WESTCHESTER PHYSICIAN

February 2016 **Volume 32, Issue 2**

PRESIDENT'S MESSAGE
BUNDLE UP!

THOMAS J. LESTER, MD
President, WCMS

The recent snow storm reminded me of growing up in Union County, New Jersey in the 1950's. A snow day was just about the best thing that could happen to us. Kind of like winning the Lottery. My brother and I would shovel snow for the neighbors, and come home at the end of a long day - tired, sore, and rich. As we bounded out the door, my mom would yell after us "Where are you going?" To which we would reply "OUT!" There was time for only one additional comment, and it was always "BUNDLE UP!!!" At the time, I understood it to mean put on your hat and gloves, but I have since learned what she really meant - Be Careful, Pay Attention!!!

Bundled payments are all the rage right now. But we have lived with limited bundles for years. The post op global period following surgery – for 90 days of visits, and care, has been bundled into the price of the procedure for the surgeon. I have recently learned that CMS has looked at the number of visits following selected procedures, and discovered that they have decreased once they were not paid separately. There is no evidence that care has suffered, or that complications have increased, just that the surgeons have not seen their post op patients as frequently once the visits were included in the price of the procedure. I thought that was a good thing, but CMS must feel otherwise. They are now considering un-bundling some of these post op visits, in an effort to save money. I am not sure CMS has thought this through completely. Once they start paying for each post op visit, the number of visits will increase, as will costs - and I predict outcomes will remain the same. Its déjà vu, yes - all over again.

The New England Journal of Medicine published an excellent review in October of 2015 of Medicare's Comprehensive Care for Joint Replacement (CCJR) program which began in January 2016.

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UPCOMING EVENTS

MSSNY Legislative Day
Tuesday, March 8, 2015
Albany, NY

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FROM THE EDITOR…
PETER J. ACKER, MD

FLINT

Medical history over the ages has been a story of continuous and remarkable progress towards eliminating the diseases and maladies that have plagued mankind. Tuberculosis, for example, was the leading cause of death in the United States in 1900. Going further back, bubonic plague, "the black death" repeatedly decimated entire cities. Our progress has been the result of eons of research into understanding the mechanics of each particular disease and devising medications as well as environmental and engineering solutions. Malaria, for example, can be treated with chemotherapeutic agents, but it also can be eliminated by mosquito eradication, mosquito netting, etc.

The advances that capture all the attention are the "magic bullets" that almost instantly turn an incurable disease into one quite treatable. Penicillin heralded the dawn of the antibiotic age which revolutionized our treatment of bacterial infections. Who doesn't know the story of Fleming's famous discovery? Getting less attention are the quotidian efforts of all the health workers and engineers who are responsible for ensuring that our water systems are healthy. Through the ages, water has proven to be a prodigious conveyer of disease and toxins.

What can be more natural than to turn on a faucet and have water stream out? I was thinking of this in the shower the other day, how we more fortunate ones have this precious life sustaining fluid at our beck and call. In many parts of the world, access to water, clean or otherwise is becoming increasingly tenuous. The **New York Times** had a long article a few weeks ago about the diminishing water tables over huge swaths of India. The **New Yorker**, also a few weeks ago, had a piece describing the link between long periods of drought in Syria several years ago and the destabilization of the entire region due to swaths of displaced farmers. It is interesting to see the price of one liquid going down (oil) while arguably the value of that other liquid can only increase. And the two fluids are inexorably linked in sort of a death dance as the burning of one is resulting in the shortage of the other.

We Americans have been complacent. Throughout our history we have enjoyed boundless land and resources.

(Continued on page 5)

MARCH ON ALBANY FOR LOBBY DAY MARCH 8, 2016 OR MARCH INTO RETIREMENT – YOUR CHOICE

JOSEPH R. MALDONADO, JR., MD, MSC, MBA, DIPEBHC

The 2016 New York State Legislative Session has begun. This year presents an EPIC moment in our legislative advocacy history akin to 1975.

The changes being proposed to current New York State laws concerning medical liability represent the greatest threat we have experienced in four decades. Changes to the date of discovery and the Statute of Limitations open a Pandora's Box for the profession. This has been brought about as a result of an injustice caused to a plaintiff whose right to justice was impaired by a more limited timeframe for redress. That limitation was the one-year-and-90-days limitation for filing a claim for injuries alleged as having occurred in a NYC Health and Hospitals Corp facility.

