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HEALTH CARE UNHINGED

"And though she's not really ill | There's a little yellow pill | She goes running for the shelter of a mother's little helper | And it helps her on her way, gets her through her busy day." —Sir Michael Philip Jagger and Keith Richards

To date, there exists no thermometer to measure vacillations in a person's mental health, which is a good thing for febriphobics, and generally speaking, neither acetaminophen nor ibuprofen can cure mental illness, especially if the diagnosis is pharmacophobia. Unlike a fractured bone or sinus infection, ailments of the mind tend to be subjective and therefore more difficult to gauge. Just as a diagnosis of schizophrenia relies on a spectrum, psychotic examples range from hallucinations to speech impediments (even for glossophobics), and bipolar affective disorder by definition alternates between periods of elevated mood and depression. While the tenth revision of the medical classification system known as the International Statistical Classification of Diseases and Related Health Problems (ICD-10) contains more than 14,400 different physical health concerns, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) still hovers around a paltry 300 scenarios from which to choose.

The dearth of clearly identifiable mental disorders is a disheartening factor for the 3.1% of American adults who have presented with serious psychological distress within the past 30 days, or the 1.5 million hospital inpatients discharged with psychosis as the primary diagnosis, the average length of stay for whom was 7.2 days (which was not fast enough for those inpatients with nosocomephobia). Add to such dismal figures some 63.3 million visits to doctors (not including iatrophobics), as well as emergency departments or other outpatient clinics, and top off the numbers by including the 41,149 suicides that took place in 2013, and one does not need a PsyD to identify a serious problem.

Notwithstanding the disparity between identifying and treating mental health and medical concerns, the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) focused on preventing health insurance agencies from imposing unequal benefit limitations upon the two. While MHPAEA had certain limitations in its initial application across health plans, the Affordable Care Act effectively eliminated any imperfections in parity. Today, a qualified health plan must include at least ten essential health benefits, although certain states require more. California, for example, mandates "chemical dependency services" must be consistent with MHPAEA, including inpatient detoxification, outpatient evaluation and treatment for chemical dependency, transitional residential recovery services or chemical dependency treatment in a residential recovery setting.

For those not quite ready to accept the changes to the mental health industry brought about by health care reform, it may be of some consolation to know that the traditional AA program now extends anonymity to those suffering from online gaming (OLGA), cluttering (CLA), underearners (UA), workaholics (WA) and spenders (SA), to name but a few. With more Californians now dying from drug overdoses than car accidents, perhaps an AA-appropriate elective should replace driver's education in each high school curriculum (with at least one exception for amaxophobics and possibly both for didaskaleinophobics).

Funding a public system for mental health in California is in many ways as complicated as diagnosing the diseases themselves. With monies from the state, counties, Federal Government through Medicaid, Substance Abuse and Mental Health Services Administration block grants, CHIP programs, and the one percent income tax from Proposition 63 (the Mental Health Services Act), one of California's greatest challenges is to protect the integrity of these funds for the intended beneficiaries. Unfortunately, even the combined strength of MHPAEA and the Affordable Care Act cannot fully stop the payer system synapses from misfiring. Left untreated, the cost of substance abuse to society is close to $900 billion (factoring in a combination of lost productivity, increased health care costs, and the burden on the criminal justice system, as well as the further cost to victims of related crimes).

In antiquity, the Oracle of Delphi or "Pythia" delivered information in the form of prophecies after inhaling oleander vapors rising from the limestone at Mount Parnassus in central Greece. These seemingly epileptic advisors counseled some of ancient Greece's best and brightest, although even Hunter S. Thompson understood how helpless and irresponsible a person in the "depths of an ether binge" could be. As mental health disorders continue to steal center stage (except for those with topophobia), treatment options remain confusing to more than just decidophobics. Likewise, the ranks of mental health practitioners tasked with doling out diagnoses can be equally disparate, including primary care physicians, psychiatrists, psychopharmacologists, mental health nurse practitioners, psychologists, social workers, members of the clergy and counselors.

The abridged version above was taken from California Healthcare News, where the complete article first appeared in November 2015.

MEDICARE — BRIDGING THE GAP BETWEEN RIDICULOUS AND SUBLIME

"Have no fear of perfection — you'll never reach it."
—Salvador Dali

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, a Cancer Treatment Center, Tuomey Home Services and a subacute skilled care program. As of 2013, 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 was aware of 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. In May 2013, the District Court entered the infamous $237 million judgment, and in June 2015 the Fourth Circuit affirmed, albeit for different reasons. 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, 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. 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.

