

# 'Shareholder Value,' the Bigger Crime, Untouched in Columbia/HCA Settlement

by Richard Freeman

On May 19, Columbia/HCA, the largest U.S. for-profit hospital chain, announced that it has reached a tentative \$745 million settlement to conclude one part of a U.S. Justice Department multi-year, multi-state investigation into Columbia/HCA's practices of widespread fraud and outright thievery. The settlement is a record for a health-care fraud case, and Columbia/HCA will likely have to pay still more to settle other parts of the case. The settlement indicates that the Justice Department did go after a major criminal enterprise.

However, the settlement also shows the cold reality, that the Justice Department did not go after the top leader of the Columbia/HCA malfeasance: financier Richard Rainwater of Fort Worth, Texas. Rainwater founded Columbia/HCA, and instituted the accounting and financial machinery that demanded the illegal practices and ferocious looting. But Rainwater was also, during this time, the close friend, business partner, and money-bags of George W. Bush, helping make Bush Governor of Texas, and is now playing a big role in Bush's Presidential campaign. Using the office of Governor of Texas, Bush helped run protection for Rainwater's Columbia/HCA. It would appear that the Justice Department, or at least part of its permanent apparatus, does not want to go after Rainwater.

It is also disappointing that the Justice Department failed to go after Columbia/HCA for an even bigger crime: its policy of "shareholder value," which fuelled the systematic destruction of the U.S. hospital system.

Columbia/HCA has shrugged off the monetary penalty: The \$745 million fine "can be easily paid," a Columbia/HCA spokesman asserted on May 30.

## Five Areas of Irregularity

The Justice Department investigation into Columbia/HCA, which started in 1996, involved five areas of irregularity: 1) diagnostic related group (DRG) coding; 2) home health-care issues; 3) overall cost reporting; 4) physician relationships; and 5) laboratory billings. The DOJ launched parallel criminal and civil investigations into each of these five areas. The tentative \$745 million settlement covers penalties

that Columbia/HCA would pay for the civil cases in areas 1, 2, and 5. The civil cases for areas 3 and 4 are still being worked on. As for the criminal side, no one issue has been resolved. A package agreement for the five areas must be worked out as a whole; that package must be in place by Sept. 30. The Justice Department may extend the time for a settlement until Dec. 31, but if an agreement has not been reached by then, all settlements are off, both civil and criminal. At that point, the government could take Columbia/HCA to court in a bruising trial that would air much dirty laundry.

The Justice Department case stems from highly irregular or illegal practices by Columbia/HCA in each area. For example, take the case of DRG billing: Columbia/HCA is the largest hospital biller of Medicare, the Federally sponsored program that pays hospital and some doctor costs for 37 million elderly and disabled in America. Medicare pays a fixed rate for treatment of roughly 470 coded illnesses. Rates vary sharply—the more severe the illness, the more Medicare pays.

Columbia/HCA used "upcoding," i.e., attached a more expensive billing code to a procedure that cost much less to perform, an illegal DRG billing. The Federal investigation probed Columbia's Cedars Medical Center in Miami, Florida. In 1992, the last year that Cedars Medical operated independently (Columbia bought it in 1993), of the total respiratory cases for which it billed Medicare, 31% were billed at the highest rate. A year later, after Columbia took over, 76% of the hospital's respiratory cases were billed at the highest rate. By 1995, some 93% of cases were billed at the top rate. It billed 355 cases of "complex respiratory infection" and only 28 cases of respiratory infection of the three lowest-paying diagnoses. Since the composition of the patient pool in this area of Miami had not changed much between 1992 and 1995, it is unlikely that there is a medical reason why the percentage of patients with complex respiratory infection should rise so dramatically. However, Medicare would pay a hospital roughly \$6,800 for a case of complex respiratory infection, but only \$3,150 for simple pneumonia. Columbia/HCA raked off the extra \$3,650 per patient from Medicare.

