Farrell Fritz, P.C.

WINTER 2008

HEALTH LAW ADVOCATE™

PUBLISHED BY THE HEALTH CARE PRACTICE GROUP OF FARRELL FRITZ, P.C., ATTORNEYS AT LAW

Welcome!

Welcome to the third issue of Health Law Advocate® newsletter. We wish you all a happy, healthy and prosperous New Year.

Health care provider issues continue to make headlines in recent weeks. This newsletter focuses on three topics that, while not covered in front page news stories, have significant financial implications for health care providers.

Please feel free to contact us with your comments and suggestions about topics that are of particular concern or interest to you. We welcome your feedback..

Christopher J. Kutner, Esq.
Michael E. McDermott, Esq.

Inside

HSA's Are On The Rise
What Does That Mean For Providers?

By Christopher J. Kutner

Health Savings Accounts or HSAs are gaining in popularity. They provide definite financial incentives to healthy consumers, such as the ability to roll interest-bearing, unused HSA funds over from year to year. From the provider's perspective, however, they create new challenges for reimbursement and administration. Here are answers to some provider FAQs:

How do HSAs work?

Consumers usually maintain HSA funds in an account with a financial institution. HSAs, however, must be coupled with a high deductible health plan ("HDHP") – an insurance product where coverage for benefits is triggered only upon the consumer's reaching the "high" deductible. Because benefits do not accrue until this high deductible is met, the HDHP premium is approximately 30-40% less than that of traditional options offering first-dollar coverage. The issuer of the HDHP therefore has less risk due to the large deductible. This dual component product will offer challenges to health care providers and consumers with respect to tracking the deductible and HSA spending.

Under the HSA arrangement, the consumer pays for most initial services (until a deductible is reached) from his or her HSA account. Depending on the health plan involved, there are different ways by which the HSA funds are drawn (i.e., checkbook held by patient; debit card; or provider submits claim to plan for determination of coverage, cost and responsibility). The consumer is incentivized to control spending; and if the consumer is fortunate and remains healthy during a plan year, the funds in the HSA roll over to the succeeding year and continue to grow. Employees thus have a financial incentive to spend their HSA funds wisely – if they do, the result will be an accumulation of wealth in the HSA account year after year.

Where do providers seek reimbursement?

As these plans continue to grow, providers will need to be attentive to the dual reimbursement sources – namely, the patient and the issuer of the HDHP. The initial inquiry when confronting a patient covered under such arrangement is whether the service being provided is being paid

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Farrell Fritz PROFILES

As in previous issues, we'd like to introduce readers to several of our colleagues who can assist health care clients with a variety of business-critical issues:

Louis Vlahos, the Farrell Fritz partner who leads our tax practice group, advises hospitals on their tax exempt status, corporate restructuring, the creation and operation of supporting organizations (including fund-raising entities), the structuring and acceptance of charitable gifts (including charitable trusts), compensation and other benefit issues, deferred compensation arrangements, and the taxation of unrelated business income. Lou can be reached at: lvlahos@farrellfritz.com

Bob G. Goldberg,tax & ERISA counsel, has considerable experience in federal tax law and employee benefits, including qualified plans, non-qualified plans, health and welfare benefits, as well as deferred compensation. Bob can be reached at bgoldberg@farrellfritz.com.

Medicare Tightens Physician Self-Referral Regulations

By Michael E. McDermott, Esq.

Physicians and hospitals face new, more restrictive regulations regarding Medicare and Medicaid compensation and other key areas, under the third phase ("Phase III") of the final regulations governing the physician self-referral ban known as the "Stark Law." The Centers for Medicare and Medicaid Services ("CMS") published Phase III on September 5, 2007, with an effective date of December 4, 2007.

While most of the Phase III provisions fine-tune existing concepts in the Stark Law and prior regulations, there is a new provision that can have a significant impact on existing relationships between physicians and other physicians and between physicians and hospitals. Phase III provides a new "stand in the shoes" concept with respect to physicians, their groups, and those that contract with them or the group.

CMS states that with respect to an arrangement between a designated health services ("DHS") entity and a "physician organization," a physician associated with the physician organization is deemed to have a direct compensation arrangement with the DHS provider if the only intervening entity is the physician organization. Once the "stand in the shoes" provision attaches, it applies to all relevant referring physicians, regardless of their status with the physician organization. In essence, CMS has eliminated the indirect compensation exception in these situations, thereby requiring the parties to fit the arrangement into either the direct compensation exception or some other Stark exception.

Phase III also includes changes to the physician recruitment and retention rules. The biggest changes include the broadening of the geographic area a hospital may recruit to, loosening of rules regarding retention of physicians, and more flexibility for physicians who recently graduated.

Other Phase III changes include:

- The elimination of the fair market value hourly wage safe harbor;
- Allowing group practices to compensate physicians based on incident-to services;
- Revising the definition of a physician in a group practice to require the contractual arrangement to be directly with the group;
- Requiring academic medical centers to include all compensation to a physician (not just the salary from the formal employer) in order to meet the exception.

