Survey: Physicians Generate an Average $2.4 Million a Year Per Hospital

While physicians are key providers of medical care at the nation’s hospitals, a new survey confirms they also are major drivers of hospital revenue. According to the survey, physicians generate an average $2,378,727 per year in net revenue on behalf of their affiliated hospitals.

Conducted by Merritt Hawkins, a physician search firm, the survey asked hospital chief financial officers to quantify how much revenue physicians in 18 specialties generated for their hospitals in the 2018 Survey of America’s Physicians. In the 2016 survey, only 34.6% of primary care physicians identified as independent in 2012, compared to only 31.4% in 2019. As these numbers show, close to half of physicians are employees compared to 34.1% of specialists.

In the 2018 Survey, 25.7% of primary care physicians identified as independent, compared to only 23.9% in 2016. This decline may be one cause for the increase in average revenues that the result was, if any.

EMPLOYED VS. INDEPENDENT PHYSICIANS

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Employed by hospital/hospital owned group/physician owned group</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>48.5%</td>
<td>43.7%</td>
<td>7.8%</td>
</tr>
<tr>
<td>2014</td>
<td>34.6%</td>
<td>52.8%</td>
<td>12.5%</td>
</tr>
<tr>
<td>2016</td>
<td>32.7%</td>
<td>57.9%</td>
<td>9.4%</td>
</tr>
<tr>
<td>2018</td>
<td>31.4%</td>
<td>49.1%</td>
<td>19.5%</td>
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Four State Medical Society Presidents: No, No, No, No to Recreational Marijuana

March 22, 2019—We, the undersigned, as presidents of our state medical societies, have joined together to express our mutual opposition regarding our states’ approval of any policies that legalize recreational marijuana.

We have serious concerns about the lack of scientific evidence that supports recreational marijuana use by adults and young adults.

Most importantly, not enough research has been done to prove marijuana is safe. We must look at the potential effect legalization will have on overall use and significant harms, including impaired driving and accidents, creation and worsening of severe mental health issues, and negative impacts on developing minds. We also must look at the data from other states where there has been an increase in teen usage and an increase in car accidents. The huge increase in teen vaping causes great concern and it is very possible that we will have a similar situation with legalized marijuana.

We need to learn the lessons from history to ensure that any legalized marijuana product does not become the Big Tobacco of the 21st Century.

States that are rushing towards legalization of recreational marijuana are ignoring how profit-driven corporations hooked generations of Americans on cigarettes and opioids, killing millions and straining public resources.

We are in full agreement that calls for a rescheduling of marijuana from Schedule I drug to a Schedule II classification. As a Schedule II drug, we need to learn the lessons from history to ensure that any legalized marijuana product does not become the Big Tobacco of the 21st Century.

MSSNY’s 213th House of Delegates (HOD) will be held April 12-14, 2019 at the Westchester Marriott Hotel in Tarrytown. Click here to view a complete list of the HOD resolutions.

Have You Seen An Increase In Automatic Down Coding of Your Visit Codes?

MSSNY has heard from a few members that they have been subjected to automatic down coding of their evaluation and management visit codes. Has this affected you or your practice? If so, please send an email to Regina McNally at rmcnally@mssny.org. Please use DOWN CODING in the subject line. Do not include any patient information; but do include the plan name, the code you billed and the code the plan reduced it to. In addition, please let us know if you filed an appeal with a copy of the medical record and what the result was, if any.
With a State Budget due by April 1, the Assembly, Senate and Governor are entering into the final days of negotiations trying to finalize the budget. Here is a quick synopsis of some of the top issues being advocated by your Medical Society.

**Medicaid**

Both the Assembly and Senate rejected the proposed estimated $80/patient Medicaid cut for deductibles for patients covered by Medicare and Medicaid. Moreover, the Assembly and Senate both rejected the 0.8% across the Board Medicaid payment cut. The Assembly and Senate also rejected the proposed repeal of the “prescriber prevails” protections in Medicaid.

MSSNY President Dr. Thomas Madejski issued a statement praising the Assembly and Senate for taking these actions. Please click here to send a letter to your legislators and the Governor urging that they continue the fight to prevent these cuts.

**Legalizing Recreational Marijuana**

The Assembly and Senate did not include the Governor’s proposal to legalize “adult use” or recreational marijuana in its Budgets, though leadership in both Houses have publicly stated their desire to continue working with the Governor on legislation to enable such use. MSSNY recently participated in a press conference with a diverse array of organizations including the PTAs, substance abuse treatment providers, County Health Officials, and Sheriffs urging that this proposal be removed from State Budget negotiations. Please click here to continue to urge your legislators to remove “adult use” marijuana from budget consideration.

**Public Health**

This week the Senate and Assembly passed legislation to create a Maternal Mortality Review Board (A.3276, Joyner/S.1819, Rivera) instead of acting on the Governor’s Budget proposal.

The Senate accepted the Governor’s recommendation to raise the age of tobacco/e-cigarette sales from 18-21. The Assembly did not, because they believe this would maximize the sales of尼古丁 pouches. Please click here to urge your legislators to support this proposal.

**Excess Insurance**

Both the Assembly and Senate supported the continued historical funding for the Excess Medical Malpractice Insurance Program that had been proposed in the Governor’s Budget

**PBMs**

The Senate accepted the Governor’s recommendation to license PBMs, and including provisions to enhance penalties for non-compliance. MSSNY supports this proposal. The Assembly did not include it in their one-house indicating that it will pursue “stand alone” legislation to regulate PBMs in New York State.

**Workers’ Comp**

The Assembly rejected the Governor’s proposal to significantly expand the use of non-physician use in Workers’ Compensation that has been opposed by MSSNY (due to the lack of provisions regarding how such practitioners would coordinate with physicians to manage the patients’ care and complete the necessary paperwork). However, the Senate accepted the approach. Please click here to urge your legislators to continue to oppose this proposal.

