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"Independent Practice Association (IPA): The Potential Path Forward for Independent Private Practice"

Thomas T. Lee, MD, President, WCMS, and
Joseph Tartaglia, MD, President, Westchester Academy of Medicine

A few months ago we wrote about the Southern New York IPA (SNYIPA). Because of the potentially significant impact, we thought we would discuss this issue with the membership again. Commercial insurance payer consolidation, the Patient Protection and Affordable Care Act (PPACA), various federal and state regulatory requirements, and rising professional liability costs impose disproportionate stress on independent physician practices. Some independent practitioners question the survivability of the independent practice model. While we do not have a crystal ball to predict the future, we would certainly like to think so.

Many federal requirements from HIPAA (1996) and HITECH (2009) meant well, but imposed significant stress, both financially and physically, on the smaller physician practices. The burden is disproportionate because smaller practices traditionally cannot absorb the tremendous ongoing human resource and technology costs to implement these measures to satisfy the requirements and avoid penalties. HIPAA increased legal, administrative, and contractor costs and documentation/disclosure complexity. Electronic health records (EHR's) are expensive, time-consuming, and necessarily interrupt work flow and efficiency. The various penalties for non-compliance with EHR and e-prescription pose further economic threats. State regulations and legislation such as the recent I-STOP rules mandating additional narcotic medication database verification imposes further staffing and time requirement on physician practices. The Affordable Care Act further threatened independent practices by implementing further regulatory requirements and concepts, coupled with the planned sustained growth rate formula (SGR) Medicare reimbursement cut of 27+ percent. The mergers and acquisitions of regional commercial insurers create oligopolies, and give insurers the unparalleled advantage when it comes to managed care contract negotiation for independent practices. Plan choices and plan benefits for patients and health care consumers are shrinking rapidly and premiums are still rising in double digits despite significant cost shifting to the patients/health care consumers and employers.

The public should be afforded diverse practice models including independent practices to fit the individual patient's preferences and needs. Bigger institutions aren't cheaper for the health care system and their complex structure and higher overhead frequently do not allow them to provide more cost effective care than a smaller office practice. In fact, one may astutely point out that larger institutions and companies can drive up costs by promoting "one-stop shopping" for testing/procedures, and internal cross-referrals. Although the public doesn't realize it, many small practices are already providing care at a significantly lower cost to them and their insurance companies, but that lower cost is not being translated into lower premiums or better benefits for the patient. The American society has a vested interest in preserving the small independent physician practice model as an alternative access point into the health care system.

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Upcoming Events
Mark Your Calendar

Thanksgiving Holiday -
OFFICE CLOSED - November 22 - 23

Monday, December 3rd - 5:00 pm
CME Committee Meeting

Thursday, December 6th - 6:00 pm
Board of Directors Meeting

Friday, December 14th - 6:00-9:00pm
Annual Holiday Party
Knollwood Country Club

Christmas Holiday -
OFFICE CLOSED - December 24 -25

New Year's Holiday -
OFFICE CLOSED - December 31 - January 1

Monday, January 7th - 5:00 pm
CME Committee Meeting

Tuesday, January 8th - 6:00 pm
Delegates Meeting

Thursday, January 10th - 6:30 pm
Board of Directors Meeting

Newsletter Submissions

Members are encouraged to submit articles, letters to the editor, classified ads, members in the news, etc. for publication in the Westchester Physician.

The deadline for the December 2012 issue is November 26th.

Please email your submissions for review to Karen Foy, Managing Editor @ *kfoy@wcms.org*

From The Editor
"For Chucky"

By Peter Acker, MD

I have been practicing pediatrics for some 25 years and, as I have chronicled from time to time in these pages, I have enjoyed the rhythms of primary care: its seasonality with the onslaught of cox sackie in the late spring, the October croupers and wheezers, the first high fevers heralding the start of influenza. Super imposed upon this regularly irregular sinusoid waves of illness (if graphed would look like an EKG of atrial fibrillation) is the unexpected, the occasional rare avis that will present itself such as the teenager with South African tick bourne fever who appeared in my office one Saturday morning spotted with small papulovesicles or the young girl who had spent hours on the beach sucking on a lemon popsicle, who livened an otherwise uneventful day last summer when she presented with the characteristic string of pearls (berloque) of phytophotodermatitis. I live for that "aha" moment that fires up the synapses and I imagine a functional MRI with bursts of oxygenated hemoglobin fanning out over my cerebral cortex. It is this mixture of the quotidian punctuated by the totally unexpected that suits my personality and temperament that craves both routine and excitement. It is a rare day that I don't approach my office with at least a tingle of anticipation as I contemplate what awaits me behind the next exam room door.

