THOMSON, RHODES & COWIE, P.C. MANAGED CARE LAW UPDATE

Volume II, Issue 2 | February 1999 | Page 1 of 3

PENNSYLVANIA CASES

Doctors' Antitrust Suit Against Washington Hospital Survives Hospital's Motion for Summary Judgment. Judge Donetta Ambrose of the U.S. District Court for the Western District of Pennsylvania allowed an antitrust case by a Washington, Pennsylvania cardiology practice against Washington Hospital, its CEO and president, and two staff cardiologists to continue after the Hospital sought to have the complaint dismissed by summary judgment. The plaintiff cardiologists sued over a moratorium on granting staff privileges to certain specialties (including cardiology) and an exclusive dealing contract entered into between the hospital and the two staff cardiologists. Claims for antitrust actions, racial discrimination and breach of contract were allowed to continue. The court granted summary judgment with respect to claims for conspiracy and interference with prospective contractual relations. In an earlier opinion, Judge Ambrose dismissed plaintiffs' claim for interference with existing contractual relationships. In denying summary judgment as to the surviving claims, the court cited the existence of issues concerning the defendants' market share, concerted actions in restraint of trade, and plaintiffs' appropriateness to bring these claims. *Allen v. Washington Hospital*, W.D. Pa., No. 96-1950, 01/12/99.

FEDERAL AGENCY ACTIONS

The U.S. Department of Justice (DOJ) Settled With a Florida Association of Surgeons and Specialists Over Illegal Joint Contract Negotiations With Managed Care Plans. The DOJ antitrust division reached an agreement with the Federation of Certified Surgeons and Specialists, Inc., a group of Florida physicians, which had been negotiating jointly with managed care plans in order to receive higher compensation than they would otherwise receive. The physicians attempted to use a Tennessee accounting firm as a third-party negotiator in order to disguise the arrangement as a legitimate third-party messenger system. The surgeons and specialists in the Federation perform 87% of all general and vascular surgeries in the five Tampa area hospitals in which they practice. The agreement requires that the conduct be discontinued. *U.S. Federation of Certified Surgeons and Specialists, Inc., et al., U.S. Dist. Ct., M.D. Fl., 99-167-CIV-T-17F, 01/26/99.*

FEDERAL LEGISLATION

Legislation Introduced in Committee to Exempt Disabled From Mandatory Managed Care Under the Medicaid Program. On January 19, 1999, U.S. Senator Jim Bunning introduced legislation to the Committee on Finance that would exempt disabled individuals from otherwise mandatory managed care enrollment under Medicaid. The bill proposes a retroactive effective date as if the measure had been part of the Balanced Budget Act of 1997. *Senate Bill 88 of 1999.*

Thomson, Rhodes & Cowie, P.C., Health Care Law Section, Two Chatham Center, Tenth Floor, Pittsburgh, PA 15219

For additional information, please contact Jerry R. Hogenmiller, Esquire at (412)232-3400

THOMSON, RHODES & COWIE, P.C.
MANAGED CARE LAW UPDATE

Volume II, Issue 2 | February 1999

FEDERAL CASES

Class Action RICO Suit Against Humana Allowed to Continue by U.S. Supreme Court. The U.S. Supreme Court's decision to allow a class action suit to proceed in Nevada against Humana Inc. brought under the federal Racketeer Influenced and Corrupt Organizations Act is expected to have tremendous impact in the future of insurance fraud cases. The plaintiff class, beneficiaries of a group health insurance policies issued by Humana Health Insurance of Nevada, Inc., alleges that Humana negotiated discounts with a hospital owned by Humana, Inc. Humana did not pass on the discounts to its insureds when calculating the insureds' 20% co-payment, resulting in Humana paying significantly less than 80% of the actual costs. The Supreme Court reviewed the issue of whether the federal RICO Act can be used against an insurance company in light of the McCarran-Ferguson Act that prohibits any act of Congress to invalidate, impair, or supercede any state law regulating the business of insurance. The Court found that the RICO Act advanced the purposes of the state insurance laws and therefore could be applied in this situation without running afoul of the McCarran-Ferguson Act. *Humana Inc., et al. v. Forsyth, et al.*, U.S. Sup. Ct., 97-303, 01/20/99.

