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Senate approves recommendations to cut Medicare, Medicaid

by John Scorza, Contributing Editor

The Senate approved a budget blueprint that recommends various enhancements to Medicare and Medicaid as well as a series of cuts to the programs, resulting in an overall savings of approximately $10 billion over five years. Supporters of the measure say the cuts will not result in decreased coverage for beneficiaries. The Senate passed the legislation (S. 1932) by a 52-47 vote on November 3.

Spending cuts. The legislation contains prescription drug payment reforms, including a new definition of average manufacturer price to reflect discounts and rebates available to retail pharmacies, and a new federal upper limit for payments to states for covered drugs that goes into effect January 1, 2007. The legislation would tighten Medicaid asset transfer rules and contains enhanced third-party recovery and state incentives to use the False Claims Act to combat fraud and abuse.

Projected savings. The bill would result in Medicare savings through changes to Medicare payment policies that would encourage and reward quality patient care while controlling rising health care costs. The legislation would achieve savings through the repeal of the regional Medicare Advantage Preferred Provider Organization (PPO) stabilization fund, which was established to promote plan entry and retention in the Medicare Advantage program. Additional savings would be realized by modifying the risk-adjusted payment system to Medicare Advantage plans.

Amendments approved. The Senate approved an amendment to the bill that would ensure that 30 states do not realize a significant reduction in federal funding next year by limiting funding cuts to one-half a percentage point. Another Senate-approved amendment would exclude discounts provided to mail order and nursing facility pharmacies from the determination of average manufacturer price and extend the discounts offered under fee-for-service Medicaid for prescription drugs to managed care organizations.

Meanwhile, the House Budget Committee on November 3, 2005, approved its version of the legislation, which recommends approximately $10 billion in savings over five years primarily by slowing the growth of Medicaid. The package includes reforms to Medicaid's reimbursement for prescription drugs and a tightening of the Medicaid rules dealing with asset transfers as a qualification of eligibility for Medicaid long-term care. It modifies the current requirements for cost-sharing in Medicaid by increasing co-pay requirements. House leaders expect to take the legislation to the House floor soon. ■

CCH Washington Bureau, November 3, 2005.

Ensuring compliance is effective response to unionizing campaigns

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

Compliance officers and consultants may question the role that they should play when a health care entity is the subject of a union campaign to organize health care workers, also called a "corporate campaign." G. Roger King, a partner in at Jones, Day whose practice is devoted to representing employers in employment relations matters, warned that compliance officers may want to exercise caution in discussions among managers and supervisors regarding union activities, because (1) the meaning of supervisor is unclear and (2) 60 courts are currently trying to determine the general nuances of this term, and they are mainly health care cases.

King stated that compliance officers should consider the following additional items during a corporate campaign:

- do not spy or survey employee union activities and do not question anyone on this topic;
- obtain information as to corporate campaigns in a lawful manner;
- know what hot buttons and points unions are pursuing to further their organizing interests, such as a potential whistleblower plaintiff, and ensure that these areas are compliant and not vulnerable to attack;
- ensure that items appearing on the Form 990, which is available to the public, are effectively explained and properly structured; and
- act quickly to get the appropriate department involved, such as human resources or the legal department.

Particular pressure points that Mr. King identified were the following:

- executive pay practices (available to the public on Form 990);
- billing and collection activities;
- whistleblower suits.

Hospitals and health systems should also ensure that policies are established as to computer use, instant messaging, and blogging, King added. ■

CCH Chicago Bureau, August 11, 2005.

Lack of facts undermines case on uninsured charges

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

A lawsuit filed by an uninsured patient of a non-profit, tax-exempt hospital was dismissed on all federal counts because the patient alleged claims that she could not support factually. The patient alleged that the hospital charged the uninsured rates that were significantly higher than the rates charged insured patients or patients covered by Medicare and Medicaid and collected inflated charges from the uninsured through aggressive measures.

"Section 501(c)(3) does not create an implied public charitable trust to provide affordable medical care when [the hospital] accepted tax-exempt status."

The individual claimed that due to the hospital's Section 501(c)(3) tax-exempt status under the Internal Revenue Code, the hospital entered into an express or implied contract with the United States government, the state in which she resides, and local state government entities.

