Calling All MSSNY Women Leaders!

The Medical Society of the State of New York recently received a Women’s Health grant aimed at educating physicians on women’s health conditions including myalgic encephalomyelitis, endometriosis and fibromyalgia.

MSSNY is currently seeking women physicians who have expertise in these conditions to serve on the planning committee and serve as faculty. This grant will have a physician driven curriculum and planning committee, whereby physicians develop and refine the educational content of the program. The planning committee members also serve as faculty for the series of webinars, live medical/grand rounds and podcasts that are slated to be developed.

For more information, or to express interest in serving, please contact Carrie Harring at charring@mssny.org.

MIPS, No MIPS, Hate MIPS? Tell Us!

Please take the three-question survey on your use/non-use of MIPS!

Click here to take MIPS Survey

MSSNY Joins House of Medicine to Urge CMS to Reject Proposal to Collapse E&M Payments

MSSNY has joined on to multiple letters to the Center for Medicare & Medicaid Services (CMS) to raise serious concern with CMS’ proposal to collapse evaluation and management (E/M) payments as part of its Medicare payment rule for 2019. Both letters express appreciation for the CMS “Patients Over Paperwork” initiative to reduce the extraordinary documentation burden facing physicians, but also note that any benefit to be gained would be sizably outweighed by the likely significant reductions in payments. Under the proposal, payments for E&M codes 99202-99205 would be $134 (instead of ranging from $76 to $211) and payments for E&M codes 99212-99215 would be $92 ($45 to $148).

MSSNY’s Statement on Regulated Marijuana

MSSNY’s statement was delivered by Joseph Sellers, MD, FAAP, FAACP at the first “Listening Session” in Albany on September 5 regarding Regulated Marijuana. The Governor has scheduled listening sessions throughout the state. MSSNY plans to be a voice at each session.

“Good evening, I am Dr. Joseph Sellers and I am an internist and pediatrician at Bassett Healthcare in Cobleskill, as well as treasurer for the Medical Society of the State of NY. Thank you for organizing these forums to obtain public input regarding the possible legalization of the recreational use of marijuana. As physicians, we are dedicated to helping our patients recover from and manage illness and injury, as well as promoting public health.

While MSSNY has adopted policy that supports drug treatment to those arrested or fined for marijuana related offenses rather than criminalization, we remain opposed to legalizing its use.

We are very concerned about the long-term effects of marijuana use, and are very concerned with legalizing its use without adequate study and authorization by the US FDA. As such, we are very concerned with the ever expanding list of medical conditions for which marijuana has been authorized by regulation to treat, where there has not been adequate clinical justification to support such use. Recognizing that there could be potential benefits, we very much support additional

On the evening of September 12, several MSSNY physicians attended a screening of a new documentary, Do No Harm, in Manhattan. In the words of the director, the film "explores the conditions that lead doctors and medical students to take their own lives, and what we can all do about it." MSSNY President Thomas Madejski, MD participated in a panel discussion following the screening.

(L to R) MSSNY Medical Student Councilor Breyen Coffin; MSSNY Treasurer Joseph Sellers, MD; MSSNY Secretary Frank G. Dowling, MD; MSSNY Immediate Past President Charles Rothberg, MD; Director Robyn Symon; Executive Producer Jill Zeiger, MD; MSSNY President Thomas Madejski, MD

(Continued on page 16)
More on Medicare Revalidation

Previously, MSSNY has reminded physicians of the requirement to revalidate their enrollment with the Medicare program. Once a timeframe is established for the physician or group, revalidation will occur every 5 years. Physicians need to know that CMS/NGS Medicare reserves the right to perform off cycle revalidations in addition to the regular 5-year revalidations and may request that a provider or supplier recertify the accuracy of the enrollment information when warranted to assess and confirm the validity of the enrollment information maintained by CMS. Off cycle revalidations may be triggered as a result of random checks, information indicating local health care fraud problems, national initiatives, complaints, or other reasons that cause CMS to question the compliance of the provider or supplier with Medicare enrollment requirements. Off cycle revalidations may be accompanied by site visits.

In addition, physicians, non-physician practitioners, and physician and non-physician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:

1. Within 30 days—
   (i) A change of ownership;
   (ii) Any adverse legal action; or
   (iii) A change in practice location.

2. All other changes in enrollment must be reported within 90 days.

The law further provides that no payment will be made (by the program or the Medicare beneficiary) for an otherwise Medicare covered item or service during the period of deactivation of billing privileges.

