

JUNE/JULY 2009 EDITION

Upcoming Events

[Save the Date—From Hospitals to Home: Paying for the Next Evolution of Post-Acute and Senior Care](#)

Thursday, September 10, 2009 (9:30AM-5PM)

Marriott Hotel City Center

500 Fayetteville Street

Raleigh, North Carolina 27601

As Federal health care reform legislation moves forward, change that will impact all aspects of post-acute and senior care looms large on the horizon. Industry groups have mobilized to inform the debate, but it remains unclear how reform efforts will impact the quality, cost and availability of care when the pieces finally stop moving.

[McGuireWoods LLP](#) will host a free, one-day conference to explore the practical implications of significant business, financial, and legal issues being faced by post-acute and senior care providers across the continuum of care at this critical juncture in American health care. Panelists will also provide insight into the future of post-acute and senior care delivery models. This unique, multi-disciplinary conference is intended for key decision makers of LTACHs, SNFs, IRFs, HHAs, CCRCs, ALFs, and hospices.

Online registration should be available by July 30. Further details will be provided on [GreisGuidetoLTACHs](#). Space is limited, so please contact [Jason S. Greis, Esq.](#) to reserve your spot in advance of registration.

- Aug. 5, 2009: [ALTHA Clinical Committee Teleconference](#)
- October 13, 2009: [ALTHA Legal Issues Meeting](#)
- Oct. 21-23, 2009: [2009 NALTH Mid-Year Event: Physician Education Clinical Conference](#)
- Feb. 17-19, 2010: [AHLA Presents 2010 Long Term Care and the Law Conference](#)

August 1, 2009 “Red Flag Rules” Implementation Deadline Approaches

The new deadline for health care providers, including LTACHs and other post-acute care providers, to comply with the “Red Flag” identity protection rules (the “Rules”), which were first published by the Federal Trade Commission (“FTC”) in 2007 as part of the Fair and Accurate Credit Transactions Act of 2003 (“FACTA”) is quickly approaching. On August 1, 2009, “financial institutions” and “creditors” covered by the Rules will be required to implement a written Identity Theft Prevention Program (“Program”) to define, detect, and respond to “Red Flags” in order to prevent and/or mitigate identity theft. Failure to comply with the Rules can result in the assessment of civil monetary penalties for violations.

The FTC announced on April 30, 2009 that it was delaying the May 1, 2009 implementation of the Rules until August 1, 2009. The previous May 1, 2009 implementation deadline was itself an extension from the original November 1, 2008 implementation date. Some commentators have speculated that further implementation delays until January 1, 2010 may still be possible.

According to the FTC, a “Red Flag” is a pattern, practice, or specific activity that indicates the possible existence of identity theft. Red flags include:

1. alerts, notifications, or warnings from a consumer reporting agency;
2. suspicious documents and/or personally identifying information (e.g., an inconsistent address or a nonexistent Social Security number);
3. unusual use of, or suspicious activity relating to, a patient account; and
4. notices of identity theft from patients or law enforcement authorities.

Red Flag Rules Apply to LTACHs

The Rules apply to “financial institutions” and “creditors” with “covered accounts.” Under the Rules, a “creditor” is any entity that regularly extends, renews, or continues credit, or accepts payment for goods and services. If an LTACH permits payment for medical services provided to a patient after those services are provided, and/or accepts installment payments, then it is considered to be a creditor for purposes of the Rules. LTACHs that accept insurance are also considered creditors if their patients are ultimately responsible for medical fees. However, LTACHs are not creditors if they merely accept credit cards as a form of payment.

An LTACH or other health care provider that is a “creditor” under the Rules must also determine if it has “covered accounts.” There are two types of covered accounts. One is an account used mostly for personal, family, or household purposes that involves multiple payments or transactions. Patient accounts are considered accounts for personal purposes. If a patient can make installment payments, then a covered account exists. The other type of account is one for which there is a foreseeable risk of identity theft.

One unique question faced by post-acute care providers, including LTACHs, SNFs, and HHAs, is whether such entities may assume that STACHs and doctors referring patients to such providers performed all proper identity theft screening. Because the Rules hold each provider responsible for maintaining compliance, post-acute care providers must have their own Red Flag policies, procedures and Program, and may not rely upon the policies, procedures, and Programs of referring providers and physicians.

Implementing an Identity Theft Prevention Program

LTACHs that qualify as creditors and which have covered accounts must develop and implement a Program designed to detect, prevent, and mitigate identity theft in connection with the opening or maintenance of a covered account. The Rules are

flexible and allow covered health care providers to establish a Program that is appropriate given the size and complexity of their organizations, and the nature and scope of their activities. All Programs, however, must include “reasonable policies and procedures” to:

1. Identify relevant Red Flags for covered accounts and incorporate those Red Flags into the Program;
2. Detect Red Flags that have been incorporated into the Program;
3. Respond appropriately to any Red Flags that are detected to prevent and mitigate identity theft; and
4. Ensure that the Program is updated periodically, to reflect changes in risks to consumers or patients.