The catalyst case—that of Laverne Wilkinson—would have seen justice had she been afforded the two-and-a-half year standard for other New York State defendants. The injustice of that limitation in NYC prompted an opportunity for trial attorneys to expand their legislative efforts not at the NYC municipal level where the injustice occurred, but rather at the state level where they can promote additional gains—such as an end to the attorney's contingency fee. In turn, the proposed changes threaten to raise medical malpractice liability insurance premiums by an estimated 25%.

The potential harms caused by proposed legislation threaten to collapse healthcare delivery in New York. Now more than ever, we need to MARCH TO ALBANY ON LOBBY DAY.

The recent decision of the New York State Court of Appeals in Davis v. South Nassau Communities Hospital poses additional liability for physicians, which need to be addressed via legislation. That decision opens the possibility for physicians to be sued by third parties for harm caused as the alleged result of a physician's treatment of a patient with whom the third party was engaged. In that case, the court held a physician liable for the harm caused to a third party by the alleged failings of the physician to advise a patient of the effects on driving when taking prescribed medications. This legislative session also threatens to impose a mandatory CME requirement for the management of chronic pain and opioid drug prescribing. **WE SIMPLY CANNOT CONTINUE.**

This is the year, as in 1975, when physicians will clamor in Albany, "ENOUGH IS ENOUGH!"

We will not stand by as the trial lawyers drive us to retire or relocate to other states. We will not sit by idly while unfunded mandates are heaped upon us. We will not sit by while the State Legislature and Executive Office bicker about which entity is responsible for cleaning up the Health Republic debacle and seek to make other parties responsible for making physicians whole for providing necessary care to patients under the reforms brought about by the ACA. If the State of New York wants physicians to participate in the SHIP and DSRIP initiatives being proposed, then the Executive Office and the Legislative branches MUST find solutions for the Health Republic debacle AND insure that narrow networks do not run doctors out of town or harm patients seeking to access care.

WE MUST MARCH ON ALBANY THIS LOBBY DAY, March 8, 2016. Contact the WCMS office or visit: https://events.r20.constantcontact.com/register/eventReg?oeidk=a07ec6iio00a38b86b0&oseq=&c=&ch=

to register to attend, and for transportation information.

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Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

REMINDER: Electronic Prescribing Mandate

The implementation date for mandatory electronic prescribing is **March 27, 2016**. Information regarding requirements can be found at https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/.

E-prescribing of both controlled and non-controlled substances is currently permissible in New York. Practitioners must ensure compliance with the requirement, including working with their software vendors to implement the additional security requirements needed for e-prescribing of controlled substances, and registering their certified software applications with the Bureau of Narcotic Enforcement

Below are highlights/key points that may be of particular interest to prescribers and pharmacists:

- A prescription generated on an electronic system that is printed out to the Official New York State Prescription form or faxed is **NOT** an electronic prescription.
- Amendments to Title 10 NYCRR Part 80 Rules and Regulations on Controlled Substances have been adopted and became effective as final regulations on March 27, 2013. The amendments authorize a practitioner to issue an electronic prescription for controlled substances in Schedules II through V and allow a pharmacist to accept, annotate, dispense and electronically archive such prescriptions.
- After March 27, 2016, a pharmacist is NOT required to verify that a practitioner properly falls under one of the exceptions from the requirement to electronically prescribe. Pharmacists may continue to dispense medications from valid written, oral, or fax prescriptions that are consistent with current laws, regulations, and Medicaid policies.

A comprehensive list of Frequently Asked Questions (FAQs) can be found at https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/docs/epcs_faqs.pdf.

The FAQs provide an explanation of the laws and regulations, pharmacy registration forms, registration for official prescriptions and e-prescribing systems (ROPES), software and data requirements, waivers and exceptions, and resource information and contacts.

Questions? Please contact the Bureau of Narcotic Enforcement at 1-866-811-7957 or via e-mail to narcotic@health.ny.gov.

FROM THE EDITOR…
PETER J. ACKER, MD

FLINT *(Continued from page 2)*

We have had large oceans to protect us from the tumultuous conflicts abroad. That is not say we have not endured many wars, but we have been able to always be on somebody else's turf. Our national equanimity though has increasingly been jolted as we read of the water crisis in California, the slow destruction of the Everglades, and most recently the crisis in Flint, Michigan.

