HOOPER LUNDY & BOOKMAN, INC.

HEALTH LAW PERSPECTIVES

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HLB Files Suit on Behalf of CHA to Halt Implementation of AB 1455 Regs

Several aspects of regulations recently promulgated by California Department of Managed Health Care (DMHC) regarding the payment and processing of claims submitted to health plans by health care providers are inconsistent with superceding California laws and therefore DMHC should be prohibited from enforcing them, according to a suit filed by Hooper Lundy & Bookman, Inc. on behalf of the California Healthcare Association.

The regulations were the result of AB 1455, enacted in 2000, and are commonly referred to as the "AB 1455 regulations."

"AB 1455 was enacted to benefit hospitals and other health care providers by requiring DMHC to develop a more efficient system of claims submission, process and payment, and to establish requirements that health plans must follow in their dispute resolution processes that will be fair, fast and cost effective," said HLB Attorney Lloyd Bookman, who is representing CHA in the matter. "However, rather than benefiting providers and establishing fair and equitable rules, the AB 1455 regulations, in several key aspects, reduce the rights of health care providers and to benefit health plans in a manner that is both beyond the authority of DMHC and in consistent with existing law."

The suit specifically challenges the following aspects of the regulations:

- The "Good Cause Requirement", which permits health plans to impose deadlines on the submissions of claims by providers and require health plans to accept late claims where the provider demonstrates good cause for the delay. "Imposing a burden on providers to demonstrate good cause for late claims would violate a long-standing and fundamental precept of California law, which would prevent a late claim from being denied as untimely unless the provider has engaged in a grossly negligent, willful or fraudulent breach of duty," Bookman said.
- The "Claims Dispute Deadline," which permits health plans to establish, at a minimum, a 365 day time limit for health care providers to submit disputes to health plans.
- Provisions regarding payments to non-contracted providers. This provision sets forth the factors DMHC will use to determine whether the amount a health plan pays to a non-contracted provider is proper for the purpose of determining whether the payment was timely and whether he health plan has engaged in an unfair payment pattern. "This aspect of the regulations is invalid for a number of reasons," Bookman noted. "For one, it is beyond the authority of DMHC to determine the adequacy of rates of payments by health plans and is inconsistent with California law with respect to emergency services, which requires health plans to reimburse the actual billed charges of health care providers."

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HEALTH CARE LAWYERS

Court Rules in Favor of Balance Billing by Non-Contracted Emergency Providers

A trial judge of the California Superior Court in Los Angeles recently rejected a health plan's assertion that non-network, emergency providers are barred from billing patients for the excess of the amount billed by the providers and the amount paid by the health plan. In *Prospect Health Source Medical Group v. St. John's Emergency Medical Specialist, Inc.* (Case No. SC076909), the plaintiff was an IPA that contracted with health plans and assumed financial responsibility for payment of physician and hospital services to enrollees. Plaintiff argued that the Medicare allowable rate is, as a matter of law, reasonable compensation for emergency medical services. The plaintiff then argued that the acceptance of partial payment from the IPA at the Medicare allowable rate created an "implied contract" to accept the Medicare allowable rate as payment in full. The plaintiff reasoned that since California's Knox-Keene Act (Health & Safety Code sections 1375, et seq.) prevented "balance billing" by providers operating under both written and oral contracts with health plans (*i.e.*, Health & Safety Code Section 1379(b)), non-contracted emergency providers operating under an "implied contract" to accept the Medicare allowable rate may not engage in "balance billing."

The court disagreed, stating that the Knox-Keene Act provision cited by the plaintiff applies to the creation and operation of network provider contracts. But the court held that the provision did not mean a non-contracted provided accepted any contractual terms with the plaintiff, much less agree that the Medicare rate was the defined "reasonable" rate for emergency medical services, merely by accepting partial payment. As the court found no implied contract between the health plan and the non-network emergency provider, there was no bar to "balance billing" by such providers. The court further rejected the plaintiff's assertion that the Medicare allowable rate is "reasonable compensation" as a matter of law, stating that it was baseless.z

This decision also is important because it rejected a opinion letter from the California Department of Managed Health Care (DMHC) written by Staff Attorney Amy L. Doberteen , which stated that "balance billing enrollees violates the Knox-Keene Act, even if the emergency physicians do not have a written contract with the health plan." The court did not find the Doberteen Letter dispositive on the grounds that it was based less upon California statutes or regulations, and more upon a distinguishable Tennessee appellate court decision that relied on a statute barring non-contracted emergency providers from "balance billing" enrollees. The court noted that California has no such law, and while the DMHC proposed a similar regulation, that proposal has not been adopted.

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Governor Proceeds with Medi-Cal Rate Cuts Despite Injunction

Adding to a five percent reduction in Medi-Cal provider reimbursement rates former Governor Davis attempted to implement, Governor Arnold Schwarzenegger has proposed an additional 10 percent reduction in his recently announced budget.

Schwarzenegger's proposed 15 percent reduction for the coming fiscal year beginning July 1, 2004 comes on the heels of a court injunction barring the implementation of the Davis proposal, which was slated to go into effect January 1.

The injunction was granted after a suit was filed by HLB on behalf of a coalition of 13 provider and beneficiary organizations led by the California Medical Association (CMA) and including the California Dental Association and California Pharmacists Association (*CMA v. Bonta*, No. DIVS032336DFLPAN, Eastern District, CA).