In an Unrelated Class Action Suit Against Humana Inc., the Florida District Court of Appeals Reversed the Certification of a Class of Enrollees. Humana recently was able to convince a Florida District Court of Appeals to reverse a class certification in a case in which the plaintiffs, a group of enrollees in Humana's Medicare managed care organization, alleged that Humana illegally failed to disclose an incentive plan that it implemented with its doctors participating in its Medicare health maintenance organization. The suit alleges that Humana did not disclose that its doctors were paid a capitated rate, that the HMO members were "locked in" with certain HMO providers, and that Humana requirements imposed certain gag clauses on its participating doctors. The court explained that class certifications in fraud cases are difficult, and in this situation inappropriate, because the plaintiffs rarely consider the allegedly fraudulent information provided to them in exactly the same manner and the information affects their decision-making in different ways. *Humana Inc. v. Castillo, et al.*, Fla. Dist. Ct. App., No. 98-01992, 01/15/99.

OTHER JURISDICTIONS

Connecticut Allows Contract With Medicaid HMO to Lapse After Investigations Reveal Quality of Care Issues. Connecticut has allowed its contract with HealthRight, a Medicaid HMO, to lapse on January 31, 1999, after investigations revealed serious concerns with the quality of care being received by the HMO's members. The HMO's 34,000 members are in the process of being transferred to other Medicaid HMOs. The alleged deficiencies relate to the provision of mental health care to children under the Medicaid program. Sources indicate that the Connecticut Attorney General will sue HealthRight to recover unwarranted payments made from the Medicaid program to the HMO. Interestingly, in November 1998, HealthRight was awarded a $50,000 grant from the American Association of Health Plans and Phizer for its "School Based Health Centers Partnership" program.

Thomson, Rhodes & Cowie, P.C., Health Care Law Section, Two Chatham Center, Tenth Floor, Pittsburgh, PA 15219

For additional information, please contact Jerry R. Hogenmiller, Esquire at (412)232-3400

THOMSON, RHODES & COWIE, P.C.
MANAGED CARE LAW UPDATE

Volume II, Issue 2 February 1999

Y2K NEWS

Medicare Carriers and Intermediaries Must Return As Unprocessable Provider Claims that are Not Y2K Compliant Starting April 5, 1999. In a January 1999 transmittal, HCFA instructed Medicare carriers and intermediaries to reject as unprocessable provider claims received on or after April 5, 1999, that are not Y2K compliant. This is a reversal of earlier instructions to the carriers and intermediaries to continue accepting non-compliant claims. The contingency plan systems are to remain intact but are to be disabled while HCFA assesses the readiness of the provider community. *Program Memorandum (Intermediaries and Carriers)*, HCFA Pub. 60AB, Trans. No. AB-99-1 (Jan. 1999).

HCFA Urges Health Care Providers to Be Ready for the Year 2000 and Provides a Readiness Checklist. HCFA sent letters to 1.25 million providers explaining that the Agency has made substantial progress in meeting the challenges of Y2K and requesting that the providers take additional steps to ensure that their own computer systems will be ready. The letter also provides a checklist for use in assessing computer systems. The letter outlines steps for providers to take to become compliant: (1) become aware of how the Y2K bug can affect your systems and identify "mission critical" items, (2) assess the readiness of the items on the list, (3) update or replace systems, software programs, and devices that are critical to business continuity, (4) test the existing and newly purchased software and systems, even if they are purportedly compliant, and (5) develop a contingency plan. *Provider Correspondence Letter*, Y2K Assistance, January 12, 1999.

Medicare Managed Care Organizations Must Certify their Y2K Readiness Status By April 15, 1999. HCFA has formulated a Certification Statement, available on its website, that requires the MCOs to indicate the status of their internal systems and that of any entity to which the MCO has delegated "mission critical" business functions. HCFA describes the purpose of the certification as a way for HCFA to "gauge where [it needs] to focus [its] attention and resources." *Y2K Certification Letter*, Gary A. Bailey (Director of Health Care Purchasing and Administration Group of HCFA), January 25, 1999.

Additional information about Y2K compliance and preparation can be found on HCFA's website at www.hcfa.gov/Y2K.

A review of recent trends in Managed Care Law, the Update is a bi-weekly publication. All original materials Copyright 1998 by Thomson, Rhodes & Cowie, P.C. The contents of this Publication may be reproduced, redistributed or quoted without further permission so long as proper credit is given to the Thomson, Rhodes & Cowie, P.C. Managed Care Law Update.

The Thomson, Rhodes & Cowie, P.C. Managed Care Law Update is intended for the information of those involved in the managed care system. The information contained herein is set forth with confidence, but is not intended to provide individualized legal advice in any context. Specific legal advice should be sought out where such assistance is required.

Prior issues are available on request. Please direct inquiries to Jerry R. Hogenmiller or L. Jane Charlton, Thomson, Rhodes & Cowie, P.C., Tenth Floor, Two Chatham Center, Pittsburgh, Pennsylvania 15219, (412) 232-3400, TRC_Law@nauticom.net.