**SESSION 1.05**

# STATE LAW ISSUES: CALIFORNIA'S ANTIFRAUD INITIATIVES - - COMING TO A STATE NEAR YOU

**By**

**Patric Hooper**
**Hooper, Lundy & Bookman, Inc.**

**November 16, 2004**
**10:00 a.m.**

**Patric Hooper, Esq**

Patric Hooper received his A.B. degree in Economics from the University of California at Los Angeles in 1970. He received his J.D. from the University of San Diego School of Law in 1973.

In 1973, Mr. Hooper began his legal career with the California Department of Justice, where, as a Deputy Attorney General, he represented various state agencies in civil litigation involving health, education, and welfare matters.

Since 1976, he has specialized in litigation against the federal and state governments involving health care matters. He has been involved in hundreds of administrative and judicial proceedings throughout the country as the lead trial and appellate attorney. His cases include some of the most important and complex Medicare, Medicaid and CHAMPUS cases in the health care field.

In 1987, Mr. Hooper together with Bob Lundy and Lloyd Bookman, formed the nation al health care law firm of Hooper, Lundy & Bookman, Inc. in Los Angeles. As a founding member of Hooper, Lundy & Bookman, Inc., Mr Hooper has continued to represent health care providers in health care disputes with federal and state governments throughout the country.

Mr. Hooper has represented pharmacies and pharmacy manufacturers in connection with nationwide and state Medicare and Medicaid fraud investigations, including those cases involving AWP and Medicaid rebate issues, and in Medicare and Medicaid payment disputes, as well as licensure and certification issues.

In addition to his involvement in resolving disputes, Mr. Hooper also regularly advises nonprofit and for-profit health care organizations regarding reimbursement, certification and licensure issues associated with business transactions and combinations. He continuously advises health care providers of Medicare, Medicaid and CHAMPUS fraud and abuse issues and on state antirebate and referral issues. Mr. Hooper is a frequent lecturer before national health care organizations on issues pertaining to the health care field and has published numerous articles on a variety of health care matters.

Mr. Hooper is a former general counsel to the National Association of Psychiatric Treatment Centers for Children, and is a member of the American Health Lawyers Association, the Healthcare Financial Management Association, the California Society of Heathcare Attorneys, and the California Clinical Laboratory Association. He was also the First Chair of the Fraud and Abuse Interest Group of the ABA Health Law Section.

# MEDI-CAL INVESTIGATIONS AND SANCTIONS ISSUES

## A. NO MORE "PAY AND CHASE"

For many years, the Medi-Cal program has been criticized for allowing "fraudsters" to get away with "millions" before taking any action to stop paying them. In other words, traditionally, Medi-Cal has paid providers without closely scrutinizing their claims until long after payments had been made. This "pay and chase" procedure allowed some dishonest health care providers to get away with excessive payments with little chances of recovering them.

Shifting from this "post hoc" method of curbing fraud and abuse, Medi-Cal has more recently begun focusing its efforts on earlier stages of the process, beginning with the process for enrolling providers in government programs. Thus, Medi-Cal is now scrutinizing much more closely information from prospective program participants before granting them the right to participate in the Medi-Cal program. Not only does this present substantial practical problems and delays in obtaining enrollment, it also gives the Medi-Cal program an opportunity to impose sanctions on new applicants as well as existing providers.

Thus, through enrollment and reenrollment processes, Medi-Cal may seek to impose sanctions on an applicant, which not only prevents the applicant from becoming enrolled in connection with a new location but also may also cause problems for currently enrolled pharmacies owned by the applicant. Medi-Cal may also deny enrollment to any applicant that is "under investigation" elsewhere. Cal. Welf. & Inst. Code § 14043.31. And, an

applicant who has been denied enrollment may not reapply for a period of three years. Welf. & Inst. Code 14043.65(b). While there are remedies available to applicants and existing providers to challenge these actions, the process can be expensive and involved.

Another way in which Medi-Cal is attempting to "sort out" potential fraudsters in advance is by limiting the enrollment process through "contracting" or bidding. Currently, Medi-Cal, is in the process of choosing independent clinical laboratories with whom the Medi-Cal program will contract. Those laboratories wishing to contract with the Medi-Cal program must meet a series of stringent and often ambiguous requirements, which surpass the requirements of the existing laws and regulations. In short, the Medi-Cal program is attempting to use the contracting process to impose "model compliance" requirements on prospective contractors which will raise the standards required for being eligible to participate, and for continuing to participate, as a provider in the Medi-Cal program.

