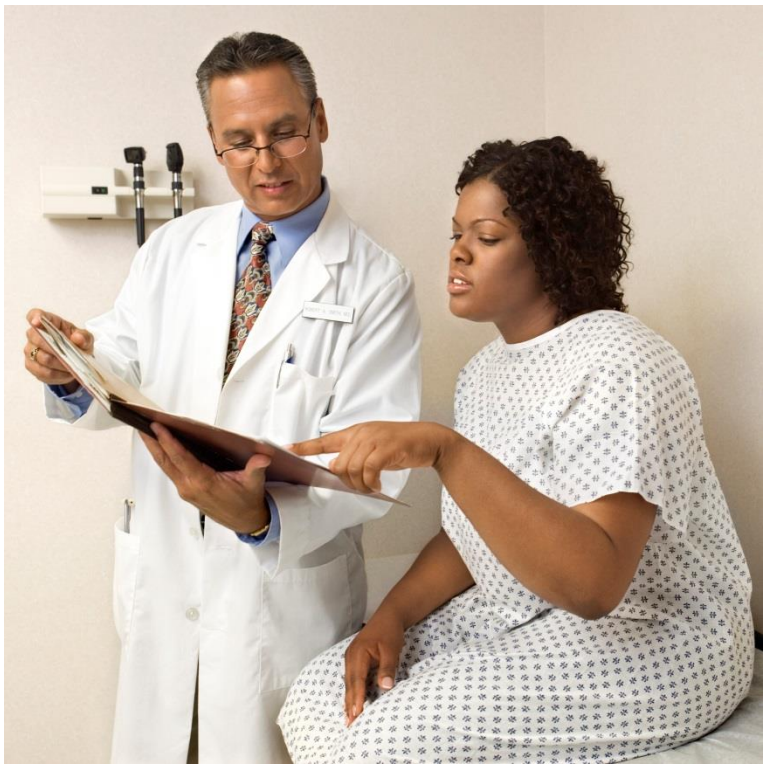
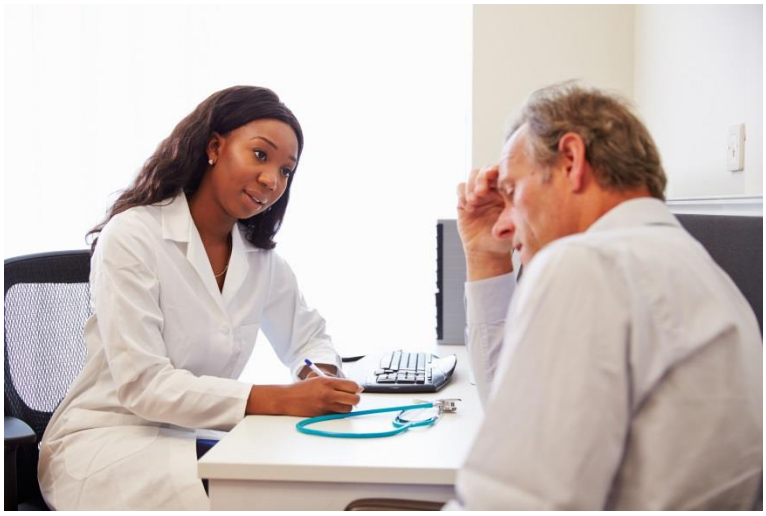


Enhancing and Assuring Quality Patient Care



MEDICAL SOCIETY OF THE STATE OF NEW YORK
2016 LEGISLATIVE PROGRAM

Division of Governmental Affairs
99 Washington Avenue, Suite 408
Albany, New York 12210
518-465-8085
albany@mssny.org

