

January 16, 2018

TO: OFFICERS, COUNCILORS, AND TRUSTEES

FROM: GREGORY PINTO, MD
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RE: REPORT FROM THE DIVISION OF GOVERNMENTAL AFFAIRS

ALBANY

Governor Signs Measure Into Law to Increase Insurer Transparency of Mental Health Parity Law Compliance

Just before the close of 2018, Governor Cuomo signed into law legislation establishing the Mental Health and Substance Use Parity Report Act, a measure that MSSNY strongly supported in conjunction with the New York State Psychiatric Association and other patient advocacy groups. With its adoption, the NY Department of Financial Services (DFS) will be required to collect key data points and elements from health insurers in order to analyze if they are in compliance with the federal and state mental health and substance use (MH/SUD) disorder parity laws.

We thank the hundreds of physicians who took the time to contact the Governor to urge that he sign the bill into law. MSSNY's letter to the Governor noted that in light of the growing opioid epidemic, it is vitally important that the state and various public stakeholders have a resource that would help those individuals make informed choices with respect to the choice of health plan. Moreover, the responsibility to provide such information will incentivize insurers to follow the laws that are intended to assure that patients have coverage for the care they need.

Timothy's Law, which works to ensure New Yorkers have access to care and treatment for mental illness and substance abuse disorders, was passed in 2006 and made permanent in 2009. This law mandated a number of provisions aimed at improving access to mental health and substance abuse care, including coverage of a variety of relevant services for children and employees of large employers and premiums and cost sharing for mental health services that are equivalent to those for physical health services. However, investigations by the New York Attorney General's office have identified numerous instances of noncompliance, including evidence of elevated levels of denials for mental health services. This necessitated proactive evaluation of insurers and health plans to ensure compliance and provide New Yorkers with the information they need to get the best possible care.

The data collected this law will be used by the DFS to ensure compliance with Timothy's Law and to prepare an annual Mental Health Parity report as part of the annual comprehensive DFS Consumer Guide to Health Insurance. In a letter of support to Governor Cuomo, the American Medical Association noted that the bill will provide important data to better compare requirements for accessing benefits that are applied to mental health and substance use disorder treatment and coverage as compared with those applied to medical/surgical benefits. The compliance report, particularly if made available to key stakeholders and open for public

inspection to patient advocates, will help regulators and others identify where appropriate oversight and enforcement are necessary.

SAVE THE DATE: MSSNY's Annual "Physician Advocacy Day" (3/6)

On January 9th, the New York State Legislature welcomed nearly 40 new members in Albany . so the need for physician advocacy and grassroots involvement is greater than ever. With so much new representation, it's vital for physicians to forge new relationships, as well as strengthen existing relationships with this new Legislature to ensure the physician community's message is well-represented.

One opportunity is to participate in MSSNY's Physician Advocacy Day that will be held on Wednesday, March 6th in the Lewis Swyer Theatre in the Egg located at the Empire State Plaza, Albany NY. Click [HERE](#) to register!

Join your colleagues from all around New York State and come to MSSNY's Physician Advocacy Day to speak with your legislators and key policymakers to ensure they're making the right choices for New York's physicians and their patients.

Join us to urge your legislators to:

- Reduce excessive health insurer prior authorization hassles that delay patient care
- Reduce the high cost of medical liability insurance through comprehensive reforms
- Reject burdensome mandates that interfere with patient care delivery
- Preserve opportunities for medical students and residents to become New York's future health care leaders
- Reject inappropriate scope of practice expansions of non-physician practitioners
- Prevent big-box, store-owned medical clinics that will negatively impact community primary care delivery
- Proceed very cautiously on paradigm shifting proposals such as legalization of recreational marijuana and creating a single payor health insurance structure.

A brief luncheon to which members of each House are invited to speak with their constituents will follow the morning program. County Medical Societies will be scheduling afternoon appointments for physicians to meet with their elected representatives.

If you have any questions/comments, please contact Carrie Haring at charring@mssny.org.

MSSNY President Urges Caution on Single Payor Proposals

With the discussion of single payor legislation heating up in Albany, MSSNY President Dr. Thomas Madejski's op-ed on the topic appeared in the January 1, 2019 edition of the *Albany Times-Union* ([The Times Union Link](#)).

