HEALTHCARE**LEGAL**NEWS

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IN THIS ISSUE

DW HEALTHCARE TEAM - RECENT NEWS

Available Now - Brian Balow authored the *Allocation and Mitigation of Liability* chapter in the BNA E-Health Treatise, E-HEALTH, PRIVACY, AND SECURITY LAW, 2nd Ed. (Dec. 2011).

In Oct., Brian Balow and Tatiana Melnik spoke on *Privacy Rights and Data Security Compliance: Legal and Business Best Practices* at the SecureWorld Expo in Detroit, MI.

In Oct., Tatiana Melnik spoke on *Cloud Computing and the Law: Concerns and Best Practices* at the A Day in the Cloud event at Automation Alley, Troy, MI.

In Nov., Brian Balow and Tatiana Melnik spoke on *Social Media, Healthcare and the Law: 2011 Update* at the Midwest HIMSS Fall Technology Conference in Indianapolis, IN.

Brian Balow and Tatiana Melnik will be speaking on social media and healthcare at the National HIMSS Conference in Las Vegas in February 2012.

DATA BREACHES IN THE SPOTLIGHT: CLASS ACTION LAWSUIT FILED AGAINST SUTTER HEALTH

By Tatiana Melnik, who is an associate in Dickinson Wright's Ann Arbor office, and can be reached at 734.623.1713 or tmelnik@dickinsonwright.com

Contrary to what many in the healthcare industry anticipated, the passage of the Health Information Technology for Economic and Clinical Health Act (HITECH Act) has not generally led to an increased number of actions against healthcare providers who have experienced data breaches. In fact, according to a December Ponemon Institute study, 96% of surveyed healthcare providers say they had at least one breach in the last two years. Further, only 47% of study respondents agreed that their organizations have sufficient policies to address issues related to data breaches.

This may, however, begin to change as consumers begin to pursue direct action against providers who suffer data breaches. On November 21, Karen Pardieck filed a class action lawsuit in California against Sutter Health, Sutter Medical Foundation, Sutter Physician Services, and Does 1 - 100, in connection with an October 2011 data breach, which resulted from the theft of a password-protected, unencrypted computer. The theft occurred at the Sutter Medical Foundation administrative office in Sacramento. The computer contained healthcare records on more than 4 million individuals, including dates of birth, medical record numbers, and, for a certain subset of the records, medical diagnoses and/or procedures, dating back to 1995.

The plaintiff alleges a violation of California's Confidentiality of Medical Information Act, arguing, in part, that Sutter was negligent in securing the computer. Additionally, the plaintiff alleges a violation of California Civil Code § 1798.82, which is California's breach notification law, alleging that the 30-day delay in notification to the affected individuals is unreasonable and violates the Civil Code.

The costs associated with defense of a class action lawsuit are staggering. As a whole, the healthcare industry has been somewhat immune from class actions related to privacy violations compared to other industries such as social media (e.g., Facebook, Google) and gaming (Sony, GameStop). However, as the Sutter Health case demonstrates, that seems to be changing and organizations should expect more cases.

What is most concerning, however, is that many organizational leaders are in fact aware of the negative repercussions from data breaches. The Ponemon Institute study found, for example, that 81% of respondents believed that as a result of data breaches, their organization had suffered from productivity loss, reputation tarnishment (78%), loss of patient goodwill (75%), loss of revenues (75%), fines and penalties (26%), lawsuits (19%) and poor employee morale (15%). Yet, many have little confidence in their organizations' ability to prevent future breaches, with only 12% stating they are very confident.

There is no debate that compliance with HIPAA and HITECH is no cheap proposition. However, as breaches continue to be publicized, and individuals become more aware of their options, healthcare organizations will become more likely targets. The time to prepare is now- by evaluation of the adequacy of existing data security measures, adoption of comprehensive data breach policies and procedures, and by training personnel to comply with these policies and procedures.

HEALTHCARE REFORM NEWS

CMS CONTINUES TO MAKE EFFORTS TO IMPROVE PRIMARY CARE

By Kevin Bernys, who is a member in Dickinson Wright's Troy office, and can be reached at 248.433.7234 or kbernys@dickinsonwright.com

The U.S. Department of Health and Human Services (HHS) recently launched the Comprehensive Primary Care (CPC) initiative to improve primary care services and deliver higher quality, more coordinated, and patient-centered care. The CPC initiative is a multi-payer initiative intended to foster collaboration between public and private healthcare payers to enhance and improve the level of primary care services. Under the CPC initiative, Medicare will work with commercial and state health insurance plans to offer additional support to primary care doctors who better coordinate care for their Medicare patients.

The CPC initiative is voluntary and will begin as a demonstration project available in five to seven healthcare markets across the country. Primary care practices that choose to participate in the CPC initiative will be given support to better coordinate primary care for their Medicare patients. This support will help primary care doctors:

- Help patients with serious or chronic diseases follow personalized care plans;
- Give patients 24-hour access to care and health information;
- Deliver preventive care;
- Engage patients and their families in their own care; and
- Work together with other doctors, including specialists, to provide better coordinated care.

