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DW HEALTH CARE TEAM - NEWS & SUCCESS STORIES

James (Jim) Burns quoted in "*Third Circuit Says Reverse Payments in Drug Patent Cases Presumptively Illegal*" by Bloomberg BNA's Health Care Daily Report – July 17, 2012.

Ralph Levy, Jr. published an article on the *Impact of "Illegality" of Payment Arrangements under Stark Law on Payment for Services of Referring Physicians* in the July-August 2012 issue of the Journal of Health Care Compliance.

Tatiana Melnik published an article on *Health Care Moving to the Clouds* in the July-August 2012 issue of the Journal of Health Care Compliance.

RECENT CASES DEAL WITH IMPACT OF TERMINATION OF EMPLOYED PHYSICIANS

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

Two recent cases highlight the need for hospitals that employ physicians to consider the collateral consequences of exercising termination rights under employment agreements. In each case, the employer-hospital exercised its contractual right to terminate the employment agreement of a physician. In both cases, the terminated physician sued the employer-hospital for damages arising from the actions by the hospital.

In one case, the physician won; the court found that the physician was entitled to compensation during the notice period prior to the effective date of termination. In the other case, the physician lost; the court found that the hospital had not breached the employment agreement with the physician when it terminated his employment as provided in the agreement. In addition, the court found that the hospital had not breached the physician's constitutional rights since he did not lose clinical privileges at the hospital that was his former employer as a result of the termination of employment.

In the first case, Swapan Chadhuri, M.D. sued Fannin Regional Hospital, Inc. and sought payment for services rendered, including services he would have provided the hospital had the hospital scheduled him to provide on-call services during the sixty day notice period that was required under the physician's employment agreement. The physician's employment agreement allowed for termination without cause on sixty (60) days notice to the employed physician. In accordance with the notice requirement in the employment agreement, in a letter dated September 27, 2007, the hospital terminated Dr. Chadhuri's employment effective November 26, 2007. During this notice period, the hospital refused to schedule the physician for on-call services resulting in the lawsuit by the physician for breach of contract.

In reversing the decision of the trial court, the Georgia Court of Appeals found that Dr. Chadhuri had not breached his employment agreement by working at another hospital while he was on call for Fannin Regional Hospital, his employer. As a result, he had not repudiated his obligations or failed to perform services called for under his employment agreement, which included provision of on-call services as needed by the hospital. As a result, his employer should have scheduled Dr. Chadhuri for on-call time during October and November, 2007. During this sixty day time period, his employment agreement remained in effect and the hospital had a need for on-call services, which it satisfied from another physician. The Court of Appeals found that the hospital should have compensated its former employee for the on-call time it normally would have scheduled during the sixty (60) day notice period.

The second case relates to an action brought by James Tate, M.D., a trauma surgeon, against University Medical Center of Southern Nevada, his former employer, seeking damages for violation of due process rights and for breach of contract by reason of the hospital's termination of the surgeon's on-call duties. In an unpublished opinion, the Ninth Circuit Court of Appeals upheld a Federal District Court decision that dismissed the surgeon's claims. The appellate court concluded that the physician did not have a right to continued employment with the hospital and termination of his on-call duties did not constitute a suspension of his clinical privileges.

These cases illustrate that as an employer-hospital negotiates physician employment agreements, it should carefully consider all aspects of contractual termination rights. Once it decides to exercise its termination rights, the hospital should adhere to the contractual provisions in the agreements for exercise of such termination clauses. More specifically, care should be taken in drafting the physician employment agreement not only to specify the mechanics and timing of any termination notice provisions, but also to address the obligations and rights of the parties to the employment agreement during the notice period if a termination notice is to be given by the employer-hospital. In other words, the physician employment agreement should clearly state what can be done and what is required from both the employer-hospital and the employed physician during the time period after a contractual termination notice is exercised by the employer-hospital, but before the agreement terminates. Based on the *Tate* case, perhaps the employment agreement should also specify what impact (if any) the termination of the employment agreement will have on an employed physician's clinical privileges at the hospital.

REIMBURSEMENT NEWS

HAPPY NEW YEAR!: INCREASE IN PAYMENTS TO HOSPITAL OUTPATIENT DEPARTMENTS AND AMBULATORY SURGICAL CENTERS HIGHLIGHTS RECENT CMS PROPOSED RULE

By Rodney D. Butler, an associate in Dickinson Wright's Nashville office, who can be reached at 615.620.1758 or rbutler@dickinsonwright.com

CMS recently proposed that as of January 1, 2013, hospital outpatient departments and ambulatory surgical centers would receive an increase in payments of 2.1% and 2.2%, respectively. These rate increases, however, would only apply to services provided to Medicare beneficiaries in these medical treatment facilities.

The underlying rationale for the proposed increase in payments to hospital outpatient departments and ambulatory surgical centers revolves around an effort by CMS to ensure Medicare beneficiaries have access to outpatient care deemed to be of high quality.

CMS projects that total payments to hospital outpatient departments under the Outpatient Prospective Payment System for calendar year 2013 will be $48.1 billion. In comparison, total payments to ambulatory surgical centers will equal $4.1 billion for calendar year 2013.

