CCH Health Care Compliance LETTER

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Wolters Kluwer Law & Business

Third party may sue a hospital for alleged EMTALA violation

A party injured by a patient has standing to sue a hospital under the Emergency Medical Treatment and Active Labor Act (EMTALA) for allegedly failing to stabilize a patient before discharge, according to a three-judge panel of the Sixth Circuit Court. Further, a question of fact exists as to whether the patient had an emergency condition and was stable when the hospital released him, the court said. Thus, the district court improperly granted summary judgment to the hospital and the case has been remanded to resolve the EMTALA issues.

The representative of the estate of the patient's wife brought an action claiming the hospital and a psychiatrist violated EMTALA and committed various negligent acts, which resulted in the wife's murder by her husband. The wife brought her husband to the emergency room for treatment of physical and mental symptoms. At that time, she informed the physician that her husband was acting in a threatening manner, which she stated made her fearful for her safety. After her husband was admitted, he was examined by several doctors, including a psychiatrist who recommended that he be transferred to the psychiatric unit for further assessment if the patient's insurance would provide coverage. Although there was no evidence that the insurance company denied coverage for care in the psychiatric unit nor that the patient refused to be transferred, the patient was not transferred to the psychiatric unit and was released from the hospital upon his request. Ten days later, the patient killed his wife.

Hospital's contentions. The hospital argued that: (1) the representative lacked standing to sue under EMTALA and (2) EMTALA requirements were satisfied when the patient was admitted and EMTALA did not apply because the patient did not have an emergency medical condition. First, with regard to standing to sue, the plain language of EMTALA states that an action can be brought by "[a]ny individual who suffers personal harm [from a hospital's EMTALA violation]," therefore, the representative of the wife has standing, the court stated.

Second, although the hospital contends that it satisfied EMTALA requirements by admitting the patient for six days and conducting further tests, EMTALA requires not only the admission of a patient with an emergency condition, but stabilization as well, the court said. The statute provides that a patient with an emergency medical condition is "stabilized" when "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during" the patient's release from the hospital. Under EMTALA, a hospital must treat a patient with an emergency condition in such a way that, upon the patient's release, no further deterioration of the condition is likely, the court explained. Thus, the statute requires more than the admission and further testing of a patient; it requires that actual care or treatment be provided as well, the

continued on page 2

EMTALA (cont.)

court concluded. In this case, it is not clear whether the hospital stabilized the patient. The evidence shows that an emergency condition existed at admission, but whether the condition existed at discharge is a question of fact to be decided by the jury and, therefore, summary judgment should not have been granted.

Psychiatrist's suit. Because the EMTALA provision does not explicitly allow claims to be brought against individuals, and other circuits have not authorized a private right of action, the granting of summary judgment with regard to the EMTALA claim against the psychiatrist was proper. ■

Moses v. Providence Hospital and Medical Centers, Inc., 6th Cir., April 6, 2009, Health Care Compliance Reporter, ¶800,638

Quality of Care

Project tests methods to reduce central line-associated infections

The Agency for Healthcare Research and Quality (AHRQ) is funding a new project to test methods for reducing central line-associated bloodstream infections in hospital intensive care units (ICUs). Hospital associations and patient safety groups in 10 states will be involved in the project. In a recent AHRQ Healthcare 411 podcast, a co-principal investigator on the project, Dr. Peter Pronovost from the Johns Hopkins University Quality and Safety Research Group, was interviewed. The following information was offered by Dr. Pronovost regarding the frequency of central line-associated infections, methods for reduction, and the goals of the AHRQ-funded project.

Definition of central lines and associated bloodstream infections. Central lines, or central venous catheters, are tubes that are placed into the large veins in a patient's neck, sometimes in the chest or groin, to administer medication or fluids, or to collect blood samples while patients are hospitalized. Bloodstream infections are considered to be associated with a central line if the central line was in use during the 48-hour period before a bloodstream infection develops.

Frequency and cost of central line infections. Central line-associated infections are common, costly, and often lethal. Research shows that: (1) there are about 250,000 cases of these infections every year; (2) at least 30,000 patients die each year from these infections; and (3) the average hospital cost for each of these infections is more than $36,000.

