

CCH Health Care Compliance LETTER

Volume 8, Issue 19

health.cch.com

September 19, 2005

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CMS relaxes HIPAA, EMTALA requirements after Katrina

by Sheila Lynch-Afryl, J.D., Contributing Editor

Standard operating procedures for Medicare, Medicaid, and the State Children's Health Insurance Programs will be relaxed to accommodate the emergency health care needs of beneficiaries and medical providers in states affected by Hurricane Katrina, according to CMS. For example, providers that perform medical services in good faith but who cannot comply with normal program requirements because of the hurricane will be exempt from sanctions for non-compliance, unless fraud or abuse occurs.

CMS will also provide the following relief immediately:

- Certain HIPAA privacy requirements will be waived so that health care providers can talk to family members about a patient's condition even if the patient is unable to grant permission;
- Hospital emergency rooms will not be held liable under the Emergency Medical Treatment and Labor Act for transferring patients to other facilities for assessment if the original facility is in the area where a public emergency has been declared; and
- Crisis services provided to Medicare and Medicaid beneficiaries who have been transferred to facilities not certified to participate in the programs will be reimbursed.

Many beneficiaries have been evacuated to neighboring states, where receiving hospitals and nursing homes have no records, information on current health care status, or verification of the person's status as a beneficiary. In this circumstance, facilities have been instructed to waive the normal burden of documentation and to presume eligibility.

CMS Press Release, Sept. 6, 2005

CAP provides MDs option for purchase/billing of drugs

Andra Popa, J.D., LL.M.,

Physicians who administer drugs in their offices will have a new billing option on January 1, 2006 because CMS issued a final interim rule that enables providers to have the option of participating in a competitive acquisition program (CAP). CMS will permit providers participating in CAP to acquire physician-injectable drugs covered under Medicare's Supplemental Medical Insurance (Part B) program, which are commonly provided incident to the physician's service.

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Participating physicians will no longer be required to perform the administrative work of purchasing and procuring drugs in their offices. Physicians will simply order the drugs they need to administer from vendors, who will bill Medicare for the drugs and bill the patients for any coinsurance or deductibles. As a result, participating physicians will only bill patients for the service of administering the drugs. Medicare will reimburse the physician the same amount for administering the drugs.

The new program will not apply to drugs included under the Prescription Drug Benefit pursuant to Medicare Part D, which will also be effective on January 1, 2006. Moreover, CAP will not apply to self-administered drugs. Physicians will be able to enroll in the new CAP program once a year.

CMS Press Release, June 27, 2005

Company settles hospital FI cost report dispute for \$55M

A company that operates long term health facilities and hospitals (Company) will receive approximately \$55 million from its Medicare fiscal intermediary (FI) in settlement of a hospital cost report issue from prior years that was under appeal according to the Company's press release. The settlement resolves

an issue related to Medicare reimbursement for rents paid to a health care real estate investment trust (REIT) following the hospital's reorganization in April 2001 through August 2003. The Company's hospitals argued that the rent payments were considered related party payments in hospital cost reporting periods prior to April 2001. According to the terms of the settlement, the FI agreed that the Company's amended rent payments to the REIT were allowable for the cost reporting periods beginning in April 2001. In response to the settlement, the Company's board of directors approved a one-time \$15 million recognition payment to approximately 49,500 non-executive caregivers and employees who did not formerly participate in the hospital's incentive compensation plans. Additionally, the board of director's approved a \$5 million grant to the hospital's charitable foundation, which will be used to fund medical research and other charitable activities over the next few years. The Company expects to receive the settlement on or before April 30, 2006.

Kindred Healthcare Press Release, June 27, 2005

JCAHO and WHO collaborate to reduce medical injuries worldwide

Recognizing that health care errors seriously harm one in every 10 patients around the world, the World Health Organization (WHO) is designating the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Joint Commission International (JCI) as the world's first WHO Collaborating Centre dedicated solely to patient safety. This action is aimed at reducing the unacceptably high numbers of serious medical injuries around the world today.