The changes recommended by CMS in the proposed rule include providing beneficiaries with additional information regarding the Quality Improvement Organizations (QIO) review process. CMS hopes that the process can be streamlined to make it more responsive to complaints concerning quality of care. In addition, it is anticipated that the new process would accelerate resolution of quality complaints. To facilitate the goals of a streamlined, responsive, and accelerated resolution process, CMS proposes creating an alternative dispute resolution program entitled "Immediate Advocacy," the purpose of which would be to resolve beneficiary complaints. Furthermore, QIOs would be permitted to transmit and receive secured electronic versions of health information and allow them to release more elaborate information concerning the results of their investigations to beneficiaries and their caregivers.

CMS is accepting comments on this proposed rule until September 4, 2012, with a final rule expected to be issued on November 1, 2012.

CMS RELEASES PROPOSALS FOR 2013 MEDICARE PAYMENT CHANGES TO PHYSICIANS

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

On July 6, 2012, the Centers for Medicare & Medicaid Services (CMS) announced proposed changes to the Medicare Physician Fee Schedule (MPFS) for services furnished by physicians during calendar year 2013. These payment changes will affect different specialties in different ways. For example, payments to family physicians will increase by approximately 7% and to other practitioners (including primary care physicians) of between 3% and 5%. By contrast, CMS proposes reductions in payments during 2013 to physicians with certain other specialties. For example, payments to anesthesiologists and cardiologists will be reduced by 3% in 2013. The payment reduction to anesthesiologists and cardiologists, viewed by CMS as "capital intensive" specialties, is primarily due to a change in the assumed interest rates for borrowings to purchase equipment and other capital items used in those specialties.

Included within the proposed payment schedule is a new separate payment to a patient's community physician or practitioner for coordination of the care of patients during the first thirty (30) days after discharge from a hospital or nursing home stay. This represents the first time that CMS has proposed to pay for the care required of patients as they transition back into the community after a stay at a hospital or skilled nursing home. This discharge transition care

payment contributes 5% of the proposed 7% increase in payments to family practitioners. In the announcement that accompanied the proposed regulations, CMS noted that this payment for discharge transition care management dovetails with the Affordable Care Act mandated program to reduce payments to hospitals that have excess readmissions for certain conditions.

CMS also noted that unless Congress acts to postpone (or repeal) the previously scheduled payment reductions under the Sustainable Growth Rate (SGR) methodology, payments under MPFS will be reduced by approximately 27%. Since 2003, SGR cuts have been averted by Congress.

Also included within the proposed rules are changes to several previously implemented quality reporting initiatives and, as authorized by the Affordable Care Act, a program in which physician groups can participate on a voluntary basis through which their payments are adjusted based on the quality and cost of care they provide to their patients. Groups with 25 or more physicians that elect not to participate in the physician quality reporting program will be subject to a 1.0% payment reduction.

ANTITRUST NEWS

THIRD CIRCUIT'S K-DUR ANTITRUST LITIGATION DECISION DELIVERS A LONG-SOUGHT WIN FOR THE FTC ON AN ISSUE THE FTC CONTENDS COSTS CONSUMERS BILLIONS EACH YEAR IN HEALTH CARE COSTS

By: James M. Burns, a member in Dickinson Wright's Washington D.C. office, who can be reached at 202.659.6945 or JMBurns@dickinsonwright.com

On July 16, 2012, the Third Circuit Court of Appeals issued its long-awaited decision in the *K-Dur Antitrust Litigation*. In its decision to reverse the district court and to decline to follow prior decisions from the Second, Eleventh, and Federal Circuit Courts on the issue, the Third Circuit ruled that "any payment from a patent holder to a generic patent challenger who agrees to delay entry into the market is prima facie evidence of an unreasonable restraint of trade".

As took place in cases in the other circuits, in the *K-Dur Antitrust Litigation*, the court considered whether the settlement of a patent infringement suit brought by a branded drug manufacturer against a generic drug maker, in which the branded manufacturer withdraws its claim that the generic infringes the patent and, in connection with the settlement, also pays the generic not to enter the market until the patent expires, potentially violates the antitrust laws. The settlements, pejoratively referred to as "pay for delay" and "reverse payment" settlements, have become increasingly common over the last ten years, and several circuits had previously held that, as long as the "delay" did not extend beyond the patent's original expiration date, the settlements were not anticompetitive. The FTC has strenuously disagreed, arguing that the practice is anticompetitive and that it costs consumers billions of dollars each year in increased health care costs. Until *K-Dur*, however, the FTC had been largely unsuccessful in persuading the courts of this view.

In addition to finding that such payments are prima facie evidence of an unreasonable restraint of trade, the Third Circuit also stated that "there is no need to consider the merits of the underlying patent suit because absent proof of other offsetting considerations, it is logical to conclude that the quid pro quo for the payment was an agreement by the generic to defer entry beyond the date that represents an otherwise reasonable litigation compromise."

FTC Chairman Jon Leibowitz applauded the decision, stating that the Third Circuit had "gotten [the issue] just right" and that "these sweetheart deals are presumptively anticompetitive." The Third Circuit decision creates a clear split among the circuits, and the FTC is expected to seek to have this issue resolved by the Supreme Court. While that may not be possible based upon the Third Circuit's ruling (unless the branded drug manufacturer seeks certiorari), only days after the Third Circuit ruled, the Eleventh Circuit again ruled against the FTC in a similar case presenting the same issue, providing the FTC with a clear path to seek Supreme Court review. With that, the issue immediately become "one to watch" at the Supreme Court for this fall, and a ruling on the issue by the Supreme Court could have significant repercussions throughout the health care industry.

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