While called "contracting," the process is anything but a true "contracting" system. A laboratory applying for a contract is given no opportunity to negotiate over any of the terms of the contract, including the price. Essentially, the "contract" is a "take-it-or-leave-it" proposition, which contains enough highly subjective criteria to potentially cause all types of problems from a compliance standpoint.

Finally, the change from a "pay-and-chase" attitude to an "up-front-review" is also being implemented in the payment process for existing providers. More and more claims are

being scrutinized during "precheckwrite" reviews, causing corresponding delays in their processing.

B. THE INVESTIGATION PROCESS

Generally speaking, under the Fourth Amendment to the Constitution, a warrant or the equivalent (such as a subpoena) is required to conduct a search of commercial premises and its records and effects. See *See v. City of Seattle*, 387 U.S. 541 (1967). However, with respect to some commercial premises, the occupant's expectation of privacy is less than the similar expectation of the occupant of a home. This privacy expectation limit pertains to "closely regulated" industries, where there is a history of extensive government oversight and a diminished expectation of privacy. However, such businesses are clearly the exception to the general rule requiring a warrant or its equivalent. *Marshall v. Barlow's, Inc.*, 436 U.S. 307, 313 (1978).

Recently, the United States Court of Appeals for the Ninth Circuit has concluded that state agencies do not have the right to search or inspect physicians' offices without warrants or subpoenas where there had been no long-standing practice of such inspections. See *Tucson Women's Clinic v. Eden*, 371 F.3d 1173, 1192 ($9^{th}$ Cir. 2004). Arguably, certain areas of pharmacies are also entitled to a high level of protection. Indeed, even if pharmacies are considered to be highly regulated, this does not mean that warrantless/subpoenaless searches are permitted. See *De la Cruz v. Quackenbush*, 85 Cal.App.4th 775 (2000).

The State Department of Health Services ("State DHS"), which administers the Medi-Cal program in California, takes the position that it may inspect the premises of providers without warrants or subpoenas and may even do so on an unannounced basis. State DHS asserts that this position is authorized under California Welfare and Institutions Code Section 14124.2(b)(1) and Section 14043.7. However, these statutes do not address the requirements of warrants or subpoenas. Rather, they speak only in terms of authorizing "unannounced" inspections in rare situations. Arguably, however, State DHS must still obtain a warrant or subpoena to perform such inspections.*

It is, however, very risky to deny access to records and premises to a State DHS investigator since such refusal could be grounds to suspend the provider from the program under Welfare and Institutions Code Section14124.2. Great care should thus be devoted to the question of whether to resist a request for inspections and/or review of records.

Because of the broad authority purportedly enjoyed by State DHS with respect to Medi-Cal inspections and reviews of records, the California Attorney General's Office has recently requested and obtained authority from the state Legislature to conduct warrantless searches of health care providers. <u>See</u> Senate Bill 1358. To convince the Legislature to authorize such warrantless searches by his investigators, the Attorney General cited State DHS' purported authority to conduct warrantless/subpoenaless searches and reviews of

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* State DHS also asserts that providers waive their right to insist on warrants/subpoenas when they sign provider and billing agreements stipulating that State DHS may inspect and review their premises and records. It is questionable whether such a blanket waiver is valid.

records. This recent state legislation is of doubtful constitutional validity with respect to warrantless criminal investigations by law enforcement personnel.

C. STATE DHS SANCTIONS

State DHS now has an arsenal of "sanctions," which it may unilaterally impose on providers suspected of fraud or abuse. They include (1) temporary withholds, Welf. & Inst. Code § 14107.11, (2) temporary suspensions, Welf, & Inst. Code § 14043.2, (3) special claims review, 22 C.C.R. § 51460, and (4) audits for recovery, Welf. & Inst. Code § 14170. The manner in which State DHS imposes these sanctions is subject to challenge for a variety of reasons.