CASE DISMISSED: ACA Does Not Pre-Empt NY’s Risk Adjustment Rules

A federal judge has ruled that the Affordable Care Act does not pre-empt New York’s new risk adjustment rules, dismissing a lawsuit from UnitedHealthcare of New York. The decision could potentially cost the insurer tens of millions of dollars. U.S. District Court Judge John Koeltl said the insurer’s claims “are meritless.”

“If Congress intended to preempt all state risk adjustment programs, it is unlikely it would have included provisions expressly leaving to the states the power to promulgate any regulations that did not conflict with the ACA,” Koeltl wrote.

Maria Vullo, the superintendent of the Department of Financial Services, said in a statement she is pleased with the federal court’s decision. “This decision correctly upholds New York’s regulatory insurance authority and clearly affirms that New York’s continued enforcement of New York insurance law and regulation is not preempted by federal law,” she said.

“Influenza 2018-19” CME Webinar on October 17; Registration Now Open

The first of MSSNY’s 2019 Medical Matters continuing medical education (CME) webinar series is: “Influenza 2018-19” on Wednesday, October 17, 2018 at 7:30 a.m. William Valenti, MD, chair of MSSNY Infectious Disease Committee and a member of the Emergency Preparedness and Disaster/Terrorism Response Committee will serve as faculty for this program. Registration is now open for this webinar here. Additional information or assistance with registration may be obtained by contacting Melissa Hoffman at mhoffman@mssny.org.

Educational objectives are:

• Describe key indicators to look for when diagnosing patients presenting with flu-like symptoms
• Describe clinical and laboratory diagnostic features and treatment specific to each flu season
• Identify recommended immunizations and antiviral medications for treatment and how best to effectively encourage patients to get vaccinated

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.

New Member Benefit

Join MSSNY’s Member Perks Program and Enjoy $4,500 in Savings!

MSSNY is pleased to announce our newest member benefit! Our new Abenity App provides members with exclusive perks and over $4,500 in savings on everything from restaurants, City Pass, AMC movie tickets, theme parks, hotels, car rentals, mortgage savings, auto care and much more!

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• Showtimes: Find movies, watch trailers and save up to 40% at a theater near you.
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• Click on this link: mssny.abenity.com
• Create a unique user name and password
• Visit the App Store and download the Abenity App

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In 2016, MSSNY’s Ombudsman Program was successful in recovering $89,815.79 for physicians who had reached a stalemate regarding unpaid claims. For calendar year 2017, we recovered a total of $308,899.18 for our MSSNY members who availed themselves of the Ombudsman service. So far for January through June of 2018, we have recouped $62,639.58 for our members.

If you are a member in good standing, this service is available to you for FREE! For further information, call 516-488-6100 ext. 334 or 332.
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Presidential Column

Physicians Covered by MLMIC Between July 2013 and July 2016 Are Eligible to Receive Distribution from Berkshire Hathaway Transaction

As you may be aware, the MLMIC Berkshire Hathaway transaction is very close to completion. DFS Superintendent Maria Vullo has approved the demutualization application, the acquisition and the application for approval of the amendments to MLMIC’s charter and bylaws. MLMIC is currently in the process of being acquired by National Indemnity Company NICO, a Berkshire Hathaway subsidiary. Currently, MLMIC is a mutual insurance company, meaning it is owned by its policyholders/insured physicians. Once the sale to NICO is complete, however, the company will be transitioned to a stock insurance company owned by NICO’s shareholders.

Policy Holders Entitled to Distribution

Any physician who was a MLMIC policyholder between July 15, 2013 and July 14, 2016 will be entitled to a distribution from the NICO transaction. It is currently estimated that the distribution for each policyholder will equal approximately 1.9 times the annual premiums paid by that provider during the eligible period. For instance, if a physician was insured for the entire three-year period and paid total malpractice insurance premium of $100,000, the physician would be entitled to $190,000 from the distribution.

In the event that a proper objection to a distribution is received by MLMIC, upon the closing of the NICO transaction, the disputed distribution payment will be placed in an escrow account until the individual and employer agree on the manner of its release, or until MLMIC is ordered to release the funds by a court or arbitration panel.

Whether you are an employer who has employed providers insured through MLMIC between July 2013 and July 2016, or an individual provider who has been covered a MLMIC policy while employed by a practice, hospital, or other entity, you may want to promptly take affirmative steps to protect your potential interest in the distribution. For more information, visit www.mlmic.com.

MSSNY Testifies

On August 23, MSSNY Executive Vice President Madejski, MD

(Please see the next page)

Yes, The Times Really Are A Changin’

The times they are a changin’.

There used to be an “Inside Albany” joke that the New York State Legislature had a higher re-election rate than the old Soviet Politburo.

