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Health -E- News

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SECTION NEWS

Upcoming CLEs: Regarding the one hour CLEs, please note that there have been changes in the date and times (in red) for some of the CLEs. If you placed them on your calendar after receiving the last Health-E-News, please correct your calendar. Here is the new schedule:

April 22nd	7:30 AM	Fraud & Abuse: Federal Laws - Civil Enforcement Policy
May 27th	11:30 AM	Fraud & Abuse: HMO and DOI Enforcement Activities
June 24th	7:30 AM	Fraud & Abuse: Stark I & II and Anti-Kickback

Board Meetings: The Board will meet on the following dates at the State Bar office, and any member of the Section is welcome to attend these meetings:

April 15 th	11:30 AM
May 20 th	7:30 AM
June 17 th	11:30 AM

NEW DEVELOPMENTS IN HEALTH LAW

Senate Bill 213 Creates Civil Penalties Under the Medicaid Fraud Act

Not included in the earlier list of bills passed by the NM Legislature, Senate Bill 213 amends the Medicaid Fraud Act to add Sec. 30-44-8 NMSA 1978, which imposes new civil penalties on providers who violate the Act.

This new section adds to the penalties listed elsewhere in the Act (i) interest on the amount of excess payments at the maximum legal rate on the date the payment was made, from the date of payment to the date of repayment, (ii) a civil penalty *of up to three times* the amount of excess payments, and (iii) the payment of legal fees and costs of investigation and enforcement of civil remedies.

It also makes a provider liable for payment of a civil penalty of up to ten thousand dollars for each "false or fraudulent claim submitted or representation made for providing treatment, services or goods." Because this provision is in the Medicaid Fraud Act, there is a question regarding whether its reference to a "false...claim" means the penalty applies to the new Mexico False Claims Act, which has no specific penalties listed within its provisions.

This new section allows the Medicaid Fraud Unit to retain as a war chest up to \$250,000 in Fiscal Year 2004, \$150,000 in FY 2005 and \$75,000 in FY 2006 from amounts recovered under the Medicaid Fraud Act. There is an obvious incentive for the Medicaid Fraud Unit to collect in FY 2004, so its activity may increase.

Senate Bill 213 makes it clear that remedies under the Medicaid Fraud Act can be cumulative, it permits HSD to adopt regulations, and it creates a five year statute of limitations under the Medicaid Fraud Act.

OMB Clears Phase II Stark II Final Regulations – CMS issues them

The Office of Management and Budget (OMB) on March 15 completed its review of the Phase II physician self-referral regulations, according to an update on the agency's Web site. In February, OMB revised the receipt date for the Stark II regulations to December 17, 2003.

To view the update on OMB's Web site, go to
<http://www.whitehouse.gov/omb/library/OMBREGSC.html#HHS>

On March 25th CMS released the regulations and a 607 page PDF file can be viewed at
http://www.healthlawyers.org/docs/ofnote_Stark2_Phase2.pdf

The Health Law Section's June CLE will discuss Stark II and the new regulations. As commentaries become available on open websites, this newsletter will post them.

The new regulations protect legitimate arrangements involving specialty groups that furnish oncology and radiology services. There is also a revised definition of compensation that is "set in advance" to allow certain common percentage compensation arrangements.

The new statutory exceptions include those for physician investment interests in publicly traded securities and mutual funds. There is also a revision to the hospital ownership exception to reflect the new eighteen-month moratorium on physician ownership of specialty hospitals as required by § 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Interpretations of statutory exceptions for compensation arrangements involving physicians are also included in the new regulations. Certain entities that provide designated health services must report their financial relationships with physicians, but the reporting is only required when a request for it is made by CMS, and not on a regular basis.

"The new regulations will protect Medicare and Medicaid beneficiaries from potentially abusive referrals, while accommodating legitimate business and financial arrangements, including those that enhance the emerging national health information infrastructure," said CMS Acting Administrator Dennis Smith. "Overall, there shouldn't be any additional burden on physicians trying to structure their business arrangements to comply with the law, and the regulations will not prevent doctors from continuing to provide high quality health care services to their patients."

The new regulations are effective July 26, 2004. Comments on the interim final rule are due June 24, 2004.

They are printed the **Federal Register**, Vol. 69, No. 59, Friday, March 26, 2004

Babies on Steroids – What next for Pediatricians?

A common steroid treatment for premature babies with lung problems can damage their brains and slow their growth, for information regarding the first long term study go to

http://news.findlaw.com/ap/o/1500/3-25-2004/20040325043008_12.html

NEW HEALTH CARE CASES

Supreme Court To Hear Suits Against HMOs

FORT WORTH, Texas (AP) - Just a day after undergoing a hysterectomy, Ruby Calad had to leave a Houston hospital because her insurance company would not pay for a longer stay. A few days later, she was rushed to the emergency room with complications she says could have been avoided had she remained hospitalized. Nearly five years later, she says she remains in constant pain and needs more surgery. She says the ordeal caused the breakup of her marriage. Calad blames her insurer, Cigna Healthcare of Texas, and the case stemming from her lawsuit against the company will be argued Tuesday before the U.S. Supreme Court. Her case - and a companion case that the high court will also hear - could establish what rights patients have to sue when an HMO refuses to pay for recommended care. Specifically, the Supreme Court is being asked to decide whether such cases can be heard in state court or federal court.

Patients like Ruby Calad, who claims her HMO refused to pay for care one of its own doctors recommended, can be sympathetic figures in court. Juries often make large awards in cases where a big company seems to have taken advantage of a little victim. That's the main reason why insurers want to move cases like Calad's into federal court, where judgments result in relatively little or no money and the reason why the hysterectomy patient's story made its way to the Supreme Court. Calad's lawyer calls hers a "classic HMO horror story," but the legal question for the Supreme Court is not whether Calad's HMO negligently pinched pennies. In deciding where suits like Calad's belong, the court will examine whether states can improvise their own patient protection laws to deal with the growth of managed care.

http://news.findlaw.com/ap/a/w/1154/3-23-2004/20040323004502_02.html

Case Docket (Aetna Health, Inc. v. Davila / Cigna HealthCare v. Calad)
http://supreme.findlaw.com/supreme_court/docket/2003/march.html#02-1845

http://news.findlaw.com/ap/a/w/1154/3-19-2004/20040319100009_31.html

This Email Newsletter is a publication for the members of the Health Law Section of the New Mexico State Bar Association. Its contents may be time dated, and references to Internet sites may change. The Content of this Newsletter does not reflect the opinions of the Members of the Board of Directors of the Health Law Section of the State Bar. This Newsletter is informational only, does not constitute legal advice. Members of the Health Law Section may submit topics for the newsletter by emailing them, or the internet site at which they can be located, to JAB@NMCounsel.com