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HEALTH CARE

AB 1000 AND CORPORATE PRACTICE IN CALIFORNIA: MORE THAN MEETS THE EYE—OR LESS?

CAROL K. LUCAS

On the way to authorizing direct access to physical therapy, the California legislature may have broadly loosened the restrictions on numerous business arrangements imposed by California's corporate practice ban. AB 1000, which went into effect on January 1, 2014, provides that patients no longer need a medical diagnosis and a referral to a physical therapist, but may directly self-refer for physical therapy treatments of up to 45 days or 12 visits (whichever comes first). AB 1000 states explicitly that it does not expand the scope of physical therapy practice and that payers are not required to provide coverage for direct access physical therapy services. Nonetheless, the bill represents the achievement of a long-held ambition of the physical therapy profession: licensed physical therapists may now market and provide services directly to the public, like other licensed professionals.

At the same time, the legislature gave physicians something they had been wanting for some time: the right to employ physical therapists in their practices. Medical groups had routinely provided physical therapy services

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LOOSE LIPS SINK SHIPS AND CARELESS E-MAILS TORPEDO A TRANSACTION

JULIE A. SIMER

What you are stands over you the while, and thunders so that I cannot hear what you say to the contrary. Ralph Waldo Emerson.

Federal antitrust laws prohibit hospital systems, like other businesses, from using a dominant market position to exclude competitors and restrain trade. Recently, e-mail communications exchanged between a hospital system and a physician group helped convince a federal judge to unwind a hospital system's completed acquisition of a physician practice.

St. Luke's Health System, Ltd. ("St. Luke's") is a not-for-profit health system that owns and operates seven hospitals in Idaho and eastern Oregon. Saint Alphonsus Health System, Inc. is St. Luke's competitor. It joined with another hospital to form an outpatient surgery center in the St. Luke's service area. The two systems vied for referrals from Saltzer Medical Group, P.A.,

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Points from the President

ADAM BASS



The health care debate rages on, but everyone agrees that the myriad new rules and regulations, both on the state and federal levels, are increasingly complex and attention-worthy.

This issue of *Points and Authorities* offers several perspectives on the business of health care, with constructive tips on navigating this new territory. This is a theme we return to annually because of its importance to our clients and the ever-changing health care landscape. Among the topics our health care attorneys address this time around are direct access to services, Medicare privileges, strategic planning for providers, and MIRCA, the Medical Injury Compensation Reform Act.

We're delighted, too, to welcome attorney Kathleen Juniper to our Health Care Practice Group. Kitty, as she's best known, comes to Buchalter with an in-depth blend of expertise in health care, government and business. Her business approach to solving problems and assisting clients meshes seamlessly with our business-oriented health care platform. Kitty is profiled on page 9 of this issue.

We're also pleased to present our roster of new attorneys, joining us across all of the firm's practice areas. Our firm is growing, thanks to your loyalty, and we look forward to continuing to collaborate on the issues that concern you most.

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UNDOING MICRA MITCHELL J. OLEJKO

It has been over thirty-five years since California became a leader in healthcare reform, addressing the malpractice insurance crisis in a measured way. In 1975, the Medical Injury Compensation Reform Act (“MICRA”) capped non-economic damages at \$250,000 and limited contingency fees that plaintiff’s attorneys could charge injured plaintiffs according to a sliding scale. No limits were placed on the amounts that an injured plaintiff could recover for medical care, lost earnings and other economic damages. The sliding scale provides for a limit of: 40% of the first \$50,000 recovered, 35% of the second \$50,000, 25% of the next \$500,000 and 15% of recoveries over \$600,000. Attorney’s fees on a \$1,000,000 recovery may not exceed \$238,333, a decrease of \$95,000 over the usual one-third contingency fee. The decrease in fees that can be charged benefits the injured plaintiff. Attempts to amend or repeal MICRA and to challenge it in the courts have occurred regularly since its enactment.

There have been many studies of MICRA. A Rand Corporation study from 2004 concluded that MICRA reduced the amounts awarded to the injured plaintiff in cases that were resolved by a jury verdict by 15%, but reduced attorney’s fees in those cases by 60%. Of the estimated savings from MICRA in those cases, savings from attorney’s fees accounted for two-thirds of all of the savings from MICRA.

Unsurprisingly, Initiative 1606 is supported by entities associated with the medical malpractice trial bar. On May 15, 2014, Initiative 1606 qualified for the November ballot. It is expected that the battle over Initiative 1606 will attract significant controversy and funding and will be the subject of ongoing campaigns that will flood our mailboxes and dominate the media this Fall.

