New Jersey Orthopaedic Society
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Monthly Report

May 2015

In this issue

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From The Statehouse
AJ Sabath, Lynn Haynes, and Charles Burton

Out of Network:
Major health insurance reform legislation (S.20 & A.4444) was introduced on Thursday May 16, 2015, that sponsors claim would provide transparency to New Jersey's current out-of-network fee structure and curtail the financial surprise dealt to insured patients receiving urgent or emergency care at an out-of-network facility.

In reality, the measure is very complex and deals with a litany of issues focusing on disclosure, out-of-network billing, healthcare price indexing, arbitration, waiver of co-pays, and penalties. Based upon our initial review of the legislation, the most egregious aspect zeros in on so called "surprise billing" situations (OON hospitals, "ologists" and OON physicians in in-network hospitals - which would impact those providing care through the ER).

The legislation seeks to address the "surprise billing" situations by creating a paid fee index, based on in-network paid fee data, and limiting reimbursement on said claims to 75%-250% of the median in-network fee.

The bill also provides for data collection that would create additional levels of bureaucracy through: (1) enhanced OON status disclosures; (2) pre-treatment disclosure of pricing; and (3) reporting of participation status to DOH.

We have been in discussions with various stakeholders from the Access to Care Coalition (various ologists, surgical specialties, primary care and hospitals), to develop a short and long term advocacy strategy. In the meantime, we are scheduling meetings with key legislators and are participating in stakeholder meetings to point out many of the shortcomings with this proposal. In addition to our individual advocacy effort, we are working with the House of Medicine and hospitals on a coordinated strategy. Please be on the lookout for future updates from us on this issue to learn how you can help our advocacy effort.

Prescription Monitoring Program (PMP)/ Opioid Abuse Legislation
We have been very involved in the Prescription Monitoring Program (PMP) legislation (S-1998/ A-3129) introduced by Senator Weinberg, Assemblyman Conaway and Assemblyman Lagana. The measure recently passed both houses and now heads to Governor Christie's Desk for further consideration. There was last-minute activity between the bill's sponsors, the Attorney General's Office and Governor's Counsels Office before it was released with amendments from the Assembly Budget Committee on March 23rd.

We were able to successfully thwart attempts by the Attorney General's Office and Governor's Counsel's Office to remove some important provisions and exemptions we fought for to include in the bill, such as the post-operative exemption for prescriptions under 30 days. Emergency departments are still exempted from checking the PMP when prescribing less than a five day supply of pain medicine. And health care professionals, other than physicians are able to check the PMP. We remained neutral in committee once we learned many of the important provisions of the bill would not be changed.

APN Scope of Practice
Governor Christie signed A.1319 / S.1152, which allows APNs to diagnose death and complete certifications. The House of Medicine has opposed this bill for a few years. Due to our collective opposition, the bill was amended to narrow the circumstances under which an APN could make the diagnosis: if s/he is the patient's primary caregiver and if the physician is unavailable.

Legal Report

Mark Manigan, Esq.
Partner, Brach Eichler LLC

National Update at-a-Glance

H.R. 2 Revises Medicare Payment Methodology
President Obama signed H.R. 2, The Medicare Access and CHIP Reauthorization Act of 2015, into law on April 16, 2015. The bipartisan bill, also referred to as the "doc fix," repealed the sustainable growth rate (SGR) as the calculation method of Medicare payment rates to physicians and establishes a new compensation regime.

From July 2015 through 2019, there will be a flat rate increase for all eligible providers of 0.5%. From 2020 through 2025, there will be a 0% increase. Beginning in 2019, eligible providers may qualify for rate increases in two ways. First, is the Merit-Based Incentive Payment System (MIPS), whereby the Secretary of Health & Human Services will establish performance criteria based on quality, resource use, clinical practice improvement activities and meaningful use of electronic health records. Eligible providers must report their previous year's data to the Secretary. Those providers performing well will have their compensation adjusted positively, while those providers performing poorly on the Secretary's metric will have their compensation adjusted negatively.

Second, is an incentive for eligible providers to participate in Alternative Payment Models (APMs) (opposed to a fee-for-service model). Providers become a qualified APM participant by demonstrating that a certain threshold percentage, which increases each year, of their payments are derived from an APM source. If a provider qualifies in 2019 through 2024, the provider is able to receive a 5% lump sum annual bonus. Although providing for two alternative models for the next ten years, H.R. 2 pushes providers towards the APM model because beginning in 2026, providers will receive either a 0.75% increase as an eligible APM participant or 0.25% increase as a non-eligible APM participant.

