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Wolters Kluwer Law & Business

Experts predict impact of McNulty memo on government investigations

by Valerie L. Witmer, J.D., Contributing Editor

The new Department of Justice (DOJ) charging guidelines for prosecuting corporate fraud represent a retreat from the directives of the Thompson memo with respect to waiver of attorney-client privilege in government enforcement actions, according to Gabriel L. Imperato, managing partner at Broad & Cassel, and Judith A. Waltz, partner at Foley & Lardner LLP.

At a recent web conference presented by the Society of Corporate Compliance and Ethics, Imperato and Waltz reviewed the memorandum released on December 12, 2006, by U.S. Deputy Attorney General Paul J. McNulty (the "McNulty memo") and discussed its implications for organizational compliance and cooperation in government investigations.

Impact. Under the directives of the McNulty memo, waiver of attorney-client privilege is no longer a prerequisite to a finding that a corporation has cooperated with government enforcement authorities, although it still may be considered in weighing the adequacy of the corporation's cooperation. Imperato and Waltz predicted that, as a result of the DOJ's change in position on waiver as well as the procedural burdens imposed on prosecutors under the revised charging guidelines, government-initiated requests for waiver of attorney-client privilege will be rare.

They also warned that the McNulty "retreat" may thwart negotiations with prosecutors while weakening corporations' credibility with prosecuting entities. They added that the new charging guidelines might create a "confusing, perhaps meaningless, distinction between being given credit for waiving, but not being punished for not waiving," and questioned whether requests for privilege waivers would cease, rendering cooperation voluntary.

Compliance guidance. According to Imperato and Waltz, prosecutors should consider the existence of a corporate compliance program when determining whether to prosecute a corporation. They warned, however, that the mere existence of a compliance program will not shield a corporation from prosecution. The DOJ will look at the effectiveness of the design and the organization's enforcement of the program. They noted that commission of crimes, despite a compliance program, may indicate that corporate management is not enforcing the program effectively.

Moreover, while Imperato and Waltz advised organizations to tailor compliance programs to the types of misconduct most likely to occur in their lines of business, they cautioned that a compliance program specifically prohibiting the conduct giving rise to potential criminal charges will not absolve the corporation from criminal liability.

SCCE Web Conference, Jan. 18, 2007.

Experts share tips on hospital-physician joint ventures

by Catherine Hubbard, M.A., Contributing Editor

Although forming a joint venture can involve risk and lead to some regulatory scrutiny, providers who fight the migration to these ventures are sure to "end up behind the times," according to Robert Hill, Jr. principal of Health Strategies & Solutions, Philadelphia. During a recent audio webcast presented by the Healthcare Financial Management Association, Hill and Craig Holm, senior vice president of Health Strategies & Solutions, offered advice on forming physician-hospital joint ventures and suggested factors to consider when deciding whether to participate in a joint venture.

Joint venture trends. Hill discussed factors driving the formation of joint ventures, which include declining (inflation-adjusted) physician reimbursement and income. Over the past five to ten years there has been a two to ten percent decline in inflation-adjusted physician income.

The operating environment for physicians and clinical practices continues to be more difficult and more challenging, he said. "Physicians have to look beyond the practice walls for income opportunities."

Joint ventures are growing, Hill noted. He attributed the growth in part to the reduction of state certificate-of-need (CON) laws. About half of the states, considerably fewer than in the past, have CON statutes in place, he said. "There's an opportunity there for physicians and other providers to provide and develop business services in the health care field," he said.

In addition, Hill explained that joint ventures opportunities are growing due to:

- *The decline of managed care/open access.* As a result of pushback on precertification and other managed care techniques, there has been more open access for covered lives than in the past. "Physicians can start a business in the community and know that they will have patients to populate that business," Hill said.
- *Technology and innovation.* There are more technical enhancements, such as imaging and scans.
- *Access to capital.* Venders and suppliers of high level technology can offer creative financing mechanisms. In addition, physicians have more access to capital to fund these initiatives.
- *Increase in outpatient procedures.* In recent years there has been a two to ten percent per capita increase in procedures such as computed axial tomography (CT) scans and magnetic resonance imaging (MRI)

Considerations. Although reimbursement trends continue to encourage the formation of hospital-physician partnerships, joint ventures face several regulatory obstacles such as Stark, state and federal anti-kickback laws, and reimbursement differentials, Hill said. In some cases hospitals can get higher reimbursement than physician groups or joint venture entities for the same imaging services, he explained.

