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Experts stress importance of documenting observational status

by Catherine Hubbard, M.A., Contributing Editor

Hospitals can expect heightened scrutiny on patient observational status as a result of a 2005 CMS announcement that it had uncovered $9.5 billion in fraud related to lack of medical necessity. According to Dr. Joseph Zebrowitz, executive vice president of Executive Health Resource, a team of physician advisors located in Newtown Square, Pennsylvania, one of the outcomes of this finding is that now hospitals must make a determination of patient status prior to discharge. "That is not going away," said Zebrowitz.

Hospitals must have a tight process in place to determine whether a Medicare patient's status should be classified as observational or inpatient for reimbursement purposes, according to experts who spoke during a recent presentation. The process must apply consistent policy to each and every case, seven days a week, the experts said. "This is truly the core value of any good compliance program," stressed Dr. Robert Corrato, chief executive officer of Executive Health Resource during an October 10, 2006, audio conference held by the Healthcare Financial Management Association.

Financial implications. According Zebrowitz, "Most people doing utilization review have not been educated as to the financial implication." One mistake a day in classifying patients can cost hospitals up to $1.7 million annually. Zebrowitz noted that the average inpatient diagnosis related group (DRG) is $5,100, while the average observation reimbursement is $400. "It's a small mistake every day that adds up," he said. Based on audit results of 16,000 cases at 80 institutions, observation was overused on average 45 percent of the time, he said.

On the other hand, patients incorrectly classified as inpatient represent a compliance risk, Zebrowitz said. In an audit, hospitals will get penalized for inappropriate one-day stays but not rewarded for under billing on inappropriate observation, he noted.

"The key to getting it right is the process," Zebrowitz said. Reviewing cases seven days a week might mean hiring someone for a few hours on weekends to review hospital admissions, he advised. Hospitals also must keep on top of changing CMS rules and regulations and incorporate "guidance" into policy and procedures, he said. Corrato added that a process in place five days per week will only be about 71 percent compliant.

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Wolters Kluwer Law & Business

Documentation. Whether it's observation or inpatient, the goal is to have each case contain documentation that will stand up to external scrutiny. "You can't leave this up to chance," Zebrowitz said.

Corrato noted that when a physician orders that a patient be placed under observation, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission.

Thus, a patient in observation may improve and be released, or be admitted as an inpatient, he said. A physician should be able to make the decision within a day regarding whether the patient should be admitted. A two-day observation "is an oxymoron," he said.

The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician, Corrato explained. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care, he added.

Physician advisors. Hospitals should use a physician expert to increase compliance, Zebrowitz suggested. The physician advisor is a physician who has expertise not only in clinical medicine, but managed care, guidelines, and CMS regulations. The advisor should be available every day, should have a team approach, should consistently apply hospital policy to medical necessity, and should have oversight and accountability, he said.

Zebrowitz outlined how the process should work. When a patient is admitted to the hospital, case management should apply the criteria to each case. If the case does not meet inpatient status, it should be referred to the physician advisor. The advisor, who reviews the case, speaks with the physician if needed, formally documents the conversation and case review on the utilization review form, and works with the physicians to facilitate discharge or placement if admission is appropriate.

"Every Medicare admission has to go under this process. There are millions of dollars at stake," he said. He noted that he was referring to medical patients, not surgical patients. "Surgical observation has a different set of rules," he pointed out.

Corrato also outlined some common mistakes in classifying patients for "observation." He provided the following examples of cases that should have been classified as inpatient admissions:

- A patient who has failed intense outpatient therapy (e.g. asthma, nausea/vomiting). If treatment fails, "the decision is either home or inpatient; not observation."
- A patient who comes in for an emergent procedure that is done normally as an outpatient. "If it's emergent, it's an inpatient."
- A patient who the physician knows well, but is sick. "Just because they're known to a physician, doesn't mean a diagnosis is clear."
- Unstable angina – the word "unstable" is not used by the physician, but the history clearly supports diagnosis.
- Patients with multiple co-morbid conditions, whose baseline makes some outpatient workups too dangerous.

Corrato commented that the information on a patient should be included on the patient's chart. "Enduring documentation ... provides a defensible position for internal and external audit," he said.