Risk reduction methods. Proper placement of the central line is critical to risk reduction. Clinicians should: (1) always wash their hands before and after the procedure, and wear a hat, mask, sterile gown and gloves; (2) use a soap called Chlorhexidine to reduce the risk of infection; and (3) take out these catheters when they're no longer needed.

Project goals. The goal of the AHRQ project is to reduce the average rate of central line-associated bloodstream infections across the U.S. in all hospitals by 80 percent. The national average is five infections per 1,000 catheter days, and the project goal is to reduce the national average to less than one infection per 1,000 catheter days.

Achieving project goals. To achieve the goals of the project, AHRQ will partner with participating hospitals to implement a checklist that ensures that patients receive required evidence-based practices and staff use those practices. Hospitals also will have to: (1) educate staff about exactly what they are supposed to do; (2) monitor and track, in a valid way, what their infection rates are; and (3) work to create a culture of teamwork in which nurses can question physicians to make sure patients always get these evidence-based interventions.

Success predicted. Dr. Pronovost and the AHRQ are extremely optimistic that they can reduce central-line-associated infections. For example, these methods have been applied in the state of Michigan where in just three months the median infection rates dropped to zero in over half of the 103 participating ICUs. Dr. Pronovost stresses that it will not be easy, but with diligent effort combining evidence with valid measurement, culture, and teamwork change, similar results can be achieved. According to Dr. Pronovost, "not only will we save lives and dollars from these infections, but we will put joy back into the clinicians' lives who toil so often at the bedside, and importantly, build national capacity to tackle one of the many other ills that befall our health care system." ■

AHRQ Healthcare 411 Podcast, March 25, 2009

CCH Health Care Compliance Letter

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Quality of Care (cont.)

Rehospitalizations within 30 days prove costly for Medicare

Unplanned rehospitalizations of Medicare beneficiaries within 30 days of leaving the hospital cost the program $17.4 billion in 2004, according to a study published April 2, 2009, on the web site of the *New England Journal of Medicine* (NEJM). This equals about 17 percent of all hospital payments from Medicare in 2004. Almost one-fifth (19.6 percent) of beneficiaries discharged from a hospital that year were rehospitalized within 30 days. Only about 10 percent of these rehospitalizations were planned.

The NEJM study noted that while "there is extensive literature on rehospitalization attributed to particular conditions, especially heart failure, there is very limited research addressing the broader issues involving the multitude of diseases and processes that contribute to rehospitalization."

Most rehospitalizations are related to medical diagnoses. The 100 most frequent rehospitalization diagnosis-related groups (DRGs) accounted for 73.2 percent of all rehospitalizations. The study notes that up to 40 percent of patients who are rehospitalized go to a hospital that is different than the one from which they have been discharged because "only holders of all-hospital discharge data, such as governments and other third party payers, have the ability to track patients across all providers and systems."

The study concludes that "[r]ehospitalization is a frequent, costly, and sometimes life-threatening event that is associated with gaps in follow-up care." ■

CCH Chicago Bureau, April 3, 2009

Anti-kickback/Physician Self-Referral

OIG: Employment contract conditioned on real estate sale OK

An employment agreement entered into between a mental health services provider and a professional clinical counselor does not generate prohibited remuneration under the anti-kickback statute, even though the contract was conditioned on the sale of real estate from the counselor to the provider. In an advisory opinion, the Office of Inspector General (OIG) indicated that it would not impose civil money penalties or administrative sanctions in relation to such an employment agreement.

Prior to being hired by the mental health services provider, the counselor had been operating a mental health practice in a building that she owned. In approximately November 2007, she approached the provider's chief executive officer about possibly selling the building. The provider agreed to purchase the building, on the condition that the counselor would be employed at the clinic that the provider planned to operate on the site.

The counselor entered into a contract to be employed by the provider, expressly conditioned on the provider's purchase of the building. The employment contract provided that the provider would pay the counselor compensation based on revenues generated by her personally as well as total revenues of the clinic. The provider purchased the building and the counselor was paid in accordance with the terms of the employment agreement.