The patient further alleged that, under this express or implied contract, the hospital agreed to provide affordable medical care to all patients, not to use aggressive debt collection practices, and prevent any private entities from profiting from the hospital's healthcare operations. This claim was barred because such a contract cannot be entered without the authorization of the secretary of the Treasury and the U.S. Attorney General, and the uninsured individual could not produce legal support for her views.

The uninsured individual also claimed that the hospital violated the Emergency Medical Treatment and Active Labor Act (EMTALA) because the hospital required her to sign a form prior to treatment that expressly stated that she agreed to pay all charges. A hospital may follow a reasonable registration process, including asking whether an individual is insured if the inquiry does not delay the screening or treatment of the patient (see 42 C.F.R. Section 489.24(d)(4)(iv)). Therefore, the hospital's registration process was reasonable and did not violate EMTALA. Jurisdiction over the remaining state law claims was not exercised. ■

Feliciano v. Thomas Jefferson University Hospital, U.S. District Court, Eastern District of Pennsylvania, No. 04-CV-04177, Sept. 28, 2005, CCH Health Care Compliance Reporter, p800,045.

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IRS officials highlight form changes for tax exempts

by Andrew Maschas, Contributing Editor

Marvin Friedlander, an Internal Revenue Service (IRS) exempt organizations Technical Manager for industry professionals that his office is now developing ways to increase compliance for tax exempt organizations. Initiatives include revamping several forms. Friedlander spoke at a heath care conference in Arlington, Va. on October 24, 2005.

Revised forms. Updates to Form 1023, the application for 501(c)(3) status, were made to make it more aggressive in determining compliance by alerting entities as to the most important tax rules regarding 501(c)(3). The IRS is also revamping Form 990. The form will focus specifically on providing detailed information on an organization's compensation, governance policies, auditing practices, conflicts of interest, professional fundraising, and contributions of non-cash property. This new form is scheduled to be in circulation by the end of calendar year 2006.

Focus on compensation. Cathy Livingston of the IRS noted that the IRS focus will be on compensation, specifically Code Sec 4958, Taxes on Excess Benefit Transactions (EBT). She pointed out that several outcomes can occur if the IRS determines that an EBT has occurred. First, the IRS will go after the individual who received the EBT; depending on circumstances, this will not affect the exempt status of the overall organization. However, sometimes circumstances will exist where the IRS will commence revocation actions to revoke the 501(c)(3) status of an organization for serious violations of excessive compensation.

Revoking 501(c)(3) status. Livingston listed the non-exclusive factors the IRS will consider when revoking 501(c)(3) status. These factors include the size and scope of the organization's regular non-profit activities; the size and scope of the EBT in relation to the size and scope of non-profit activities; whether the EBT is an isolated incident or the product of repeated transactions; the safeguards implemented by the organization to prevent EBTs; and whether the organization has self corrected or has sought correction of the error.

She mentioned that these factors are useful in several instances, such as advising a client even if there is no IRS involvement to put the organization on notice of the guidelines and also that it is useful if under investigation to gather evidence demonstrating that these factors have been complied with to the best of the organization's ability. This is important to remember because the IRS agent is also bound by these factors when determining if an organization's status should be revoked. ■

CCH Washington Bureau, Oct. 24, 2005.

IRS focus on non-profit executive compensation for 2006

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

Tax-exempt hospitals will be part of a new critical initiative outlined by the Internal Revenue Service (IRS) in 2006, according to newly released IRS Implementing Guidelines. The IRS is considering a compliance project that analyzes (1) the manner in which executive compensation is calculated; and (2) how charitable care requirements are calculated. The Exempt Organizations Compliance Unit (EOCU) would send compliance check letters to a significant number of hospitals requesting that they answer questions as to these areas, as well as other possible issues.

The IRS also will focus on potential issues related to the tax-exempt status of bonds. Specifically, the IRS will review tax-exempt bond issuances by 501(c)(3) entities for possible violations of private benefit rules. In a cover letter to the guidelines, Martha Sullivan, the Director of Exempt Organizations (EO), discussed a shift toward enforcement that began in 2005, stating that "a stronger enforcement presence will enable the EO to better target and address abuses in the tax-exempt sector, one of four [IRS]-wide strategies."

IRS Letter and Fiscal Year 2006 Exempt Organizations Implementing Guidelines, October 2005.