http://www.facebook.com/MSSNY

http://twitter.com/mssnytweet

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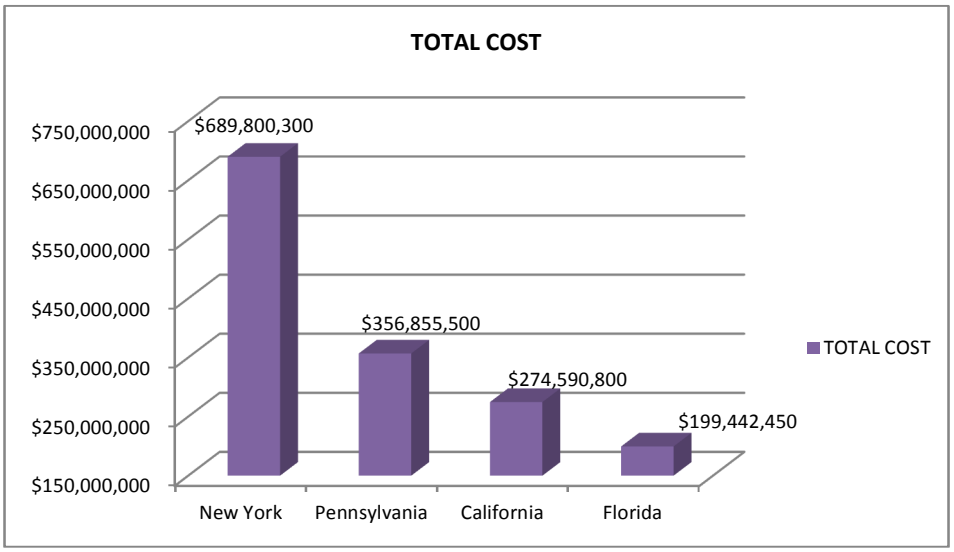
Assuring Our Patients Can Receive Timely Quality Care

The Need for Medical Liability Reform

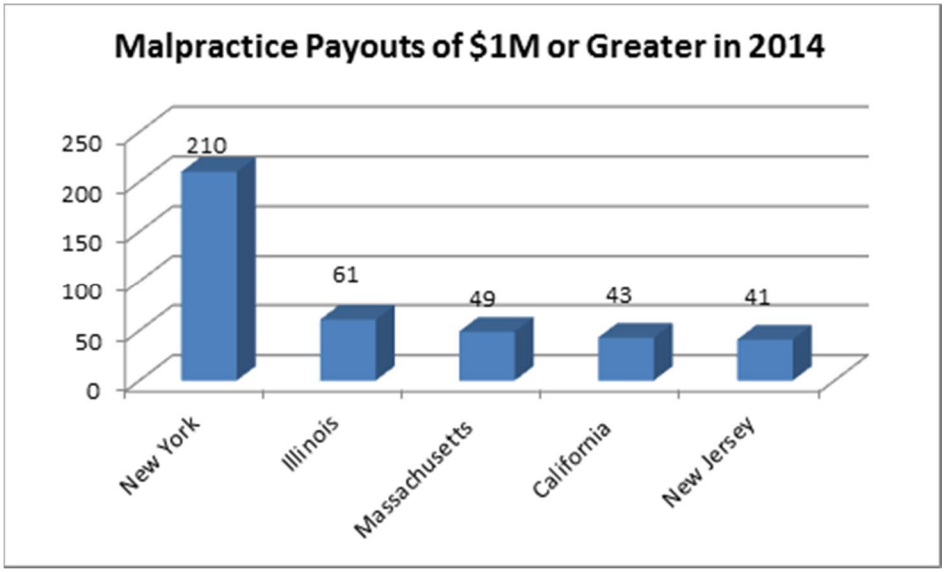
Many New York physicians continue to pay liability premiums that far exceed those in any other state. In fact, they often pay premiums that far exceed $100,000 and some even exceed $300,000! The combined effect of reduced revenues and high overhead costs if unaddressed will ~~result in~~ exacerbate the already unbearable financial strain for many practices and a continued erosion of our patientsô access to needed care. The cost of medical liability coverage for the 2015-16 policy year is:

- $338,252 for a neurosurgeon in Nassau and Suffolk counties;
- $186,639 for an ~~Ob-GYN~~ obstetrician in Bronx and Richmond counties;
- $145,534 for an orthopedic
- $132,704 for a general surgeon in Kings and Queens counties; and
- $134,902 for a vascular surgeon or cardiac surgeon in Bronx and Richmond counties



Little wonder, as malpractice payouts in New York State continue to be far out of proportion to the rest of country. For example, in 2013, according to a report by Diederich Healthcare, New York State had by far and away the highest cumulative number of medical liability payouts, nearly two times greater than the state with the next highest amounts, Pennsylvania, and far exceeding states such as California and Florida. Additionally, the report indicated that the New York per capita medical liability payment of $38.83 was far away the highest in the country, exceeding the second highest state Pennsylvania by 57%, the third highest state New Jersey by 67%, and the fourth highest state Massachusetts by 74%. Remarkably, it was13 times greater than Texas!