Need for increased physician education. "Most physicians have no understanding of what observation means," said Corrato, noting that many don't realize that:

(1) the same services can be delivered under observation or inpatient, and

(2) physician reimbursement is essentially the same regardless of status.

"Physicians need to understand that this is a claim status; it is not a clinical status," he said adding that physicians don't have a financial disincentive to classify the patients correctly.

Hospitals should educate physicians on the three-day qualified stay review for patients who need to move to a skilled nursing facility, the financial impact on patients, and the impact of observation on length of stay data on behalf of the hospital, Corrato said. ■

CCH Washington Bureau, October 16, 2006.

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Kaiser CCO offers tips on emerging compliance issues

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

At the Health Care Compliance Association's annual conference on October 6, 2006, Daniel P. Garcia, J.D., M.B.A., gave the attendees a rare glimpse inside the compliance program of one of the nations largest integrated delivery systems. As chief compliance officer for Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals, Garcia is responsible for ensuring that Kaiser Permamente meets the compliance, ethics, and integrity standards required under federal and state laws, regulations, and accreditation requirements.

Garcia offered a surprisingly candid picture of the past and emerging compliance challenges facing Kaiser. With 9 million members and approximately 875,000 Medicare beneficiaries, Garcia heads a program on a scale that most compliance officers can't relate. Kaiser's size means it is scrutinized heavily by the federal government, and Garcia is often forced to tackle issues well before a smaller program would. Consequently, his methods can serve as a guidepost for smaller compliance programs.

Privacy and security issues. Garcia noted that regulatory agencies, both state and federal, are devoting more time to privacy and security issues as we move to an increasingly electronic health care culture. He specifically referred to an instance of a stolen Kaiser employee's laptop containing beneficiary information, which has been a problem plaguing many providers in recent years. Garcia admitted that allowing physicians and others to store personal health information on laptops was an outdated practice. To address the problem, Garcia instituted a policy making it unacceptable to access or store personal health information on personal laptops unless such information is encrypted. In addition, there is now an approval process in place to encrypt such information on laptops or other devices.

Garcia likened Kaiser's encryption policy to a "cultural revolution," and added that restricting personal health information to physicians was counter to what they believed was in the best interest for patient care. According to Garcia, the first step in instituting new privacy policies is to get physicians to accept new ideas about protecting health information in light of technology advances.

Claims appeals and grievances. Garcia discussed recent interactions with the government regarding the processing of appeals and grievances. Specifically, Garcia discussed a CMS audit that uncovered deficiencies with respect to timeliness. In response, Kaiser instituted a corrective action plan; however, a follow up audit of the plan revealed more problems. As a result, Garcia reorganized the process. He noted that there were communication errors with CMS such as receiving different sets of instructions from the regional and national offices. To address this problem, he identified a business center within Kaiser to communicate exclusively with CMS.

Compliance rules of engagement. Garcia stressed that a company's leadership and financial decisions must be subject to review. In regards to how compliance personnel and company leadership interact, he referred to what he called the "compliance rules of engagement."

- *Compliance has enforcement powers.* Garcia noted that it is important for employees at every level to understand compliance standards and procedures.
- *All senior executives are ultimately accountable to the Chief Compliance Officer for compliance.* Consequences for noncompliant behavior must be demonstrable. Garcia noted that high ranking executives have been terminated for failing to cooperate with training.
- *All significant business decisions must be subject to compliance review.* Although it's not standard in most companies, compliance should have the ability to stop products and projects. For example, Garcia stalled a project involving health reimbursement accounts because of compliance concerns regarding potential overcharges.

Garcia's take home message was, ultimately, a company's financial objectives cannot be achieved without achieving its compliance objectives. A well run compliance program is essential to helping an organization reach its goals. ■

CCH Chicago Bureau, HCCA Annual Conference, Oct. 6, 2006.

Keeping your friends close and your business partners closer: Legal dynamics in the relationships among hospitals, physicians and manufacturers (Part II)

by Steve Miller, J.D., and Jeffrey Miller, J.D., Contributing Editors

Hospitals, physicians and manufacturers of health care-related products around the world strive to provide the highest quality health care products and services achievable. In a complex (and sometimes counterintuitive) regulatory environment defining the limits to appropriate business transactions can be a challenge. This four part article provides an introduction to the federal anti-kickback statute that addresses hospital and manufacturer rules in discounting prices without discarding compliance, and provides guidelines for physician consulting and professional services arrangements.