**NYS LEGISLATURE PASSES BILL TO CREATE A MATERNAL MORTALITY REVIEW BOARD**

The New York State Legislature passed a measure supported by MSSNY and ACOG, District 2 to establish a Maternal Mortality Review Board for the purposes of reviewing data and information related to maternal mortality and morbidity in New York State. The board will also assess the cause of death and analyze any possible preventable factors in order to develop strategies for reducing the risks of harm and death. New York currently ranks 30th out of 50 states in maternal death rate which is compounded by significant racial and ethnic disparities. The bill, S. 1819/A. 3276-A, sponsored by Senator Gustavo Rivera and Assemblywoman Latoya Joyner, will now go to Governor Andrew Cuomo for his signature. The Governor had also called for the creation of a Maternal Mortality Review Board within the context of his budget. The Governor also released a report on the status of maternal mortality in NYS. According to the report, “In NYS, the maternal mortality rate for black women was 51.6 deaths per 100,000 live births, compared to 15.9 deaths per 100,000 live births for white women in 2014-2016. Black women are approximately three times more likely to die than white women.” MSSNY issued a statement praising the Legislature for passing this legislation, and the Governor for advancing this issue. MSSNY’s Committee on Health Disparities, in collaboration with the NYS Department of Health, will also conduct a two hour CME program on maternal mortality on April 12 at the MSSNY House of Delegates.

**NURSING HOMES EXEMPTION FROM E-PRESCRIPTION REQUIREMENT READY FOR EXECUTIVE ACTION**

Both the Senate and Assembly have passed legislation that would exempt for two years nursing home oral medication prescriptions from the state requirement that all prescriptions be electronically submitted. Senator Rivera’s S.4183 and Assemblyman Gottfried’s A.1034-A are now ready to be sent to the governor for his signature. MSSNY’s Long-Term Care subcommittee has been a strong supporter of this legislation because nursing homes present unique circumstances that often make compliance with the current e-prescription mandate impractical. This legislation will allow for time to rectify the situation. In nursing homes, physicians are not physically present 24 hours a day, so RNs are allowed to take orders for medication for physicians safely and without delay for the residents who need them. In these instances, the physician would then sign the oral order within 48 hours. This legislation would extend to March 2021 an already existing exemption established by the NYS Department of Health that is due to expire later this year.

**PHYSICIANS URGED TO CONTACT LEGISLATORS TO SUPPORT ENACTMENT OF BEHAVIORAL HEALTH INSURANCE PARITY REFORMS AS PART OF 2019-20 BUDGET**

Physicians are urged to advocate to their legislators that they include the extensive Behavioral Health Insurance Parity Reforms (BHIPR) that have been proposed in the Governor’s Budget. A letter can be sent from here. MSSNY has been working with the New York Psychiatric Association and other patient advocacy groups in support of this legislation.

The proposed reforms would expand upon New York’s existing parity laws and help to curtail health insurer practices that restrict New Yorkers suffering from Mental Health Conditions (MHCs), Substance Use Disorders (SUDs) and Autism Spectrum Disorders (ASDs), from accessing their health insurance benefits for care and treatment. Among the important proposed reforms include:

- Prohibiting prior authorization for medication assisted treatment;
- Requiring that clinical review criteria used by health insurers be approved by the Commissioner of the OMH or

(Continued on page 14)
“MLMIC is a gem of a company.”

- Warren Buffett, CEO, Berkshire Hathaway

MLMIC is now part of Berkshire Hathaway.

For more than 40 years, MLMIC has been a leader in medical malpractice insurance. In fact, we’re the #1 medical liability insurer in New York State. Now, as part of the Berkshire Hathaway family, we’re securing the future for New York’s medical professionals.

When it comes to medical malpractice insurance in New York, nothing compares to MLMIC.

Learn more at MLMIC.com or call (888) 996-1183.
A Lot of Somebodies Are On Your Side

Colleagues,

It has been an honor and pleasure to serve you as MSSNY President this past year. I wish I could share with each of you the exhilaration I felt at times advocating for our patients, our members, and all physicians to improve the health and the practice of medicine in New York.

The MSSNY President periodically gets calls from members and non-members in distress. Most times the distress is not severe and I’m able to listen, discuss the issue and suggest MSSNY or other resources to help our colleague I’ve spoken with colleagues who have conflicts with insurers, hospitals, regulators, and governmental authorities. Often MSSNY is able to assist them in resolution, or direct them to help, while preserving their confidentiality. More difficult discussions are with physicians involved in disciplinary hearings. Unfortunately, those calls often occur toward the end of the process, when options are limited. (The best advice I can give them is to hire representation that has experience with OPMC hearings. I highly recommend our MSSNY Counsel, Garfunkel Wild, which has extensive experience.)

The pundits who opine about improving healthcare speak endlessly about integration of systems and care, but we still often practice in silos and are individually and professionally isolated. Cynics might think that is by design to keep physicians from providing greater leadership to create a more patient-centric healthcare system. The trend towards employment, larger groups, and tribalism in health systems has reduced our camaraderie and potential to support each other.

We need to change that.

OPIODS IN OUR PRACTICES

I had a discussion with a colleague who is living the opioid crisis with his patients and is in the cross hairs of the OPMC. He was gracious enough to allow me to share some general details with readers. He reached out to me to alert me to his difficulties out of concern for his fellow physicians who may have similar circumstances. This physician treats many patients, including a cadre with chronic pain. He has a significant uncertainty about the final shape of the budget.

The Governor’s proposed Budget contained a significant number of proposals on both sides of the fence – some MSSNY greatly supports in the area of improving public health, and some we oppose. MSSNY’s dedicated Government Affairs staff have been working late nights at the Capitol and throughout Albany, working to advance MSSNY’s agenda to help create a better state for physicians to continue to be available for their patients. Importantly, many MSSNY physician leaders also took the time to come to Albany on March 6 to advocate for these priorities.

(Continued on page 13)
Council Notes from March 5 Meeting in Albany

Representatives from OPMC and the Board of Medicine led a discussion on “Physician Wellness.” Presenters were Arthur Hengerer, MD, Chair, OPMC; Robert Catalano, MD, MBA, Executive Secretary, OPMC; Keith Servis, OPMC Director; and Stephen Boese, Executive Secretary, NYS Board of Medicine. They stressed that the discussion was about burnout, not misconduct, and provided a roadmap to burnout awareness efforts and physician wellness support. Following a summary of the OPMC Workgroup Discussion on Burnout, they looked at the potential for collaborative efforts with MSSNY going forward and the next steps to address Physician Wellness.

Kevin Sabet, Ph.D, president and CEO of Smart Approaches to Marijuana (SAM) presented “Efforts to Stop Legalization of Marijuana in New York State.” He warned of the perils of opening up marijuana shops in the middle of a drug epidemic and stressed that the effort is to prevent another “big tobacco” situation. He also noted that medical use should be determined by science, not popular vote. Following Dr. Sabet’s presentation, a counterpoint to the discussion was presented by representatives from Governor Cuomo’s office. Axel Bernabe, Associate Counsel for Health, Office of Governor Cuomo, and Jason Starr, Assistant Counsel, Office of Governor Cuomo, presented “Overview of the Proposal to Legalize Marijuana in New York State.”