The temporary withholding of Medicaid payments from a provider suspected of fraud or wilful misrepresentation without a hearing is authorized by the federal Medicaid regulation, 42 C.F.R. § 45523, and state law, Welf. Inst. Code § 14107.11. However, such a withholding must be based on "reliable" evidence of fraud or wilful misrepresentation and may only be imposed on a "temporary" basis. An indefinite imposition of a temporary withhold arguably violates due process of the law and the federal Medicaid regulation.

Similarly, temporary suspensions of a provider's Medi-Cal status must be based on solid evidence and may only be temporary. However, State DHS routinely imposes temporary suspensions at the same time it imposes temporary withholds on providers. Moreover, the suspensions are seldom temporary. And, most of the time the suspensions are based on nothing more than the fact that a provider is "under investigation."

At some point in the process, a provider accused of fraud or wilful misrepresentation must be given a full hearing to clear its name. The written-only administrative appeal process furnished to providers by State DHS under the state legislation (Welf. & Inst. Code § 14043.65) does not satisfy the due process requirement of a "full opportunity" to be heard. Essentially, the written only administrative appeal process employed by State DHS is a one-sided, meaningless process, which seldom yields a fair result. A copy of a favorable state court decision challenging a sanction is attached.

The imposition of special claims review on a provider is considered to be less drastic than a temporary suspension or temporary withhold. However, as a practical matter, being placed on special claims review can result in substantial delays in payment and even nonpayment because of the burdensome paperwork requirements typically imposed on a provider through the special claims review process. Recently, State DHS has eliminated the administrative appeal process for special claims review. Once again, the imposition of special claims review without furnishing a provider an opportunity to be heard may be of questionable validity.

Audits for recovery are authorized under federal Medicaid laws and regulations as well as state laws, including California Welfare and Institutions Code Sections 14170 and 14171 and 22 C.C.R. Sections 51016-51047. Prior to January 1, 2004, when a noninstitutional provider, such as a pharmacy, filed an administrative appeal of the findings of an audit, State DHS was precluded from recouping any alleged overpayment pending the outcome of the administrative appeal process. And, because the administrative appeal

process pertaining to audits for recovery is a very meaningful process, as opposed to the written-only appeal process furnished providers in temporary sanction cases, the deferral of recoupment was very important. However, beginning January 1, 2004, State DHS is authorized to recoup alleged overpayments resulting from audits notwithstanding the fact that the provider files an administrative appeal.

Providers challenging audit findings have had substantial success through the administrative appeal process. And, there are unique rights available to pharmacies in connection with such appeals which can be used to minimize alleged overpayments. For example, under 22 C.C.R Section 51488.1(a)(9), the amount of recoupment in any alleged overpayment must be limited to the difference between the allowable ingredient costs of the products that were actually dispensed and the amounts that were actually billed to Medi-Cal in certain circumstances.

## D. ALLEGED KICKBACK ACTIVITIES

Both federal and state laws prohibit providers from offering or paying remuneration directly or indirectly to induce persons to refer individuals for the furnishing or arranging for the furnishing of Medi-Cal services or to recommend, purchase, etc. services or items paid for by Medi-Cal. See Welf. & Inst. Code § 14107.2. The government believes that retail pharmacies and pharmacy manufacturers, wholesalers, distributors, etc., engage in activities prohibited by the antikickback laws.

The *PharMerica Drug Systems* case is just one example of the government's efforts to crack down on such alleged kickback arrangements. In that case, on June 17, 2004, the Office of Inspector General of the Department of Health and Human Services informed PharMerica Drug Systems, Inc., that it was proposing to impose a civil money penalty of $200,000 and damages of $21,600,000, as well as proposing to exclude PharMerica from participating in Medicare, Medicaid, etc. for ten years, as a result of unlawful kickbacks. The specific allegations are set forth in the attached copy of the June 17, 2004, letter from the Office of Inspector General to the provider.

In addition to the federal government, State DHS and the State Attorney General's Office are also "cracking down" on alleged kickback practices, especially with respect to the marketing and sales of pharmacy products. The TAP pharmaceutical products cases are examples of the crack-downs. The TAP cases involve, among others, allegations of the manipulation of average wholesale pricing, the so-called marketing of the "spread," and remuneration given, in cash and in kind, to physicians to prescribe TAP's drugs.