The collaboration of JCAHO, JCI and WHO will focus worldwide attention on patient safety and best practices

that can reduce safety risks to patients and coordinate international efforts to spread these solutions as broadly as possible. This will be accomplished by collaborating internationally with ministries of health, patient safety experts, national agencies on patient safety, health care professional associations, and consumer organizations.

JCAHO Press Release, August 23, 2005



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CCH Health Care Compliance Letter is published 24 times a year by CCH INCORPORATED, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is \$305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Health Care Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A. All rights reserved. ©2005 CCH INCORPORATED, A WoltersKluwer Company.

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Proposed rule plans AKB safe harbor by Gene' Stephens, J.D.,

A proposed rule was issued that would amend the anti-kickback (AKB) statute to create a new safe harbor for certain agreements involving health centers that receive section 330 funding under the Public Health Service Act and the Health Centers Consolidation Act of 1996, PubLNo 104-299.

Specifically, section 431 of the Medicare Modernization Act of 2003 (MMA), PubLNo 108-173, amends the anti-kickback statute to exclude, as a violation, any remuneration between a health center described under sections 1905(1)(2)(B)(i) or 1905(1)(2)(B)(ii) of the Social Security Act and an individual or entity providing goods, items, services, donations, loans or a combination of these to section 330 health centers under a contract, lease, grant, loan, or other agreement.

The individual or entity must provide the remuneration under a "protected arrangement" and specify a fixed amount or percentage that it will give to the health center. In addition, the protected arrangement must be documented with both parties' signatures, specify all of the goods items, services, donations, and loans the individual or entity has provided to the health center.

Arrangements protected under the AKB safe harbor provisions must be made pursuant to a "contract, lease, grant, loan, or other agreement." The agreement must: (1) be in writing, (2) be signed by the parties, and (3) cover all the goods, items, services, donations, and loans to the individual or entity to the health center.

Congress intended to permit some health centers to accept certain remuneration that might otherwise implicate the anti-kickback statute in instances where the remuneration furthers a core purpose of the federal health centers' programs of ensuring available and quality health care services to otherwise under-served populations.

Section 431(b) of the MMA further requires HHS to promulgate regulatory standards regarding the new safe harbor.

Proposed Rule, 70 FR 38081, July 1, 2005

Indictments for concealment and false statements stand by Andra Popa, J.D., LL.M

The indictments of a divisional director and nurse consultant of a nursing and rehabilitation center for two separate offenses under two separate statutes for concealing a material fact and making false statements in connection with the delivery of health care benefits and in a matter under government jurisdiction did not constitute double jeopardy because Congress expressly intended that these offenses be prosecuted under both statutes, the elements required by each of the statutes are not the same, and in this case, the concealment and false statements were separate acts that may be treated as separate offenses.

The government indicted the director, a nurse consultant, and a supervisory nurse on charges related to omitting a resident's name from a list of all residents

who had fallen since the last unannounced quality assurance inspection by a state agency, including asking staff to turn the injured resident to conceal her injury and hiding and directing others to hide the patient's chart. The director and the nurse consultant objected to the counts based on the double jeopardy clause of the Fifth Amendment, which in part protects against multiple punishments for the same offense, or multiplicitous indictments.

The magistrate judge properly addressed whether (1) Congress intended each violation to be a separate offense and, if so, (2) whether the offenses constituted the same offense within the meaning of the double jeopardy clause. First, by placing the crime of intentionally concealing a material fact and the crime of knowingly making a false statement in connection with the delivery of health care benefits in two separate sections of 18 U.S.C. § 1035 and creating separate elements under each section, Congress expressed its intent to treat each violation as a separate offense.

Similarly, Congress intended that the act of concealment by trick, scheme or devise in relation to a matter under government jurisdiction, under 18 U.S.C. § 1001(a)(1), to constitute a separate offense from the act of making a false statement under U.S.C.

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Mandatory overtime and health care staffing dilemmas: Legal and practical considerations

by Judith Tichenor, J.D., L.C.S.W.

