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Health Care Update

In this Issue

National News

Immediate Action for Health Care Employers: FICA Refunds and Exemptions in 2010

In 2010, hospitals have an opportunity to claim a refund for prior FICA contributions on behalf of medical residents, and may also qualify for an employer exemption from their 6.2% Social Security payroll contribution for every newly hired qualified employee.

IRS Administrative Decision to Refund Medical Resident FICA

In March 2010, the Internal Revenue Service made an administrative determination to accept that medical residents are excepted from FICA taxes based on the "student exception" for tax periods ending before April 1, 2005. The IRS will be contacting hospitals, universities and medical residents who filed FICA refund claims for these periods within the next several months to provide more information and procedures. Hospitals with pending claims do not need to take any action at this time.

HIRE Act Provides Employer Exemption for 6.2% Social Security Payroll Contribution in 2010

Hospitals also can immediately take advantage of the HIRE Act, signed into law on March 18, 2010. At its core, the Act grants employers an exemption for their 6.2% Social Security (FICA) payroll contribution for every new qualified employee hired after February 3, 2010 and before January 1, 2011. The exemption is effective for wages paid from March 19, 2010 through December 31, 2010.

To qualify, a newly hired worker must certify, in a signed affidavit (IRS Form W-11 or another similar statement signed under penalty of perjury), that he or she: (i) has not worked for more than 40 hours during the 60-day period preceding the employee's employment; (ii) is not being employed to replace another employee except one who quit voluntarily or was fired for cause (including downsizing); and (iii) is not "related" to the employer under rules set forth in the U.S. Tax Code. The IRS does not require submission of the affidavits, but an employer must maintain the affidavits with its payroll and income tax records.

The Act also allows an additional income tax credit equal to 6.2% of the paid wages for every new qualified employee retained for 52 consecutive weeks—up to $1,000—to be taken on the employer's 2011 income tax. To qualify for this additional tax credit, the wages paid to the employee during the last 26 weeks must be at least 80% of wages paid for the first 26 weeks.

Department of Labor Clarifies FMLA Leave for Child Care

On June 22, 2010, the U.S. Department of Labor's Wage and Hour Division (WHD) issued an interpretation of the Family and Medical Leave Act that broadens the right of an employee to take FMLA leave for a child for whom the employee is acting in loco parentis (in the place of the parent). The WHD Opinion states that persons who are "in loco parentis" include those with day-to-day responsibility for the care and financial support of a child.

This ruling received quite a bit of press and was seen as victory for the Gay/Lesbian/Bisexual/Transsexual community because it opens the door for a same sex partner to take FMLA leave to care for the partner's child. The ruling can also apply to opposite sex domestic partners, a grandparent who is assuming responsibility for a child because the parents are unable to provide care, or another family member who assumes care responsibilities when the parents die.

The WHD opinion does not alter the FMLA's definition of a spouse, so FMLA leave to care for a spouse with a serious health condition remains restricted to a husband or wife, as defined by federal law. The Defense of Marriage Act (DOMA), a federal law passed in 1996, defines "marriage" as a legal union between one man and one woman as husband and wife, and a "spouse" as a person of the opposite sex who is a husband or wife. Note, the DOMA was recently struck down by a Massachusetts federal court, so it is possible that the FMLA definition of "spouse" may change in the future.

CMS Revokes Medicare Enrollment for Failure to Update Information

Over the past few months, the Centers for Medicare and Medicaid Services (CMS) and the Texas Medicare contractor, Trailblazer Health Enterprises have initiated widespread enrollment revocation proceedings against numerous Texas physicians and health care suppliers. Possibly in response to pressure to clean up Medicare enrollment records, CMS has begun to use a seldom enforced regulatory provision authorizing it to revoke the enrollment of a provider whose enrollment information is not current, particularly with respect to physical address. Revocation of enrollment is a minimum of one to three years.

Medicare regulations require all Medicare providers and suppliers to resubmit and recertify the accuracy of their enrollment information every five years. In addition, when that information changes, suppliers (including physicians) must report the enrollment changes to Trailblazer within 30 days for a change of ownership, any adverse legal action, or a change in practice location, and within 90 days for changes to all other enrollment information.