As is well known now, the powers that be in Flint, Michigan decided to change their source of water as a cost saving measure. So rather than use water from one of the largest sources of fresh water in the world, Lake Huron, they elected to pipe it in from a local river. The ultimate consequences of that decision, the dramatic increase in the lead concentration in the water supply and the consequent rise in lead levels in the children of Flint are now the subject of almost daily newspaper articles. In following this story, I was greatly heartened to learn that it was a fellow pediatrician, Dr. Mona Hanna-Attisha who took on the establishment political and health authorities to sound the alarm in September at a press conference. She endured tremendous push back over the next two months until finally it was conceded that she was right all along.

It is a cautionary tale for all us.

UPCOMING WCMS/WAM MEETINGS & EVENTS

9th District Delegate Meeting
Thursday, February 4, 2016—6:00pm
WCMS Offices

WCMS Board Meeting
Thursday, February 18, 2016—6:00pm
WCMS Offices

MSSNY Legislative Day
Tuesday, March 8, 2016
Albany, NY

WCMS Board Meeting
Thursday, March 17 2016—6:00pm
WCMS Offices

MSSNY House of Delegates
Friday, April 15– Sunday, April 17
Tarrytown, NY

CMS Administrator Announces the End of Meaningful Use – NOT

JONATHAN KRASNER

Recently, Andy Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services (CMS), spoke at a health care conference. The text of his speech can be found here. His remarks touched on many subjects including Meaningful Use. The MU program is controversial because many providers feel, and with good reason, that portions of MU are a waste of time, difficult to achieve and don't improve the provision of healthcare. Twitter blew up when Administrator Slavitt made the following comment: *"The Meaningful Use program as it has existed, will now be effectively over"*. This is only a partial truth, and anyone who relies on Twitter for news will be seriously misinformed. Meaningful Use, and especially the concept of using EHRs in the documentation and provision of care, is NOT going away. MU was intentionally designed to have a limited life. The legislation which established MU was passed in 2009 as part of the American Recovery and Reinvestment Act - the MU program itself was implemented in 2011. For many, if not most providers, MU incentive payments have already been received. A phase out of MU has already been contemplated and its replacement is called MIPS - more on this later.

Like many issues in Washington, Meaningful Use became a political football in the past year. Many lobbying organizations put pressure on Congress to end the program. Perhaps because of this lobbying effort Administrator Slavitt issued his guidance to show that Washington was listening. However, the full text of what he said was: *"The Meaningful Use program as it has existed, will now be effectively over and replaced with something better."* Just what "something better" is has not yet been fully defined. Stay tuned.

Starting in 2017, another piece of legislation, MACRA, will take effect. Associated with MACRA is MIPS, or the Merit-Based Incentive Payment System. In CMS's own words: The MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program based on quality, resource Use, clinical practice improvement and the **Meaningful Use of certified EHR technology.** According to Jim Tate, an expert in the field of Meaningful Use: *"The failure to achieve MU of CEHRT under MIPS will cost eligible providers 25 of their maximum 100 composite MIPS scores. The potential loss of revenue dwarfs the current "payment adjustment" under the CMS EHR Incentive Program."*

Will MU change going forward? Absolutely. Administrator Slavitt intends to make changes in the design of the program, and likely even change the name. Meaningful Use has become "persona non grata" to many, and perhaps rebranding is in order.

How does all of this affect HIPAA? According to an article in Healthcare Information Security, *"The biggest impact of the Meaningful Use program so far has been to wake up some healthcare providers about the importance of security and privacy"*. Administrator Slavitt, in addition to his comments above, signaled an increasing emphasis on interoperability – the capability for clinical systems to easily exchange data electronically. This is an area where MU fell short, but remains an area of continued focus. With increasingly greater emphasis being placed on electronic patient data and data exchange, the protection of patient data will take on an even higher priority. We can therefore expect government focus on enforcing HIPAA compliance to only continue to grow in the future.