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. 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 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." 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."

The abridged version above was taken from California Healthcare News, where the complete article first appeared in July 2015.

HEALTH CARE'S ADVENTURES IN WONDERLAND: PROVIDER AGREEMENTS FOR ELECTRONIC HEALTH RECORDS — By Craig Garner and Jessica Weizenbluth

Modern health care provides its own spin on the word "complex," while at the same time forging possible paths toward what may be "unwinnable" scenarios. For the modern physician, the universe within which he or she exists requires updated definitions for words such as "complex" and "challenging," especially as that "perfect storm" also known as health care reform continues to age. Somewhere in between the 2015 Physician Quality Reporting System ("PQRS"), the Physician Value Based Payment Modifying Policies ("VBP") and tenth revision of the International Statistical Classification of Diseases and Related Health Problems (also known as ICD-10), physicians continue to find themselves still struggling to adopt electronic health records ("EHR") in practice.

In 2004 President George W. Bush announced his administration's objective for "development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care." In fact, President Bush predicted that by 2014 there would be "an interoperable electronic health record for each U.S. resident." Needless to say, President Bush's goal is still a work in progress. A decade later, 2015 has been a busy year for federal regulations on EHR incentive programs and meaningful use for EPs, all of which has occurred concurrently with the downward payment adjustments under the Medicare EHR Incentive Program, updates to the certification criteria as well as the Health IT Certification Program by the Office of the National Coordinator ("ONC"), and the solidification of the fate of the Merit-Based Incentive Payment System ("MIPS") for EPs long into the future.

Today, the Federal Government has outlined four specific goals in its attempt to apply the "effective use of information and technology to help the nation achieve high-quality care at lower costs, a healthy population, and engaged individuals." These goals include: (1) the advancement of person-centered and self-managed health; (2) the transformation of health care delivery and community health; (3) the fostering of research, scientific knowledge and innovation; and (4) the enhancement of the nation's health IT infrastructure. A laudable objective notwithstanding, EHR implementation nevertheless has met with certain challenges along the way.

These so-called challenges present for certain Providers as larger obstacles to implementation. On the front line of health care reform, physicians must lead the EHR charge, even as they face the greatest risk individually without many opportunities to align independently. Though many consider EHR to be cost prohibitive, the Federal Government addressed implementation, in part, when it encouraged physician and hospital alignment to further EHR. The track on which EHR exists appears to be incapable of derailment, but Providers would be remiss to think that the contractual agreements that create a vehicle with which they can join the convoy contain the entire gamut of necessary rails. Rather, each Provider should examine the path ahead, paying careful attention to key terms that may prove the difference between digital success and demise.

Notwithstanding the importance of Provider success when it comes to EHR implementation, each and every Provider path intersects with HITECH and the privacy obligations set forth in HIPAA. The success of health care reform depends in large part on innovation, including the replacement of paper medical records with EHRs. Still, the Federal Government recommends the same degree of vigilance as before. Recently, the OIG urged the Federal Office of Civil Rights to *strengthen* its oversight of the ways in which covered entities comply with the privacy standards under HIPAA as well as OCR's follow up on reported breaches of patient health information.

In the past several years, the United States has spent billions of dollars to safeguard the entirety of health information, from broken bones to heart surgery to mental illness, all of which are protected by federal and state law from public disclosure. When it comes to PHI and EHR, the law of our nation affords each and every patient strict confidentiality. The influence of HIPAA and HITECH on health care has changed its very infrastructure, protecting the disclosure of a broken finger equally as a diagnosis of iatrophobia.

Without Provider participation and cooperation, however, HIPAA and HITECH mean nothing. Failure by any Provider to follow the strict requirements of HIPAA and HITECH may result in loss of license, significant financial penalties, or both. To be sure, Providers have financial incentives to comply with HIPAA and HITECH, including meaningful use. To avoid penalties and enjoy the financial incentives of statutes and regulations relating to EHR, there will soon come a Developer agreement into which Providers must enter. Providers should be mindful that such agreements, although necessary, can be treacherous, and they must pay careful attention to all terms included therein, especially since HIPAA and HITECH are rather unforgiving.

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