There is, of course, that key feature of primary care: establishment of long term relationships, which is particularly the case in pediatrics. New parents, who learn to worry in a way they have never worried before, call often and at all hours, perforce a burden we pediatricians bear. It does have a positive benefit as well: an intimate relationship is forged during those late night consultations which endure throughout infancy, to the days of toddler tantrums and toilet training, to the angst filled teenage years. This longevity of relationship is a pleasure that the newly minted pediatrician can look forward to, but cannot yet experience. In addition, having reached the quarter century mark, there is a growing presence of grandkids in the practice. I recently had the pleasure of hugging a mother who came in with her son and daughter-in-law and their newborn. After the hug, we looked at each other, the unspoken words lying pregnant between us – how did this happen, where did the time go? A marvel!

Yet longevity also suffers us to bear witness to the unimaginable: an unnatural demise of a member of the generation below us. Charles (Chucky) Melillo was a patient of my office since his birth. I first met him when he was a very active toddler and then later knew him as a towheaded elementary classmate of my daughter, Karen. He died after an accident on a football field. Karen, who was not a close friend of Chucky's, had not seen him since elementary school, but still remembered him well – his high energy and good spirits. Charlie was twenty-seven and had forged a career as fireman and paramedic. His parents were immensely proud of their son. His wake and funeral drew hundreds of people, testimony to the fact that he touched many during his all too short life. A tragedy. ♦

(continued from page 1) *Independent Practice Association*

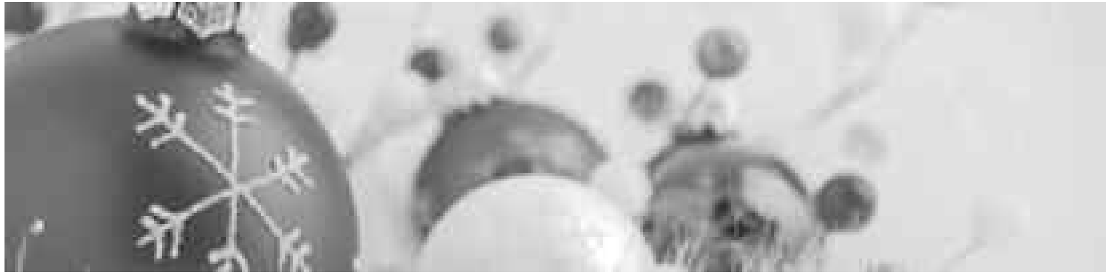
Is there a way for the small independent medical business to survive in this increasingly hostile business environment? The past decade has witnessed an economic environment, characterized by lower reimbursement and higher overhead. The options available often lead to diminished autonomy and altered professional relationships with our patients. One can choose to join a teaching institutional IPA, just to be dropped arbitrarily. Others favor the employment model of multi-specialty groups or hospitals/facilities. What will happen to the ability of the individual physician to render personalized quality medical care to his patients and his ability to choose his own working conditions? The goals of independent practices should be to legally and effectively negotiate with managed care companies and be treated fairly relative to our colleagues in large multi-specialty groups or the hospital setting. Last year, a community-based, non-institutional IPA called the Southern New York IPA (SNYIPA) was started in an attempt to help preserve the private practice model of medicine. The philosophy and goals of this community-based, clinically integrated IPA are consistent with that of the Medical Society and the concept was approved by its Board of Directors.

An Independent Practice Association (IPA) consists of an independent group of physicians and other health-care providers who are under contract to provide services to members of different HMOs, as well as other insurance plans. What makes SNYIPA unique is its ability to offer a clinically integrated model without requiring a single tax ID. Clinical integration is more than buying an EHR system and using e-prescription. It entails the commitment by member physicians to establish, adopt, implement, and monitor evidence-based and clinical guidelines for substantially all the specialties of the IPA membership. Clinical guidelines have been drafted and modified by physician members for multiple specialties based on logical implementation of our professional/specialty society published guidelines and government/insurer policies and guidelines. With its clinical integration programs, SNYIPA hopes to deliver improved patient care/outcome and a better product line to the insurers to obtain favorable contracts. The guidelines emphasize both process and outcome measurements. By keeping the patients healthier and happier, SNYIPA believes its structure and services add value to the health care delivery system. One should also note that the IPA structure is a recognized and accepted model under the final rules for an Accountable Care Organization, should SNYIPA decide to take that additional step.

The goal of SNYIPA is to preserve the choice and option for a physician or physician group to remain in independent private practices. We do not object to a physician joining a hospital or group if that's the best fit; however, we object to physicians having no choice but to join particular practice patterns or going out of business. SNYIPA is Medical Society value driven: "Created by physicians for physicians." It is physician-centered and non-institution based, so physicians from a wide geographic region can join - from anywhere in southern New York region to neighboring areas like Fairfield County in Connecticut. Already the IPA has highly favorable EHR pricing from a major national CCHIT-certified vendor and other potential membership benefits.