Council approved the following amended substitute resolution, which was referred by the 2018 House of Delegates: MSSNY will correspond with the state Office of Mental Health, the Office of Alcoholism and Substance Abuse Services and the Department of Health to determine the mechanism for primary care physicians to access records of mental health and substance use disorders to afford those patients the best medical care. MSSNY will educate its members on what options are available and will transmit a copy of the resolution to the AMA to work towards federal regulations on the matter.

No, No, No, No to Recreational Marijuana

(Continued from page 1)

government funding can be sought for necessary research that clearly defines the positive and negative elements of marijuana use. When we have the science, we can make qualified and quantified decisions about legalization.

To date, ten states have legalized recreational marijuana. Let’s stop the tide now.

While we are cognizant of the legal inequity that is all too often attached to marijuana use, we agree with the AMA that public-health-based strategies are a better solution than either the old commitment to incarceration or this new attempt to dodge the problem through legalization. We must keep patients first and ahead of profits and taxable revenue.

As physician leaders, we agree, as one voice, that the legalization of recreational marijuana does not serve the best interests of our patients nor will it serve the best interest of our states.

Thomas J. Madejski, MD
President, Medical Society of the State of New York

John W. Poole, MD
President, Medical Society of New Jersey

Claudia B. Gruss, MD
President, Connecticut State Medical Society

Andrew W. Dahlke, MD
President, Medical Society of Delaware

NOTE: Recreational marijuana has been taken out of Gov. Cuomo’s budget.

CMS Revises Immediate Jeopardy Guidance

In March, CMS Administrator Seema Verma announced in a blog post “revisions to the guidance surveys use to spot immediate jeopardy, requiring them to fill out a three-question template that describes the incident.” Verma explained that the changes are due to recent media attention focused on harm at facilities, saying, “Despite stringent safeguards, alarming stories continue to be reported about people, including some of our most vulnerable individuals, who have experienced harm in healthcare settings.” CMS also removed “culpability” as one required component of immediate jeopardy, and adds psychological harm as a component.

Zocdoc Pricing Change; DOH Says Change is Not Illegal nor is it Fee Splitting

At the request of MSSNY, our General Counsel, Garfunkel Wild, P.C., met with the New York State Department of Health (DOH) to discuss DOH’s opinion concerning Zocdoc’s new pricing model scheduled to go into effect on April 1, 2019.

DOH had issued an opinion that Zocdoc’s change in pricing model from charging customers a flat annual fee, to a reduced annual fee with per booking fees based on physician specialty, does not constitute an illegal referral business or fee splitting under New York law. After that meeting, DOH advised Garfunkel Wild that DOH’s opinion is still valid.

Zocdoc previously advised that it was also seeking guidance on its new pricing model from the federal government. To date, Zocdoc has not advised us that it has received such guidance.

However, Zocdoc had previously advised that it has modified its electronic scheduling platform to no accept appointment requests from patients who self-identify as Medicare or Medicaid beneficiaries. Whether to participate with Zocdoc under its new pricing model remains a business decision for physicians and their practices. Any MSSNY member who requires specific guidance or has questions should contact MSSNY for further information.

New Yorkers Ages 65 and Older Are 16% of Population

A study published by the Center for an Urban Future indicates that people aged 65 and older now make up 16 percent of New York’s population, a record high. This in turn is straining state and county services for senior citizens, such as home-care aides and meal delivery.
Top 10 Fatal or Harmful Prescribing Errors

Below is a list of 10 top prescribing errors that cause death or severe harm to patients, as cited by *The Pharmaceutical Journal*.

Note: The journal used data from observational research, patient safety incident reports yellow card reports and medical indemnity claims to determine the top 10 errors.

1. **Drug prescriptions were omitted or delayed.** An analysis of 64 prescribing incidents that were reported to the NHS National Reporting and Learning Service found that 37.5 percent of the incidents involved prescriptions that were forgotten or delayed.

2. **Anticoagulants.** Unsafe anticoagulant therapy, using oral warfarin, the newer direct-acting anticoagulants, injected heparin and low-molecular-weight heparins have all been reported in error incidents that have caused death and serious harm.

3. **Unsafe opioid prescribing.** In one case, more than 450 patients died after being prescribed opioid medications at Gosport War Memorial Hospital in England.

4. **Insulin prescribing.** Almost one-third of inpatients with diabetes experienced a medication error during their hospital stay, according to NHS Digital.

5. **Nonsteroidal anti-inflammatory drugs.** These drugs are responsible for 30 percent of hospital admissions for adverse drug reactions, including bleeding, heart attack and kidney damage, according to the report.

6. **Drugs that require regular blood test monitoring.** Some drugs, like angiotensin-converting enzyme inhibitors, lithium and diuretics require regular blood testing. Often, if there is not regular monitoring of blood, these drugs can cause serious harm or even death.

7. **Known allergy to medicine.** Often, patients with known and documented allergies are exposed to a drug and suffer adverse events.

8. **Drug interactions.** Drug interactions can reduce efficacy or increase adverse effects.

9. **Loading doses.** Loading doses, when a prescriber initially gives a higher dose at the beginning before dropping down to a lower maintenance dose, is a big prescribing error because miscalculations can occur.

10. **Oxygen.** While not often described as a drug, the report claims that it should be treated as one. It is prescribed for hypoxaemic patients, and the administration of an inappropriate concentration of oxygen can have serious or even fatal consequences.

*MSSNY-PAC*

*(Continued from page 4)*

Critical issues such as fighting unfair Medicaid cuts, opposing the legalization of recreational use of marijuana, supporting the licensing of PBMs, supporting removing prior authorization burdens and Workers’ Compensation reform all have differing levels of support or opposition amongst legislators. While there is one party rule throughout NYS government, there are many different perspectives affecting the consideration of these issues that must be navigated.

For example, the Assembly or Senate may conceptually support a particular policy reform MSSNY supports, but they may object to its inclusion in the State Budget, due to a concern that the Budget should be reserved only for fiscal measures.

Stay tuned for more details. Hopefully by the team you read this the Budget will have been decided.

**HOUSE OF DELEGATES COMING RIGHT UP**

Also fast approaching is the 2019 House of Delegates, the venue via which physician leaders across the State debate and shape MSSNY policy positions. Resolutions submitted by delegates will be thoroughly researched and discussed amongst reference committee members. Together with the physician testimony they receive in hearings at the HOD, the Reference Committees will make recommendations to the full House as to what should be adopted. These adopted resolutions will become official MSSNY policy that will guide our advocacy efforts.