Holm shared some tips for forming strong and positive relationships, and factors to consider when deciding whether to form a joint venture. He advised the following:

- Recognize the differences between the hospital environment and physician practice environment. Decision making at the hospital level is comparatively slow and deliberate, while clinical decisions are made more quickly at the physician level.
- Represent physician-hospital partnerships as binding and long-term initiatives.
- Involve physicians in hospital leadership.
- Demonstrate financial benefits of any physician-hospital partnership.
- Improve hospital operations, quality, and efficiency.
- Build trust and enable an evolution to a more substantial collaboration.
- Involve legal counsel. "We find it useful to have legal counsel sit at the table early on," Holm said.

Finally, when forming physician-hospital joint ventures, providers should consider not only the risks of the venture, but also the cost of business as usual. Holm warned, "Don't fight the inevitable outmigration of ancillary services and technical fees."■

CCH Washington Bureau, Jan. 8, 2007.

CCH Health Care Compliance Letter

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Tax-Exempt Organizations

Unfair trade practices argument in charity care case moves forward

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

A federal court in Illinois has ruled that a case alleging violations of the state consumer fraud law for overcharging an uninsured patient can proceed to trial. The case represents the latest judicial opinion on the charity care issue. Specifically, stake holders have debated whether tax-exempt hospitals are offering enough charity care to justify their tax-exempt status. Similar cases have been filed across the county alleging that charging uninsured patients more than insured patients for the same services constitutes an unfair trade practice.

The patient argued that because she was uninsured, the hospital charged her significantly more than what an insured patient would have been charged. Furthermore, she claimed that hospital agents failed to inform her that she might be eligible for a charity care write-off of the charges and turned her case over to a collections agency. The patient contended that her bill exceeded the reasonable value of its services, and the hospital had a policy of overcharging uninsured patients though it is a charitable organization.

State public policy. The court determined that the patient met the unfair practices test based on previous judicial determinations that state tax exemption laws are an expression of state public policy. At trial, the patient will have to prove that the hospital's charity care practices are in violation of state policy. The court also determined that the patient adequately alleged that the hospital's practices were oppressive or unscrupulous and injure consumers.

Although this opinion is not a final determination on the merits of the case, the recent trend in Illinois has been to increase expectations for the provision of charity care. Last year, the Illinois Attorney General introduced legislation that would have required hospitals to spend eight percent of their operating costs on free care for the poor and uninsured. In October, 2006, the state Department of Revenue revoked a hospital's tax exemption based in part on inconsistencies in the application of its charity care policy. Those inconsistencies included referring patients with unpaid charges to collection agencies even when a portion of the charges had been reduced pursuant to the charity care policy.■

Hill v. Sisters of St. Francis Health Services, Inc., No. 06-C-1488, Dec. 20, 2006, Health Care Compliance Reporter, ¶800,253.

HIPAA

Jury returns guilty verdict in first HIPAA trial

by Valerie L. Witmer, J.D., Contributing Editor

The owner of a Florida claims handling company has been convicted of conspiracy to commit fraud, computer fraud, identity theft related to the use patient information from a local medical clinic, and violating the Health Insurance Portability and Accountability Act (HIPAA) through wrongful disclosure of personally identifiable health information. This HIPAA prosecution was the first HIPAA violation case that has gone to trial in the U.S., according to the Department of Justice (DOJ).

Identity theft and Medicare fraud. Fernando Ferrer, Jr., the owner of Advanced Medical Claims, Inc., purchased patient information from a former Cleveland Clinic employee. According to the indictment, the clinic employee accessed to the clinic's computer system to download the personal identification information of more than 1,100 of the clinic's patients and sold the information to Ferrer. Ferrer then provided the information to others who used it to file fraudulent claims for Medicare reimbursement. The theft resulted in the submission of more than $7 million in fraudulent Medicare claims, with approximately $2.5 million paid to providers and suppliers.