Potential collaboration with other regional IPA's with a similar philosophy continues to be explored. The IPA model can also potentially facilitate future practice collaboration/merger/sales since many IPA members are on the same EHR platform implemented with identical clinical guidelines. It is not single institution based, so physicians from a wide geographic region can participate in this program. Members of Southern New York IPA, unlike members of a teaching hospital-based IPA, are not subjected to the whims of a teaching hospital-based IPA, which has and can continue to unilaterally and drastically change its membership criteria based on institutional strategy or policy.

If a physician or physician group wishes to maintain practice autonomy and is willing to participate in the clinical integration program, the IPA model is a perfect and viable path going forward. Though the current application and annual membership dues are a mere fraction of other area IPA's, we expect the fees to rise significantly as we successfully secure our initial contract. Upon reaching a threshold of physicians in particular specialties, the IPA may elect to limit further membership in such specialties. An application and participating physician agreement can be downloaded at Southern New York IPA's website at www.southernnewyorkipa.com under the Application Process tab. If you have any questions, please feel free to contact either of us or email the Southern New York IPA at info@southernnewyorkipa.com. ♦



The Westchester Academy of Medicine

and the

Westchester County Medical Society

Invite their Members and Families to our

ANNUAL HOLIDAY PARTY

Friday, December 14, 2012

6:00 – 9:00 pm

Knollwood Country Club

200 Knollwood Road Extension

Elmsford, NY 10523

(914) 592-7411

TO RSVP, fill out your name and the number of guests below and fax it to (914) 967-9232.

Name: ____________________ **# of Adult Guests**_________

Email: ____________________ **# of Child Guests**_________

Come & Take a Chance on Some Great Items!

Also, please cons ider donating an item for our Raffle, to be held in conjunction with our Holiday Party. All proceeds from this Raffle benefit the Westchester Academy of Medicine and our Scholarship Fund activities. Contact Karen Foy at 914-967-9100 or by email kfoy@wcms.org.

The Realities of Healthcare Reform from the Westchester Business Community

By Kira Geraci-Ciardullo, MD, WCMS Past President & Vice Speaker, MSSNY

As I sat down to eat my buffet lunch at this very noble and interesting seminar on healthcare, I glanced quickly at my plate. Did I take the appropriate amount of vegetables? Was there just a bit too much dressing? Was the portion of chicken appropriate for my BMI? Was I consuming too much caffeine?

If I myself was concerned about these issues, then I believe these would be appropriate reflections and even necessary for my health. But now others will be watching…… from the government to your employer. Would it cost your job or your bonus or would you need to dedicate more of your paycheck to your health care premium, if you exceed your correct BMI, if you smoke, if you fail to exercise three times a week? If you consume caffeine or alcohol in excess, will you be held accountable? Maybe.

I was given the opportunity to attend the FORUM ON HEALTHCARE REFORM sponsored by the Westchester County Association on September 27, along with my colleague Dr. Louis McIntyre, WCMS Vice President. We represented the Westchester County Medical Society in a room filled with healthcare executives, medical directors, hospital administrators and business owners. The agenda was extensive, the speakers varied and the message clear: healthcare premiums are too high, healthcare costs are too high, the problems will be resolved by the entity in society that pays for those premiums - the large business employers. It was clear these business people and healthcare executives were not expecting the government or the recent federal law to resolve their problems.

The lineup of speakers began with a 30 minute speech given by Emme Deland from NY Presbyterian Hospital who read the speech prepared by illness stricken Dr. Herb Pardes. She described the current healthcare situation as "fluid managed chaos." The first rhetorical question posed said it all: "Increased quality at decreased cost…is this an achievable goal?" She went onto discuss the now well-worn concept of paying for value and linking reimbursement to quality, and emphasized that this needs to be fair and reasonable. She also spoke about the new, and perhaps necessary, trend of transparency in comparing costs, outcomes, and reducing variations among physicians in healthcare delivery. No room for mavericks here. She also rightly emphasized that reimbursements in the hospital systems are well below the costs of care. This theme came up with several speakers indicating a need for better collaboration, and innovative strategies to streamline care, reduce error and redundancy in an effort to provide, once again, the best health care for the dollar.

The current president of the Westchester County Association began the morning's first panel discussion by highlighting what he described as the four C's in this healthcare environment: complexity, change, consolidation, convergence, capital, competition and collaboration. Buried within his comprehensive comments (two more C's ?), he described once again this fluid chaos of a number of health organization consolidations involving physician groups, hospitals and insurers as well many new healthcare delivery structures such

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(continued from page 6) *The Realities of Healthcare Reform*

as ACOs, MCOs and physician practice management groups. There indeed seemed an endless variety of evolving structures all aiming to "navigate the shoals."