There are considerable, significant issues raised by the government's allegations in these types of cases, including, but not limited to, the fact that virtually every government agency has been aware of the inaccurate nature of average wholesale prices for many years and have taken into consideration such inaccuracies in setting Medicaid payment rates. The so-called marketing of the "spread" between Medicaid rates and actual sales prices to physicians and pharmacies has also been well known to government agencies for years and

acquiesced in by such agencies, thus creating significant issues regarding the alleged wrongful intent of persons involved in these issues.

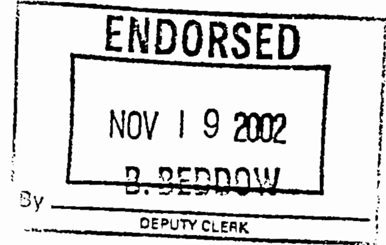
## E. THE CIVIL RIGHTS ACT

Pharmacies and other providers do not forfeit their constitutional rights when they agree to participate as providers in the Medicaid program. Thus, in situations in which overzealous government investigators, auditors and others have deprived providers of their rights, affirmative action may be taken under the Civil Rights Act, 42 U.S.C. § 1983.

Examples in which government agents may violate the constitutional rights of pharmacies include improper searches of pharmacies, improper allegations of fraud for which a pharmacy is not given an adequate opportunity to clear its name, and the imposition of "temporary" sanctions, which turn out to be indefinite in length.

While the courts have concluded that Medicaid providers do not necessarily have a property interest in the continued participation in the Medicare and Medicaid programs, which is protected by the due process clause of the constitution, they have confirmed that providers have a "liberty" interest to be free from unfounded allegations of dishonesty, which is protected by the due process clause of the United States Constitution. In other words, when a provider is unjustifiably accused of being a "fraudster" the provider must be given an opportunity eventually to clear his or her name at a meaningful time. See *Cox v Boxer*, 359 F.3d 1105 (9th Cir. 2004). While *Cox* did not involve a provider of health care services, its reasoning is very important in any case in which a provider accused of fraud is not given

a meaningful opportunity to clear its name. Attached is a copy of a recent federal court decision discussing some of these civil rights issues.




SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

., M.D., Dept. 33 No. 02CS01331

Petitioner,

v. JUDGMENT

THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES,

Respondent.

______________________________________/

The petition filed in this proceeding came on regularly for hearing in Department 33 of the above-entitled court on November 13, 2002, before the Honorable Lloyd G. Connelly, Judge of the Superior Court. Petitioner was represented by Patric Hooper, and respondent was represented by Barbara Haukedalen and Timothy Cornforth.

Following oral argument and consideration of the briefs and evidence presented by the parties, the court announced its finding and conclusion that respondent has failed to comply in petitioner's case with the procedural due process requirements of federal Medicaid regulations authorizing respondent to temporarily withhold Medi-Cal payments owed to medical service providers pending investigation of their billing practices for fraud: Respondent has withheld Medi-Cal payments owed to petitioner since July 2000 pending an investigation of her billings by the Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) within the Department of Justice to determine whether there is sufficient evidence of fraud to bring criminal proceedings against petitioner. But respondent has failed to establish, in accordance with the terms and intent of the

federal regulations, that the investigation is being conducted expeditiously so that the withholding of payments from petitioner pending its completion is temporary rather than indefinite in duration and does not unduly burden her property interest in the withheld payments. (See 42 C.F.R. § 455.23(c). See also § 455.13(b)(2); 52 Fed. Register 48814 (December 28, 1987) ("*C. Timing of a Withholding Action*: . . . expectation [of federal Medicaid administrator in promulgating regulations for withholding of Medicaid payments for fraud] that State Medicaid and investigative agencies] act expeditiously both in addressing any case in which a withholding action has been undertaken and in notifying the provider when the investigation has been terminated."). And see Bergeron v. Department of Health Services (1999) 71 Cal.App.4th 17, 23-27 (adequacy of due process procedural protection of Medi-Cal provider's property interest in withheld payments pending fraud investigation of her billing practices pursuant to 42 C.F.R. § 455.23).)