Another recent article in *OB-GYN News* details that New York State has by far and away the greatest number of medical liability awards of greater than $1 million (210), 3.5x highest than Illinois (61), the state with the second highest total and nearly 5x greater than California (43), a state with a far greater number of physicians;



Meanwhile, a recent study by the Medical Group Management Association concluded that practice expenses per physician have risen more than 50% in the past decade, nearly twice as much as inflation generally, and compared with a 3% increase in Medicare reimbursement over the same time. As such, New York can no longer sustain such an expensive and flawed medical liability adjudication system if we wish to assure that our healthcare system will be able to accommodate the patient demand that comes as our population ages, as well as the over 2,000,000 newly insured patients who are starting to receive coverage through New Yorkôs new Health Insurance Exchange.

We need comprehensive reform of our flawed medical liability adjudication system to reduce these costs. MSSNY supports a number of reforms that have been enacted in many other states whose medical liability insurance costs are far less than New Yorkôs. These reforms include: placing reasonable limits on non-economic damages; identifying and assuring qualified expert witnesses; eliminating joint and several liability; strengthening our weak Certificate of Merit requirement; and assuring statements of apology are immunized from discovery. Other important measures we support include alternative systems for resolving Medical Liability claims such as Medical Courts or a Neurologically Impaired Infants Fund that applies to physicians.

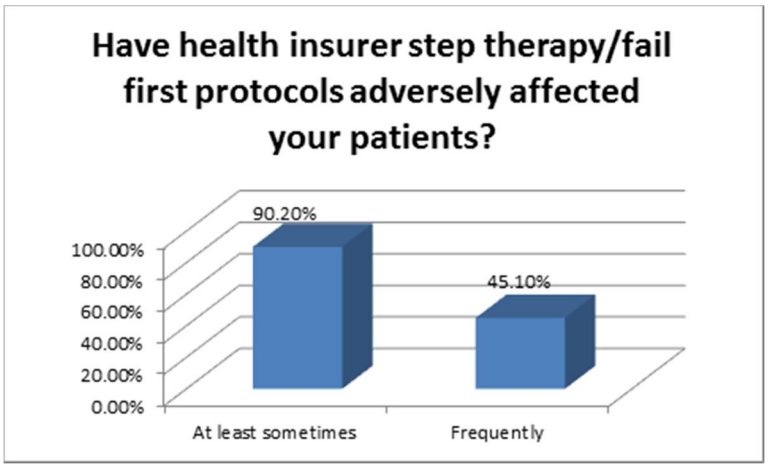
Given these real threats to our health care system, it is also imperative legislators reject ñstand-aloneò measures to expand medical liability that would most certainly exacerbate these problems, such as legislation that would:

- Change NYôs statute of limitations to a ñdate of discoveryòrule ï Estimated 15% premium increase.

- Expand ñwrongful deathò damages to permit ñpain and sufferingò ï Estimated 53% premium increase.
- Permit the awarding of pre-judgment interest ï Estimated 27% premium increase.
- Eliminate statutory limitations on attorney contingency fees ï Estimated 10% premium increase.
- Prohibit ex-parte interview by defense counsel of the plaintiffôs treating physician.
- Change loss share rules regarding non-settling defendants

Efforts to reform our medical liability adjudication system must be comprehensive!

Addressing Health Insurer Administrative Hassles



The increased availability of subsidized health insurance coverage through New Yorkôs Exchange and Basic Health Plan is a positive development for our patients, but more and more are finding themselves underinsured due to the increasingly inadequate coverage and narrow networks offered by insurers. Exacerbating these problems are the increasing administrative burdens that health insurers impose that inappropriately delay and deny needed care for patients, and the reduction and unfair delays in payment to physicians when needed care is delivered. These tactics can adversely impact patient care and make it harder and harder to for physicians to remain in practice.

