AHMC Agrees to Purchase Four Tenet Hospitals

HLB Client, AHMC, Inc. has finalized an agreement to purchase four hospitals in the San Gabriel Valley from Tenet Healthcare Corp. for an estimated $100 million, marking the first formal acquisition in a group of 19 Southern California hospitals Tenet put up for sale in January.

The four acute care hospitals included in the transaction are:

- Garfield Medical Center in Monterey Park, with 210 beds;
- Greater El Monte Community Hospital in South El Monte, with 117 beds;
- Whittier Hospital Medical Center, with 181 beds;
- Monterey Park Hospitals, with 101 beds

The negotiation and execution of the acquisition involved Hooper, Lundy & Bookman’s expertise across a range of disciplines.

“Sales and acquisitions of hospitals are becoming increasingly complex,” noted HLB Principal Todd Swanson, lead partner on the deal. “The issues specific to each hospital in the transaction and the current regulatory and economic environment all contributed to the challenging nature of the transaction. The ability of AHMC to reach agreement with Tenet under these challenging conditions reflects the company’s commitment to this purchase. We are very pleased to advise AHMC, and to be able to provide the breadth of services required for this significant acquisition.”

AHMC, Inc. and its affiliated companies have operated Alhambra Hospital since 1998 and Doctors’ Hospital Medical Center of Montclair since 2001.

For more information, please contact Mr. Swanson at 310.551.8195 or tswanson@health-law.com.

PacifiCare Attempts to Recoup Interest Paid to Providers

Recently, HLB issued a letter to our clients noting that it has come to our attention that PacifiCare has not been paying interest on late payments for Secure Horizon claims to its contracted providers. We noted in the letter that we believe PacifiCare is required to do so. We are currently representing a number of hospitals in arbitration against PacifiCare on this issue and have recently prevailed on behalf of a client.

Since issuing the letter, we have learned that PacifiCare is additionally attempting to recoup interest payments it paid in the past for late claim payments.

Medicare regulations require Medicare+Choice organizations to include a prompt payment provision in
their contracts with providers. In addition, the contract between PacifiCare and the Centers for Medicare and Medicaid Services (CMS) allowing PacifiCare to operate as a Medicare+Choice plan, requires that PacifiCare include in its contracts with providers a prompt payment provision.

All of the PacifiCare provider contracts we have reviewed contain a prompt payment provision. Specifically, these contracts incorporate the prompt payment provisions in the California Knox-Keene Act, Health and Safety Code section 1371, which requires payment of 15% interest for payments made 45 working days after receipt of an HMO claim.

PacifiCare, however, has refused to comply with these contractual provisions claiming that section 1371 is superseded by the Medicare regulations. PacifiCare is relying on an unpublished federal district court order, in California Association of Health Plans v. Zingale, to support its position.

We believe that PacifiCare’s position is wrong for a number of reasons. First, the California Supreme Court and California Appellate Courts have consistently ruled that the federal Medicare regulations do not preemt the Knox Keene-Act, except in the following four areas: (i) benefit requirements (including cost-sharing requirements); (ii) requirements relating to inclusion or treatment of providers; (iii) coverage determinations (including related appeals and grievance processes); and (iv) requirements relating to marketing materials. We do not believe that state prompt payment provisions fall within any of these areas.

CMS has taken the position that state prompt payment standards that are more stringent than the federal standards are not preempted by the Medicare+Choice regulations. Section 1371 is more stringent that the Medicare prompt payment provisions.

Finally, the Zingale decision has no precedential value because it is an unreported decision, and California courts are not required to follow decisions of federal district courts. We believe that PacifiCare misconstrues the Zingale ruling. In that case, the judge simply ruled that the Medicare regulations preempted state standards in the four areas listed above. The judge did not rule that the Medicare+Choice regulations preempted the prompt payment and interest provisions of the Knox-Keene Act.

If you are interested in learning more about these issues, please call Daron Tooch (310) 551-8192, Glenn Solomon (310) 551-8179 or Scott Kiepen (415) 875-8510.

**CMS Issues Proposed PRRB Rule**

On June 25, 2004, the Centers for Medicare & Medicaid Services (CMS) proposed to revise the regulations governing Medicare Part A provider appeals. The proposed rule would further revise the process of reopening previously made reimbursement determinations. Comments on this proposed rule must be received by CMS on or before August 24, 2004.

