

November 1, 2016

TO: OFFICERS, COUNCILORS, AND TRUSTEES

FROM: GREGORY PINTO, MD
THOMAS LEE, MD
MOE AUSTER, ESQ., SENIOR VP FOR LEGISLATIVE AND REGULATORY AFFAIRS
PAT CLANCY, VP, PUBLIC HEALTH AND EDUCATION

RE: REPORT FROM THE DIVISION OF GOVERNMENTAL AFFAIRS

STATE-LEVEL ACTIVITY:

New Law Reduces Physician Reporting Burdens When a Physician Must Issue a Paper Prescription

Governor Cuomo has signed into law legislation (S.6779, Hannon/A.9335, Gottfried) strongly supported and advocated for by MSSNY which eliminates the requirement for a physician to report a litany of information to the New York DOH when he/she must issue a paper prescription in lieu of an e-prescription. Instead, the new law requires that the physician make a notation in the patient's medical record that a paper/oral/fax prescription was issued in those circumstances, articulated in the statute, that are excepted from the general e-prescribing requirement. These circumstances include:

- Temporary technological or electrical failure;
- When the prescription will be dispensed by a pharmacy located outside the state;
- When the physician reasonably determines that an e-prescription would be impractical for the patient to obtain the medication in a timely manner, and such delay would adversely impact the patient's medical condition.

MSSNY thanks the many physicians across New York who responded to our call to contact their legislators and the Governor to express their support for this legislation. MSSNY worked closely with the Healthcare Association of New York State (HANYS) and numerous specialty societies to advocate for this important change to the law.

Upon learning that the bill was signed into law, MSSNY President, Malcolm Reid, MD issued the following statement. "We are pleased that Governor Cuomo has signed into law legislation to reduce the reporting burdens in those situations when a physician must issue a paper prescription. We thank Senator Hannon and Assemblyman Gottfried for championing this legislation. We look forward to working with the Governor and the Legislature to address other obstacles related to e-prescribing that interfere with patients timely receiving needed medications".

Physicians Urged to Contact Governor Cuomo To Sign Step Therapy Override Bill

All physicians are urged to send a letter (<http://cqrcengage.com/mssny/app/onestep-write-a-letter?4&engagementId=225193>) to Governor Cuomo requesting that he sign into law a bill (A.2834-D/S.3419-C) that would establish specific criteria for physicians to request an override of a health insurer step therapy medication protocol when it is in the best interest of their patients' health.

The bill has not as of yet been delivered to the Governor.

MSSNY strongly supported this bill, and worked with a wide array of patient advocacy organizations, specialty societies, hospitals, and pharmaceutical manufacturers to achieve passage of this legislation. We know the insurers are strongly fighting this bill, so the Governor's office needs to hear your support.

MSSNY representatives and several other patient advocacy groups have had multiple meetings with the Governor's office to urge that this bill be signed into law. Moreover, in August, dozens of patient advocates rallied at the State Capitol in support of this bill.

The bill would require a health insurer to grant a physician's override request of an insurer step therapy protocol if one of the following factors are present: 1) the drug required by the insurer is contraindicated or could likely cause an adverse reaction; 2) the drug required by the insurer is likely to be ineffective based upon the patient's clinical history; 3) the patient has already tried the required medication, and it was not effective or caused an adverse reaction; 4) the patient is stable on the medication requested by the physician; 5) the medication is not in the best interests of the patient's health. While the legislation would generally require the health insurer to make its decision within 3 days of the override request of the physician, the insurer would be required to grant the override request within 24 hours of the request if the patient has a medical condition that places the health of such patient in serious jeopardy if they do not receive the requested medication. Perhaps most importantly, if the physician's request for an override is denied, it would enable a physician to formally appeal the decision both within the plan's existing appeal mechanism as well as taking an external appeal.

MSSNY President Dr. Malcolm Reid recently sent a Letter to the Editor of the *Albany Times-Union* in response to op-ed from the New York Health Plan Association in opposition to this bill. Specifically, Dr. Reid's letter noted that New York's physicians are proud to partner with patients and patient advocacy groups to support legislation to strongly regulate health insurance company prescription fail first+protocols+and that legislation is necessary because there have been many instances where patients' health has been adversely impacted by overly strict application of these protocols.

