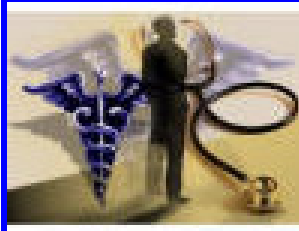


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SECTION OF THE STATE BAR OF NEW MEXICO



## Health -E- News

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### SECTION NEWS

#### THE FALSE CLAIMS ACT AND THE HEALTHCARE INDUSTRY: NEW ISSUES FOR ATTORNEYS AND PROVIDERS

and  
2007 LEGISLATIVE UPDATE

Thursday, April 19, 2007  
State Bar Center, Albuquerque

3.7 General CLE Credits (Both Sessions); 2.7 General (A.M.), 1.0 General  
(P.M.)

|                                               |       |
|-----------------------------------------------|-------|
| Standard Fee (Both Sessions)                  | \$129 |
| Health Law Section Member (Both Sessions)     | \$119 |
| Standard Fee, (A.M. Session only)             | \$95  |
| Health Law Section Member (A.M. Session only) | \$85  |
| Standard Fee, (P.M. Session only)             | \$45  |

Co-Sponsor: Health Law Section

### SCHEDULE OF EVENTS

|           |                                                                                                                                                                                    |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 8:00 a.m. | Registration                                                                                                                                                                       |
| 8:30 a.m. | <b>The DRA: Implications for State Medicaid Programs</b><br>Larry Heyeck, Esq., Deputy Director, Medical Assistance<br>Division,<br>Human Services Department, State of New Mexico |
| 9:20 a.m. | <b>I Can't Find MAHFOOCOO in the Dictionary</b><br>Katherine Vincent, Esq., Director, MFCU Medicaid Fraud<br>Control Unit, New Mexico Office of the Attorney General               |
| 9:45 a.m. | Break                                                                                                                                                                              |

10:00 a.m.     **Trends in False Claims Act Prosecutions: What’s Going On Outside New Mexico?**  
David Johnson, Esq., Rodey Law Firm

10:45 a.m.     **What To Do When The Government Comes Calling**  
**(or when a compliance officer says, “I think we have a problem.”)**  
Linda Baumann, Esq., Partner, Arent Fox, Washington, D.C.

11:30 a.m.     Lunch (provided at the State Bar Center)  
Health Law Section Board Meeting

#### **P.M. SESSION**

12:30 p.m.     **Legislative Update**  
Barbara Quissel, Gabe Parra, and Jeff Gilmore, attorneys at law.

1:30 p.m.     Adjourn

## **DEVELOPMENTS IN HEALTHCARE LAW**

### **U.S. Supreme Court issues important Qui Tam Decision**

The Supreme Court has ruled (6-2) that it lacked jurisdiction over a Relator’s (plaintiff in Qui Tam talk) complaint after the Department of Justice (DOJ) amended the complaint to include allegations for which the Relator was **not** the original source.

This ruling could impact a number of Qui Tam actions, which are filed by private citizens (often whistle blowers) under seal. The DOJ investigates the allegations in the complaint and can then decide to take over the prosecution of the complaint or defer. If the DOJ defers, the Relator can pursue the lawsuit. It is a fundamental requirement of the False Claim Act (31 USC §§3729-3733) that the Relator be the “original source” of the information about the alleged false claim. It is not uncommon, however, for the DOJ, after it investigates, to discover additional violations not alleged in the complaint, and to conclude the complaint’s original allegations are not worthy of prosecution.

To be an original source, the Relator must be a person that “has direct and independent knowledge of the information on which the allegations are based.” 31 USC §3730(e)(4)(b). In *Rockwell* the court looked at the **final** allegations pursued by the government as the benchmark for evaluating the original source requirement.