Specifically, the proposed rule impacts the Provider Reimbursement Review Board (PRRB) appeals process, the three-year reopening process, and intermediary appeals involving amounts between $1,000 and $10,000. This summary of selected, major proposed revisions focuses solely on some of the proposals involving PRRB appeals and the reopening process. The following summary of proposals is provided in the order that CMS discusses them in the Federal Register.

**Time Periods and Deadlines**

The proposed rule seeks to clarify deadlines by defining “date of receipt.” Different “date of receipt” definitions apply for a party to a proceeding (e.g., a provider) and a reviewing entity (e.g., the PRRB or CMS). “Date of receipt” takes on much more significance in the proposed rule, since it appears that CMS has proposed to eliminate the current date of mailing/postmark rule for most (if not all) deadlines.

Date of receipt by a party or affected nonparty is presumed to be 5 days after the “date of issuance” of a mailed document (which CMS apparently considers the postmark date), unless it is established that the material was actually received on a later date. For a reviewing entity, the date of receipt is presumed to be the date that “Received” is stamped on the document, unless it is established that the document or other material was actually received on a different date.

**Self Disallowance**

The U.S. Supreme Court has held that a provider may appeal an item, even when there was no adverse determination, when the provider could not claim the cost on the cost report as a result of Medicare program requirements that the provider wished to challenge. This process has become known as “self disallowance.”

In the proposed rule, in order to “self disallow,” the provider would need to file the cost report
under protest regarding an item which the provider believes may not be allowable or may not be in accordance with Medicare policy. Significantly, this proposal appears aimed at preventing providers from claiming “self disallowance,” for the first time, during the appeals process. Under the proposal, all self-disallowed claims would need to be initiated with the original filing of the cost report. CMS has further proposed to give itself the authority to require self-disallowed amounts to be audited before payment is made as a result of an appeal or court victory.

**Hearing Request Timelines**

Under the Medicare Act, providers have 180 days to appeal a notice of program reimbursement (NPR) to the PRRB. Historically, providers were presumed to have received the NPR five days after the date on the NPR and could mail in an appeal request on the 185th day after the date on the NPR. However, the statute, regulation, PRRB instructions, and CMS Administrator decisions have generated some conflicts and confusion over the precise deadline for submitting a PRRB hearing request.

CMS proposes to provide that the 180-day period begins on the date of receipt of the NPR, or, where applicable, the expiration of the 12-month period following the issuance of the NPR. CMS has proposed a date or receipt definition, as discussed above, which presumes receipt by the provider five days after the postmark date, unless there is evidence establishing a later date of receipt. CMS proposes to define the ending date of the 180-day period as the date that the Board receives the hearing request. However, receipt by the PRRB is proposed to mean the date the PRRB stamps “Received” on the appeal request. Thus, under the proposal, a provider would need to make certain that the PRRB receives the hearing request no later than 185 days after the date that the NPR was postmarked (unless the provider has convincing evidence that it received the NPR more than five days after it was mailed out).

**Hearing Request Contents**

The proposed rule is intended to require the provider to establish with specificity that the PRRB has jurisdiction over each appealed item. The proposed rule would require that the provider “demonstrate” that all requirements for a PRRB hearing are met. In the preamble, CMS indicates this demonstration should include “argument and supporting documentation.” Further, for each specific issue appealed, the provider would need to provide an explanation of its dissatisfaction with the determination, including an account of: 1) why the Medicare payment is incorrect, 2) how and why the Medicare payment must be determined differently, and 3) for self-disallowed items, the nature and amount of each such item and the reimbursement or payment sought. CMS does not indicate the penalty for failure to submit a complete or satisfactory appeal letter.

**Provider Hearing Rights**

CMS's proposal in the section “Adding Issues to an Original Hearing Request” will very likely be a particularly controversial aspect of the proposed rule. The current provision allows providers to add an issue to a pending individual PRRB appeal until the live hearing commences. In stark contrast, the proposed rule would prohibit a provider from adding an issue to an individual appeal more than 240 days after the provider received the NPR.