We've complied with HIPAA; now what? Preparing for and responding to HIPAA-related complaints and government investigations- Part I

by W. Andrew H. Gantt III, J.D. and Anthony B. Casarona, J.D.

Covered entities, which include health plans, healthcare clearinghouses and certain healthcare providers, should now have in place HIPAA compliance programs including comprehensive privacy and security policies and procedures. However, even the most well thought out compliance programs will be susceptible to gaps that could be the basis for HIPAA-related complaints and government investigations. Accordingly, as the government's attention moves from HIPAA implementation to enforcement, covered entities' compliance programs should include procedures for responding to complaints and government investigations in order to minimize their potential liability. Part I of this article provides a general overview of the HIPAA enforcement process and identifies certain key elements of an effective HIPAA compliance program to respond effectively to a patient or customer complaint. Part II, appearing on December 12, 2005, discusses government investigations and what to expect following a government investigation.

The HIPAA Enforcement Process

For the past three years, the Department of Health and Human Services ("HHS") [1] has emphasized that HIPAA enforcement will be a "complaint-driven" process which will consist of progressive steps that will provide opportunities for covered entities to demonstrate compliance or submit corrective action plans.[2]

For covered entities, HHS' complaint-driven approach to enforcement has meant that, in general, HIPAA enforcement actions will originate as a result of disgruntled patients, employees or others with whom a covered entity has relationships. However, in its most recent proposed rule regarding HIPAA enforcement (the "Enforcement Rule"), HHS has reserved the right to conduct compliance reviews of any covered entity on its own initiative without any specific complaint.[3] Under this scenario, HHS would request, and the covered entity would be obligated to provide, documentation regarding its policies, procedures and practices, and access to its facilities, books, records, accounts and other sources of information, including PHI, that are pertinent to ascertaining the covered entity's compliance with HIPAA.[4]

Thus, while the government's position appears to be that its enforcement efforts will be tied predominantly to third party complaints, covered entities must be prepared for and have policies and procedures in place to ensure that they are complying with HIPAA's requirements and which address, not only complaints from third parties, but also government audits.

Establishing a first line of defense: Implementation of policies and procedures

The complaint-driven enforcement process adopted by HHS highlights the importance of comprehensive compliance programs as a covered entity's first line of defense for reducing exposure and risk under HIPAA. To this end, covered entities can decrease the probability of complaints arising with an effective overall HIPAA compliance plan, and reduce the likelihood that any complaints that do arise will lead to significant penalties and fines with a well thought out policy for responding to complaints and government investigations.

As a preliminary matter, all covered entities should now have in place privacy and security policies and procedures focused on preventing unauthorized use and disclosure and protecting the security and integrity of protected health information ("PHI"). These policies and procedures are the foundation of a covered entity's HIPAA compliance plan and, if implemented properly, will go a long way towards making sure that the covered entity is prepared to react swiftly if and when problems do arise.

Training. One key element of an effective HIPAA compliance plan is training. Covered entities are required to train each member of their workforce on the requirements of the Privacy Rule and Security Rule as well as the covered entity's policies and procedures. While there may be a tendency to

view this requirement as an administrative, time-consuming burden, it is critical that covered entities recognize the importance of this element of their compliance plan. Having a well trained workforce is one of the most effective risk management tools at a covered entity's disposal since these are the individuals who will be handling PHI and, thus, the likely source of any breach, whether inadvertent or intentional, that may arise. As such, training should not be viewed as a one-time effort to satisfy HIPAA's requirements. Rather, training should be an on-going process designed to keep a covered entity's workforce abreast of the results of, and modifications to, its compliance plan. This will ensure that as the covered entity responds to gaps in, and growing pains associated with, its initial HIPAA compliance efforts, its workforce is fully educated and prepared to act in a manner that reduces, not increases, the covered entity's liability exposure.

"Performing internal and external audits on a regular basis will help a covered entity identify gaps in its compliance plan which need to be addressed to reduce the occurrence of events which may form the basis of a complaint."

Sanctions policy. Another critical element of a good HIPAA compliance plan is an effective sanctions policy. A covered entity must develop and apply sanctions, which may range from warnings and reprimands to termination, for failure to abide by the covered entities privacy and security policies and procedures.

