

FEBRUARY 2009 EDITION

Community Page Launched!!! I am excited to inform readers about the launch of the *GreisGuide to LTACHs* [Community Page](#). Registered weblog users may post and respond to postings in forums devoted to LTACH development and administration issues and matters important to physicians and patients. Human resource professionals and job seekers alike are also encouraged to use the [Community Page](#) to post and search for LTACH-related career opportunities. In addition to responding to any questions I receive, I also look forward to engaging in [Community Page](#) discussions. Happy blogging to all . . . see you around the neighborhood.

Upcoming Events. In addition to the events highlighted below, a list of additional upcoming events is available on the [weblog](#).

- [Preparing for a RAC Audit Webinar](#). On Tuesday, March 3, 2009, at 1 PM (EST) a team of health care attorneys from McGuireWoods and members of Marsh Risk Consulting's Global Clinical HealthCare Consulting Team will co-host a free lunchtime webinar discussing how to prepare for, and minimize risks associated with, recovery audit contractor (RAC) audits. Although RACs did not focus on claims for Medicare reimbursement submitted by LTACHs during CMS's Demonstration Program, RACs will certainly be scrutinizing LTACH claims in the foreseeable future. Please call me at 312.849.8217 to register for this event. Additional event details are posted on the [weblog](#) by [clicking here](#).
- [McGuireWoods 6th Annual Health Care and Life Sciences Private Equity and Finance Conference](#). On Thursday, February 26, 2009 McGuireWoods will host its annual health care and life sciences private equity and finance conference. Over 150 participants have already registered (50 spots remain), and a number of members of the LTACH community will be in attendance. Additional registration and event

information is available on the [McGuireWoods website](#). Please contact me at 312.849.8217 if you are interested in attending free of charge.

House SCHIP Bill Containing Ban on Physician Ownership and Investment in Hospitals (including LTACHs) to be Reconciled Against Senate Bill. On January 14, 2009 the House of Representatives voted to reauthorize the State Children's Health Insurance Program (SCHIP). The House version of the SCHIP bill ([HR 2](#)) includes a provision proposed by House Ways and Means Health Subcommittee Chairman Fortney Pete Stark that would prevent construction of new physician-owned hospitals and restrict the expansion of current physician-owned hospitals by amending certain provisions of the Federal physician self-referral law (commonly known as the Stark Act). Congressman Stark has said that the provision banning future physician ownership in hospitals would prevent "unethical kickbacks that physicians receive from ownership in hospitals, most of which are of questionable safety and quality." *This legislation, if passed, would significantly impact current physician ownership and investment interests in LTACHs and specialty hospitals, and would altogether ban future physician investment and ownership in such facilities.*

The Senate version of the SCHIP bill (S 275), which the Senate passed on January 26, 2009, did not contain a similar ban on physician ownership or investment. The Senate bill will now go back to the House for further consideration and inconsistent provisions will be reconciled in congressional compromise negotiations. The House is expected to vote on the Senate bill by February 6, 2009 and then send it to President Obama to be signed. It is unclear what the outcome might be of congressional negotiations to include this controversial provision in the final bill.

In the meantime, however, the [Physician Hospitals of America](#) (PHA) has been actively lobbying to

prevent inclusion of such a provision in the final bill that will be sent to the White House. The PHA is asking impacted organizations and physicians to contact “all Democratic House members who have physician-owned hospitals in their districts or projects underway and ask them to contact Speaker Nancy Pelosi, Majority Leader Steny Hoyer and Ways and Means Committee Chairman Charles Rangel to object to the damaging impact the House passed language (HR 2) would have on their districts.”