Part I provided the background on the anti-kickback statute and the details of how an arrangement may be protected from prosecution under the statute, including: (1) demonstrating that one of the basic elements of the statute are not satisfied, potentially including that there was and is no intent to induce the referral of patients or business through the arrangement; (2) satisfying the requirements of one of the statute's exceptions or safe harbors; and (3) obtaining formal OIG acquiescence to the arrangement through the statute's advisory opinion process. The discount safe harbor was described in detail, including the categories of buyers, and specifically addressed hospitals and seller manufactures requirements.

Part II continues to discuss the discount exception and potential discount risks; consignment arrangements; implementing controls to prevent unidentified discounts; and the effect of failing to satisfy the requirements of the safe harbor.

Identifying potential discount risks

Straightforward discount pricing arrangements present a manageable risk to the hospital and device manufacturer; a greater risk lies in unintended and "unidentified" discounts that may accompany these agreements. Discounts are commonly made on per-item, per-sale, terms that are defined in a written agreement and are accounted for easily. For example, a flat reduction of 5 percent or 10 percent designed to make a product more competitive is easily documented on the invoice, and accounted for by the hospital. Even volume discounts based on purchase of a specific a product during a specific time period can be tracked, documented and accounted for without undue difficulty. Other potential discounts may occur as the result of the more practical dynamics associated with the manufacturer or supplier - hospital relationship. Hospitals often need devices or other products at a moments notice. In an effort to meet customer demands, suppliers of these products often employ flexible inventory practices that may lead to unintended discounts. The following scenarios present potential undocumented discounts that raise questions of discount safe harbor compliance:

Consignment sales. In some arrangements, a manufacturer or supplier provides the hospital with products on a "consignment basis." In other words, the manufacturer or supplier will provide the hospital with product that will be maintained in the hospital's inventory, but is not charged to the hospital until the product is employed. For example, a manufacturer of orthopedic braces and prosthetics may provide a hospital with a supply of product that the hospital can self-customize and employ on its orthopedic unit for patients recovering from surgery. Because the device is necessary for the provision of inpatient care, the device is covered by the DRG payment for the inpatient stay. In some cases, the supplier may not charge the hospital unless the device is employed. Similarly, suppliers of cardiac devices may provide a hospital operating room with a number of pacemakers or stents to ensure availability. Weak inventory controls on the part of the supplier or hospital creates the risk of product employed for patient care going unaccounted for and uncharged. This raises the question of whether the free product has resulted in a discount on products that were paid for by the hospital, especially where the practice becomes routine.

Product exchange. Even arrangements that require the hospital to pay "at the time of sale" for the product it receives do not fully insulate the parties form the risk

of unintended discounts. This is especially the case when the vendor launches a new and improved version of the product or when it is discontinuing the product to replace it with something totally new. In many of these cases, the hospital will have much of the old product in stock and paid for, when the new product goes on the market. Both the hospital and the supplier have reasons to begin immediately using the new product. The hospital will want to use the new product because its physicians are demanding it and because the improved product is better for its patients. The supplier wants to get the new product into hospitals and physicians hands as soon as possible to show strong sales numbers, and to begin recouping research and development costs. At the same time, the hospital cannot afford to simply discard the old product and the supplier's sales associate will be under pressure to help the hospital to address the situation. If the solution is to replace the old device with a new one, an unintended discount may arise if the new product is more expensive than the product it's replacing. A similar problem will arise when a hospital purchases a large number of a product that it later decides is not appropriate or not usable by its physicians. A product exchange situation rarely will involve two equally priced items.

Items related to the transaction. A third potential undocumented discount involves items that are provided by a supplier to a hospital or physician that are related to, but unaccounted for in a transaction. For example, when a pharmaceutical manufacturer is supplying a medication to a physician that needs to be stored in a refrigerated environment. If the physician does not have sufficient capacity for storage and the supplier provides the physician with a small refrigerator in which to maintain the medication, the question of whether the value of the refrigerator becomes a discount on the cost of the medication. This problem can manifest itself in a variety of different forms: storage devices, inventory management or billing systems, etc.