For example, one MSSNY survey showed that 90% of physicians indicated that health insurer step therapy protocols for prescription medications at least ñsometimesò adversely affected their patients and 45% indicated that it ñfrequentlyò adversely affected patients.

Another MSSNY survey found that significant numbers of patients are facing deductibles imposing huge out of pocket costs before health insurers will even begin to pay for care. Nearly 21% of responding physicians indicated that ~~one~~ ¼ - ½ of their patients now face deductibles of $2,500-$5,000, and that 32% of responding physicians indicated that up to 10-25% of their patients face deductibles of $2,500-$5,000. And while insurers are reducing their physician networks, many are also refusing to offer patients out of network coverage options.

Of perhaps greatest concern, health insurers are now being incentivized by government to impose untested value based payment structures that will give them broad new powers to further cut physician payments based upon hard to define ñqualityò targets. These are particular difficult to meet for the tens of thousands of New York physicians who are struggling to implement enormously expensive EHR systems into their practice workflow. At the same time, insurers are consolidating and greatly enhancing their market share, such as the recent announcements of the mergers between Aetna and Humana, and Anthem and Cigna.

There is a need to ñlevel the playing field between market dominant insurers and community physicians seeking to assure their patients can receive the care they need. *Therefore, MSSNY will continue to strongly push for the enactment of legislation that would enable physicians to collaborate with their colleagues to collectively negotiate relevant patient care terms with insurance companies.* In addition, MSSNY supports numerous other reforms to address pervasive insurer abuses, including the following:

Reduce Administrative Burdens to Delivering Care

- Require medical necessity determinations be made by physicians practicing in the same or similar specialty as the physician recommending treatment;
- Permit physicians to override a health plan step therapy prescription medication protocol;
- ~~Assure~~ Continuity in Prescription Drug Coverage when formularies/prescription tiers change;
- Reduce the time frame that health plans have to review physician-recommended patient treatment;
- Assure greater transparency when a physician contracts with a rental network entity
- Require health insurers to use standardized prior authorization forms and electronic PA platforms

Assure Fair Payment for Providing Needed Patient Care

- Require insurers to offer patients coverage options for out of network care;
- Require insurer payment to physicians for advocating for patients to receive necessary care or testing;
- Reduce the time frame in which health plans may recoup payments made to physicians, and prohibit extrapolation-generated repayment demands;
- Prohibit health plan recoupment based where the plan previously confirmed eligibility;
- Assure fair payment for facility fees for physicians performing office-based surgical practices.

Fair Workers Compensation/No-Fault Reform

- Assuring fair payments for delivery of care to injured workers and opposing unfair cuts;

- Reducing undue administrative burdens including streamlining burdensome claim forms;
- Assuring carriers pay claims timely;
- Opposing carrier-driven efforts to impose overbroad restrictions on the ability of physicians to be paid fairly by No-Fault carriers for the care they deliver to auto accident victims.

Enhancing Quality of Care

Attracting & Retaining Physicians in NYS

The Center for Health Workforce Studies reported recently that the in-state retention of new physicians has gradually declined from a high of 54% in 1999 to the lowest since the survey began of 45% in 2014. This is particularly troubling as demand for physician services continues to outpace physician supply, particularly in ophthalmology, urology, psychiatry, pathology, general internal medicine, general/family medicine, and otolaryngology. There are areas of the state and populations that are already underserved by the current physician supply. The implications of the forecasts for these areas and populations are dire. New York must do more to attract and retain physicians, including advocacy to assure adequate funding of the Dorctors Across New York program.