Dr. Madejski noted that one of the most appealing aspects of the NYHA is the potential to reduce administrative burdens associated with delivering patient care. Physicians increasingly report difficulties with challenging insurer-imposed prior authorizations that lead to unnecessary delays in patients receiving needed care. And physician burnout arising from these administrative burdens is a very real and pervasive issue. However, there is concern among many physicians that budget pressures could force state bureaucrats implementing a single-payer system to impose even more burdensome prior authorization requirements. Furthermore,

many physicians are concerned that these same budget pressures could create enormous pressure to constrain payments for care at a time when physicians already face immense overhead costs that exceed those in any other state.+

He went on to note that failure to adequately address the many questions with transitioning to a single-payer system may not be in the best interest of New Yorkers. We must make sure that, in our efforts to address the current barriers patients face in receiving care, we do not impose new ones.+

Workers Compensation Board Finalizes Fee Schedule Increases to Take Effect April 1

The New York Workers Compensation Board has finalized regulations providing for an overall 5% increase in the medical fee schedule for care to injured workers that will be applicable April 1, 2019. For more information, [click here](#):

Moreover, the WCB finalized regulations to increase the physician deposition and hearing testimony fee from \$400 to \$450, also effective April 1 for more information, [click here](#).

The WCB also clarified that payment of such witness fees shall be paid by the carrier within ten days of the testimony, and suggest physicians who have not been paid within that time frame contact the WCB for enforcement.

Certainly, this a positive step forward, but there are concerns with some aspects of the changes. For example, the WCB decided to implement changes in reimbursement for electrodiagnostic testing that had been opposed by MSSNY, certain specialty societies and many physicians. As is noted in the WCB Summary of Public Comment:

The Board received comments objecting to the change in CPT codes resulting in reductions in reimbursement for EMG studies and EDX testing. Needle EMG tests have received proportionate increases. Surface EMGs are not recommended under the Medical Treatment Guidelines and therefore have no fee associated. Fees for NCV reflect changes to the CPT codes themselves, as created by the American Medical Association, and the method for billing, and will be reimbursed at 200% of the Medicare level, so no change has been made.+

On the other hand, the Board decided to not implement a change to Physical Medicine Ground Rule 2 that MSSNY had opposed. Here, the Summary of Public Comment stated:

The Board received many comments disagreeing with physical medicine Ground Rule 2 . specifically, the 12 sessions/180-day limitation. In response, the Board has decided not to implement this change, so Ground Rule 2 will read as it did previously: Physical medicine services in excess of 12 treatments or after 45 days from the first treatment, require documentation that includes physician certification of medical necessity for continued treatment, progress notes, and treatment plans. This documentation should be submitted to the insurance carrier as part of the claim.+

While the changes are a positive step forward to better assure access to care for injured workers, these modest increases are the first positive updates in over two decades. During this same time, the costs of running a medical practice increased well over 30% (as measured by the Medicare Economic Index). As a result, MSSNY will continue to press the case for further

increases to better assure there remains a comprehensive network of physicians to provide needed care for injured worker patients.

DFS Fines Aetna and Oscar More Than \$2.5 Million For Violations Of Insurance Law

NY Department of Financial Services (DFS) Superintendent Maria Vullo announced that DFS had imposed fines against Aetna and Oscar totaling more than \$2.5 million for violations of New York Insurance Law. According to the DFS press release, Aetna will pay a civil penalty of \$1.95 million for violations including the failure to make prospective determinations, including pre-authorizations, and failure to acknowledge and respond to members' complaints within required timeframes. Oscar Insurance Corp. will pay a civil penalty of \$576,950 for violations including the failure to adhere to deadlines for utilization reviews and failure to include detailed explanations of adverse determination notices.

Regarding Aetna, a DFS market conduct examination found that from 2012 through 2015, Aetna failed to comply with a number of consumer/provider protections, including: completing pre-authorizations determinations within three business days of receipt of all necessary information; Responding to members' complaints within the required time frames; sending initial adverse determination letters to the insured and providers within 30 days; and making an appeal determination within 60 days of all necessary information to conduct an appeal.

Under the consent order, Aetna will review and revise all of its procedures related to utilization review, appeals, grievances and complaints to ensure that timely determinations and notifications are given to insureds, providers, and other recipients. Moreover, Aetna will reprocess all preventive care claims where cost sharing was inappropriately applied and make overdue payments, including interest; and reprocess all claims that were inappropriately denied, and make overdue payments, including interest.

Regarding Oscar, a DFS market conduct examination found that from 2013 through 2015, Oscar failed to comply with a number consumer/provider protections, including: failing to make a determination for prospective utilization reviews within three business days; Failing to make a determination for concurrent utilization reviews within one business day; and failing to include an accurate and detailed explanation of the clinical rationale for the denials in the adverse determination notices;

Under the consent order, Oscar Insurance will be: revising EOB statements to include the appropriate forfeiture language; revising adverse determination notices to include a detailed explanation of the clinical rationale for denials; and reviewing and revising all procedures, related to utilization review to assure that timely determinations are made.