In the past decade or so, health care management has found itself on the horns of a major staffing dilemma. Due to the ever-growing shortages in nurses and nursing assistants to provide care, health care organizations have been increasingly forced to search for options to meet their staffing needs. Perhaps the worst human resource shortage known to healthcare organizations remains the desperately growing shortage of nurses. The forecast for the future is even grimmer, with a projected shortage of over 1 million nurses expected by the year 2010.

Health care organizations and their executives are finding themselves in the crosshairs of a 4-way dilemma and staring at what is tantamount to four crises in health care staffing. These four crises emanate from:

- a drastically shrinking pool of nurses and nurse assistants who remain able and willing to serve;
- the growing passage of statutory restrictions on, or outright prohibitions against, requiring excessive work hours from health care staff;
- the emergence of statutory regulation in the form of staff-to-patient ratio minimums; and
- the appearance of studies indicating that, after all, nurses and their assistants are human and have basic needs that must be met order to control human error and reduce turnover or abandonment of the field altogether.

In desperate efforts to meet the needs of patients, health care organizations have faced these roaring threats with some controversial quasi-solutions to the staff shortage problem, called quasi-solutions by this author because they seem to simultaneously both answer and exacerbate the staffing shortage issues. One of those frequently used, sometimes abused, and most unpopular answers to the professional shortage problem is mandatory overtime. Stimulating controversy and causing rising dissension between management and the health care workforce, mandatory overtime has been facing growing disfavor as a staffing strategy among nursing professionals, their professional organizations, and their labor unions. This is especially so in light of the recent studies suggesting that longer nursing staff hours, whether in the form of overtime (mandatory or otherwise) or 12-hour shifts, cause increased medical errors and higher risks to patient safety.

Can a health care employer impose mandatory overtime? At the moment, eight states have enacted statutes restricting or outright prohibiting mandatory overtime for nurses and other caregivers. Those states are California, Connecticut, Maine, Maryland, Minnesota,

New Jersey, Oregon, and Washington. In addition to these states, Illinois added itself to the list on July 28, 2005. Not all of the statutes have the same regulations, and not all of them cover the same types of health care employees. For example, New Jersey's law covers all healthcare workers. Oregon's statute, on the other hand, limits overtime for RNs, LPNs, and CNAs. The statutes for Maine, Minnesota and Washington only apply to nurses.

Regarding the definition of overtime, California's and Minnesota's laws limit nursing shifts to no more than 12 hours in a 24-hour period except in emergency situations. West Virginia requires nurses who work more than 12 hours be allowed at least 8 hours off. The state of New Jersey goes farther, protecting nurses from being mandated by their employers to work more than 8 hours a day or 40 hours per week. Virtually all of the statutes prohibit the discrimination or retaliation against nurses by their employers for refusal to work beyond the required shift. At least 9 more states have bills limiting mandatory overtime for health care professionals in the works.

The emergency provision allows health care organizations to suspend the "no mandatory overtime" requirement long enough to deal with the crisis situation. Again, most of the laws limit the definition of emergency to national or state disasters, catastrophic event, natural disasters, disasters related to terrorism, or any reason that prompts the activation of the organization's disaster plan.

Federal legislation has been proposed and is in the legislative process to grant nurses across the nation nursing freedom from mandatory overtime except in emergency situations.

Weighing in on the side favoring legislation limiting of shift durations are recent studies questioning the wisdom of the currently popular 12-hour shift for nursing personnel, let alone the use of overtime, mandatory or otherwise. Specifically, the American Hospital Association reported that a study published by the journal *Health Affairs* on July 7, 2004 indicated that hospital nurses working

shifts of 12.5 hours or more are three times more likely to make an error than nurses who worked shorter shifts. Data in the study was collected from 393 members of the American Nurses Association and they recorded hours worked, overtime, days off and sleeping patterns for 28 days. The data reportedly showed the nurses made a total of 199 errors and 213 near errors during the study period. Only 7 percent of the hours recorded involved mandatory overtime, suggesting that the errors might be even worse if more hours were added onto the 12.5-hour shifts.

