

Medicare – Bridging the Gap Between Ridiculous and Sublime

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“Have no fear of perfection – you’ll never reach it.”

Salvador Dali

Somewhere in Rural America

Settled in 1845, the city of Sumter rests in the bucolic middle of South Carolina and boasts the only public park in the United States containing all eight known species of swan. Originally named Sumterville, this sleepy, rural Southern town has for nearly one hundred years been home to the Tuomey Healthcare System

(“Tuomey”), an acute care hospital also providing a 36-bed nursery, 10 operating suites, Cancer Treatment Center, Tuomey Home Services and a subacute skilled care program. As of 2013, and affirmed in June 2015, Tuomey also faced a record-breaking \$237,454,195 judgment for violating federal law.

The path leading up to this verdict was a crooked one. As it attempted to hedge projected losses of more than \$15 million at the turn of the millennium over the next fifteen years, Tuomey knew the treacherous landscape into which it entered, and from the outset had no intention of navigating the federal physician self-referral prohibitions (commonly known as the “Stark Laws”) or the Federal False Claims Act (“FCA”) alone. To secure its end, Tuomey consulted with a former Inspector General for the Department of Health and Human Services, a prominent health care law firm, and its longtime counsel, Nexsen Pruit, who in turn sought assistance from a national consulting firm. While implementing new contracts with local physicians, Tuomey’s lone hold out, Michael Drakeford, M.D., filed the *qui tam* action in 2005 that

resulted in the record-breaking outcome.

Although Dr. Drakeford filed his lawsuit in 2005, it was not until two years later that the Federal Government intervened. The first Tuomey trial began in 2010, ending with the District Court setting aside the jury’s decision. In 2012, the Fourth Circuit reversed this position, returning everything to the lower court for a new trial. In May 2013, the District Court entered the infamous \$237 million judgment, and in June 2015 the Fourth Circuit affirmed, albeit for different reasons. The judgment, which Tuomey could most likely never afford to pay, may well end up costing the Federal Government more in prosecution fees than it will collect against Tuomey in the long run. With the exception of Dr. Drakeford, who may get some percentage of what the Federal Government collects, both the system and the American taxpayer come up losers.

Nothing Is Ever Easy

Also in June 2015, the Office of Inspector General (“OIG”) issued a fraud alert pertaining to physician compensation arrangements and

the “significant liability” they may cause. Reminding physicians that medical directorships and other compensation arrangements should reflect fair market value, among other things, the OIG noted that transgressions in health care law may result in criminal, civil and administrative sanctions. The existence of a healthcare infrastructure made labyrinthine by the minutiae found within the Stark Laws and the FCA needs no introduction to the modern health care provider, and those practitioners fated to travel the maze must stand vigilant against surprises to be found in the form of strict regulations for those who deliver medical treatment funded by the Federal Government.

Make no mistake, Medicare ordinances often vacillate between the ridiculous and the sublime, and within this netherworld of health care law nothing is simple at surface level, and the landscape is continually changing. One such example is Medicare’s inability to define that common event which takes place every day between 11:59 p.m. and 12:01 a.m. Known to most of us as “midnight,” the Centers for Medicare & Medicaid Services (“CMS”) first introduced the “two-midnight rule” in October 2013 to determine the propriety of an inpatient admission for payment under Medicare Part A if the physician (or other qualified health care practitioner) admits for inpatient status with the expectation the stay will extend beyond two midnights. If the physician believed the hospital stay to be less than two midnights, CMS advised practitioners to bill the care under outpatient services. Now, nearly two years later, CMS has proposed

yet another modification to this unpopular and controversial rule, this time focusing on the “rare and unusual” exceptions policy contained within the two-midnight benchmark. With these most recent changes, CMS has expanded possible inpatient admissions to include physician case-by-case determinations, shifting away from an inflexible matrix to make such determinations retrospectively. Although still subject to review, CMS plans to empower Quality Improvement Organization contractors to review short inpatient stays, rather than the Medicare administrative contractors used prior to the update.

CMS hoped the two-midnight rule would deter hospitals from billing patient claims as observations in an effort to shield them from contracted government audits. In such cases, patients suffered from higher out-of-pocket expenses, while providers rallied behind their mantra that the government should not interfere with clinical judgment. When Congress suspended the two-midnight rule for 18 months, some experts estimated this freeze cost the Federal Government an additional \$5 billion in the form of improperly paid claims. Once again, it appears that everyone lost.

The U.S. Supreme Court Saves the Day...Maybe

A trifecta of sorts, June 2015 was also the month in which the United States Supreme Court finally ruled on the latest threat to the Affordable Care Act, the Fourth Circuit’s decision in *King v. Burwell*. While the issues presented before the Supreme Court were narrow – whether or not federal tax credits

are available to individuals in states that participate in a federal Health Insurance Marketplace or Exchange (the “Exchange”) – the implications proved limitless. Prior to the decision, experts predicted that a ruling against the availability of federal tax credits in states that had an Exchange maintained by the Federal Government would compromise health insurance for eight million people, while others would be forced to endure a premium spike. The collateral damage, so the prediction went, could potentially eviscerate the ability of millions to comply with the Affordable Care Act’s Individual Mandate, a deep crack in healthcare reform’s foundation that many believe the law would be unable to endure.

While the ruling has been made, the result remains unclear. In a 6-3 decision, the Supreme Court saved the Affordable Care Act once again, and maintained the *status quo*, at least for now. Whether or not one agrees with Justices Scalia, Thomas and Alito, no dissent in which they join should be ignored. This particular dissenting opinion takes issue with the Court’s interpretation of the plain language used by the Affordable Care Act, and also notes that by usurping decision-making authority reserved only for Congress, the Supreme Court “both aggrandizes judicial power and encourages congressional lassitude.”

The implications of such actions outside the authority of the Court, so the dissent contends, authorize the Internal Revenue Service to spend tens of billions of dollars in tax credits for federal Exchanges each year, as well as jeopardizing

the price stability of health insurance for millions of Americans and compromising the necessary amount of Federalism with which the Affordable Care Act will ultimately find success. Reaching back in time to quote assurances from Alexander Hamilton that the “judiciary . . . has no influence over . . . the purse,” Justice Scalia concludes his dissent by predicting that the

Supreme Court’s “somersaults of statutory interpretation” shall only serve to create a legacy that the Supreme Court “favors some laws over others, and is prepared to do whatever it takes to uphold and assist its favorites.” Should this prediction have long-term merit, once again, everyone loses.

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