CCH Health Care Compliance LETTER

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Crowding in hospital emergency departments continues to occur

Emergency department crowding continues to occur in hospital emergency departments, and some patients wait longer than the recommended time frames, according to a recent study by the Government Accountability Office (GAO).

2003 GAO study. In 2003, GAO reported that most emergency departments in metropolitan areas experienced some degree of crowding (Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities, GAO-03-460). For example, the GAO found in 2003 that two out of every three metropolitan hospitals reported ambulance diversions — asking ambulances to transport patients to other facilities.

Purpose of study. The Senate Committee on Finance requested that the GAO conduct this study because of continued reports of crowded conditions in emergency departments, often associated with adverse effects on patient quality of care. The Committee specifically asked the GAO to review information made available since 2003 on emergency department crowding, including (1) ambulance diversion, (2) wait times, and (3) patient boarding. In conducting the study, the GAO examined national data; conducted a literature review of 197 articles; and interviewed HHS officials, professional and research organizations, and individual subject matter experts.

National data results. National data shows that (1) about one-fourth of hospitals reporting going on ambulance diversion at least once in 2006, and (2) wait times in the emergency departments increased, and in some cases exceeded recommended time frames. Although officials interviewed and articles reviewed by the GAO noted that the boarding of patients in the emergency department who are awaiting transfer to an inpatient bed or another facility continues to be a problem, national data on the extent to which this occurs is limited. Some of the articles reviewed by the GAO discussed strategies to address crowding, but these strategies have not been assessed on a state or national level.

Average wait time. The GAO analyzed 2006 data from HHS' National Center for Health Statistics on the average wait time to see a physician in an emergency department and the percentage of visits in which the wait time exceeded the recommended time frames based on following patient acuity levels:

- **Immediate**. The average wait time was 28 minutes, with 73.9 percent of patients waiting longer than the one minute recommended time frame.
- **Emergent**. The average wait time was 37 minutes, with 50.4 percent of patients waiting longer than the maximum 14 minute recommended time frame.
- **Urgent**. The average wait time was 50 minutes, with 20.7 percent of patients waiting longer than the maximum 60 minute recommended time frame.

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- **Semi-urgent**. The average wait time was 68 minutes, with 13.3 percent of patients waiting longer than the maximum two hour recommended time frame.
- **Nonurgent**. The average wait time was 76 minutes, with no emergency departments in 2006 reporting visits with wait times in excess of the maximum 24 hours.

Factors contributing to crowding. Articles reviewed and individual subject-matter experts interviewed by GAO reported that a lack of access to inpatient beds continues to be the main factor contributing to emergency department crowding. One reason for a lack of access to inpatient beds is competition between hospital admissions from the emergency department and scheduled admissions. For example, elective surgeries may be more profitable for the hospital than emergency department admissions. Additional factors contributing to emergency department crowding, may include patients' lack of access to primary care services or a shortage of available on-call specialists.

HHS concurrence. In commenting on a draft of this GAO report, HHS noted that the report demonstrates that emergency department wait times are continuing to increase and frequently exceed national standards. ■

GAO Report, GAO-09-347, April 30, 2009

CMS prepares DMEPOS suppliers for round one rebid

CMS is taking the opportunity to educate suppliers on the key steps they will need to take in preparation for the round one rebid for the durable medical equipment, prosthetics, orthotics, and suppliers (DMEPOS) competitive bidding program. The DMEPOS competitive bidding program was implemented so that Medicare and its beneficiaries can reap substantial cost savings when suppliers offer their durable medical equipment (DME) and supplies at competitive prices. Also the program will help ensure CMS pays appropriate prices for DME goods and services, an area in which overpayments are common, according to CMS.

In the original DMEPOS competitive bidding program, bids resulted in prices that were an average 26 percent lower than prices on the existing 2008 DMEPOS fee schedule. These lower prices would amount to substantial savings for Medicare beneficiaries when they have to pay out-of-pocket costs related to their 20 percent deductible.