The first panel was composed of Dr. Scott Hayworth of Mount Kisco Medical Group, Kevin Dahill of Northern Metropolitan Hospital Association, Joanne Cunningham of the NYS Homecare Association and John Caby of Provider engagement at NY Empire Blue Cross and Blue Shield. They shared their vision of healthcare's future from their unique perspectives. Dr. Hayworth addressed the need for public buy-in to this transition to a "world of value" and he was the only one who strongly advocated for tort reform as a key component of healthcare reform and cost reduction. Mr.Dahill spoke directly to the fact that hospitals are highly regulated by the state and this does not allow for easy and efficient change when needed. Ms. Cunningham echoed these sentiments for home healthcare, which is also highly regulated and has been pummeled by major cuts. She focused on the fact that they deal with the chronically ill and that this is the "sweet spot" in driving the healthcare dollar. She sees the industry as focusing more on care management and working with existing partners such as VNS. Mr. Caby from the Blues focused his comments on the three medical home pilots they supported that have reduced overall costs.

The second panel, however, really caught my attention. This was moderated by Rick Wald from Deloitte Consulting's employer health reform strategy practice. His focus was to have the business community discuss how they could best manage employee health insurance premium costs. He outlined that the new law requires employers to provide health insurance for FTE working greater than 30 hours a week or pay a penalty. If employers pay the penalty the employees will need to "go shopping" at the State-Run Healthcare Exchanges. Your state medical society leaders are actively participating in the initial structuring of these exchanges which are going full speed ahead in New York with the Governor's blessings. Hence, employers will have new choices, new rules, new variables and new penalties in the new order.

Mr. Iselin of Global Insurance Regulatory and Transactions Practice did discuss briefly the issues involved in setting up the exchanges including : which health plans will be selected?; which insurance products will be offered?; will new networks be designed?; how affordable will they be?

So…herein comes my dilemma with my lunch. If the employer continues to pay directly for health care premiums for its full time employees, then they would need to be in a position to control costs. Mr. Kyu Rhee, VP of Integrated Services for IBM, discussed at length what he sees in his worldwide view of healthcare within the company. They have created a wellness health benefit design for their employees. He states that if you look at systems that work and have better outcomes, there exists with the healthcare structure 50 % specialty care and 50% primary care. The US is 70% specialty care. He advocates for promoting primary care within the context of family and community. This change alone will reduce costs.

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Mr. Joel Seligman, CEO of Northern Westchester Hospital, promotes three strategies for his employees. First, promoting healthy behaviors and providing financial incentives; second, aggressive cost management by looking at those employees that are the most sick and helping them improve care quality; and third,improving workplace environment from food served, to lighting, to providing bike racks for those who wish to cycle to work.

Mr. Marden from United Healthcare stated that large employers should institute cultural changes that will make employees healthier and reduce costs. I am not sure if I heard him say that United would reduce premiums if you actually turned out to be healthier…a topic for another day. But he did say that there should be member accountability, that there should be programs to target sick members and streamline care, that wellness programs should be incentivized and that employers needed to "promote quality providers." This has been done by some large employers and there was a 24% savings in health care costs. Once again I wasn't sure I heard a reduction in premiums.

So once again to my lunch……maybe just salad without the dressing …and water please. Then off for a brisk bike ride. Is it too much to ask? ♦

Welcome Putnam County Medical Society Members!

The WCMS Board of Directors and staff would like to extend a warm welcome to our colleagues in Putnam County.

Under an agreement recently signed by the leadership of both the WCMS and the PCMS, Putnam County members will now enjoy all the membership benefits afford to the WCMS members. You will also be receiving our monthly newsletter, all blast faxes and emails, Legislative Alerts, and invites to the many events put on by the WCMS, such as: Annual Meeting held in June, our annual Membership Pool Party, held in August, Golf Outing, held in September, and our Holiday Party which will be held on Friday, December 14th, at Knollwood Country Club. We hope you will be able to attend.

We welcome your input and ideas. We have many committees that we hope you will consider serving on. In the next few weeks you will be receiving a membership packet that will have more information on the benefits of membership and committees. In the meantime, should you have any questions, please call or email Brian Foy, Executive Director, at bfoy@wcms.org, or Karen Foy, Director of Membership & CME, at kfoy@wcms.org.

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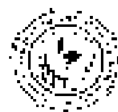

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WCMS Board Highlights - October 2012

At its meeting on October 11, 2012, the WCMS Board...

- **Received the Report of the Executive Committee and the President, as presented by Thomas Lee, MD. Dr. Lee reported that *the Executive Committee*:**
  - Recommended, and the Board unanimously approved awarding the 2013 WCMS "Friend of Medicine" Award to William Mooney, President and CEO, Westchester County Association, for his leadership in the business community in helping bring heath care issues to the forefront in Westchester County, while increasing focus on advocacy and education on health care issues in the business community with physician input and involvement. The WCMS will present its award to Mr. Mooney at the 2013 Annual Meeting, scheduled for June 7, 2013 at Westchester Country Club. All members are invited.