The CPC initiative will test two models simultaneously: a service delivery model and a payment model. The service delivery model will test comprehensive primary care, which is characterized as having the following five functions:

1. Risk-stratified Care Management;
2. Access and Continuity;
3. Planned Care for Chronic Conditions and Preventative Care;
4. Patient and Caregiver Engagement; and
5. Coordination of Care Across the Medical Neighborhood.

Under the payment model, the Centers for Medicare and Medicaid Services (CMS) will pay participating primary care practices a monthly fee in addition to the usual Medicare fees that they would receive for delivering Medicare covered services. In addition, in years 2-4 of the initiative, the payment model will include the potential to share in any savings to the Medicare program from below target medical costs of the subject population. The participating primary care practices will also receive compensation from the other healthcare payers participating in the CPC initiative.

REIMBURSEMENT NEWS

DIALYSIS REIMBURSEMENT CHANGES ANNOUNCED FOR 2012

By Ralph Levy, Jr., who is Of Counsel in Dickinson Wright's Nashville office, and can be reached at 615.620.1733 or rlevy@dickinsonwright.com

CMS recently announced that on average the bundled base payment for dialysis services under the prospective payment system (PPS) that first became effective in 2011 will increase in 2012 by 2.1% over the reimbursement rates in effect for 2011. This increase is based on the CMS legally required annual update of PPS for dialysis services based on any changes in the market basket of dialysis services costs and any productivity adjustments during the period being evaluated.

Along with this change, CMS announced the quality improvement performance standards that will apply for 2012. If in 2012 (the baseline year for 2014 payments), a dialysis provider fails to meet these standards (which are part of the ESRD Quality Incentive Program, called QIP), CMS will reduce by up to 2% the payments during 2014 to the dialysis provider from the amount that would be otherwise payable to the provider. The QIP changes are significant in that they require tracking during 2012 of additional clinical measures by dialysis providers.

CMS FINALIZES PAYMENT RULES FOR 2012

By: Bojan Lazic, , who is an associate in Dickinson Wright's Grand Rapids office, and can be reached at 616.336.1008 or blazic@dickinsonwright.com

On November 1, CMS issued its Final Rules related to the physician fee schedule, home health prospective payment system (HH PPS) and the outpatient prospective payment system (OPPS) that applies to hospitals and outpatient facilities. These payment and policy changes will become effective as of January 1, 2012.

According to the final fee schedule, physician pay rates will be cut by 27.4 percent. The amount of physician payment for a particular service is determined by multiplication of the relative value units for the service by a fixed dollar conversion factor and a geographic adjustment factor. The conversion factor will be $24.6712 in 2012 compared with $33.9764 for 2011. CMS estimates that as a result of these reductions, total payments under the physician fee schedule in 2012 will be approximately $80 billion. Historically, Congress has intervened and reversed these cuts. However, in light of the impasse earlier this year over budget cuts and the debt ceiling, Congress may not intervene in which case substantial reductions in physician reimbursements will occur.

Similar to physician payments, CMS estimates that payments to HH PPS will decrease by 2.3 percent, or roughly $430 million. The rule reflects the combined effect of market basket and wage index increases totaling $290 million and reductions to the HH PPS rates totaling $720 million. CMS will implement the reductions to account for increases in aggregate case mix that are largely related to billing practices rather than changes in the health status of patients. In addition, PPACA applies a 1 percent reduction to the 2012 home health market basket amount. Since the 2012 market basket is equal to 2.4 percent, the payment update for home health agencies for 2012 will be 1.4 percent.

The bright spots in the final rules can be found in the OPPS final rule in which CMS increased payments to ambulatory surgical centers (ASCs) by 1.6 percent and to hospitals and outpatient facilities by 1.9 percent. The payment increase to ASCs reflects the 2.7 percent consumer price index increase for all urban consumers, minus a 1.1 percent multifactor productivity adjustment required by PPACA. The increase to hospitals and outpatient facilities is based on the projected hospital inpatient market basket percentage increase of 3 percent for inpatient services paid under the hospital Inpatient Prospective Payment System (IPPS) reduced by the 1.1 percent productivity adjustment required by PPACA.

LITIGATION NEWS

BEWARE OF AMBIGUOUS PROVISIONS IN PHYSICIAN EMPLOYMENT AGREEMENTS

By Ralph Levy, Jr. • rlevy@dickinsonwright.com

Care should be taken in drafting employment agreements with physicians. Despite much judicial focus on covenants not to compete and nonsolicitation provisions that are contained in physician employment agreements, as illustrated by a recent case, this word of caution should apply equally to all provisions of these employment agreements.

In the case, which was brought by the physician-employee, an Oklahoma federal judge was asked to interpret a physician employment agreement in which an issue arose as to the location at which the physician was to perform the services contemplated by the agreement. The agreement in question provided that the physician was required to work "primarily" for a hospital-employer at a specific hospital "and from time to time" at another hospital.

As a result of this ambiguity, the court refused to find that as a matter of law, the hospital-employer had breached the physician employment agreement when it had assigned the physician to work at the alternative location specified in the physician's employment agreement. As a result, the court concluded that the jury that hears the trial of the lawsuit and not the trial judge of the case must interpret the meaning of the clause in question.