Health care management's position. Health care managers take the position that mandatory overtime is a necessary tool to address the growing need for the adequate staffing of nursing professionals. They argue that without it, they will be left short-staffed on all units, especially and including the most critical care units, such as ICUs and emergency rooms. Lacking adequate staffing, hospitals will be forced to close and/or consolidate units, divert emergencies to other facilities, and lose positions as a result. The American Organization of Nurse Executives (AONE) state in their Policy Statement on Mandatory Overtime that, while the practice of using mandatory overtime is "widespread...at times, the stories (of abuse through mandatory overtime) have been overblown." Still, as a result of the negative impact mandatory overtime appears to have on the nursing profession and its image, AONE views the practice as a "last resort, limited to crisis situations" that would, without proper staffing, endanger the health and safety of patients.

The workforce's view on mandatory overtime. Nurses, professional nursing associations, and union representatives see and experience the mandatory overtime issue quite differently, and are in good part responsible for the push for the existing mandatory overtime statutes and legislation. They argue that the practice, and the resultant professional fatigue, stress, and poor health not only causes increased danger to patients, but to the health care workers themselves. Furthermore, these advocates of more reasonable hours insist that mandatory overtime is one of the overriding factors actually exacerbating the staffing shortages by making health care professions most undesirable for career seekers.

Finally, the advocates insist that other service professions, such as truck drivers, have mandatory overtime limits for safety reasons, and, therefore, so should health care professionals. This position has been further enhanced by the fact that, although the current anti-mandatory overtime laws and legislation do not apply to physicians, medical residents in the U.S. won a rather large victory in the reduction of their long hours. Often taking the form of multiple double and triple shifts across a pay period, resident shifts now are limited to no more than

80 hours per week, with minor exceptions as a result of new rules issued by the American Council for Graduate Medical Education (AGCME) in June 2002.

However, as a report from the American Federation of Nurses and Health Care Professionals acknowledges, all Americans are working far more hours than their European counterparts, and possibly, far more hours than they should be. Both of the nurse authors state under their bios that they have each had to work up to 18 hours at a time, sometimes for several weeks in a row. There is no sign of this changing in the direction of improved schedules anytime soon. A recent erosion of truck driver mandatory overtime protections by changes in DOL regulations permitting truck drivers to drive 11-hour shifts before being required to take a rest from the wheel instead of the previous 10-hour mandate further underscores the mixed and changing attitude at the federal government level toward safety as a priority in light of the growing shortage of trained truck drivers.

Management's attempts to control staff refusal of mandatory overtime. Efforts to control the growing resentment and refusal to perform mandatory overtime have been relatively unsuccessful. In addition to the increasing number of state and federal legislation to limit the reported abuse of health care professionals' time and sense of security, government officials and unions have begun to more aggressively demand enforcement and cooperation from health care management.

For example, Michigan Attorney General Jennifer Granholm in June 2002 ruled that a nurse's refusal to work overtime was not, standing alone, sufficient grounds for professional discipline in that state. The opinion was issued at the request of State Senator Bob Emerson. Emerson had asked whether the state's Public Health Code requires the Michigan Board of Nursing to discipline a nurse who turns down an employer's demand for overtime work. The Code does not give the Board of Nursing power to discipline a nurse for failing to work overtime, but rather, for failure to exercise due care or behave in ways that impair the safe practice of the nursing profession.

According to John Karebian, chief labor officer of the Michigan Nurses Association (MNA), healthcare organizations would rather use overtime instead of increasing wages and benefits or improve the healthcare work environment to attract additional nurses. Thus, overtime becomes a popular staffing mechanism. Many nurses work 12-hour shifts, and then are required to work an additional 4 hours after their shift ends, according to the MNA.

When nurses have refused to work such overtime, facilities have threatened to charge them with patient aban-

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donment. Such a charge can be used to justify suspension or revocation of a nurse's license. However, Granholm stressed that there is no section that specifically mandates a nurse to comply with an employer's demand to work overtime. Nor does the Code express that overtime refusal, without more, is a violation of the code. Granholm pointed out that each case deserves its own evaluation, and that a nurse could be disciplined for patient abandonment if she agreed to four hours of overtime and then left the premises 45 minutes after the overtime shift began. The ruling also does not protect a nurse from internal repercussions if he or she refuses overtime.