A copy of the Aetna consent order can be found [here](#).

A copy of the Oscar Insurance Company consent order can be found [here](#).

MSSNY Raises Concern with DOH Proposal Regarding Office-Based Surgery Reports

MSSNY has written to the New York State Department of Health to express its concerns and suggested revisions to regulations proposed by the NYSDOH that would require Office-Based Surgery (OBS+) practices to report cumulative procedural information to NYSDOH. The proposed reporting requirements were published in the New York State Register on October 17 with a 60-day comment period.

The proposed regulation would require each OBS practice to report in a form and format specified by the Department information including, but not limited to, practice identifiers, types of procedures, and number of each type of procedure performed in office-based surgery practices. The proposed regulation would also set forth the manner for how adverse events are reported to DOH, as well as grant the DOH discretion to use the data gathered to develop and implement guidelines and criteria for quality improvement.

The MSSNY comments to the NYSDOH note its agreement with the goal of the proposed regulation to help place in context how frequent or rare particular adverse events are occurring in OBS settings, given the importance of quality improvement to assuring patient safety. However, MSSNY expressed concerns with the lack of needed specificity in the proposed regulation, including the specific information OBS practices will be required to report to DOH on an ongoing basis.

Moreover, MSSNY's comments raise concerns that some practices could find it difficult to report procedural information in a manner to be determined by DOH given that physicians are at different stages of implementing Electronic Health Record (EHR) systems. Given the significant EHR implementation challenges facing many physicians, some physicians have either not implemented them or use very rudimentary systems, making a new requirement for the collection and reporting of information difficult to satisfy. Furthermore, there were concerns with the possibility that procedures could be required to be reported by its CPT code, even though some OBS facilities do not internally track these services by CPT code (since they are not submitted to insurance).

Recognizing the goal of the regulation to facilitate quality improvement and patient safety, MSSNY has also suggested that DOH amend the regulation to permit OBS accrediting bodies to file these reports on the physician's behalf since the information sought by DOH often overlaps with reports that many physicians are already making to their respective OBS accrediting bodies.

NY DFS Approves Cigna-Express Script Merger with Several Conditions

The New York Department of Financial Services (DFS) announced (https://www.dfs.ny.gov/about/press/pr1812131_cigna.htm) that it had approved the purchase by Cigna of PBM Express Scripts. MSSNY had submitted to DFS a letter detailing its concerns with this transaction in connection with the hearing that had been scheduled by DFS for last Friday, December 7, but the hearing was postponed after only one other group had requested to testify.

As noted in various MSSNY e-news publications, MSSNY's letter urged DFS to place meaningful guardrails to ensure that our patients' ability to receive the care or medication they need from the physician or pharmacy of their choice is not disrupted or made more burdensome. Concerns included: the anticompetitive effects of a health insurer purchasing a PBM when that PBM continues to provide services to other health insurance companies; the lack of a regulatory structure in New York regarding the actions of PBMs; and the risk of even more burdensome prior authorization requirements.

While MSSNY is still reviewing the final Opinion and Decision (https://dfs.ny.gov/about/hearings/cigna_122018/cigna_opinion_decision_12132018.pdf), at first glance, many of the conditions of approval appear similar to those that were required by DFS as part of its approval of the CVS acquisition of Aetna, including:

- Prohibiting increased health insurance rates to pay for the cost of the acquisition;
- Prohibiting dividends to be paid by Cigna without the express prior approval of DFS for 3 years;
- Prohibiting preferential PBM pricing of Express Scripts to any Cigna-affiliated health insurer, to better ensure insurance competitors can continue to fairly purchase PBM services from Caremark;
- Limiting changes to Cigna's healthcare provider networks for 3 years, including maintaining access to non-chain New York pharmacies;
- Contributing \$20 million to New York State, to support health insurance education and enrollment activities and strengthen New York health care transformation activities, which may include payments to the New York State Health Care Transformation Fund
- Requiring an independent third-party audit to assess whether Cigna employees have accessed Confidential Information from Express Scripts in violation of firewall policies; and

Furthermore, the decision contained a requirement that the parties agree to take no action to oppose legislation to directly regulate PBMs in New York State (The Governor has again proposed a PBM licensing requirement in his 2019-2020 Executive Budget).

