HOOPER LUNDY & BOOKMAN, INC.

HEALTH LAW PERSPECTIVES

Volume 2, No. 7 July 2000

HLB Files Class Action to Halt Illegal DHS Medi-Cal Enforcement Activities

Medi-Cal providers are being subjected to unlawful enforcement activities, despite individual court rulings finding that the Department of Health Services and the State Controller have violated provisions of governing federal Medicaid laws, according to a suit seeking class action status filed by HLB attorneys Patric Hooper and Mark Hardiman.

"This suit attempts to stop certain practices that the state continues to employ even though the courts have declared these practices illegal for individual clients," Mr. Hooper said.

Representing the class currently are a clinical laboratory and a physician who have been terminated from Medi-Cal and other health care programs and who have been subject to temporary withholding of 100 percent of their Medi-Cal payments, have had their provider numbers temporarily suspended, and/or have been disenrolled from the Family PACT program, a federal/state health care program similar to Medicaid. The suit was filed on behalf of providers in the state who have been subject to similar actions based on allegations of fraud and abuse or willful misrepresentation. Mr. Hooper estimates these providers to number in the hundreds.

In addition to protecting providers, the suit also seeks to question a number of cutting-edge issues, including:

- The creation of an internal Medi-Cal fraud bureau within DHS that violates federal Medicaid laws.
- The fraud bureau's use of warrantless searches in surveying facilities.

"Simply put, the wrong state officials are using the wrong procedures to implement the wrong enforcement actions to the severe detriment of providers, patients, state taxpayers and the rule of law," Mr. Hooper said.

For more information, contact Mr. Hooper at (310) 551-8165.

High Court Ruling Leaves Qui Tam Liability Issues Open

The United States Supreme Court has ruled that a private individual who brings a *qui tam* (whistleblower) action on behalf of the United States has standing to sue so long as the United States has suffered an injury *(Vermont Agency of Natural Resources v. United States ex rel. Stevens)*. The Supreme Court also held that states may not be sued by qui tam relators, but its ruling has left a number of questions open.

The majority decision, written by Justice Scalia, is clear that a private individual bringing a False Claims Act (FCA) suit on behalf of the U. S. government (without U.S. intervention) may not sue a state or state agencies.

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Thus, for example, a private relator cannot bring a *qui tam* suit against state-run hospitals, when the federal government does not intervene.

However, the Court's decision is consistently written with references to "private individual" and "*qui tam* liability," which suggests that the holding might be limited to situations in which the government does not intervene. And based on comments issued in a concurring opinion and a dissenting opinion, the Court might have engaged in a different analysis (and might have reached a different result) if the United States had intervened in the case. Thus, the Court's holding should not be read to mean that a state is not liable under the FCA when the United States intervenes.

Also unclear is whether the Court's holding applies not only to states and state agencies, but also to counties and municipalities. While the Court's decision does not directly address this issue, one of the bases for the Court's holding is that governmental entities, as opposed to just states, should not be subjected to punitive damages. However, other aspects of the Court's decision do not necessarily apply to counties and other governmental entities, and prior to the *Stevens* decision, the lower courts were split on whether the FCA applies to counties. Thus, it appears that, although counties may now have good arguments that they should not be subjected to FCA liability, the issue remains unresolved.

In light of the Supreme Court's decision, county and state providers should be aware of possible challenges to a *qui tam* suit brought by a private relator or to an FCA suit brought directly by the United States. A state provider can obtain the dismissal of a relator's qui tam lawsuit if the United States does not intervene, and can seek the dismissal of an FCA case brought directly by the United States. A county provider may still need to litigate its liability under the FCA, whether or not the United States intervenes.

Significantly, The *Stevens* case does not immunize states or counties from California's False Claims Act. County and state providers, regardless of the *Stevens* decision, therefore need to continue to make certain that false or fraudulent claims are not submitted to the state or federal governments.

For more information, contact Lloyd Bookman, David Henninger, or Jon Neustadter, at (310) 551-8111.

OIG Issues Hospital, Hospice Advisory Opinions

The Health and Human Services Office of Inspector General recently issued two new Advisory Opinions.

In the first, OIG concluded that a program by which a hospital's non-physician employees could be rewarded for submitting cost-savings suggestions to the hospital would not violate the anti-kickback statute, notwithstanding the fact that some of the employees were health care professionals who would be in a position to order Medicare covered services from the hospital.