Supreme Court to Decide on Key ACA Issue
The U.S. Supreme Court recently heard oral arguments in the case of King v. Burwell, in which the Supreme Court will decide whether individuals who purchase health insurance through the federal insurance exchange are entitled to federal subsidies. The plaintiffs in the underlying case argued that according to the plain language of the Affordable Care Act (ACA), only individuals who buy health insurance through an exchange established by a state are entitled to federal subsidies, and therefore an IRS regulation which allows

payment of subsidies to individuals who buy insurance through the federal exchange is inconsistent with the ACA. The Supreme Court agreed to hear the plaintiff's appeal from the ruling of the Fourth Circuit Court of Appeals, which found that the language of the ACA is ambiguous enough to permit the Court to give deference to the IRS's interpretation of the ACA to allow subsidies to be paid to individuals who purchase health insurance through the federal exchange.

Based on the questions posed by the Justices during oral arguments, analysts believe that the Supreme Court is split regarding how to interpret this part of the ACA. If the Supreme Court overturns the decision of the Fourth Circuit and finds that only those who buy health insurance through a state exchange can receive federal subsidies, many people who purchased health insurance through the federal exchange may be forced to drop their coverage due to the lack of ability to pay. In addition, the individual mandate of the ACA may be weakened because more people would qualify for an exemption from the individual mandate based on the insurance no longer being considered affordable. A decision is expected in June or July of this year.

Supreme Court Rules on Workplace Accommodations for Pregnant Employees
In Young v. United Parcel Service, Inc., the United States Supreme Court held that employers may have to accommodate pregnant workers if they accommodate other employees who, for different reasons, are not able to perform jobs requiring heavy lifting. The decision stemmed from the denial by United Parcel Service (UPS) of light-duty work for a pregnant driver, who was then forced to take unpaid leave. The plaintiff petitioned to the Supreme Court after an appeals court upheld a lower court's decision to grant summary judgment in favor of UPS.

The plaintiff argued that by failing to accommodate the plaintiff to the same extent that it accommodated other, non-pregnant employees who were similar in their inability to work, UPS had violated the Pregnancy Discrimination Act (PDA), which was enacted to clarify that discrimination based on pregnancy, childbirth or other related medical conditions is included in the definition of discrimination "because of sex" under Title VII of the Civil Rights Act of 1964. UPS argued that the plaintiff was different than those other employees, whom UPS had accommodated because they had been injured on the job or had a disability covered by the Americans with Disabilities Act. The Supreme Court rejected the appeals court's decision, finding that while the PDA does not require that pregnant employees are automatically entitled to workplace accommodations, a pregnant employee can claim disparate treatment under the PDA, and liability will depend upon whether the employee can prove that the protected trait itself motivated the disparate treatment by the employer.

SCOTUS Prohibits Providers from Suing States to Improve Medicaid Rates
On March 31, 2015, the Supreme Court of the United States issued a 5-4 decision in Armstrong v. Exceptional Child Care Center, Inc., 135 S.Ct. 1373, which reversed the decision of the United States Court of Appeals for the Ninth Circuit, as well as the state courts in Idaho, and held that providers of Medicaid services do not have a cause of action to challenge a state's Medicaid rates. The lawsuit was initially brought by two home health care workers who challenged Idaho's low Medicaid reimbursement rates. The lawsuit claimed that the State of Idaho was unfairly keeping Medicaid rates at 2006 levels despite studies showing that the cost of providing care had substantially increased. In its opinion, the Ninth Circuit affirmed the decision of the state courts and held that reimbursement rates should bear a reasonable relationship to provider costs.

The lower court's decision increased reimbursement and cost the state approximately $12 million in 2013.

The Supreme Court held that the Medicaid Act did not authorize providers' private action for injunctive relief to enforce against a state the act's reimbursement-rate standard. In other words, the Court concluded that Medicaid providers cannot sue the state for paying them too little under the Medicaid Act. Instead, it is the federal government that is supposed to enforce the broadly worded reimbursement provisions.