See *Rockwell International Corp. et. al. v. United states* at

[http://www.healthlawyers.org/email/pg/070328fraud/syllabus\\_opinion.pdf](http://www.healthlawyers.org/email/pg/070328fraud/syllabus_opinion.pdf)

### **Qui Tam cases relaxing the Rule 9(b) requirement**

Rule 9 of the Federal Rules of Civil Procedure (New Mexico’s state rules contain a similar provision) has been a difficult hurdle for many qui tam Relators (plaintiffs who bring lawsuit on behalf of the government) to clear while making allegations regarding False Claims Act violations. Rule 9 requires fraud to be pled with specificity.

However, there has been a developing trend of allowing more leniency in pleading *qui tam claims*. See the recent Illinois U.S. District Court opinion, *United States ex rel. Absher*, No. 04-2289 (.C.D. Ill. March 2, 2007) which relies on *Corley v. Rosewood Care Center, Inc.* 142 F.3d 1041 (7<sup>th</sup> Cir. 1998). The *Absher* court noted that the defendant had resisted attempts at discovery, and while the Relators had first

hand knowledge of the alleged incidents because they were nurses and observed them, they were isolated from the billing functions and could know information held in the defendant's exclusive control. In the "lesson's learned" category, for both Rule 9 and 56 purposes, counsel for Relators may want to serve somewhat specific discovery with the complaint, and counsel for defendants may want to avoid leaving the impression their client is stonewalling discovery.

## **Virginia Supreme Court says corporation that has no license cannot enforce a non-compete**

The court held that where a corporation did not have a license to practice medicine, it was a non-professional entity that lacked a legitimate business interest in enforcing a non-compete clause. The original agreement was with a professional corporation, owned by a single doctor, who died. The owner's wife became the sole shareholder and owner, and she was not licensed to practice medicine. When she tried to enforce the covenant, the court held that because the corporation did not have a license to practice medicine, it could not enforce the covenant because it had no business interest. See *Parikh v. Family Care Center*, No. 060934 (Va, Mar.2, 2007).

[Editor's Comments - This is a great case to discuss on the section's list serve. <http://groups.yahoo.com/group/SBNM-HealthLawSection>

Does New Mexico law expressly permit the corporate practice of medicine? Where is it so stated? As a matter of public policy, should an entity that is not licensed to practice medicine be allowed to enforce a covenant prohibiting a licensed doctor from practicing under a license properly issued by the state?

The NM Professional Corporations Act, NMSA §53-6-3 1978 Comp., provides for the incorporation of an individual or group of individuals to render the same professional service to the public. It is clear that a professional corporation may only render services through its officers, employees and agents who are duly licensed or otherwise legally authorized to render such professional services. (§53-6-7). But the professional corporation is *not issued a license* to practice medicine. Without exception, every provider licensing statute licenses an individual – not the business entity. What if doctors form a limited liability company either to operate as a practice group or as a joint venture with some other type of provider? The LLC is not issued a license to practice medicine. Are the members of an LLC entitled to the same protections as the shareholders in a professional corporation? Where in the LLC Act does it mention licensed professionals as they are mentioned in the Professional Corporations Act?

Many states have express statutes or case law that permit or prohibit the corporate practice of medicine and for years the New Mexico Professional Corporations Act has been viewed at such a statute, but the scope of the "practice" has never been tested in or defined by the New Mexico courts.

New Mexico has no statute expressly addressing this issue, and the seminal NM case involving covenants not to compete, *Lovelace Clinic v. Murphy*, 76 NM 645, 417 P.2d 450 (NM 1966) involved an unincorporated association of doctors, not a corporation, partnership or other form of business entity. The Lovelace covenant was contained in amended articles of association, and no legal challenge was made to the association's right to enforce the covenant.

The only other "authority" of which this Editor is aware, is an Attorney General's opinion issued in 1987, which concluded that a corporation organized and controlled by non-physicians could provide medical services to the general public through employed physicians. See N.M. A.G. Op. No. 87-39, 1987 WL 270340. This opinion cites to a number of statutes and cases to support its rationale. However, with no disrespect intended to Hal Stratton, as Franklin Jones (a mentor of mine) often said, "an AG's opinion normally isn't worth the paper it is written on."