Implementing controls to prevent unidentified discounts

The extent to which a relationship between a manufacturer or supplier and a hospital is subject to the risk of an improper discount relies on each entity's control over its inventory, sales and/or purchasing procedures. To reduce the risk of undocumented discounts suppliers and hospitals should consider the following:

Suppliers: implement strong inventory control systems;

- document inventory provided to sales staff;
- reduce the amount of inventory over which sales staff has direct control;
- implement standard arrangements that have been reviewed by legal counsel;
- prohibit sales staff from changing the terms of the agreement in any material fashion; and
- include in the price terms of the arrangement any tertiary items that the recipient may need to manage the product.

Hospitals require written arrangements for the purchase of items and supplies;

- implement strong inventory controls systems to record all items received from a supplier and reconcile against invoices;
- train staff to identify potential discount items; and
- conduct audits of invoices, purchasing and clinical records to ensure appropriate identification all items received from suppliers.

The effect of failing to satisfy the requirements of the safe harbor. Failing to satisfy the requirements of a safe harbor does not mean that the arrangement is illegal; only that the transaction is not insulated from prosecution. To be illegal the arrangement would have to violate the federal anti-kickback statute itself. Any such finding would require a case-by-case analysis of the particular facts and circumstances involved, including a showing of criminal intent.[43] Manufacturers should be extremely careful with the approach of any arrangement that would fail to achieve safe harbor protection, however. Intent is inferred, from the point of view of hindsight, from the words and deeds of the individuals involved in the transaction, and if not well documented can be difficult to demonstrate years following the completion of the arrangements.

Manufacturers can support a finding of legality by making efforts to demonstrate their proper intent, such as ensuring that the terms of the transaction are economically sound and transparent, by accurately documenting the purpose and development of the transaction, and by ensuring that contemporaneous representations regarding the transaction are within legal guidelines and are supported by sufficient documentation and analysis. In contrast, manufacturers risk the appearance of illegal intent when:

(1) the terms of the transaction are opaque or make no economic sense;
(2) contemporaneous representations are outside legal guidelines, or are inaccurate or only partially accurate; and
(3) inadequate documentation or objective analysis exists and when there appear to be efforts to shield the transaction from scrutiny.

Should the facts and circumstances demonstrate that even one purpose of the arrangement was to induce new or continued referrals of patients or other business (and not necessarily the primary purpose of the transaction); the arrangements could be found to violate the statute.[44]

Part III of this article will discuss manufacturer-physician consulting and professional services arrangements including compensation arrangements. Part IV will discuss charitable

donations to hospitals including anti-kickback concerns. Industry guidance and codes of ethics regarding hospital/manufacturer relationships also will be discussed in Part IV.

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[43] As stated by the OIG, "[t]he failure of a particular arrangement to comply with the safe harbor does not determine whether or not the arrangement violates the anti-kickback statute … . Arrangements that do not qualify for the safe harbor must be evaluated on a case-by-case basis to determine whether there has been a violation and whether an enforcement proceeding is warranted." *Final rule,* 64 FR 63517, 63518, 63545, Nov. 19, 1999.

[44] *See United States v. Greber,* 760 F.2d 68 (3rd Cir. 1985), *cert. denied,* 474 U.S. 988, 106 S.Ct. 396 (1985) (the intent standard is satisfied if the payment made is at least in part for the purpose of inducing referrals); *Compare United States v. Bay State Ambulance,* 874 F.2d 20 (1st Cir. 1989) (the intent standard is satisfied only if the primary purpose of the payment is to induce referrals).

Experts advise on Medicaid contractor FCA compliance

by Catherine Hubbard, M.A., Contributing Editor

As the Deficit Reduction Act of 2005 (DRA) is implemented, Medicaid managed care organizations will need to grapple with an increasing number of state False Claims Acts (FCA) and prepare to defend themselves against lawsuits, according to Shauna Alonge, a partner in the law firm of Crowell & Moring LLP.

The DRA included new corporate compliance requirements, state incentives to fight Medicaid fraud, and increased HHS oversight under the Medicaid Integrity Program. At a seminar held in Washington, D.C on October 26-27, 2006, representatives from the law firm of Crowell & Moring advised on compliance concerns regarding these new Medicaid initiatives.

Alonge predicted there will be enactment of new and amended FCA provisions, more government investigation and *qui tam* suits. She also predicted there will be increased incorporation of integrity provisions into state Medicaid requests for proposals and managed care contracts as well as increased auditing of managed care operations. "That will require more corporate resources to prepare and respond to these audits," she said.