Those who are HOD veterans understand the extensive amount of work that goes into turning an idea into MSSNY policy. They also understand that the work of making these policies reality does not end at the conclusion of the HOD.

Indeed, turning these policy positions into governmental action takes substantial effort and resources.

It is therefore vital that we work to create a favorable political environment that is supportive of our agenda.

**SUPPORT MSSNYPAC**

Your support of MSSNYPAC is essential to the success of our agenda. The PAC helps to elect candidates to office who understand our concerns, and helps to develop and expand relationships with key policymakers that could be the difference between policy success and failure.

You already make a significant financial and time investment through your participation at the HOD. Why not take the next step to help make your ideas reality.

If you are not already a member, please join here: www.mssnypac.org/contribute. If you are a member, we thank you and ask you to please increase your contribution. And please ask a colleague to join as well.

Please understand that your contributions and recruitment efforts go a tremendous way toward improving New York’s medical practice environment, and/or preventing its further deterioration.

Do not wait for the “other guy”. Be the change you desire. The future you save may be your own.

Congratulations to Our Colleagues!

5 Reasons to Call, Now:
1. Founded in Freeport, 1958.
2. First practice on Long Island to adopt routine collaborative care for complex spinal conditions.
3. Only our experienced neurosurgeons will perform your surgery.
4. Leaders in “Bloodless” brain and spine surgery, including laser spine surgery, radiosurgery, and other advanced minimally invasive techniques.
5. Make the Right Call for:
   • Brain Tumor
   • Herniated Disc
   • Trigeminal Neuralgia
   • Spinal Stenosis
   • Brain Aneurysm
   • Back Pain

Where Patients Come First.

1-844-NSPC-DOC

nspc.com
MSSNY is proudly offering the following CME seminars at the 2019 House of Delegates in Tarrytown on Thursday April 11th and Friday April 12th. All programs will take place at the Westchester Marriott Hotel.

THURSDAY, APRIL 11

9am-12:45pm:
MLMIC’s Free Risk Management Program
This year’s program will address several topics including Top Risks of the Office Practice Setting, Effective Coordination of Hospitalist Care, and High Exposure Liability Cases.

Attendance at this complimentary educational event will enable physicians to earn 3.75 AMA PRA Category 1 CME Credits™ and provide the opportunity to complete a second component of the program online, at their convenience, to:

Earn additional CME credits
• Secure a 5% premium credit on their primary insurance policy
• Qualify for participation in the “free” Section 18 excess medical malpractice insurance program

Registration is required; Call 212-576-9601.

MLMIC Insurance Company (MLMIC) is accredited by the MSSNY to provide continuing medical education for physicians.

MLMIC designates this live lecture activity for a maximum of 3.75 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

1:00-2:00pm:
Medical Matters: What’s Your Diagnosis? Infectious Diseases – Register here
Faculty: William Valenti, MD
Educational Objectives:
• Identify the modes of transmission of infectious agents
• Discuss presumptive treatment of infectious diseases in advance of diagnostic testing results
• Describe two scenarios and review questions and answers

The Medical Society of the State of New York (MSSNY) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Medical Society of the State of New York designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

2:00-3:00pm:
Veterans Matters: The Special Mental Health Needs of Women Veterans - Register here
Faculty: Malene Ingram, MD, Lt. Col. US Army Reserves

Educational Objectives:
• Review how the increased role of women in the military has impacted their mental health
• Describe mental health concerns unique to women veterans and how to identify and treat them
• Identify the barriers that women veterans face in getting the specific care they need
The Medical Society of the State of New York (MSSNY) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Medical Society of the State of New York designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

3:00-4:00 pm:
Protect Your Patients, Your Practice, and You!
Join us at the OMSS Annual Meeting for an interactive presentation by Garfunkel Wild on Medical Records, including the impact on records of the controlled substances “epidemic,” what to consider when emailing and texting, dealing with non-compliant patients, additional areas of exposure from EMRs, and what to include in a telemedicine record.

Business meeting to follow, 4:00 – 6:00, Putnam Room
Register at sbennett@mssny.org

The Medical Society of the State of New York (MSSNY) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Medical Society of the State of New York designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

FRIDAY APRIL 12

1:00–2:00pm
Health Matters for Women: Myalgic Encephalomyelitis and Fibromyalgia - Register here
Faculty: Florence Shum, DO

Educational Objectives:
• Review potential causes of chronic diffused pain and fatigue
• Discuss how to accurately diagnose Fibromyalgia and Myalgic Encephalomyelitis

The Medical Society of the State of New York is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Medical Society of the State of New York designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

2:00–4:00pm
Improving Maternal Mortality Trends in New York State – Seminar and Panel Discussion - Register here
Faculty: Linda Clark, MD, Lisa Eng, MD, Kenyani Davis, MD & Lauren Tobias, Director, Division of Family Health, NYS DOH

Educational Objectives:
• Review maternal mortality trends in NYS
• Examine racial disparities around maternal morbidity and mortality
• Identify potential practice models to improve patient outcomes

The Medical Society of the State of New York is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Medical Society of the State of New York designates this live activity for a maximum of 2.0 AMA/PRA Category 1 credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

4:00–6:00pm
Physician Wellness: Moving from Resilience to System Culture Change
Faculty: Arthur Hengerer, MD, Maria Basile, MD, Brian White, MD
To view the flyer, please click here.
To register, please click here.

Educational Objectives:
• Understand the impact of organizational attempts to address physician stress
• Envision large-scale changes in our health care system that can protect against physician burnout
• Participate in needs assessment for

(Continued on page 17)
Don’t miss it while you’re at the HOD!

MSSNY 14th Annual Poster Symposium

Friday, April 12, 2019
1:30 – 4:00 pm
Marriott Garden Terrace

Medical Society of the State of New York
AMA Survey: 28% Say Prior Authorization Led to Adverse Patient Events

Prior authorizations are hazardous to patients’ health, according to more than one-quarter of physicians.

In a survey (PDF) by the American Medical Association, 28% of 1,000 responding physicians said the prior authorization process required by health insurers for certain drugs, tests and treatments has led to serious or life-threatening adverse events for patients.

The survey specifically asked doctors if the prior authorization process ever affected care delivery and led to a serious adverse event, such as a death, hospitalization, disability or permanent bodily damage or other life-threatening event for a patient in their care.

