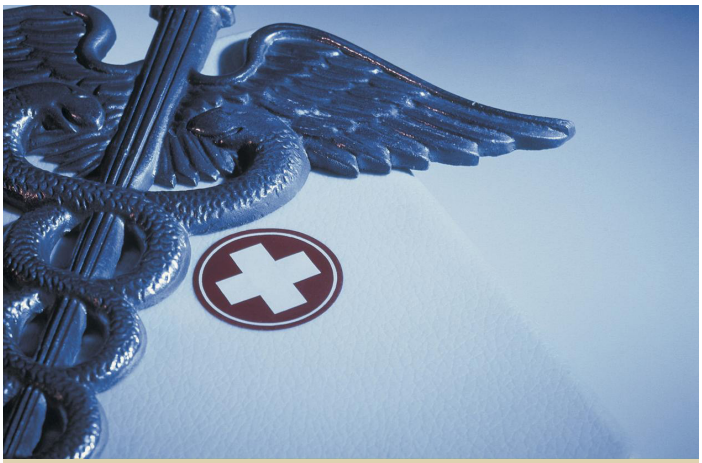

**Feburary 2015 • Volume 5, Number 1**



IN THIS ISSUE



DW HEALTHCARE BLOG
http://www.dwhealthlawblog.com/



DICKINSON WRIGHT'S

# HEALTHCARE **LEGAL**NEWS

## TENNESSEE SUPREME COURT HOLDS THAT HEALTHCARE PROVIDERS CAN ONLY COLLECT WHAT INSURANCE COMPANIES ARE WILLING TO PAY

*by Keith C. Dennen, who is a Member in Dickinson Wright's Nashville office, and can be reached at 615.780.1106 or kdennen@dickinsonwright.com*

A woman is seriously injured in a car accident. It is not her fault. She is taken to the emergency room where she is treated. When she is released, the hospital bills total $100,000. The woman has health insurance. The hospital submits its claim and the health insurance company pays $25,000.00 – the amount owed after the "contractual" adjustment. The hospital accepts the payment.

That should be the end of the story. However, the Tennessee law gives the hospital a lien on any recovery from a third party. So, the woman sues the driver of the other vehicle. The driver's insurance company pays $100,000 to the injured woman. The hospital refuses to "release" its lien because the hospital asserts that it is entitled to another $75,000.00 – the difference between the insurance company payment and the amount of the hospital bill.

This story sounds like fiction, but it is very real. This story is based on a fact situation that the Tennessee Supreme Court reviewed in Diane West v. Shelby County Healthcare Corporation d/b/a Regional Medical Center at Memphis No. W2012-00044-SC-R11-CV (Tenn. Dec. 19, 2014).

The Tennessee Supreme Court explained that the non-possessory hospital lien is a creature of statute designed to protect hospitals from losing money for providing care to people who then recovered monetary damages from third parties. A debt owed to the hospital is a prerequisite to the lien. Further, the lien statute, Tennessee Code Annotated Section 29-22-101(a) limits the lien to "all reasonable and necessary charges for hospital care, treatment and maintenance of ill or injured persons."

The Court noted that no party challenged the necessity of the care provided. Therefore, the Court focused its attention on the "reasonableness" of the cost of those services. The Court concluded that the non-discounted charges reflected in the Hospital's bill were not reasonable for two reasons:

1. The amount of the charges did not reflect what is actually being paid in the marketplace. The court noted that virtually no public or private insurer actually pays full charges. Therefore, the "reasonable" charge is the charge that insurers actually pay and hospitals are willing to accept.

2. The contracts between the hospital and the insurance companies

limited the amounts that could be charged to the insureds. By entering into these contracts, the Hospital willingly capped the obligation of the injured party.

Thus, the Court held that the lien ceased to exist when the hospital accepted full payment from the insurance company. Finally, the Court refused to recognize an independent cause of action against the driver who caused the accident.

