January 10, 2021

TO: **OFFICERS, COUNCILORS, AND TRUSTEES**

FROM: **GREGORY PINTO, MD**
THOMAS LEE, MD
MOE AUSTER
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RE: **REPORT FROM THE DIVISION OF GOVERNMENTAL AFFAIRS**

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ALBANY

Governor Identifies Legislative Priorities in State of State Message: Supports Increased Telehealth Payments, Expanded Insurance Coverage, and Loan Support for Physicians, but also Concerning Scope Changes

This afternoon, Governor Kathy Hochul presented her legislative priorities for the year in her first State of the State Address. As outlined in her briefing book 2022StateoftheStateBook.pdf (ny.gov), among the most notable items relating to health care:

- Require health insurers to reimburse Telehealth Services at the same levels as traditional Services
- Increase Funding for the Doctors Across New York Program to provide loan forgiveness up to $120,000 for doctors who work in underserved areas for three years.
- Expand the SUNY Pre-Medical Opportunity Program and the Diversity in Medicine Program which recruits and trains a diverse healthcare workforce that represents the diversity of the patients in underserved communities
- Expand from 200% FPL to 250% FPL eligibility for New York's Essential Plan coverage for those who make too much to qualify for Medicaid.
- Eliminate the $9 premium for CHIP coverage for children in families between 160 and 222% FPL
- Expand Medicaid coverage for post-partum care for one year after birth
- Expanding naloxone and buprenorphine access by mandating pharmacies to maintain a stock of these medications
- Create a new Pharmacy Benefits Bureau to begin licensing PBMs and hire a new compliance team to investigate PBM business practices and review complaints of misconduct. Additionally, this team will expand DFS's ongoing efforts to investigate significant spikes in prescription drug prices and to require drug manufacturers — or whoever is responsible for the price increase — to show a reasonable justification for sudden increases.
- Advance regulations to ensure that New Yorkers are not charged surprise out-of-network costs when a healthcare provider is incorrectly listed as in-network in the insurer's provider directory, an insurer provides incorrect information about a provider's network participation status in response to a request from a consumer, or the insurer fails to respond to a consumer's request for such information.
- Eliminating remaining statutory written practice agreement requirements for nurse practitioners to practice in collaboration with a physician

- Joining the Interstate Medical Licensure Compact to permit out of state physicians to be licensed in New York and New York physicians to be licensed in other states more easily
- Updating the definition of "emergency medical services" to include community paramedicine, which permits EMTs to provide some non-emergency health care services

Many of these items will be included within the Executive Budget that is presented by Governor Hochul on or about January 18.

Go to MSSNY Webpage for More Information on No Surprises Act Implementation

The implementation of the federal No Surprises Act (NSA) on January 1, 2022 means that physicians must familiarize themselves with the many aspects of this law that will impact the care they provide to patients both when they are out of network and in-network.

For more information on these new requirements, physicians can go to the following page on the MSSNY website**:** Preparing for the No Surprises Act - (mssnyenews.org) where they can find a

1) Toolkit AMA toolkit for physicians: Preparing for implementation of the No Surprises Act (ama-assn.org) developed by the American Medical Association
2) Several guidance letters prepared by the New York Department of Financial Services regarding integrating these NSA provisions into New York State~~'s~~ law
3) The model notice all physicians, hospitals**,** and other health care providers will need to provide to their patients, in their office and posted on their website, regarding patient protections against surprise billing. model_provider_disc_balance_bill_protections_20211217.docx (live.com)

Physicians are also reminded that MSSNY's General Counsel, the Garfunkel Wild law firm, has developed a working group to assist physicians in implementation of the law, including hosting a webinar on February 1 at noon to discuss what health care providers need to know. GW Complimentary Webinar – February 1, 2022 – Federal No Surprises Act – One month in. What have we learned? What questions remain? | Garfunkel Wild**.**

A Veto, a Signing and a Compromise – Governor Hochul Takes Action on Several Trial Lawyer Bills

MSSNY thanks the many physicians who took the time to send letters to Governor Hochul to raise objections to three problematic pro-trial lawyer bills opposed by MSSNY and many other groups but passed by the State Legislature that could further hamper all defendants generally in litigation in New York State. Governor Hochul vetoed one of the bills, signed one of the bills and reached an agreement with the Legislature on the third bill to significantly limit its impact.