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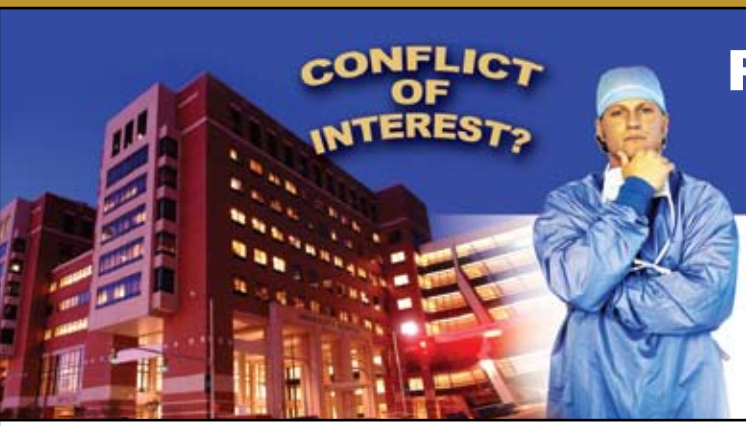

Protecting Hospitals' Interests When Credentialing Providers

By Christopher J. Kutner, Esq.

Imagine a scenario where a hospital issues privileges to a cardiologist to perform cardiac catheterization procedures at its facility. Yet that cardiologist also has an ownership interest in a local specialty hospital providing the same services. Can the hospital be sure that the doctor's financial interests are aligned with its own?

This topic was more prominent years ago, prior to the institution of the Medicare Modernization Act of 2003, which provided a moratorium on development of physician-owned specialty hospitals. Now that the moratoriums on physician ownership have expired, hospital boards need to be proactive in protecting their financial interests and ensuring that potential conflicts of interest with providers are fully vetted and addressed. Failure to take such steps to preclude such arrangements, or passively permitting such arrangements to exist to the financial detriment of the hospital, is arguably a breach of the director's duty owed to the hospital.

Hospitals should protect against their physicians directing healthier patients to facilities in which they have an ownership interest, while admitting the sicker patients to the hospital, or obtaining ownership interests in facilities providing the same services as that of the hospital. Conflict of interest statements are commonly used in businesses where there is a potential for this type of behavior. At least hospitals can annually request that providers disclose ownership/financial interests that may be adverse to the hospital.

Obviously, the hospital and provider communities do not agree on what should be permitted. Physicians would like to be able to own, and compete for, professional services also performed at a hospital. Some of the arguments in favor of such arrangements include that the services provided in the specialty hospital are more cost-effective, there are better outcomes, and competition will increase quality.

The ultimate question becomes whether a hospital's governing board should be permitted to deny or revoke privileges to providers who are in an arrangement that conflicts with the objectives of the hospital. From a hospital's perspective, the answer should be a resounding yes.

New York's Public Health Law provides that a hospital's governing body would be engaged in an improper practice if staff membership or professional privileges were denied for reasons unrelated to patient care standards, patient welfare, the objectives of the institution, or the character or competence of the applicant. Whether or not the objectives of the institution include the ability to preclude arrangements by staff physicians and those with professional privileges economically adverse to the hospital may be tested in the months and years to come. In the meantime, hospital governing boards need be vigilant in protecting the interests of the hospital in this regard.

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While Phase III is intended to be the final phase of regulations, it is clear from comments in the preamble to Phase III, as well as proposed changes to the Medicare Physician Fee Schedule, that CMS is not finished tinkering with Stark.

If physicians and entities that contract with them have not already done so, now would be a good time to review existing arrangements involving self-referrals to ensure compliance with these new regulations.

Welcome to THE FIRM

Farrell Fritz welcomes the following attorneys who have recently joined the firm.

Kelly M. Canavan, real estate counsel; **Brian C. Doyle**, commercial litigation counsel; and **William R. Anderson**, real estate associate, have joined our Bridgehampton office.

Bob G. Goldberg, tax counsel; **Robert M. Harper**, trusts & estates and litigation associate; and **Nicole S. Howard**, corporate and real estate associate, have joined our Uniondale office.

Ralph J. Esposito, trusts & estates counsel, has joined our East Hampton office.

KUDOS

Congratulations to partners **John J. Barnosky**, trusts & estates, and **John P. McEntee**, commercial litigation, on being named Super Lawyers by *New York Super Lawyers* magazine.

Congratulations also go to **Steven N. Davi**, labor & employment, and **David A. Scheffel**, commercial litigation, on their promotions to counsel.

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from the HSA account or from the HDHP. These two sources will often involve two separate and distinct methods for obtaining reimbursement. Providers need to know this ahead of time.

Under §223 of the Internal Revenue Code, the maximum contribution for 2007 is $2,850 for an individual HSA and $5,650 for a family. For 2008, the limits increase slightly to $2,900 and $5,800, respectively, under high-deductible plans. Providers will, therefore, seek payment at the point of service from their patients until the deductible is achieved. At that point, the claims will then be submitted to the insurer offering the HDHP component for reimbursement.

What fee schedule applies?

Providers should pay close attention to the language in their contracts with health insurance companies offering HDHPs. For example, if the patient is paying for services from the funds in the HSA account, does the provider's fee arrangement with the insurance company apply or can the provider charge a fair market rate? The language in the provider agreement with the insurance company likely dictates the fee arrangement with the insurer. The insurance company clearly benefits from this arrangement; even though the HDHP premium is less than with a first-dollar coverage product, the insurance company's risk is reduced by the fee arrangement and the patient's incentive not to spend HSA funds.

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