with Blue Cross to provide therapy providers for the Blue Cross PPO product. PTPN provided credentialing, and quality management.

One of the membership criteria of PTPN was that it would not accept as a member a therapist who had an office within a certain geographical radius of an existing member’s office. The geographic radiuses were flexible, depending on the population in the area. In dense urban areas, the radius was one-half mile. In more rural areas, the radius could be up to 8 miles. Plaintiffs claimed that they were not able to join the network, and therefore could not realistically compete for Blue Cross PPO members, since they each had an office within the restricted radius of other PTPN members.

Plaintiffs argued that the membership criteria constituted a geographic division of markets among competitors (i.e. PTPN members), i.e. a horizontal restraint of trade, and that the PTPN/Blue Cross agreement

constituted a vertical restraint of trade by which Blue Cross accepted and endorsed the geographic membership criteria.

PTPN and Blue Cross argued that the geographic rules were appropriate, since they resulted in assured geographic dispersion of the therapists, which was consistent with statutory and regulatory requirements for health plans/PPO’s to assure geographic accessibility.

Defendants also argued that state law specifically authorized various aspects of the matters at issue. Specifically, in 1982, the California Legislature adopted Insurance Code § 10133 to allow an insurer to “negotiate and enter into contracts for alternative rates of payments with institutional and ... professional providers, and offer the benefit of these alternative rates to ensure to select those providers.” This statute authorized the contract between Blue Cross and PTPN.

Further, in 1985, the Legislature adopted three statutes, Business & Professions Code § 16770, Insurance Code § 10133.6 and Health & Safety Code § 1342.6, in response to the *Arizona v. Miracopa County Medical Society* case. Those statutes found that “the formation of groups and combination of providers and purchasing groups for the purpose of creating efficient-sized contracting units be recognized as the creation of a new product within the health care marketplace, and be subject, therefore, only to those anti-trust prohibitions applicable to the conduct of other presumptively legitimate enterprises.” These statutes authorized the formation of the PTPN provider network.

Finally, the Legislature adopted Health and Safety Code § 1373.9, which requires insurers to give “reasonable consideration” to proposals by providers wishing to contract, unless the providers propose to serve a geographic area that is adequately served by the plan’s existing providers. Both statutes and regulations (28 CCR § 1300.67.2, et seq.) recognize the importance of ensuring geographic accessibility of services. In light of these statutes, defendants successfully argued that the creation of PTPN was specifically authorized by statute and therefore could not be violative of state anti-trust law. Plaintiffs argued that the geographic membership restrictions were not “formation” of the network, but rather constituted post-formation conduct. The Court rejected this argument, and specifically

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found that the creation of such networks, and their contracting with health plans and PPO's, were-pro-competitive, and specifically authorized by statute.

The Court recognized that PTPN needed to attract a sufficient number of members to satisfy the regulatory requirements on Blue Cross, while at the same time limit its membership sufficiently that PTPN's members would receive a sufficient volume of business to justify accepting discounted rates. It held that the PTPN's enforcement of its geographic restrictions was protected from anti-trust enforcement because it was conduct aimed at maintaining the efficient size of the contracting unit (i.e. the network).

Plaintiff's case essentially directly attacked the PPO model of preferred providers and selective contracting. The Court resoundingly rejected the challenge. This is the first appellate decision expressly addressing these issues in California. Certified for publication, the Opinion was issued March 23, 2007 and is entitled *Lori Rubenstein Physical Therapy, Inc. v. PTPN, Inc and Blue Cross of California*.

On April 10, 2007, the court of appeals denied plaintiffs request for reconsideration.

For additional information, please contact Mr. Hartz at 310.551.8164.

Potentially Costly Wage Index Issues Loom for Hospitals

HLB has recently become aware of two wage index issues that could prove costly to California hospitals.

The firm is currently representing more than 200 hospitals in a significant Medicare appeal issue. The issue involves the Centers for Medicare and Medicaid Services' (CMS) method of accounting for, and making budget neutral, the wage index rural floor. The wage index rural floor requires that a non-rural hospital's area wage index cannot be lower than rural hospital's area wage index in that state.