Bona fide employee. The provider certified that the counselor is a bona fide employee and that the compensation she receives is based on professional services she performs. The provider also certified that it paid market value for the building and that the price did not include payment for referrals. The OIG accepted these certifications as true.

The anti-kickback statute does not prohibit payments made by employers to their bona fide employees for employment in the furnishing of items or services for which payment may be made under Medicare, Medicaid, or other federal health care programs. The statute includes a safe harbor provision that excepts from its reach "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services."

Assuming the counselor meets the definition of a bona fide employee and the price paid for the building in no way reflected the value of any referrals or generation of business between the parties, the arrangement does not violate the anti-kickback statute and no adverse action would be taken by the OIG. ■

OIG Advisory Opinion, No. 09-02, March 26, 2009, Health Care Compliance Reporter, ¶500,206

On The Front Lines

Recession Opportunities: Compliance with Charity Care Obligations and Maintaining Tax-Exempt Status

by Paul R. DeMuro, CPA, MBA, JD, CHC, Julie S. Marder, JD & Robert C. Levels, JD

As more patients become uninsured and underinsured during these difficult times, revenue pressures may tempt hospitals to restrict their charity care policies. Taking this action, however, may merely transfer what could have been charity care into bad debt, with the result that nonprofit hospitals may have more difficulty justifying their tax-exempt status. Instead, compliance officers may be able to convert certain bad debts into charity care. This article explores the competing considerations for developing and administering charity care policies, highlighting opportunities to ensure compliance with charity care obligations and maintaining tax-exempt status given the increase in the number of patients who cannot pay for medical services during the economic downturn.

Defining charity care and bad debt

The term "uncompensated care" refers to any care provided for which a hospital does not receive payment, which includes both charity care and bad debt.[1] "Charity care" and "bad debt" tend to be defined inconsistently. Sometimes the terms are defined broadly: charity care is any free or discounted care provided to patients with demonstrated inability to pay, while bad debt arises when patients capable of paying their medical bills fail to pay.[2] Other definitions focus on the provider's expectations: charity care is granted without any expectation of payment, while bad debt arises when a hospital expects to be paid but has been unable to collect.[3] Hospitals also may choose to provide discounts for uninsured patients, prompt payers, or low-income individuals who do not qualify for charity care. These discounts will amount to uncompensated care, but they cannot be considered charity care for tax exemption purposes.[4] For tax exemption purposes, charity care must be provided pursuant to a policy that identifies financial need. The Internal Revenue Service (IRS) and the Centers for Medicare and Medicaid Services (CMS) afford hospitals wide latitude to craft policies to determine financial need.

Charity care and federal tax-exempt status

Nonprofit hospitals comply with their federal tax exemption obligations by providing "community benefit."[5] Charity care is just one type of community benefit, and nonprofit hospitals are not required to provide any set amount of charity care. Yet, leaders seeking to reform the community benefit standard, such as Senator Charles Grassley (R-Iowa), often look to charity care as an indicator of whether a nonprofit hospital should be able to maintain its federal tax-exempt status.

In 2006, the IRS began to study in depth community benefit and executive compensation practices and reporting of nonprofit hospitals.[6] The resulting report, released in February 2009, highlights the prominent role that uncompensated care continues to play across the nation. In evaluating the amount of uncompensated care provided as a percentage of nonprofit hospitals' total revenues, the study found that, on average, nonprofit hospitals dedicated 7 percent of their revenue to uncompensated care (median is 4 percent). Moreover, uncompensated care accounted for 56 percent of the community benefits provided by these hospitals. When research hospitals were removed from the sample population, uncompensated care accounted for 71 percent. With no shortage of uncompensated care in sight, this study suggests that nonprofit hospitals should have little trouble meeting the federal community benefits standard for tax exemption.

As the IRS noted, however, the study is limited because respondent hospitals had a great deal of discretion in determining which activities would be considered a community benefit and how the value of those activities would be measured. Indeed, a vast array of activities may qualify as community benefit for federal tax exemption purposes, but, in many states, only charity care appears to qualify a hospital for state and local tax purposes. Thus, while a hospital may be tempted to restrict charity care during the economic downturn, doing so may inadvertently place state and local tax exemptions at risk. Accordingly, this study underscores the great opportunity that

nonprofit hospitals have to convert much of their extensive uncompensated care into charity care to better position them to meet the expectations of the federal, state, and local officials with respect to the provision of charity care.