The court stated that, to provide the process due petitioner's property interest under the federal regulations, it will require respondent to present evidence that the fraud investigation of petitioner's billing practices is being expeditiously conducted and will be completed within a specified period of time that is reasonable in duration considering all of the nature and circumstances of the investigation. In addition, the court will require respondent to take all feasible steps to bring about the completion of the investigation within that specified period. If respondent is unable to produce evidence that the investigation will be completed within a reasonable time, or if the investigation is not actually completed within that time, then the court will consider other remedies to protect petitioner's property interest, including an order that respondent release withheld payments to petitioner.

THEREFORE IT IS ORDERED, ADJUDGED AND DECREED that:

1. a writ of mandate issue from this court requiring respondent to:

a. Serve and file, within ten days of receiving personal service of the writ, declarations and other documentary evidence (1) indicating the type, number and hours of activities conducted to date by BMFEA personnel to investigate petitioner's billing practices for fraud, (2) estimating the type, number and hours of activities required to complete the

investigation, and (3) specifying the approximate date on which completion of the investigation can reasonably be expected in light of the nature and scope of the investigation. Petitioner shall have ten days from service of the declarations and other documentary evidence to serve and file a brief and documentary evidence addressing whether respondent's evidence is sufficient to establish that completion of the investigation by the date specified will be expeditious and consistent with the procedural due process requirements of 42 Code of Federal Regulations sections 455.23 and 455.13. Respondent shall have five days from service of petitioner's brief to file a reply.

b. Take the steps necessary to have the investigation completed by the approximate date specified above in paragraph a.

c. File a return no later than the specified completion date, indicating the status of the investigation.

If respondent does not provide the documentary evidence required pursuant to paragraph a, or if the court finds that the evidence provided is insufficient to establish that the investigation will be completed expeditiously and consistently with the federal regulatory due process requirements, or if the investigation is not completed on or about the approximate date specified for its completion, the court will convene proceedings to consider such other remedies and orders as are necessary to satisfy the procedural due process requirements of 42 Code of Federal Regulations sections 455.23 and 455.13

2. Petitioner shall recover her costs of suit in the amount of $______.

Dated: NOV 1 9 2002

LLOYD G. CONNELLY

LLOYD G. CONNELLY
JUDGE OF THE SUPERIOR COURT

**GOVERNMENT AND INDUSTRY PERSPECTIVE**

**HOT TOPICS**

John Cronin
General Counsel
California Pharmacists Association

Tom Temmerman
Senior Assistant Attorney General
California Department of Justice

**DESK AUDITS:**

Effective July 1, 2004, DHS has instituted a new system for claim review as an enhancement of its anti-fraud program. Payments are processed as before, but checks are delayed by one week to accomplish this additional review (Budget impact – one time savings of $149 million in FY 2004-2005). During this review, claims will be computer screened for irregularities and a small number of claims (100 per week) are selected at random for verification.

Verification involves contacting the provider and obtaining documentation to support the claim. This can include:

- Original Rx
- Documentation of refill authorization
- Invoice to document purchase of specific drug (NDC)
- Documentation of receipt by recipient (signature)
- Other

Failure to provide the requested documentation will result in withholding of payment for the specific claim and may trigger additional audits.

Note: last payment scheduled for FY 2004-2005 (June 30, 2005) will be delayed one day to place it into the next fiscal year. Payment schedule is scheduled to return to normal the following week.

**LEGISLATION (ASP - WSP - SP - EAC)**

| Government | Industry |
|---|---|
| Traditionally pharmaceutical pricing has been based on a marketable spread. The intent behind legislation is to eliminate that basis and substitute something more apparent and connected to real world pricing. | The current reimbursement system is a creature of the payers, including government. Pharmacies have responded to what the system gives them, which has resulted in utilizing "the spread" to maximize profitability. Payers have been aware of this aspect of the payment system and have, on occasion, encouraged its use. |
| California has been obligated statutorily to pay most pharmaceuticals on an Average Wholesale Price basis. This has been used to generate unknown or hidden profits that have | The profits generated by use of AWP are neither hidden or excessive and have been an essential element of the reimbursement system for years. Pharmacies object strongly to use of |