- **Welcomed William Zurhellen, MD, President of Putnam County Medical Society.**

Dr. Zurhellen and/or his designee will be attending WCMS Board meetings and reporting on activities or issues of interest in the Putnam County medical community. In accordance with the recently signed Memorandum of Understanding, PCMS members will be included in all WCMS activities and be invited to attend all Board/committee meetings.

- **Heard from Joseph Tartaglia, MD, President Westchester Academy of Medicine.** ***Dr. Tartaglia proudly reported that the Academy had just received a 4-year renewal of its CME Accreditation by MSSNY.*** Dr. Tartaglia also reported the Academy Golf Outing and Fundraiser, held on September 20, is expected to net over $6,000 for the Academy CME Program and its Scholarship Fund. ***The Board thanked Dr. Tartaglia for his leadership and extraordinary personal efforts to make the golf outing a success.***

- **Discussed the Biennial Legislative Brunch held on September 23rd at Knollwood Country Club.**

While the Brunch was very well-attended by incumbent legislators and their challengers, the physician turnout was disappointing. The Board discussed the future viability of the Brunch and, if continued, what the format should be to draw larger physician participation and input.

- Heard an update from the Executive Director, Brian Foy, who reported that an invitation was sent and accepted by the leadership of the Fairfield (CT) County Medical Association (FCMA) to present to the WCMS Board on December 6th regarding activities and programs of interest to physicians across the border. FCMA and WCMS have established a "Shared Member" program for physicians who wish to be dual members and attend programs/events in either county.

- ***Approved the Report of the Membership Committee.*** Kira Geraci-Ciardullo, MD, Membership Chair, also reported that the WCMS planned to host an Open House for new members (within the past year) on October 18. The Open House, which will be held once or twice a year, will be an opportunity for new members to meet WCMS leadership and staff and ask questions as well as learn about opportunities for involvement.

- On behalf of Melissa Gill, MD, Young Physicians Chair, ***Dr. Geraci-Ciardullo reported that the program on "Social Media Threats to Physicians," presented by Michael Schoppmann, Esq., WCMS Legal Counsel, on October 9th was excellent and well-attended.*** This program was very well received by physicians and will likely be repeated in the near future.

Volunteers Needed to Serve Needy Areas in Wake of Hurricane Sandy

Due to damages from Hurricane Sandy, the New York City Department of Health and Mental Hygiene has issued an Alert #31 for trained health care professionals to volunteer at the New York City shelters. New York City physicians interested in volunteering must first register for the New York City Medical Reserve Corp.

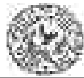
To register for the NYC Medical Reserve Corps (MRC) on line go to: http://www.nyc.gov/html/doh/html/em/emergency-mrc.shtml. The registration link is at the bottom of the home page. Membership in MRC provides indemnification under General Municipal Law section 50K against medical liability for all activities with MRC. Further details can be obtained at this NYC Department of Health and Mental Hygiene website: https://a816-health29ssl.nyc.gov/sites/NYCHAN/WebPages/home.aspx

Other counties may have activated their Medical Reserve Corps. If you are interested in volunteering outside of New York City, please contact your local public health or emergency management officials.

Or join ServNY by going to:
https://apps.nyhealth.gov/vms/appmanager/vms/public

ServNY is a registry of health care and mental health professionals who wish to volunteer during an emergency or major disaster. Registering simply tells the NYS Department of Health that you are open to the idea of volunteering in case of an emergency. It does not guarantee that you will be called upon, nor does it mean that you must participate if called. Volunteers may be needed for several hours up to several weeks. When volunteers are needed, an alert message will be sent via phone and email to all ServNY members – or a limited pool of members depending on the specific need of the incident – asking for volunteers to indicate their ability to respond. Those volunteers who respond to the request, and are selected, will then be given specific instructions.

It is important to remember that by joining ServNY and/or the MRC, physicians will have certain liability protections and will be authorized by ServNY and/or the MRC to serve in the public health emergency. ServNY was established as a joint project with the New York State Department of Health and the Medical Society of the State of New York, and in partnership with county health departments, the New York City Department of Health and Mental Hygiene, hospital associations, and other medical professional organizations. The registry, established in the aftermath of the 9/11 terrorist attacks, in currently used by all local health departments and Medical Reserve Corps for management of volunteer programs. ♦



News from MSSNY

CMS Issues Medicare Payment Rule for 2013

On November 1, the Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period for Medicare's payments for physician fees for 2013. The CMS press release noted that it includes a new policy to pay a patient's physician or practitioner to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility stay. The changes in care coordination payment and other changes in the rule are expected to increase payment to family practitioners by 7%, and other primary care practitioners 3-5% if Congress averts the statutorily required reduction in Medicare's physician fee schedule.

