MEDICAL SOCIETY OF THE STATE OF NEW YORK 2022 HOUSE OF DELEGATES

Report of the Reference Committee on Socio-Medical Economics
Presented by: Ronald Solomon, MD, Chair

Mister Speaker and Members of the House of Delegates:

Your Reference Committee recommends the following consent calendar for acceptance:

SUNSET REPORT RECOMMEND FOR ADOPTION

1. 2022 Sunset Report for Socio-Medical Economics

RECOMMENDED FOR REAFFIRMATION

2. Resolution 250 - Sheltering from Unfair Health Insurance Practice
3. Resolution 251 - Every Worker Deserves Payment

RECOMMENDED FOR ADOPTION

1. Resolution 253 - Patient Centered Medical Home Administrative Burdens
2. Resolution 254 - Patient Centered Medical Home Metrics and Funding

RECOMMENDED FOR ADOPTION AS AMENDED

6. Resolution 252 - Clarification of Downgraded Modifiers For New York Independent Dispute Resolution
7. Resolution 255 - Value Based Payment Models. Evidence Based Medicine and Quality of Care
8. Resolution 256 - CMS Innovation Projects
9. Resolution 257 - Ninety Day Refills and Care Gap Failures
10. Resolution 259 - Coverage for Personal Protective Equipment

RECOMMENDED FOR REFERRAL TO COUNCIL

11. Resolution 258 - Pharmacogenetics Insurance Coverage
12. Resolution 260 - Concurrent Processing of Procedure Equipment

1. POLICY SUNSET REPORT

THE REFERENCE COMMITTEE RECOMMENDS THAT THE SUNSET REPORT FOR SOCIO-MEDICAL ECONOMICS BE AMENDED BY RETAINING MSSNY POLICY 120.952:

120.952 Insurance Companies Dis-enrollment of Participating Physicians
The Medical Society of the State of New York will seek legislation that would expand physician protections similar to those enunciated in Public Health Law § 4406-d for non-renewal of a network contract for both managed care plans and HMOs in order to enable physicians to have the right to appeal a plan's non-renewal decision and have a hearing, if needed.
The Medical Society will urge the Department of Financial Services to require that all health insurance companies doing business in the State of New York provide clear and concise justification with appropriate documentation which substantiates a decision to terminate or non-renew a physician's participation status. When a physician receives a notification that his/her participation agreement is being terminated or not renewed, an appropriate appeals mechanism be provided which allows adequate time for the physician to seek appropriate counsel (if necessary) and to assemble any necessary and supporting documentation which may be needed to assist in the appeal. (HOD 2012-259)

RECOMMENDATION A:
Retain the policy as it is still relevant ~~Sunset, current legislation on the floor "An ACT to amend the public health law and the insurance law, in relation to health care professional applications and terminations."~~

RECOMMENDATION B:
THE REFERENCE COMMITTEE RECOMMENDS THAT THE REMAINDER OF THE 2022 SUNSET REVIEW REPORT FOR SOCIO-MEDICAL ECONOMICS BE ADOPTED.

The Reference Committee heard testimony from physicians recommending MSSNY Policy 120.952 be retained because health insurers continue to unfairly remove physicians from participation with health insurance networks without providing appropriate appeal rights. While the Reference Committee was made aware of legislation (A.4177, Lavine/S.2528. Rivera), for which MSSNY is actively advocating, to provide due process consistent with the policy, it believed that this policy should be continued as long as the problem continued to exist. The Reference Committee agreed with this recommendation to retain this policy and urges that the rest of the sunset report be adopted.

2. RESOLUTION 250 - SHELTERING FROM UNFAIR HEALTH INSURANCE PRACTICE

Original Resolution 250 reads as follows:
Resolved, that the Medical Society of the State of New York supports legislation and/or regulation that limits the amount of time from the date of service health insurance companies have to claw back reimbursement to physicians; and be it further

Resolved, that the Medical Society of the State of New York supports legislation and/or regulation that limits the number of charts reviewed annually for the purposes of clawing back reimbursement to physicians; and it further

Resolved, that this resolution be forwarded to the American Medical Association.

RECOMMENDATION A:

THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING REAFFIRMATION OF MSSNY POLICY INSTEAD OF RESOLUTION 250:

> **165.918 Time Limit for Retrospective Denials:**
> MSSNY continues in its efforts to seek legislation, regulation or other appropriate means to prohibit retrospective refund requests by health plans in all circumstances except fraud. Short of achieving a complete ban on retrospective refund requests, MSSNY seek legislation, regulation or other appropriate means to limit to 90 days the time within which a health plan can seek such a refund, or other significant restrictions on the ability of health plans to seek such refunds, such as limiting the time that a health plan can seek a refund to the same time that a physician has to file a claim with such health plan. (HOD 2003-69; Reaffirmed HOD 2013; Reaffirmed HOD in lieu of 2017-108)

RECOMMENDATION B:
THE REFERENCE COMMITTEE RECOMMENDS REAFFIRMATION OF MSSNY POLICY 165.918.