## What the Government Chose Not To Investigate

What the Justice Department chose not to investigate goes to the heart of why Columbia/HCA was established. In 1987, Rainwater, with his 35-year-old assistant Richard "Rick" Scott, formed the Columbia Hospital Corp. In 1988, Rainwater and Scott each anted up \$125,000 and formed a partnership with 110 doctors to buy two hospitals in El Paso, Texas. The deal was financed with a \$65 million loan from Citibank (a hallmark of Columbia takeovers is Wall Street financing). Columbia bought many hospitals, often shutting them down, in order to transfer that hospital's patients to other Columbia-owned hospitals. This increased the profitability at the hospitals that were left open, but left entire communities without hospitals.

On Feb. 10, 1994, Columbia undertook a \$7.6 billion merger with Hospital Corporation of America (HCA), owned by the Nashville, Tennessee-based Frist family, which had 97 hospitals in 21 states. With Wall Street backing, by 1996, Columbia/HCA owned 342 hospitals in 36 states (and a few in England and Switzerland), 130 surgery centers, and 200 home health-care agencies. It owned 30% of all hospitals in Florida, and 17% of all hospitals in Texas.

Columbia/HCA implemented a policy of "shareholder value," the Wall Street plan by which a company, or infrastructure, such as hospitals, are stripped of assets to the point they become non-functional, and the loot is used to prop up artificially inflated stock values, and as dividends and other payments to wealthy individuals and families. To do this, Rainwater insisted that all Columbia/HCA hospitals adopt an accounting mechanism called Earnings Before Depreciation, Interest, Taxes and Amortization (Ebdita), to measure cash flow before certain expenses. Rainwater and Scott demanded that for each hospital group, Ebdita increase by 5-50% per year. To achieve that, a hospital had three options: It could increase its patient flow, but that would require closing down competing hospitals. It could increase prices (or overbill for its services), but only if it could get away with it. Or, it could impose fierce budget-cutting. Columbia/HCA central management drove hospitals to carry out budget-cutting to meet Ebdita quotas. The whole Columbia/HCA system was steered by this policy.

The results were devastating. In 1995, at the Sunrise Medical Center in Las Vegas, Columbia/HCA headquarters demanded that Ebdita be increased by 50%. Staffing was cut by 7%; 15 nursing managers were fired, and registered nurses were cut back, to be replaced by licensed practical nurses, who have less training and earn much less. The Columbia/HCA vice president in charge of the operation stated, "That blew me away. I knew we would have to scrape, cheat, and lie and do everything in our power to get that [Ebdita] number to increase."

The pattern was the same at Columbia/HCA hospitals

across the country: Hospitals that were not sufficiently profitable, were closed, hospital divisions were shuttered, essential services were reduced, and so on.

Columbia/HCA placed America's more than 5,000 traditional not-for-profit hospitals in a pincer movement, forcing them to adopt shareholder-value policies. It could purchase supplies 20-30% cheaper; it was cutting staff and services to increase its profits; it was paying bonuses to have doctors refer the highest-paying patients to Columbia/HCA, and so on. With its amassed financial wealth, Columbia/HCA could steal patients from an independent hospital, or take over that hospital outright. At the same time, health maintenance organizations were putting limits on coverage for patient surgeries, the length of hospital stays, and post-operative rehabilitation. In the midst of this battlefield, in order to compete, the small or medium-sized independent hospital either adopted the budget-cutting, or went out of business (see "How Wall Street 'Shareholder Value' Destroyed America's Hospital System," *EIR*, April 7).

The DOJ investigation is too narrow: Its scope of investigation should go after the destruction of the U.S. hospital system. What about those who died or were seriously maimed because of Columbia/HCA shareholder-value policies? What about those who died, either because Columbia/HCA shut

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down its own hospital, or drove an independent hospital out of business? During 1985-97, there were 575 independent hospitals that shut down, permanently impairing the health infrastructure of America. And Columbia/HCA played a prime role.

### **George W. Bush and Richard Rainwater**

The May 19 *Wall Street Journal* reported, “While the government had originally raised the specter of indicting high-level executives, what transpired was the indictment of four mid-level managers in Tampa, Florida.” It would appear the DOJ had enough evidence to indict and prosecute Rainwater, but it appears that the DOJ will not do that. That is more than peculiar.