Audits. Finally, audits (both internal and external) and documentation are other tools that covered entities can use to their advantage in the event that they are faced with a complaint or government investigation. Performing internal and external audits on a regular basis will help a covered entity identify gaps in its compliance plan which need to be addressed to reduce the occurrence of events which may form the basis of a complaint. Moreover, if, through regular audits, a covered entity can demonstrate that its compliance plan is working, it increases the likelihood that a problem that does arise will be viewed as an isolated incident rather than a pattern of bad conduct. Similarly, if a covered entity maintains thorough documentation of its HIPAA compliance efforts, including, among other things, accurate and up-to-date disclosure logs, policies and procedures, training logs, and steps taken and money spent to implement its compliance plan, this could be used to demonstrate that a single event resulting in a complaint is not part of a more wide-spread compliance deficiency.

Process. In addition to the core privacy and security policies and procedures that covered entities must adopt to demonstrate compliance with HIPAA, they must also have a process in place for individuals to file complaints and for documenting and dispensing of complaints when they arise. Specifically, covered entities must designate an individual to receive and respond to complaints (e.g., privacy or security officer), have policies and procedures for responding to complaints in a fair, confidential and non-retaliatory manner, and document the resolution of, and any corrective action taken in response to, complaints.

Policies. In terms of a covered entity's policies for addressing complaints, two items are of particular importance. First, it is important to recognize that disgruntled individuals may file complaints either directly with the covered entity or with the Office for Civil Rights (OCR) or CMS. Thus, there is a great incentive for a covered entity to ensure that individuals know the covered entity is available to receive complaints and that members of its workforce will work diligently with the individual to resolve complaints before they are elevated to OCR or CMS. Of similar import, is that the covered entity document all privacy complaints, including the nature of the complaint, investigative findings (i.e., whether a violation occurred), a description of corrective action taken or why no corrective action was necessary, and any measures taken to mitigate the effects of a violation found as a result of a complaint. This documentation will be invaluable in the event that the government gets involved in a particular matter. However, it will also allow a covered entity to review and trend complaints to make sure that any gaps in its compliance program are being adequately addressed.

What to do when problems arise

Once you have implemented your policies and procedures, established a process for responding to complaints and accumulated pages of documentation, you may receive a patient complaint or, worse, notice of a government investigation. The first step in responding to a complaint or investigation is to remember that, as a result of your diligence and preparation, you have a plan. Now you just need to carry it out and, in doing so, be mindful of several important points.

As a preliminary matter, upon receipt of a complaint or notice of a government investigation, covered entities must determine when and to what extent to involve outside legal counsel. Generally, in-house counsel should be notified upon receipt of any complaint or notice of government investigation, which will allow the covered entity and its counsel to assess quickly the severity of the matter, the proper course

On the Front Lines

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of action and the need for outside legal assistance. The extent to which a covered entity will need to involve outside legal counsel will be case-specific, but will likely be significant in cases where the covered entity receives a complaint suggesting that the covered entity has engaged in intentional wrongdoing or a particularly egregious breach of privacy (e.g., disclosures for pecuniary benefit of the covered entity or others) or a notice of an investigation by OCR, CMS, or any other governmental authority.

Third Party Complaints

Response team. If a complaint is received from a third party, such as a patient or employee, it is in the covered entity's best interest to promptly and thoroughly investigate and respond to the complaint. While there can be no assurance that dissatisfied complainants will not turn to the government for help, they will be less inclined to do so immediately if they feel that the matter is being addressed by the covered entity.

Upon receipt of a complaint, the privacy or security officer, as applicable, should establish a response team and immediately begin a formal investigation. The complainant should be contacted as soon as possible following receipt of the complaint and told that the matter is being investigated internally. Additionally, the process (at least in general terms) and timing for investigating and resolving the complaint should be explained to the complainant at this time.

If, at the conclusion of the covered entity's investigation, it is determined that there was not a violation of HIPAA or the covered entity's policies and procedures, the complainant will be notified of the investigation findings and provided with an opportunity to respond. If the complainant does not appear to be satisfied with the disposition of the complaint, the covered entity should consult with its legal counsel to determine whether any additional steps should be taken.