| | |
|---|---|
| resulted in gross overpayments by Medi-Cal. | the term "gross overpayments." They are accurate payments based on the system the payers set up and compel pharmacies to use. |
| They also have resulted in Supplemental Rebate contracts that are not public that bring the ultimate cost of the innovator down. Government has been operating both in the dark and in secret. The goal is to eliminate both. | Pharmacists and pharmacies agrees that the Supplemental Rebate contracts between Government and Manufacturers should be public. The current situation results in an overstatement of the true cost of any pharmacy benefit. |
| It was recognized that along with real world product pricing had to also come adjustments to the dispensing-administrative-filling fee inequities that had arisen over the years. | Too little emphasis has been placed on this point. For too long payers have acknowledged the inadequacy of the dispensing fees but have persisted in retaining a reimbursement system that relies on the spread to bring pharmacy revenues to a level that is profitable. The two parts of the payment system are interdependent, a fact that payers are reluctant to recognize and unwilling to address. Pharmacies can rightly make a claim of fraud for the failure of payers to pay a fair fee. |

**HIGHLIGHTS - SB 1103, Committee on Budget and Fiscal Review. Budget Act of 2004: health.**

. . .

Sec. 14105.45

(a) (1) "Average sales price" means, of a drug or biological, the sales price for a National Drug Code for a calendar quarter for a manufacturer for a unit, calculated as follows:

(A) The manufacturer's sales to all purchasers, (there are exclusions)

(C) In calculating the manufacturer's average sales price, the price shall include volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates, other than rebates under Section 1927 of the Social Security Act (42 U.S.C. Sec. 1396r-8).

(4) "Estimated acquisition cost" means the department's best estimate of the price generally and currently paid by providers for a drug product sold by a particular manufacturer or principal labeler in a standard package.

(8) "Maximum allowable ingredient cost" (MAIC) means the maximum amount the department will reimburse Medi-Cal pharmacy providers for generically equivalent drugs.

(11) "Wholesale selling price" means the weighted (by unit volume) mean price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor.

(12) "Selling price" means the price used in the establishment of the estimated acquisition cost. The department shall base the selling price on the average sales price reported by manufacturers pursuant to subdivision (c). The selling price shall not be considered confidential and shall be subject to disclosure under the California Public Records Act . . .

(b) (1) Reimbursement to Medi-Cal pharmacy providers . . . shall consist of the estimated acquisition cost . . . of the drug plus a professional fee for dispensing. . . $7.25 per dispensed prescription . . . in a skilled nursing facility or intermediate care facility shall be eight dollars ($8) . . .
(2) The department shall establish the estimated acquisition cost . . . as follows:
. . . the estimated acquisition cost shall be equal to the lowest of the average wholesale price minus 17 percent, the selling price, the federal upper limit, or the MAIC.

**FRAUD APPROACH**

| Government | Industry |
|---|---|
| • AWP, WAC and other basis of government payments rely in the industry to report accurate, meaningful pricing information.<br>• Government maintains that AWP is a term with common English language definition, i.e. average wholesale price.<br>• Manufacturers have maintained that the term has no meaning other than an arbitrary price set by them calling it a "sticker price".<br>• In reconciling these positions one federal judge[1] stated "Defendants repeatedly assert that they had no duty to disclose . . . a "sticker price" . . . never intended to reflect the drug's true average wholesale price . . . The argument is ultimately unpersuasive. There is a difference between a sticker price and a sucker price." | Reform of the reimbursement system is necessary. Payers determine how that system is set up with little regard for reimbursement levels based on true costs and reasonable profits. Providers and manufacturers have functioned within this system in a predictable manner that maintains business viability, which has required use of the spread by providers and rebates to payers. It is unreasonable to consider such adjustments as "fraud" because they have been undertaken with the full knowledge, acceptance and even encouragement of the payers. In short, payers, including government programs cannot claim fraud when they have been a willing participant is the establishment and maintenance of the current (flawed) system. |

**LIABILITY**

Manufacturers: The claim itself need not be false if the transaction is "underpinned by fraud". A California court has held that the manufacturer caused a distributor to submit false claims to the government because the contract for parts was based on false info from the catalogues and the

[1] In re: LUPRON® MARKETING AND SALES PRACTICES LITIGATION, STEARNS, District Judge. (295 F.Supp.2d 148)

distributor's bill was false because it was for parts other than as ordered. Here the false information is the reported AWP. The manufacturer need not be the recipient or beneficiary of the contract.[2]

- Marketers: Marketing done by both the manufacturers and the middlemen that promotes greater spread related profits, offers incentives and remuneration falls within the parameters of the law. Marketing the spread has been a common occurrence and is well documented.

