TO: **MSSNY's Officers, Councilors and Trustees**

FROM: **MSSNY Legislative & Physician Advocacy Committee**

DATE: **December 14, 2022**

RE: **Late Resolution B – 2022 House of Delegates**
Introduced by the 6th District Branch

The following late resolution was referred to the MSSNY Council after it was accepted by the House of Delegates for consideration at the May meeting. The resolution was forwarded to the Legislative & Physician Advocacy Committee for further study and recommendation for the Council's consideration.

RESOLVED, all peer to peer care reviews must be a "true" peer to peer. The peer to peer reviews must be performed by a physician, and that physician must hold a current NY medical license and be board-certified in the same specialty as the care providing physician, and where appropriate the physician representing the care denial organization must be subspecialty board certified in a field germane to the request; and be it further

RESOLVED, peer to peer time lines may not be unreasonable. Any mandated time line for a care providing physician must allow for a peer to peer to occur within two weeks of the care providing physician being notified of the requirement for a peer to peer. The time chosen must be one that is convenient for the care providing physician being mandated to have a peer to peer by the denial company, and be it further

RESOLVED, all companies/organizations that are de facto functioning as 'denial agents' for payers need to be immediately brought under the auspices of the NY state Department of Financial Services and as such become subject to all rules and regulations for health care payers, and be it further

RESOLVED, that physicians have the right to recoup for their currently uncompensated time and resources required to schedule and complete a peer to peer review to address a denial of patient care by charging a fee $200 per hour of time required to address the peer to peer request with a minimum compensation of $100 per peer to peer to be paid to the care providing physician office by the denials company, and be it further

RESOLVED, physicians performing a peer to peer on behalf of the denials company must have all records germane to the case, and have reviewed the entirety of these records prior to meeting with the care providing physician for a peer to peer, failure to do so would result in the care providing physician having the case found in their favor without further denial, and be it further

RESOLVED, that in the event of a denial finding after a peer to peer, or any other reason for a denial, there may not be a time limit placed on resubmitting a request for care, and be it further

RESOLVED, that any physician working on behalf of a denials company will become personally, medically and legally responsible for any lapse in care, failures of care, or negative outcomes that arise due to denials of, or delays in, care as directed by the care providing physician, and be it further

RESOLVED, that MSSNY push aggressively for legislative action on all of these resolves during the next legislative session, and be it further

- **RESOLVED, that MSSNY bring this to the AMA to develop a national agenda on this issue**

There was consensus at the October 17 and December 14 meetings of the Legislative & Physician Advocacy Committee that the resolution raised numerous concerns about aberrant health insurer practices that were experienced by physicians across the State, and that MSSNY needed to continue to work to fix them. However, it was also noted that this resolution overlaps substantially with several existing MSSNY policy statements, that relate to ensuring health insurer's ensure utilization review by same-specialty physicians, ensuring health insurers are legally liable for the consequences of their denials and requiring health insurer payment for excessive prior authorization wait times. Moreover, with regard to comments expressed that these policies are not addressing the problem sufficiently, committee remembers were advised that MSSNY has already undertaken aggressive efforts to address these problems, through advocacy to the Legislature, various state agencies and where appropriate, the insurers themselves. Just a few of these examples over the last year include:

- Advocacy for legislation (A.879/S.8113) that passed the Senate and Assembly, but vetoed by the Governor, that would prohibit health insurers from denying a claim or prior authorization request unless that claim is reviewed by a New York licensed physician practicing in the same or similar specialty as the physician delivering the care. MSSNY has been working with a contingent of patient advocacy groups in support of this legislation.

- Advocacy for legislation (S.5909/A.3276) that passed the Senate and Assembly, but vetoed by the Governor that would prohibit health insurers from imposing step therapy requirements for medications to treat a mental health condition (which would free physicians from having to spend excessive time obtaining pre-authorization for these medications). MSSNY has been working with a contingent of patient advocacy groups in support of this legislation.

- Advocacy for legislation (A.9908/S.8299) that would permit physicians to bypass otherwise applicable prior authorization requirements if that physician has achieved at least 90% approval for their previous prior authorizations for that procedure, as well as advocacy for legislation (A.7129-A/S.6435-B) that would prohibit repeat prior authorization requirements. MSSNY has been working with a contingent of patient advocacy groups in support of this legislation.

- Promoting the services of Heather Lopez, MSSNY's Director of Payment & Practice, who within just over a year of employment, has helped physicians across the State recoup or save millions of dollars from abusive health insurer practices.

With all these existing policies and ongoing efforts, the most practical step is to re-affirm these existing policies. Recognized that these concerns still are not satisfactorily addressed even with these existing policies, it is also recommended that an additional resolved be added highlighting the urgency of resolving the problems identified in the resolution. It should be further noted that there are elements of the initial proposed resolution where it could be legally inappropriate for MSSNY to advocate because it sets forth a specific fee to be defined in law or regulation.

RECOMMENDATION: That the MSSNY Council adopt the following substitute resolution:

RESOLVED, that MSSNY Policies 120.925, 120.944, 165.968, 265.902 and 265.964 BE RE-AFFIRMED; and be it further

RESOLVED, that MSSNY continue to take all necessary steps, including media strategies, to aggressively advocate to state/federal oversight agencies and the State Legislature for relief of abusive health insurer practices that inappropriately delay needed patient care and delay fair payment for delivering this care.

120.925 Peer-to-Peer Reviews by Insurers. The Medical Society of the State of New York will seek legislation to change peer to peer review by insurers to include evidence-based criteria publicly available and to be conducted by a physician of the same specialty and responded to the physician practice on a timely basis via fax or electronically. This legislation should also limit peer to peer and prior authorization reviews to only those cases that do not fall within the evidence based criteria. (HOD 2017-252; Reaffirmed HOD 2020-270)

120.944 Changes in Pre-certification for Medications to Reduce Delays. The Medical Society of the State of New York will continue to advocate to reduce the circumstances when pre-authorization for needed patient medications are required, including eliminating the requirement for annual re-authorization once a prior authorization for a prescription medication has been approved. The Medical Society of the State of New York will advocate to ensure that health plan pre-authorizations for prescriptions be completed within 24 hours. (HOD 2014-58; Reaffirmed HOD 2015-53; Reaffirmed HOD 2019 in lieu of res 68)

165.968 Liability of Managed Care Entities As Well As Their Employees, Agents, Ostensible Agents And Representatives: MSSNY will develop or support legislation or regulation requiring that whenever an employee, agent, ostensible agent and/or representative of a managed care entity makes a determination that affects a patient's health, both the individual and the entity should be held liable for any adverse outcome to the patient arising directly from the determination or as a consequence of the determination. (HOD 1997-114; Reaffirmed HOD 1998-84; Reaffirmed HOD 2014; Reaffirmed HOD 2015-57; Reaffirmed HOD 2020-56)

265.902 Charge for Referrals and Prior Authorizations. MSSNY to seek the introduction of regulation/legislation to allow physicians to be paid by health insurers for referrals and prior authorizations reflecting their costs in time and personnel for each and every referral or prior authorization sought. (HOD 2008-53; Reaffirmed HOD 2018)

265.964 Review of Pre-Authorizations by a Licensed Physician. MSSNY will seek legislation to require that all pre-authorizations for procedures be reviewed by a New York State licensed practicing physician who is board certified or board eligible in the same specialty as the requesting physician prior to any denial of pre-authorization. (HOD 2000- 67; Reaffirmed HOD 2014