**Filing a Late Appeal**

The current rule authorizes the PRRB to permit a provider to submit a late appeal if the provider can demonstrate “good cause.” The proposed rule would set forth specific criteria for granting a good cause extension. Specifically, good cause relief would only be available if there were extraordinary circumstances beyond the provider’s control, such as natural or other catastrophes. Significantly, a change in law, regulation, CMS rulings or Medicare policy in general would not be a permissible basis for a “good cause” extension of time to request a hearing. Also, the proposed rule would permit the CMS Administrator to review a decision to grant or deny a request for good cause but would prohibit judicial review of either the PRRB’s or CMS’s decision regarding good cause.

**Parties to a Hearing**

CMS proposes to authorize the intermediary to designate a CMS representative, possibly an attorney, to defend the intermediary’s position in proceedings before the PRRB. Further, CMS proposes to allow itself the ability to submit amicus curiae briefs for the PRRB’s consideration.

**Proceedings Prior to Hearing**

The proposed rule would make several changes in pre-hearing procedures. For instance, CMS would require the intermediary to promptly review the provider’s appeal and expeditiously attempt to join the provider in resolving factual or legal issues. The proposal would eliminate the intermediary’s
responsibility to assure all documents in support of each party’s position are in the record. CMS proposes to delete the current 60-day deadline for submission of position papers and instead give the PRRB authority to establish deadlines as it deems appropriate.

Moreover, CMS proposes to require position papers to set forth the relevant facts and arguments regarding the PRRB’s jurisdiction over each issue in the appeal. Jurisdictional exhibits would be submitted with the position paper while exhibits regarding the merits would be submitted pursuant to a schedule established by the PRRB.

CMS has made a number of detailed proposed revisions regarding discovery and subpoenas. This article will not enumerate them, but the reader should carefully review them.

**Failure to Follow Board Rules**

CMS proposes to add a new regulation to provide the PRRB with authority to dismiss an appeal if a provider fails to meet any filing or procedural deadlines or other requirements. However, CMS also proposes to allow the PRRB to issue an order requiring the provider to show cause why the Board should not dismiss the appeal or to take any other appropriate remedial action. Finally, if the intermediary fails to meet deadlines, CMS proposes to allow the PRRB to issue its decision based solely on the written submissions already on file. However, despite CMS’s statement in the preamble, the text of the regulation does not provide this remedy.

**Reopening**

CMS proposes to revise the reopening regulation to indicate that a reopening decision is not subject to judicial review. This revision would codify a Supreme Court decision. CMS would also clarify that so long as a request to reopen is received within three years of the date of the determination, it is timely and subsequent work on that request (e.g., the notice to reopen or the reopening determination) need not also occur within the three years.

CMS also proposes to make it clear that only a matter actually revised through a reopening may be appealed. This proposal is meant to eliminate the impact of a court decision holding that matters considered but not revised during a reopening could be appealed.

Further, CMS proposes to change current policy to allow an intermediary, on its own or on request, to reopen any determination on appeal at the PRRB, even if it is the very same issue being considered in that appeal.

**Additional Proposals**

CMS states that it is considering three additional revisions to the regulations:

1. Permission of ex parte contacts concerning procedural matters.
2. A conflict of interest procedure pursuant to which, upon receipt of a credible allegation that a party’s counsel has a conflict of interest, the PRRB would have authority to order such a party to show cause why the case should not be dismissed or other appropriate action taken.
3. After a provider prevails in an appeal, CMS may require the intermediary to determine the reimbursement effect, or whether reimbursement should be allowed at all for any reason, where an item is denied without being audited or denied on one particular basis but other bases have not been fully considered.

**Conclusion**

This is the first major, sweeping revision to the PRRB appeals process in over thirty years. Providers, consultants and representatives should carefully review this proposed rule and consider commenting. Any submission of comments must be received by August 24, 2004.

For additional information, please contact Jon Neustadter at (310) 551-8151 or jneustadter@health-law.com

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**OIG Issues Hospital Subpoenas**

The federal Office of Inspector General (OIG) recently mailed subpoenas to hospitals across the country in connection with the government’s investigation of Healthcare Financial Advisors (HFA).

HFA was a health care consulting firm that specialized in cost reporting and other health care financial matters. HFA joined with a number of other health care consulting firms several years ago to form Certus Corporation.