Enhancing Quality of Care Through Peer Review

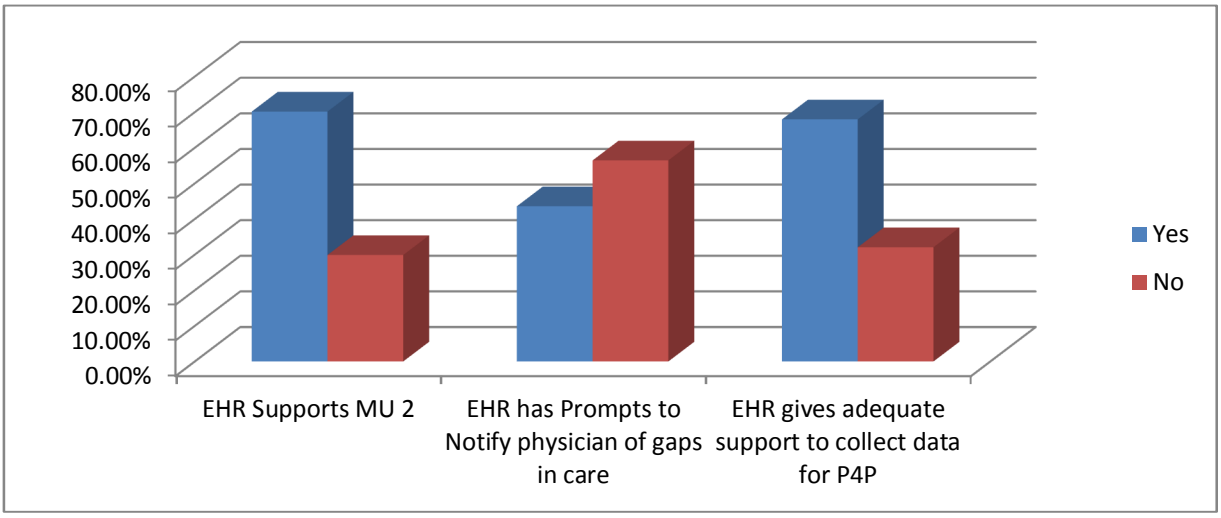
Current law impedes peer review quality improvement efforts by permitting attorneys access to statements made at a peer-review meeting by a physician who subsequently becomes a party to a malpractice action which involves the conduct which was the topic of discussion at the peer-review meeting. MSSNY will work to enact legislation which would extend existing confidentiality protections to all statements and information volunteered at peer-review quality assurance committees within hospitals, in office-based settings and across integrated care settings including multi-group and accountable care organizations.

Enhancing Quality of Care Through eRx

E-prescribing is one of several solutions advanced to improved patient safety and quality of care through clinical decision support and ready access to patient medication history. NYS has mandated electronic submission of all prescriptions by March 27, 2016. The law does provide certain exceptions to the e-prescribing mandate and allows for the issuance of a one-year renewable waiver to physicians who can demonstrate economic hardship, technological limitations that are not reasonably within the control of the physician, or other exceptional circumstance. MSSNY will work to assure that the waiver process is available to physicians for whom purchase and implementation of e-prescribing technology is impractical. MSSNY will also work to assure that the technologies used as part of the prescription drug monitoring registry are compatible with all e-prescribing systems so that physician consultation with the PMP registry is streamlined.

Enhancing EHR Functionality and Usage

Response to MSSNYôs survey on EHR usage and functionality is consistent with results of other surveys which show a level of dissatisfaction with regard to EHR systems. While 78% of respondents to MSSNYôs survey are using or plan within two years to use EHRs in their practice or at their hospital, 53% stated that they are either disappointed or very disappointed with their EHR. Notably, 38% of the respondents stated that their EHRs cannot generate routine reports to help manage their patient population, like diabetics, hypertension or ad hoc reports like finding patients due for a flu shot and 29% replied that their EHRs do not support meaningful use stage 2 (MU-2) or provide guidance on how to achieve MU-2. 56% responded that their EHR did not have prompts to notify them of gaps in patient care. Of the 45% of physicians who stated that they were currently participating in pay for performance (P4P) programs that require reporting from their EHRs, 32% stated that their EHR did not give adequate support to collect data to support their P4P program. Many stated that they or their staff either manually aggregated the data or purchased additional software to do so. MSSNY will work to enhance the functionality of EHR technology and will work to identify resources to assist physician adoption of such technology. MSSNY will also work to protect patient information from unauthorized disclosure.