Under the DRA corporate compliance requirements, entities that receive or make annual payments under the state plan of at least $5 million will be required to establish written policies for employees, contractors and agents containing "detailed information" about the FCA, she said. These entities will have to figure out their states' FCA provisions, said Alonge. "It's a fairly onerous task to defend against one of these, and it can take many years," she said.

Margit Nahra, counsel in the Health Law Practice Group of Crowell & Moring LLP's Washington, D.C. office, said the HHS Office of Inspector General (OIG) Work Plan for fiscal 2007 will focus on a review of the completeness and accuracy of Medicaid managed care encounter data, continued scrutiny of Medicaid fee-for-service payments for beneficiaries enrolled in managed care, and renewed scrutiny on early and periodic screening, diagnostic, and treatment (EPSDT) services, especially mental health services.

Alonge and Nahra prepared a list of 10 action items for Medicaid managed care organizations:

- Update written policies as necessary to address the FCA. Confirm federal and state provisions addressed, as well as whistle-blower protections and fraud detection and prevention procedures.
- Conduct training and education on updated provisions.
- Revise employee handbooks to identify specific discussion of state and federal FCAs and rights of employees to whistle-blower protections. Alonge recommended establishment of a point of contact for employee questions.
- Review policies regarding disenrollment of beneficiaries. Confirm appropriate notice procedures and removal from membership rolls. Nahra said that OIG understands plans want beneficiaries on their plans as long as possible. "They're looking at whether they bring people off the rolls on a timely basis when people are switching plans or going to fee-for-service," Nahra said. "You need to make sure you're responding appropriately," she said.
- Review post-disenrollment policies. Confirm appropriate handling of the information.
- Review procedures for provision of EPSDT services.
- Review marketing and enrollment practices. "OIG has always been concerned about marketing," Nahra observed. She noted that OIG will be looking at whether plans engage in door-to-door marketing or cold calling. In addition, she said, its search will not be limited to certain geographic areas.
- Review reasonableness of administration costs and confirm necessity and appropriate allocation. States generally do not regulate this area for plans, Nahra said. "Make sure you're keeping an eye on that," she said. "This will be looked at on an increasing basis," she added.
- Confirm data integrity processes, including testing and validation of data before

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transmission to states, with special emphasis on validity of encounter data.

- Review systems access policies.

The Medicaid provisions of the DRA are effective in January, Alonge said, adding that plans need to be prepared. "We've got two months – not a lot of time," she concluded. ■

CCH Washington Bureau, Oct. 27, 2006.

Physician investment guidance applies equally to medical device companies

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

In response to a request by The Advanced Medical Technology Association (AdvaMed) regarding physician investments in medical device companies, the Office of Inspector General (OIG) published a special fraud alert on October 6, 2006, in which it reiterated that the 1989 special fraud alert regarding joint ventures remains in effect.

AdvaMed was established to advocate for its member companies from the medical device industry. In its letter to the OIG, AdvaMed noted that some physician investment arrangements in medical device companies raise important health policy and legal questions and sought OIG's guidance concerning the agency's legal analysis applicable to such arrangements. Specifically, AdvaMed's letter requested:

- confirmation that specified OIG fraud and abuse guidance applies to arrangements in which physicians both receive an equity ownership interest in a device company or distributor and generate a substantial portion of the entity's revenues through ordering, or influencing orders for its devices;
- clarification regarding OIG's analysis of arrangements when a substantial portion of the entity's revenues are derived from business generated directly or indirectly by physician investors; and
- publication of additional factors deemed by OIG as applicable to physician investment in medical device manufacturing and distributor entities.

OIG response. In its response, the OIG stressed that the 1989 special fraud alert regarding joint ventures and physician investments is current and applies to all industry stake holders involved in joint ventures with physicians, including medical device manufacturing and distribution entities.

The OIG went on to say that the amount of revenue generated by a physician investor, whether directly or indirectly, is a relevant factor in analyzing a joint venture under the anti-kickback statute. As an example, the OIG cited the small entity investment safe harbor at 42 C.F.R. §1001.952(a), which states that entities can receive no more than 40 percent of their revenues from physician investors.