This case should cause some concern for healthcare providers in Tennessee. Can a hospital or a doctor collect more than the amount that an insurance company actually pays for services rendered to an uninsured patient? According to this case, the answer is no.

## SETTING THE STAGE FOR VALUE BASED PAYMENTS AND NATIONWIDE INTEROPERABILITY OF ELECTRONIC HEALTH DATA

*by Rose J. Willis, who is a Member in Dickinson Wright's Troy office, and can be reached at 248.433.7584 or rwillis@dickinsonwright.com*

Last month, Federal agencies issued frameworks for improving the U.S. health care system by increasingly tying value based payments to the delivery of health care services and achieving nationwide interoperability of electronic health data, setting the stage for accomplishing these goals in an aggressive timeline over the next three years.

In a brief article published on January 26th in the New England Journal of Medicine,[1] Sylvia Burwell, the U.S. Secretary of Health and Human Services (HHS), summarized HHS's plans for improving the U.S. health care system. According to Ms. Burwell, efforts will be focused on three methods for improvement: (1) using incentives to motivate higher-value care by increasingly tying payment to value through alternative payment models; (2) changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and (3) harnessing the power of information to improve care for patients.

It should come to us as no surprise that HHS intends to ramp up its efforts to tie payment for health care services provided to Medicare beneficiaries to quality and cost. Perhaps surprising to some, however, is the aggressiveness of this goal, in particular as it relates to alternative payment models ("APMs"). According to Ms. Burwell, HHS's objective is to tie 85% of all Medicare fee for service payments to quality or value by 2016 and 90% by 2018. As part of this, by the end of 2016, 30% would be paid through APMs (such as accountable care organizations and bundled payment arrangements tied to quality and cost) and by the end of 2018, 50%.

It is estimated that currently 20 percent of the $362 billion in Medicare fee-for-service payments are made through APMs.[2] According to HHS, as recently as 2011, Medicare had "made almost no" payments through APMs.[3] HHS's plan represents an aggressive 50 percent increase in that level by the end of 2016.

Oncology care, the only health care specialty that was specifically mentioned in the article, was targeted as the starting point for developing and testing HHS' new payment models for specialty care. Last August, the Center for Medicare & Medicaid Innovation (CMMI) released a preliminary design of the Oncology Care Model,[4] an initiative for alternative payment in chemotherapy services provided to Medicare fee for service beneficiaries by "physician practices furnishing chemotherapy." We could see additional APMs tested for oncology care, and will likely see similar plans for other specialty care providers over the coming year.

Four days after the publication of Ms. Burwell's article, the U.S. Office of National Coordinator for Health Information Technology (ONC) issued its proposed plan for nationwide interoperability of electronic health data[5] (the "Plan"). In the Plan, ONC outlined short term and long term goals over the next 10 years, setting 2017 as the deadline for which a "majority of individuals and providers across the care continuum should be able to send, receive, find and use a common set of electronic clinical information."[6]

Under the Plan, the ONC does not expect that every health care provider will use the same software tool, nor does the ONC envision a national healthcare software platform. The ONC recognizes that there is no "one size fits all" approach and therefore seeks what is called "baseline interoperability." Baseline interoperability requires technical and policy conformance among networks, technical systems and their components in a manner that allows innovators and technologists to vary the usability in order to best meet the user's needs based on the scenario at hand, technology available, workflow design, personal preferences and other factors.[7]

Ms. Burwell's article and the ONC Plan have now set the stage for accomplishing the Federal government's methods for improving the delivery of healthcare in the U.S. If accomplished within the estimated timeframes, the U.S. health care system will look dramatically different in the next three years. Along those lines, healthcare providers and suppliers should expect no break in upcoming issuances of new guidelines, rules and regulations in furtherance of these interests.

---

[1] See "Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care", Sylvia M. Burwell, January 26, 2015, found at http://www.nejm.org/doi/full/10.1056/NEJMp1500445.

