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

Physicians Question Whether CMS' Part B Drug Proposal Plan Usurps Clinical Judgment, Cripples Specialists: Medicare's overhaul of the way it reimburses doctors for more than $20 billion worth of outpatient drugs they administer each year has drawn criticism from physicians. Financially, although some physicians will receive higher payments, the current plan is economically disastrous to a handful of specialties, particularly oncologists, ophthalmologists and rheumatologists. Those specialists, who earn substantial shares of their revenue from Medicare's longstanding method of paying them a drug's average sales price, or ASP, plus 6%, will see a significant decrease in reimbursements. Critics of the bill argue that this is another example of the government inserting itself in patient care and usurping the care physicians provide to their patients. The CMS, however, states that their decisions do not impact patient care as physicians may still prescribe the same drugs. The plan is based on a study from the Medicare Payment Advisory Commission, academic studies and models already adopted by private payers. Policy experts who support the plan argue that the payment structure derived from Part B drugs has created a perverse incentive that needed to be ended. Medicare has been moving away from fee for service to value-based payment models but until now policy experts were surprised that it had yet to target drug spending. Under a second phase of the pilot, the CMS intends to test a "menu of value-based purchasing options." The purpose of the second phase is to hopefully allow the CMS to enter into voluntary agreements with drug manufacturers to link patient outcomes with price adjustments, which would give Medicare some say in determining the prices it pays for drugs.

Doctors Contemplate Delicate Talks As Medicare Pays for End-Of-Life Counseling: Medicare's new policy will reimburse doctors for giving end-of-life advice during a senior's annual wellness visit or in a routine office visit. Nurse practitioners and physician assistants will also be reimbursed for speaking with patients about end-of-life issues. Although Medicare's policy has broad support from health providers and patient groups, neither physicians nor the American Medical Association ("AMA") foresee a surge in end-of-life planning among Medicare's more than 50 million enrollees. The AMA, which supports Medicare's new policy, projects that Medicare will reimburse fewer than 50,000 counseling sessions in 2016. Under the rule, physicians can now bill Medicare $86 for an office-based, end-of-life counseling session with a patient for as long as 30 minutes; however, there are no rules on what doctors must specifically discuss during those sessions. For example, physicians can advise patients seeking guidance on completing advance directives, such as if or when they want life support measures such as ventilators and feeding tubes, and how to appoint a family member or friend to make medical decisions on their behalf if they cannot. A similar reimbursement plan was previously discussed in 2009, as part of the congressional debate over the Affordable Care Act. In 2009, though, the proposal to have Medicare pay for such discussions sparked political controversy and fueled concern that they would lead to so-called "death panels" that could influence decisions to avoid medical care. Expectedly, the proposal was quickly dropped from the Affordable Care Act..

New Bill Seeks to Alter Law on Registered Surgical Practices Bill A-3101, sponsored by Assemblyman Herb Conaway, Jr., M.D. (D-7), introduced on February 22, 2016 and reported out of committee on the same day after its second reading, seeks to amend existing law by allowing registered surgical practices to convert to, or combine with, ambulatory care facilities. If passed by the Legislature and signed by the Governor, the bill would also permit non-profit hospitals to acquire joint ownership interests in medical practices. An increase in the number of operating rooms would not be permitted; for example, a registered surgical practice which converts to an ambulatory care facility would be limited to the number of operating rooms which previously existed in the surgical practice, and a registered surgical practice which combined with an existing ambulatory care facility would be limited to the combined number of operating rooms maintained by both the surgical practice and ambulatory care facility before the combination occurred. In cases where a non-profit hospital acquires an interest in a practice, the bill provides that all clinically-related decisions must be made by a practitioner and be in the best interests of the patient. The bill also places limits and phase-ins on the uniform gross receipts assessment which much be paid following the conversion or combination.

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