According to a firm analysis, the rural floor budget neutrality adjustment as implemented by CMS violates the law's requirement of budget neutrality and may prove costly to hospitals.

In a related issue, HLB is handling appeals with the Provider Reimbursement Review Board regard-

ing understated wage indexes for certain California MSAs-virtually all hospitals in MSAs that also include University of California medical centers.

The basis for these appeals is the significant reduction in wage indices for these MSAs as a result of substantial adjustments made to reported wage data for the five University of California Medical Center campuses to remove costs associated with their pension and post-retirement benefit plans. These adjustments occurred as a result of an OIG audit and a change in Medicare policy that now purports to prohibit hospitals from using GAAP to calculate their pension and post-retirement benefit costs. Serious questions have been raised about the validity of these adjustments.

Although adjustments were made to the UC's wage data, they will affect the Medicare inpatient hospital reimbursement for all other hospitals in the MSAs where the UCs are located.

HLB submitted a rebuttal to the OIG's position. Both the audit report and the rebuttal may be found at <http://oig.hhs.gov/oas/reports/region9/90500039.htm>.

For additional information, please contact Lloyd Bookman, Byron Gross, or Jon Neustadter at 310.551.8111.

Conlan Reimbursement Plan Implementation Begins

By Michael Dubin

On November 17, 2006, the San Francisco Superior Court approved an implementation plan (the "Plan") in the case of *Conlan v. Shewry, Case No. 987697*. When this case first began almost 10 years ago in June, 1997, it was entitled *Conlan v. Bontá*, and was brought by three petitioners/Medi-Cal beneficiaries to require the Department of Health Services (DHS) to develop a mechanism for Medi-Cal beneficiaries to obtain prompt reimbursement for out-of-pocket payments they made for covered services during the "retroactivity" period - the three months prior to applying for Medi-Cal coverage.

The Plan responds to a number of appellate decisions in this case which addressed five key issues. The Plan requires the DHS to:

- Send notice to all current and former Medi-Cal beneficiaries who may have claims arising after

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June 27, 1997 — the date the case was originally filed;

- Provide monetary reimbursement to any individual who has a valid claim arising after June 27, 1997;
- Provide reimbursement for valid claims for payments made by or on behalf of beneficiaries from the date an application for Medi-Cal is filed until the date it is approved (the “evaluation” period), but only for services rendered by Medi-Cal providers;
- Provide reimbursement for valid claims for payments made by or on behalf of beneficiaries for services rendered by non-Medi-Cal and Medi-Cal providers during the retroactivity period; and
- For valid claims, provide reimbursement to beneficiaries for the amount paid, not to exceed the rate established for that service under the Medi-Cal Program.

In developing the Plan, the Court required DHS to adopt enforcement mechanisms which “aggressively encourage” providers to cooperate with DHS in administering the *Conlan* reimbursement process. The DHS complied by revising the Plan to include Medi-Cal fund recoupment provisions, whereby a provider’s failure to pay a valid claim triggers DHS’s permanent diversion of Medi-Cal funds in order to directly reimburse the beneficiary.

Under the Plan, the DHS agreed that it would begin the process of sending out approximately 11 million letters to former and current Medi-Cal beneficiaries notifying them that they may qualify for *Conlan* reimbursement. The Notice was prepared in English and nine other languages, and the first batch of Notices was sent on December 26, 2006. During the first quarter of 2007, the Notices were being sent out at the rate of approximately 100,000 a day at an estimated aggregate cost of more than \$3,000,000. The DHS and Medi-Cal intend on mailing additional and periodic bulletins to notify beneficiaries of any changes and to remind them of impending deadlines and their submission obligations.

At the present time, a Beneficiary Claim Form and an accompanying information packet can only be obtained via mail by requesting it from the DHS’s Beneficiary Service Center (BSC) — which was established specifically to assist with the *Con-*

lan reimbursement process. The BSC is staffed with 40 telephone operators, including translators in each of the nine languages. The telephone number for the BSC is (916) 403-2007. In order to submit a claim, a beneficiary must complete the standardized packet and submit the following materials: (1) a Beneficiary Claim form; (2) an STD-204; (3) a summary itemizing the covered expenses (including proof of payment for a service); (4) a copy of the beneficiary’s Medi-Cal Beneficiary Identification Card; (5) the provider’s name(s), address(es) and phone number(s), if known; and (6) for those services requiring authorization, documentation showing the medical necessity of the service.

