

HEALTHCARELEGALNEWS



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DW HEALTHCARE TEAM - NEWS & SUCCESS STORIES

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

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

On **March 22**, Tatiana will be speaking on **telemedicine and telehealth** at the Spring Conference of Michigan Medical Group Management Association.

On **March 27**, Tatiana will be speaking through a webinar on **Data Breaches and Medical Offices at Risk of Direct Action by Patients** for the Missouri Medical Group Management Association. Please contact Tatiana at tmelnik@dickinsonwright.com if you are interested in participating in the webinar.



FIDUCIARY DUTIES TO EMPLOYER CAN PREVENT COMPETITION BY 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.

Before resigning employment to work for a competitor or otherwise assisting the competitor, a physician or other individual who provides healthcare services to an employer and who also serves as an officer or director of the employing hospital or practice group should be aware of the potential exposure for breach of fiduciary duty owed to the employer. In a recent Kentucky case, three physicians who were members of the board of directors of a medical facility ("Lexington Clinic P.S.C.") began negotiations with a recruiter for a company ("Baptist Healthcare System") that wanted to build a competitive medical facility to that owned by Lexington Clinic P.S.C. In response to these actions, which included signing a letter of intent to become employed by Baptist Healthcare System and actively soliciting fellow physician-board members and staff to join a new primary care clinic that will be established by the competitor, Lexington Clinic P.S.C. filed legal action against the three physicians.

The Kentucky Court of Appeals reversed the trial court's dismissal of the complaint against the physicians as a result of its failure specifically to refer to the applicable Kentucky statute that governs actions for breach of fiduciary duty against current and former corporate directors. Even though the underlying complaint filed by Lexington Clinic P.S.C. did not refer to the applicable statute, the appellate court found that the complaint generally contained allegations that if found true would create liability under the Kentucky statute. Accordingly, the complaint should

be liberally construed and should not be dismissed in a motion for summary judgment based on failure to plead the statute.

The decision does not address why Lexington Clinic P.S.C. did not pursue claims for breach of employment agreements against the physicians. However, the lesson to be learned from this case is that even if a physician or other individual who provides healthcare services can resign from employment and/or solicit employees for a competitor without breaching any employment agreement with the employer, an additional area of potential exposure exists if the resigning employee also serves as a director or officer of the employing entity. In most states, officers and directors of corporations and other legal entities have fiduciary duties to that entity not to take action that is adverse to the entity for which they serve as an officer or director. These obligations are imposed either by law or by statute, and thus arise regardless of the provisions of any applicable employment agreement; the scope and duration of these duties will vary state by state and also based on the position(s) held by the employee(s).

In some states, these fiduciary duties will continue even after the individual resigns as an officer or director of the employing entity. If the individual also owns equity in the employer, these obligations may also arise under the entity's governance documents (e.g., bylaws, shareholders agreement, operating agreement or the like). Thus, care should be taken to analyze governance documents, employment agreements and applicable state law before a physician or other individual who provides healthcare services to an entity begins to consider taking actions to compete against the employing entity.

FRAUD AND ABUSE NEWS

IMPACT OF ILLEGALITY OF PAYMENT ARRANGEMENT UNDER STARK LAW ON PAYMENT FOR SERVICES PROVIDED BY REFERRING PHYSICIAN

By Ralph Levy, Jr • rlevy@dickinsonwright.com

A recent case points out the dangers in using the fraud and abuse laws to justify a healthcare provider's failure to pay for services rendered by a referral source. In this case, the court found as a matter of law that a hospital that received services from a physician who was a referral source must still pay for services even though it did not have a written agreement with the physician that meets one of the safe harbors under the Stark law.

In *Braun v. Promise Regional Medical Center-Hutchison Inc.*, physician Steven D. Braun sued for unpaid compensation for services that he provided to a hospital. For over ten years, the physician served as medical director for the hospital under a written employment agreement. In accordance with its terms, the hospital terminated the agreement on written notice to Dr. Braun as of the date specified in the notice. However, Dr. Braun continued to provide services to the hospital as its medical director for over thirty months without receipt of compensation for these services. In defense to the legal action for unpaid compensation, the hospital argued that it could not

compensate Dr. Braun for his services because a written agreement was not in place with him as was required for the services arrangement to meet a safe harbor under the Stark law. In refusing to dismiss Dr. Braun's claim, the District Judge found that it was inequitable for the hospital to refuse to pay the physician for services he performed for the hospital after termination of his employment agreement. In reaching this conclusion, the court noted that "[t]he Stark Act, however, does not by its terms prohibit unwritten agreements [with physicians who have financial relationships with hospitals] or limit the power of a court to issue equitable remedies where there are no agreements."

This case severely limits the use of the fraud and abuse laws either by a healthcare provider to avoid paying for services or by a physician or other referral source as a legal justification not to perform services under an agreement with the provider. This tactic is often used in negotiations between a healthcare provider (such as a hospital, physician group or outpatient provider of healthcare services) and a physician, physician group or other service provider regarding the potential extension of a contract for services that by its terms will soon expire. Typically, the underlying service agreement will expire as of a specified date in the agreement and there is no contractual requirement for the continued provision of services to the healthcare provider after expiration. This problem is particularly acute where the remaining term of the agreement is less than one year- arguably a failure to comply with the one year Stark safe harbor requirement for the arrangement. Another potential use of this tactic would be where some provision of the written agreement does not comply with a regulatory safe harbor, such as failure of the compensation method contained in the agreement to meet a safe harbor requirement.