Rebidding details. The registration period will begin during the summer of 2009 and the round one rebidding period should start in the fall. In preparation for the fall bidding period, suppliers should ensure they have: (1) the appropriate state licenses; (2) updated their Medicare enrollment files with the National Supplier Clearinghouse; and (3) the appropriate accreditations and bonds needed to participate in the competitive bidding program. New improvements to be implemented for the round one rebid include: (1) an upgraded online bid submission system, (2) early bidder education, and (3) increased oversight of bidders who are new to product categories or competitive bidding areas for compliance with new CMS requirements.

Although the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (PubLNo 110-275) did not fundamentally change the original DMEPOS competitive bidding project, it did require certain changes be made. CMS was required to terminate contracts that were awarded in the first round of the DMEPOS competitive bidding program that was held in July 2008. Also, MIPPA required the establishment of a financial document review process and required suppliers to report subcontract relationships with other suppliers. Further, MIPPA specifically excluded certain items and areas from competitive bidding and granted hospitals an exemption to the program when the hospital furnished certain types of DMEPOS items to their own patients.

A meeting of the Program Advisory and Oversight Committee took place on June 4, 2009, before the announcement of a detailed timeline. Additional information regarding the DMEPOS competitive bidding program is available at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp#TopOfPage. ■

CMS Press Release, May 29, 2009

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State issues guidance on obtaining medical records for criminal investigations, trials

Maryland's Attorney General (AG) issued an opinion regarding the procedures the State's Attorney (SA) for Carroll County, Maryland should use to obtain medical records for criminal investigations and trials. According to the AG, a SA should be able to obtain medical records for use in a criminal investigation or prosecution in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the Maryland Confidentiality of Medical Records Act if he or she follows proper analytical steps and procedures, as outlined below.

Written confidentiality procedures. As a prerequisite under state law for using compulsory process (i.e., subpoena, search warrant, court order) to obtain medical records for criminal matters, a SA should have written procedures for protecting the confidentiality of medical records.

Generally, a SA must use some form of compulsory process to obtain medical records. In some instances, however, medical information may be provided without patient authorization or compulsory process. For example, information may be provided about suspected child abuse without compulsory process. "Directory information" (i.e., the presence and general health condition of the patient) also may be provided without compulsory process.

Confidentiality laws. The application of confidentiality laws depends on the origin and type of records. Therefore, the following issues must be addressed:

- If the records relate to the health of an identifiable individual, then the records generally will fall within the definitions of "medical records" under the state medical records law and "protected health information" under the HIPAA regulations. If the information sought is merely "directory," both laws generally permit the release of such information without compulsory process.
- Most health care professionals and facilities that have custody of medical records are considered a "health care provider" for purposes of the state medical records law and a "covered entity" under the federal HIPAA regulations. Both laws restrict disclosure by the custodian. If the current custodian of the records is not a "covered entity," the HIPAA regulations likely will not apply. On the other hand, even if the current custodian of the records is not a "health care provider," state law may restrict their use or "redisclosure" if the custodian obtained them from a health care provider.

Protection under other laws.

- If the records relate to an individual's participation in a *substance abuse treatment program*, those records may not be used to prosecute that individual, and the SA will not be able to obtain records from the program for purposes of criminal prosecution unless the patient consents to disclosure or the information relates to a crime against the treatment program or its personnel.
- If the records concern the provision of *mental health services* to one or more identifiable individuals, there are special state law restrictions. Unless the patient consents to disclosure, mental health records may be obtained for judicial proceedings only pursuant to a court order. A SA, however, may obtain mental health services records without a court order to investigate certain specified offenses by the provider of those services, if the SA has written confidentiality procedures and the information identifying the patient is removed from the records.
- If the records are in the custody of a government agency or they relate to a government program such as a state medical assistance program, the public information act or a statute governing the program may limit disclosure of the records. In that case, a court order may be required to obtain the records.

Preemption. If more than one confidentiality law applies, the SA will need to satisfy the requirements of the "more stringent" law.

