HOOPER LUNDY & BOOKMAN, INC.

HEALTH LAW PERSPECTIVES

Newsletter
Volume 6, No. 5

June 2004

AG Announces Comprehensive Medi-Cal Fraud Fighting Plan

Attorney General Bill Lockyer has announced his plan to combat Medi-Cal fraud through legislation, the creation of a task force and expanding the number of employees assigned to Medi-Cal fraud investigations.

Lockyer's plan includes a package of six bills that he says will help the state Attorney General's office to more aggressively detect, investigate and prosecute Medi-Cal fraud, which he estimates costs the state as much as $3 billion annually. The bills include:

SB 1170 by Sen. Deborah Ortiz, requires drug manufacturers, wholesalers and retailers to submit expanded pricing information to the state for purposes of establishing reimbursement rates for drugs in the Medi-Cal formulary. Lockyer said that passage of this bill would end what is arguably the largest, single source of Medi-Cal fraud and abuse by "injecting transparent and fair rules" into the current rate-setting methodology. (Note, the language for this bill had not been submitted at press time).

SB 1359 by Sen. Jim Brulte provides Medi-Cal referring and rendering providers and beneficiaries with notification of all goods and services that the beneficiaries were reported to have received. This notification requests that discrepancies be immediately reported to authorities.

SB 1360 by Sen. Jim Brulte would provides a monetary reward for reporting fraud—such as 10 percent of the total amount recovered, up to a maximum of $1,000 —- for information that leads to a recovery.

SB 1358 by Sen. Martha Escutia expands the California Department of Justice's authority to conduct on-site inspections of the provider 's records and business facilities "when there is reason to believe that a provider has or will defraud the Medi-Cal program." This authority "exactly mirrors" the California Department of Health Services' (DHS) existing authority to visit providers during the course of its investigations, according to Lockyer.

SB 1361 by Sen. Jim Brulte makes an individual who knowingly and willfully interferes with a criminal investigation of fraud and/or abuse in the Medi-Cal program subject to a sentence enhancement of an additional two years and a $10,000 fine. Examples of obstruction of justice include: making fraudulent statements; falsifying records; destroying/concealing evidence; intimidating or unduly influencing potential witnesses and falsely scapegoating the innocent.

SB 1850 by Sen. Mike Machado was devised to help end the exploitation of economically-disadvantaged, non-English speaking immigrants and the urban poor by requiring DHS to establish geographic service areas that are reasonable in distance to the beneficiary's place of residence and ensure ad-

In this issue:

Hooper Lundy & Bookman, Inc.
HEALTH CARE LAWYERS

equate health access and choice; and to prohibit Medi-Cal reimbursement to providers who deliver goods and services to beneficiaries who are outside of the beneficiaries 'service areas, unless there is a medical necessity.

Further, the multidisciplinary task force will be charged with modernizing the state's fraud detection technology. The task force will be chaired by Greg Papadopoulos, executive vice president and chief technology officer for Sun Microsystems. Other members will be appointed from academia, health care, high tech and law enforcement, according to the attorney general's office. The task force will be charged with three points of the Lockyer plan:

- Creating a fraud detection system based on "best business" standards used by industries traditionally targeted by fraud;
- Building an auditing system to measure the level of fraud and identify areas that suffer the highest losses;
- Establishing an electronic clearinghouse so local, state and federal law enforcement regulatory and licensing agencies can effectively share information and coordinate their activities.

Finally, Lockyer's plan also includes hiring additional peace officers and prosecutors for the Attorney General's Bureau of Medi-Cal Fraud and Elder Abuse to more aggressively investigate and prosecute Medi-Cal fraud. His hiring proposal assumes that the federal government will pay for 75 percent of the expenses of the additional employees. Lockyer proposes this portion of the plan to be included in the May Revise of the budget.

HLB is following the progress of the above legislation. For additional information, please contact Patric Hooper (phooper@health-law.com) or Robert Valencia (rvalencia@health-law.com) at 310.551.8111.