Nurses respond by taking more control. One of the ways nurses are taking back their time is by voluntarily terminating their employment within health care organizations and turning to staffing agencies to find them work in whatever medical setting they choose. Some nurses believe it is the only way they can continue in the profession given the some of the more stressful and unappealing aspects of nursing work, and highest among those aspects is mandatory overtime.

Over 110,000 nurses work as agency nurses, a 66 percent increase since 1996. By working with an agency,

a professional nurse regains some measure of control over his or her professional work- and home life. Not only can agency nurses pick the medical settings they want to work in, but they also can choose the days of the week and the number of hours worked. Thus, nurses avoid the multiple dilemmas, including higher risk of harm to patients, greater stress due to increased personal and family problems, and fatigue as a result of working too much mandatory overtime.

Other advantages include the avoidance of facility politics and a renewed sense of meaning from their work as a consequence of taking care of fewer patients. To add to the attraction, an agency nurse is paid, on the average, about 25 percent more than a staff nurse. Of course, there are drawbacks to this autonomy, including the loss of medical and health care benefit plans paid by the health care organization employer. Clearly, a surprising number of nurses and nurse assistants are willing to pay for their own or do without such benefits in exchange for greater control over their time and assignments.

Impact of the 2004 Fair Labor Standard Act (FLSA) changes.

While primary care, staff, LPNs, nursing assistants, and other non-executive nurses should have always been seen as non-exempt, and therefore paid at least time-and-a-half for overtime, the 2004 exemption status changes provided under the FLSA provides only minimum standards of protection for nonexempt employees. States can and often do exceed these standards and provide greater protections than those offered under federal law.

Health care employers in particular must take into account myriad state statutes that also govern the wages and hours of professional caregivers. State laws vary considerably in this area, ranging from maximum hour restrictions for in-house companions employed by third-party employers to bans on mandatory overtime for nurses in acute-care facilities. Employers must implement the new federal wage-hour rules with an eye to the

patchwork of state laws that may also apply. However, it should be noted that the problems and complaints stemming from the use and reliance upon mandatory are not focused on improper pay practices for overtime worked. Rather, the emphases for concern are patient and health care worker safety, reduction of staff stress, and staff contentment.

Understand the origins, develop a solution. Before succumbing, or seeing an organization succumb, to one or more of the health care staffing dilemmas, it would behoove health care managers to evaluate the origins of these dilemmas without bias for their own position. Health care organizations must face the fact that some of the problems they are currently enduring have been wrought by that very management philosophy and corresponding conduct from decades past. Given that the average age of nurses in medical-surgical units is now 47, where in the 1970s it was 28, two phenomena can possibly be sited as the genesis for the health care staffing crisis.

Moreover, professional nurses began to hear a familiar refrain from a management that said to them: "Your services are no longer needed." In the name of cost efficiency, one nurse per shift became "the company line" as all that was necessary to provide quality care, and the other job positions once held by RNs and LPNs could be filled by the much less expensive nursing aides. Accordingly, nurses were laid off and replaced. Many of them left the field in response, and only some have since returned.

No easy answers. According to some authorities, creating a "culture of retention" is key. Good compensation helps, but it is far from the only priority nurses have in deciding where to work, or even whether to remain in nursing. A study by the University of Washington revealed that, of the 17 percent of respondents who raised salary as an important issue for the recruitment and retention of nurses, none stated that higher salaries were

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On The Front Lines (Cont.)

as effective for good recruitment and retention as other approaches. Other elements that the nurses indicated they look for when in a healthcare organization were:

- the healthcare organization's promotion of teamwork;
- the creation of a positive nursing environment;
- a reduction of the patient-nurse ratios to a manageable patient load level;
- making full use of a nurse's capabilities; and
- rewarding nurses with more decision-making authority.