- Importantly, one bill (S.2199/A.473) was vetoed by Governor Hochul which would have expanded the time period for the imposition of New York's excessive 9% judgment interest in cases where a plaintiff's request for summary judgment was not initially granted, but then overturned on appeal. Her veto message raised concerns regarding the "significant negative impact on defendants in litigation" including health care providers and state and local governments, "all of which are already under a great amount of strain due to COVID-19."
- The second bill (S.7052/A.8041 "The Comprehensive Insurance Disclosure Act") was signed into law, which imposes a much more detailed list of requirements for any defendant to provide with respect to the insurance that may be responsible to pay for any award in a personal injury action. However, Governor Hochul engaged in negotiations with the Legislature for "chapter amendments" that will significantly reduce the burden this law would otherwise impose on defendants in these

actions. The chapter amendments include eliminating the requirement that the insurance application be provided in discovery, eliminating the requirement to provide information on any lawsuits that may erode the applicable insurance policy's limits, and eliminating the bill's required disclosure of the amount of any payment of attorney fees that erode or reduce the insurance limits.

- The third bill (S.7093/A.8040) was signed into law which modifies the current NY law governing the "hearsay" exception for a statement made by an employee to now permit the introduction into evidence of any statement by the employee within the course of their employment and during that employment relationship.

MSSNY will continue to coordinate with MLMIC and other allied groups to ensure physicians are further informed about the implications of these new laws.

Governor Hochul Signs Bills to Increase PBM Transparency & Limit Insurers' Ability to Make Mid-Year Formulary Changes

Governor Hochul signed two bills into law in late December that are critical to helping patients access the medications they need and to ensure greater oversight of pharmacy benefit formulary development practices. MSSNY thanks the many physicians who took the time to send letters to Governor Hochul in support of these bills over the last several months.

The first piece of legislation, (A.1396, Gottfried/S.3762, Breslin), signed at the 11th hour on New Year's Eve, will provide greater accountability and transparency of the practices of Pharmacy Benefit Managers (PBMs). The bill was amended from the version that passed the Legislature in 2019, but was vetoed by Governor Cuomo, to address concerns raised in the Governor's veto message two years ago. Governor Hochul signed the legislation with an agreement that there will be several chapter amendments to the law by the Legislature in the coming legislative session.

The bill requires that PBMs be licensed by the Department of Financial Services (DFS) and adhere to standards established by DFS. It also calls for disclosure of all possible revenue streams, terms, and conditions, that they place on their networks of pharmacies. One of the chapter amendments will ensure that the DFS is the entity that will be responsible for ensuring that the law is enforced. MSSNY has supported greater oversight and regulation of PBMs as one way to address restrictive formularies and excessive prior authorization requirements that interfere with patients obtaining needed medications. The law takes effect on or about March 31, 2022.

The second bill, (A.4668, People-Stokes/S.4111, Breslin), is going to significantly limit the ability of health insurers to move medications to higher cost-sharing tiers for their prescription drug formularies during a policy year. The bill was revised from the version that passed both the Assembly & Senate two years ago, but was vetoed by then Governor Cuomo. To address concerns raised in his veto message, the new law will prohibit the applicability of a mid-year formulary change to a patient who was on the medication at the beginning of the policy year, or suffers from a condition for which the medication is part of a treatment regimen for that condition. However, other mid-year formulary changes could still occur. Based upon a chapter amendment negotiated by Governor Hochul with the State Legislature, the provisions will take effect for policies beginning January 1, 2023.

We will provide further updates on the implementation of these important new laws as well as the negotiated chapter amendments.