No more.

In the September primaries, seven incumbent Democrat State Senators lost to their challenger. Six of these had been members of the Independent Democratic Conference (IDC), a caucus which had worked closely with the Republican majority over the last six years.

Thrown in the fact that there are five GOP Senators who are retiring, and that means that there will be at least 12 new State Senators at the start of the 2019 Legislative Session.

That’s nearly 20% of the State Senate.

Then consider that there are seven State Senators who are running for their first reelection. That means that over 40% of the State Senate is brand new.

And, on top of all this, there is a significant possibility of a change in political control in the New York State Senate, which has had majority of Republicans for most of the last several decades.

Challenges and Opportunities

There are challenges and opportunities with so many new members of the State Legislature.

(Continued on the next page)
The NY Department of Financial Services recently released its *2018 Consumer’s Guide to Health Insurers*, which ranks insurers by complaints, internal and external appeals, grievances, and dispute resolution, as well as by quality of care in various categories such as child and adolescent health, women’s health, adult health and behavioral health. It also includes information on health insurers’ accreditation, and resources such as contact information for insurers, how to make a complaint and how to apply for health insurance offered on New York’s health insurance marketplace.

For 2017, the insurers with the highest overall ranking based on the lowest number of complaints are:
- MVP Health Services Corp.
- Independent Health Benefits Corp.
- Independent Health Association Inc.
- Genworth Life Insurance Company of New York
- Community Blue (Health Now)
- Delta Dental of New York (dental coverage only)
- John Hancock Life & Health Insurance Co.
- Eastern Vision Service Plan (vision coverage only)
- Principal Life Insurance Co.
- HM Life Insurance Company of New York

Some of the noteworthy findings of the report are:
- For **Prompt Payment** complaints, CDPHP had the best ranking among HMO plans and MVP had the worst ranking among EPO/PPO plans. Empire had the worst ranking among HMO plans, and GHI the worst among EPO/PPO plans.
- For **Overall complaints**, Independent Health had the best ranking among HMO plans and MVP the best among EPO/PPO plans. Empire had the worst ranking among HMO plans, and GHI had the worst among EPO/PPO plans.
- **There were 1,512 external appeals of health insurer denials of care, of which approximately 38% where reversed entirely or in part.**
- **For “Access and Service”, CDPHP had the highest ranking among HMOs and Empire had the highest among PPOs. However, Empire had the lowest ranking among HMOs and MVP had the lowest among PPOs.**
- Regarding IDR for “surprise” medical bills, of the 332

(Continued on page 12)
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According to the Substance Abuse and Mental Health Services Administration (SAMHSA) there are 751 physicians in New York State that have a waiver to treat opioid dependency with approved buprenorphine products. The 751 physicians are certified to treat 30 patients and there are 146 physicians who are certified to treat 100 patients.

Under the Drug Addiction Treatment Act of 2000 (DATA 2000) qualified physicians may apply for waivers to treat opioid dependency with approved buprenorphine products in any settings in which they are qualified to practice, including an office, community hospital, health department, or correctional facility. A “qualifying physician” is specifically defined in DATA 2000 as one who is:

- Licensed under state law (excluding physician assistants or nurse practitioners)
- Registered with the Drug Enforcement Administration (DEA) to dispense controlled substances
- Required to treat no more than 30 patients at a time within the first year
- Qualified by training and/or certification

Also, in order to maintain a waiver, a physician must be capable of referring patients to counseling and other services. To qualify for a waiver, a licensed physician (M.D. or D.O.) must meet any one or more of the following criteria and provide supporting documentation for all that apply:

- Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties
- Hold an addiction certification from the American Society of Addiction Medicine (ASAM)
- Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association
- Have completed required training for the treatment and management of patients with opioid use disorders. This involves not less than eight hours of training through classroom situations, seminars at professional society meetings, electronic communications, or training otherwise provided by ASAM and other organizations.
- Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic medication in Schedule III, IV, or V for maintenance or detoxification treatment. The physician’s participation should be confirmed in a statement by the sponsor of the approved medication to Department of Health and Human Services (HHS).
- Have other training or experience that the state medical licensing board (of the state in which the physician will provide maintenance or detoxification treatment) considers a demonstration of the physician’s ability to treat and manage patients with opioid dependency.
- Have completed other training or experience that HHS considers a demonstration of the physician’s ability to treat and manage patients with an opioid dependency. The criteria of HHS for this training or experience will be established by regulation.