The AMA surveyed the sample of practicing physicians, which included 40% primary care physicians and 60% specialists, online in December. The AMA said that despite widespread calls to reform the prior authorization process, the survey illustrates that existing processes remain costly, inefficient, opaque and hazardous in some cases.

In response to the survey, America’s Health Insurance Plans (AHIP) defended the use of prior authorizations and said it is working with the AMA and other physician groups to improve the process.

Last January, six leading health industry groups, including the AMA and AHIP, released a consensus statement outlining steps for improvement. Six major industry groups — including America’s Health Insurance Plans and the AMA — joined forces to improve the prior authorization process. The groups agreed to five steps:

1. Reduce the number of prior authorizations required based on physicians’ performance
2. Review procedures and drugs that require authorization and regularly evaluate which require those requests
3. Increase communication to cut down on wait time
4. Protect the continuity of care for patients with ongoing treatments so they don’t face care gaps when coverage or prior authorization requirements change
5. Speed up the adoption of electronic standards for prior authorization.

The group said it is working with its members to launch demonstration projects for scalable approaches, using new technology to automate and streamline prior authorization to improve integration with provider workflow. Among all managed care, the percentage of covered services, procedures and treatments that require prior authorization is relatively small, less than 15%. That means 85% do not require prior authorization, AHIP noted.

Prior authorizations can help protect patients by ensuring treatment is safe, medically necessary and appropriate, the group said. “But when it comes to prioritizing patient safety over convenience for the clinician, patient safety must be first and foremost. There is work to be done — and we need partnership and collaboration with providers to move forward and truly improve care for patients,” AHIP said.

Through the survey, however, physicians expressed their concerns about the impact of prior authorizations, including:

- More than 9 in 10 physicians (91%) say that prior authorization programs have a negative impact on patient clinical outcomes.
- Nearly two-thirds of physicians (65%) report waiting at least one business day for prior authorization decisions from insurers — and more than one-quarter (26%) said they waited three business days or longer.
- More than 9 in 10 physicians (91%) said that the prior authorization process delays patient access to necessary care, and three-quarters of physicians (75%) report that prior authorization can at least sometimes lead to patients abandoning a recommended course of treatment.
- A significant majority of physicians (86%) said the burdens associated with prior authorization were high or extremely high, and a clear majority of physicians (88%) believe burdens associated with prior authorization have increased during the past five years.
- Every week a medical practice completes an average of 31 prior authorization requirements per physician, which take the equivalent of nearly two business days (14.9 hours) of physician and staff time to complete.
- To keep up with the administrative burden, more than a third of physicians (36%) employ staff members who work exclusively on tasks associated with prior authorization.

While both sides said they are willing to work collaboratively to create a better process, doctors clearly remain frustrated.
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates
Resolution: 2019 - 5

INTRODUCED BY: Third and Fourth Districts
SUBJECT: Former Speakers as Permanent Members of the
House of Delegates
REFERRED TO: House Committee on Bylaws

Whereas, House speakers are elected to that position for a
total of 10 years (five years as vice speaker plus five years
as speaker); and

Whereas, The positions of Speaker (plus vice speaker) are
unique positions that necessitate a deep understanding of
both Parliamentary Procedure and the workings specific to
our House of Delegates; and

Whereas, The position of Speaker often (but not always)
results in that position, because of its long tenure, precluding
other MSSNY leadership positions that would lead to contin-
ued involvement in the House of Delegates; therefore be it

Resolved, That Article III Section I of the Bylaws of the
Medical Society of the State of New York be amended to
allow former House Speakers to be given permanent mem-
bership in the House of Delegates, similar to that given to
Past Presidents.

The House of Delegates shall be composed of: (a) duly
designated delegates from the component county medical
societies; (b) officers of the Medical Society of the State of
New York, councilors, and trustees; (c) a duly designated
delegate from each district branch; (d) a duly designated
delegate from each recognized specialty society; (e) duly
designated delegates from the medical student section; (f) the
Commissioner of Health of the State of New York, or a
deputy designated by the Commissioner, provided that any
representative shall be a member of the State Society; (g)
past-presidents of the State Society and any past president
of the American Medical Association, provided that indi-
vidual is a member of the Medical Society of the State of New
York who shall be members for life; (h) any past executive
vice-president of the State Society, who shall be a member
for life, provided that individual is a member of the Medical
Society of the State of New York, who resides in the State of
New York and is not otherwise a member of the House of
Delegates for life in accordance with this section; (i) any
past deputy executive vice-president of the State Society
who has served a minimum of three years as deputy execu-
tive vice-president, who shall be a member for life, provided
that the individual is a member of the State Society, resides
in the State of New York, is not otherwise a member of the
House of Delegates for life in accordance with this section,
and is elected as a member for life by a majority of the
members of the House of Delegates present and voting; (j)
a representative from each of the medical schools in New
York State, provided said representative is a member of the
Medical Society of the State of New York; (k) delegates
representing the resident and fellow section; (l) a delegate
representing the organized medical staff section; (m) del-
egates representing the young physicians section; and (n)
elected officers, trustees, and speakers of the American
Medical Association, provided those individuals are mem-
ers of the Medical Society of the State of New York; and (o)
past Speakers of the MSSNY House of Delegates who shall
be members of the House for life, provided that individual is
a member of the Medical Society of the State of New York.

For information or to order FREE
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Ask KFF: 3 Questions on Why Insurers Deny Claims

Henry J. Kaiser Foundation
1. What do we know about how or why claims are denied?

Pollitz: If you look on an Explanation of Benefits (EOB), which Carol Marley clearly did, the individual consumer can see why her claim was denied. Despite insurance companies knowing this information, those reasons for denial aren’t included in the data put out from CMS. As a result, we have this overall statistic that on average about 1 in 5 claims are being denied on the ACA Marketplace, but we can’t say why. We do know issuers’ denial rates vary quite a bit. Some are less than 10 percent, and some are more than 40 percent. Without any other detail on what’s going on, it’s hard to know how the plan really works. Does it pay claims reliably? If claims are denied, is there any kind of pattern? By how much are reporting differences driving the variation? The ACA requires all plans — including employer plans and marketplace plans — to report data to HHS to make these kinds of internal operations more transparent, but right now data are only being collected from ACA Marketplace plans, sold to individuals and families on Healthcare.gov. So we don’t know much about employer plans like the one Carol Marley was on, because there currently aren’t similar reporting requirements, even though HHS has that authority.