Enhancing Quality & Integration Through HIT

The State, through several initiatives, is taking steps to encourage health insurers and HMOs to significantly change the way in which physicians and other providers are paid, moving away from traditional fee for service to payment based on value. Under this paradigm, in order to leverage enhanced payment, physicians and other healthcare stakeholders will need to integrate their care settings, engage professionals to coordinate care delivery and track patient outcomes. Resources are needed to assist physicians in these efforts.

The State Medicaid Program received approval from CMS to invest $8B for comprehensive delivery and payment reform through the Delivery System Reform Incentive Payment (DSRIP) program to promote community based collaborations/integration with the goal of reducing avoidable hospital readmissions by 25% over five years. 25 Performing Provider Systems (PPSs) have been established statewide to achieve improved clinical health outcomes and population health goals. Under this initiative, the state is required to transition traditional Medicaid managed care payment to a system wherein by 2019 80-90% of MCO-physician payment contracts are based on value based payment (VBP) methodologies of which at least 35% involve health care providers sharing so-called ñdownsideò 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 contracts with commercial payers. The State has received a SIM (State Innovation Model) grant to assure that 80% of the stateôs 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.

The transition from fee for service to value based payment is an enormous challenge for physicians many of whom currently lack the technological, analytical and staffing resources needed to adjust their practice to this shifting paradigm. Data show that only 39.4% of New York physicians in private practice have adopted EHRs. Unfortunately, none of the money being targeted for DSRIP and the SIM will go to support or incentivize physician adoption of this technology, even though physician care is the very heart of our care delivery system. Without it, physicians will not be able to demonstrate performance and will experience reduced revenue. Financially challenged practices will close over time dramatically impacting access to care. In addition to seeking resources to enhance EHR adoption, MSSNY will explore methods to assist solo and small practice physicians not associated with ACOs, IPAs or other integrated systems to coordinate the care they provide, track performance and negotiate with insurers and HMOs.

Eliminating Health Disparities

MSSNYôs long-standing commitment to finding real solutions to improve access to high-quality medical care for all New Yorkers is reflected in the work of its Committee to Eliminate Health Care Disparities. This work includes attracting a more diversified physician workforce, increasing the numbers of minority faculty teaching in medical schools, expanding medical school pipeline programs in rural and urban areas to address the shortage of physicians in medically underserved areas of New York State, and, where appropriate, support for legislation that addresses the root problems of health care disparities. Cultural competence and health literacy are both extremely important aspects of providing optimum health care to minority populations. Securing reimbursement for language services for patients with limited English proficiency is essential. The collection and aggregation of health care and demographic data on a regional and institutional level is also necessary to facilitate analysis by race and ethnicity.

Quality through Physician-Led Team-Based Care

There are many different types of health care providers who each provide essential care for our patients. They are an important part of our health care system. However, patients benefit most from the combined care of a team, headed by a physician whose education and training enables them to oversee the actions of the rest of the team, to provide the patient with optimal medical treatment. MSSNY supports this concept and will continue to work toward achieving this goal. MSSNY opposes any expansion of the scope of practice of non-physician health care providers that will enable them to practice beyond their education and training, and/or without physician supervision, collaborative relationship, or required physician referral. Also MSSNY will oppose legislation to allow corporately owned retail clinics and any alteration of the corporate practice of medicine doctrine.

MSSNY supports enactment of legislation or promulgation of regulation to:

- assure that the advertisements of all health care professionals adequately inform the public of their professional credentials and require that all health professionals wear badges which identify their professional title; and
- enable otolaryngologists to dispense hearing aids at fair market value.

Assuring Clinical Clerkship Slots for U.S. Medical School Students

The New York State Education Department has approved fifteen ñDual Campusò International Medical Schools (DCIMS) to send their students to New York to perform mandatory long-term clinical clerkships. Seven of these are located in the Caribbean. In recent years the class sizes of LCME/COCA accredited U.S. Medical schools in New York State have increased. At the same time the offshore schools, especially in the Caribbean, have proliferated and have experienced rapid increases in their class sizes as well. According to the NYS DOH, approximately 4,000 clinical clerkship slots are needed for U.S. medical school students. Offshore medical students also need over 2,000 clinical clerkship slots. However, the DCIMS have not been accredited by any national or international accrediting agency comparable to the LCME/COCA and do not have the infrastructure within their home country to provide clinical rotations to their students. Consequently, they rely on sending their students to the hospitals in the U.S., particularly to hospitals located in New York, to provide clinical rotations. The DCIMS pay hospitals in New York, especially in