May Budget Revision Reverses Proposed Medi-Cal Provider Rate Cuts

A number of significant health care cuts in Governor Schwarzenegger's initial budget proposal have been reversed in the revision he released May 13.

Perhaps most notably, the governor eliminated an additional 10 percent cut to Medi-Cal provider reimbursement that he had proposed in January. In a recent telephone conference with beneficiary and industry representatives regarding the proposed redesign of the Medi-Cal program, California Health and Welfare Secretary Kim Belshe stated that the elimination of this proposed reduction in Medi-Cal rates was the direct result of a preliminary injunction granted in December 2003 by the U.S. District Court in Sacramento to a coalition of 20 provider and beneficiary organizations led by the California Medical Association, including the California Dental Association and California Pharmacists Association. The coalition is represented by Hooper, Lundy & Bookman, Inc. (CMA v. Bonta, No. CIV-S032336 DFL PAN, E. D. Cal., 2003). That injunction blocked the five percent cut enacted by the Legislature that was scheduled to take effect on January 1, 2004.

The State has appealed the preliminary injunction to the Ninth Circuit Court of Appeals where it is seeking to overturn the earlier Court of Appeals victory obtained by HLB in *Orthopaedic Hospital v. Belshe,* 103 F.3d 1491 (9th Cir. 1997).

In addition to withdrawing his Medi-Cal rate cut proposal, the governor also withdrew a number of proposals that would have resulted in reduced benefits, including proposals to set enrollment caps for the Healthy Families program, a block grant for immigrants, copays for various health care programs and the elimination of In Home Supportive Services (IHSS) residual programs.

For more information, please contact Byron Gross at 310.551.8125 or Craig Cannizzo at 415.875.8511.

CMS Issues Final Rule for Inpatient Rehabilitation Facilities

The Centers for Medicare & Medicaid Services (CMS) has announced its final rule revising the criteria for classifying hospitals as inpatient rehabilitation facilities (IRFs) for purposes of Medicare payment.

IRFs currently provide specialized care for patients recovering from 10 specified conditions requiring intensive inpatient rehabilitation therapy. These conditions currently include stroke, spinal cord injuries, congenital deformity, amputations, major multiple traumas, fracture of femur, brain injuries, neurological disorders, burns, and polyarthritis. Because of the level of intensive rehabilitation services required for individuals treated at these facilities, Medicare pays for treatment in an IRF at a higher rate than it pays for rehabilitation in other settings, such as an inpatient hospital, skilled nursing facility, home health or the outpatient setting.

Although these 10 conditions have been used to assist CMS in classifying facilities that specialize in providing intensive inpatient rehabilitation services to beneficiaries, many have recommended that the list be updated to account for changes in medical practice, including other conditions that may now be appropriate for intensive inpatient rehabilitation. Based on extensive comments and analysis, CMS is issuing a final rule that it says address these concerns.

The final rule replaces "polyarthritis" with three arthritis-related medical conditions, and adds knee or hip joint replacement, thus increasing from 10 to 13 the number of "qualifying" medical conditions used to classify a facility as an IRF. For example, Medicare will now count a patient towards the compliance threshold if the patient has severe or advanced osteoarthritis involving two or more major joints (elbows, shoulders, hips, or knees, but not counting a joint that has been replaced), and have met other medical criteria outlined in the regulation. The proposed rule had required three or more joints to be affected by severe or advanced osteoarthritis.

The final rule also provides for a transition to targeting payments to facilities that treat a large share of patients with diagnoses likely to require intensive rehabilitation. In the first year, the final rule requires only a limited percentage of patients of an IRF's total patient population to have one of the qualifying medical conditions in order for a facility to be classified as an IRF.

For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the compliance threshold is set at 50 percent of the IRF's total patient population. For cost reporting periods beginning on or after July 1, 2005, and before July 1, 2006, the compliance threshold is set at 60 percent of the IRF's total patient population. For cost reporting periods beginning on or after July 1, 2006, and before July 1, 2007, the compliance threshold is set at 65 percent of the IRF's total patient population.