If, at the conclusion of the covered entity's investigation, it is determined that there was a violation of HIPAA or the covered entity's policies and procedures, the covered entity should develop a corrective action plan, which may include, among other things, appropriate workforce training, sanctions, steps that will be taken to mitigate the harmful effect of any unauthorized use or disclosure of PHI and changes to the covered entity's policies and procedures, if necessary, to ensure that similar violations do not occur. The complainant should be notified in writing of the investigative findings and the resulting corrective action plan. Again, if the complainant does not appear to be satisfied with the disposition of the complaint, the covered entity should consult with its legal counsel to determine whether any additional steps should be taken.

"...in-house counsel should be notified upon receipt of any complaint or notice of government investigation, which will allow the covered entity and its counsel to assess quickly the severity of the matter, the proper course of action and the need for outside legal assistance."

If, after investigating a specific complaint regarding an unauthorized use or disclosure of PHI, the covered entity determines that additional individuals may have been affected, the covered entity should identify the affected individuals, and consider whether its duty to mitigate any known harmful effect includes an obligation to notify these individuals that the privacy or security of their PHI has been breached. While this is a matter that should be discussed with outside legal counsel, it should be noted that an effective corrective action plan may negate the need to notify each affected individual.

Document investigation. Finally, and most importantly, every step in the complaint resolution process should be documented and maintained by the covered entity. Specifically, the covered entity should document the initial complaint, any conversations with the complainant or other affected parties, the investigative process and findings, any corrective action plan and any subsequent communications where the complainant expressed satisfaction or dissatisfaction with the resolution of the complaint. ■

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1 Within HHS, the authority for administering and enforcing compliance with the Privacy Rule has been delegated to the OCR and responsibility for administering and enforcing the Security Rule has been assigned to the Centers for Medicare & Medicaid Services ("CMS").

2 See Civil Money Penalties: Procedures for Investigations, Imposition of Penalties, and Hearings: Interim Final Rule, 68 Fed. Reg. 18,895, 18,897 (April 17, 2003); HIPAA Administrative Simplification; Enforcement: Proposed Rule, 70 Fed. Reg. 20,224, 20,226 (April 18, 2005).

3 Id. at 20,226.

4 45 C.F.R. § 160.310.

Trends

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Claims of unfair debt collection practices sustained

by Gene' Stephens, J.D.

Uninsured patients' claims that the debt collection practices of a group of hospitals violated the Fair Debt Collection Practices Act (FDCPA) was sufficient to sustain a claim because the patients pled sufficient facts to allege the debt collector status of the hospitals.

The patients claimed that the hospitals acted as debt collectors because of their attempts to collect debts through an agency that was alleged to have created the false impression that the debts were being pursued by a third party.

The hospitals argued that the patients failed to state a claim for relief under the FDCPA and that the hospitals did not constitute debt collectors within the meaning of the Act because their primary function was to provide health care and not the collection of bills.

The FDCPA prohibits deceptive and misleading practices by debt collectors who collect the debts due to another, but deems a creditor a debt collector when the creditor attempts to collect its own debts by using a name other than its own to indicate that a third person is collecting the debt. The hospital's use of a different name to collect debts on its behalf fell within the reach of the FDCPA because a less sophisticated consumer would be led to believe that the agency was a third party acting on behalf of the hospitals. Therefore, the hospitals' motion to dismiss was denied.

Carlson v. Long Island Jewish Medical Center, U.S. District Court, Eastern District of New York, CV-04-3086, July 11, 2005, CCH Health Care Compliance Reporter, 800,044.

Patient's EMTALA claim sustained due to likely deterioration of health

by Gene' Stephens, J.D.

A patient's claim that a hospital violated the Emergency Medical Treatment and Assisted Labor Act (EMTALA) when she was discharged from the hospital without receiving proper stabilization for her high blood pressure was upheld because the patient raised substantial issues of material fact regarding whether she was released at a time when deterioration of her condition was likely.

EMTALA requires hospitals to provide medical examinations and treatment to stabilize a patient's medical condition and prohibits a hospital from discharging a person with an emergency medical condition before stabilization. Testimony on behalf of the plaintiff revealed that the hospital's emergency room doctors failed to take specific steps to stabilize the patient's blood pressure before she was released.

Additionally, the emergency department's nursing records indicated that the patient suffered a fall and her blood pressure readings were heightened prior to her discharge. The emergency department also ordered an ambulance to transport the patient home, which raised more questions regarding the stability of the patient's condition. The patient's negligence claims did not withstand the hospital's motion for summary judgment, however, because the patient failed to present a factual basis for her claim of direct corporate liability of the hospital's failure to train its personnel or failure to establish procedures for its emergency department.