Possible sentence. At sentencing, Ferrer faces statutory maximum prison terms of five years on the conspiracy count, five years on the computer fraud count, ten years on the wrongful disclosure of individually identifiable health information count, and two years on each count of aggravated identity theft. In addition, he may be required to pay fines totaling $750,000.■

DOJ Press Release, Jan. 24, 2007.

Compliance risks arising from the safe harbor and Stark II exceptions allowing donations supporting e-prescribing and electronic health record systems, Part II

by Timothy P. Blanchard, J.D., Contributing Editor

This article is Part II of a three-part series that identifies compliance issues and risks resulting from significant limitations that remain in the new regulations, and proposes potential approaches for use by compliance professionals in assisting their organizations to navigate around those compliance traps.

Part I of this article provided background on the fraud and abuse laws and the safe harbor and Stark exception regulations for e-prescribing and EHR, and focused on the scope of protected technology and the "necessary" and "used predominantly" criteria under the new regulations. Part II discusses the range of protected donors and recipients of e-prescribing and EHR technology, as well as the interoperability requirement.

Range of protected donors

The electronic health record (EHR) rules protect individuals and entities that provide services covered by a federal health care program and submit claims or requests for payment to the federal health care programs, either directly or through reassignment. Parties protected under the Stark exception are physicians, physician-related entities,[22] and entities furnishing designated health services (DHS).[23] The EHR safe harbor protects donations by hospitals, group practices, physicians, nursing and other care facilities, pharmacies, laboratories, durable medical equipment (DME) suppliers, oncology centers, community health centers, federally qualified health centers (FQHCs), dialysis facilities, and "health plans," subject to certain additional requirements. Specifically, to qualify as a protected donor, the entity must be one that:

> Furnishes or arranges under agreement with contract health care providers for the furnishing of items or services to enrollees, or furnishes insurance coverage for the provision of such items and services, in exchange for a premium or a fee, where such entity:
>
> (i) Operates in accordance with a contract, agreement or statutory demonstration authority approved by CMS or a state health care program;
>
> (ii) Charges a premium and its premium structure is regulated under a state insurance statute or a state enabling statute governing health maintenance organizations or preferred provider organizations;
>
> (iii) Is an employer, if the enrollees of the plan are current or retired employees, or is a union welfare fund, if the enrollees of the plan are union members; or
>
> (iv) Is licensed in the state, is under contract with an employer, union welfare fund, or a company furnishing health insurance coverage as described in conditions (ii) and (iii) of this definition, and is paid a fee for the administration of the plan which reflects the fair market value of those services.[24]

This definition can be satisfied by a wide array of organizations, including but not limited to prescription drug plan sponsors, Medicare Advantage Plans, and Medicaid managed care plans. Compliance officers should document compliance with these criteria before initiating an EHR technology donation program.

The EHR Rules do not protect donations by pharmaceutical, device, or DME manufacturers because "there is a substantial risk that, in many cases, manufacturers' primary interest in offering technology to potential referral sources would be to market their products."[25] It is unclear why the safeguards required under the rules would not be as effective with regard to these manufacturers as with respect to hospitals and other types of providers and suppliers that furnish items or services to patients and submit claims to Medicare for those items or services. The Office of Inspector General (OIG) has asserted its ability to sanction the latter entities with exclusion, and these entities are not immune from prosecution under the anti-kickback statute.

Nevertheless, compliance officers in potential donor or recipient entities must be aware of this distinction and certain other potential compliance traps that it may create. For example, although OIG appears to focus on the distinction between direct and indirect relationships with patients and the Medicare program, it is not clear whether a device company that operated as both a manufacturer and a DME supplier would be considered a protected donor under the EHR rules. Perhaps more troubling are potential issues with respect to indirect relationships with manufacturers and

otherwise permitted donors. Compliance officers should carefully review any relationships with pharmaceutical, device, or DME manufacturers that might be viewed as attempts to circumvent these distinctions.