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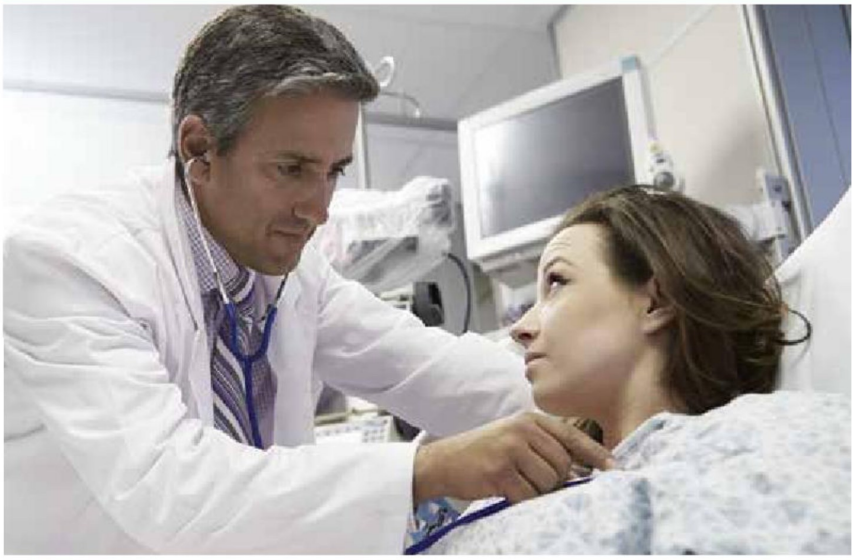
Kaiser Employer Health Benefits Survey, 2013



New Exclusive Member Benefit

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Late breaking news on medical-legal developments affecting physicians and health care professionals

New York State Department of Health Announces Online Medical Marijuana System: The New York State Department of Health ("DOH") announced the launch of its online Medical Marijuana Patient Certification and Registration System. The online system allows qualified patients to enroll in the Medical Marijuana Program so they will be able to purchase medical marijuana when it becomes available in 2016. In order to obtain medical marijuana, a patient must receive a DOH Medical Marijuana Program certification from a registered physician. The patient must then access the DOH's online Patient Certification and Registration system to apply for a registry identification card. In order to apply using DOH's online system, each patient must have a valid DOH Medical Marijuana Program certification form issued and signed by a registered physician, a photographic identification, documentation of his or her temporary or permanent New York State residency, and designated caregiver information, if applicable. A patient under the age of 18 or who is otherwise incapable of consenting must apply through a proxy. For additional information and instructions on the patient registration process, go to http://www.health.ny.gov/regulations/medical_marijuana/patients/ For more information about the Medical Marijuana Program, visit: https://www.health.ny.gov/regulations/medical_marijuana/

Advocacy Groups Pushing to Require Federal Exchange Health Plans to Cover Medications Used to Treat Opioid Addiction: Physician and consumer advocacy groups are putting pressure on the Center for Medicare and Medicaid Services ("CMS") to require that health plans sold on the federal exchanges be required to provide coverage for medications used to treat opioid addiction. These groups contend that opioid addiction therapy should be considered an "essential" insurance benefit. According to the Centers for Disease Control and Prevention, more than 28,000 people died from overdoses of prescription pain medication, heroin and other opioids in 2014. The federal government has stated opioid abuse constitutes a "public health crises," and has requested healthcare experts to offer their opinions on whether coverage for medication-assisted treatment ("MAT") for opioid addiction should be mandated under the Affordable Care Act. The Act requires health insurers to cover ten essential health benefits, including substance abuse disorder services and prescription drugs, but it is not clear whether this encompasses coverage for the full range of MAT for opioid addiction. However, health insurers and their lobbying groups contend that benefits should be determined by individual insurers in discrete markets, and that mandating coverage for specific treatments will upset the balance between coverage mandates and affordability and lead to increased premiums and market instability, and will also constitute a precedent for mandating essential health benefits in the future.

Senate Committee Suggests Congress Pass Legislation to Better Track Device Medical Device Safety: A recent report revealed that the number of deadly infections associated with the use of contaminated medical scopes far exceeds previous estimates by nearly twice as much as previously reported by regulators. The report, which was authored by the Senate Health, Labor, Education and Pensions Committee, found that as many as 250 patients who had acquired antibiotic-resistant infections in 25 separate incidents between 2012 and 2015 were linked to the same type of contaminated duodenoscopes. The report criticized the FDA's response to initial reports that there was a possible link between outbreaks of multidrug-resistant infections and contamination of the scopes even after product maker's cleaning and disinfecting instructions were correctly followed. Particularly damning were assertions that regulators waited months after beginning their investigation on duodenoscopes in September 2013 before taking action to alert the public of a possible risk associated with their use. Going forward, one of the committee staff's key recommendations called for Congress to require health insurance claims to include the FDA's unique device identifier codes to improve tracking and monitoring of device safety and efficacy.

For more information on the above items, contact Kern Augustine Conroy & Schoppmann, P.C. at 1-800-445-0954 or via email at info@DrLaw.com.

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PRESIDENT'S MESSAGE

BUNDLE UP!

