New York State Society of Dermatology and Dermatological Surgery

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Governmental Affairs Update: September 2015

The 2015 Legislative Session concluded in late June. We are already hard at work laying a foundation for our advocacy priorities for 2016. Among the items which will receive much attention next year include the following:

Date of Discovery Statute of Limitations
Legislation (A.285, Weinstein) to change New York's 2 ½ year medical liability statute of limitation to a "date of discovery" rule will receive significant attention in 2016. Despite a huge push from some media outlets and the trial lawyers, the State Legislature finished its 2015 session without enacting legislation to change the statute of limitations in medical liability actions -the bill passed the Assembly and a similar proposal (S. 911-A, Libous) advanced to the Senate floor on the last day of Session, but the Senate did not bring it up for a vote.

However, conversations on this issue will continue throughout the end of the year. During a press conference with the Governor and Assembly Speaker discussing end of Session agreements, Senate Majority Leader Flanagan noted in response to a question from a *Daily News* reporter that issues like malpractice reform "have never been done in isolation" and that immediately following the conclusion of Session a series of roundtables with parties on both sides of this issue will be convened so that the issues can be addressed "sooner rather than later".

The Medical Liability Mutual Insurance Company (MLMIC) citing a *Milliman* actuarial study estimates that enactment of this legislation could trigger premium increases of 15%. The Senate's comprehensive focus on liability reform in conjunction with a date of discovery statute of limitation should present an opportunity for medicine to raise issues to counteract and address New York's failed medical liability adjudication system with the goal of bringing down the cost of medical liability insurance for all physicians.

Mandatory Continuing Medical Education on Pain Management and End of Life Care
Since the imposition of I-STOP and the requirement for prescribers to consult the prescription monitoring program (PMP) database before prescribing a schedule II, III or IV controlled substance, legislation (S.4348, Hannon/A.355, Rosenthal) has been introduced (and passed by the Senate) which would require physicians to take three hours of continuing education on the following topics: I-STOP and drug enforcement administration requirements for prescribing controlled substances; pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention,

screening, and signs of addiction; responses to abuse and addiction; and end-of-life care.
The New York State Assembly did not vote on the legislation this year. It is likely, however, that there will be a concerted drive to enact a CME mandate next year—a year in which every state legislator is up for re-election. Many patient advocates, concerned that members of their family are becoming addicted to opioids because their physicians are not aware of or ignore the addictive qualities of opioids are calling for enactment of this legislation.

Truth in Advertising
Despite best efforts, legislation **(S.4651-C, Griffo/A.7129-D, Stirpe)** which would assure that health care professionals are appropriately identified in their one-on-one interaction with patients and in their advertisements to the public was not enacted this year. Specifically, the bill would require that advertisements for services to be provided by health care practitioners identify the type of professional license held by the health care professional. In addition, this measure would require all advertisements to be free from any and all deceptive or misleading information. Ambiguous provider nomenclature, related advertisements and marketing, and the myriad of individuals one encounters in each point of service exacerbate patient uncertainty. Further, patient autonomy and decision-making are jeopardized by uncertainty and misunderstanding in the health care patient-provider relationship. Importantly, this measure would have also required health care practitioners to wear an identification name tag during all patient encounters that includes the type of license held by the practitioner.

While the bill advanced to the floor of the Senate and was placed on an Assembly Committee agenda, changes were proposed to the Assembly bill which could not be embraced. Of concern is the issue of whether practitioners should be subject to professional misconduct in all instances where they fail to wear the identification badges. We will be working with MSSNY, the NYS Society of Anesthesiology, the bill's sponsors and the chairs of the respective Higher Education Committees throughout the end of this year to resolve open issues with a view toward early passage of the bill in 2016.

Scope of Practice
Each year we face challenges from non-physician practitioners who wish to expand their scope of practice, often intruding into the scope of medical practice. Two bills were defeated again this year but we must remain proactively vigilant in our efforts against them in 2016.

1. S.816 (Libous)/ A.3329 (Morelle) – a bill that would permit oral and maxillofacial surgeons to perform a wide range of medical surgical procedures involving the hard or soft tissues of the oral maxillofacial area. This could include cosmetic surgery, such as face lifts, rhinoplasty, bletheroplasty, and other procedures, and would allow them to do these procedures in their offices, despite the fact that they are not included within the regulatory oversight structure which governs office-based surgery for physicians.

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2. A.719 (Pretlow)/ S.4600 (Libous) - a bill that would expand the scope of practice of podiatrists to diagnose, treat, operate or prescribe for cutaneous conditions of the ankle up to the level of the knee, which could include skin cancers or diabetic wounds.

Regulatory Impact of Delivery System Reform Incentive Program (DSRIP) and the State's Health Innovation Plan (SHIP) on the Practice of Medicine

Much has been happening within the state over the summer months which may change the shape of our health care system in New York State over the next few years.

The State received approval from CMS to invest $8B for comprehensive Medicaid delivery and payment reform through the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community based collaborations/integration with the goal of reducing avoidable hospital readmissions by 25% over five years. The state's goal is to transition traditional Medicaid managed care (MCO) fee for service payment over five years to a system where 80-90% of MCO-physician payment contracts are based on value based payment (VBP) methodologies of which at least 35% must involved health care providers sharing some so-called "downside" risk.

The design of the value based payment methodologies will likely not just define a payment structure for the Medicaid program. It may also be replicated in contract with commercial payers..

The State has also received a SIM (State Innovation Model) grant to assure that 80% of the state's population receives primary care within an "advanced" primary care setting and that 80% of such care will be paid for under value based financial arrangements.

Work groups have been established to iron out the parameters of value based payment arrangements based not on dollar amounts or volume but on the achievement of quality metrics and the level of risk sharing.

There are many facets of these discussions which must be brought to the attention of our elected representatives such as the fact that State data show that only 39.4% of physicians in New York State have adopted EHRs and that little if any of the money being targeted for DSRIP and the SIM will go to support or incentivize physician adoption of this technology. Without it, physicians will not be able to demonstrate adherence to quality metrics and will thus lose money under the VBP arrangements over time potentially severely impacting access to care. Moreover, there is little to no discussion regarding how to empower solo and small practice physicians who are not associated with ACOs, IPAs or other integrated systems.

It is too soon to know the impact that these changes will have on payment and other contractual arrangements entered into by MCOs and non-primary care specialists serving Medicare and commercial carrier enrollees.

ICD-10 Implementation: CMS one-year leniency FAQs

In July 2015, CMS and the AMA made a surprise announcement that will help providers make the transition to ICD-10 by the Oct. 1, 2015 deadline.

CMS announced that for 12 months following the Oct. 1, 2015 implementation deadline, Medicare claims will not be denied if providers use the wrong ICD-10 code, as long as the code is in the right category. CMS is also teaming up the AMA to provide webinars, on-site training, and other tools to teach providers about the new codes.

CMS also unveiled the creation of an ICD-10 ombudsman and online resources designed to aid the medical community. This includes Road to 10, a website that contains primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation.

AMA has created AMA Wire to help prepare physicians for the Oct. 1 deadline.