The essence of this proposal is to change a core decision made when California enacted the non-economic damages limit—that the cap not be increased for inflation. This decision was revisited several times (because the late seventies and early eighties were periods of runaway inflation in the United States) but was never changed. The Initiative would not begin to adjust for inflation on its effective date but would travel back in time and insert an inflation provision in MICRA as of its enactment—overruling the judgments made when it was enacted and those made by later Legislatures. After the initial adjustment, the cap would be annually adjusted for inflation. This change would also apply retroactively to cases that are pending on the effective date of Initiative 1606. Because of the extraordinary inflation in the late seventies and early eighties, the proposed cap would increase to about \$1,100,000 under the Initiative; if the increase in inflation was calculated instead beginning in 1985, the year the California Supreme Court held that MICRA was constitutional, then the proposed cap would be about \$560,000.

Initiative 1606 is an example of the current trend in designing initiative measures. Rather than seek an up or down vote on the core issue, measures are designed with messages or

elements expected, if the polling is correct, to resonate with the public and to draw focus away from the core of the proposal. For example, while the Initiative will increase the amount of attorney’s fees paid by injured plaintiffs, the Initiative adds an unneeded reference to the existing attorneys fee provision of MICRA. This would permit supporters to assert that the Initiative limits attorney fees when it has the opposite effect.

In addition, the increase in the amount that can be recovered for non-economic damages has been combined with a proposal to require drug testing of physicians (and to impose the cost on physicians and hospitals) and to require use of the CURES (Controlled Substance Utilization Review and Evaluation System) prescription database before a physician may prescribe certain drugs (to reduce or eliminate prescribing to patients seeking opiate prescriptions from multiple physicians). There are many undeniably tragic situations involving both of these issues and the issues are expected to resonate with the public. But each of these issues has other solutions, such as a diversion program to avoid harm to the public and to permit recovery by the physician. Funding for these programs can also be increased with salutary results and these programs have suffered from budget cuts along with other important state funded programs in California. Similarly, the CURES database is underfunded and, as a result is not used or useful. While SB 809 has been adopted to begin to address this issue the changes will be implemented slowly.

The result of this Initiative is to increase the cost of healthcare. All purchasers of malpractice insurance will have increased costs which will be passed on to purchasers of health care, whether it is to the government, to employers or to individuals or groups who purchase exchange plans. The Legislative Analyst’s Office estimated the costs to state and local government alone to be “likely at least in the low tens of millions of dollars annually, potentially ranging to over one hundred million dollars annually.” State and local government have few choices to meet this increased cost: reduce expenditures in other government programs, increase taxes or shift the cost to the private sector.

If the goal is, as it should be, to protect patients from harm and compensate them when harm occurs in an efficient and fair manner then the promise of the future is to develop a system that, on the one hand, efficiently compensates persons injured during the course of medical care on a no-fault basis while at the same time taking steps to improve the system of care to reduce harm. Returning to 1975 is not the way to address either issue.

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RISK TAKING IN THE PROVIDER WORLD: IS A KNOX-KEENE PLAN A GOOD STRATEGIC MOVE FOR YOU?

KITTY JUNIPER

Reimbursement for health care services in California continues its shift toward capitation, resulting in health care providers increasingly forming their own health plans under the Knox Keene Health Care Service Plan Act (the “Act”). A health plan license allows providers to contract directly with government entities, become qualified health plans on the Exchange or participate in broad-based risk arrangements down streamed by other commercial health plans.¹ Providers can also use their plan licenses in conjunction with Accountable Care Organizations or to structure innovative payment models.

Corporate entities often form health plans as a means to employ doctors and avoid California’s corporate practice of medicine laws and other commercial practice restrictions. Specialized health plans, in particular, have used their plan licenses to employ or contract with doctors in retail settings to provide convenient, accessible services to patients. These specialized plans are well positioned to contract with commercial payers and qualified health plans to provide newly mandated essential benefits under the Affordable Care Act or drive traffic to health plan networks as a result of their retail presence.

Types of Knox-Keene Health Plans

Knox-Keene health plans are categorized as (i) full-service plans that arrange for the provision of basic and essential benefits as defined in the Act, and (ii) specialized plans that provide services in a single specialty. Specialized plans may be formed for vision, dental, mental health, acupuncture or chiropractic. A discount health plan that provides members with access to providers who discount their fees, is another model for either category.