The relevant portion of the House SCHIP bill would generally:

- Grandfathering. Grandfather physician-owned hospitals with a Medicare provider agreement that are in operation on January 1, 2009. Hospitals under development as of January 1, 2009 would not be grandfathered under the proposed House bill.
- Prohibit Increases in Physician Ownership and Investment. Prohibit physicians from increasing their ownership or investment interest in physician-owned hospitals above the percentage held by such physicians on January 1, 2009. For example, physicians owning 10% of an LTACH on January 1, 2009 could not increase their ownership or investment interest above 10%.
- Prohibit Expansion. Prohibit the addition of beds, operating rooms, and procedure rooms in physician-owned hospital going forward from the date of enactment of the legislation. This provision would likely be construed as an additional ban on LTACH development supplementing the three-year moratorium already in place on the establishment and classification of new LTACHs, LTACH satellite facilities, and LTACH beds in existing LTACHs or satellite facilities.
- Annual Reporting. Require physician-owned hospitals to submit an annual report to the Department of Health of Human Services identifying each physician owner and investor and the nature and extent of all ownership and

investment interests. This information would be publicly available on CMS’s website.

- Patient Disclosure. Require physician-owned hospitals to have procedures in place to require that any physician owner or investor disclose his or her ownership or investment interest to a patient at the time the patient is referred to the hospital in which he or she has an ownership or investment interest.
- Disclosure via the Internet and in Advertising. Require physician-owned hospitals to disclose any physician ownership or investment interest on the hospital’s website and in any public advertisement.
- Bona Fide Ownership. Ensure that ownership in hospitals by physician owners or investors is bona fide and satisfies the Stark Act’s Whole Hospital Exception.
- Assessment and Initial Treatment. Require physician-owned hospitals to have the capacity to provide assessments and initial treatment of patients and refer and transfer patients to hospitals with the capacity to treat the needs of patients. It is unclear whether some LTACHs may be required to expand the limited scope of their Emergency Department services.

Whatever your stance on this issue, I encourage you to contact your congressional representative, the Physician Hospitals of America, the National Association of Long Term Hospitals, and/or the Acute Long Term Hospital Association if you may be impacted by this legislation. Time is quickly running out to make your voice heard. Please also feel free to [contact me](#) if you have any questions about this legislation or its potential impact.

Strategic Considerations for Physician Call Coverage Arrangements. I have recently spoken with a number of administrators and CEOs interested in entering into compensated call coverage arrangements or expanding the scope of their existing compensated call coverage programs with hospitalists, intensivists, and other physicians. Call coverage arrangements generally provide an excellent opportunity for LTACHs to align hospital and physician patient care objectives and for

creating strategic long-term relationships with physicians. These arrangements, however, also have the potential to adversely impact a hospital's bottom line and raise a number of practical legal and business considerations discussed below that should be carefully considered.

1. Fraud and Abuse Concerns.

In September 2007 the Office of the Inspector General of the Department of Health and Human Services (OIG) published [Advisory Opinion No. 07-10](#) (Advisory Opinion), which analyzed a specific compensated call coverage arrangement and also provided helpful general drafting guidelines. The OIG pointed out that there are legitimate reasons for entering into compensated call coverage arrangements (e.g., physician shortages in a hospital service area). The OIG, however, also noted that notwithstanding legitimate reasons for entering into such agreements, compensated call coverage arrangements create considerable risk that physicians may demand such compensation as a condition for referring patients to a hospital, or to joining or remaining on staff. The Advisory Opinion therefore affirmed that compensation for call coverage services must be "reasonable" in light of the specific circumstances of each agreement.

The OIG reiterated that compensation may be found to be "reasonable" where it: (a) represents fair market value; (b) for necessary services; and (c) is not determined in a manner that takes into account the volume or value of referrals or other business between the parties. The methodology used to determine fair market value compensation may properly take into account:

- the actual burden on the physician in providing call coverage (e.g., whether coverage is provided on weekdays versus weekends, and the likelihood of a physician having to come in when on-call);
- the likelihood that a physician would be required to provide uncompensated care;

- patient demographics (including both clinical case mix and payor status);
- the severity and urgency of illness typically encountered by a physician when on-call; and
- the likely extent of follow-up treatment after discharge.