Compulsory process in criminal investigations. In criminal investigations, the SA may use the following processes to obtain medical records:

- The SA may obtain medical records by means of grand jury subpoena, search warrant, or court order without satisfying any criteria beyond that normally required for such process, if it

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On The Front Lines

Dealing with CMS' Alphabet Soup: What Compliance Professionals Need to Know to Effectively Manage RACs, MACs and HACs

by Kathy Johnson, RHIA

New CMS regulations regarding Hospital Acquired Conditions (HACs), Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) can adversely affect unprepared hospitals and health networks. Like any change, preparing for HACs, MACs and RACs causes anxiety and takes time. Proactively looking at the whole, rather than the sum of the parts, can alleviate stress and put processes in place to make the transitions easier for everyone. With more new coding requirements like the Acute Care Episode (ACE) three-year demonstration project on the horizon, it is important for leaders and their organizations to prepare for and adapt to each set of regulations as they approach and take effect. With different sets of regulations building one on another and a pipeline of ongoing change ahead, proactive planning and management offers the most reliable way to protect an organization's compliance, financial, and legal best interests.

Causing confusion and concern throughout the industry, new regulations from the Centers for Medicare and Medicaid Services (CMS) may only look like a spoonful of alphabet soup, but Hospital Acquired Conditions (HACs), Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) can wreak havoc on electronic record initiatives, organizational structure, work flow and processes, communication, and education for unprepared hospitals and health networks. Many compliance and legal pitfalls exist, but knowing what has been done, understanding what needs to be done, and effectively prioritizing efforts to ensure compliance can make all the difference.

First, leaders should reflect and gather information on what's been done to prepare for these regulations at an enterprise level, noting any efforts to meet customer quality requirements, comply with regulations, or ensure accuracy and reliability of codified data. Specifically, executives should determine which regulations pose the greatest threat or require the greatest amount of process and procedural changes, then designate these as higher priority.

This type of effective preparation can help organizations avoid financial, compliance, and legal setbacks and capitalize on new opportunities. Taking stock of what's been done to date provides a good baseline understanding of what needs to be done and helps organizations prepare, transition, and embrace change more efficiently and seamlessly. Plus, much of the effort spent preparing for certain regulations will lay the groundwork required to comply with others, because the transitions happen simultaneously with some working toward the same end. Getting ready for RACs, for example, helps organizations prepare for MACs, and preparation for present on admission (POA) requirements can help smooth the way for HACs.

Recovery Audit Contractors

Of the many government initiatives, RACs seem to receive the most public attention, and organizations should have this transition behind them. From a compliance perspective, RACs may not represent the biggest regulatory threat for hospitals and health networks in 2009, but the potential financial implications cannot only endanger an organization's financial health; they also can have a trickle down effect on other compliance initiatives. So it's critical to understand their potential impact and steps that have and will be taken to address them.

CMS developed the RAC program to identify and correct improper Medicare payments, reduce future improper payments, and improve its error rate. CMS released an "Update to the Evaluation of the 3-Year Demonstration" in January, which includes many statistics on the appeals process through August 31, 2008, including the number of claims, those appealed, and those with a favorable decision for the provider.

With the demonstration complete and several important RAC related rollout dates already past (see regional rollout

map for more information), most hospitals should be proactively reviewing claims data to identify and correct risk areas. Executives should look to their RAC team to ensure proper measures are being taken, as well as their health information management (HIM), legal, revenue cycle, quality improvement, and case management groups. Good questions to ask include the following tip of the iceberg. Do we have a protocol in place for re-billing, self reporting or self disclosure? Are we prepared to handle the five levels of the RAC appeal process?

Hospitals and health networks that have yet to assess their preparedness have fallen far behind. They should immediately determine where their organization stands and any work that lies ahead. From a legal and compliance standpoint, it's important to understand that RAC reviews conducted during the demonstration program aligned with Office of the Inspector General (OIG) focus areas. Assuming the national RAC rollout follows suit as it should, organizations can leverage data mining and analysis completed for the OIG to monitor improvements and stay informed about developing issues with RACs.

