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Late breaking news on medical-legal developments affecting physicians and health care professionals

UnitedHealth to Drop Out of Most Affordable Care Act Exchanges: In mid-April, UnitedHealth CEO Stephen Hemsley announced the company would pull out of most of its ACA marketplaces. However, the company will not withdraw from all the exchanges, and will continue to sell individual plans in what Mr. Hemsley said would be a "handful" of states. Thus far, UnitedHealth has withdrawn, fully or partially, from Arkansas, Georgia, Louisiana, Michigan and Oklahoma. Previously, the company had sold plans in thirty-four (34) states, and has not yet announced which states it plans to stay in. However, a recent analysis from the Kaiser Family Foundation concluded that UnitedHealth's withdrawal will not have a major impact on competition and prices on a national basis, as it has a relatively small ACA footprint and has consistently charged higher premiums for its products. Despite heavy losses in its ACA plans (expected to be some $1 billion on its exchange plans for 2015 and 2016), UnitedHealth nevertheless obtained substantial profits (said to total approximately $5.8 billion in 2015) from its other lines of business.

Medicare Draft Regulations Would Radically Change How Physicians are Paid: In a new 962-page proposed rule, CMS advances radical alterations to the way physicians will be paid for treating Medicare patients. The regulations were proposed pursuant to the 2015 Medicare Access and CHIP Reauthorization Act, which replaced the controversial "sustainable growth rate" formula. In order to move more physician payments through so-called "value-based arrangements," the regulations set forth a "Quality Payment Program." Physicians will have to choose one of two paths: the "Merit-based Incentive Program" ("MIPS," into which the majority of practitioners are expected to fall) or a qualifying "Alternate Payment Model" ("APM"). Although, based upon data from 2014, Medicare spending on inpatient services was nearly double that spent on physicians, CMS has targeted physicians to be responsible for keeping hospital expenditures down. Basically, MIPS combines parts of the Physician Quality Reporting System ("PQRS"), the Value Modifier ("VM" or "Value-based Payment Modifier") and the Medicare Electronic Health Record ("EHR") incentive program into one single program, theoretically based upon quality of care, resource use, clinical practice improvement and meaningful use of certified EHR technology. Based upon a composite performance score in each of these four categories, physicians will receive either a positive, or a negative, adjustment in compensation. Negative adjustments are capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022 and beyond, while positive adjustments must be paid out in an amount equal to the total negative payment adjustments among all providers, and can reach up to three times the amount of negative adjustments. To participate in an APM requires a physician to be in a qualifying program (one of which is the Accountable Care Organization ("ACO")), which may have the effect of steering doctors into large group practices or into employment by hospitals**.**

Discipline Imposed in New Jersey Affects a Physician's Status in New York: In a recent decision of the New York State Supreme Court, Albany County, Mehta v. Rosen (April, 20, 2016), a finding of professional misconduct against a physician in New Jersey led to adverse collateral consequences to the physician's status in New York. In 2004, the physician sued a health insurer in NJ for payment of disputed claims and the insurer counterclaimed for fraud. The court granted summary judgment in the insurer's favor on its fraud claim and the parties then settled the lawsuit. Subsequently, the New Jersey State Board of Medical Examiners ("NJSBME") charged the physician with professional misconduct on the basis of the fraud judgment. After a hearing the Administrative Law Judge ("ALJ") concluded that two violations were proven, but that no sanctions were warranted. The NJSBME rejected the ALJ's determination and imposed suspension to be served as "probation" and a $10,000 penalty. Pursuant to New York Education Law §6530, a finding of professional misconduct in another state may lead to charges against a physician in NY, and the New York State Office of Professional Medical Conduct ("OPMC") initiated its own action against the physician on the basis of the adverse finding in NJ. The physician entered into a consent agreement with OPMC, to be subject to censure and reprimand and pay a $3,000 fine. Several months later the Office of the Medicaid Inspector General (OMIG) notified her of her exclusion from the Medicaid program. The physician then commenced an Article 78 proceeding in Supreme Court, contending OMIG had exceeded its lawful authority and had no rational basis to exclude her from the Medicaid program as she had not participated in the program in NY, or treated Medicaid patients there, for over 15 years. Nevertheless, Medicaid exclusion has serious adverse collateral consequences to a physician's practice, including exclusion from other health care programs. Despite this argument, the court held that OMIG had a rational basis to exclude her from the Medicaid program. Citing the NYS Court of Appeals decision in Koch v. Sheehan, the Court in Albany stated that the physician…"and her attorney should have considered all ramifications of entering into a Consent Agreement," and that "concern over whether she would face possible exclusion from the Medicaid list, should have been brought up during negotiations with OPMC."

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