The Advisory Opinion also provided the following helpful examples of suspect compensation structures that might disguise improper kickbacks:

- compensation based on "lost opportunity" or similarly designated payments that do not reflect bona fide lost income;
- payment structures compensating physicians where no identifiable services are provided;
- aggregate on-call payments that are disproportionately high compared to a physician's regular medical practice income; and
- payment structures that compensate an on-call physician for professional services for which he or she receives separate reimbursement from payors or patients resulting in the physician being paid twice for the same services.

The OIG emphasized that while, in many instances, market conditions make it difficult for providers to sustain call coverage without providing compensation, the lawfulness of each arrangement must be evaluated based on the totality of facts and circumstances.

2. Determining Fair Market Value Compensation.

The Advisory Opinion noted with approval that the fair market value (FMV) of compensation to be paid under the arrangement was determined by an independent third party experienced in valuing call coverage services. Furthermore, the valuation firm set out the considerations and methodology used for calculating FMV in an opinion letter to the hospital. The OIG noted that obtaining a FMV valuation was "a prudent practice" since determining FMV for call coverage compensation can be extremely difficult.

Some LTACHs are reluctant to incur the cost (typically from \$3,000 to \$8,000) of engaging a valuation consultant. As the OIG has indicated, however, engaging an appraiser is a cost-effective solution when one considers the potential financial and criminal penalties involved under the Federal Anti-Kickback Statute and the Stark Act (there are recommendations for valuation consultants on the [Business Resources](#) page of the weblog).

3. Selecting a Compensation Structure.

Hospitals have various options when structuring compensation under call coverage arrangements. LTACHs commonly pay physicians a flat hourly fee regardless of whether a physician is called in to provide professional services. There is growing opinion that such fees are problematic since, as one of my colleagues has commented, the hospital is essentially paying a physician to “refrain from leaving town or hitting the town.” If a physician is not called in to provide professional services then there is a valid argument that the fair market value of maintaining availability and remaining competent to perform services should be different than the rate paid to a physician called in to provide professional services.

It has therefore becoming increasingly common to compensate a physician at a higher rate when he or she is called in (an “activation fee”). For example, based upon a FMV analysis performed by an independent valuation consultant, a hospital may pay an intensivist \$100 per hour when called in, and \$50 per hour when on-call. Differentiating compensation in this manner has also been found to result in cost savings.

Structuring call coverage arrangements to comply with the Federal Anti-Kickback Statute’s FMV requirement becomes more difficult when a physician insists on billing payors and patients for professional services *and* receiving an hourly fee. As described in the Advisory Opinion, these types of compensation structures are suspect. Where such a compensation structure is absolutely necessary under a particular set of circumstances,

hospitals may wish to *significantly* decrease the amount of compensation paid to take coverage to avoid paying physicians in excess of fair market value compensation. This type of compensation structure should generally be avoided. Various other call coverage compensation structures exist and should be considered.

4. Impact on Financial Performance.

It is important to note the negative financial consequence for facilities of entering into paid call coverage arrangements where physicians have previously provided call coverage on an uncompensated basis. Hospital net income has been shown to drop significantly as a direct result of such arrangements. If a comprehensive hospital-wide or system-wide call coverage compensation plan is not developed in advance, such arrangements can “open the floodgates” for other physicians, who previously were uncompensated to provide call coverage, to demand compensation.

5. Guidance from the IRS, CMS, and the OIG.

Call coverage arrangements can provide substantial benefits including better clinical outcomes and improved physician recruitment and retention. Whether the benefits outweigh the potential legal and economic risks, however, often depends upon careful planning. LTACHs considering entering into compensated call coverage arrangements may want to consider the following IRS, CMS, and OIG guidance:

- Develop a form agreement establishing consistent insurance, indemnification, confidentiality, and determination of fair market value provisions. The form also should provide a clear statement of a physician’s duties and responsibilities, both when on call and when a physician is called in, and require physicians to maintain and turn in records of the time spent providing call coverage.
- Engage an independent third-party valuation company experienced in valuing call coverage

arrangements to determine the fair market value of compensation. Prior to entering into such agreements, the hospital's Board of Directors should review and approve all call coverage agreements together with the valuation company's compensation recommendations.