To read the CMS press release announcing the rule go to www.cms.gov then click on "Site Tools & Resources" followed by "Media Release Database" followed by "Fact Sheets".

Please remain alert for further analysis of the rule to be provided by the AMA.

The press release notes that the final rule also includes a statutorily required 26.5% cut to Medicare payment rates as a result of SGR methodology, but that the Obama Administration is committed to fixing the SGR update methodology and ensuring these payment cuts do not take effect.

In addition, the press release notes that the final rule continues with the implementation of the physician value-based payment modifier required under PPACA which provides differential Medicare payments to physicians based on comparison of the quality of care furnished to beneficiaries and the cost of care. The statue allows CMS to phase in the value modifier over three years from 2015 to 2017. For 2015, the final rule applies the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above. This change was adopted to gain experience with the methodology and approach before expanding to smaller groups.

The press release also notes that the final rule makes changes to the PQRS and the Electronic Prescribing (eRx) Incentive Program, the two quality reporting programs applicable to the MPFS, and updates the Medicare Electronic Health Records (EHR) Incentive Pilot Program to simplify reporting and align the various programs' quality reporting approaches so they support the National Quality Strategy. Moreover, the final rule also lays out next steps to enhance the Physician Compare website, including posting names of practitioners who, as part of the Million Hearts campaign, successfully report measures to prevent heart disease.

The press release further notes that the final rule contains a provision opposed by organized medicine that would permit Certified Registered Nurse Anesthetists (CRNAs) to be paid by Medicare for providing all services that they are permitted to furnish under state law. This change will allow Medicare to pay CRNAs for services to the full extent of their state scope of practice. The rule also allows Medicare to pay for portable x-rays ordered by nurse practitioners, physician assistants and other non-physician practitioners.

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Finally, the press release also discusses how Medicare will pay for molecular pathology services. These tests will be paid under the Clinical Laboratory Fee Schedule with 2013 payment set by the gap filing method. The final rule also requires a face-to-face encounter as a condition of payment for certain durable medical equipment (DME) items for orders written on or after July 1, 2013.

CMS: Increased Medicaid Payment for Primary Care

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to implement a provision of the Affordable Care Act that provides increased payments to certain primary care physicians for specified Medicaid primary care services. Under this provision, certain physicians who provide eligible primary care services will be paid the Medicare rates in effect in calendar years (CY) 2013 and 2014, instead of their usual state-established Medicaid rates, which may be lower than federally established Medicare rates. The payment increase applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine or related subspecialists. States will receive 100 percent federal financial participation (FFP) for the difference between the Medicaid state plan payment amount as of July 1, 2009, and the applicable Medicare rate.

The rule provides information about how CMS and states will work together to make the increased payments operational. The rule includes information about the identification of eligible providers and services and how to meet the statutory requirements when making these payments for services provided through managed care. The rule also provides important information on how this policy applies to the Vaccines for Children (VFC) program, which has its own statutory requirements for billing and payment, and updates the administration fees that may be billed under VFC based on medical inflation rates.

Qualifying Providers

Through the Affordable Care Act, primary care services eligible for the higher Medicaid payment must be delivered by a physician who specializes in family medicine, general internal medicine, or pediatric medicine. This rule specifies that certain physician subspecialists (for example, pediatric cardiologists) who are board certified in those specialties or provide primary care within the overall scope of those categories also qualify for the enhanced payment. The rule also clarifies that the higher payment will be made for primary care services rendered by practitioners – including, for example, nurse practitioners – working under the personal supervision of any qualifying physicians.

Implementing the Increase Payments in Fee for Service and Managed Care

The rule provides multiple options for states to allow for flexible implementation in fee-for-service and managed care settings. The rule permits states to either “lock” rates at the level of the Medicare physician fee schedule in effect at the beginning of 2013 and 2014, or modify the rates in alignment with all updates by Medicare. For operational ease, it does not require states to make site of service adjustments, permitting them instead to make payments at the Medicare rate applicable to the office setting. It also permits states to either pay in accordance with all Medicare locality adjustments

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(continued from page 13) *News from MSSNY*

within the state or to develop a rate for each code based on the mean Medicare rate over all counties in the state to be paid on a statewide basis. The regulation provides that all of the requirements related to the increased payments apply to services reimbursed by Medicaid managed care plans. States must incorporate the increased payment into contracts with such entities.

Interaction with the Vaccines for Children Program
The rule provides for payment of vaccine administration fees under the VFC program at the lesser of the VFC regional maximum administration fee (the VFC "ceiling") or the Medicare rates in 2013 and 2014. This is consistent with VFC program rules which limit payments to the VFC ceiling, which is the state's regional maximum amount, and to one payment per vaccine administered. Because the VFC ceiling rates were issued on an interim basis in 1994 and have never been updated, the rule also updates these rates using the Medicare Economic Index, which is a measure of medical practice cost inflation.