Full service and specialized plans may design and sell their own benefit products directly to individual members and employer or other groups, large or small. Health plans that operate in the retail world (mostly specialized plans) can structure individual memberships that allow consumers to “walk-in,” purchase a membership and receive services on the spot.

Many provider-based health plans are formed as “limited” full-service plans, which enter into global risk contracts

with other health plans (akin to provider contracts) rather than offer their own products. The limited health plan may receive increased capitation rates or administrative fees by performing certain duties delegated to them by the other health plan, e.g., credentialing, utilization management, quality assurance. Other health plans may be formed solely for the purpose of creating Medicare Advantage Plans, to which they are restricted.

A provider considering whether to establish a health plan must determine how the arrangement fits into its strategic plan, short-term and long-term. Operating health plans are costly in terms of time and money and the benefits they achieve must be carefully analyzed.

Benefits of Forming a Knox-Keene Health Plan

A health plan structure can be advantageous for several reasons:

- a. *Clinical Integration and Quality Improvement:* A health plan structure offers a roadmap to improving quality and integrating affiliated provider entities due to the Act’s program requirements and the clinical integration involved. Today, providers need a track record showing their abilities to deliver high quality and cost-efficient services in order to contract into higher-tier health plan networks and increase their reimbursement rates. This, combined with the increased transparency in quality and cost ratings, makes the need for improved quality critical to a provider’s success.
- b. *Financial Integration and Efficiencies:* Risk-sharing arrangements amongst providers and with larger health plans frequently contain cost containment mechanisms. A health plan structure can help to align different types of providers and streamline operations to create system-wide financial efficiencies.
- c. *Ownership of Plan and Employment of Health Care Professionals:* A health plan can be corporate-owned and operated and employ medical professionals to provide services to health plan members. This is important to entities that prefer an employment model and view it as a key to aligning providers.

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GOT MEDICARE BILLING PRIVILEGES? ARE YOU SURE? TRAPS FOR THE UNWARY IN MEDICARE ENROLLMENT

CHRISTINE COHN

To receive payment for items and services furnished to Medicare beneficiaries, a health care professional or facility must have approved Medicare billing privileges, which requires enrollment in the Medicare program. Failure to update or apply for Medicare enrollment in a timely fashion, or comply with other rules governing Medicare billing privileges, risks the complete denial of claims for payment. This article highlights a few fundamentals of Medicare enrollment, which may help health care professionals and facilities avoid a few simple mistakes and their potentially extreme consequences.

First, some definitions within the Medicare program:

- a “provider” furnishes patient care services for those who are awaiting, receiving, or recuperating from treatment rendered by intervening practitioners. Providers include hospitals, hospices, home health agencies and skilled nursing facilities.
- a “supplier” furnishes the goods and services that actually comprise patient care and treatment, e.g., physicians, physician group practices, other health care professionals, ambulatory surgery centers and portable x-ray units.

Trap: Physicians, certain non-physician practitioners and group practices have thirty days to notify the Medicare administrative contractor (“MAC”) about a change in practice location. Missing the deadline will preclude payment for services rendered more than thirty days prior to the effective date of the updated Medicare enrollment.

When a Medicare-participating physician group practice hires a new physician or a non-physician practitioner (an “NPP”), i.e., a nurse practitioner, clinical nurse specialist, certified mid-wife or physician assistant, the group practice must ensure that Medicare enrollment for the new hire is properly linked to the group at the practice location where he or she will provide services. For example, if the group hires a physician who is already enrolled in the Medicare program, but is enrolled at the location of the physician’s former employer, the physician

must submit a complete Medicare enrollment application indicating the new employer’s practice location. The complete application package must be submitted within thirty days of commencing services at the new location. 42 C.F.R. § 424.516(d)(1)(iii).

Specifically, the new hire will have to submit a Center for Medicare and Medicaid Services (“CMS”) Form 855I initial application and Form 855R to reassign his or her Medicare benefits to the new employer. Alternatively, the physician can use the internet-based Provider Enrollment, Chain and Ownership System (“PECOS”) located at <https://pecos.cms.hhs.gov/pecos/login.do>.