What we do know is that insurers can program their automated processing systems to be more or less forgiving — kicking out every claim that even has one comma in the wrong place, for instance. And if the wide variation of plan denial rates on the ACA Marketplace are any indication, at least some of the variation is probably because some insurers are more reliable payers of claims. But we can’t determine the exact reasons yet.

2. How are CMS’s proposed changes to the denial rate data likely to change analysis of this issue? What could it impact?

Pollitz: Today, insurers are only reporting the number of in-network claims submitted in a year, the number of those that are denied, the number of appeals, and what happens to the appeals. That’s one number in each of those categories, for the whole year, for all of the plans one issuer sells in that state on Healthcare.gov. So it’s highly aggregated. There aren’t any reported reasons for the denials.

CMS has proposed that this year it will start collecting more data and displaying it at the individual plan level. They’ll also begin to collect reasons behind denials in five categories for the future, including an ‘All Other’ category. Based on a report of all plans from Connecticut we highlighted in our analysis, I’m expecting “All Other” will be a large share of the denials.

This beginning stage of improving transparency would give consumers a little more information. Eventually, these data will provide some relative numbers as they’re thinking through a choice of 10 plans on the ACA Marketplace. At some point, as consumers compare prices they may look at claim denial rates as well, though I don’t know how much they could rely on data that’s currently reported without all of the reasons for denials detailed.

3. Are there any steps consumers could take now to make a difference when they experience denied claims and the resulting surprises on their medical bills?

Pollitz: Under the ACA, people have a right to appeal any time a claim is denied. And if the insurance company says no upon reconsideration, people also have a right to go to external review, where an independent organization looks at the case and makes a binding decision. The appeal is intended to be a protection for people, so if a claim is denied inappropriately, they have an opportunity to get that fixed. But our analysis shows less than one half of 1 percent of the in-network denied claims were appealed by people with coverage from Healthcare.gov. In over 85 percent of those that were appealed, the insurer upheld its denial at reconsideration. Less than 1 out of every 11,000 denied claims went to external review.

While the total number of denied claims could be inflated by duplicate claims denials, the data nonetheless show that denied claims do not usually make it to external review. There are lots of reasons why people don’t appeal claims, including because they’re sick, which is why they were making the claims in the first place. It’s all the more reason why denial data that is more comprehensive can tell a more detailed story. Not only because this matters to patients, but also because transparency makes oversight and accountability easier.

I think there’s a desire on all sides for clearer data. We really can’t figure out what proportion of denials results in care going uncompensated for the patients — or for their providers. And insurers may get a bad reputation for activities that perhaps aren’t so bad after all.

‘Idiot,’ ‘Dumb’: Partners HealthCare Flags ‘Cranky’ Comments to Improve EHR Alerts

Partners HealthCare in Boston is trying a new method to improve clinical decision support in its EHR, according to a study published in the Journal of the American Medical Informatics Association.

Clinical decision support alerts seek to analyze EHR data to inform patient care, for example, by identifying potentially dangerous drug interactions or potential medications to prescribe. However, these alerts can malfunction — and many hospitals don’t have tools in place to discover when clinical decision support alerts aren’t working correctly.

To address this issue, researchers from Partners HealthCare and its affiliated Brigham and Women’s Hospital decided to analyze the text comments physicians sometimes submit after overriding a clinical decision support alert. Their goal was to see whether a look at override comments could suggest which alerts were in need of review.

The researchers analyzed how frequently physicians used “cranky” words — such as “dumb,” “idiot” and “please stop” — along with how frequently an alert received override comments to rank which alerts may be malfunctioning.

In total, the researchers said override comments helped identify malfunctions in 26 percent of the health system’s alerts.

“Override comments are a rich data source for finding alerts that are broken or could be improved,” the study authors wrote. “Even for low-resource organizations, reviewing comments identified by the cranky word list heuristic may be an effective and feasible way of finding broken alerts.”

Becker’s Hospital Review
number of legacy patients who remain on higher opioid doses due to tolerance, or failure of attempts to taper off, or substitute non-opioid treatments. Some also receive benzodiazepines for coexistent anxiety. While there is some increased risk with the combination, there are clearly situations that require both prescriptions. We shared our frustrations with the lack of coverage for non-opioid therapies, inadequate access to consultation expertise for complex chronic pain patients, inadequate mental health and behavioral resources and the increased non-medical burden of caring for these patients.

Clearly, the increased appropriate scrutiny of opioid use is changing practice patterns. While we have reduced prescription opioid use, there have been unintended consequences. Sadly, one of his patients with a history of substance use disorder and acute pain overdosed on heroin when the patient did not have access to prescription opioids for his painful condition, or medication assisted treatment for his substance use disorder. I face similar challenges in my practice.

I offered sympathy and support with regards to his current predicament, and we discussed ways for him to move forward. After hearing more details, I gave him information about resources available through MSSNY. The internist in me usually looks for deeper meaning or trouble. I came away convinced that he was not a risk to himself or his patients. I asked him if I could reach out to some mutual friends and he was agreeable to that. After further discussion with those colleagues we agreed to talk periodically. My other colleagues agreed to reach out to him periodically as well.

That’s not enough.

PEER SUPPORT

The MSSNY mission statement speaks to improving the practice of medicine and the betterment of public health. MSSNY has been working hard on those issues and we have made progress. Our Committee on Physician Wellness has created a number of resources for physicians to maintain their health and wellness and avoid burnout (mssny.org). Our legislative advocacy, particularly our push for collective negotiation (click here) aims to improve the practice environment. Reducing distractions, barriers to care, and rationing by inconvenience is critical to physician and patient health. I am also tasked our Immediate Past President, Dr. Charles Rothberg, to work with our Committee on Physician Wellness to implement a peer support program. Improving the mental health of our patients, our colleagues, and ourselves is one of the greatest gifts we can give each other. Happy physicians and happy patients are a match made in heaven.

Thank you again for the opportunity to serve you as MSSNY President.
Deaths from opioid overdoses have increased dramatically over the last decade. In 2017, the latest year for which the U.S. government has statistics on the trend, more than 47,000 Americans died of opioid overdoses.

One major factor contributing to the rising number of people who get addicted to opioids and die from overdoses is the increasing number of prescriptions written by doctors to treat pain. Overdose deaths related to such prescriptions increased five times from 1999 to 2017.

But according to the latest study looking at opioid prescribing patterns, published in the New England Journal of Medicine, recent efforts to address the rising number of prescriptions may be working to limit the number of opioids that doctors dispense.