- Select an appropriate compensation structure that takes into consideration the unique characteristics of the hospital, the physician, and specialty in question.
- Amend the medical staff bylaws to require physicians to provide a certain amount of uncompensated call coverage each year. These agreements can be costly if implemented with numerous specialties and such an amendment can be an important cost containment tool.

Please [contact me](#) if you have questions about compensated call coverage arrangements generally or if you have questions about implementing a system-wide call coverage policy.

AHA Urges OMB to Block Hospital Reporting to CMS About Financial Ties to Doctors. The American Hospital Association (AHA) urged the White House Office of Management and Budget (OMB) in a [letter](#) dated January 16, 2009 to prevent the Centers for Medicare & Medicaid Services (CMS) from implementing a rule requiring up to 400 randomly selected hospitals (including LTACHs) to report information, supply documents, and make certain legal certifications regarding their relationships with physicians in a Disclosure of Financial Relationships Report (DFRR).

CMS has said the DFRR would be used to help determine hospitals' and doctors' compliance with the Federal physician self-referral law commonly known as the Stark Act. However, AHA argued in its letter that even by CMS's own assessment, the survey would not "produce reliable information for determining hospital compliance [with the Stark Act] or for any future policy development." Furthermore, AHA called the reporting requirement unfair because CMS would not use the data to approve hospital financial relationships with physicians. CMS also suggested that it would use

collected information to inform future Stark Act rulemaking and reporting requirements. Although this survey would be a one-time event, CMS has stated that it would consider future, separate rule making to institute regular reporting for select hospitals depending upon the information gathered.

The most recent draft of the DFRR contains eight worksheets. The first six worksheets address direct and indirect physician investment and ownership interests in hospitals. The seventh worksheet requests information about rental, personal service and recruitment arrangements between hospitals and physicians. The last worksheet includes a series of questions targeting non-monetary compensation arrangements and medical staff benefits exceeding approved limits and charitable donations by physicians to hospitals.

Based upon responses from hospitals and other industry representatives, CMS has concluded that surveyed hospitals should be able to complete the DFRR in approximately 100 hours at a cost of \$4,080. These estimates reflect CMS's questionable belief that: (i) hospitals already maintain the information required to complete the DFRR, and (ii) the task of completing the report should be largely administrative (although CMS recognizes that many hospitals may seek assistance from accountants and lawyers. The time and monetary burden of compiling data for, and carefully responding to, the survey will likely be substantially higher. A number of commentators, including the AHA, believe that CMS has not adequately accounted for the costs associated with completing the DFRR. The AHA, for example, commented that the time needed to complete the DFRR would be at least 200 hours, and would require significant assistance from legal counsel familiar with the complexities of the Stark Act. CMS has also assumed that the average hourly bill rate for legal counsel competent in addressing Stark Act issues is \$57.

CMS would require each hospital to complete and return the DFRR within 60 days of its receipt. The agency has commented that although it has authority to impose civil monetary penalties of up to

\$10,000 per day for late responses, it would not penalize hospitals that fail to respond to the DFRR until after it has provided a notice letter to hospitals that do not timely return the DFRR. Additionally, CMS has agreed to grant extensions to hospitals that are able to show good cause for failing to respond. No timeframe for implementation of the DFRR has yet been suggested.

Please [contact me](#) if you have questions about the DFRR, if you require assistance in conducting a Stark Act compliance audit, or if you have general questions about government investigations or compliance with Federal and state physician self-referral laws.

An Interview with Jerry Amato, C.E.O. of Specialty Hospital of Washington-Hadley.