The Reference Committee heard significant testimony in support of the resolution because health insurers continue to engage in abusive audit practices that are adversely and unfairly impacting physician practices. In some cases, the claims reviews can go back multiple years. The Reference Committee was advised that New York has a law that limits to 2 years the time period for health insurers to recoup previously paid claims, as well as MSSNY's legislative efforts to limit health insurer audits, including legislation (A.870, Gottfried) to prohibit health insurer extrapolation audits. Your Reference Committee was also made aware of existing MSSNY policies, including Policy 165.918, that provides even stronger protections for physicians than what was proposed in the proposed Resolution 250. Given the very strong policy already adopted by MSSNY, the Reference Committee recommended that existing policy be re-affirmed in lieu of the proposed resolution.

3. RESOLUTION 251 – EVERY WORKER DESERVES PAYMENT

Original Resolution 251 reads as follows:
Resolved, that the Medical Society of the State of New York work with the New York State Department of Financial Services, the Department of Health and other appropriate regulatory agencies to make it mandatory that the insurance companies be responsible to inform the physician or the entity seeking approval, in real-time:

1-whether the patient is insured or not
2-if their coverage expires before the procedure or is expected to expire in short-term,
3-if they are not the primary provider for the patient.

Or be obliged to provide a timely and fair compensation for the service rendered; and be it further

Resolved, that the Medical Society of the State of New York partner with the relevant New York State regulatory authorities and stakeholders to create new regulations for insurance companies, such that there be a time limit for request for reimbursement, not exceeding six months; and be it further

Resolved, that the Medical Society of the State of New York partner with the relevant New York State regulatory authorities and stakeholders to create new regulations for insurance companies, such that all individuals, in any venue, activity, or specialty, are entitled to remuneration for work performed; and be it further

Resolved, that Medical Society of the State of New York partner with the relevant New York State regulatory authorities and stakeholders to create new regulations for insurance companies, such that the phrase "payment may not be guaranteed" should be banned from any contractual agreement with an insurance company; and be it further

Resolved, that Medical Society of the State of New York forward the above resolution to the American Medical Association's House of Delegates for advocacy directed at regulating insurance companies at the federal level.

RECOMMENDATION A:
THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING REAFFIRMATION OF MSSNY POLICY INSTEAD OF RESOLUTION 251:

> **165.927 <u>Physicians Should Not Be Financially Liable in Retrospective</u> <u>Denials</u>**
> MSSNY will seek, by legislation, regulation, or other appropriate means, the following:
> (a) To prohibit retrospective denials caused by the employer's failure to pay premiums in a timely fashion, or the employer failing to provide the carrier with timely and correct eligibility data.
> (b) To prohibit a payor from attempting to retroactively deny or adjust a claim after payment is made to a physician for care rendered.
> (c) That should obtain a complete ban on retrospective denials or adjustments not be able to be enacted, seek to prohibit insurers from making a retroactive denial and/or adjustment of a reimbursement beyond 90 days after payment is made to the physician for care rendered.
> (d) In the event that an insurer attempts to issue a retroactive denial or adjustment after payment is made to the physician, to require such insurer to provide the physician with a detailed explanation on each patient as to the circumstances surrounding the retroactive adjustment or reimbursement and/or denial, and provide the physician with an effective opportunity to counter the reasons for the adjustment.
> (e) In the event that an insurer has already paid the physician for a service, but later issues a retrospective denial or adjustment, to prohibit such insurer from attempting to recoup its payments for that service via offsets on payments for other services.
> MSSNY will work regularly with all appropriate regulatory agencies to ensure that the regulators are kept apprised of payment policies employed by plans which do not comport with the law. (HOD 2001-65; Reaffirmed HOD 2010-259; Reaffirmed HOD 2019-63)

RECOMMENDATION B:
THE REFERENCE COMMITTEE RECOMMENDS REAFFIRMATION OF MSSNY POLICY 165.927.