According to the president of the American Nursing Association, Barbara Blakeney, employers need to "create a work environment that addresses the stress and strain of the job through a wholesale rethinking of their expectations. Nurses should have a say in setting appropriate work levels and reducing mandatory overtime."

Becoming the "employer of choice" also goes a long way to enhance recruitment and retention, thereby reducing the impact staff shortages have on at least

an individual facility basis. Employers of choice rarely rely on "mandatory" policies on anything that can be better addressed through cooperation, conciliation, and collaboration. Nursing managers even in these institutions acknowledge that failure to have mandatory overtime as an option will lead to short staffing of units, causing higher pressure on the existing shift nurses. Units may have to be closed in states where mandatory nurse-to-patient ratios exist. Emergency rooms may have to divert.

However, health care employers of choice are learning to adapt by creating incentives for nurses and nursing assistants to work at least some of the needed hours, including the use of clear career ladders so that nurses know their hard work will be rewarded both financially and with professional growth.

In order to deal with the health care staffing dilemma, one thing is clear: there will be no shortage of the need for creative and collaborative thinking on the parts of both health care management and health care, specifically nursing professionals. Perhaps both management and workers are partially

responsible for failing to realize that human "resources" are finite by design—requiring 8 hours of sleep, adequate nutrition and hydration, adequate rest and recreation, and spiritual renewal in order to provide peak job performance day after day. Once that profoundly necessary realization is made, then, like all necessities, newer and better health care human resource "inventions" will follow, and such turmoil-generating solutions like mandatory overtime will be, happily for both sides, replaced - and not a moment too soon for patients, health care workers, and their managers.

Judith Tichenor is the senior planning giving officer at the Children's Memorial Hospital Foundation in Chicago, Illinois. She is also an attorney writer/analyst who has served in both the health care and outpatient psychiatric fields as clinical social worker for over 23 years. She practiced as an attorney for seven years concentrating in employment law, workers' compensation, and mental health law. She also served as a medical social worker, volunteer coordinator, and bereavement program director for the first JCAHO-accredited, Medicare-certified home health hospice in the United States.

Quality of Care

Initiative posts new quality measures to web site by Gene' Stephens, J.D.

New hospital quality measures regarding surgical infection prevention and pneumonia deterrance and treatment have been posted to a web site which reports on the quality of local hospitals to provide consumers with improved information when making decisions about their care. The web site, updated and approved by the Centers for Medicare and Medicaid (CMS) and the Hospital Quality Alliance (HQA), now provides a total of twenty quality measures, which also include ten "starter

set" clinical measures that short-term acute care hospitals must agree to report publicly in order to receive incentive payments created by the Medicare Modernization Act (PubLNo. 108-173). The latest surgical infection prevention measures are part of a larger set of patient safety measures that will be collected as part of the Surgical Care Improvement Project, which was designed to improve patient safety, as well as reduce the incident of postoperative infections and complications by twenty-five percent by the year 2010 in all of the nation's hospitals.

Increase in hospital participation. Several hospitals have increased the amount of information they provide to CMS and HQA on qual-

ity of care measurements, as over 90 percent of the participating hospitals are reporting on at least ten measures, and over 70 percent are reporting on 17 of the quality measures. Of the hospitals reporting on the measurements, twenty percent of the facilities took the lead in reporting on patient safety regarding the new surgical infection prevention measures. In addition, over 450 critical access hospitals have submitted data, resulting in an eleven percent increase in reporting.

A complete list of the 20 quality measures is available at www.hospitalcompare.hhs.gov.

CMS Release, Sept. 2, 2005.

Health Care Compliance Portfolio Story Suggestions

CCH's Health Care Compliance Portfolio group welcomes any story ideas or suggestions you may have. Please contact Jeff Reinholz, Managing Editor reinholj@cch.com with your ideas.

Tax Exempt

Hospital exemption definition modified by Larry Perlman, J.D., LL.M, C.P.A.