Range of protected recipients

The EHR rules recognize that widespread dissemination of EHR technology would not be furthered by limiting the class of protected recipients (except as limited by the scope of potential Stark violators), and accordingly do not limit recipients to the relatively narrow categories protected under the e-prescribing Rules (medical staff, group practice members, or prescribing professionals). Rather, the EHR safe harbor permits donations of EHR technology to any "individual or entity engaged in the delivery of health care,"[26] without regard to whether the recipient is on a medical staff, is a member of a group practice, or is in the network of a particular health plan. Accordingly, the EHR safe harbor will protect donations to a wide range of providers and suppliers, including group practices, physicians, nurse practitioners, nurses, therapists, audiologists, nursing and other care facilities, pharmacies, laboratories, DME suppliers, community health centers, FQHCs, and other suppliers. The EHR rules permit donations to any individuals and entities engaged in the delivery of health care, regardless of whether a recipient has an existing relationship with the particular donor;[27] so unlike the e-prescribing rules, the EHR rules do not require that recipients of EHR donations be members of a medical staff, group practice, or pharmacy network, network pharmacists, or prescribing practitioners.

Interoperability requirement

To qualify for protection under the EHR rules, it is not sufficient for the donated technology to facilitate the exchange of EHR information between the recipient and the donor.[28] The EHR Rules require that the EHR software be "interoperable." While the EHR safe harbor does not further define this critical term, the EHR Stark exception defines "interoperable" as:

> [A]ble to communicate and exchange data accurately, effectively, securely, and consistently with different information technology systems, software applications, and networks, in various settings; and exchange data such that the clinical or operational purpose and meaning of the data are preserved and unaltered.[29]

According to OIG, "software will not be considered interoperable if it is capable of communicating or exchanging data only within a limited health care system or community."[30]

Donors and recipients must be aware of evolving interoperability standards and criteria recognized by the Department of Health and Human Services (HHS) to comply with this stringent standard. It appears that interoperability criteria and meaningful compliance testing will evolve slowly as technical issues regarding software functionality and interface standards are resolved.

As a practical matter, donors are unlikely to accept the risk of performing their own interoperability assessments. The EHR rules deem software to be interoperable if a certifying body recognized by HHS has certified the software no more than 12 months prior to the date of the donation. Most donors will seek to satisfy this requirement by selecting software that is currently certified by an appropriate organization.[31] Organizations will need to monitor developments regarding certification standards closely to assure continuing compliance across potentially lengthy rollout periods of donation programs.

Based on the language of the EHR rules, it does not appear that a donor having qualified for the exception under one interoperability standard should have to upgrade to a subsequent software version in order to continue to qualify. Rather, each donation should be evaluated based on the facts and circumstances at the time of the donation. Even if this interpretation were ultimately confirmed, however, changes in certification status or requirements in the middle of a donation program rollout would be problematic and introduce potentially significant technical and compliance costs and exposures because significant donation programs may have taken place over considerable periods of time. Accordingly, these issues should be considered explicitly at the outset of any EHR technology donation project, and agreements with software vendors should address responsibility for such developments.

The EHR rules also prohibit donors from taking any action to limit or restrict the use, compatibility, or interoperability of donated EHR technology with other or e-prescribing systems.[32] In the case of e-prescribing technology that can be used for any patient without regard to payor status, the donor also is prohibited from limiting the recipient's right or ability to use the technology for any patient. The EHR rules also require that, where possible, recipients be able to use the donated technology for all patients without regard to payor status.[33] These limitations are important safeguards against fraud and abuse because they reduce the risk that a donor would offer proprietary technology to secure the recipient's referrals or make referrals of other providers more difficult or less advantageous.

The non-interference requirement, however, should not be interpreted to require donors to provide additional interfaces that might be requested by a recipient[34] to facilitate connectivity to another particular vendor, service, or provider. A donor should not be required to provide additional interfaces or upgrades to retain the protection of the EHR rules. If such upgrades or additional donations are provided, the parties will need to satisfy the cost-sharing requirements, discussed in Part III of this article, with respect to the additional donation. Part III also will address

recipient selection considerations and other implications of the new regulations, including tax-exemption and state law issues.

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[22] These entities include: physician group practices, health plans, managed care organizations, provider-sponsored organizations ("PSOs"), or independent practice associations that employ physicians or operate facilities that could accept reassignment of physicians' claims for provided DHS.