NYS Department of Financial Services (DFS) Makes Audio-Only Telehealth Coverage Policy Permanent

After ongoing, temporary emergency regulations from DFS, the department has made permanent policy that requires private commercial insurance plans to cover Telehealth services delivered via audio-only. An insurer may still engage in reasonable fraud, waste and abuse detection efforts, including to prevent payments for services that do not warrant separate reimbursement.

The new policy was adopted to mitigate health and safety risks during the ongoing pandemic and because Telehealth has proven to be an effective tool in providing quality care for patients around the state. View the permanent regulation.

Additionally, it is important to note that a statute was enacted in 2020 that requires Medicaid to cover audio-only Telehealth services. The New York State Department of Health (DOH) also issued guidance for how Medicaid will continue to cover Telehealth services, including audio-only.

Legislation Signed into Law to Remove Prior Auth Requirements for MAT

Governor Hochul has signed legislation (A.2030/S.649-A) into law that will eliminate prior authorizations for all Medication Assisted Treatment ("MAT") for patients enrolled in Medicaid or Medicaid Managed Care plans that are prescribed "in accordance with national professional guidelines for the treatment of substance use disorder." Similar legislation to eliminate prior authorization requirements for MAT prescribed to patients enrolled in state-regulated commercial insurance plans became law in 2019.

MSSNY together with several other patient advocacy groups supported this important legislation, which will take effect on or about March 22, 2022.

Legislation Signed into Law to Require Co-Prescribing Naloxone for Certain Patients Taking Opioid Medications

Governor Hochul has signed legislation (A.336-A/S.2966-A) into law that will require physicians and other health care practitioners to co-prescribe an opioid antagonist for the first opioid prescription of the year to a patient where the patient 1) has a history of substance abuse disorder; 2) has concurrent use of a benzodiazepine or non-benzodiazepine sedative hypnotics or 3) is taking at least 90 MME per day in prescribed opioids. The requirement does not apply to patients in a hospital, nursing home, mental health facility, or hospice.

While MSSNY is a strong proponent for ensuring patients have access to opioid antagonists with a minimum of hassles, it raised concerns with the potential overbroad nature of this requirement as it was being considered by the State Legislature. Importantly, the sponsors of the legislation amended the bill by significantly narrowing the applicable patient cohort to whom the co-prescribing requirement applies, which had set at 50 MME daily under the original version of this legislation.

The law will take effect on or about June 27, 2022.

New York Department of Financial Services (DFS) Secures $3.1 Million For New Yorkers Using Mental Health & Substance Use Disorder Parity Compliance Review

Acting New York State Department of Financial Services (DFS) Superintendent, Adrienne A. Harris announced that it had secured $3.1 million following a review of whether New York insurers were in compliance with state and federal cost-sharing requirements for mental health and substance use treatment.

DFS reviewed mental health and substance use disorder parity reports that insurers must submit every two years to gauge if insurers were providing the same level of mental health and substance abuse disorder benefits that they do for medical care. The review found that Aetna, Oscar, and Wellfleet sold policies that required consumers to pay a copayment or coinsurance for mental health and substance use disorder benefits that was not permitted under the law.

The three insurers have agreed to DFS' findings and signed consent orders. The violations, monetary penalties, and consumer restitution amounts include:

- Aetna Life Insurance Company was fined $874,000 for violation of MHPAEA and New York Insurance Law, $376,000 for erroneous data reporting, and will return $439.20 to consumers;
- Oscar Insurance Corporation was fined $1,000,000 for violation of MHPAEA and New York Insurance Law and will return $465,800 to consumers; and
- Wellfleet New York Insurance Company was fined $425,000 for violation of MHPAEA and New York Insurance Law and will return $7,326.70 to consumers.

MSSNY worked together with the New York State Psychiatric Association (NYSPA) and other mental health care advocates in 2019 to help enact legislation to establish the parity compliance report requirements.

The overall DFS monetary penalty is $2,675,000, of which $2,299,000 will go to the Behavioral Health Parity Compliance Fund to provide funding for initiatives that support parity implementation and enforcement, including DFS' Behavioral Health Ombudsman Program. The remainder of the funds will go to the state's General Fund. The total amount being returned to consumers is $473,565.90.