After Rainwater founded Columbia in 1987, he supervised its expansion. At one time, he and his wife, Darla Moore, held more than one-quarter of a billion dollars in stock in Columbia/HCA, and he drained a lot of money out of the company in earnings. The managers of the hospitals in the Columbia/HCA chain took orders from Rainwater and Scott. Columbia/HCA was one of the most centralized businesses in the United States. For example, with regard to the “upcoding” practice, which was at the center of the hundreds of millions of dollars of fraud that Columbia/HCA committed against Medicare, the March 27, 1997 *New York Times* reported: “At Columbia, employees responsible for billing Medicare recalled being presented with lists of focus [billing] codes.” These codes were the more lucrative ones that the employees were supposed to use, i.e., the practice came from the top. On a witness stand, if Rainwater could “not recall” authorizing the focus codes, there apparently are many employees who can detail how indeed he did authorize them.

Why wasn’t Rainwater indicted? Could it be that Rainwater, assigned by Wall Street the task of building up the personal fortune of George W. Bush, is protected? It was Rainwater who brought Bush into part ownership of the Texas Rangers baseball team, in which “Dubya” made more than \$14 million when he sold his stake. It was Rainwater who structured Bush’s investment into Rainwater’s Crescent Real Estate Equities, whose worth grew to up to \$1 million — while Bush was invested in Crescent, Crescent bought up and destroyed Charter Behavioral, the largest chain of private psychiatric hospitals in America. In turn, in 1995, it was Gov. George W. Bush who vetoed the Patients Protection Act, passed by the Texas state legislature. When provisions of the Act passed over his veto, Bush ordered the state Insurance Commissioner to make a notable exemption, to protect Columbia/HCA’s profits. Rainwater and Bush share the same shareholder-value ideology.

It would appear that a faction of the Justice Department fears that a vigorous prosecution of Rainwater and top levels of Columbia/HCA could shine light on the shareholder-value policy — which the oligarchy does not wish exposed.

## **HMOs Put American Children at Risk**

by Linda Everett

Children represent well over one-third of enrollees in managed health-care plans in the United States. Yet there is a growing body of evidence that managed-care policies are responsible for harming, maiming, or killing children, undermining the nation’s most advanced pediatric treatment protocols and its critical safety net of pediatric services.

Children’s hospitals annually provide inpatient care for half a million children suffering from sudden trauma, critical illness, or chronic illness and/or permanent disability, with major teaching hospitals also providing another huge component of total inpatient pediatric services. Both types of facilities have been hard hit by constricted payment rates by health maintenance organizations (HMOs), as well as by Federal and state budget cuts. The Federal Balanced Budget Act of 1997, for example, slashed Medicare and Medicaid payments to hospitals, including funding for treatment of disproportionately high numbers of indigent patients, and for the extra costs of training doctors.

The cuts are increasingly forcing general community hospitals to reduce the number of pediatric beds, among others, or to close their pediatrics units entirely, and shifting those patients to children’s hospitals. So, at the same time that there is a greater need for more highly specialized pediatric care, along with specialized outpatient medical staff and services, we are witnessing the most extreme pressures yet on these facilities, whose mission it is to never turn away a sick child (they are often filled to 100% capacity). This is a direct result of managed care’s parasitical policies.

We refer to “managed care” as essentially an insurer’s or HMO’s interference with a physician’s — or, a nation’s — ability to deliver medically necessary treatment. The strictest managed-care plans include the HMO capitated system, in which a flat rate is paid to a primary care doctor (the “gatekeeper”), per person per month, which is supposed to cover all medical care the person needs, with tight control over prescription drugs, and referrals for specialists or tests. If the cost of care exceeds the HMO’s limits, the doctor or hospital loses financially in any number of ways. Less strict managed-care plans may utilize an array of rules, restrictions, and preferred lists of doctors or hospitals to restrict care and costs. To make a profit, they (and the insurers behind them) must continually ratchet up the looting process, and compete for pools of patients or facilities to loot.