Regardless of which party to the services agreement asserts the illegality of the payment arrangement, both the recipient of services and the provider of services must look to local law to determine the legal rights and responsibilities of each party. For example, if under local law an illegal compensation method invalidates a contract for services, the recipient of services contemplated under the contract after its termination for illegality may still be required to pay fair value for the services received. In this instance, the value of these services need not be that which was specified in the now invalid personal services arrangement. As in the *Braun* case, most jurisdictions will require payment for services under the legal theory that it is unjust for the provider of services not to receive compensation for services rendered.

Healthcare providers should take heed of the *Braun* decision in negotiations with physicians and other providers of services-- particularly as to an expiring service arrangement or contract that the recipient of services wants to terminate. In the *Braun* case, if the hospital did not want to pay Dr. Braun for medical director services after it had terminated his employment agreement, it should have obtained services of the type provided by Dr. Braun from another physician for an agreed upon compensation under a written agreement that met a Stark safe harbor. This case also serves as a reminder to hospitals and other healthcare providers that bill Medicare or other governmental payors to make certain that, both as part of its policies and in practice, written agreements complying with the Stark and Antikickback safe harbors are in place with all referral sources to which the hospital or service provider also pays for services rendered.

LITIGATION NEWS

AS CONSOLIDATION IN HEALTHCARE INCREASES, SO DOES ANTITRUST ENFORCEMENT: AN APPLICATION OF THE STATE ACTION DOCTRINE AND AN ANALYSIS OF TWO INSTRUCTIVE CASES



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As healthcare providers look to consolidation as a way to remain competitive, regulatory agencies are aggressively staking out their turf and challenging consolidations which have the potential to yield anticompetitive results.

Recently, the FTC challenged two similar consolidations, however, the courts that reviewed the actions by the FTC reached different results. In *F.T.C. v. Phoebe Putney Health System* and *In the Matter of ProMedica Health System, Inc.*, the FTC challenged acquisitions of acute care inpatient rural hospitals by competitors. In challenging the transaction, the FTC argued in both cases that consolidation in rural geographic areas would result in unacceptably high post-acquisition market shares and has the potential of reducing competition by allowing the newly merged entity to demand and receive higher reimbursement rates.

The two cases differ in one important aspect: in *Phoebe*, the Eleventh Circuit found that the state action defense exempted the acquisition of a privately owned hospital in the market by a statutorily authorized public health authority (called the "Authority" in its opinion). The Authority acquired the assets of the privately run hospital and then leased the newly acquired assets to the same non-profit entity which operated the only competitor hospital. As a result, the Authority owned directly the assets of both competitor hospitals which were operated by a non-profit entity controlled by the Authority in the rural market.

Although the Eleventh Circuit acknowledged the acquisition of the second hospital by the Authority likely would violate Section 7 of the Clayton Act, it ultimately upheld both the acquisition and the subsequent lease of the acquired assets to the Authority's nonprofit subsidiary. The Court reasoned that a Georgia state statute clearly authorized the acquisition. The Court explained that, "a political subdivision, like the Authority, enjoys state action immunity if it shows that, through statutes, the state generally authorizes [it] to perform the challenged action and that, through statutes, the state has clearly articulated a state policy authorizing anticompetitive conduct."

In *ProMedica*, however, neither hospital could avail itself of the state action immunity because there was no specific statute authorizing the contemplated conduct. Ultimately, the FTC invalidated the acquisition and ordered total divestiture.

Both *Phoebe* and *ProMedica* involved rural health systems attempting to consolidate services, create efficiencies and ensure economic viability in the face of a precarious economy and the ever changing landscape of federal healthcare reform. A few conclusions can be reached from a close analysis of these two cases. First, considering the current economic state and uncertainty regarding the effect of federal healthcare legislation, healthcare systems undoubtedly will look for opportunities to consolidate services, programs and facilities to remain viable. Second, healthcare systems will want to take a closer look at *Phoebe* and the use of governmental units to serve as a "straw man" and exempt the transaction from antitrust scrutiny as state action. Third, although there might be a case like *Phoebe* where the Court unequivocally held the state action doctrine to apply, every indication is that the FTC will vigorously challenge any healthcare consolidations it feels stand a chance at significantly reducing competition.

What remains to be seen, however, is how the other Federal Circuits, and other federal agencies might react to what could be an effective strategy to avoid increased antitrust enforcement. Further, in those states which may not have sufficient statutory authority or other state mechanisms in place to facilitate acquisitions of hospitals (particularly if a governmental agency is a "straw man" and does not bear the economic risk of operations post-acquisition), watch out for legislative lobbying from healthcare. Regardless, 2012 is already shaping up as an interesting year as antitrust and healthcare law continue to intersect.

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