Medicare: Many Physician Group Practices Would Reduce Available Appointments Without "Doc Fix"

Forty-five percent of physicians group practices say they would reduce appointments for new Medicare beneficiaries if Congress does not take steps to avert scheduled cuts to Medicare physician reimbursement rates, according to a recent MGMA-ACMPE survey.

Under the sustainable growth rate formula, physicians face a 27% cut to Medicare reimbursement rates, scheduled to take effect on January 1, 2013. The survey included responses from more than 1,000 group practices with more than 26,000 practicing physicians.

The survey found that:

- 76% of respondents said that they would reduce staff salaries and/or benefits if the cuts are not averted; and
- 60% said they have delayed purchasing new equipment or facilities over the past decade because of payment instability from short-term fixes to Medicare's SGR.

Meanwhile, 18% of respondents said they are participating in a new Medicare payment delivery model or pilot project, such as the Medicare Shared Savings ACO program, the Pioneer ACO model or bundled payments.

In a news release, MGMA-ACMPE President and CEO Susan Turney, MD said that the findings show that "physician practices are willing to engage in new Medicare payment and delivery models that reward high-quality, cost-effective patient care outside of fee-for-service." She added, "Now Congress must do its part, repeal the SGR, and provide stability in Medicare payments so physicians can explore and test new patient-centered approaches." ♦

Call for Resolutions to 2013 MSSNY Annual Meeting!

The Annual Meeting of the MSSNY House of Delegates is set for April 12-14, 2013, at the Westchester Marriott in Tarrytown. All resolutions are due to MSSNY by February 15. The WCMS Delegation to MSSNY will begin meeting in early January to consider resolutions submitted by members. ***ANY member of the WCMS may submit a resolution or topic, in writing,*** directly to the WCMS, Attn: Brian Foy, Executive Director at bfoy@wcms.org. Do not worry about resolution format; we are interested in your ideas for new MSSNY policy or changes to current policy. WCMS will put your ideas into the required format. If you have any questions, please call Mr. Foy at 914-967-9100. Please submit your resolutions/topics to WCMS at your earliest convenience but no later than January 7, 2013.

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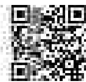

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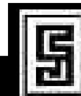

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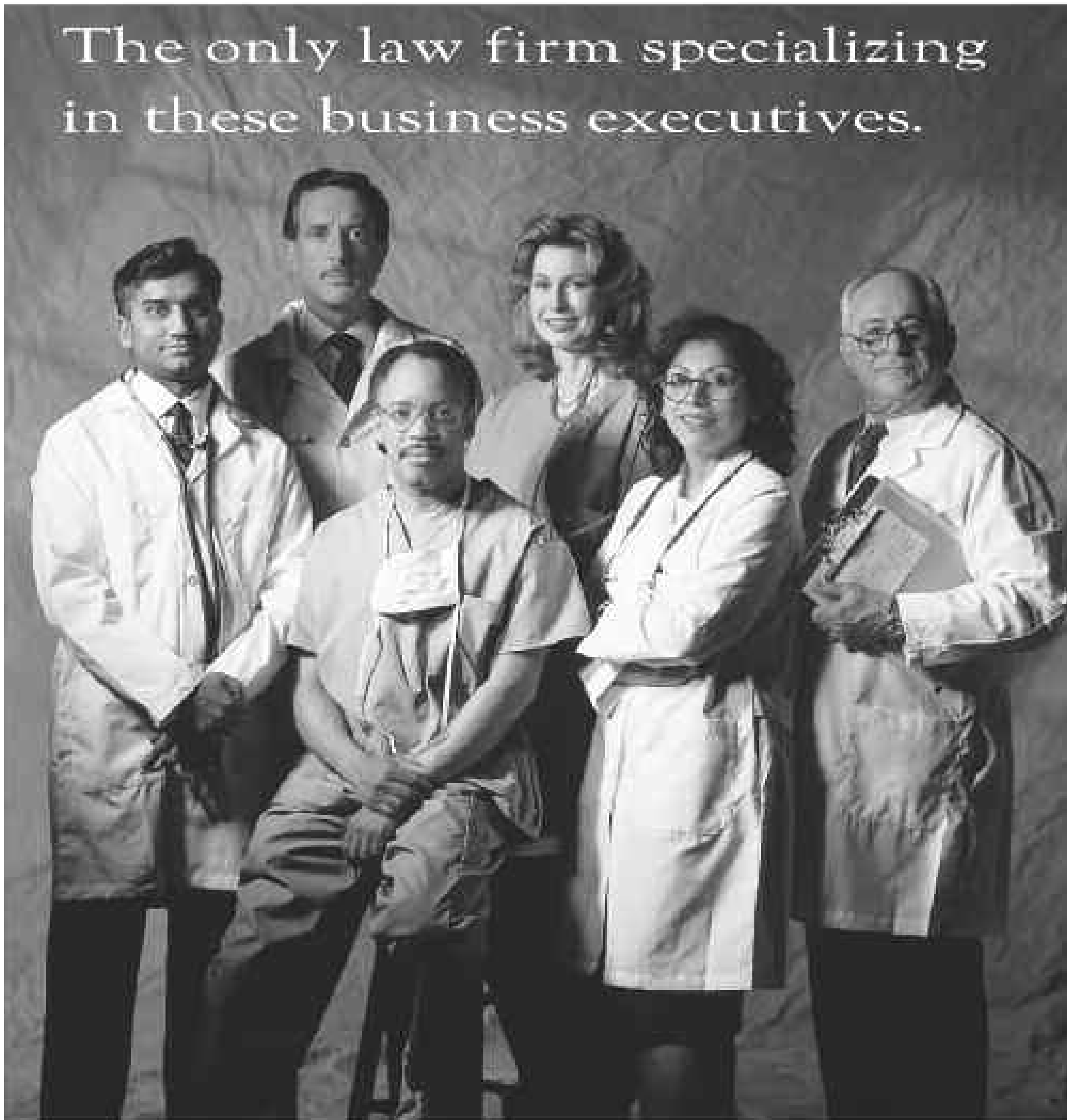