The Plan establishes a 120-day timeline for the adjudication of claims. The first day commences when the DHS receives a completed claim. From day 2 to 15 after claim submission, the DHS redistributes the claim to the appropriate department, depending on the service type (i.e., medical, dental, skilled nursing...). The DHS will also confirm receipt of the claim in writing. By day 15, the DHS will notify the beneficiary of one of three things: (1) that the completed claim has been denied (with an explanation of the reasons for the denial and information regarding appeal and hearing rights); (2) that additional information is required; or (3) that the claim has been approved. In the event of a denial, the beneficiary has 90-days to request a State Hearing.

If the claim is approved, the DHS will contact the provider by letter and instruct the provider to directly reimburse the beneficiary. If the provider is a Medi-Cal provider, the letter will state that DHS will recoup Medi-Cal funds from the provider (if it does not reimburse the beneficiary and provide confirmation within 30 days) or request a State Hearing. From day 16 to 60 after claim submission, the DHS will evaluate the provider’s response. If a State Hearing is requested by the provider, the request will be forwarded to the Department of Social Services’ (DSS’s) State Hearing Division, along with the pertinent information including the identities of the provider and the beneficiary. From day 60 to 120 after claim submission, two things can happen. First, the provider can pay the claim and instruct the DHS to close it. Second, the DHS can initiate recoupment action to permanently divert Medi-Cal funds from the provider sufficient to fully reimburse the beneficiary. If Medi-Cal funds are

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not available, the DHS will directly reimburse the beneficiary but only up to the allowable Medi-Cal rate for the covered service.

In order to receive reimbursement, a beneficiary must submit his or her claim by certain deadlines. For services received from June 27, 1997 through November 16, 2006, the claim must be submitted by November 16, 2007, or within ninety (90) days after the issuance of a Medi-Cal card, whichever is longer. For services received after November 16, 2006, the claim must be submitted within one (1) year of receipt of services or ninety (90) days after the issuance of the Medi-Cal card, whichever is longer.

In developing the appeal procedures under the Plan, the DHS worked with the DSS to expand their current hearing process to include *Conlan* reimbursement appeals. In formulating the State Hearing process, the DHS met weekly with the DSS to identify changes to the current process, specify procedures, and review the legal authority to implement the new State Hearing Procedure. The Plan provides that the State Hearing process is the sole and exclusive administrative remedy regarding *Conlan* reimbursement. The jurisdiction of the DSS to conduct the State Hearings has not yet been challenged by any provider. A provider has only 30 days from notification of recoupment to pay the claim or request a hearing. The hearing may be conducted by telephone, videoconference

or in person, and the parties are each entitled to receive a copy of all applicable documents prior to the hearing. A request for a State Hearing tolls the 120-day payment deadline and stays any recoupment action by the DHS. A party may designate a representative to present its evidence, which may include an attorney, employee or any other third party. The DSS may adopt other or additional procedures regarding the State Hearings; however, no such guidelines or regulations have yet been promulgated. If a provider or beneficiary disagrees with the finding of the Administrative Law Judge handling the case, they may appeal the decision under the Writ of Mandamus procedures under California Code of Civil Procedure § 1094.5.

As mentioned above, reimbursement Notices have only recently been sent out by the DHS. Claims are beginning to trickle in to the DHS, and the claims adjudication process is underway. The DHS expects the volume to increase over the course of the next several months, but it is unclear at this time how the *Conlan* reimbursement process will impact each of the provider groups. Remember, if you receive a notification that a claim is valid and must be paid, time is of the essence in order to avoid possible recoupment action.

For additional information on the Conlan reimbursement process, please contact Mark Reagan or Michael Dubin at 415.875.8500.

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CALENDAR

June 12, 13, 19

California Hospital Association Reimbursement Seminar, Costa Mesa, Pasadena, Sacramento. Lloyd Bookman, Patric Hooper, John Hellow, Larry Getzoff, Byron Gross, Jon Neustadter and Mark Hardiman present a full day seminar covering significant reimbursement developments.

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