Nevertheless, physicians remain concerned with the increasing consolidation in the health care system. MSSNY's letter to DFS expressing concerns with this transaction, as well as its letter to the US DOJ regarding the CVS purchase of Aetna (*see related article*) noted that the efficiencies that are promoted and marketed to supposedly occur are hardly ever borne out after these transactions are consummated. Inevitably, these mergers create market dynamics that almost always result in further administrative burdens placed on physicians seeking to assure their patients receive the care or medication they need.

WASHINGTON

MSSNY Submits Comments to Department of Justice re CVS-Aetna

US District Court Judge Richard Leon has ordered the US Department of Justice to respond to numerous comments filed to it raising concerns with the proposed mega merger between CVS and Aetna. According to media reports (<https://nypost.com/2018/12/18/judge-delays-cvs-aetna-merger-for-months/>), this development is expected to delay approval of the merger until at least Spring 2019.

Among the comments to the US DOJ is a letter from MSSNY President Dr. Thomas Madejski summarizing MSSNY's extensive concerns with this merger among corporate behemoths. The DOJ letter also appended testimony provided by MSSNY Immediate Past President Dr. Charles Rothberg at an October NY Department of Financial Services hearing (https://www.mssny.org/Documents/2018/Home/CVS-Aetna_DFS_Hearing_Testimony101918.pdf). The letter also summarizes the extensive concerns that had been raised by NY DFS Superintendent Maria Vullo, the American Medical Association (AMA), the American Antitrust Institute and New York State Assembly Insurance Committee Chair Kevin Cahill.

Moreover, the Pharmacists United for Truth and Transparency (PUTT) and the Pharmacists Society of the State of New York (PSSNY) have jointly filed a motion asking Judge Leon to stop CVS and Aetna from further integration while the Court determines the merger's harmful effects.

<https://www.pharmacytimes.com/news/pharmacist-groups-urge-federal-judge-to-stop-cvsaetna-merger>).

The US DOJ had approved the merger in October under the condition that the companies sell Aetna's Medicare drug plan business to preserve competition. The acquisition of Aetna by CVS had also been signed off by every state reviewing the transaction, including New York, which approved the merger in late November with numerous conditions (<https://dfs.ny.gov/about/press/pr1811261.htm>).

MSSNY's letter to the DOJ highlighted that, even though the NY DFS had approved the acquisition, it did so highlighting several problems with the merger, including that the companies had not provided any concrete analysis that the CVS/Aetna merger would result in specific reduced costs for New York consumers, or any business plan or study of asserted improved health outcomes to benefit New Yorkers.

Moreover, MSSNY's letter to the DOJ reiterated the extensive concerns articulated by the AMA. Judge Leon's concerns about the transaction included the strong opposition by the AMA, which had argued to the DOJ that it would leave consumers with fewer health care choices. In addition to Medicare prescription drug plan choices, AMA also raised concerns about reduced health insurance competition and patient community pharmacy options.

President Approves Bill to Provide Funding for States to Prevent Maternal Deaths

President Donald Trump has signed into law legislation, the Preventing Maternal Deaths Act, to provide millions of dollars in funding to states to establish maternal mortality committees. The bill had been passed by the US Congress in early December. The purpose of such committees are to investigate pregnancy-related deaths and use the findings to prevent others.

In the United States, the maternal mortality rate is 26.4 deaths per 100,000 (about 700 per year). That rate increased 250% between 1987 and 2014, according to the Centers for Disease Control and Prevention (CDC). The CDC estimates that 60% of the deaths are preventable. The maternal death rate is more than three times higher for African American women than white women in the United States, according to the CDC.

MSSNY working together with the American College of Obstetricians & Gynecologists. District II have supported legislation in the 2018 Legislative Session to establish a Maternal Mortality Review Board in New York. The MMRB would be comprised of a multidisciplinary team of medical experts tasked with reviewing data on maternal deaths, identifying the root causes of these events, and disseminating evidence-based best practices to prevent them in the future. The board's primary focus will be on quality improvement rather than punishment, reviewing outcomes of care, conducting peer reviews, and collaborating on process improvements. As a necessary component to achieving this mission, the bill contains broad confidentiality protections to the board's proceedings to allow for open and honest dialogue and review. However, some are advocating that the confidentiality provisions be minimized, which could seriously undermine the quality improvement goals of the MMRB. MSSNY will again work with ACOG in 2019 to achieve passage of a MMRB in New York (which has been proposed in the Governor's 2019-2020 Executive Budget).