The effective date of Medicare enrollment for physicians, NPP’s and organizations comprised of physicians and NPP’s is the date when the enrollment application is initially filed, if that application is subsequently approved by the MAC, or the date when the supplier first began furnishing services at the newly enrolled practice location, *whichever is later*. § 424.520(d). The date of filing the application is likely to be the later of the two dates. Therefore, if the new hire completes the application process by submitting the application forms and all required supporting documentation within thirty days of his or her starting date with the new employer, the effective date of billing privileges will coincide with a date that falls within thirty days of the new hire’s commencement of services for the new employer.

The Medicare rules generally permit physicians, NPP’s and physician and NPP organizations to *retrospectively* bill for services rendered up to thirty days prior to the effective date of enrollment. 42 C.F.R. § 424.521(a)(1). If the effective date assigned for the new hire’s Medicare billing privileges is no more than thirty days after his or her first date of employment, the group practice will be able to bill retrospectively for all of the physician’s Medicare-covered services performed for the group, beginning with the first date of service. The same thirty-day deadline and retrospective billing opportunity applies to a physician or NPP who must enroll in the Medicare

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AB 1000 AND CORPORATE PRACTICE IN CALIFORNIA: MORE THAN MEETS THE EYE—OR LESS?

CAROL K. LUCAS

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in their offices through employed physical therapists until the California Physical Therapy Board announced in 2010 that such employment violated the corporate practice ban and constituted unprofessional conduct for a physical therapist, which conduct could lead to licensure action. Medical groups were understandably dismayed by this about face on the part of the Physical Therapy Board; having an employed physical therapist in the office was convenient, enhanced patient compliance and expanded the rehabilitation services the practice could offer. Further, the ability to bill for physical therapy services represented income to the practice. In order to restore the status quo ante 2010, AB 1000 added licensed physical therapists to the list of licensed professionals who could be officers, directors, minority shareholders and professional employees of medical corporations and podiatry corporations. It also added 10 categories of licensees who could be shareholders, officers, directors and professional employees of physical therapy corporations, including physicians and surgeons, podiatrists, acupuncturists, naturopathic doctors, registered nurses and psychologists.

AB 1000 went much further, however, by adding the following language to Corporations Code Section §13401.5, the primary section governing professional corporations in California: “This section does not limit employment by a professional corporation designated in this section of only those licensed professionals listed under each subdivision. Any person duly licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act may be employed to render professional services by a professional corporation designated in this section.”

Until this amendment, §13401.5 had carefully listed out, for each specific type of professional corporation, all of the other licensed persons who could be officers, directors, minority shareholders and professional employees of a particular type of professional corporation. If a license category was not listed, a person holding that license could not provide professional services through that type of professional corporation. For example, dentists were not listed under medical corporations although physicians and surgeons were listed under dental corporations. That meant, until January 1, 2014, that a medical group could not employ a dentist even though a dental corporation could

employ a physician. Further, no dentist could own shares in a medical corporation or serve on its board, even though a physician could own up to 49% of the stock of a dental corporation and be a member of its board of directors.

As a result of the language added to §13401.5 any of the listed professional corporations may now employ any licensed person and offer their services. In theory, as a result of AB 1000, a properly constituted audiology corporation, owned by licensed audiologists and speech-language pathologists as authorized by §13401.5(e), could open a clinic and offer medical services through employed physicians. This would represent a significant change in corporate practice as it relates to inter-license practice in California.

Licensees should be cautious in implementing this new authority, however. A number of previously existing statutes applicable to individual licensed professions appear to be in direct conflict with the current version of §13401.5. For example, Business and Professions Code §3109, applicable to optometrists, prohibits employment of optometrists except by optometric corporations or ophthalmologists (but not other medical specialties), in direct conflict with §13401.5. It is not clear which section would prevail if a medical corporation (other than one practicing ophthalmology) employed an optometrist, even though optometrists are listed among the authorized persons who may be officers, directors, minority owners or professional employees of a medical corporation. Even more uncertain is the result if an optometrist were employed by a license category that does not explicitly list optometrists as permitted professional employees, such as a physician assistant corporation. Only time will tell how these conflicts will be resolved or whether AB 1000 represents a significant erosion of corporate practice in California.

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RISK TAKING IN THE PROVIDER WORLD: IS A KNOX-KEENE PLAN A GOOD STRATEGIC MOVE FOR YOU?