During this 3-year transition period, CMS will monitor what impact the revised criteria for classifying facilities as IRFs has on utilization and patient access to appropriate rehabilitation services. In addition, CMS plans to promote a research program to make it possible to assess the efficacy of rehabilitation services in various settings.

If at the end of this 3-year period CMS does not take further regulatory action, then 75 percent will be the compliance percentage used for cost reporting periods beginning on or after July 1, 2007.

The final rule takes other steps devised to ease IRF requirements. Specifically, the rule:

- Establishes an administrative presumption that if the facility's Medicare patient population complies with the rule, the facility's total population complies.
- Counts toward the new percentage threshold, both patients whose principal diagnoses matches one of the 13 qualifying medical conditions, as well as those who have a secondary medical condition that meets one of the conditions. The secondary condition must cause a significant decline in the patient's functioning such that, even in the absence of the admitting condition, the individual would require intensive rehabilitation treatment that is unique to IRFs and that cannot be performed appropriately in another care setting.
- Changes the period of time to review patient data to determine compliance with the new percentage threshold from the most recent 12-month cost reporting period to the most recent, appropriate and consecutive 12-month time period.

The final rule was published in the May 7 *Federal Register,* and will become effective for cost reporting periods beginning on or after July 1, 2004.

For more information, please contact Jon Neustadter at 310.551.8151 or jneustadter@health-law.com.

Medco Settlement Nets $3.6 Million for California

On April 26, 2004 Medco Health Solutions, Inc., the world's largest pharmacy benefits manager, reached a settlement with twenty states, including California, regarding claims that the company violated state unfair trade practices laws. The states argued that Medco encouraged prescribers to switch patients to prescription drugs based on rebates paid to the company by pharmaceutical manufacturers, but failed to pass on savings to patients or health plans. The states further alleged that Medco failed to inform the prescribers and patients of additional rebates that were paid by pharmaceutical manufacturers for using the drugs.

As part of the settlement, Medco agreed to cease switching drugs where the cost of the new drug exceeded the prescribed drug and where the switch was made to avoid competition from generic drugs. Medco further agreed to make certain disclosures to patients and prescribers, including informing both of the actual cost

savings to health plans and difference and co-payments paid by patients, disclosing the financial incentives to Medco for switching drugs, as well as the material differences of side effects between the prescribed and proposed drug.

Medco is also required to obtain authorization from the prescriber before effecting any drug switch. Patients must be informed that they may decline the drug switch and obtain the originally prescribed drug. On a going-forward basis, Medco is required to monitor the effects of drug switches on the health of patients and adopt a code of ethics and professional standards regarding drug switching.

The settlement also prohibits Medco from refusing to contract with health plans that do not use the average wholesale price (AWP) data to set pricing terms. Similarly, the settlement includes a release that excludes any state claims against Medco based on AWP or other pricing mechanisms.

According to California Attorney General Bill Lockyer, California will receive approximately $3.6 million of the $20 million in government restitution paid by the company. According to the Lockyer, Medco also agreed to pay consumers $2.5 million related to switches between cholesterol-controlling drugs from 1999 to the present.

For more information, please contact Stacy Bratcher at 310.551.8157 or sbratcher@health-law.com.

Calendar

May 14 HLB Attorney Patric Hooper speaks at the American Bar Association's Health Care Fraud Conference in New Orleans on *U.S. v. Mackby.*

June 3,4 HLB Attorney David Henninger co-presents *Health Law in California: The Legal Implications of Health Care Delivery Systems and Managed Care,* presented by National Business Institute June 3 in Anaheim, June 4 in Los Angeles

Hooper Lundy & Bookman, Inc.

HEALTH CARE LAWYERS

1875 Century Park East, Suite 1600
Los Angeles, California 90067-2799

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE
PAID
NASHVILLE, TN
PERMIT 989