State and local tax-exempt status and greater charity care obligations

State and local tax exemption laws vary widely across the country, many imposing more burdensome obligations than the federal government. For example, to qualify for state property tax exemption in Utah, hospitals must not only meet the federal tax exemption standard, they also must engage in some "act of giving," such as the provision of charity care. In Texas, property tax exemption is contingent upon meeting reporting requirements and specified quantitative standards. In Illinois, the standard for sales and property tax exemption is not merely a general provision of community benefits, it is a specific requirement to provide charity care to all who need it.[7] Meeting this difficult charity care standard is critical for Illinois hospitals because sales and property tax exemption is particularly valuable in Illinois. In Illinois, sales and property tax exemptions constitute approximately 96 percent of the value of all tax exemptions received by hospitals,[8] whereas this figure is only approximately 50 percent nationally.[9]

Class action law suits impose charity care obligations

Decisions and settlements from class action lawsuits may impose additional obligations to provide charity care. In 2004 and 2005, a series of lawsuits were filed across the country, alleging that certain nonprofit hospitals overcharged uninsured patients or provided too little charity care.[10] Many of these class actions settled and, as part of the settlement agreements, hospitals committed to certain levels of discounted and charity care. Some of these class action suits are still being resolved, but recently, many new claims have been dismissed and motions for class certification have been denied. As a result, hospitals now may be less susceptible to new litigation regarding charity care, but they may be legally bound by obligations from settlement of past claims against them.

Compliance issues to consider in re-evaluating charity care policies

Given the current economic downturn, a hospital may be forced to provide increased amounts of uncompensated care regardless of its charity care policy. As more patients become unemployed or underemployed, more patients will become uninsured or underinsured, and they are more likely to be financially incapable of paying their medical bills.

If uncompensated care is increasingly inevitable, it may be beneficial for hospitals to provide this care as charity care, rather than allowing it to become bad debt. With the exception of Medicare patients for whom government reimbursement of bad debt is possible, increasing levels of defaulted medical bills will only hurt both the hospital and the patients. The hospital will be forced to give away uncompensated care, but it will not receive the benefit of counting this towards complying with its charity care obligations. Additionally, patients with no hope of making payment will be forced to endure the collection process, harming both the patients and economic recovery efforts. Moreover, as local press publicizes these patients' unpleasant experiences, the hospital's relationship with its community suffers. Thus, the hospital may benefit from including as many low-income patients as possible in its charity care program.

Compliance officers should consider the following issues when evaluating their charity care policies in light of the current recession. These issues are based on commentators' observations of charity care policy[11] and an informal review of individual charity care policies from hospitals across the country. Because a part of tax exemption requirements for charity care are dictated by state and local law, and because extensive variation exists among these laws, it will be important to review one's state and local laws governing charity care obligations before employing the charity care policies of out-of-state hospitals for guidance. Moreover, hospitals also should evaluate each of these issues in light of the needs of their individual institutions and the communities they serve.

1. Notice of charity care policy. In addition to measures already taken to post charity care notices conspicuously within the hospital, charity care policies and applications should be conspicuously posted on the hospital's website. Hospitals that clearly and simply explain their charity care policies on their websites may gain an advantage in attracting charity care applicants. Yet, a surprisingly large number of hospital websites simply tell patients to call a financial counselor for information. With so little information provided online, patients may not realize that they are eligible for free or discounted care and, in that case, they will not take the additional step of calling during a workday for more information. In contrast, some hospital websites not only describe their charity care policies online, they allow patients to apply for charity care online. Other hospitals provide convenient tools such as "charity care calculators" that allow patients to predict how much charity care they may be qualified to receive.

2. When to apply? Ideally, hospitals will assist patients in applying for charity care as soon as is practical. Many charity care policies require patients to be reminded about the availability of charity care at various points throughout the patient experience. Patients could be asked to apply for charity care upon scheduling their appointments, upon registration,

at the point of service (or stabilization for emergency patients), in each bill, and in some states, even after a collection action has commenced. In addition, hospitals may consider including charity care applications in their standard registration form packet. When registration staff learns that patients are uninsured, they may ask those patients if they are interested in applying for discounted medical care. If the patient responds affirmatively, registration staff could provide that patient with a registration packet that contains a charity care application in lieu of an insurance information form.