Click here to access a copy of the consent orders.

Judge Orders NYC to Delay Implementation of Retiree Health Care Switch to Medicare Advantage Until April 1st: Opt-Out Period Extended To June 30th

Following negotiations this past summer between municipal unions, and the city of New York, an agreement was reached to transition New York City retirees from their current, traditional Medicare plan to Medicare Advantage (MA) plans. Beneficiaries will have the ability to opt-out of the NYC Medicare Advantage Plus Plan and remain enrolled in their current, traditional Medicare plan. The new plan is being administered by Emblem and Empire Blue Cross/Blue Shield and coverage for these enrollees is now scheduled to begin on April 1, 2022 and retirees have until June 30th to opt-out of the program all together.

As reported in NY Focus (Judge Orders City to Delay Retiree Health Care Switch Until April 1), the judge overseeing the case laid out a series of conditions that the city must comply with before implementing the new Medicare Advantage plan. He specified that retirees must be allowed to opt-out of the plan until at least June 30, 2022—three months after the plan is scheduled to go into effect. In addition, the City must take steps to ensure that retirees are fully informed about what treatments and procedures are included in the new plan, and which doctors will and will not be participating. Confusion among retirees about what services will be included in the plan has been widespread, especially after the city mailed them a guide to the plan that contained numerous errors–and then refused to send a follow up correction.
The City must also send retirees a letter correcting the errors in its initial plan by January 7, 2022 and the letter must contain information on how retirees can obtain a corrected Enrollment Guide, free of charge, and list the specific websites with the corrected Enrollment Plan.

Moreover, starting January 7, 2022, until the plan becomes active on April 1st, the city must submit biweekly reports detailing its efforts to contact providers to inform them about the plan,

and a schedule for how and when it will contact additional providers. The Organization of Public Service Retirees' underlying case seeking to stop the move outright is still under consideration and will be decided when the preliminary injunction has been lifted.

Many MSSNY members have raised concerns about possible adverse impacts on patients once their new MA coverage becomes effective. To that end, several MSSNY physician leaders met virtually on October 21st with representatives from Empire Blue Cross Blue Shield to discuss questions from physicians regarding the possible impact of the upcoming transition for patient care delivery. The issue was also discussed extensively at the November 4 MSSNY Council meeting. Moreover, Kings County Medical Society Past-President, Dr. Donald Moore, testified regarding the potential new prior authorization requirements at a hearing about the issue, that was held on Thursday, October 28th by the New York City Council Committee on Civil Service and Labor.

MSSNY will continue to work with affected physicians and their patients to monitor the materials developed for retirees and physicians regarding this transition to ensure they are accurate. Empire and Emblem have also developed educational materials for physicians and other providers including webinars. MSSNY will monitor the impact of the new plans if or when they're implemented for reports of potential pre-authorization and claims hassles for physicians, and barriers to care for patients.

WASHINGTON

Senate Passes Legislation to Prevent Medicare Cuts; President Expected to Sign

In December, Congress passed and the President signed into law legislation to halt most of the cumulative 10% Medicare physician payment cuts that had been scheduled to take effect on January 1. President Biden is expected to sign the bill into law. Specifically, the legislation:

- Delays the resumption of the 2% Medicare sequester for three months (January 1-March 31, 2022). The legislation then provides for a 1% sequester for the following three months (April 1-June 30, 2022), with the full sequester to be re-implemented on July 1, 2022.
- Provides for a one-year increase in the Medicare Physician Fee Schedule of 3% (0.75% less than the conversion factor boost provided for 2021).
- Eliminates through 2022 the scheduled 4% Medicare PAY-GO cut
- A one-year delay in the cuts to the clinical lab fee schedule.
- A one-year delay in the Medicare radiation oncology demonstration.

MSSNY had worked with the AMA and state and specialty societies across the country to urge members of Congress to sign a letter to Speaker Pelosi and Leader McCarthy to prevent these cuts. 252 members of Congress signed this letter Physician Pay 2021.10.14 final.pdf (house.gov), including 15 members of New York's Congressional delegation.