NY DFS Issues Guidance To Insurers of New Substance Abuse Coverage Requirements

The New York Department of Financial Services recently issued a 9-page guidance to health insurance companies reminding them of new requirements enacted earlier this year to expand coverage for substance use disorder treatments. This includes expanded prescription drug coverage, and expanded inpatient and outpatient coverage, coverage for naloxone, and expedited pre-authorization requirements. To read the guidance, click here: http://www.dfs.ny.gov/insurance/circltr/2016/cl2016_06.pdf

MSSNY and AMA Both Urge the New York DFS to Reject Anthem-Cigna Proposed Merger

MSSNY President Dr. Malcolm Reid and AMA antitrust expert Henry Allen each presented testimony on September 8 to the New York State Department of Financial Services urging DFS to reject the proposed takeover of Cigna by Anthem, the parent of Empire Blue Cross/Blue Shield.

To read the joint MSSNY-AMA Press release, click here: <http://www.ama-assn.org/ama/pub/news/news/2016/2016-09-08-anthem-cigna-deal-new-york-state.page>.

To read a *Modern Healthcare* article summarizing the hearing, click here: <http://www.modernhealthcare.com/article/20160908/NEWS/160909910>

Dr. Reid's testimony emphasized the already very difficult practice environment for physicians in New York State that has become worse in recent years, as a result of the narrowing of health insurer participating provider networks and increasing pre-authorization burdens. The recent litigation initiated by the US Department of Justice to block this proposed merger as well as the proposed Aetna-Humana merger validated the very serious concerns held by many physician and patient advocacy groups in New York State and across the country, stated Dr. Reid.

The AMA testimony focused on the huge market impact if Anthem were to purchase Cigna, and the perspective that the benefits would accrue to the insurer. "In effect, the costly process of merging two giant insurance bureaucracies is born on the backs of patients and employers," stated Mr. Allen.

In calling for a public hearing in August, DFS Superintendent Maria Vullo released a letter (http://dfs.ny.gov/about/press/pr160803_anthem_cigna_letter.pdf) noting that DFS has "serious concerns that

Anthem's proposed acquisition of Cigna will adversely impact the competitiveness of the health insurance market and harm consumers in New York.

This action followed the filing of litigation by the US Department of Justice (See the press release here: <https://www.justice.gov/opa/speech/principal-deputy-associate-attorney-general-bill-baer-delivers-remarks-press-conference>) to block the proposed Anthem takeover of Cigna, as well as the proposed Aetna takeover of Humana.

The DOJ intervention had been strongly supported by the American Medical Association, numerous state medical societies across the country including MSSNY, and several powerful consumer/patient advocacy groups.

The letter from Superintendent Vullo noted the huge market impact if Anthem and Cigna were permitted to merge. It would increase Anthem's market share across commercial products to 31.2% statewide, of which Anthem would command 9.8% of New York's fully insured market and 47.6% of the self-insured market. The biggest impact would be felt in the New York City metro area, where Anthem would control nearly 70% percent of the commercial self-insured market in the Bronx and Staten Island, 63% in Queens and Brooklyn, and 55% in Putnam County.

MSSNY Participates in DFS Out of Network Reimbursement Workgroup Discussions

For the last several months, MSSNY Councilor Dr. Thomas Lee, MSSNY Legislative & Physician Advocacy Committee member Dr. Michael Brisman, and MSSNY member Dr. Mark Reiner have represented the physician community in a workgroup convened by the New York Department of Financial Services (DFS) to analyze and make recommendations regarding out of network reimbursement in New York. The Work Group was created by the Surprise Medical Bill Law enacted in 2014 negotiated and supported by MSSNY, and consists of representatives of physicians, consumers, health insurers and businesses.

The Work Group has had discussions on a number of different topics, including the availability of out of network insurance coverage across New York State, the functioning of the Independent Dispute Resolution (IDR) process for emergency and surprise OON bills, whether the IDR process should be expanded to situations where a consumer receives incorrect network participation information, whether there should be a single OON reimbursement methodology and whether there are suitable alternatives to the use of Fair Health as the out of network reference point. Not surprisingly, the insurance representatives have opposed the expanded availability of OON coverage and have sought to marginalize the use of the Fair Health database as the template for out of network coverage. Instead, they would promote the use of Medicare, in-network or a blended rate as the template for out of network coverage, which has been strongly opposed by the physician representatives.

While the final Work Group report had a statutory deadline of October 1 to submit a report to the Legislature, the contentious nature of the discussions has delayed the issuance of the final report.