A revenue notice has been amended to further clarify the term “hospital” for purposes of the Minnesota sales and use tax exemption for purchases used in providing hospital services. Hospital components, such as clinics, rehabilitation centers, and outpatient surgical centers, must be approved as charitable

Code Sec. 501(c)(3) in order to qualify for the exemption. Rural health clinics may qualify for the exemption if approved by the Centers for Medicare and Medicaid Services as provider based.

An exempt hospital and a nonprofit unit that is operated exclusively for charitable purposes may be part of the same legal entity. Examples include nursing homes, assisted living facilities, or independent living facilities. A legal entity that includes a nonprofit unit and a hospital may not meet the requirements for the nonprofit exemption. However, when a legal entity

contains either an exempt hospital or a nonprofit unit, it may claim the hospital exemption on purchases for both the hospital and the nonprofit unit, as long as the nonprofit unit meets the requirements for charitable organizations under the applicable Minnesota regulation.

A nonprofit unit is not required to apply for nonprofit exempt status when it is part of the same legal entity as the qualifying hospital.

Revenue Notice No. 98-02, Sales and Use Tax-Hospital Exemption, Minnesota Department of Revenue, Modified July 5, 2005

Fraud and Abuse (cont.)

§ 18 U.S.C. § 1001(a)(2) and U.S.C. § 1001(a)(3). Further, the statutory elements differ between the two statutes. Under §1001, the government must prove that the act was done under the jurisdiction of the federal government, while under §1035, the government must prove the act was done in a matter involving a health care benefit program in connection with the delivery or payment of health care benefits. In addition, Congress intended that conduct be punishable under both statutes because it was well aware of §1001 at the time that it passed §1035 and did not suggest in anyway that the two statutes could not be applied together. The magistrate judge also properly rejected the director's motions to dismiss counts related to 18 U.S.C. § 1001 on grounds that the government failed to allege that the director intended any falsification or concealment to bear a relation or a purpose to some matter within the jurisdiction of the government. A particular state of mind is not necessary and knowledge of federal agency jurisdiction is not required.

United States v. Dose U.S. District Court for the Northern District of Iowa, July 28, 2005

Not charging jury with amount of loss warrants new trial

by Andra Popa, J.D., LL.M

A licensed clinical counselor who was convicted of mail fraud, wire fraud, and health care billing fraud was granted a new trial because the jury was not charged with calculating the amount of loss caused by the billing fraud, resulting in the violation of the counselor's Sixth Amendment right to a trial by jury. Under *Blakely v. Washington* and *United States v. Booker* (see ¶ 800,023), determinative factual issues at trial must either be admitted by a defendant or found by a jury beyond a reasonable doubt or the conviction and subsequent sentencing will violate the Sixth Amendment right to trial by jury. Because the jury was not instructed

to calculate the amount of loss, two factors improperly impacted its determination. First, the testimony of a special agent from the Federal Bureau of Investigation that estimated the financial loss caused by the counselor's alleged billing fraud amounted to over \$1 million dollars was poorly calculated and unsupported. Second, the special agent's flawed estimate likely had a powerful emotional impact on the jurors, many of whom likely believed that billing fraud contributes to higher premiums for their own health insurance. The determination of the financial loss should have been submitted to the jury as it is intertwined with the jury's consideration of guilt or innocence as well as sentencing. The counselor's motion for an acquittal due to insufficient evidence was denied without prejudice. Unless the trial court holds otherwise, the counselor and the physician who owned the psychiatry/psychotherapy practice should be tried together.

United States v. Williams, U.S. District Court for the Northern District of Ohio, Feb. 4, 2005

HIPAA Security Guide

One of the most important facets of healthcare compliance is the challenge of being compliant with the Health Insurance Portability and Accountability Act (HIPAA). CCH's *HIPAA Security Guide* is designed to be an expert yet straightforward resource to help you meet the HIPAA compliance challenge.

Electronic forms and news updates available over the internet

The *HIPAA Security Guide* is not limited to print only, but delivers the power of an online research tool as well. It delivers current HIPAA news and updates while the online research tool provides forms to assist in developing policies and procedures, targeted for HIPAA compliance.