Compliance professionals can make other valuable contributions to their organization's RAC readiness effort. They should consider, among other things, contributing to efforts to develop the organization's criteria for RAC appeals and the standard language to be used in appeals. Risk management, legal, and compliance experts also can play invaluable roles in drafting communications for beneficiaries to help them understand what a RAC denial means and what their provider is doing in response to a RAC denial. CMS will send communications of their own to the beneficiaries; so encouraging proactive management and careful planning on this front can help organizations navigate the appeals process more smoothly.

Planning also should include deciding whether or not the internal RAC process will be integrated into the organization's corporate compliance program. Some organizations have their corporate compliance and patient financial services teams coordinate RAC audits. In addition, risk management should contribute by conducting comprehensive RAC vulnerability analyses to identify where the organization is today and what priorities need to be addressed moving forward.

The overall goal of all RAC preparedness efforts should focus on mitigating future exposure. By implementing quality management programs that review claims, educate staff, and monitor developments on an ongoing basis, compliance executives can position their organizations for smooth transitions and organizational change in light of RAC regulations.

Medicare Administrative Contractors

MACs, like RACs, focus primarily on billing and reimbursement. Once in effect, MACs will completely replace fiscal intermediaries and carriers and should be fully operational by March 2010. The MAC program aims to improve CMS customer service for providers by offering a single point of contact, increasing provider education and training, and improving claims and payment accuracy. Also similar to RACs, the MAC program rollout will happen in stages over various regions, but unlike RACs, the MAC program focuses on current, individual claims, rather than retrospective and aggregate claims data.

The MAC program restructures how claims are processed, and many departments will be affected by an organizational transition to accommodate MACs, particularly if the organization is unprepared. Because MACs focus so heavily on the claims process, executives should look to their patient financial services, information technology and revenue cycle departments to ensure necessary measures are in place. Many valid concerns exist, but some of the most important areas to investigate include the interdependencies of processes throughout the organization, the specific organizational processes most affected, and the need to identify resources that can help interpret CMS policy and regulations.

Compliance professionals should focus on high priority processes and procedures and help to specifically define them in ways that enable optimal performance, remembering that RAC preparations may have addressed some issues. Engaging in measurement, evaluation, tracking, and reporting as individual components of overall business transparency and integrity provides other opportunities to contribute. Offering guidance on how and when to execute self disclosure in the event issues arise during internal assessments, though, is one of the most important steps compliance professionals must be sure to complete.

Developing relationships with MACs can also help. By the March 2010 target, there will be 19 MACs in place to handle claims for Part A, Part B and durable medical equipment suppliers. As these new contacts take over, hospitals and health networks have the opportunity to start fresh with these CMS representatives. With just 19 MACs nationwide, executives should be sure to take advantage of any opportunities for face time to ensure open communication and transparency with their organization's contact.

Just as preparation done for RACs can help organizations prepare for MACs, preparing for POAs will help hospitals and health networks with HACs.

Hospital Acquired Conditions

HACs stress the importance of value-based pricing and determining liability for a wide range of conditions and related issues, much like POA reporting. Unfortunately, organizations that mishandle or improperly code HAC or POA data create a risk of malpractice and other liabilities, as well as increased costs to their organizations.

As of October 2008, CMS no longer provides reimbursement over and above the typical inpatient prospective payment

system (IPPS) rate for care required to treat several types of healthcare-associated conditions. Under these regulations, CMS holds hospitals accountable and compensates them based on the value of care provided to patients. Therefore, any cost of treating a condition acquired during an inpatient hospital stay that was reasonably preventable is the responsibility of the hospital and will not be paid by Medicare or the beneficiary.

Examples of conditions that can qualify as HACs include foreign object retained after surgery, air embolism, blood incompatibility, falls and trauma, deep vein thrombosis and pulmonary embolism following certain orthopedic procedures, and certain surgical site infections. CMS also classifies certain events as "never events," or serious reportable adverse events. These include surgeries on the wrong body part, surgeries on the wrong patients, or the wrong surgery altogether.