AMA, AHA File Lawsuit to Challenge Faulty HHS Rules Implementing Surprise Billing Law

The American Hospital Association (AHA) and American Medical Association (AMA) filed a lawsuit Thursday against several federal agencies challenging these agencies' misguided implementation of the federal No Surprises Act (NSA).

The lawsuit challenges a narrow but critical provision of a rule issued on Sept. 30 by the U.S. Department of Health and Human Services (HHS) and other agencies. The provision being challenged ignores requirements specified in the NSA which could significantly adversely narrow care options for patients in hospitals across the country. The rule and this flawed provision took effect on January 1.

The AHA and AMA noted in an accompanying press release that "they strongly support protecting patients from unanticipated medical bills and were instrumental in passing the landmark No Surprises Act to protect patients from billing disputes between providers and commercial health insurers."

However, the legal challenge is necessary because the federal regulators' interpretation upends the careful compromise Congress deliberately chose for resolving billing disputes. As noted in the AMA/AHA press release "the new rule places a heavy thumb on the scale of an independent dispute resolution process, unfairly benefiting commercial health insurance companies. The skewed process will ultimately reduce access to care by discouraging meaningful contracting negotiations, reducing provider networks, and encouraging unsustainable compensation for teaching hospitals, physician practices, and other providers that significantly benefit patients and communities."

Specifically, the federal regulation directs arbiters under independent dispute resolution (IDR) to presume that the health insurer's self-determined median in-network rate is the appropriate out-of-network rate and limiting when and how other factors come into play. The lawsuit argues that the regulations are an improper deviation of the law as written by Congress which set forth a series of factors to be considered in the IDR without any one factor being the dominant consideration over the others.

Physicians should be aware that the lawsuits do not prevent the law's core patient protections from moving forward on January 1, 2022. MSSNY has written several newsletter articles regarding other key provisions of the law that physicians should be sure they are following: MSSNY eNews: November 19, 2021 – 10 Key Provisions of No Surprises Act Implementation in NY –

The Texas Medical Association filed a lawsuit in a Texas federal court making similar legal challenges against HHS' interpretation of the NSA.

The Physicians' Advocacy Institute has filed an amicus brief to support both the AMA and TMA actions on behalf of itself and 10 other state medical societies including MSSNY.

For additional information, please see copies of the filed complaint and motion to stay by the AMA and AHA. Please remain alert for further updates.

Provider Relief Fund Phase 4 Payments Going Out This Week

In December, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), announced the distribution of approximately $9 billion in Provider Relief Fund (PRF) Phase 4 payments to health care providers who have experienced revenue losses and expenses related to the COVID-19 pandemic. This includes nearly 5,000 providers in New York State totaling over $750 million.

The average payment for small providers is $58,000, for medium providers is $289,000, and for large providers is $1.7 million. More than 69,000 providers in all 50 states, Washington, D.C., and 8 territories will receive Phase 4 payments.

The PRF Phase 4 payments, in addition to the $8.5 billion in American Rescue Plan (ARP) Rural payments to providers and suppliers who serve rural Medicaid, Children's Health Insurance Program (CHIP), and Medicare beneficiaries, are part of the $25.5 billion the Biden-Harris Administration is releasing to health care providers to recruit and retain staff, purchase masks and other supplies, modernize facilities, or other activities needed to respond to COVID-19. The AMA has advocated for more of the PRF to be distributed, particularly those providers who serve in rural areas and who see low-income patients. In response, HHS is reimbursing smaller practices at a higher percentage of their revenue losses and expenses due to COVID-19, as well as using Medicare reimbursement rates to calculate payments for practices that care for Medicare, Medicaid, and CHIP patients.

It is important to keep in mind that funds received over $10,000 in the aggregate during a PRF reporting period will trigger a reporting requirement through the Provider Relief Fund Reporting Portal. Additional information on PRF reporting and auditing may be found here.

For more information on the PRF Phase 4 monies, please the materials below:

- HHS Press Release
- State-by-state breakdown of the Phase 4 payments