[23] *See* 42 C.F.R. §411.351. Accordingly, any entity furnishing the following items and services is an eligible donor under the EHR Stark exception: Clinical laboratory services; physical therapy, occupational therapy, and speech pathology services; radiology and certain other imaging services; radiation therapy services and supplies; DME and related supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

[24] 42 C.F.R. §1001.952(l)(2).

[25] *Final rule*, 71 FR 45110, 45128, Aug. 8, 2006.

[26] *See* 42 C.F.R. §1001.952(y)(1).

[27] *See* 42 C.F.R. §411.357(w).

[28] The Stark regulations already permit laboratories and imaging suppliers to provide information technology used solely for ordering tests and receiving test results to referring physicians, notwithstanding long-standing concerns regarding laboratory donations that have independent value to a physician's practice. *See* 42 C.F.R. §411.351 (defining remuneration).

[29] 71 FR at 45126 (safe harbor); *see also* 42 C.F.R. §411.351 (Stark exception).

[30] 71 FR at 45126-27; *Final rule*, 71 FR 45140, 45155-56, Aug. 8, 2006. In the absence of additional guidance regarding the definition of interoperable for purposes of the EHR safe harbor, reference to the definition in the Stark exception appears reasonable.

[31] HHS recognized certain interoperability and other certification criteria for ambulatory EHR established by the Certification Commission for Healthcare Information Technology (CCHIT), but has yet to recognize any certifying bodies for purposes of the Rules since regulations regarding the criteria for these organizations were not published until August 4, 2006.

[32] *See* 42 C.F.R. §§411.357(w)(3), 1001.952(y)(3).

[33] 42 C.F.R. §§411.357(w)(5), 1001.952(y)(4).

[34] Indeed, as noted below, such a request might be viewed as improper under the Rules.

Trends

Bush proposes to shift funds to cover uninsured

by Catherine Hubbard, M.A., Contributing Editor

The Affordable Choices Initiative would redirect portions of existing federal health care funding to "help the states that are coming up with innovative ways to cover the uninsured," according to the proposal announced by President Bush in his State of the Union speech January 23, 2007.

The President's initiative would help states make basic private health insurance available and provide additional help to Americans who cannot afford insurance or who have persistently high medical expenses, according to a White House fact sheet. For states that provide access to health insurance, the initiative would redirect federal funding to assist states in helping their poor and hard-to-insure citizens afford private insurance. "States that make basic private health insurance available to all their citizens should receive federal funds to help them provide this coverage to the poor and the sick," said Bush.

Senate Finance Committee Chairman Max Baucus (D-Montana) said he will review Bush's proposals carefully to see if they will help to cover the uninsured. He added that he "will move aggressively to renew and expand children's health care coverage" through the State Children's Health Insurance Program (SCHIP), and will "explore pooling arrangements that may extend health coverage to even more Americans."

New Jersey Governor Jon Corzine said Bush's "willingness to provide funding to states experimenting at ways to cover the uninsured is a positive step, as long as it is not done at the expense of the successful SCHIP, Medicaid and Medicare programs."

Uwe Reinhardt, professor of Economics and Public Affairs at Princeton University, said that Bush's plan to shift disproportionate share hospital payments to states that develop innovative plans to expand coverage "wouldn't do much" for states like California, which are moving toward universal coverage. Reinhardt backed expansion of health care insurance for all children. He said that under such a plan, parents should have to opt out of coverage. "It would be impossible for a kid not to be insured," he said, adding, "[t]hat would be achievable within a year." ■

CCH Washington Bureau, Jan. 24, 2007.

Restrictions on promotion of pharmaceutical products tightened

by Valerie L. Witmer, J.D., Contributing Editor

An updated version of the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) Code of Pharmaceutical Marketing Practices imposes stricter requirements on member pharmaceutical companies for marketing their products to health care professionals. The revised code, which became effective January 1, 2007, strengthens and clarifies the standards for ethical marketing prin-

ciples and practices to ensure that health care providers receive objective, truthful, and scientifically sound information about pharmaceutical products and understand the appropriate uses of those products.

New requirements. Changes to the IFPMA code include stricter provisions regarding international events, company sponsorship of health care professionals, and provision of hospitality and entertainment, as well as more precise definitions of acceptable gifts.