MSSNY-Home Care Workgroup Seeks to Reduce Administrative Burdens

As directed at this year's House of Delegates, MSSNY has established a work group with the Home Care Association of New York State (HCA) to collaborate on efforts to address overbearing administrative burdens that stand in the way of patients receiving, and physicians ordering, needed home care services. The first meeting of the group took place in September and another is scheduled for the end of October.

One of the most important issues under discussion is how best to reduce the burden of the so-called Face-to-Face requirement included in the ACA. This provision requires a certifying physician to document that he or she, or a non-physician practitioner (NP or PA) working with the physician, has seen the patient, as a precondition of eligibility for Medicare and Medicaid coverage for home health services. Many home care agencies and physicians have noted that the CMS regulations implementing this provision have created unnecessary and overly burdensome documentation requirements that are delaying or denying coverage for needed home care services. One home care provider shared an example of a CMS review agent denying the

patient's coverage for services based on his assessment of the physician's documentation, despite concurring that the patient met the requisite eligibility criteria and indeed needed the services.

On the federal level, New York Representatives Tom Reed (R-Southern Tier) and Paul Tonko (D-Capital District) initiated a sign on letter to CMS with over 70 other members of Congress to urge simplification of the Face to Face requirement. Specifically, the letter noted that the current regulations contain complicated, confusing, and overlapping documentation requirements that exceed the intent of the law passed by Congress. These requirements have imposed a significant burden on home health providers and physicians in our districts.

On the state level, as the state has now moved (as of July 1) to implement Face-to-Face for Medicaid, HCA and MSSNY, the Healthcare Association of New York State (HANY) and the Iroquois Healthcare Alliance have met with the New York DOH to urge mitigation of such an added layer of burden for Medicaid. These groups have also suggested areas where the Face to Face requirement could be eliminated entirely for Medicaid, such as within the context care delivered under managed care, or other managed care-like models, such as within a regional Performing Provider System (PPS) established under DSRIP, or an ACO, health home or other integrated model.

The work group has also discussed the importance of assuring physicians are properly educated regarding these federal requirements, including the importance of completing certification in a timely and comprehensive manner.

MSSNY Representatives for this work group include Dr. Evelyn Dooley-Seidman, Chair of MSSNY's Long-Term Care Committee; MSSNY Board of Trustees Member Dr. Andrew Kleinman; Dr. Ruth Kleinman; Dr. Eugene Kalmut; and Dr. Jay Slotkin.

To view a brief CMS power point presentation regarding these Face to Face rules, go here: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/homehealthpps/downloads/face-to-face-requirement-powerpoint.pdf>. To read a detailed FAQ document prepared by CMS, go here: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/homehealthpps/downloads/qandasfull-revised-062712.pdf>

For more information about the activities of the Task Force, please contact mauster@mssny.org.

MSSNY Comments on State "All Payor Database" Proposed Regulations

MSSNY has written to the New York State Department of Health to express serious concerns with its proposed regulations to implement an All Payor Database in New York consisting of claims data from every licensed New York health insurance plan. While the letter notes the importance of collecting and analyzing information to investigate trends in care delivery and develop best practices, it also noted our concern that a database that consists only of claims information and which does not include other aspects of care delivery contained in the medical records could result in presenting misleading information to the public. The letter also notes our concern that that regulation does not only contemplate release of quality data, but also potentially includes the release of payment and fee data, which could be highly misleading. Finally, MSSNY recommended the regulation create an advisory group to provide guidance on data release and data aggregation. Other states such as Vermont and Maine have established by regulation a formal committee of individuals representing physicians, hospitals, health plans and consumers to review requests by groups for such data. On September 29, Patrick Roohan, NY DOH Director Office of Quality and Patient Safety, presented to the MSSNY Health Information Committee, regarding the creation of the APD.

It should also be noted that a recent US Supreme Court ruling prohibited the mandatory collection of payment data from self-insured payors. As a result, MSSNY has expressed concerns to various state policymakers that the exclusion of such data will have the effect of significantly skewing the remaining data in the claims database.