Once SAMHSA verifies that the background of a physician is correct and valid, DEA assigns the qualified physician a special identification number. DEA regulations require this identification number and the physician’s regular DEA registration number on all buprenorphine prescriptions for opioid dependence treatment. Under DATA 2000, individual physicians may have a maximum of 30 patients in opioid dependence treatment at a time for the first year.
Governor Announces Series of Listening Tour Locations for Regulated Marijuana

Governor Andrew Cuomo has announced a series of listening sessions on regulated marijuana slated for September and October. The purpose of these sessions is to garner input from community members and key stakeholders on the implementation of a regulated marijuana program in New York State. This input will assist the regulated marijuana workgroup in drafting legislation for an adult-use marijuana program for the legislature to consider in the upcoming session. A copy of the governor’s press announcement is available here.

MSSNY will have representation at each listening session. The remaining listening tour dates are as follows:

- Monday, September 24 - Queens
- Tuesday, September 25 - Brooklyn
- Wednesday, Sept. 26 - Staten Island
- Thursday, September 27 - Long Island
- Monday, October 1 - Newburgh
- Tuesday, October 2 - Binghamton
- Wednesday, October 3 - Buffalo
- Thursday, October 4 - Rochester
- Tuesday, October 9 - Syracuse
- Wednesday, October 10 - Utica
- Thursday, October 11 - Watertown

Click here to register for individual listening sessions.

Council Notes—September 13, 2018

- MLMIC Vice President and Assistant Secretary Donald Fager reported to Council that the Berkshire Hathaway transaction is very close to completion and thanked MSSNY for its support. Department of Financial Services Superintendent Maria Vullo has approved the Demutualization Application, the Acquisition Application and the application for approval of the amendments to MLMIC’s Charter and By-laws. Mr. Fager noted that the final step is policyholder approval.

- Council approved the MSSNYPAC Endorsement recommendations for candidates running for re-election to the New York State Legislature and to the US Congress. Click here to view the list.

- Physicians’ Day at the Races, which took place at the Saratoga Race Track in July, was a great success and raised $13,000 for MSSNYPAC. Plan to join the fun next summer for another Physicians’ Day at the Races!

- MSSNY President Dr. Tom Madejski and New York County Medical Society president Dr. Naheed Van de Walle reported on a September 5 meeting in which MSSNY and New York County Medical Society leaders met with NYS Assembly Health Committee Chair Richard Gottfried to discuss and raise questions about various aspects of his legislation (A.4738) that would create a single payor system in New York State.

- Elizabeth Amato, Vice President, SHIN-NY Programs at New York eHealth Collaborative (NYeC) provided an update on the Data Exchange Incentive Program (DEIP), which provides physicians with up to $13,000 to help connect to the SHIN-NY. Overview documents are available online at www.nyehealth.org/deip. Or contact NYeC with any questions at deip@nyehealth.org.

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November 2, 2018 is Garfunkel Wild’s 5th Annual NY Metro ASC Symposium at the Marriott Marquis (Manhattan).

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For over 75 years, we’ve focused on insuring physicians and their incomes.
Visits from DEA Representatives

On Monday, August 13th, the Medical Society of the County of Erie hosted a meeting in order to better understand the DEA’s role in audits and investigations of buprenorphine providers. Representing the medical community at this meeting were: Thomas Madejksi, MD, President-MSSNY, Gale Burstein, M.D. Chair, Public Health Committee (MSCE) & Commissioner-Erie County Department of Health, Nancy Nielsen, MD, PhD, Senior Associate Dean for Health Policy, Medicine, SUNY at Buffalo and Christine Nadolny, Executive Director-MSCS. Representing the DEA were: Edward Orgon, Resident Agent in Charge-US DEA, Joseph Cowell, Group Supervisor – US DEA Diversion Squad and Michael Cereo, Group Supervisor, US DEA Tactical Diversion Squad.

There are two types of visits that a prescriber might receive from the DEA: Compliance Inspections and Audits.

A Compliance Inspection is a minimally-invasive visit to an office wherein the DEA representative interviews the provider and may check buprenorphine stock on hand. This is done un-announced, but we received assurances that the DEA does not “shut down the office” while this is taking place, is done in a very respectful manner and in a way that does not alert that patients that the DEA is on the premises.

There are also audits, which are normally only done after a compliance inspection and only if the DEA feels that a more thorough audit of the practice may be necessary.

According to Mr. Cowell, the only reason the audits are conducted is to ensure that buprenorphine is not being diverted onto the streets and prescribing physicians are employing all the prescribing protocols put forth by SAMHSA and state and federal regulations, which includes:

- Verifying the prescriber’s credentials
- Checking on the number of patients under the prescriber’s care
- Ensuring that patients are monitored regularly during their treatment
- Verifying the ages of patients being treated
- Verifying the number of prescriptions being written v. number of patients
- Effectiveness and outcomes of treatment with buprenorphine
- Verifying that patients being referred to counseling, are required to undergo urine testing for substances being administered (and results of testing).
- Verifying whether the prescriber is dispensing or administering buprenorphine on site or prescribing buprenorphine.