"Getting ready for RACs . . . helps organizations prepare for MACs, and preparation for present on admission (POA) requirements can help smooth the way for HACs."

CMS and several private insurance payers that include Wellpoint, Cigna, and BlueCross BlueShield have non-payment policies for all "never events" and states are following suit. A group of states including Maine, Massachusetts, New York, and Pennsylvania are currently enacting laws to put similar non-payment policies in place regarding never events.

As when dealing with RACs and MACs, compliance, legal, and risk management professionals must determine what's being done at the enterprise level to maximize compliance, minimize risks, and reduce the number of HAC incidents taking place. Across the organization, executives should focus first and foremost on identifying and correcting the root causes of potential HACs.

Risk management teams can do more than lead efforts to prevent HACs by ensuring basic preventive steps exist at the point of care. They also should work to ensure the organization properly (1) determines and codes whether a diagnosis was present at the time of the beneficiary's admission as an inpatient, (2) documents the POA status for all diagnoses on CMS claims, and (3) follows relevant billing and reimbursement guidelines for each HAC that is subject to payment reduction. Again, effective POA preparation should be completed, which should lessen the burden associated with HAC preparation.

Beginning in October 2007, all IPPS hospitals were required by CMS to submit POA Indicator information for all primary and secondary diagnoses. From January 2007 to March 2008, CMS processed POA Indicator data and educated IPPS hospitals on reporting errors. Since April 2008, CMS returns all claims lacking proper POA reporting. Hospitals and health networks successfully navigating these POA regulations with minimal denials should have an easier time preparing to manage HACs.

HACs have the potential to cause enterprise-wide impact and should be addressed as such. Executives should work to address issues related to HAC readiness from point of care to coding and claim submission, ensuring physicians and others affected understand the regulations, their role in managing them, and potential implications. Education plays a huge role in preparing an organization for HACs and the many intricacies they contain.

Many are surprised to learn that certain conditions are not classified by POA requirements as HACs. Any conditions acquired in an outpatient setting like the emergency room or during any other instance that occurs prior to the admission, for example, are not classified as HACs, but hospitals may not receive entitled reimbursement in these situations if coders misrepresent these pre-admission developments as HACs. Every organization's compliance effort must include aggressive monitoring for over or under reporting of HACs in coded data.

The compliance and financial implications of ensuring these measures are taken can be staggering. It cannot only mean the difference between regulatory compliance and noncompliance; it also can help organizations avoid mountains of improperly coded and unreimbursed procedures.

Conclusion

Like any transition, preparing for HACs, MACs and RACs causes anxiety and requires the time of many throughout the organization. HACs, MACs and RACs can positively or negatively impact many hospital initiatives, but the efforts to prepare for them should never occur in a vacuum. By proactively looking at the whole, rather than the sum of the parts, executives can alleviate stress and put processes in place to make the transitions easier for everyone.

With more new coding requirements like the Acute Care Episode (ACE) three-year demonstration project on the horizon, it's incredibly important for leaders and their organizations to prepare for and adapt to each set of regulations as they approach and take effect. With different sets of regulations building one on another and a pipeline of ongoing change ahead, proactive planning and management offers the most reliable way to protect an organization's compliance, financial, and legal best interests. ■

Kathy M. Johnson, RHIA, Director of Coding Services for Care Communications, has held health information management (HIM) director and various coding positions for more than 25 years. At present, Johnson manages the Care Communications, Inc. Coding Consulting Services division and conducts Coding Quality Reviews and Education Programs. She also works closely with health care executives to streamline and improve revenue cycles, claims processing and other critical hospital functions. Johnson has helped many healthcare organizations improve their Joint Commission survey preparation, compliance, and documentation standards. She has many years of experience performing coding audits and working with physicians, coding staff, supervisors, and directors. Contact her at kjohnson@care-communications.com.

has written procedures to preserve the confidentiality of medical records.