Love v. Rancos Hospital, U.S. District Court, District of New Jersey, No. 01-5456, June 29, 2005, CCH Health Care Compliance Reporter, p800,031.

Attachment standards promote use of electronic claims

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

Covered entities requesting and providing additional clinical information related to providers' claims for services would be required to use the Health Insurance Portability and Accountability Act (HIPAA)(PubLNo 104-191) standards when conducting an electronic transaction, under a proposed rule published Sept. 23, 2005. Covered entities would be required to comply with the standards for electronic healthcare claims attachments 24 months from the effective date of the final rule, while small health plans would have 36 months from the effective date of the final rule to comply.

The proposed rule suggests that the following be adopted: (1) standards for the content; (2) standards for the format of communicating clinical information; and (3) Logical Observation Identifiers Names and Codes (LOINC) for the specific identification of additional information being requested as well as the coded answers that respond to the requests. The final rule will not be implemented for several years. The purpose of the set of standards is to improve the claims adjudication process when additional information is required. Comments from the public are requested and must be received no later than November 22, 2005.

Proposed rule, 70 FR 55990, September 23, 2005, CCH Health Care Compliance Reporter, 730,002.

In the News

Hospital denied wage data corrections

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

A district court properly denied summary judgment to a hospital seeking an award of an adjusted reimbursement reflecting the reclassification of the hospital to a different Metropolitan Statistical Area (MSA). The district court is barred under Medicare law from overturning the Secretary's reclassification decisions; it also lacks jurisdiction to order the reclassification based on the wage data or an adjusted reimbursement payment.

While the hospital's separate application for reclassification to a different MSA was dismissed, a group application in which it participated was granted. Because the Secretary failed to make timely corrections to wage data that the hospital submitted, the hospital received a substantially lower level of reimbursement. Therefore, the hospital brought suit to obtain the balance.

In response, the Secretary denied the hospital the wage data corrections sought. On appeal, the district court noted that the Secretary acted arbitrarily and capriciously in its denial and that the hospital's wage index should be revised and its Medicare reimbursement recalculated. Yet, the district court determined that its review was precluded by the Secretary's policy that it will not consider revised wage data to revisit past adjudications of requests for geographic reclassification. The district court's motion for summary judgment was affirmed. ■

Palisades General Hospital v. Leavitt, U.S. Court of Appeals for the District of Columbia, Oct. 14, 2005, CCH Health Care Compliance Reporter, p800,048.

State circuit court grants class certification on behalf of uninsured patients

A state circuit court judge certified a class in a suit filed on behalf of thousands of uninsured patients. The suit alleged that the one of Oregon's largest hospitals consistently overcharged the uninsured by billing them higher rates.

Turner v. Legacy Health System, Circuit Court of the State of Oregon, Fourth District, Oct. 4, 2005.

Long term regulatory plan for Stark on HHS agenda for 2006

All HHS rulemaking actions under development or review, including all the proposed rules and final rules that CMS expects to issue in the next 12 months, have been itemized in a semiannual publication. CMS expects to issue about 30 proposed rules and about 23 final rules during this time period. CMS is also developing 31 long-term regulatory plans, one of which relates to the Stark laws.

Semi-Annual Inventory of Rulemaking under Development, Notice, 70 FR 64554, Oct. 31, 2005, CCH Health Care Compliance Reporter, p760,009.

Overview of antitrust actions in health care services and products discusses activity

An overview of the Federal Trade Commission's (FTC) antitrust actions involving providers of health care services and products has been issued in a report by the Health Care Services and Products Division of the FTC's Bureau of Competition.

Federal Trade Commission Report, Oct. 1, 2005, CCH Health Care Compliance Reporter, p680,004.

Provider failed to exhaust remedies

A district court lacked subject matter jurisdiction to require CMS or the intermediary to reopen a hospital's cost reports because the hospital did not exhaust its administrative remedies by failing to pursue the Provider Reimbursement Review Board appeals available related to the cost reports in question.

Michael Reese Hospital and Medical Center v. Thompson, U.S. Court of Appeals for the Seventh Circuit, No. 04-2839, Oct. 14, 2005, CCH Health Care Compliance Reporter, p800,049.