The biggest danger occurs when a physician group closes an office, or opens a new office to replace the old office. In either event, the physician must notify the Medicare carrier within 30 days by filing a Form 855B Change of Information. Under the regulations, CMS may make site visits to a Medicare provider or supplier's location to determine if the entity is still furnishing Medicare covered items and services at that address. Through

various audit tools, CMS has identified suppliers in Texas that it believes have not notified CMS of address changes. CMS then schedules a site visit to a closed office, determines that the supplier is in fact no longer furnishing Medicare items or services at that location, and then exercises discretionary authority under the regulations to revoke the enrollment for that supplier. This has the same effect as a debarment on the basis of formal sanctions under other Medicare rules that have usually been applied on the basis of intentional conduct.

Understandably, CMS may want to revoke the Medicare privileges for a supplier that is no longer operating. However, revoking the enrollment of a large medical group with multiple locations, simply because one location was closed without timely notifying the carrier, is a draconian remedy that can force suppliers out of business and leave hundreds or thousands of Medicare beneficiaries without a treating physician. Efforts to overturn these revocations have had mixed success. In most circumstances, the economic and patient continuity damage done by an enrollment deactivation or revocation is impossible to correct.

What is the best way to prevent this from happening to your practice? Staff should be intimately familiar with the CMS Form 855B and the Provider Enrollment, Chain, and Ownership System (PECOS). Any time your Medicare enrollment information changes, whether it is adding or deleting owners, adding or deleting offices, or changing address information, such changes must be filed with the carrier within 30 days of the date of the action. If the Medicare contractor requests filing of a revalidation enrollment form, do not ignore that request. Suppliers who fail to provide revalidation information within 60 days of request are also subject to enrollment revocation.

The recent 21% cut in Medicare reimbursement to physicians has resulted in the voluntary defection of many physicians from the Medicare program, so it remains to be seen whether the involuntary removals of physicians from the Medicare program can be sustained, as fewer providers remain for an increasing number of Medicare patients.

New Medicare Preventive Services Will Trigger Concierge Restructuring

Effective January 1, 2011, all Medicare beneficiaries will be entitled to an annual wellness visit with a physician and Personalized Prevention Plan. Although the prevention plan is free, with no cost-sharing, providers are awaiting CMS guidelines, due to be released in March 2011, on whether the annual visit itself must also be free. The Personalized Prevention Plan shall include a health risk assessment, a list of the patient's current health care providers and prescription medications, an updated medical history, height, weight and blood pressure measurements, a screening schedule over the next 5-10 years for appropriate preventive services and a list of health factors the patient may face, along with appropriate treatment options. The annual wellness visit is not available in the first twelve (12) months of a beneficiary's enrollment, during which time new enrollees are already entitled to a covered "Welcome to Medicare" exam. Specific requirements related to the two potentially different services will hopefully be clarified in the CMS guidelines.

For concierge physicians, this new coverage will have a significant impact. Similar to the way in which many concierge practices carve out the "Welcome to Medicare" exam from the annual retainer amount paid by patients, the newly-covered wellness visits and personalized prevention plans will also need to be excluded from the benefits included in the annual retainer fee. It remains essential for concierge practices that participate in the Medicare program to avoid charging Medicare beneficiaries separately for services that are already reimbursed/covered by the Medicare program. Concierge practices will need to examine their form of patient agreement and the description of their concierge program and make the necessary revisions prior to January 1.

CMS Postpones Hospital Disclosure of Financial Relationships Report

The Deficit Reduction Act of 2005 (DRA) required the Secretary of HHS to submit a report to the Congress addressing physician ownership in hospitals. In the report, the Centers for Medicare and Medicaid Services (CMS) stated that pursuant to 42 CFR § 411.361, hospitals would be required to provide information on a periodic basis concerning their ownership/investment interests and compensation relationships with physicians. Accordingly, CMS created the Disclosure of Financial Relationships Report (DFRR), which is a mandatory disclosure of information regarding financial relationships between hospitals and physicians, for purposes of compliance with the physician self-referral statute and regulations.

Section 6001 of the Patient Protection and Affordable Care Act (PACA) also establishes additional requirements (in new section 1877(i) of the Social Security Act) for hospitals to qualify for exceptions to the ownership or investment prohibition. Among other requirements, Section 6001 of the PACA limits expansion to hospitals that have physician ownership or investment and mandates certain disclosure obligations for physician-owned hospitals and referring physicians that have an ownership or investment interest in a hospital.

CMS has recently determined that mandating hospitals to complete the DFRR may duplicate certain reporting obligations related to physician ownership and investment set forth in Section 6001 of the PACA. As such, CMS has decided to delay implementation of the DFRR, and instead focus on implementation of Section 6001 of the PACA. Accordingly, this represents a shift in current focus by CMS to physician ownership interests. CMS has indicated that it will re-visit the necessity to collect information regarding physicians' compensation relationships after it collects and examines the ownership information.