"Studies have already documented serious problems with access to medical services for Medi-Cal patients, principally resulting from the very low rates paid to physicians, dentists and other providers by California," said HLB attorney Byron Gross, who, along with Craig Cannizzo, is representing the provider coalition in this case. "Further, many pharmacists have stated they will stop participating in Medi-Cal if rates are cut further, as they will be dispensing most drugs at a loss. Thus, we don't believe the Department of Health Services will be able to come up the necessary credible studies to support the additional 10 percent rate reduction proposed by the Governor."

In his 42-page ruling and injunction, U.S. District Court Judge David F. Levi stated that a five percent cut in Medi-Cal payments approved by the California legislature earlier last year violated federal Medicaid law because the state failed to consider how the cuts would affect access to care for the poor, disabled, elderly and children who receive care through the Medi-Cal program.

"Because the state failed to consider the effect of a rate reduction on beneficiaries' equal access to quality medical services, in view of provider costs, the pending

rate reduction is arbitrary and cannot stand," the judge wrote in his ruling.

The basis for the judge's ruling lies in an earlier landmark Ninth Circuit Court of Appeals ruling, *Orthopaedic Hospital v. Belshe*, in which Hooper, Lundy & Bookman represented the state's hospitals. In that ruling the court required the state to retroactively increase hospital outpatient rates.

"In the *Orthopaedic Hospital* ruling, the court found that Medi-Cal rates must be consistent with the costs of providing efficient, economical and quality care," said Gross. "The *Orthopaedic* court further ruled that the state must base its rates on reasonable cost studies and provider justification if the rates deviate from the costs." In addition, federal law requires access to health care services for Medicaid beneficiaries that is equal to access for the general population.

"Here, the Legislature made a five percent cutback without study on access or quality of care," Gross said. "This, it is unfathomable that there would be justification for the additional cuts."

The court ruling in the current case affects those Medi-Cal recipients who receive their services through the traditional fee-for-service mechanism. This group represents the neediest of Medi-Cal recipients—those who are blind, disabled and/or over 65. The ruling does not affect recipients in Medi-Cal managed care programs. The judge found that the health plan contracts with the state gave them the obligations that would protect beneficiaries, Gross noted.

Additional highlights of the Governor's proposed budget include:

- Controlling county Medi-Cal administration costs through requiring counties to meet productivity and performance standards.
- Revising the Medi-Cal rate methodology for Federally Qualified Health Centers and Rural Health Clinics.
- Notice that the federal Government will recoup $47.1 million from the state for Federally Qualified Health Centers overpayments.
- Reduction of the Medi-Cal provider "float" by delaying the Medi-Cal check writing by one week
- Expanding billing audits for Medi-Cal non-contracting hospitals, which the governor estimates will save the state $1.4 million in 2004-2005 and $15.3 million in 2005-2006.
- The possible expansion of managed care into additional counties, a review and reform of managed care reimbursement policy and encouragement of the Aged, Blind and Disabled into managed care.
- Possible proposal to conform Medi-Cal optional benefits with private plans.
- Possible proposal of co-payments for Medi-Cal benefits. Co-payments would be deducted from provider reimbursement and providers would be required to collect from the beneficiaries.
- The state may offer different benefit packages, with different co-payments, for the various mandatory and optional populations within Medi-Cal.
- The state many simplify eligibility by aligning Medi-Cal's eligibility standards and processes with those of CalWORKS and Supplemental Security Income/State Supplementary Payment (SSI/SSP) program.
- Reform of Medi-Cal Adult Day Health Care, as proposed for the 2003-2004 fiscal year by the prior Administration.
- Reduction of Medi-Cal interim rates by 10 percent for non-contracting cost reimbursed acute care hospitals.
- Imposition of a quality improvement assessment fee on Medi-Cal Managed Care Plans.
- Updating the statewide maximum allowances for Mental Health Medi-Cal services.
- Reduction of provider rates by 10 percent in public health caseload programs.
- Proposal of a two-tier benefit package for children in families with incomes between 200 percent and 250 percent of the Federal Poverty Level. No savings would accrue until the 2005-2006 fiscal year and administrative costs would increase by $263 thousand in 2004-2005 for implementation. The lesser benefit package would provide the current benefit package without the dental and vision coverage for the same co-insurance that is now paid. The better benefit package would include dental and vision coverage and a higher, unspecified co-insurance payment.

For additional information regarding the suit, please contact Byron Gross at (310) 551-8111 (bgross@health-law.com) or Craig Cannizzoat (415) 875-8500 (ccannizzo@health-law.com).

CALENDAR

January 29	HLB Attorneys Elspeth Delaney and Jodi Berlin conduct a teleconference for the California Hospice and Palliative Care Association on *Corporate Compliance: Can Your Board Meet the Test of Legal & Public Scrutiny?*
February 2	HLB Attorney Mark Reagan speaks on *Avoid the Risk: How to Stay in Business With an Effective Compliance Plan* at the California Association of Homes and Services for the Aging public policy pre-conference, Sacramento.
March 6	HLB Attorney Elspeth Delaney speaks on *Auditing and Monitoring your ASC's HIPAA Program* at the annual meeting of the American Association of Ambulatory Surgical Centers, Orlando Florida.
19-21	HLB Attorney Lloyd Bookman speaks on *DMHC's AB 1455 Regs and the Related CHA Lawsuit* at the California Society of Healthcare Attorneys conference, Monterey.
31-April 2	HLB Attorney Jon Neustadter speaks on *PRRB Practice and Procedure* at the American Health Lawyers Association Medicare and Medicaid Payment Institute, Baltimore.

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