3. Flexible application deadlines. It may be advantageous to build flexibility into a hospital's charity care policy to ensure that charity care determinations can be reconsidered in certain circumstances. For example, especially in light of the currently turbulent economy, hospitals can emphasize that charity care determinations may be re-evaluated upon dramatic changes in financial status. Moreover, hospitals may want to consider charity care applications even after collection has commenced. Allowing patients to apply for charity care at this late stage may enable hospitals to convert bad debt into charity care. Indeed, some hospitals take the initiative to convert bad debt into charity care vis-à-vis late stage re-evaluation, even if a patient fails to complete a charity care application. Such hospitals refer to publicly available information, homeless status, Medicaid enrollment, or even credit reports to support their decision to award charity care. When analyzing these options, however, compliance officers must be careful to consider state law restrictions on the deadline for determining charity care. According to some commentators, qualification for charity care must be determined prior to billing to count towards certain states' tax exemption laws.[12] Other commentators encourage hospitals to continue screening for charity care patients throughout the revenue cycle.[13]

4. Making charity care appealing in a down economy. While "charity care" appears to be the accepted term of art hospitals use internally, compliance officers should consider adopting a more neutral public name for their policies. Especially in light of the current recession in which many hardworking individuals find themselves suddenly unemployed or underemployed, potentially qualified patients may shun the idea of receiving any form of "charity." Thus, by referring to a charity care application as one for "discounted medical care" or something equally judgment free and including the application among a patient's routine admission paperwork, hospitals may increase participation in their charity care programs.

5. Sliding scale. Allowing a hospital's charity care sliding scale to be adjusted periodically in light of changing social and economic conditions, assuming this is not a contravention of any settlement or other agreement, may help the hospital to better ensure compliance with its charity care obligations. This is particularly true during a recession. Given the increasing loss of jobs and loss of health insurance, growing numbers of patients will likely qualify as indigent or medically indigent. Instinctively, hospitals may assume that decreasing their sliding scales so that fewer patients will qualify for charity care would reduce hospital spending and increase revenue. While such a policy would control the number of charity care patients served, it may do nothing to control that an increasing proportion of the patient mix will be less able to pay their bills. As outlined above, it will likely be in a hospital's best interests, from both compliance and public relations perspectives, to embrace these struggling patients as part of its charity care program, rather than lose them to bad debt. Depending on the needs of the community and available resources, hospitals might even consider increasing the values of their sliding scale so that more patients may qualify for charity care.

Considerations when reducing the amount of charity care

If a hospital ultimately decides that it must curtail its charity care policy, however, the following compliance issues should be considered:

- Does the state in which the hospital is located establish a minimum level of charity care that nonprofit hospitals must provide?
- Has the hospital been involved in a class action suit in which the cost of medical care was at issue? Many such class action settlements result in binding obligations to provide discounts and charity care at a particular level. Be sure that any contemplated decreases in charity care do not violate the terms of these settlement agreements.
- Has the hospital or network made representations on publications or websites regarding the charity care that the hospital will provide? Be sure that any contemplated decreases in charity care do not violate the expectations that such representations may have created.

Conclusion

Although current financial strain may tempt hospitals to scale back charity care policies in attempt to preserve revenue, hospitals should look at this recession as unique opportunity to expand the provision of charity care. By responding to economic hardship with generous charity care policies, nonprofit hospitals may convert inevitable bad debt into charity care that will benefit the hospital's patients and preserve the hospital's tax-exempt status. ■

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[1] Heather O'Donnell & Ralph Martire, Center for Tax and Budget Accountability, An Analysis of the Tax Exemptions Granted to Cook County Non-Profit Hospitals and the Charity Care Provided in Return at 9 (2006).

[2] Healthcare Financial Management, P & P Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers at 1-2 (2006).

[3] Congressional Budget Office (CBO)., Congress of the U.S., A CBO Paper: Nonprofit hospitals and the Provision of Community Benefits at 2 (2006).