Finally, the OIG noted that it would consider offering additional guidance specific to manufacturing and distribution entities in the future. ■

OIG Fraud Alert, Oct. 6, 2006, Health Care Compliance Reporter, ¶520,028.

Jury returns $48 million fraud verdict against Medicaid HMO

by Katherine G. Geraghty, J.D., Contributing Editor

A federal jury has returned a $48 million verdict against a health maintenance orginization and its Illinois affiliate for discriminating against eligible Medicaid beneficiaries by failing to market its Medicaid managed care health plan to pregnant women and other people with extensive health conditions while receiving federal and state funds to do so. The verdict amounts to one of the largest fraud jury verdicts against a Medicaid contractor.

Amerigroup was paid $243 million from 2000-2004 to set up a Medicaid managed care health plan in Illinois that would help low income people, including pregnant women who had inadequate prenatal care, to navigate the complicated healthcare system. In accordance with federal law and its contract with the state, Amerigroup was required to market to all eligible Medicaid beneficiaries and was prohibited from discriminating on the basis of health status or need for health services. As a result of Amerigroup's discrimination, it spent less than half of the funds they were paid by state and federal governments on providing healthcare. In total, the jury found that Amerigroup submitted 18,130 false claims to the Medicaid program.

The amount of the jury award will be tripled under the federal False Claims Act and the Illinois Whistle-blower Reward and Protection Act for a total damage award of $144 million. Illinois Attorney General Lisa Madigan and U.S. Attorney Patrick Fitzgerald will ask the court to impose additional penalties against the company, ranging from $5,500 to $11,000 for each of the false claims submitted by Amerigroup. The lawsuit stemmed from allegations made by a whistle-blower who was fired from the company in 2002 and is entitled to receive 15 to 25 percent of the damages awarded in the case. ■

Illinois Attorney General Press Release, Oct. 31, 2006.

In the News

Pelosi calls for vote on amending donut hole

House Minority Leader Nancy Pelosi (D-California) is urging House Speaker J. Dennis Hastert (R-Illinois) to bring drug negotiation legislation to the House floor in November. In an October 26 letter, she asked him to bring to the floor Democratic legislation to allow the Secretary of Health and Human Services to negotiate for lower drug prices when the House returns after the November elections. In the letter, Pelosi said thousands of seniors are falling into the doughnut hole, continuing to pay premiums without getting prescription drug coverage. "It simply isn't right that after incurring approximately $2,000 in drug costs, seniors must continue to pay monthly premiums – and pay for their next $3,000 in prescription costs – until they receive another penny of prescription drug coverage," she said.

CCH Washington Bureau, Oct. 31, 2006.

OPPS rule expands quality reporting measures

In the 2007 hospital outpatient prospective payment system (OPPS) final rule, CMS announced that will implement new steps to make payments more accurate and to promote higher quality and value in outpatient care by tying rate increases to the reporting of quality measures beginning in 2009. The final rule also includes an expansion of the hospital reporting of additional quality measures for inpatient services beginning in fiscal year 2008, based on measures endorsed by the National Quality Forum (NQF) and supported by the privately-led Hospital Quality Alliance (HQA). Under the rule, hospitals, for the first time, will be required to report consistent measures on patient satisfaction with hospital care to receive a full inpatient prospective payment system payment update. Also for the first time, hospitals will report risk-adjusted outcome measures to receive the full payment update, including 30-day mortality measures for patients hospitalized with an acute myocardial infarction, or heart failure.

CMS News Release, Nov. 1, 2006.

Hospital underpayments at all time high

According to the American Hospital Association (AHA), in 2005, 65 percent of hospitals received Medicare payments less than cost while 77 percent received Medicaid payments less than cost. AHA annual survey data reflect underpayments totaling $15.5 billion for Medicare and $9.8 billion for Medicaid in 2005. In contrast, Medicare and Medicaid underpayments in 2000 were $1.4 billion and $2.6 billion, respectively. AHA annual survey data also reflected approximately $28.8 billion, or 5.6 percent of expenses, in uncompensated care for 2005. The uncompensated care figures represent the estimated cost of bad debt and charity care to hospitals. Cost data was calculated by multiplying uncompensated care charge data by the ratio of total expenses to gross patient and other operating revenues. The survey results are particularly important this year given the attention at the state and federal levels on the tax-exemption and charity care.

American Hospital Association Fact Sheets, Oct. 2006.