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

CMS Warns of Possible Delay of MACRA Implementation. On July 13, CMS Acting Administrator Andy Slavitt and senators showed that they have heard and understand the calls to slow down plans for implementing the Medicare Access and CHIP Reauthorization Act (MACRA). Slavitt said he knows small physician practices might not have enough time to prepare for the important changes in Medicare payments if they go into effect on Jan. 1 as planned, particularly since the CMS Final Rule on new payment models is not expected to be announced until November. The Senate Finance Committee expressed concerns over the short period between the Final Rule announcement and the planned implementation date. In response to repeated questions concerning this issue, Slavitt advised that the CMS is open to alternatives that include postponing implementation and establishing shorter reporting periods. Additionally, Slavitt also suggested that the CMS was considering modifying reporting requirements to ease the burden on physicians. For instance, CMS could obtain data through an automated database such as a registry. Also, in instances where a practice demonstrates strength in a particular area of care, that practice might not have to report such data. Similarly, if physicians do not see a high volume of Medicare patients, they might not be required to report data. Unfortunately, there is still much uncertainty surrounding MACRA that may not be resolved until the Final Rule comes out in November.

CMS Report Notes High Deductible Plans Will Curb Physician Spending. Healthcare spending is expected to grow 5.8% annually, outpacing the overall gross domestic product by 1.3 percentage points between 2015 and 2025. According to a new CMS report, however, spending on physician services during the next decade is likely to be significantly slower and limited in part by the continuing rise of high-deductible health plans. Actuaries at the CMS found that currently one in four employer health plans had high deductibles in 2015, up from one in five in 2014. Sean P. Keehan of the CMS' Office of the Actuary said "research has found that moving into high-deductible health plans or being subject to other increases in cost sharing tends to have a disproportionate impact on the use of physician and clinical services, such as preventive care." The Office of the Actuary found that 2015 was the first year of an expected 4-year trend of accelerating out-of-pocket spending resulting from both fading coverage gains under the Affordable Care Act and more people being moved to high-deductible plans or coverage that requires other forms of increased cost sharing. Plans that emphasize cost-sharing have been criticized widely in the healthcare community as they both reduce patients' use of both necessary and unnecessary care. The CMS report also found that physicians will likely be affected in 2016 by private health plans' continued expansion of "narrow networks" of providers, designed as a way to "prevent sharp increases in health prices." For a copy of the CMS report, please see: http://content.healthaffairs.org/content/early/2016/07/12/hlthaff.2016.0459.full.

New Jersey Appeals Court Affirms Award in Favor of Physician Against Aetna. In an unpublished decision, *Aetna Health, Inc. v. Srinivasan*, No. A-2035-14T2, slip op. (N.J. App. Div. Jun. 29, 2016), the Superior Court of New Jersey, Appellate Division, affirmed an award on a physician's counterclaim against Aetna. As an unpublished decision, the case does not constitute precedent and is not binding upon lower courts, but it represents that rare case where a doctor prevailed against an insurance company. Aetna sued an out-of-network doctor on several claims, including insurance fraud, alleging the doctor overcharged from 3 to 35 times more than other providers. The doctor, an interventional cardiologist employed by Hackensack University Medical Center ("HUMC"), does not maintain his own practice or medical office, but provides emergency services to HUMC's ER patients. The doctor counterclaimed for tortious interference, unjust enrichment and abuse of process. In pretrial proceedings all of Aetna's claims, other than for negligent misrepresentation, were dismissed. In the liability phase of a bifurcated trial, the jury rejected Aetna's claim and the doctor's counterclaim for abuse of process, but entered a verdict for the doctor on his other counterclaims. At the damages trial, the judge granted Aetna's motion to involuntarily dismiss the tortious interference claim, and the jury awarded the doctor $1,918,462.72 in damages, plus pre-judgment interest, for a total award of $2,124,113, on the unjust enrichment counterclaim. On the basis of the nature of the doctor's practice as precluding discussion of fees with his patients, and DOBI regulations on "balance billing," the Appellate Division approved the jury's award of a "reasonable fee," noting that although the defendant had billed some $8 million for his services, the jury only awarded him approximately $2 million in damages, but also affirmed the trial court's dismissal of the tortious interference counterclaim, on the basis that the doctor had failed to prove a causal connection between Aetna's interference and his damages.

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