[2] See "Big change: Feds to tie more Medicare payments to 'value'", Dan Mangan, January 26, 2015.

[3] See id.

[5] See The Center for Medicare & Medicaid Innovation: Preliminary design for an oncology-focused model, available at http://www.advisory.com/~/media/Advisory-com/Research/OR/Blog/2014/CMS%20Innovation%20Center%20oncology%20model%20preliminary%20design%20paper.pdf.

[5] See "Connecting Health and Care for the Nation A Shared Nation Interoperability Roadmap" Draft Version 1.0, January 30, 2015, available at http://www.healthit.gov/sites/default/files/nationwide-interoperability-roadmap-draft-version-1.0.pdf.

[6] See id., at 10.

[7] See id., at 11.

## WILL THE ACO PROPOSED RULE SAVE THE SHARED SAVINGS PROGRAM?

*by Jessica L. Russell, who is an Associate in Dickinson Wright's Troy office, and can be reached at 248.433.7503 or jrussell@dickinsonwright.com*

In 2011, CMS implemented the Accountable Care Organization ("ACO") Shared Savings Program, which aims to promote increased savings for the Medicare program, improve health care quality, and create a more efficient and effective health care delivery system. While many deemed the ACO to be the future of health care models, the program's initial performance has not met the industry's high expectations.

At the onset of the program, ACO participants had the ability to choose between two tracks (called the "one-sided track" and the "two-sided track"). The two-sided track allowed for higher rewards (a return of60% of savings), but penalized an ACO's poor performance at the same percentage. The one-sided track provided lower returns, but exempted participants from penalties for three years before being automatically moved to the two-sided track. In exchange for the reduced risk, savings were reduced to 50% of the participant's savings for the year. Due to the exemption from penalty, almost all program participants opted for the one-sided track. However, in the first year of the program, only about half of the 220 participating ACOs experienced Medicare savings, while the other half had costs exceeding Medicare's spending benchmarks and were not eligible for shared savings.

Since the onset of the program, many ACO participants expressed that three years was an insufficient amount of time to establish the required infrastructure before being moved to the two-sided track. In addition, many argued the savings bonuses were too minimal in comparison to the high costs of implementing the necessary health care delivery system. According to a survey conducted by National Association of ACOs, two-thirds of participants were unwilling to take on additional risk and indicated they would be unlikely to continue with the program once they are required to accept penalties after the third year.

In response to these concerns and to incentivize continued participation in the ACO program, CMS recently proposed a rule that may encourage some participants to take on more financial risk for greater rewards and allow other participants to reduce their risk so they will remain in the ACO program.

Among key provisions, the rule proposes to protect ACOs in the one-sided track from penalties for up to six years instead of three, allowing ACOs more time to implement the necessary changes to the infrastructure of their current health care systems. However, if the ACO wishes to avoid penalties after its third year, it may need to meet several additional eligibility requirements and its savings rewards would drop from 50% to 40%.

To encourage participants to opt for the two-sided track, the minimum savings rate ("MSR") and minimum loss rate ("MLR") would be modified so as to be computed based on each individual ACO participant's number of assigned beneficiaries rather than a set rate for all. The MLR and MSR are the percentages of the participant's spending benchmark that a participant must exceed or save before being penalized or being eligible for shared savings. Therefore the proposed change may encourage smaller ACO participants to opt for the riskier track, since the MLR and MSR can be altered to better match a participant's resources. For example if a smaller ACO participant has a higher MLR, it will have more leeway as to how much it can exceed its benchmark before being subjected to penalities.

In addition to the modifications to the two original tracks, CMS also proposes a "Track Three," that will allow for a participant to receive 75% of savings in exchange for additional risk (responsibility for 75% of losses). However, savings would be capped at 20% of the ACO's benchmark and losses would be capped at 15%. Unlike the original two-sided track, the MSR and MLR will be set at 2%, which may encourage more participants to opt for the new track.