CMS Issues Preliminary Briefing on Accountable Care Organizations

CMS has published a preliminary set of questions and answers regarding the Medicare Accountable Care Organizations (ACOs) Shared Savings Program. The ACO Shared Savings Program was established pursuant to Section 3022 of PACA. CMS plans to establish the ACO Shared Savings Program by January 1, 2012. ACO agreements would begin on or after January 1, 2012, and each agreement would be for at least three years. CMS hosted a special open door forum on ACOs on June 24, 2010 to solicit comments from physicians, physician associations, hospitals, consumer groups and other interested stakeholders regarding implementation of the ACO Shared Savings Program. Specifically, CMS sought input regarding topics such as joint accountability among providers, cost and quality measures to assess performance, risk adjustment, benchmarks for defining shared savings, and Medicare beneficiary protections and allocation to ACOs. CMS expects to provide further details regarding the program in a Notice of Proposed Rulemaking this fall.

CMS Issues Proposed Rule on Hospital Patients Visitation Rights

On April 15, 2010, President Obama issued a Presidential Memorandum on Hospital Visitation to the Secretary of Health and Human Services. The Memorandum tasked the Centers for Medicare & Medicaid Services (CMS) to develop proposed requirements for hospitals to address visitation rights for patients. In response, on June 18, 2010, CMS issued a proposed rule that would require hospitals to implement written policies and procedures regarding the visitation rights of patients. Under the proposed rule, hospitals must inform patients of their visitation rights, any clinical restrictions on those rights, and their right to receive any visitors that they designate. Visitors must not be restricted or denied on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability. Hospitals must also

ensure that all visitors designated by the patient enjoy visitation privileges that are no more restrictive than those for immediate family members. CMS is accepting comments on the proposed rule.

Nurse Staffing Company–Business Due Diligence Tips

Many health care providers us the services of nurse staffing companies. In light of the importance of the services to be provided, it is important that providers fully investigate these companies before entering into any arrangements. At a minimum, the following due diligence should be conducted before hiring a nurse staffing agency:

- Confirm Company is duly organized and in good standing by requesting current corporate good standing certificate
- Review Company's financial statements for most recent year-end
- Lien search in Company's state of formation to augment financial review
- Request evidence of insurance and certificate naming health care provider as an additional insured
- Confirm Company's payment of payroll taxes, unemployment insurance and workers compensation premiums by examining prior year's W-2 reporting
- Review Company's hiring/compliance guidelines and policies
- Review tests/screening of personnel provided by Company
- Require bonding/E&O coverage for Company
- Google search Company and key officers
- Review licensing issues
- Site visit to Company
- Professional references

Decision Highlights Risks of Nurse Wage Information Exchange

On July 22, 2010, the United States District Court for the Northern District of New York issued a decision that is important to employers. In a case involving allegations of a conspiracy to suppress nurse wages, the Court denied the defendants' motions to exclude plaintiffs' expert testimony and their motion for summary judgment. *Fleischman v. Albany Medical Center*, 06-CV-0765 (N.D.N.Y. July 22, 2010). Thus, barring settlement, the case is positioned to proceed to trial.

Fleischman v. Albany Medical Center, 06-CV-0765 (N.D.N.Y.), is one of four nearly identical class-action antitrust lawsuits filed by nurses in Chicago, Albany, Memphis and San Antonio in June of 2006. Each of the complaints contained two counts. Count one alleged that hospitals conspired to suppress nurse wages, amounting to a per se violation of Section 1 of the Sherman Act. Count two alleged that the hospitals conspired to exchange nurse wage information and that the exchange unreasonably suppressed nurse wages in violation of the Act. Approximately six months later a nearly identical lawsuit was filed by nurses in Detroit.

In each of the cases plaintiffs have struggled to develop a reliable method of proving injury-in-fact and damages. For example, on September 29, 2009, Judge Grady issued a decision in the Chicago case denying the plaintiffs' motion for class certification. The Court found that the plaintiffs' method for proving classwide injury-in-fact through the testimony of their expert was unreliable and "essentially inadmissible." *Reed v. Advocate Health Care*, 2009 U.S. Dist. LEXIS 89576 *65 (N.D. Ill., September 29, 2009). The case was dismissed without appeal shortly thereafter when the plaintiffs accepted a nuisance value settlement.