[4] Healthcare Financial Management, *supra* n. 2 at 7.

[5] O'Donnell, *supra* n. 1 at 6-7.

[6] IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report, Feb. 2009, available at: http://www.irs.gov/pub/irs-tege/frepthospproj.pdf.

[7] CBO, *supra* n. 3 at 5.

[8] O'Donnell, *supra* n. 1 at 2.

[9] CBO, *supra* n. 3 at 3.

[10] *Hospitals: California Court Approves Final Settlement in Catholic Healthcare West Uninsured Case*, BNA's Health Law Rep., Jan. 18, 2007.

[11] Healthcare Financial Management Ass'n, Patient Friendly Billing Worksheet for Reviewing Financial Assistance Policies (2005); Healthcare Financial Management., *supra* n. 2.

[12] O'Donnell, *supra* n. 1 at 9.

[13] Healthcare Financial Management, *supra* n. 2 at 5.

Fraud & Abuse

SNF penalized for failure to report abuse investigation

A skilled nursing facility (SNF) was obligated to report the findings of an abuse investigation to state officials even though none of the facility's staff members were implicated, according to a Departmental Appeals Board (DAB) decision. The DAB's appellate division determined that a civil money penalty (CMP) of $50 a day was properly imposed against the SNF.

Incident of abuse. The investigation stemmed from an April 2007 incident during which one resident pulled a folding pocket knife from his pocket and displayed it to another resident. The resident who pulled the knife reported to the SNF's director of nursing that he didn't intend to use the knife but wanted the other resident to get out of a chair that he considered to be his.

An administrative law judge found that the SNF took a series of measures in the days following the incident to reasonably protect other residents. The facility conducted a prompt and sufficient investigation, in which the director of nursing interviewed the two residents involved and the staff member who reported the incident. The SNF, however, did not report the result of its investigation to state officials.

Reporting requirements. Federal law requires the SNF to report the results of an investigation to a state survey agency, according to the DAB decision. The plain language of 42 C.F.R. § 483.13(c)(4) requires facilities to report the results of all investigations of suspected abuse to state officials, including the state survey and enforcement agency. The regulation explicitly requires reporting of the results of all investigations, not merely those that substantiate abuse.

The DAB noted that facilities are not permitted to view their internal investigations as an opportunity to pre-screen whether an alleged or suspected instance of abuse is substantiated or involves misconduct by staff. Because the SNF failed to comply substantially with a federal regulatory requirement, the imposition of the CMP was proper. ■

Singing River Rehabilitation & Nursing Center v. CMS, DAB Decision No. 2232, March 5, 2009, Health Care Compliance Reporter, ¶300,333

Qui tam relator substitution permissible

The estate of a *qui tam* relator could be substituted for the relator upon the relator's death in a False Claims Act (FCA) suit. In granting the estate's motion for substitution, the District Court for the Southern District of New York stated that under the intended purposes of the FCA the relator acts as a mechanism of enforcement by which the government can recover for its injury. Extinguishing the claim of a *qui tam* relator upon death, according to the court, would not encourage private persons to pursue fraud claims on behalf of the government.

Background. The *qui tam* relator had brought allegations against a medical center for filing incorrect Medicare cost reports that resulted in intentional overbilling of services. The relator claimed personal knowledge of the events alleged in the complaint. The complaint was unsealed and served to the medical center, but before the medical center could respond to the allegations, the *qui tam* relator died. The relator's wife was appointed administrator of the estate and sought substitution as the relator under federal rules of civil procedure.

Court's rationale. The court concluded that *qui tam* actions brought under the FCA survive the death of the relator because the remedial nature of the FCA was best served if a *qui tam* action did not close with the death of the relator.

Although damages for FCA allegations contain both punitive and remedial purposes, the treble damages in the statute are remedial in nature, as they were intended to hasten actions on the part of the relator to make the government aware of the alleged false claims. The court noted that these treble damages served "not to punish, but to quicken the self-interest of some private plaintiff who can spot violations and start litigating to compensate the government."