In the second opinion, OIG approved a program by which various free services would be provided by a hospice to nursing home patients with terminal illnesses who have a prognosis of less than one year to live. The patients would not be eligible for the Medicare hospice benefit, either because they would have a life expectancy of over six months or because they have elected to continue curative treatment rather than hospice care. The services did not duplicate any services which the nursing homes were obligated to perform under the Medicaid per diem amounts which they received. This opinion addressed a concern that the OIG had specifically identified in its special fraud alert, *Fraud and Abuse in Nursing Home Programs with Hospices,* that hospices might attempt to get referrals from nursing facilities by taking up the burden of services for which the nursing facility was financially responsible. While OIG believed that the services had some monetary value and were at least in part intended to induce the patients to choose to receive care from the hospice at an appropriate time, OIG nevertheless allowed the program.

For more information, contact Brad Tully at (310) 551-8160.

HLB Attorney Honored for Dedication to Child Welfare Issues

HLB Attorney Linda Randlett Kollar recently received three honors for her contributions in the field of child welfare.

For her work with private child welfare agencies, Ms. Kollar received the *Reflections of Excellence* award from the David and Margaret Home, Inc. which honored her for her work as an attorney, as well as for her previous contributions as a social worker for the Los Angeles County Department of Children and Family Services.

In addition, Ms. Kollar also recently received recognition for her

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Commentary

HMOs May Not Shift Liability for Hospital Claims

As a result of increasing volatility within the managed care industry, many health plans are attempting to shift financial responsibility and liability for payment of hospital outpatient services to independent practice associations or medical groups with which they have contracted. We believe that health plans are prohibited from shifting such liability under the provisions of most health plan agreements as well as under the Knox-Keene Act.

Most agreements between hospitals and health plans provide that the hospital is to submit claims for services provided to health plan beneficiaries to the health plan, and that the health plan will pay such claims within a certain time period. The health plans, however, have entered into capitated agreements with IPAs or medical groups that have shifted the risk and obligation for payment of hospital outpatient services to the IPAs or medical groups. The hospitals typically are not a party to these agreements.

As a result of entering into these agreements, the health plans have refused to administer claims for these outpatient services. They have instructed hospitals to bill the IPAs and medical groups directly and to seek payment from such groups. Most hospitals do, in fact, bill the medical groups and accept payment directly from them.

Many IPAs and medical groups in California are financially unstable, have cash flow problems, or are on the brink of insolvency. As a result, hospital outpatient claims are sometimes being paid untimely or not at all. If these medical groups do file for bankruptcy, health plans may attempt to force hospitals to file their claims for payment in the bankruptcy action. Unless the hospital has a direct contract with the IPA or medical group, however, we believe that hospitals may pursue payment of such claims from the health plans outside the bankruptcy process.

The refusal of the health plans to administer and to pay the claims may be a breach of their agreements with hospitals.

Moreover, refusal of the plans to ensure timely payment of these claims would appear to violate the Knox-Keene Act. Thus, a plan cannot waive or assign its obligations to make timely payment on hospital outpatient claims to hospitals by contracting with IPAs or medical groups to pay such claims. The health plans remain contractually and statutorily liable to ensure timely payment of such claims.

In addition, Health and Safety Code section 1349.3(a) was recently amended to provide that "[o]n and after January 1, 2000, no licensed health care service plan shall contract with any person, other than a licensed health care service plan or licensed health care service plan with waivers, for the assumption of financial risk with respect to the provision of both institutional and noninstitutional health care services and any other form of global capitation." Although the statute has not yet been interpreted by any court, it is possible that it may be interpreted to prohibit health plans from entering into capitation agreements with IPAs and medical groups that shift the risk of hospital outpatient services to such IPAs or medical groups.

Finally, health plans that do not have the capability to administer hospital outpatient claims may be in violation of the Knox Keene Act and its applicable regulations. Plans cannot avoid their statutory obligations by simply taking the position that they do not have the capability to adjudicate claims.

For more information, please contact Daron Tooch at (310) 551-8192) or Angela Mickelson at (310) 551-8170).

dedication and compassion for children from the California Assembly and the Los Angeles County Board of Supervisors, which recognized her achievements with private child welfare agencies.

"It is unusual for an attorney to be able to have the kind of practice that allows you to maintain idealism, help clients fulfill their mission, and ultimately help protect children," Ms. Kollar said, noting that the challenges for child welfare agencies are mounting.

"Because of cuts in funding, community programs are finding themselves responsible for an increasing number of higher acuity children to care for," she said. "As the children become more challenging and difficult, the agencies are facing increased litigation and the necessity for revamping the regulations to protect these agencies is mounting."

As a result, Ms. Kollar said she continues to focus on advocating for her client agencies, insulating them when she can and working with administrative agencies and the Legislature to help them understand the need to address the agencies' changing role.

CALENDAR

July 25 HLB Attorneys Angela Mickelson and Todd Swanson speak at the National Business Institute's Health Law Seminar in Anaheim. Ms. Mickelson will speak on "Managed Care Contracts" and Mr. Swanson will speak on "Merging and Acquiring Medical Practices."

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