In *Fleischman*, however, the plaintiffs used a different expert and pursued a different theory to show injury-in-fact and damages. In *Fleischman,* the plaintiffs' expert used adjusted

agency nurse bill rates as a benchmark to determine what the competitive staff nurse wages would have been in the absence of the alleged conspiracy. Although the defendants argued that this opinion was flawed and unreliable, the Court disagreed and held that the testimony would not be excluded. The plaintiffs also offered the testimony of another expert to show that the alleged wage information exchanges facilitated a conspiracy and reduced the defendants' incentives to compete. Again, the Court denied the defendants' motion to exclude the testimony on the grounds that it was unreliable and unsupported.

The Court also denied the defendants' motion for summary judgment. With respect to Count one, plaintiffs had no direct evidence of a conspiracy. However, the Court ruled that the plaintiffs provided sufficient circumstantial evidence of a conspiracy to create an issue of fact for the jury. In particular, the Court relied upon the numerous direct exchanges of wage information among the defendants through emails, telephone calls and in-person conversations at job fairs and professional association meetings. It also noted that this information exchange included both current and future nurse compensation information. In addition, the Court found that this exchange of information was contrary to the defendants' unilateral economic self-interest. According to the Court, in the absence of a wage suppression agreement, the defendants would not want to exchange such information with their competitors because they knew that this information could be used to "poach" their nurses. With respect to Count two, the Court also ruled that the plaintiffs provided sufficient evidence to create a triable issue concerning whether the defendants' exchange of wage information unreasonably restrained trade. In doing so, the Court pointed to the plaintiffs' expert testimony showing: (1) that nurse wages in *Albany* were in fact suppressed; (2) that nurses were under utilized in Albany; and (3) that the exchange of wage information created disincentives for the defendants to compete.

What is abundantly clear from the Court's decision in *Fleischman* is that it is critically important for employers to have in place an effective antitrust compliance program. The program must ensure that its employees exchange wage and benefit information only in ways that satisfy the safety zone requirements of the joint enforcement policy statements by the Department of Justice and Federal Trade Commission with respect to the exchange of wage and price information. To satisfy these requirements, employers should exchange wage and benefit information only through written surveys that meet the following conditions: (1) the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association); (2) the information provided by survey participants is based on data more than 3 months old; and (3) there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

Frequently, persons involved in recruitment or in the compensation process are unaware that direct exchanges of wage information or the participation in surveys that do not satisfy the above requirements can create antitrust risks, even if there is no intent to reach agreement on the wages that will be offered. Allegations that the defendants engaged in such information exchanges are at the heart of each of the five nurse wage suppression lawsuits. These cases are very expensive to defend and the potential damage exposure is enormous. Thus, employers should ensure that they have a compliance program in place that instructs their employees concerning what they can and cannot do in connection with the exchange of wage information and that they are reminded of the appropriate limitations on a periodic basis.

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Recent Speeches and Publications

"Health Care Reform and Its Impact on Health Care Providers" webinar moderated by **Deborah Gordon**, panelists include **Neal Goldstein**, **Kristin McGurn**, **Thomas Shapira** and **David Weiner**

"Landscape of Government Health Care Compliance Enforcement," presented by **Neal Goldstein**, Amercian Society of Interventional Pain Physicians Annual Meeting

Joan Gale quoted in "ADAA Might Have Resulted in Expansion of FMLA Leave for Adut Children," published by *SHRM* (July 22, 2010)

"Employers Guide to Health Care Reform" webinar moderated by **Ben Conley**, panelists include **Deborah Gordon**, **Kristin McGurn**, **Ronald Kramer** and **David Weiner**

"An Employer's Guide to Health Care Reform for the Plastics Industry" webinar for Plastics Industry Trade Association, co-sponsored by Seyfarth Shaw and SPI. Seyfarth Panelists included **Jennifer Kraft, Ronald Kramer, Kristin McGurn** and **Leon Sequeira**

"Healthcare Employers Under Attack: The Rise of Wage and Hour Class Action Lawsuits," written by **William Schurgin**, **Kristin McGurn** and **Noah Finkel** for *CCH Health Care Compliance Letter* (July 13, 2010)

"An Employer's Guide to Health Care Reform for the Newspaper Industry" webinar for *Inland Press Association*, lead by **Kristin McGurn** and **Ben Conley**

Deborah Gordon, **Neal Goldstein** and **Ben Conley** are all contributing authors to the American Health Lawyers Association's *Healthcare Reform Resource Guide*

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