The American Medical Association, American Dental Association and the American Hospital Association had all urged the Court to protect Medicaid from state cutbacks, and this decision is a blow to providers who claim that Medicaid rates are not covering their costs. Now, providers will have to take any objections to Medicaid rates to the U.S. Department of Health & Senior Services. Patient access will be impacted as well because Medicaid beneficiaries may have more difficulties finding doctors who will accept Medicaid.

Ninth Circuit Court Affirms FTC's Challenge to Hospital Physician Group Merger
The Ninth Circuit Court of Appeals recently upheld a ruling ordering St. Luke's Health System Ltd. to unwind its purchase of a physician practice group, siding with the Federal Trade Commission (FTC) despite the hospital's claims that the deal would help it meet health care reform requirements. A three-judge panel upheld the lower court's decision that St. Luke's acquisition of Saltzer Medical Group P.A., the largest physician group in the Idaho region, violated federal anti-trust law.

Notably, this is the first challenge of a hospital-physician group merger by the FTC that has proceeded to trial. The court's opinion supports what federal antitrust enforcement agencies have been saying since the Affordable Care Act (ACA) was enacted --- reliance on health care reform and the ACA's emphasis on integration will not save an otherwise anticompetitive merger.

The opinion also confirms the heavy burden defendants in similar cases face when they attempt to justify an anticompetitive merger by relying upon "efficiencies" that the merger may provide in their respective markets. Accordingly, any potential efficiencies resulting from a merger need to be rigorously supported because once a merger challenge reaches court, an "efficiencies" defense will rarely succeed.

CMS Delays Publishing Overpayment Final Rule Until February 2016
Centers for Medicare & Medicaid Services announced a one-year delay in the publication of final regulations under the Affordable Care Act's "60-day overpayment" rule, which requires providers and suppliers to report and return overpayments received from the Medicare or Medicaid programs within sixty days of discovery. Citing "the complexity of the rule and scope of comments" as reasons for the delay, CMS now states the final rule will be published in February 2016.

Proposed regulations were published in February 2012. The proposal, among other things, would alter the definition of what it means for a provider or supplier to "know" of any overpayment. The proposed rule would include in the definition of "know or known" a caveat that "deliberate ignorance" will not exculpate a provider or supplier from failing to report overpayments. In addition, the proposed rule would establish a "10-year-look-back" period.

OIG Rejects Criticism About Hospital Review Process
The U.S. Department of Health & Human Services, Office of Inspector General (OIG) released a letter addressed to the American Hospital Association (AHA) affirming the OIG's position with respect to its hospital Medicare compliance review process. The AHA previously sent a letter to the OIG objecting to the review process, citing alleged legal defects. The OIG stated that the hospital reviews are intended to reduce Medical billing errors and strengthen compliance, and called the reviews "a critical component of educating providers about how to identify and remediate risk areas in billing." Importantly:

- In response to the AHA's claim that the OIG should not use extrapolation in audits reviewing short inpatient stays, the OIG noted that it had already suspended its review of short inpatient stays after October 1, 2013
- The OIG agreed to work with Centers for Medicare & Medicaid Services (CMS) to determine the offset to Medicare Part A overpayments after the AHA claimed that the OIG was artificially inflating announced overpayments by not offsetting the estimated Part A overpayment amounts with the amount of Medicare Part B payment to which a hospital is entitled
- The OIG emphasized that, despite the AHA's suggestion that the OIG should not review claims beyond applicable statute of limitations periods, CMS allows for re-opening of claims at any time if there is reliable evidence of fraud or similar theft
- The OIG disagreed with the AHA's accusation that it misapplies or misinterprets certain Medicare requirements because the requirement of documenting a physician's written order is supported by legal authority and cancelled surgeries should not be billed to Medicare as they are not reasonable and necessary for the treatment of illness or injury.

Focus on the States

New Jersey Supreme Court Rules Health Center Is Not Entitled to Full Charitable Immunity
The New Jersey Supreme Court recently ruled in Kuchera v. Jersey Shore Family Health Center, 111 A.3d 84 (N.J. 2015), that a health center was entitled to only limited liability and not full charitable immunity. In Kuchera, the sole issue before the court was whether the Jersey Shore Family Health Center (the "Center")and its parent, Jersey Shore University Medical Center, was entitled to full charitable immunity, or the limited liability afforded to nonprofit entities organized exclusively for hospital purposes, after the plaintiff brought a suit against the Center for a slip-and-fall case.