The Program must also be: (i) approved by the LTACH’s Board of Directors, or appropriate committee or management; (ii) managed by the Board of Directors or senior employees; (iii) include appropriate staff training; and (iv) provide for oversight of any subcontractor service providers or vendors. Once a year, a written report on the Program should be submitted to the Board, committee, or management discussing any compliance concerns by contracted vendors, any incidents regarding identity theft, and any recommended changes to the Program.

More information regarding the Red Flag Rules is available on the [FTC’s website](#) where the FTC has posted a useful [F.A.Q. Guide](#) answering commonly asked questions regarding the Rules, and has created a manual entitled [Fighting Fraud with the Red Flag Rules: A How-To Guide for Business](#). The FTC has also developed a [site specifically dedicated to health care providers’ questions](#) regarding the Rules.

Health Care Legislation Update: The Impact on Post-Acute Care Providers and Physician-Owned Hospitals

President Obama’s since expired deadline to hold Congressional pre-conferences and floor votes on comprehensive healthcare reform legislation before Congress’s August recess prompted a flurry of

legislative activity in June and July. On Tuesday, July 14, 2009, the House released its Tri-Committee health care reform bill, officially titled [H.R. 3200](#), America's Affordable Health Choices Act of 2009 (the "Tri-Committee Bill"), and with its party-line vote on Wednesday, July 15, 2009, the Senate Health, Education, Labor, and Pensions ("HELP") Committee became the first congressional committee to approve a [health care reform bill](#). The Senate Finance Committee's health reform bill has not yet been released.

Post-Acute Care Bundling Proposals

Section 1152 of the Tri-Committee Bill requires the Secretary of Health and Human Services to "develop a detailed plan" to reform post-acute care payment services provided by LTACHs, SNFs, IRFs, hospital-based outpatient rehabilitation facilities and HHAs. The plan is required to include detailed specifications for developing a post-acute care bundled payment model that takes into consideration the following factors, among others:

1. the type of post-acute care provider;
2. whether payments for physicians should be included in the bundle;
3. the period covered by the bundle;
4. whether bundled payments should be paid to acute-care hospitals or post-acute care providers;
5. the extent to which payment rates could be established to achieve efficiency offsets expected to be achieved through bundling;
6. the nature of protections needed to ensure that individuals receive appropriate, quality care;
7. the application of gainsharing, anti-referral, anti-kickback and anti-trust laws; and
8. how bundling rules would impact various provider-based rules (i.e. the LTACH 25% Rule).

It is interesting to note that the Tri-Committee Bill does not require HHS to implement a payment bundling demonstration project, but instead only requires a detailed plan analyzing the feasibility of post-acute payment bundling to be developed. As currently drafted, post-acute bundled payments could still be a number of years away since the

establishment of a demonstration project would likely be the next step. It should be noted, however, that Congressmen Rangel and Waxman are contemplating introducing amendments to the Tri-Committee Bill to hasten the speed at which a bundled payment pilot program would be implemented.

Physician-Owned Hospitals

Section 1156 of the Tri-Committee Bill contains a provision that would prevent construction of new physician-owned hospitals and restrict the expansion of current physician-owned hospitals, including physician-owned LTACH joint ventures. The provision is almost identical to one contained in the House's version of the State Children's Health Insurance Program ("SCHIP") bill introduced earlier this year. The provision would significantly impact current physician ownership and investment interests in physician-owned hospitals and would altogether ban future physician investment and ownership. If passed in its current form, the legislation would:

1. Grandfather physician-owned hospitals with a Medicare provider agreement that are in operation as of January 1, 2009. Hospitals under development as of January 1, 2009 would not be grandfathered under the proposed Tri-Committee Bill;
2. Prohibit physicians from increasing their ownership or investment interest in physician-owned hospitals above the percentage held by physicians on January 1, 2009;
3. Prohibit the addition of beds, operating rooms, and procedure rooms in physician-owned hospital going forward from the date of enactment;
4. Require physician-owned hospital to submit an annual report identifying each physician owner and investor and the nature and extent of all ownership and investment interests;
5. 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;

6. Require physician-owned hospitals to disclose any physician ownership or investment interest on the hospital's website and in any public advertisement; and
7. Ensure that ownership in hospitals by physician owners or investors is bona fide and satisfies the Stark Act's Whole Hospital Exception.

A similar ownership restriction and development prohibition is expected to be included in the Senate Finance Committee's Bill, although experts believe that the effective date of the physician ownership restriction contained in that bill will likely be July 1, 2009.