The OIG’s investigation of HFA has been ongoing since approximately 1998. The OIG had previously issued subpoenas to a limited number of hospitals. We have learned that a number of these hospitals have themselves become the subjects of government investigations concerning their cost reporting practices. At least one facility, Lovelace Medical Center in Texas, entered into a settlement agreement with the Medicare program involving the repayment of substantial sums.

As with all government subpoenas, we believe it is critically important for hospitals to carefully pre-
pare and consider their responses to the current OIG subpoenas. These subpoenas, on their face, are drafted broadly and would appear to require the production of voluminous materials including materials not related directly to HFA.

It has been our experience, however, that it may be possible to narrow the scope of the response through discussions with the OIG. The OIG agent responsible for the subpoenas has been receptive to a reasonable narrowing of the scope of the subpoenas.

We understand that the government will be reviewing the materials submitted in response to the subpoenas to evaluate its concerns with HFA, and, potentially, to determine the liability, if any, of the responding hospitals. Accordingly, we would suggest that hospitals review the materials they are submitting in response to the subpoenas and the work that had been done by HFA to evaluate the hospital’s potential exposure.

For additional information, please contact Lloyd Bookman or Mark Hardiman in Los Angeles (310) 551-8111, Mark Reagan or Pam Riley in San Francisco at (415) 875-8500, or Mark Johnson in San Diego at (858) 812-3070.

Non-Compliant Electronic Medicare Claim Payments Delayed

Effective July 6, electronic Medicare claims received that do not meet Health Insurance Portability and Accountability Act (HIPAA) standards will be treated as paper claims and paid more slowly than HIPAA-compliant electronic claims, according to the Centers for Medicare and Medicaid Services (CMS).

Under a modification to its HIPAA contingency plan announced in February, non-compliant electronic claims will still be accepted by Medicare, but their payment will take 13 additional days, according to CMS.

HIPAA requires that health care claims submitted electronically be in a format that complies with the applicable electronic transaction standard adopted for national use. While the HIPAA electronic transaction standards that were adopted apply to all covered transactions by covered entities, this modification to the CMS compliance plan will only affect covered entities submitting Medicare claims to a Medicare contractor.

Medicare is required to pay compliant electronic claims no earlier than the 14th day after the date of receipt. Non-electronic claims cannot be paid earlier than the 27th day after the date of receipt. By treating non-compliant electronic claims as paper claims, Medicare will pay them 13 days later than compliant electronic claims, according to CMS.

For additional information, please contact Elspeth Delaney at 310.551.8138 or edelaney@health-law.com.

Medi-Cal and Pharmaceutical Reimbursement: Facing the Challenges of Increased Regulatory Scrutiny

A Seminar Presented by Hooper, Lundy & Bookman, Inc.

You are invited to join us for a half-day seminar addressing current Medi-Cal regulatory and enforcement challenges facing manufacturers and providers of pharmaceuticals.

Topics Covered include: Developments in Medi-Cal Provider Enrollment; Pricing, Reimbursement & Reporting; Compliance and Government Investigations; Perspectives from Industry as well as the California Department of Justice.

Plan to Attend if you are in-house counsel, compliance executive, oversee pharmacy services or operations, or are an executive Medi-Cal specialist for a pharmaceutical manufacturer, wholesaler, closed or open door pharmacy.

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Cost: $50 per person

Please contact Robert Valencia for additional information at (310) 551-8167 or rvalencia@health-law.com.
CALENDAR

September 28, 30  HLB Co-sponsors Medi-Cal and Pharmaceutical Reimbursement: Facing the Challenges of Increased Regulatory Scrutiny with the California Pharmacists Assn. Sept. 28, Westin LAX, Los Angeles; Sept. 30, Hilton, Oakland Airport. Topics include: Developments in Medi-Cal Provider Enrollment; Pricing, Reimbursement and Reporting; Industry Perspective; Government Perspective; Compliance and Government Investigations. For registration information, please call (310) 551-8111.

October 19  HLB attorneys Jodi Berlin and Elspeth Delaney speak on Compliance Policies for Your Hospice at the California Hospice Foundation Fall Conference, Las Vegas.


15  HLB Attorney Patric Hooper speaks on California’s Pharmaceutical Enforcement Initiatives at the Fifth Annual Pharmaceutical Regulatory Compliance Congress, Washington, D.C.