The comment period set by CMS expired on February 6th, 2015. Responses to this proposed rule will present an interesting development in the ACO Shared Savings Program and could significantly impact the success of the ACO model in 2015 and the years to follow.

## CMS ANNOUNCES NEW RULES THAT MAKE OWNER DOCTORS LIABLE FOR ALL PRACTICE MEDICARE DEBTS

**Even after they leave the Practice.**

*by Keith C. Dennen, who is a Member in Dickinson Wright's Nashville office, and can be reached at 615.780.1106 or kdennen@dickinsonwright.com*

CMS announced its final rules on "Medicare Provider Oversight" On December 3, 2014, (http://federalregister.gov/a/2014-28505). According to CMS' press release,

> These new rules strengthen oversight of Medicare providers and protect taxpayer dollars from bad actors. These new safeguards are designed to prevent physicians and other providers with unpaid debt from re-entering Medicare, remove providers with patterns or practices of abusive billing, and implement other provisions to help save more than $327 million annually.

What do these rules really mean for physicians and other providers?

**Ownership has its downside!** CMS will deny enrollment to any person who was an owner of a provider or supplier that has an outstanding Medicare debt. This provision applies even if the person was a minority owner who did not participate in the management of the entity. CMS intends to use this provision to collect Medicare Debts from physicians who do not otherwise have any responsibility for repayment of the debt.

The prior rules limited the persons responsible for Medicare overpayments to the entity or the billing physician. Now, CMS can use its power to deny Medicare enrollment to any physician, physician extender or other person who was an "owner" of the practice during the one year prior to termination of the entity's Medicare enrollment. Of course, the physician has an option – the physician can pay the full amount of the practice's Medicare Debt or enter into a payment arrangement with Medicare to pay the amount in full.

The term "Medicare Debt" is a new term. That term means any amount owed to Medicare regardless of the basis for the liability. It includes overpayments, but it is not limited to overpayments. Finally, a liability is a "Medicare Debt" even if the practice is appealing the determination and the appeal has not been fully resolved.

Similarly, enrollment may be denied to an entity if it owned, or if its current owner owned, an entity that has an unpaid Medicare Debt. The entity can avoid denial by paying the Medicare Debt in full.

**Felons are not allowed.** A felony conviction is now grounds for denial or revocation of Medicare enrollment. In its final rule, CMS announced that it intends to deny and revoke Medicare privileges of any provider or supplier "convicted" of a federal or state felony within the preceding 10 years. More importantly, Medicare extends this taint to any person who was an owner or "managing employee" of a provider or supplier.

The "Offenses" include traditional crimes: murder, rape, assault; financial crimes: extortion, embezzlement, income tax evasion and crimes that result in mandatory exclusion from Medicare. In addition, CMS adds "any felony that placed the Medicare program or its beneficiaries at immediate risk. CMS, however, states that the term "Offenses" is not "limited in scope or severity" to these crimes. Futher, CMS includes "pretrial diversion" in its definition of "conviction."

According to CMS, it is up to the enrollee to determine whether a person has a felony conviction within the past ten (10) years. Further, CMS will not provide any guidance on whether a particular felony will result in revocation.

**Abusive Billing Practices.** Finally, Medicare announced that it would revoke the privileges of any provider or supplier that it determines engages in "abuse of billing privileges."

The term "abuse of billing privileges" includes submission of a claim for services that could not be furnished to a patient on the date of service. CMS notes that these include claims for services when the beneficiary is dead, the directing physician or beneficiary is out of the country, or the equipment necessary is not present at the location where the testing occurred.