- Publishers: Manufacturers report their WACs and their AWP/SWPs to the publishers. The publishers attempt to confirm the reported prices by contacting the three largest wholesalers. Confirmation may be broad all inclusive inquiries (e.g. Wholesaler is asked if a particular manufacturer's products are reimbursed at SWP and accept a single yes covering all products). There is no verification or certification process. There is nothing compelling either the manufacturers or the wholesalers to supply data.

- Middlemen (Wholesalers, Distributors, Vendors, PBMs, GPOs) They pay the WAC prices, receive discounts, negotiate special off-invoice deals and then deal with providers. They may or may not pass on discounts depending on the contracts with retail.

- Providers: The California False Claims Act (Government Code 12650 *et seq.*) Provides that "Any person who commits any of the following acts:

    (8) Is a beneficiary of an inadvertent submission of a false claim and subsequently discovers the falsity of the claim, and fails to disclose the false claim to the state within a reasonable time.

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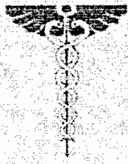
[2] *City of Pomona v. Superior Court*, 89 Cal. App. 4th 793, 2001



# MEDI-CAL UPDATE

Part 1
Program and Eligibility
www.medi-cal.ca.gov

## June 2004

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### Important Notice About 2004 – 2005 Budget

If the State of California does not enact the fiscal year 2004 – 2005 budget by June 30, 2004, the Department of Health Services (DHS) will direct the Fiscal Intermediary, EDS, to implement provisions to continue processing and adjudicating claims as outlined below.

EDS will continue to process and adjudicate claims for the following programs, regardless of the date of service:

- Medi-Cal
- Family PACT (Planning, Access, Care and Treatment)
- Child Health and Disability Prevention (CHDP) Medi-Cal
- California Children's Services/Medi-Cal (CCS/Medi-Cal) *
- County Medical Services Program (CMSP)
- Children's Treatment Program (CTP)

* EDS will withhold all CCS-only reimbursements regardless of dates of service. The last warrant date for CCS-only claims is June 30, 2004.

Effective for dates of service on or after July 1, 2004, claims submitted by provider types for which contingency funding is not available will continue to be processed, but reimbursement for these claims will be withheld until the State budget has been approved and EDS receives approval from the State to resume reimbursement. The following programs will be affected by the temporary withhold:

- Expanded Access to Primary Care (EAPC)
- Cancer Detection Programs: Every Woman Counts
- Child Health and Disability Prevention (CHDP) (State-only)
- Healthy Families Program (HFP)
- Genetically Handicapped Persons Program (GHPP)

All providers are asked to continue rendering services and submitting claims for processing.

### Random Sampling and Pre-Checkwrite Review of Claims

Effective for dates of payment on or after July 1, 2004, the Department of Health Services (DHS) will implement a new process to monitor Medi-Cal claims. All Medi-Cal claims will be subject to an additional week of review prior to release of payments. As a result of the one-week extension, claim payments for checkwrite date July 8, 2004 will be scheduled for July 15, 2004. The *Checkwrite Schedule* in the Part 1 provider manual has been updated to reflect the new payment dates.

The Governor's Anti-Fraud Initiative (AB 1107, Stats. 1999, c. 146) and other recent statutes (AB 1098, Stats. 2000, c. 322; SB 1699, Stats. 2002, c. 768; and SB 857, Stats. 2003, c. 601) have strengthened the authority of DHS to combat fraud and abuse in the Medi-Cal program. DHS has intensified its efforts to reduce fraud by verifying claims prior to approval for payment.

*Please see* **Random Sampling**, *page 3*

## EDS/MEDI-CAL HOTLINES

Border Providers ........ (916) 636-1200
DHS Medi-Cal Fraud Hotline ........ 1-800-822-6222
Telephone Service Center (TSC) ........ 1-800-541-5555
Provider Telecommunications Network (PTN) ........ 1-800-786-4346

*EDS • PO Box 13029 • Sacramento, CA • 95813-4029*

For a complete listing of specialty programs and hours of operation, please refer to the Medi-Cal Directory in the provider manual.