FEDERAL-LEVEL ACTIVITY:

Please Review Comprehensive Medicare Quality Payment Program Summaries

On October 14, CMS issued its final rule implementing the Medicare Quality Payment Program that starts in 2017. The rule implements the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs adopted as part of the MACRA law enacted by Congress in 2015. The American Medical Association (AMA) has prepared two summaries that physicians can review from MSSNY's website to familiarize themselves with the important provisions of this rule. You can access these documents by clicking [HERE](#)

(http://www.mssny.org/Documents/2016/Governmental%20Affairs/Federal%20Advocacy/102016/QPP_Summary_10-17-16_Final.pdf) and [HERE](#)

(http://www.mssny.org/Documents/2016/Governmental%20Affairs/Federal%20Advocacy/102016/QPP%20Highlight%20Chart%2010_17_16.pdf).

As has been widely reported, there were positive changes contained in the final rule that provide some flexibility to physicians in complying with new Medicare Merit Based Incentive Payment System (MIPS). These include:

- enabling physicians who report at least some 2017 data before March 31, 2018 to avoid a 2019 Medicare payment penalty;
- increasing from \$10,000 to \$30,000 the annual Medicare revenue threshold requiring participation in the MIPS program;
- reducing from 90% to 50% the percentage of Medicare patients of which a physician has to report quality measures;
- Reducing from 11 to 5 the number of measures to be reported in the Advancing Care Information category (which replaces Meaningful Use); and
- Eliminating the Value based component in the 2017 MIPS evaluations.

At the same time, there is concern that some of these provisions did not go far enough, or will be phased out after 2017. Review of all the provisions of the final rule is ongoing. Medical societies across the country including the AMA, MSSNY and the Coalition of State Medical Societies had advocated for additional flexibility, particularly for smaller practices that may not have the infrastructure necessary to be successful in these value-based payment programs.

On **November 21 and December 6**, the AMA will host educational webinar sessions to help physicians prepare and understand what the final rule means for their practice.

To Register for November 21 : <https://cc.readytalk.com/r/y70aavsqh5g0&eom>

To Register for December 6: <https://cc.readytalk.com/r/j8d0v8kh1qr3&eom>

These sessions will cover the same material. Physicians and medical society staff are welcome.

Reports show 2017 Medicare payment adjustments

As reported in the September 29 AMA Advocacy Update, Medicare has made available two new reports with information on 2015 cost and quality data that indicate which physicians or practices will see related Medicare payment adjustments in 2017.

The 2015 Physician Quality Reporting System (PQRS) Feedback Reports and 2015 Annual Quality and Resource Use Reports (QRUR) were released on September 26, and CMS mailed letters to physicians beginning September 26 if they will have a penalty.

The payment adjustments detailed in these reports are NOT the result of MACRA legislation passed by Congress in 2015. They are associated with current federal statutory pay for performance programs that are being replaced in 2019 with the new MIPS system created under MACRA.

2015 PQRS penalty letters notify physicians and groups who are scheduled to receive a 2% penalty in 2017 based on 2015 PQRS reporting. The PQRS feedback report allows physicians to look up whether they will receive the 2% 2017 PQRS penalty, and contains detailed information on program year 2015 PQRS reporting results.

The 2015 Annual QRURs provide information on how practices performed on quality and cost measures used in the Value Modifier (VM) and whether their VM payment adjustment will be positive, negative or neutral and the specific amount. VM penalties can range from -1% to -4% depending on practice size and performance. Bonus payments depend on how much money is collected from penalties and to date the 2017 bonus size has not been publically announced by CMS.

Practices that believe there are errors in the report or calculation of the payment adjustment should file for an informal review by the end of November.

How to access the reports:

- An Enterprise Identity Management (EIDM) account with the appropriate role is required for participants to obtain 2015 PQRS feedback reports and 2015 Annual QRURs.
- If you already have an EIDM account, [visit the CMS website](#) to sign up for the appropriate EIDM role or contact QualityNet Help Desk to determine if someone in the practice already has that role.
- To sign up for an EIDM account, visit the [CMS Enterprise Portal](#) and click %New User Registration+under %login to CMS Secure Portal.+
- For more information on viewing the reports, view the [PQRS Analysis and Payment webpage](#) and [How to Obtain a QRUR webpage](#).

Information on the informal review process:

- To request an informal review of a 2017 PQRS negative payment adjustment, view the %2015 Physician Quality Reporting System (PQRS): 2017 Negative Payment Adjustment - Informal Review Made Simple+ guide on the [PQRS Analysis and Payment webpage](#).
- To request an informal review of the 2015 QRURs or the 2017 Value Modifier calculation, see the [2015 QRUR and 2017 Value Modifier webpage](#).