In addition, "abuse of billing practices" occurs when CMS determines that a provider "has a pattern or practice of submitting claims that fail to meet Medicare requirements." In making this determination CMS considers:

- The percentage of submitted claims that were denied.
- The reason(s) for the claim denials.
- Whether the provider or supplier has any history of final adverse actions (as that term is defined under § 424.502) and the nature of any such actions.
- The length of time over which the pattern has continued.
- How long the provider or supplier has been enrolled in Medicare.
- Any other information regarding the provider's or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

Once revoked, the provider, supplier, owner or managing employee is barred from participation in Medicare for a period ranging from one (1) year to three (3) years.

Significantly, CMS can take this action without any finding of "fraud" or other intentional action. Thus, revocation can occur simply because the physician's staff makes mistakes.

One area that is likely to create issues for physicians is CMS' position on "medical necessity." CMS will not inform the medical community of its position on "medical necessity." It has stated on numerous occasions that decision is one left to medical practitioners. But, CMS in its commentary to its rule, refused to include an exception to revocation for "good faith" disagreement among medical practitioners about medical necessity. Instead, CMS stated that it will make the decision of medical necessity when it revokes the practitioner's Medicare billing privileges. At that point, the practitioner may appeal the decision through CMS' administrative appeal process.

Finally, CMS announced that the time period for submission of claims once billing privileges are revoked has been reduced to 60 days from 180 days.

## CARE RECIPIENTS' LIMITED RIGHT TO DISCRIMINATE BASED ON PROTECTED CHARACTERISTICS OF CARE PROVIDER

*by David J. Houston, who is a Member in Dickinson Wright's Lansing office, and can be reached at 517.487.477 or dhouston@dickinsonwright.com*

Healthcare provider institutions including hospitals, clinics, medical practices, nursing homes and home health care providers (here, "Institutions") are occasionally called upon to balance the preferences of Consumers against the interests or possible rights of their employee Care Providers. This may occur when Consumer complaints target assigned direct Care Providers – nurses, nurse aides, home health care workers, physicians, specialists, or others. Sometimes a Consumer may refuse services from a Care Provider. These issues also surface in other contexts. For example, staffing services that employ and assign these "Care Providers" on a *locum tenens*, leased, or other arrangement, to the Institution or directly to the Consumer, must also be responsive to Consumer complaints.

**The Patient's "Right to Choose" The Care Provider**

Any number of commentators discuss the phrase, "patient right to choose providers." This purported "right" is based on three primary sources:

- Court decisions establishing the right of all patients to "control" treatment, *including the provider* of that treatment;
- Medicare and Medicaid statutes establishing covered patients' rights to choose providers;
- The Balanced Budget Act of 1997.

In addition, some states have adopted so-called "right to choose" statutes or regulations. For example, under Indiana regulations governing long-term care facilities, residents have a right to "choose a

personal attending physician and other providers of services." 410 IND. ADMIN. CODE 16.2-3.1-3(n)(1).

**Consumer Choice or Complaints Implicating a "Protected Characteristic"**

Consumer complaints, and to a lesser extent, provider requests, may be a "red flag." Possible reporting obligations, Consumer and Care Provider privacy rights, and of course, consumer satisfaction, receive close attention in these situations. However, statutorily-protected *employment non-discrimination* rights of the Care Providers can occassionally be overlooked. This is an area where those worker rights may be – or may *appear to be* – in conflict with the related right of the Consumer to select her or his Care Provider. Confusion concerning conflicting principles is not helped by the outmoded and anecdotal application of "BFOQ" (*bona fide occupational qualification*) concepts and/or historical rulings.

**The Right to Choose vs Protected Characteristics**

So, what happens when a sincerely-held Consumer belief or preference implicates a "protected characteristic" of the Care Provider, such as his or her race, ethnicity, perceived or apparent religious affiliation or, most problematic, *gender*?

Courts that have faced the question have drawn the line between Consumers' gender preferences, and other preferences, especially *racial* preferences.