- A SA also may use a State's Attorney's subpoena under the Annotated Code of Maryland, Criminal Procedure, §15-108, to obtain medical records. When using a State's Attorney's subpoena, however, or any other process that could be characterized as administrative, federal law requires a demonstration that (1) the information sought is relevant to a legitimate inquiry, (2) the amount of information sought is specific and limited in scope to the purpose for which it is sought, and (3) the need for the information cannot be satisfied by information not identified with a particular individual.
- The SA is not required to give notice to the individual who is the subject of those records. The health care provider or entity that receives the subpoena, however, may choose to notify the individual.

Compulsory process in criminal trials. In criminal prosecutions (trials) the following processes may be used:

- Medical records obtained during investigation may be used in a resulting prosecution. Protection of the confidentiality of individual patients may be accomplished through redaction, protective order, and the designation under the state rules of confidential medical information in court filings.
- A SA may use a subpoena for pre-trial production of medical records if a court order is obtained demonstrating that there is a likelihood that the records contain information relevant to an issue in the case.
- A SA may use a subpoena duces tecum for a hearing or trial. This rule ordinarily does not require a court order, however, a recipient of a subpoena who is subject to the HIPAA regulations will need a court order, "satisfactory assurances" that the prosecutor has notified the patient, or similar assurances that the prosecutor will seek a protective order from the court to preserve the confidentiality of the records.
- The special limitations concerning the use of mental health records and records of substance abuse treatment programs also apply to subpoenas issued under state rules. ■

Maryland Attorney General Opinion, 94 Op. Att'y Gen. 44, May 11, 2009, Health Care Compliance Letter, ¶470,032

Antitrust

Joint venture between PHO, health plans is legitimate, FTC says

A physician-hospital organization's (PHO) proposal to clinically integrate its members' provision of health care services and contract jointly with health plans and other payers on a fee-for-service (FFS) basis to provide services to plan beneficiaries would be a legitimate joint venture and not stifle competition, according to an Federal Trade Commission (FTC) letter.

The PHO is comprised of a county hospital with a medical staff of 319 physicians and over 200 other physicians, 40 of whom are employed by the county hospital. The PHO offered physician services through a provider network where each physician separately and individually agreed to accept FFS reimbursement rates. The PHO, along with 50 additional contracted physicians and 19 non-physician health care providers whom are not formal members of the PHO, also provides services to beneficiaries of three self-insured employers in the region and a variety of third-party payers and programs in the region.

Proposed arrangement. The PHO would participate as a single health network to provide beneficiaries with medical and other health care services, including hospital services, to person covered under health benefits programs offered by self-insured employers and other payers in the region.

Central to the proposal would be the PHO's plan to implement a web-based health information technology system to help identify high risk and high cost patients and improve physicians' efficiencies. The PHO would monitor achievement of physician performance and make recommendations for both individual and group performance.

Under the terms of the proposed arrangement, an open enrollment period would permit for a limited time other physicians in the region to join the PHO. The PHO would be contracting on behalf of the physician members who joined the program, including negotiating and agreeing to the prices to be charged for those physicians' services under the program. Physicians also would generally agree to refer patients to other PHO network physicians when medically appropriate.

FTC analysis. The FTC noted that: (1) the organization's program would create substantial integration among its participants to improve quality and cost-effective care; (2) joint contracting with payers on behalf of the organization's competing physician members would be subordinate and reasonably related to the organization's plan to integrate its members' provision of services; and (3) the proposal would be unlikely to increase the market power of the organization because members would be able to contract individually outside of the proposed program.

The high degree of interdependence among the PHO participants also lent support to significant clinical integration. Imposing a time-limited offer to join the PHO, along with performance monitoring, would likely discourage providers not fully committed to the program from joining. In turn, this would assure those who chose to participate would be fully committed to the PHO's goals and requirements. Thus, the proposed program would likely not impede competition and would not be challenged by the FTC. ■

FTC Staff Letter Re:TriState Health Partners, Inc. Advisory Opinion, April 13, 2009, Health Care Compliance Reporter, ¶660,054

Anti-Kickback

Compensation of physicians for on-call services

A proposed arrangement by a hospital to amend its by-laws to provide compensation to physician's for on-call services performed on behalf of the hospital's indigent and uninsured payments would be not be subject to administrative sanctions under the anti-kickback statute, according to the Office of Inspector General (OIG). The hospital is a nonprofit, 400-bed general hospital and the sole provider of acute care inpatient hospital services in the county. Under current bylaws, all members of the active staff provide on-call coverage in the emergency department and care for patients referred to them while they are providing emergency department coverage.