The Charitable Immunity Act, N.J.S.A. 2A:53A-7 to -11, contains two separate limits on liability for personal injury, caused by alleged negligence, which has occurred at the site of a nonprofit entity. The first, N.J.S.A. 2A:53A-7 et seq., grants total immunity for such actions to nonprofit entities organized exclusively for charitable, educational, or religious purposes. The second, N.J.S.A. 2A:53A-8, contains a limit on damages for such actions to no more than $250,000.00, to nonprofit corporations, societies or associations organized exclusively for hospital purposes.

The court held that the Center, and its parent, was a nonprofit institution organized exclusively for hospital purposes rather than for religious, charitable, or educational purposes and, as such, was only afforded the protection of limited liability. The court reasoned that a nonprofit entity's certificate of incorporation and by-laws, although

informative, is not dispositive. The court's real inquiry must look into how the organization consistently conducts its affairs, which requires a fact-sensitive inquiry to determine which protection should actually be applied to that organization.

$8.5 Million Verdict Awarded Against Concierge Medicine Firm for Malpractice of Contracting Physician

In what is believed to be the first malpractice verdict ever returned against a concierge management firm, a Palm Beach County, Florida jury awarded $8.5 million to the estate of a plan member in an action against MDVIP Inc., the nation's largest concierge medicine practice.

The jury found that Dr. Charles D. Metzger qualified as an agent of MDVIP at the time that he treated the decedent, and that negligence liability passed via the agency relationship to MDVIP. The plaintiff claimed that a blood clot in the patient's leg was misdiagnosed multiple times by Dr. Metzger and other MDVIP-affiliated staff, resulting in a worsening condition that eventually required leg amputation. The patient later died of leukemia.

Industry observers indicate the ruling is significant and may cause concierge companies to more stringently review the credentials of physicians seeking to become members of their networks. The Florida district court ruling controverts the assumption of concierge companies that they are immune from liability for malpractice because they merely act as brokers between doctors and patients. MDVIP representatives have indicated that they intend to appeal the verdict.

New Mexico Court Rules Hospital Cannot Fire Physician for Conduct During Peer Review

In Yedidag v. Roswell Clinic Corp. (N.M. 2015), the New Mexico Supreme Court ruled that a hospital cannot terminate a physician for his disruptive behavior while serving on a peer review committee because, under the New Mexico Review Organization Immunity Act (ROIA), the content and actions of the peer review committee are confidential. In this case, Roswell Clinical Corp. terminated Dr. Yedidag because he "attacked" a physician by asking the physician certain questions during peer review. Dr. Yedidag argued that the hospital cannot fire him for his actions because the peer review process is confidential and the employer-hospital should not have access to such information. The New Mexico Supreme Court agreed and further stated that only the medical staff would be able to evaluate Dr. Yedidag's behavior.

New Jersey has a statute similar to the New Mexico ROIA, providing that individuals who participate in peer review committees for a hospital cannot be held liable for their actions on behalf of the committee. Therefore, New Jersey hospitals should be mindful that a physician's disruptive behavior while participating in peer review may not be grounds for termination of the physician's employment. Nonetheless, the hospital's medical staff may be able to investigate the physician's behavior in accordance with the medical staff Bylaws.

Bill Introduced to Authorize Telemedicine in New Jersey

Senate Bill S2729, if passed into law, would, among other things, expressly permit the practice of telemedicine in New Jersey and would require managed care plans, Medicaid, the State Health Benefit Commission's and the School Employees Health Benefit Commission's health care plans to pay for medical services provided via telemedicine at

a rate equal to the reimbursement rate provided for in-person services.

Additionally, the bill would provide a mechanism for physicians, registered nurses, practical nurses, advance practice nurses, physician assistants, psychologists, psychoanalysts and licensed social workers to obtain reciprocal licenses to practice in New Jersey if the providers are licensed by another state in their particular specialty. The bill also would expressly permit physicians and advance practice nurses to prescribe medications to patients based upon an examination that is performed via telemedicine.

PriMed Consulting Update

Gabrielle Lamb, Vice President of Business Development

New Jersey 'Medical Malpractice Insurance 101'
A medical professional's guide

The selection of the optimum NJ medical malpractice insurance policy, at the most competitive premium, can be a daunting task. This process can be all the more confusing for a physician who has just completed his or her training, is ready to begin practicing medicine in a solo or group environment, and is lookng to purchase their first NJ Medical Malpractice Insurance policy.