Under the new rules, pharmaceutical companies may not organize or sponsor events for health care professionals that take place outside their home country unless logistical or security considerations warrant use of a foreign venue, as in the case of an international scientific conference with participants from several countries.

Member companies may sponsor health care professionals to attend events only if the sponsorship is limited to payment of travel, lodging, meals, and registration fees. The code prohibits payments to compensate health care professionals for their time spent attending events. Further, member companies may not condition sponsorship upon an obligation to prescribe, recommend, or promote any pharmaceutical product.

Tightened restrictions on the provision of hospitality and entertainment to health care professionals mean pharmaceutical companies may only provide moderate, reasonable hospitality in the form of refreshments or meals incidental to the main purpose of the event and modest entertainment that is secondary to the hospitality. Moreover, the event must be held in a venue that is conducive to the scientific and educational objectives of the event.

In addition to strengthening the ethical standards for these promotional activities, the revised code clarifies what constitutes acceptable gifts from member companies to health care professionals. Promotional aids and reminder items of minimal value may be provided so long as they are relevant to the health care professional's practice. Items of medical utility are also acceptable provided that they are of modest value and are beneficial to the provision of medical services and for patient care.

Gifts that are prohibited under the new code include cash or cash equivalents and gifts for the personal benefit of the health care professional. The code does not, however, prohibit occasional gifts unrelated to the practice of medicine in acknowledgement of significant national, cultural, or religious holidays, where such gifts are allowed under local law and in accordance with local practice.

According to IFPMA Director General Dr. Harvey E. Bale, "The updated provisions of [the] new Code reflect the industry's concern to underscore that its life-saving products are promoted in an ethical manner." ■

IFPMA Press Release, Jan. 3, 2007; IFPMA Code of Pharmaceutical Marketing Practices, April 21, 2006.

Pay for performance measures increasingly used in commercial insurance

by Geri Szuberla, J.D., Contributing Editor

Nearly 90 percent of health maintenance organizations (HMOs) used pay-for-performance incentives in their contracts with doctors and one-third of the HMOs included pay-for-performance arrangements in their hospital contracts in 2005, according to a new study supported by the Department of Health & Human Services' (HHS') Agency for Healthcare Research and Quality (AHRQ). These arrangements reward doctors and hospitals for adhering to evidence-based standards of clinical care.

The findings of the study, "Pay-for-Performance in Commercial HMOs," have significance outside the commercial HMO sector as the federal government looks to incorporate pay-for-performance into traditional Medicare by 2009, according to researchers.

Survey responses. Researchers from the Harvard School of Public Health and Harvard Medical School in Boston surveyed health plans that offered commercial HMO products in 41 U.S. markets with at least 100,000 HMO enrollees. The markets in the sample represented 91 percent of U.S. HMO enrollees and 78 percent of the U.S. metropolitan population. Questions pertaining to physicians' participation in pay-for-performance programs focused on the magnitude and structure of incentive payments, the types of performance indicators included, and whether physicians practiced individually or as a group. For hospital pay-for-performance programs, researchers asked about three specific measures promoted by the Leapfrog Group, a quality improvement organization. Those measures included intensive care unit staffing, use of computerized physician order entry systems, and volume standards for high-risk procedures.

Of the 242 HMOs surveyed, 52 percent said they used pay-for-performance in provider contracts in 2005. Nearly two-thirds of HMOs that require the majority of enrollees to designate a primary care physician as a gatekeeper to specialty services used pay-for-performance programs, compared with 25 percent of HMOs that do not require the majority of their enrollees to select a primary care physician.

Among 113 HMOs using pay-for-performance programs for physicians, 13 percent focused on the individual doctor as the unit of payment. One-third of programs were designed to reward only the top-rated physicians or physician groups. Nearly two-thirds offered rewards for attaining a pre-determined performance threshold. The bonus potential for physicians in these programs generally was equal to 5 percent of payments from the plan.

Quality indicators. Nearly all health plans with physician programs included measures of clinical quality (100 percent of capitated plans; 79 percent of non-capitated plans). Use of information technology and patient satisfaction measures were relatively common elements of physician incentive programs, the study found. Although 38 percent of health plans said they used pay-for-performance programs in hospital contracts, use of Leapfrog Group's measures was relatively low. Nearly three-quarters of HMOs said they relied on other measures of hospital quality.