Medicare Long-Term Care Hospital Improvement Act of 2009 Regulatory Relief

Earlier this Spring legislation known as the Medicare Long-Term Care Hospital Improvement Act of 2009 ("LTCHIA") was introduced with strong bipartisan support in both the House and Senate (H.R. 2124; S. 935). The Act was introduced for the purpose of extending certain payment and regulatory relief (i.e., a reprieve from the "25% Rule," which generally reduces payment for a certain percentage of patients transferred from short-term acute-care hospitals to LTACHs) gained by LTACHs under the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"). The provisions of LTCHIA were not included in the Tri-Committee Bill, but industry insiders have expressed optimism that the relief sought under LTCHIA will appear in the Senate Finance Committee Bill and/or that the final conference reconciliation package will contain the LTCHIA provisions.

Be on the Lookout For—

1. 2010 LTCH PPS Final Rule by July 31, 2009. On June 3, 2009, the Centers for Medicare & Medicaid Services ("CMS") published two regulations impacting payments under the long-term care hospital prospective payment system ("LTCH-PPS"). First, CMS published an interim final rule with comment period revising the [Medicare severity long-term care diagnosis-](#)

[related group \("MS-LTC-DRG"\) relative weights for federal fiscal year \("FY"\) 2009](#) due to the misapplication of CMS's established methodology in the calculation of the budget neutrality factor in the final rule. This error resulted in relative weights that are higher, by approximately 3.9%, or \$130 million for all of FY 2009 (October 1, 2008 through September 30, 2009). However, due to agency limitations on retroactive rulemaking and prospective adjustments to rectify prior errors, CMS only applied the corrected weights to the remainder of FY 2009 (that is, from June 3, 2009 through September 30, 2009). CMS estimated the changes would decrease aggregate LTCH-PPS payments by approximately \$43 million for all LTCHs through the end of FY 2009.

Second, CMS issued a "supplemental" proposed rule revising the [proposed rate year \(RY\) 2010 MS-LTC-DRG relative weights](#) and the proposed RY 2010 high cost outlier fixed-loss amount included in its May 22, 2009 proposed rule based on the revised FY 2009 MS-LTC-DRG relative weights contained in the interim final rule. CMS estimates that under the supplemental rule, payments to LTCHs would increase by approximately \$101 million (or about 2.2%) from FY 2009 to RY 2010. Note that this estimate is 0.6% lower than the 2.8% increase originally stated in the May 2009 RY 2010 proposed rule.

2. RTI Report by July 31, 2009. Section 114(b) of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA") required the Secretary of Health and Human Services to conduct a study on the feasibility of establishing national LTACH facility and patient criteria for purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, LTACHs. CMS awarded a contract for this study to Research Triangle Institute International ("RTI"), which was previously awarded a contract in 2005 to evaluate the feasibility of developing patient and facility-level characteristics for LTACHs that could distinguish LTACH patients from those treated in other acute

care settings. According to an anonymous source within CMS, the agency is presently reviewing the report's recommendations for legislation and administrative actions and CMS hopes to post the report on its website by the end of July 2009.

Facility News—

RehabCare Announces New LTACH Joint Venture

RehabCare Group, Inc. announced June 30, 2009 that it had entered into an agreement to acquire certain assets from Gulf States LTAC of Dallas, formerly owned by Gulf States Health Services and a group of Dallas-area physicians. RehabCare will manage the daily operations of the 60-bed LTACH, which was renamed Dallas LTAC Hospital. This hospital represents RehabCare's twelfth freestanding hospital nationwide and its sixth LTACH.

Specialty Hospitals of America Accepts First Patients in New LTACH Satellite

Specialty Hospitals of America ("SHA") announced on July 4, 2009 the official opening of a new 50-bed satellite LTACH of Specialty Hospital of Washington-Capitol Hill, which will be located at United Medical Center in southeast Washington, D.C. The new hospital, named The Specialty Hospital of Washington at United Medical Center will provide care to residents of southeast D.C. and the Mid-Atlantic region. "The new hospital will fill a long-standing and vital need in this neighborhood," says Chad Eichelberger, Chief Operating Officer of Specialty Hospital of Washington. "We employ new, state-of-the-art equipment that is among the best the country, so doctors can feel comfortable discharging appropriate patients into this long term critical care hospital, freeing up beds in the short term critical care unit." He adds, "the new hospital is an essential

component in the continuum of care, and allows patients with a wide range of needs to be treated in one location."

Developing, Buying and Selling Facilities

Please contact me if you are interested in developing, buying, and/or selling LTACHs and other post-acute care providers, acute care hospitals, dialysis centers, ambulatory surgery centers, billing companies, management companies, and various other healthcare-related businesses.

Looking for Guest Columnists

Do you have an LTACH-related story or news that you want to share with peers? Please [contact me](#) if you are interested in reaching a large audience of key executives and professionals in the LTACH industry.

Questions and Comments

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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