In the study, researchers led by Wenjia Zhu, a fellow in the department of health care policy at Harvard Medical School, and Nicole Maestas, an associate professor also in the department, found that new prescriptions for opioids dropped by about half from 2012 to 2017. The researchers analyzed national claims data from Blue Cross-Blue Shield from more than 86 million people to monitor prescriptions for opioids. They calculated the monthly incidence of new opioid prescriptions as the percentage of enrollees getting a prescription for an opioid who had never received such a prescription or who had not received one in the previous six months. During the study period, the monthly incidence of opioid prescriptions dropped by 54%, and the number of doctors prescribing opioids for the first time to patients or to people who had not had them prescribed in the last six months also declined, from 114,043 to 80,462.

However, Maestas and her team found that physicians who continued to prescribe opioids were more likely to prescribe them for longer periods and at higher doses than the Centers for Disease Control and Prevention (CDC) guidelines currently recommend for first-time users.

"On the one hand, we are very much encouraged," says Maestas. "The study does suggest that every month, fewer people are being started on opioids, which means the risk of developing opioid addiction and other adverse outcomes is lower because of that. Our enthusiasm is a bit tempered, however. One group of providers didn’t seem to get the message."

The research team focused on the time period between 2012 and 2017 because in 2016, the CDC issued revised guidelines designed to address the burgeoning opioid epidemic, advising doctors that opioids should not be the first drugs used to treat most cases of pain and advising how to prescribe the drugs in ways that might reduce the risk of addiction. For people prescribed opioids for the first time, the CDC recommends starting with a three-day supply and at the lowest dose. In the study, among the doctors who continued to prescribe opioids, 57% were prescribing them for longer than three days and at higher doses for people getting the painkillers for the first time.

By focusing on first-time prescriptions, or prescriptions for people who hadn’t been given opioids in the last six months, the team revealed areas where recent efforts to control opioid abuse are falling short. Programs to monitor prescriptions by doctors, for example, are mostly centered at hospitals, and Maestas found that many of the physicians continuing to prescribe outside of the CDC guidelines were primary care doctors in private practice; 80% of them prescribed opioids for longer than three days and at higher doses for people getting the painkillers for the first time.

Initial prescriptions are a reasonable place to focus in trying to control the opioid epidemic, she says, since legitimate prescriptions for the drugs are often the gateway to addiction and abuse. "We’re looking at the beginning of the road and saying, ‘Let’s stop that person who just had surgery from having a bottle of leftover pills sitting in the medicine cabinet,’” she says.

The study also raises another concern about the effect that more awareness about opioid abuse is having on the treatment of pain. Rather than prescribing at lower doses and for shorter periods of time, about 30% of doctors did not prescribe opioids at all to people who had not used them before. The study did not delve into whether these people were provided with other options to manage their pain, but Maestas says the pendulum may be swinging from one extreme of over-prescribing opioids to perhaps, in some cases, under-managing pain.

"We have been [too] light on opioid control policies for a long time," she says, adding that the current study’s results should help to refine such advice in coming years. "It’s good news that some providers are changing their behavior, but not all providers are. The data suggest that that some could use additional education around this issue.”

Legislative, Governor State Budget Negotiations

(Continued from page 2)

- Designated by the Commissioner of OASAS;
- Requiring that medical necessity criteria with respect to benefits for MHCS/SUDs and ASDs be made available to the physician or patient upon request;
- Prohibiting an insurer from taking any adverse action in retaliation for the physician filing a complaint, making a report, or commenting to a government body regarding policies and practice that violate this statute.

While there is a possibility that similar legislation could be taken up outside of the State Budget, there is concern that any delay in the enactment of the BHIPR could delay the effective date by a whole year – leaving individuals and families vulnerable to utilization review and other practices that may not comply with the federal and state MH/SUD, ASD parity laws.

**PRE-AUTHORIZATION PROHIBITION FOR MEDICATION ASSISTED TREATMENT ADVANCES IN THE ASSEMBLY**

Assemblyman Dan Quart’s A.2904 has passed through the Insurance and Codes committees and has advanced to third reading, ready for a vote in the Assembly. The bill would require health insurers to provide patient access, without prior authorization requirements, for initial and renewal prescriptions for buprenorphine and long-acting injectable naltrexone for the treatment of substance abuse disorders. In 2016, this policy was implemented for Medicaid, but not for commercial insurers. The purpose of this bill is to establish parity for all patients in New York by ensuring that addicted persons with commercial insurance coverage can access medication assisted treatment as prescribed by their health care providers without unnecessary barriers. A similar provision was included in the Governor’s budget proposal. It was included in the Senate’s one-house budget proposal but removed from the Assembly’s one-house budget.
Women in Medicine: Reaching Your Potential Now!

Women Physicians Caucus
Friday, April 12, 2019
5:00 – 6:30 pm
Grand Ballroom B

A panel presentation on PAY, PROMOTIONS and CAREER ADVANCEMENT in Academic Medicine, Private Practice and Organized Medicine

Gender imbalance in medicine and academic sciences still exists. Hear three women physicians who have achieved significant leadership positions describe their own pathways, provide advice on how to achieve success, and show how to overcome gender bias, gender pay gaps and system-wide barriers to career advancement.

Learn how to achieve success in your career!
Register at sbennett@mssny.org
previous 12 months. This includes both net inpatient and outpatient revenue derived from patient hospital admissions, tests, treatments, prescriptions, and procedures performed or ordered by physicians.

Cardiovascular surgeons topped the list of physicians examined in the survey. Full-time cardiovascular surgeons generate an average of nearly $3.7 million a year on behalf of their affiliated hospitals, according to the survey, followed by invasive cardiologists at $3.5 million, neurosurgeons at $3.4 million and orthopedic surgeons at $3.3 million.

It is not just physician specialists who generate high dollar volumes for hospitals, the survey indicates. Family physicians generate an average of $2.1 million in net revenue annually for their affiliated hospitals, while general internists generate an average of almost $2.7 million.

The average net revenue generated by all physicians included in the survey ($2,378,727) is up 52% from 2016, the last year Merritt Hawkins conducted the survey. Average revenue generated by each of the 18 medical specialties included in the survey increased compared to 2016, in most cases significantly.