The Reference Committee heard significant testimony in support of the resolution because health insurers continue to engage in practices to take back previous payments based upon allegations that the patient was not insured at the time of the health care service was provided. The Reference Committee heard testimony that it was unfair to make the physician financially responsible when the fault will often lie either with the insurer who failed to update their records or with the employer providing the coverage failing to timely notify the insurer. However, like resolution 250, the Reference Committee was advised of existing MSSNY Policy 165.927 that is more specific and more protective of physician rights than the proposed resolution. Specifically, it urges MSSNY to advocate for a law that would "prohibit a payor from attempting to retroactively deny or adjust a claim after payment is made to a physician for care rendered", as well as other goals to limit excessive health insurer overpayment recovery powers. The Reference Committee was made aware that MSSNY has regularly brought this concern to legislators and to state regulators. Therefore, the Reference Committee recommends that this existing policy be re-affirmed in lieu of the proposed resolution.

4. RESOLUTION 253 – PATIENT CENTERED MEDICAL HOME ADMINISTRATIVE BURDENS

Original Resolution 253 reads as follows:
RESOLVED, that the Medical Society of the State of New York work with the National Committee for Quality Assurance (NCQA) and other regulatory bodies to streamline and eliminate unproven metric collection that takes time away from patient contact and quality care; and be it further

RESOLVED, that the Medical Society of the State of New York urge the American Medical Association to also seek regulations to reduce the increasing strain that Patient Centered Medical Home (PCMH) metrics are placing on physicians and patient care.

RECOMMENDATION:
THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 253 BE ADOPTED

The Reference Committee heard testimony from several physicians that support. Specifically, the problem is that there are several reporting measures developed by national agencies such as NCQA that are either cumbersome to collect and report, or do not make much sense to collect and report. Therefore, the Reference Committee recommends that the resolution be adopted.

5. RESOLUTION 254 – PATIENT CENTERED MEDICAL HOME - METRICS AND FUNDING

Original Resolution 254 reads as follows:
RESOLVED, that MSSNY work with the National Committee for Quality Assurance (NCQA) to implement stricter criteria for approval of those metrics and practices that organizations select to ensure that they are evidence-based; and be it further

RESOLVED, that MSSNY work with National Committee for Quality Assurance (NCQA) to provide adequate funding and technical assistance to Patient Centered Medical Home recipients to implement evidence-based practices.

RECOMMENDATION:
THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 254 BE ADOPTED

The Reference Committee heard testimony from several physicians that support. Specifically, the problem is that the current NCQA guidelines are not specific enough and strictly targeted for evidence-based practices that will increase the overall healthcare of the patient. Therefore, the Reference Committee recommends that the resolution be adopted.

6. RESOLUTION 252 – CLARIFICATION OF DOWNGRADED MODIFIERS FOR NEW YORK INDEPENDENT DISPUTE RESOLUTION

Original Resolution 252 reads as follows:
RESOLVED, that MSSNY advocate with Department of Financial Services to establish a clear mechanism for the provider to indicate to the Independent Dispute Resolution entity that their charges for consideration in the dispute should be their standard charge for that code, reduced by standard downgrade modifiers.

RECOMMENDATION A:

THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE AMENDMENT BE ACCEPTED INSTEAD OF ORIGINAL RESOLUTION 252:

RESOLVED, that MSSNY advocate with the Department of Financial Services to establish a clear mechanism to ensure that a physician submitting a surprise medical bill dispute to an Independent Dispute Resolution entity is not penalized for submitting a claim that includes an appropriate modifier such as a code that recognizes the services of an assistant or co-surgeon.

RECOMMENDATION B:
THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 252 BE ADOPTED

The Reference Committee heard testimony from several physicians that supported the resolution. Specifically, the issue is that, when a physician brings a surprise out of network bill dispute to the Independent Dispute resolution process for services involving a modifier such as use of an assistant surgeon, the IDR reviewer will consider the full charge for such services in its review rather than the discounted charge based upon the modifier. This failure to account for the discounted fee that would normally be due for an assistant or co-surgeon makes it far more likely for the IDR reviewer to award the health insurer, not the physician. This unfairly penalizes the physician. The Reference Committee recommends that the resolution be amended to more specifically articulate this concern raised by the sponsor of the resolution.

7. RESOLUTION 255 – VALUE BASED PAYMENT MODELS, EVIDENCE BASED MEDICINE AND QUALITY OF CARE

Original Resolution 255 reads as follows:
RESOLVED, that the Medical Society of the State of New York seek legislation prohibiting hospitals, insurance companies and healthcare organizations from establishing rules that limit physicians to one set of guidelines.

RECOMMENDATION A:
THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE AMENDMENT BE ACCEPTED INSTEAD OF ORIGINAL RESOLUTION 255:

RESOLVED, that MSSNY advocate to ensure that reimbursement from a health insurer or health system for patient care not be conditioned upon following of a single set of treatment guidelines.