KITTY JUNIPER

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d. *Data and Management Services:* Effective data gathering and reporting is absolutely necessary with health care reform. Whether or not a health plan chooses to employ its health care professionals, it still can assist providers in integrating by providing key management services, including staffing, data gathering and reporting services and evidence-based medicine software.

e. *Referrals and Managed Care Contracting:* Health plans have the ability to direct patient referrals within their networks and to enter into plan-to-plan contracts that benefit their networks.

f. *Increased Reimbursement and Acceptance of Delegated Tasks.* Accepting delegated tasks from larger health plans can lead to increased provider reimbursement and more control over operations.

g. *Product Development.* A health plan can be licensed to develop its own health plan benefit products for employers or individuals, providing flexibility for innovative providers.

Costs of a Knox-Keene Plan

While a health plan structure offers clear advantages, the costs include the following:

a. *Start-up Costs.* Obtaining a Knox-Keene license includes the costs of an application fee, deposit, maintenance of tangible net equity, attorney and financial consultant fees, staff, insurance and marketing. These costs vary according to the type of health plan. A new health plan that offers group contracts has to have the financial fortitude to continue operations while selling and negotiating those contracts.

b. *Ongoing Compliance and Operational Costs.* Compliance with regulatory requirements is ongoing and includes, without limitation, financial, expansion and advertising filings, routine audits every three years and other filing submissions triggered by changes in plan operations. In addition, health plans need to maintain their administrative capacity and limit spending for non-health care services.

c. *Financial Assessments.* The Department of Managed Health Care (“DMHC”) imposes annual assessments on health plans on a per member basis and for audits.

d. *DMHC Oversight.* A health plan is subject to the DMHC’s oversight and monitoring and non-compliance can result in costly penalties. A health plan needs to implement a compliance plan to assist in avoiding fines and penalties that can result from delays and non-adherence to the Act’s program requirements.

A health plan license carries a multitude of benefits in the risk-based world of health care reimbursement. If it fits within a provider’s strategic plan, the next steps will be to determine its corporate structure, ownership, partnerships, potential lines of business, timeline, software and data base, policies and procedures for program requirements, financial projections and management. Putting together a solid project team is essential to accomplishing these goals in the shortest and least expensive manner.

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1 The Act requires that any person who undertakes to arrange for the provision of or pays for health care services to subscribers or enrollees, in return for a prepaid or periodic charge from or on behalf of the subscribers or enrollees, must obtain a Knox Keene license.

LOOSE LIPS SINK SHIPS AND CARELESS E-MAILS TORPEDO A TRANSACTION

JULIE A. SIMER



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("Saltzer") the largest, independent multi-specialty physician group in Idaho. In 2008, St. Luke's decided to acquire the Saltzer group.

Meanwhile, the Federal Trade Commission ("FTC") and the Idaho Attorney General began an investigation of the intended acquisition and requested that St. Luke's delay the transaction while the investigation was pending. Nonetheless, St. Luke's proceeded with the closing, and the St. Luke's-Saltzer entity became the largest provider of adult primary care services in Nampa, Idaho. Subsequently, the FTC and St. Luke's' competitors filed an antitrust lawsuit to unwind the deal.

The FTC alleged that the acquisition eliminated competition between Saltzer and the primary care physicians employed by St. Luke's. It also alleged that St. Luke's' market power would prevent the area's competing hospitals from obtaining physician referrals and drive up prices.

Although the Court acknowledged that the health care industry is moving toward a more integrated system, it was concerned that the added leverage would permit the hospital system to negotiate higher reimbursement rates from health plans.

The evidence produced by the FTC and St. Luke's' competitors included e-mails from St. Luke's' Chief Executive Officer ("CEO") to its Chief Financial Officer and Chief Operating Officer. The email discussed revenue and volume shortfalls in 2011 and outlined a plan for improvement: "Pressure Payors for new/directed agreements."

In court, the CEO asserted that he did not mean that St. Luke's could pressure payors for higher reimbursement, but rather that it could pressure them to direct more patients to St. Luke's high quality and low cost clinics. The Court was not convinced, however. The Court pointed out that the "pressure" language was contained under a heading entitled "Price Increase" and was part of a discussion on how to increase income. Similarly, in an internal e-mail exchange the Saltzer CEO stated that if the negotiations with St. Luke's went well, "there would be the clout of the entire network."

Relying upon this and other evidence, the Court concluded that the acquisition violated Section 7 of the Clayton Act and the Idaho Competition Act, and it ordered St. Luke's to fully divest itself of Saltzer's physicians and unwind the acquisition. While these e-mails may not have been the sole basis of the Court's decision, they implied that the purpose of the acquisition was to decrease competition and raise prices rather than improve patient service and quality.