MORE OUTPATIENT VISITS, HIGHER COSTS, MORE ACUITY

While the number of hospital inpatient stays has decreased or remained flat in recent years, the cost per hospital stay has increased, said Singleton, one factor that may be driving the comparatively high revenue averages generated by physicians. In addition, the number of hospital outpatient visits has more than tripled since 1975 and the average cost of these visits has grown, a further reason for physician revenue increases, according to Singleton. Patient demographics and patient acuity also are playing a role. As the population ages and as patient acuity increases, utilization of healthcare services provided by

(Continued on page 17)
Physicians Generate an Average $2.4 Million a Year Per Hospital

(Continued from page 16)

or generated by physicians also increases, as do physician generated revenues.

COST/BENEFITS

The survey also provides a cost/benefits analysis showing which physicians provide the best return on investment by comparing salaries in various medical specialties to revenue generated by physicians in those specialties. Family physicians, for example, average a starting salary of $241,000, according to Merritt Hawkins’ data, while generating nine times that much in hospital revenue. Orthopedic surgeons average $533,000 in starting salary while generating six times that much in hospital revenue.

THE “$3 MILLION CLUB”

Four types of specialists – invasive cardiologists, neurosurgeons, orthopedic surgeons, and cardiovascular surgeons – all generate in excess of $3 million net a year on average for their affiliated hospitals, the 2019 survey indicates. Cardiovascular surgeons, added to the survey in 2019, are the highest revenue generators at $3,697,916 per year, followed by invasive cardiologists at $3,484,375 per year, neurosurgeons at $3,437,500 per year and orthopedic surgeons at $3,286,764 per year. The chart below lists types of physicians (primary care and specialists) by average annual net revenue generated per their affiliated hospitals.

NUMBER OF DIAGNOSTIC TREATMENTS/TESTS BY AGE

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15</td>
<td>3.4%</td>
</tr>
<tr>
<td>16-44</td>
<td>29.2%</td>
</tr>
<tr>
<td>45-64</td>
<td>30.0%</td>
</tr>
<tr>
<td>65+</td>
<td>37.4%</td>
</tr>
<tr>
<td>U.S. Population 65+</td>
<td>14.0%</td>
</tr>
</tbody>
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PATIENT AGING DRIVING UTILIZATION

The relatively high net revenue generated by various medical specialists on behalf of their affiliated hospitals seen in the 2019 survey may be in part a reflection of patient demographics. Over 10,000 baby boomers turn 65 every day. Patients 65 years old and older generate a disproportionate number of physician visits and generate a disproportionate number of medical procedures and tests. Though they represent only 14% of the population, patients 65 and over generate 34% of inpatient procedures and 37.4% of diagnostic tests, according to the Centers for Disease Control and Prevention (see graphs below), and account for 34% of all healthcare spending.

A copy of the complete survey report is available here.

CME at MSSNY 2019 House of Delegates

(Continued from page 8)

institutional intervention strategies
• Review survey tools to help measure the health of medical staffs
• Identify and prioritize actionable strategies for institutional wellness

The Medical Society of the State of New York is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Medical Society of the State of New York designates this live activity for a maximum of 1.0 AMA/PRA Category 1 credits™. Physician should only claim credit commensurate with the extent of their participation in the activity.

5:00-6:30 pm

Women in Medicine: Reaching Your Potential Now!

A panel presentation at the Women Physicians Caucus on PAY, PROMOTIONS and CAREER ADVANCEMENT in Academic Medicine, Private Practice and Organized Medicine. Gender imbalance in medicine and academic sciences still exists. Hear three women physicians who have achieved significant leadership positions describe their own pathways, provide advice on how to achieve success, and show how to overcome gender bias, gender pay gaps and system-wide barriers to career advancement. Learn how to achieve success in your career! Register at rarsenian@mssny.org

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Med Students Love NY, Too!

Medical students came to Albany in large numbers on State Legislation Day to protect their future as New York physicians.

April 2019 • MSSNY’s News of New York • Page 17
United, Anthem, Permanente Doctors: Time for Hospitals/Payers Trust Each Other

Limited trust has existed between payers and providers thanks to disagreements over networks, prior authorization and price variation; however, now is the time to change this dynamic, executives from UnitedHealth Group, Anthem and Permanente Medical Group wrote in a JAMA opinion piece.

FIVE TAKEAWAYS:

1. The authors — Lewis Sandy, MD, executive vice president of clinical advancement at UnitedHealth; Hoangmai Pham, MD, vice president of provider alignment solutions at Anthem; and Sharon Levine, MD, former director and senior adviser of the Permanente Medical Group in Northern California — said new payment models are pointing to possible changes.

2. “Perhaps most fundamentally, rigid boundaries between being a payer and being a care provider have begun to blur,” the authors wrote. “While organizations such as [Oakland, Calif.-based] Kaiser Permanente have had decades of experience with the blurring of such boundaries, only recently have large numbers of medical groups taken on risk arrangements for defined populations, stimulated by the opportunities in the Medicare Advantage program and new payment models from [CMS].”

3. The authors continued: “Although this is a long-term journey, evidence of improvement in hospital readmissions, quality metrics, and costs managed by medical groups is beginning to emerge. Payers have realized the need to work collaboratively with physicians and medical groups to have a meaningful influence on costs and quality of care. Both parties may be finally accepting that one cannot succeed without the other.”

4. Opportunities for progress include creating competence across parties, ensuring transparent quality measurement and understanding the motive of each party, according to the executives.

5. “Relationships should change from being based on contracts to relationships built on a shared covenant to patients and to system improvement,” the authors concluded. “The next decade could be transformational, or it could be a missed opportunity. It is the responsibility of each person and organization in the U.S. healthcare system to make transformation real — in care delivery, in payment, and most powerfully, in relationships.”

For the full JAMA piece, click here.
Live Seminar at MSSNY House of Delegates

The Special Mental Health Needs of Women Veterans

Thursday, April 11, 2019 @ 2:00pm

Where: Westchester Marriott Grand Ballroom D&E
670 White Plains Rd ★ Tarrytown, NY 10591

Faculty: Malene Ingram, MD, ★ Colonel, US Army Reserves
President of Schenectady County Medical Society

Educational Objectives:
★ Review how the increased role of women in the military has impacted their mental health.
★ Describe mental health concerns unique to women veterans and how to identify and treat them.
★ Identify the barriers that women veterans face in getting the specific care they need.

To Register, Please Click Here
Contact: Melissa Hoffman at mhoffman@mssny.org or 518-465-8085

Funding provided by the New York State Office of Mental Health

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Education: BA/BS required. MPH or MBA desirable. We expect innovation and project initiation. The Executive Director will receive a contract that increases remuneration commensurate with membership growth.
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