The government's partial assignment of the legal claims to the relator, but concurrent retention of substantial rights in the *qui tam* action indicates the relator was but a means for government enforcement of the statute. The relator's claims are not against the defendant, but "against" the government for a share of the reward. As such, the death of the relator would not extinguish the underlying *qui tam* action. ■

Colucci, U.S. ex rel. v. Beth Israel Medical Ctr., S.D. N.Y., No. 06 Civ. 5033, March 25, 2009, Health Care Compliance Reporter, ¶800,631

HIPAA

Consulting company's records not entitled to HIPAA protection

The Health Insurance Portability and Accountability Act (HIPAA) does not protect from disclosure peer review reports and related documentation in the possession of a business that provides medical and legal consulting services, according to a federal district court.

The company argued that the documents were being subpoenaed only for the purpose of harassment and that producing the documents would falsely portray the company. The company also sought protection under HIPAA, claiming that the documents contain detailed medical and health care information and should be exempt from production.

Covered entities. Entities covered by HIPAA include (1) health plans, (2) health care clearinghouses, and (3) health care providers. The consulting business does not qualify as a covered entity under any of those three categories and, therefore, HIPAA does not prevent enforcement of the subpoena.

Moreover, even if HIPAA restrictions did apply, the individual indicated that he is willing to accept redacted documents that are not individually identifiable. This process would negate any patient privacy interests potentially at stake.

Burden of production. The company also argued that responding to the document request would be an immense burden, requiring an inordinate amount of time and resources that would not normally be expended on its every day workload. Because the information requested is highly relevant to the plaintiff's claim but the consulting company is not a party in the underlying lawsuit, the court ordered that one-half the costs of production be shifted to the plaintiff. ■

Miller v. Allstate Fire & Casualty Insurance Company, W.D. Penn., Civil No. 07-260, March 17, 2009, Health Care Compliance Reporter, ¶800,626

In the News

Waiver authority invoked for flooding emergency

HHS has declared a public health emergency in certain counties in North Dakota and Minnesota, invoking its authority under Social Security Act §1135(b) to permit CMS to waive or modify the requirements, deadlines, or timetables of health care providers to ensure that sufficient health care items and services are available to meet the need of Medicare, Medicaid, and Children's Health Insurance Program enrollees. The emergency declaration was made because of flooding along the banks of the Red and Missouri Rivers resulting in the evacuation of hundreds of patients and residents by health care providers. Information regarding the emergency declaration and the waiver is available on the CMS Emergency Web site at http://www.cms.hhs.gov/Emergency/12_StormFlood.asp#TopOfPage.

CMS Memo to State Survey Agency Directors, S&C No. 09-30, March 30, 2009, Health Care Compliance Reporter, ¶350,146

Cash incentives tested in nursing homes

Nursing homes in Arizona, Mississippi, New York and Wisconsin will be asked by CMS to participate the Nursing Home Value-Based Purchasing Demonstration to determine if cash incentives will improve the quality of care and efficiency of operations. Participating facilities will be awarded points for performance on quality measures in: (1) nurse staffing, (2) avoidable hospitalizations, (3) resident outcomes, and (4) the scope and severity of deficiency citations received during inspections. Nursing homes with the highest scores or the greatest improvement in their score will be eligible for a performance payment. Savings generated by improved performance will fund state pools from which payments will be made to qualified nursing homes. CMS officials anticipate that at least 100 nursing facilities in each state will apply for this demonstration, which is expected to run from July 2009 through June 2012. CMS will mail an application kit to each Medicare-certified nursing home in the demonstration states.

CMS Press Release, March 27, 2009

Health IT policy committee members named

Gene L. Dodaro, Acting Comptroller General of the United States and head of the Government Accountability Office (GAO) has appointed 13 members to the Health Information Technology Policy Committee. The committee was established by the American Recovery and Reinvestment Act (ARRA) (PubLNo 111-5) to make recommendations on creating a policy framework for the development and adoption of a nationwide health information technology (HIT) infrastructure, including standards for the exchange of patient medical information. An additional seven members will be appointed by the Secretary of HHS, the Majority and Minority leaders of the Senate, and the Speaker and Minority leader of the House of Representatives. The President may also appoint other members as representatives of relevant federal agencies.

GAO Press Release, April 3, 2009