RECOMMENDATION B:
THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 255 BE ADOPTED.

The Reference Committee heard testimony from several physicians who shared the goal of the resolution to ensure physicians were not required to follow patient care protocols which they did not believe were in the best interests of their patients. However, some physicians testified that the wording for the resolution needed to be clarified to more specifically articulate the goal of the resolution to help ensure physicians are protected from adverse consequences of ensuring their patients receive care that is recommended by the physician, even if it diverts from protocols. Therefore, the Reference Committee recommended that the resolution be revised to reflect a statement with which it believed most physicians would agree: that physicians not be financially penalized for providing care to patients they believe is most appropriate to treat that patients' condition.

8. RESOLUTION 256 – CMS INNOVATION PROJECTS

Original resolution 256 reads as follows:
RESOLVED, That, to help protect seniors and persons and persons with disabilities, the Medical Society of the State of New York urge the American Medical Association to:

1. Take note of any projects that CMS's Center for Medicare & Medicaid Innovation has initially devised as models, but may now be expanding into full–scale projects that could potentially be used to broadly transform the entire Medicare program; and
2. Push for Congressional oversight over any such projects.

RECOMMENDATION A:
THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE AMENDMENTS BE ACCEPTED INSTEAD OF ORIGINAL RESOLUTION 256:

RESOLVED, that MSSNY work with the AMA to continue to advocate against mandatory participation in Centers for Medicare and Medicaid Innovation (CMMI) demonstration projects, and advocate for CMMI instead to focus on the development of voluntary pilot projects; and be it further

RESOLVED, that MSSNY and the AMA advocate to ensure that any CMMI project that requires physician participation be required to be approved by Congress.

RECOMMENDATION B:
THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 256 BE ADOPTED.

The Reference Committee heard mixed testimony on this resolution. Testifiers in support noted the importance of assuring Congressional oversight over decisions affecting Medicare physician payment. One example is the Medicare joint replacement bundled payment program (https://innovation.cms.gov/innovation-models/cjr) that was at one point a mandatory program. Testifiers raising concerns noted that there are some physicians that are very interested in participating in pilot projects that hold the possibility to enhance patient care and assure fair payment. The Reference Committee was also made aware of an AMA policy that calls upon the AMA to "continue to advocate against mandatory Center for Medicare and Medicaid Innovation (**CMMI**) demonstration projects" and to "advocate that **CMMI** focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties." Therefore, the Reference Committee recommended adopting portions of this policy into a MSSNY policy.

9. RESOLUTION 257 – NINETY DAY REFILLS AND CARE GAPS FAILURES

Original Resolution 257 reads as follows:
RESOLVED, that practices are not fiscally penalized if patients fail to refill their timely prescriptions and be it further

RESOLVED, that pharmacies are not allowed to infringe on our profession for financial benefit if they do not refill the 90-day prescriptions in lieu of receiving greater renumeration, and be it further

RESOLVED, that MSSNY and the AMA demand accountability for any insurance provider who violates their policies while simultaneously denying the patients the very same 90-day provision used to deny physicians due payment (s)

RECOMMENDATION A:
THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE AMENDMENTS BE ACCEPTED INSTEAD OF ORIGINAL RESOLUTION 257:

RESOLVED, that MSSNY advocate to ensure that physicians are not financially penalized by health insurers for patients' refusal to obtain medications recommended by their physicians; and be it further

RESOLVED, that MSSNY advocate to ensure that health insurers cover, and pharmacies dispense prescription medications in quantities recommended by the patients' physicians

RECOMMENDATION B:
THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 257 BE ADOPTED.

The Reference Committee heard testimony from several physicians in support of this resolution due to various circumstances where patients either cannot or do not obtain the prescriptions or re-fills that are prescribed by their physicians. However, there were concerns from the Reference Committee regarding the vague language used in the proposed resolves. Therefore, the Reference Committee recommended adoption of the above substitute resolution which reflects what they believe to be the consensus goal to ensure that patients can obtain medications in the quantities recommended by their physician, and that physicians are not penalized for patient non-compliance.

10. <u>RESOLUTION 259 – COVERAGE FOR PERSONAL PROTECTIVE EQUIPMENT</u>

Original Resolution 259 reads as follows:
RESOLVED, that MSSNY advocates either through regulation or legislation that all insurers within New York State provide reimbursement for personal protective equipment used in the care of patients to which they have contractual obligation; and be it further

RESOLVED, that a similar resolution be brought to the AMA.