The lesson of this story is clear: Be cautious when sending communications that discuss competitive strategy. Words such as "leverage," "pressure," "clout," or "advantage" may be misconstrued in a courtroom. Communications about integration strategy should always stress the true goals of patient satisfaction, increased efficiency, and improved outcomes.

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ATTORNEY PROFILE

KITTY JUNIPER

Kathleen Juniper, better known as Kitty, recently joined Buchalter Nemer as Of Counsel in the firm's Health Care Practice Group. Her focus is on helping clients develop strategic regulatory solutions, obtain government approvals and resolve managed care issues.

When Kitty is not in the office, she might be found volunteering, gardening or being a faithful rock n' roll fan at a local rock concert. She is past president of the Lawyers Club of San Diego, served for many years on its advisory board and was the recipient of the bar association's Belva Lockwood Award. She was also a Director of the San Diego Volunteer Lawyers program, San Diego County's oldest and largest pro bono legal services program for the indigent. Now an Orange County resident who recently relocated from San Diego, Kitty has her eyes on other nonprofit organizations to which to volunteer her time.

Kitty has a diverse background with legal and management experience in business, government, private practice and government relations, all coming together to form solid expertise in health care, business and regulatory work. She began her legal career with the Federal Trade Commission in Washington, DC, where she worked under Robert Reich, former U.S. Secretary of Labor. Her focus there on strategic planning and consumer protection matters, proved to be a good basis for her legal and business career.

In her home state of Ohio, Kitty became involved in politics first fundraising for a congressional campaign and then directing (successfully) a Columbus city council campaign. Thereafter, Lenscrafters recruited her to become its first in-house counsel and government relations director as the company expanded nationally and internationally. She led the team to launch a vision health care plan in California, and as its President, was engaged in strategic planning, operations and regulatory work. She was appointed to the California

Advisory Board on Health Care Service Plans and later transitioned into private practice, working in business, regulatory and health care law.

When health care reform hit, Kitty's practice needed a more robust platform from which she could provide the best product to her clients. After working for a boutique health care law firm, Hooper Lundy & Bookman, she joined us here at Buchalter in January 2014. Kitty is now an integral part of our Health Care Practice Group.

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GOT MEDICARE BILLING PRIVILEGES? ARE YOU SURE? TRAPS FOR THE UNWARY IN MEDICARE ENROLLMENT CHRISTINE COHN

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program for the first time. Missing the deadline will preclude payment for services rendered more than thirty days prior to the effective date of Medicare enrollment.

Trap: CMS may deactivate the Medicare billing privileges of a provider or supplier who fails to submit a reimbursement claim for twelve consecutive calendar months. Medicare payment will be lost for any services performed after the twelve-month period of non-billing.

CMS has the discretion to deactivate the billing privileges of a provider or supplier who fails to submit any Medicare claims for twelve consecutive calendar months. If a provider or supplier is enrolled in Medicare at multiple practice or service locations, program instructions require the MAC to deactivate the billing privileges applicable only to the non-billing location.

Medicare beneficiaries have no financial responsibility for any expense incurred by a provider or supplier for otherwise covered items and services furnished after deactivation. The attempt to collect payment from a Medicare patient may result in criminal liability. § 424.555.

Trap: The Medicare program will not pay for certain items and services unless they are ordered by a physician or qualified NPP who is enrolled in the Medicare program.

Upon receipt of a patient referral for home health services, the home health agency should confirm that the ordering physician is enrolled in Medicare. Similarly, a clinical laboratory, imaging services supplier or a supplier of durable medical equipment, prosthetics, orthotics and supplies (“DMEPOS supplier”) should check the enrollment status of the ordering physician or qualified NPP. If the National Provider Identifier shown on the reimbursement claim for the ordering physician or NPP does not correspond to an enrolled individual, the MAC will deny payment to the home health agency, clinical laboratory, imaging services supplier or DMEPOS supplier. § 424.507.

Trap: An application for Medicare enrollment may be denied if the applicant, or any owner of the applicant, has not repaid a Medicare overpayment.

Under the Medicare rules, enrollment may be denied to a physician or NPP who has not repaid a Medicare overpayment. § 424.530(a)(6). Enrollment may also be denied to any provider or supplier if the applicant’s owner has not repaid an overpayment. Implicitly, however, an applicant owner’s overpayment will impede enrollment only if the applicant has disclosed the owner in the Form 855 application.

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Points & Authorities

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