Press Release, Agency for Healthcare Research and Quality, Nov. 1, 2006.

Trends (cont.)

Overcrowding in hospitals not improving

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

Seven out of every eight hospital executives, administrators, and managers believe that overcrowding has failed to improve at their facilities in the last year, and overcrowding continues to be one of the top five hospital management concerns, according to a survey by the American College of Emergency Physicians. The study also revealed that more than 70 percent of the administrators who responded say that while their facilities have a stated goal of admitting patients from their emergency department within two hours of arrival, almost half fail to meet that goal more than half the time.

"These survey results confirm what we have been seeing for several years in emergency departments nationwide," said Brian Keaton, president of the American College of Emergency Physicians. The survey also found that 28 percent of respondents said their organizations have had to postpone or cancel surgeries because of bed shortages; and 80 percent of reporting organizations said they have a standing committee that addresses patient flow issues, underscoring its importance.

Easing overcrowding. The good news, according to the survey results, is that the executives and administrators say they are increasingly optimistic about their organizations' ability to manage the flow of patients through their hospital. An overwhelming majority (94 percent) said they believe that technology, either by itself or in combination with changes in staff and processes, can reduce overcrowding. According to a study by the Advisory Board "a typical 300 bed hospital moving from the bottom quartile of Average Annual Bed Turns (annual admission divided by average staffed beds) to the top quartile in bed efficiency could yield 4,500 additional admissions and well over $10 million in revenue annually."■

American College of Emergency Physicians Press Release, Jan. 15, 2007.

In The News

Health care spending growth slows in 2005

Health care spending growth in the U.S. decreased for the third consecutive year in 2005, increasing 6.9 percent compared to 7.2 percent in 2004 and 8.1 percent in 2003, according to CMS. The growth in 2005 marks the slowest rate of growth in health spending since 1999. This slowdown in spending growth is due in part to the anticipated lagged effects of the 2001 recession, as well as to weaker growth in prescription drug spending, CMS reported.

CMS Press Release, Jan. 9, 2007.

Commission proposed to preserve Medicare

Senators Pete Domenici (R-New Mexico) and Dianne Feinstein (D-Calififornia) on January 22, 2006, unveiled a bipartisan plan to create a commission to find ways to preserve Social Security and Medicare. The Social Security and Medicare Solvency Commission Act (S. 355) would create a permanent, 15-member commission made up of congressional members and outside experts to make recommendations on how best to ensure the long-term solvency of the entitlement programs. Medicare trustees predict expenditures will outstrip assets in 2012, and that the fund will run dry by 2018, Feinstein said. "We've got to address the problem now. The longer we wait, the more difficult it becomes," she said at a press briefing on Capitol Hill.

CCH Washington Bureau, Jan. 22, 2007.

State AG joins kickback suit

Illinois Attorney General Lisa Madigan today intervened in a lawsuit against several Chicago area radiology centers over their payment of illegal kickbacks to referring doctors. The complaint alleges that the radiology centers entered into sham "lease" agreements with doctors under which the doctors pay a reduced rate for magnetic resonance imaging (MRI) and computed axial tomography (CT) scans but charge the patient's insurance a higher rate, and then keep the difference. The lawsuit claims the defendants' actions violate the state Consumer Fraud and Deceptive Business Practices Act, as well as Illinois' anti-kickback law, the Insurance Claims Fraud Prevention Act.

Illinois Attorney General Press Release, Jan. 17, 2007.

Think tank settles, reorganizes operations

Connecticut Attorney General Richard Blumenthal announced a settlement that disbands the Healthcare Research & Development Institute (HRDI), a privately owned think tank that brings together hospital industry executives and suppliers. According to Blumenthal, HRDI claimed to provide health care consulting services to vendors serving the health care field, but in reality, the organization was an "anticompetitive club where only select corporations from the health care supply industry were permitted membership." Under the settlement, HRDI will dissolve its organization and create an entirely new one made up of only hospital CEOs and other health care industry professionals, excluding any vendors and their representatives. HRDI also will pay Connecticut $150,000.

Connecticut Attorney General Press Release, Jan. 25, 2007.