Jerry, tell me about your background and how you came to work for Specialty Hospitals of America. I grew up in Eastern Ohio and attended Wheeling Jesuit College where I majored in Respiratory Care. I was first introduced to the LTACH sector in 1996, while working in Las Vegas for a small 27-bed LTACH called Horizon Specialty Hospital. In 2000, I had the opportunity to join HealthSouth and open their flagship LTACH in Las Vegas, which opened in July 2001. In July 2003, I was promoted to Administrator of the facility. In 2006, I move to Kansas City, Missouri to become CEO of a 127-bed licensed LTACH. Currently, I am the CEO of the Specialty Hospital of Washington Hospital and Skilled Nursing Center-Hadley in Washington, D.C.

Tell me about SHW-Hadley and what makes it special. SHW-Hadley is a freestanding 82-bed LTACH and 63-bed skilled nursing center located in southwest Washington, D.C. We are a Joint Commission Accredited facility. Our core programs complex respiratory care, particularly ventilator management (our weaning rate is above the national standard) and management of complex wounds. SHW-Hadley has a 10-bed ICU, and a 12-bed step down unit is being developed. There is physician coverage 24 hours a day, with an intensivist rounding in the ICU throughout the day.

Currently the facility is seeking approval to reopen its surgical suite, which was closed under a previous owner. SHW-Hadley has many long term employees, which translates into providing stable, quality patient care. The facility has embarked on a Culture of Patient Safety and integrating that Culture into every discipline and daily activity.

What are some of the key opportunities and risks that you see for SHW-Hadley, for LTACHs in general, and/or for post-acute care? Opportunities for Hadley include: the reopening of a surgical suite; evaluation of Hadley's space for physician offices, outpatient clinics, or urgent care; further expansion of our campus; and bringing additional health care services to our surrounding community. Some of the risks surrounding LTACHs and all healthcare facilities generally is the shortage in clinical disciplines (e.g., nurses, therapists, and physicians), the continual re-education of our referral sources and regulators about the level of care provided by LTACHs, and how vital LTACHs are to the overall health care continuum of quality patient care.

What do you think will happen to the LTACH industry when the Federal moratorium on new LTACH beds expires? I believe that LTACH companies will continue to grow, either through acquisition or through organic growth by strategically placing LTACH beds in underserved markets. Facilities that have been establishing new relationships so as not be dependent on any one referral source for more than 25% of their admissions and putting into place solid utilization management programs will continue to be successful.

What is the accomplishment you are most proud of since joining SHW-Hadley? Since joining SHW-Hadley in June 2008, the accomplishments that I am most proud of include: a successful Joint Commission survey; the successful initial Joint Commission survey for our laboratory services; and the establishment of our Special Procedure Room, where we perform bronchoscopies, bedside debridement, and other procedures.

Development Highlights.

- RehabCare Group, Inc. (RehabCare) and Methodist Medical Center plan to open a 56,000 square foot, 50-bed freestanding LTACH in Peoria, Illinois in the third quarter of 2009. The parties are joint venture partners in the project, with RehabCare owning a majority ownership interest in the new LTACH. RehabCare also has two additional LTACH capital projects planned for 2010. RehabCare plans to open a new freestanding facility in the third quarter of 2010 in Austin, Texas with its joint venture partner The Seton Family of Hospitals. The facility will house both the Central Texas Specialty Hospital, a 40-bed LTACH, and a new 36-bed inpatient rehabilitation facility. RehabCare and its joint venture partner, Floyd Healthcare Resources, also plan a 21-bed expansion of their existing 24-bed HwH located on the grounds of Floyd Medical Center in Rome, Georgia.

Developing, Buying and Selling Facilities. We are regularly approached by companies and individuals interested in developing, buying and selling LTACHs and other post-acute care provider

facilities, acute care hospitals, dialysis centers, ambulatory surgery centers, billing companies, management companies, and various other healthcare-related businesses. Please contact me if you have an interest in any of these opportunities.

As always, please [contact me](#) if you have questions about the Newsletter or a weblog topic, if you would like to be removed from my distribution list, if you are interested in advertising on the weblog, or if you know of someone who would like to receive the Newsletter. More frequent content updates are posted regularly on the weblog, together with links to valuable business and legal resources, recently published articles, presentations, white papers, and details regarding upcoming industry events.

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