When a covenant-not-to-compete is between a newly recruited doctor or shareholder, and it is written in such a way that the covenant belongs to the corporation and not the licensed practicing shareholders of the corporation, can the unlicensed corporation enforce it? Apparently not in Virginia.

## **CMS launches new Part D website**

The Centers for Medicare & Medicaid Services (CMS) has launched a new section on the CMS public website that will serve as a centralized repository for public data about contracts and plans, enrollment numbers, service area data, and contact information for Medicare Advantage (MA), Prescription Drug Plan (PDP), cost, PACE, and demonstration organizations.

The CMS website provides:

- Monthly Contract and Enrollment Summary Report;
- Monthly Enrollment by Contract;
- Monthly MA Enrollment by State/County/Contract;
- Monthly PDP Enrollment by State/County/Contract;
- MA Contract Service Area by State/County;
- PDP Contract Service Area by State/County;
- State Service Area;
- Plan Directory for MA, Cost, PACE, and Demo Organizations;
- MA Claims Processing Contacts; and
- Annual Reports by Plan.

The monthly updates to contract and enrollment reports are scheduled to be done by the 15th of each month. To access these updates, go to <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/>

*[Editor Comment: We thank Caroline Wade Blankenship (Miller Stratvert PA, Albuquerque, NM) for providing this email alert to the AHLA which was shamelessly borrowed for this newsletter.]*

## **Efforts to establish pay-for-performance system for Medicare will be complicated, study says**

[Congressional Quarterly](#) (3/30, Carey) reports on a recent study published in the March 15 issue of the *New England Journal of Medicine*, which states, "Efforts to establish a 'pay-for-performance' system in Medicare may be complicated by the number of physicians Medicare patients typically see." According to researchers at the Center for Studying Health System Change and Memorial Sloan-Kettering Center, a "Medicare patient seen by the typical physician in the nationally representative study was treated by seven different doctors in four different medical practices in a given year" and only "about 35 percent of beneficiaries' visits were with the doctor...responsible for their care under the most common 'pay-for-performance' methodology used to assign patients to physicians." With many "different physicians and practices provid[ing] care to an individual Medicare patient, it is difficult to identify which provider is responsible for which patient. Physicians also are unlikely to have a critical mass of patients who are their primary responsibility and about a third of the patients they would be held responsible for will switch to a different provider the next year." This "raises serious questions about how meaningful a Medicare pay-for-performance program would be for patients in the current fee-for-service system where care is so widely dispersed," said Hoangmai H. Pham, the study's lead author and senior health researcher at the Center for Studying Health System Change, a nonpartisan policy research organization." While many "lawmakers and healthcare analysts say linking Medicare reimbursement to the quality of care delivered would both improve healthcare services and lower costs," some physicians "have expressed concern over the design of performance measures and how they will be implemented." The study's authors suggest that "Medicare consider prospectively assigning patients to physicians and practices to establish clearly which providers will be held accountable for coordinating patients' care," instead of "using claims data to retrospectively assign patients to physicians."

## **Colorado governor signs bill protecting medical whistle blowers**

The [AP](#) (3/30, Paulson) reports, "Gov. Bill Ritter signed a measure Thursday that would allow nurses and...hospitals to blow the whistle without getting fired if they believe medical safety is being compromised." Ritter noted, "The common ground here (is) providing the best possible healthcare and consumer information to the people of Colorado, while also protecting the interests of our healthcare workers and our hospitals." Steven Summer, president of the Colorado Hospital Association, said, "Colorado hospitals recognize the critical role that nurses play in the delivery of patient care. We remain committed to the disclosure of information that will help patients learn more about the quality of care provided in our hospitals."