Whether you are a new-to-practice physician, or someone who has experience practicing in NJ/NY, we believe that you can benefit from a basic understanding of the NJ Medical Malpractice Insurance market. Here is a brief summary of the basic critera that may impact your coverage or premiums:

1. Type of coverage: NJ Medical Malpractice insurance carriers offer primarily two kinds of policies: Occurrence (or Occurrence Plus, Permanent Protection) and Claims-made. Occurrence policies are higher in premiums in the initial 4 years since they include permanent protection for physicians, or what is commonly known as 'tail coverage.' Most NJ Medical Malpratice carriers offer both types of coverage.
2. Claims history: One of the most important criteria NJ Medical Malpractice insurance underwriters consider is the past claims history of the physician. Most carriers usually look at the prior 10 years history, which would include all open and closed or settled medical malpractice cases. However, there are differences in how surchargeable claims are defined by various carriers.
3. NJ Carriers vs RRGs: There are 8 NJ Medical malpractice insurance carriers currently in the market. In addition, there are a number of RRG's (Risk Retention Groups) offering policies, primarily to large groups or physicians who have an above-average claims experience. We urge physicians to keep in mind that price should not be the only consideration in deciding on a malpractice carrier: more important is the reputation of the carrier, along with long-term value & stability.
4. Discounts: There are several discounts offered by NJ Medical Malpractice insurance carriers: Some are offered by most carriers, in some shape or form, while other discounts may be specific to some carriers only. Some types of exclusive discounts are: Specialty soceity discounts, Purchasing Alliances, etc. As an example: The NJOS (New Jersey Orthopaedic Society) has a purchasing alliance that offers exclusive discounts to its members if they are insured by MDAdvantage of New Jersey.
5. Specialist brokers/agents: Physicians and surgons will benefit greatly if they work with an experienced NJ Medical Malpractice insurance broker who can provide guidance and

expertise in selecting the most appropriate malpractice coverage at the most competitive premium. Besides, working with a broker does not add to your cost: You can have a broker do the leg work for you without any additional cost to you.

For more information, or help with your medical malpractice insurance, please contact PriMed Consulting. 800.528.3758. Email: info@primedconsulting.com www.primedconsulting.com

Varbeco Wealth Management Update

The Role of Alternative Investments

The term "alternative investments" covers a range of investments that fall outside of traditional investments such as stocks, bonds, and cash/cash equivalents. Alternative investments include hedge funds, managed futures, private equity, private debt (business development companies) and real estate (real estate investment trusts).

Alternative investments historically have sought to provide investors with several potential investment advantages, including diversification and risk reduction. Changing financial markets demand an allocation strategy that incorporates more than just stocks, bonds and cash.

Alternative investments were once available exclusively to institutional investors, and carry certain restrictions including investment minimums and eligibility requirements, which may exclude their practical use by individual investors. However, thanks to financial innovation and the growth of the alternative strategy marketplace, a growing number of alternative strategies are becoming available to individual investors.

Alternative investments are quickly gaining traction in the marketplace as an attractive option for investors to potentially diversify their investments, manage market volatility and provide an alternative source for return. Incorporating alternative investments gives individual investors the opportunity to create more efficient portfolios that potentially offer better risk-adjusted returns.

Alternative investments typically have low or negative correlation to other asset classes over long periods, meaning that the investment performance is independent of other investments. This low correlation means that when other investments are down, alternative investments may continue to perform.

Traditional investments may target a specific geographic area of the globe or a specific sector of the U.S. equity market and invest in companies that they anticipate will rise in value. Alternative strategies can also access traditional securities, like stocks, but use them in an "alternative" manner by employing options strategies or short-selling. Alternative investments can also access other markets, securities, currencies and commodities to provide a unique strategy to complement an existing portfolio of stocks and bonds.

Last year the 2 best performing asset classes came from the Alternative arena. Activist strategies (hedge fund) were up over 30% and some Managed Futures funds were up

over 20%.

We currently can offer exposure to a number of Alternative investments options including Hedge funds (both direct and fund of funds), Private Equity, Long-short (both equity and fixed income), Business Development Companies, Non-traded REITs, and Managed Futures.

Now could be a good time to explore the advantages of owning some Alternative Investments in your portfolio. Please contact me if you have any questions at dvargo@varbeco.com or (877)972-7900.

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