Legal Corner

News on medical-legal developments affecting physicians and health care professionals from Kern Augustine Conroy & Schoppman, P.C.

New York ACO Law Amended

Governor Cuomo has signed into law legislation that provides significant amendments to the New York State law governing accountable care organizations (ACOs) in the state, effective October 3, 2012. New York's ACO law, enacted in March 2011 as a demonstration program, provided that an entity that wants to operate as an ACO in the state must obtain a certificate of authority (CA) from the NYS Commissioner of Health. The Commissioner was to issue regulations establishing the criteria for the issuance of a CA and was limited to issuing no more than 7 CAs. To date, the Commissioners has not issued regulations for the issuance of CAs and no CA has been issued to any applicant to operate as an ACO in NY. Moreover, there has been uncertainty whether the law, including the requirement to obtain a CA, would apply to ACOs that are approved by CMS to participate in the Medicare Shared Savings Program. The new legislation amends the ACO law to remove the 7 CA limit and requires the Commissioner to establish a program to promote and regulate ACOs. In addition, an ACO approved by CMS may apply for a CA as a "Medicare-only ACO"and the Commissioner "shall" issue such certificate to any entity that documents its status as approved by CMS. The CA will apply only to the Medicare-only ACOs in actions in relation to Medicare beneficiaries under its authorization from CMS.

Pharmacists to Give Shingles Vaccinations

The NYS Department of Education has proposed emergency regulations that will authorize pharmacists who are certified to administer immunizations against influenza and pneumococcal disease to also administer vaccinations to prevent acute herpes zoster, better known as shingles. An appropriately certified pharmacist may administer immunizations against influenza or pneumococcal disease to patients 18 years of age or older pursuant either to a patient specific order or a non-patient specific order issued by a licensed physician or certified nurse practitioner. With respect to non-specific orders, the immunization must be prescribed or ordered by a physician or nurse practitioner with a practice site in the county (unless the county has a population of 75,000 or less, in which case the physician or nurse practitioner may have a practice site in an adjoining county). In the case of immunizations to prevent shingles, the order or prescription issued by the physician or nurse practitioner must be patient specific. The Departments says the emergency regulations are necessary to implement legislation that become effective on October 16, 2012, so that pharmacist can begin to treat patients in need of the shingles vaccination, which is recommended for patients 50 years of age or older who have had chicken pox. The regulation will be adopted when the Board of Regents meets in December, with an effective date of no earlier than December 26, 2012.

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(continued from page 17) Legal Corner

Oxford Fined for Failure to Explain Coverage

The NYS Department of Financial Services (DFS) has announced that Oxford Health has been fined $665,000 for failing to explain cover to its health plan members. Oxford was cited for approximately 300,000 instances of failing to provide explanation of benefit statements (EOBs). State law requires that the EOB explain what services the plan covers and how consumers can appeal when they believe claims are improperly denied. The violations are cited in an Examination Report undertaken by the NYS Department of Insurance (the predecessor to DFS) for the period October 1, 2001 through December 31, 2008. Oxford failed to send EOBs for certain claims, and in certain instances failed to provide specific explanation of any denial, reduction or other reasons for not providing reimbursement for the amount claimed. The two Oxford companies fined are Oxford Health Plans NY, Inc. and Oxford Health In surance, Inc. Oxford responded that the violations were not the result of any conscious policy to evade the requirements of the Insurance law or regulations. Oxford must submit a corrective action plan to DFS within 60 days of the approval of the Stipulation it agreed to with DFS. If you would like more information go to http://ow.ly/exLFd. ♦

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