(Continued from page 1)

The program mandates bundled payments for elective total knee and hip replacements including hospital costs, professional fees, and rehabilitation services for 90 days following surgery. It is a 5 year program, covers 196 metropolitan areas, and 750 hospitals – and includes us. 400,000 Medicare beneficiaries receive a hip or knee replacement yearly at a cost of almost $15 Billion. The average cost for a 90 day bundle is $26,000 but the costs vary depending on the risk stratification of the patients – from $15,000 to well over $100,000. The hospitals will be held responsible for the program, and will suffer the financial burden, and control any bonus payments. Baseline costs will be a mix of hospital specific, and regional costs - over the years 2012-2015. The first 2% savings will be taken by CMS, and the remainder would be available to the hospitals to share with the surgeons, and SNFs, and would incentivize everyone to work together. The surgeons would continue to receive Medicare fee for service payment for their work. There would be no downside risk in 2016, but increasing risk starting in 2017. Up to 30% of the revenue received by hospitals for joint replacement would be placed at risk in years four and five, or available as a bonus - a huge amount of money. Quality measures would include complication rates, 30 day re-admission rates, and patient experience measures (HCAHPS), and the hospitals and providers would have to score above the 30th percentile nationally to receive ANY payments.

Are we ready for this? Will the hospitals, surgeons, and rehabilitation centers really cooperate to lower costs? At whose expense? As a surgeon, or acute care hospital, I would love to reduce length of stay and lower costs from rehab facilities, but I suspect they may see it differently. Smaller hospitals may be crippled by a bad year with several very sick patients that skew their results. The financial consequences could be devastating.

BUNDLE UP!!!

Executive Budget Seeks to Marginalize Physician Care to Injured Workers

The Governor's proposed Budget released last week contains sweeping changes to long standing Workers' Compensation laws to, according to the supporting memo: ensure the system provides more timely and appropriate medical and wage replacement benefits to workers; provide broader and more accessible options for medical care; make hearings more accessible through flexible scheduling and use of virtual hearings; and streamline Workers' Compensation Board processes and administration to expedite decision making.

While these goals are obviously shared by the physician community, the proposal includes a number of seriously problematic proposals that could further discourage physician participation in the Workers' Compensation program. Among the proposals:

• Removes the authority of county medical societies to recommend physicians to serve as treating providers or independent medical examiners under Workers Compensation, which is currently an important community function provided by county medical societies;

• Enables treatment of injured workers and direct payment for care by nurse practitioners and physician assistants, without clarity as to: how non-physicians treating patients with serious health conditions will coordinate patient care delivery with physicians; whether new funds will be allocated or whether existing fees will need to be cut to cover this expanded list of care providers; and whether a non-physician can perform an IME of an injured worker to review the care provided by a physician to an injured worker;

• Removes the requirement for a referral by a physician for an injured worker as a pre-condition to receive psychological care;

• Expand the circumstances when a physician or other health care provider can have their authorization removed and empowers the Board to impose a $5,000 fine on a physician or any other Board-authorized health care provider for violating a Workers Compensation rule; and

• Prohibits an injured worker not subject to a collective bargaining agreement from seeking medical treatment from outside a Workers Compensation PPO before 120 days after his or her first visit to a preferred provider organization provider. Of further concern, the proposal does not address any of the many excessive administrative hassles identified by physicians that have caused many physicians to choose to not participate in the Workers Compensation program. While there have been some modestly positive actions taken by the WCB in recent years to encourage physician participation in the WC program through removal of arbitration fees and development of an electronic portal for facilitating authorizations from carrier, the Budget proposals, if enacted, could further chase physicians away from the program. MSSNY has reached out to labor organizations to coordinate its advocacy in opposition to these adverse proposals.

♦

Holding of 2016 Date-of-Service Claims for Services Paid Under the 2016 Medicare Physician Fee Schedule

On October 30, 2015, the CY 2016 Medicare Physician Fee Schedule (MPFS) final rule was published in the Federal Register. In order to implement corrections to technical errors discovered after publication of the MPFS rule and process claims correctly, Medicare Administrative Contractors will hold claims containing 2016 services paid under the MPFS for up to 14 calendar days, (i.e., Friday, January 1, 2016 through Thursday, January 14, 2016). The hold should have minimal impact on provider cash flow as, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt.

MPFS claims for services rendered on or before Thursday, December 31, 2015 are unaffected by the 2016 claims hold and will be processed and paid under normal procedures and time frames.

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