In determining whether the arrangement meets the requirements for the application of the anti-kickback safe harbor, the key inquiry was whether the proposed compensation would: (1) be fair market value in an arm's-length transaction for actual and necessary items or services, and (2) not be determined in a way that considers the volume or value of referrals or business between the parties.

According to the OIG, the arrangement presented little risk of fraud and abuse because: (1) the hospital stated that the payment amounts would be determined based on the fair market value for the services provided and would only provide compensation for services completed by the physicians, (2) the hospital has a legitimate reason for revising its on-call policy due to the physicians' dislike of participating in on-call services as well as the shortage of specialists leading to the outsourcing of emergency care, (3) the features of the arrangement would minimize the risk of fraud by imposing a number of responsibilities on the physicians for payment to be made and the compensation would be offered uniformly to the physicians, and (4) the arrangement appears to be an equitable mechanism for the hospital to compensation physicians that provide care it is required to provide. ■

OIG Advisory Opinion, No. 09-05, May 14, 2009, Health Care Compliance Reporter, ¶500,209

In the News

Kennedy, Baucus issue joint statement

Senator Edward M. Kennedy (D-Mass), Chairman of the Health, Education, Labor, and Pensions Committee, and Senator Max Baucus (D-Mont.), Chairman of the Finance Committee, have issued a joint statement affirming their commitment to find common ground on health care reform legislation: "For both of us, reforming the nation's health care system to cut cost, improve quality and provide affordable coverage remains the top priority on our two committees. We have worked together closely over many months and will continue to do so. We intend to ensure that our committees report similar and complementary legislation that can be quickly merged into one bill for consideration on the Senate floor before the August recess." The statement was issued in response to media reports of a split between the two Democrats due to Kennedy's long-held position favoring a large government-sponsored bill that would compete with private insurers, and Baucus' efforts on a bipartisan bill with Sen. Charles E. Grassley (R-Iowa), which would minimize the government plan option.

Joint Statement from Senators Kennedy and.Baucus, June 2, 2009

Secretary Sebelius appoints CMSO director

HHS Secretary Kathleen Sebelius has announced the appointment of Cindy Mann to serve as Director of the Center for Medicaid and State Operations (CMSO). Mann most recently served as a research professor and executive director of the Center for Children and Families at Georgetown University's Health Policy Institute. From 1999-2001, Mann served as director of the Family and Children's Health Programs Group at the Health Care Financing Administration (HCFA), now CMS. Prior to her work at HCFA, Ms. Mann led the Center on Budget and Policy Priorities' federal and state health policy work. She also has extensive state-level experience, having worked on health care, welfare, and public finance issues in Massachusetts, Rhode Island, and New York. She holds a law degree from New York University School of Law.

HHS News Release, May 29, 2009

Health reform bill predicted to arrive in October

President Obama on June 2 said the "make or break period" for action on health care reform legislation is between now and the August recess. Following a White House meeting, Senate Finance Chairman Max Baucus (D-Mont.), predicted a bill would reach the president's desk in October. Baucus said that "all options are on the table" and indicated that the president "might consider" proposals to tax employer-provided health insurance. White House spokesman Reid Cherlin said that, while all options should be considered, they should include the revenue proposals in the president's budget. Obama said the White House will work with Congress on a bill that reforms the underlying health care system "promoting best practices, not just the most expensive practices." The president said that "reform is a necessity" and that the soaring cost of health care is unsustainable for families, businesses and government.

CCH Washington Bureau, June 2, 2009