*OPT OUT is a new service designed to save time and increase Medi-Cal accessibility. A monthly e-mail containing direct Web links to current bulletins, manual page updates, training information and more is now available. Simply "OPT OUT" of receiving this same information on paper, through standard mail. To download the OPT OUT enrollment form or for more information, go to the Medi-Cal Web site at* www.medi-cal.ca.gov*, click "Publications" and then "OPT OUT."*

## Stop Illegal Tobacco Sales

The simplest way to stop illegal tobacco sales to minors is for merchants to check ID and verify the age of the tobacco purchasers. Report illegal tobacco sales to 1-800-5-ASK-4-ID.

**For more information, see the Department of Health Services Web site at http://www.dhs.ca.gov.**

MEDI-CAL FRAUD
**IS AGAINST THE**
## LAW

**MEDI-CAL FRAUD COSTS TAXPAYERS MILLIONS EACH YEAR AND CAN ENDANGER THE HEALTH OF CALIFORNIANS.**

**HELP PROTECT MEDI-CAL AND YOURSELF BY REPORTING YOUR OBSERVATIONS TODAY.**

**DHS MEDI-CAL FRAUD HOTLINE**
**1-800-822-6222**

**THE CALL IS FREE AND YOU CAN REMAIN ANONYMOUS.**

Knowingly participating in fraudulent activities can result in prosecution and jail time. Help prevent Medi-Cal fraud.

**Random Sampling** *(continued)*

DHS may conduct claim reviews using one of two review methodologies to ensure program integrity and the validity of claims for reimbursement. The first review methodology will be a random sampling of claims submitted by Medi-Cal providers. The second review methodology will be based on a pre-checkwrite review criterion, such as irregular billing patterns, designed to identify potential fraudulent billing.

**Random Sampling**
It is the intent of DHS that all claims submitted by Medi-Cal providers be subject to random review regardless of provider type, specialty or service rendered. If claims are selected for random review, the selection will not imply fraud. This effort is geared entirely toward promoting program integrity across all Medi-Cal claim types and will ensure that all claims have appropriate Medi-Cal policy applied.

DHS will verify that claims randomly selected have sufficient documentation to approve the claim for payment. Medi-Cal providers will be notified if a claim requires additional documentation prior to approval for payment. Claims may be held longer than one week pending further examination. Failure to comply with the request for documentation may result in suspension from the Medi-Cal program, pursuant to *Welfare and Institutions Code* (W & I Code), Section 14124.2.

If additional evidence of claim validity is required, the evidence shall be requested in accordance with W & I Code, Section 14104.3(a)(3). EDS has been instructed to randomly select claims submitted for reimbursement before approval is granted to pay the claim. The randomly selected claims will be identified in the Provider Telecommunications Network (PTN) as "in process" until the claim is approved for payment.

**Pre-Checkwrite Review**
In addition to the claims randomly selected for verification, claims for services rendered by Medi-Cal providers may be subject to a more comprehensive review on a weekly basis. This review will be based on a set of criteria, such as irregular billing patterns, designed to identify potential fraudulent billing. Claims selected for more comprehensive review may require the provider to submit adequate documentation to substantiate billed services. Failure to comply with the request for documentation may result in suspension from the Medi-Cal program, pursuant to W & I Code, Section 14124.2.

Every week starting July 1, 2004, all claims will be held in an "in process" status for a period of seven days pending DHS verification. Claims having an "in process" status in excess of seven days are those identified by DHS either through random sample or pre-checkwrite review, and will be subject to validation by DHS. Medi-Cal providers will either receive notice from DHS that additional information is required to adjudicate the claim or will receive payment after validation of the claim is complete.

## 2004 – 2005 Checkwrite Schedule

Effective immediately, the checkwrite schedule is updated for fiscal year 2004 – 2005. This schedule reflects warrant release dates and Electronic Fund Transfer dates of deposit for the following programs:

- Medi-Cal
- County Medical Services Program (CMSP)
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Family PACT (Planning, Access, Care and Treatment)
- Abortion
- Healthy Families Program (HFP)
- Child Health and Disability Prevention (CHDP)
- Cancer Detection Programs: Every Woman Counts
- Expanded Access to Primary Care (EAPC)

*This information is reflected on manual replacement page check 1 (Part 1).*