

What Does A County Owe for Non-Contracted Emergency Services?

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California Welfare and Institutions Code (WIC) 17000 imposes a mandatory duty upon each county to relieve and support its indigent residents. Sacramento County fulfills this duty through its County Indigent Services Program (CMISP). In 2008, after terminating its contract with a third party administrator, Sacramento County invoked a policy of excluding from the scope of CMISP's coverage any services that were provided by a non-contracted hospital.

When this policy was made, the County did not have a contract with U.C. Davis Medical Center (UCDMC), the County's only Level 1 trauma center. The County refused to pay for CMISP beneficiaries who came to UCDMC's emergency room. UCDMC filed a writ of mandate proceeding in the Sacramento County Superior Court. The County argued that under WIC 16817 it had unbridled discretion to pay only contracting hospitals.

Nice try. Implicit in the County's position was that any county could obtain emergency services from any hospital for free so long as the County had at least one contract with another hospital. In July 2010 the court ruled that the County's policy excluding non-contracted hospitals from the scope of its covered services was an abuse of discretion. The court reasoned the County could not use its authority to be selective in the use of providers to exclude hospital emergency services that were the closest or otherwise most appropriate for the patient.

Left unresolved was the more interesting question: at what rate would the non-contracted provider of emergency services be paid? This September the court began to address the rate issue in a series of pretrial motions that sought to establish or exclude evidence at trial.

UCDMC requested a ruling that the court should determine the reasonable value of the services UCDMC provided. The court refused this ruling. Instead, it ruled that the County is primarily responsible for determining the County's rates. The court's role is only to review the County's determination of rates under an abuse of discretion standard.

Since the court's July 2010 ruling that the County did not have the power to help itself to free lunches, the County Board of Supervisors had exercised its discretion to establish Medi-Cal rates as the rate for payment for non-contracted emergency services. The County requested a ruling that these rates applied to the unpaid claims for services at UCDMC. The Court refused this ruling because of the absence of any administrative record for the court to review to assess whether adopting Medi-Cal rates was a reasonable exercise of administrative discretion.

The case will now move to the next stage, the assessment of the reasonableness of the County's establishment of new rates for non-contracted emergency services. In a closing footnote, the court noted that while it would not prescribe a standard for adoption by the County, "the court will expect that the standard adopted by the County will be reasonably/factually related to the provider's costs of rendering specific services." Nevertheless, the court left open the possibility that below cost Medi-Cal rates might meet the test of reasonable administrative discretion.

The final decision of the Sacramento County Superior Court will have no precedential effect. Its reasoning may be persuasive for other courts that need to address similar county rate issues. The final decision may be appealed by one or both parties. The results of an appeal would be precedential. Stay tuned for further developments in a county's obligation to pay for emergency services. ❖

Supreme Court Hears Challenge to California 10% Medicaid Cuts

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The eyes of the nation were on California's Medicaid program (known as "Medi-Cal") when the United State Supreme Court began its new term on October 3, 2011. The first case on the Supreme Court's docket was California healthcare providers' challenge to the State's ten percent cuts to reimbursement rates paid to providers who participate in the Medi-Cal program.

In April 2008, Medi-Cal providers filed lawsuits against the California Department of Health Care Services, the State agency responsible for implementing the cuts, challenging the State's ability to implement the cuts without first ensuring that such cuts would not adversely impact Medi-Cal patients' quality of care and access to care. The providers asserted the State action violated the provisions of the federal Medicaid law that require that reimbursement rates be high enough to ensure that Medi-Cal patients have access to the same kind of healthcare services available to the general population. The California Court of Appeals for the Ninth Circuit agreed, and the State has since been enjoined by the federal courts from implementing the cuts.

Apparently because the federal government is in the process of drafting regulations to address the access to care issue, the Supreme Court declined to consider the Ninth Circuit's ruling on this issue. Instead, the Supreme Court agreed to consider the narrow legal question of whether individuals have the right to sue State government agencies to challenge State action as inconsistent with federal laws under the Supremacy Clause of the United States Constitution.

History would seem to be on the side of the providers, as **Justice Sonia M. Sotomayor** noted that federal courts have been deciding cases in which individuals brought suit under the Supremacy Clause to compel States to conform under a variety of federal laws since 1824.

However, the Supreme Court's agreement to hear this appeal suggests a willingness to reconsider the issue. **Justice Stephen G. Breyer** may have voiced the basis for this willingness when he asked providers' counsel whether the federal courts could be flooded with challenges to State statutes if limits were not imposed and questioned why the job should not be left to State agencies to implement federal law.

On the other hand, **Justice Anthony M. Kennedy** cited a brief submitted by former Health & Human Services officials that noted that almost \$400 billion of Health & Human Services Agency expenditures (which include the Medicaid program) are supervised by 50 people. According to the former HHS officials, HHS lacks the resources to address such claims and it would be more efficient and more consistent with the proper application of federal law to allow these challenges to be brought in the courts.

The **U.S. Solicitor General** also participated in the argument and focused on the Medicaid program as an exercise of the federal government's power under the Spending Clause of the United States Constitution. The Solicitor General urged the Supreme Court to treat the Medicaid program as a contractual

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relationship between the federal and State governments, allowing providers to assert rights under the contract only if they are intended third-party beneficiaries of the contract, with equitable relief only available in cases of individual discrimination or where a party has the right to bring an action for civil deprivation of rights under 42 U.S.C. § 1983.

The State and Solicitor General also argued that intervention by the courts is not necessary because if the federal government believes State action is inconsistent with federal law, it can cut off the funding for the State's Medicaid program. **Justice Ruth Bader Ginsburg** questioned the adequacy of this "drastic" remedy, since the exercise of it would "hurt the people that Medicaid was meant to benefit."

The Court also considered the role, if any, the lack of federal approval of a State Plan amendment implementing the rate cuts should play in its deliberations. The Medicaid program is jointly funded by the State and federal governments. Each State's Medicaid program is implemented pursuant to the terms of a document called a State Plan, which is developed by the State and approved by the Centers for Medicare and Medicaid Services ("CMS"), the HHS agency responsible for overseeing the Medicaid program. When a State seeks to make material changes to its State Plan, it submits a State Plan amendment to CMS for approval of the changes. In the case of the ten percent Medi-Cal cuts, no State Plan amendment has ever been approved by CMS. **Justice Elena Kagan** questioned whether this case had arisen because the State "end ran the administrative process" by putting the new rate schedule into effect before obtaining CMS approval.

If the Supreme Court concludes that the providers did not have the right to sue the State to challenge the cuts as a violation of federal law, the current injunctions will be lifted since the federal courts did not have the authority to hear the providers' lawsuit. The question may then arise whether the State can recoup the payments it has made during the years that the injunctions have been in effect. A narrow ruling would also impact the ability of individuals to challenge State laws on the grounds that they conflict with federal laws in areas outside of healthcare.

In addition, the question is raised whether providers will continue to participate in the Medi-Cal program if the State continues to cut reimbursement rates and the impact it would have on the healthcare delivery system in California if fewer providers choose to participate in the Medi-Cal program. When Medi-Cal patients are unable to obtain preventative and maintenance healthcare services, they will be forced to wait until they suffer a health crisis and seek care in emergency rooms. It would be ironic if in the long run the Medi-Cal program ultimately paid more for increased emergency services than was saved by cuts to reimbursement rates pursued in the interest of short-term budget relief.

While there is no set time period in which the Justices must reach a decision, it is likely a decision will be rendered in the early part of 2012. ❖



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