## **Joint Commission Report: National strategies needed to better serve increasingly diverse patient population in American hospitals**

To view this complete new release and the report, please visit [www.jointcommission.org](http://www.jointcommission.org). (OAKBROOK TERRACE, Ill. – March 29, 2007). A new Joint Commission report recommends targeted strategies to address language and cultural issues that increasingly pose challenges to hospitals seeking to deliver safe, effective care to diverse American population.

The recommendations in *Hospitals, Language, and Culture: A Snapshot of the Nation* result from a study of how 60 hospitals across the country are providing health care to culturally and linguistically diverse patient populations. The project examined the challenges of providing care and services to populations that may not speak the same language or share the same customs; how hospitals are addressing these challenges; and promising practices that can be used by hospitals across the country.

## **Medicare D "doughnut hole" woes could get worse**

The [Los Angeles Times](#) (4/2, Alonso-Zaldivar) reports on the impact of Medicare Part D's "doughnut hole," which "leaves some recipients with \$3,000 in costs to pick up themselves." The Times notes that Sierra Health Services is one of the private companies that "was supposed to help," but that "the Sierra Rx Plus plan lost \$3 million in January, its first month of operation. Faced with that red ink, the company announced in late February that next year it would no longer offer a plan that covers brand-name drugs in the gap. About the same time, hundreds of enrollees started getting notices that their Sierra coverage was being discontinued for nonpayment -- although some said they already had sent in checks. Medicare officials recently intervened to order about 2,000 customers reinstated, including about 200 AIDS patients." The Times cites this incident as indicative of the "problems inherent in Medicare's partnership with private insurers to provide drug coverage for elderly and disabled Americans. Because Sierra was the only major plan to cover brand-name drugs in the gap this year, recipients may have no comparable option for 2008."

## **AHRQ releases gender-specific, bilingual health brochures**

[HealthDay](#) (4/2, Preidt) announces the availability of "two new gender-specific, evidence-based checklists designed to help women and men understand which medical checkup tests they need to stay healthy" by the U.S. Agency for Healthcare Research and Quality. The "Your Checklist for Health," available in English and in Spanish, is a "pocket-sized brochure that patients can take with them when they visit their healthcare provider. The checklists help patients discuss screening tests they might need."

Meanwhile, the [New York Times](#) (4/2, Abelson) provides questions patients should ask prior to surgery. And, the [Wall Street Journal](#) (4/1, Gerencher) provided information to enable patients with "how and where to find the best" substance-abuse treatment program.

## **Stark Final Rule delayed – yet again**

Three years ago the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule interpreting the federal physician self referral prohibition commonly known as the Stark Law (the "Stark II Phase II" rule). In general, CMS had 3 years to issue a final rule after the publication of an interim final rule. More specifically, the Social Security Act provides that an interim final rule shall not continue in effect if a final rule is not published before the expiration of the regular timeline (in this case 3 years) unless the Secretary publishes a notice of continuation that includes an explanation as to why the deadline was not met. The recent publication of the notice extends the timeline for publishing the final rule for 1 year.

The new deadline for issuance of the final Stark rule is March 2008. CMS could publish the final rule earlier but no predicted timeline has been suggested. For the industry, the delay in the issuance of the final Stark rule continues the status quo. The interim final rule published in March of 2004, remains in effect and healthcare lawyers and their clients will continue to speculate on what changes CMS might implement in the final rule or suggest in a companion proposed regulation.

[Editor's Comment: These "Final Rules" have the gestation period of the seven year locust. Perhaps no action is better than a new set of rules.]

### **THE USUAL DISCLAIMER**

***This e-mail newsletter is a publication for the members of the Health Law Section of the State Bar of New Mexico. 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 or the Board of Bar Commissioners of the State Bar of New Mexico. This newsletter is informational only, and 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 John Bannerman, whose email address is [JAB@NMCounsel.com](mailto:JAB@NMCounsel.com).***