> Taken together, [prior cases] hold that gender may be a legitimate criterion … for accommodating patients' privacy interests. It does not follow, however, that patients' privacy interests excuse disparate treatment based on race. … The privacy interest that is offended when one undresses in front of a doctor or nurse of the opposite sex does not apply to race. Just as the law tolerates same-sex restrooms or same-sex dressing rooms, but not white-only rooms, to accommodate privacy needs, [the Civil Rights Act] allows an employer to respect a preference for same-sex health providers, but not same-race providers.

The court specifically rejected the contention that Medicare, Medicaid, or state law allowed or required accommodation of Consumer preferences based on race.

*Note*, that there may be a different outcome in "private" or "direct pay" situations. One court has stated that, "[i]f a racially-biased resident wishes to employ at her own expense a white aide [state] law may require [the care institution] to allow the resident reasonable access to that aide."

**Protected Characteristics – Expanding Scope**

The concept that workers' personal attributes or affiliations are entitled to legal protection was essentially unknown at common law. Not until the civil rights movement of the 1960s did society and lawmakers come to believe that anti-discrimination laws served a societal goal.

The Civil Rights Act of 1964 originally prohibited discrimination based on "race, color, religion, sex (gender), or national origin." Prohibitions against discrimination based on age and disability were later passed. The concept of "protected characteristics," once clearly defined, has expanded through court and administrative actions. For example, statutory protection against "sex" discrimination has come to include, "same sex" preference. The Equal Employment Opportunity Commission (EEOC) takes the position that this protection also includes "gender identification" and "transgender" status. Additionally, state law may protect other "characteristics" such as being a smoker (Nevada, Kentucky), sexual orientation and gender identity (Nevada), height, weight and marital status (Michigan).

**Recommendations**

Institutional and other employers of Care Providers must be cognizant of the potential for Consumer complaints that are motivated by impermissible discriminatory intent. A sound written policy stating the employer's commitment to non-discrimination is appropriate. Additionally, the institution should have policies in place to ensure that no Care Provider assignment inadvertently implicates a "protected characteristic."


## DICKINSON WRIGHT OFFICES

**Detroit**
500 Woodward Ave.
Suite 4000
Detroit, MI 48226
Phone: 313.223.3500

**Nashville**
424 Church St.
Suite 1401
Nashville, TN 37219
Phone: 615.244.6538

**Grand Rapids**
200 Ottawa Ave., NW
Suite 1000
Grand Rapids, MI 49503
Phone: 616.458.1300

**Columbus**
150 E. Gay St.
Suite 2400
Columbus, OH 43215
Phone: 614.744.2570

**Phoenix**
1850 North Central Ave.
Suite 1400
Phoenix, AZ 85004
Phone: 602.285.5000

**Lansing**
215 S. Washington Square
Suite 200
Lansing, MI 48933
Phone: 517.371.1730

**Las Vegas**
8965 South Eastern Ave.
Suite 280
Las Vegas, NV 89123
Phone: 702.382.4002

**Toronto**
199 Bay St., Suite 2200
Commerce Court West
Toronto ON M5L 1G4
Phone: 416.777.0101

**Music Row**
54 Music Square East
Suite 300
Nashville TN 37203
Phone: 615.577.9600

**Las Vegas - Sunset**
8363 West Sunset Rd.
Suite 200
Las Vegas, NV 89113
Phone: 702.382.4002

**Washington, D.C.**
1875 Eye St., NW
Suite 1200
Washington, DC 20006
Phone: 202.457.0160

**Saginaw**
4800 Fashion Square Blvd.
Suite 300
Saginaw, MI 48604
Phone: 989.791.4646

**Lexington**
300 W. Vine St.
Suite 1700
Lexington, KY
Phone: 859.899.8700

**Ann Arbor**
350 S. Main St.
Suite 300
Ann Arbor, MI 48104
Phone: 734.623.7075

**Troy**
2600 W. Big Beaver Rd.
Suite 300
Troy, MI 48084
Phone: 248.433.7200