RECOMMENDATION A:
THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE AMENDMENTS BE ACCEPTED INSTEAD OF ORIGINAL RESOLUTION 259:

RESOLVED, That the Medical Society of the State of New York reaffirm MSSNY Policy 270.958; and be it further

RESOLVED, that MSSNY continue to advocate for legislation, regulation, or other appropriate regulatory intervention to ensure that health insurers help their network physicians cover the costs of Personal Protective Equipment necessary for providing patient care.

RECOMMENDATION B:
THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 259 BE ADOPTED

The Reference Committee heard testimony in support regarding the significant increase in the cost of PPE during the pandemic which became a major practice expense that health insurers failed to reimburse, despite MSSNY outreach to the New York Health Plan Association, the NYS

Department of Financial Services and the Legislature. In addition to insurance reimbursement, MSSNY has been actively advocating based upon existing policy 270.958 to have the state or federal government be a central supplier of low or no cost PPE. The Reference Committee believes that the MSSNY policy should reflect the multiple steps that can be taken to ensure physicians have adequate PPE. Therefore, it recommends the above substitute resolution incorporating elements of the proposed resolution and re-affirming MSSNY Policy in this area.

> **270.958 Personal Protective Equipment Preparedness and Purchase**
> The Medical Society of the State of New York will advocate that all community-based physicians and its member institutions are appropriately protected by the use of personal equipment (PPE) through the COVID-19 pandemic and beyond. MSSNY will work with the New York State Governor's Office and the New York State Department of Health to develop mechanisms for New York State to become a central purchaser of PPE for community-based physicians, institutions, and other health care entities in need of such equipment. (Substitute adopted by Council 6/4/20; HOD 2020-167 and Late B)

11. <u>RESOLUTION 258 – PHARMACOGENETICS INSURANCE COVERAGE</u>

Original Resolution 258 reads as follows:
RESOLVED, that insurance companies should cover testing for enzyme deficiencies prior to administration of medications; and be it further

RESOLVED, pharmaceutical companies create protocols for testing and informed consent forms to aid clinicians and patients to make informed decisions; and be it further

RESOLVED, all genetic testing and enzyme deficiencies should be covered if they impact potential life-saving treatment and severe morbidities if testing is not done.

RECOMMENDATION:
THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 258 BE REFERRED TO COUNCIL

Your Reference Committee heard testimony regarding the importance for certain patients undergoing chemotherapy to have coverage for dihydropyrimidine dehydrogenase (DPD) enzyme testing. The Reference Committee was also made aware of legislation (A.3191, Fahy/S.1462, Breslin) that would require health insurers to pay for this testing. While the Reference Committee was sympathetic to the goal of ensuring that health insurers pay for tests for patients that are recommended by their physician, it believed the resolution should be referred to Council for more study from physicians with expertise in this specific area.

12. <u>RESOLUTION 260 – CONCURRENT PROCESSING OF PROCEDURE EQUIPMENT.</u>

Original Resolution 260 reads as follows:
RESOLVED, that MSSNY will advocate for a state law or regulation that requires insurers to pay all the CPT codes of a given procedure or operation at the same time; and be it further

RESOLVED, that MSSNY ask the AMA to advocate for federal law or regulation that requires insurers to pay all the CPT codes of a given procedure or operation at the same time.

RECOMMENDATION:
THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 260 BE REFERRED TO COUNCIL.

Your Reference Committee heard much testimony in support of this resolution. They raised concerns that, with the implementation of the federal No Surprises Act, health insurers are staggering processing and payment for various aspects of patient care services related to out of network care provided by a physician in a hospital. While the Reference Committee shared the concerns, they also had concerns that, as written, the resolution could be interpreted to encourage health insurers' to delay payment for other types of services if any part of the service was under review. For example, New York's current "Prompt Payment" law requires health insurers to pay any undisputed portion of a claim within 30 days of submission, but as written if enacted into law this resolution could enable health insurers to delay payment on all portions of a claim submission even if only one component of the claim was being contested. Therefore, the Reference Committee recommended referring this resolution to Council to understand the problem in greater detail and create proper wording for this resolution.

Your chairperson is grateful to the committee members, namely, Christian Coletta, Richard Chang, MD, Jennifer Cushman, MD, Melissa Grageda, MD, and Peter Sosnow, MD.

Your Reference Committee Chairman also wishes to express his appreciation to Heather Lopez, Moe Auster, Maureen Ramirez, Jennifer LaRose, and Cayla Lauder for their help in preparation of this report.

Respectfully submitted,

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