the New York City area, as much as $18 million per year to secure these slots to the detriment of U.S. medical students, who cannot secure clinical rotations in their desired locations, or possibly even in New York State. MSSNY will work with the Associated Medical Schools of New York (AMSNY) to secure legislation to prohibit the sale of clerkship slots to medical schools that are not LCME or COCA accredited.

Protecting Public Health

The Medical Society of the State of New York believes that primary prevention of diseases is important to the health and well-being of all New Yorkers and the best way to prevent diseases is by immunizations. Vaccines are responsible for the control of many diseases; however, New York State is experiencing an outbreak of measles and pertussis due to many individuals choosing not to be immunized or have children immunized. MSSSY will again place an emphasis on programs that will improve adult immunization rates and will continue to advocate for use of the adult and child schedule for immunizations as developed by the Advisory Council on Immunization Practices. The Medical Society will continue to oppose religious or philosophical exemptions to New York State immunization law.

The recent world outbreak of Ebola, measles, and the rapid spread of enterovirus-D68 (EV-D68) clearly shows the need to ensure that physicians and New York State residents are prepared for a public health emergency. Additionally, the state has seen large increases in hurricanes and flooding disasters that have caused severe disruptions in peopleôs lives and indeed, health. MSSNY remains committed to preparing the public and physicians for the next public health emergency.

MSSNY supports legislation to limit the promotion of tobacco products in the state by all tobacco companies; to prohibit the sale of tobacco, e-cigarettes and nicotine dispensing devices and products to anyone less than 21 years of age; to increase penalties for the sale of tobacco, e-cigarettes and nicotine dispensing devices to persons less than 21 years of age and supports legislation that would ban smoking in pediatric setting. MSSNY is a strong proponent of including e-cigarettes under the provisions of the Clean Indoor Air Act and supports having the Food and Drug Administration having the ability to regulate e-cigarettes.

The Medical Society of the State of New Yorkôs House of Delegates in May 2015 adopted a revised policy on assisted suicide *MSSNY Policy 95.989 Physician Assisted Suicide and Euthanasia:* ñPatients, with terminal illness, uncommonly approach their physicians for assistance in dying including assisted suicide and euthanasia. Their motivations are most often concerns of loss of autonomy, concerns of loss of dignity, and physical symptoms which are refractory and distressing. Despite shifts in favor of physician-assisted suicide as evidenced by its legality in an increasing number of states, physician-assisted suicide and euthanasia have not been part of the normative practice of modern medicine. Compelling arguments have not been made for medicine to change its footing and to incorporate the active shortening of life into the norms of medical practice. Although relief of suffering has always been a fundamental duty in medical practice, relief of suffering through shortening of life has not. Moreover, the social and societal implications of such a fundamental change cannot be fully contemplated. MSSNY supports all appropriate efforts to promote patient autonomy, promote patient dignity, and to relieve suffering associated with severe and advanced diseases. Physicians should not perform euthanasia or participate in assisted suicide.ò

Preserving the ability for women to have access to reproductive and sexual health care services is a key public health component that MSSNY has long supported. Efforts must continue to help reduce the rate of unintended pregnancy and maternal mortality in New York State. The Medical Society supports efforts to expand access to emergency contraception, including making emergency contraception pill more readily available and will continue to support sexual health education programs amongst adolescents. The Medical Society will oppose any legislation that criminalizes the exercise of clinical judgment in the delivery of medical care.

The **Medical Society of the State of New York (MSSNY) was created in 1807** to contribute to the professional and personal development of member physicians by representing the profession as a whole and advocating health-related rights, responsibilities and issues to promote a favorable environment for the practice of medicine and improvement of the health of the residents of New York State.

For information or to get involved with MSSNYôs advocacy efforts, contact MSSNYôs Division of Governmental Affairs at 518-465-8085.