A physician practicing medicine in a lawful way has nothing to fear from either type of visit from the DEA.

Mr. Cowell provided some statistics, which prove that these types of aforementioned actions by the DEA are rare. Of the 16,000 prescribers in the jurisdiction of the Division of the DEA that Mr. Orgon oversees, there have been only 20 cases of physicians being prosecuted criminally in the last 5 years. There is always a thorough investigation and evidence in hand before the DEA will “shut the office down” and bring an indictment against a provider.

The number of visits to provider’s offices (within the 17 counties overseen by this particular DEA office’s jurisdiction) have steadily decreased from 40 visits in 2013 to 9 visits in 2017; indicating that providers are prescribing within the confines of the law. The DEA has not conducted one inspection or audit in the 17 counties of a buprenorphine provider to date in 2018.

It was clear during the discussion that all parties involved have the same goal in mind, which is the safe prescribing of buprenorphine; to stop diversion of buprenorphine on the streets; and keeping the health and safety of the public as the main priority.

Will The Department Of Labor Show Up At Your Practice? The Deadline for Updating Your Practice’s Sexual Harassment Prevention Policy Is Fast Approaching

By Andrew L. Zwerling

By now, most employers in New York State are aware of the recent legislative change imposing on all employers the obligation to conduct annual interactive sexual harassment training and to have a sexual harassment prevention policy in place. Surprisingly, however, while most employers have either commenced the requisite training that must be completed on or before January 1, 2019 or have scheduled such training, many are operating under a misimpression concerning the required sexual harassment prevention policy that will leave them non-compliant by the deadline of October 9, 2018 for such policies.

Specifically, many employers when queried about the required policy respond that they have an existing sexual harassment prevention policy and assume that such policy is sufficient to meet the statutory mandate. The reality, however, is that the recent New York State mandate requires that such policies contain additional criteria that most pre-existing policies did not possess. For example, such policies must now include a standard complaint form for use by employees who feel they have been victims of sexual harassment or by other employees who are reporting sexual harassment on behalf of other employees. Similarly, New York State requires that such policies fully inform employees of their rights of redress and all available forums for adjudicating sexual harassment complaints administratively and judicially. While most pre-existing policies informed employees of the employer’s internal complaint mechanism, most did not inform them of the entities to which employees could make such complaints externally.

Fortunately, for those medical practices with existing sexual harassment prevention policies, the road to compliance requires relatively minor changes. That said, however, with the clock for compliance winding down, it is recommended that implementation of such changes be done as quickly as practicable.

Andrew L. Zwerling is a Partner-Director at Garfunkel Wild P.C. with over 35 years as a trial and appellate lawyer in State and Federal courts, including his successful argument before the United States Supreme Court. He specializes in employment law, and conducts internal investigations for clients relating to sexual harassment and other personnel issues. His direct line is 516-393-2581.
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resolutions reached, the provider’s charge was found more reasonable in 141 claims, the plan’s payment more reasonable in 49 claims, a “split decision” in 75

**Grievances—EPO/PPO Health Plans 2017**

<table>
<thead>
<tr>
<th>EPO/PPO Health Plan</th>
<th>Filed Appeals</th>
<th>Closed Appeals¹</th>
<th>Reversals on Appeals</th>
<th>Reversal Rate (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company²</td>
<td>1,801</td>
<td>1,736</td>
<td>645</td>
<td>37.15%</td>
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<tr>
<td>CDPHP Universal Benefits, Inc.</td>
<td>118</td>
<td>120</td>
<td>30</td>
<td>25.00%</td>
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<tr>
<td>CIGNA Health and Life Insurance Company²</td>
<td>2,809</td>
<td>2,279</td>
<td>550</td>
<td>39.94%</td>
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<tr>
<td>Empire HealthChoice Assurance, Inc.²</td>
<td>7,424</td>
<td>7,798</td>
<td>2,473</td>
<td>31.71%</td>
</tr>
<tr>
<td>Excellus Health Plan, Inc.²</td>
<td>2,779</td>
<td>2,675</td>
<td>846</td>
<td>31.63%</td>
</tr>
<tr>
<td>Group Health Incorporated²</td>
<td>294</td>
<td>289</td>
<td>121</td>
<td>41.87%</td>
</tr>
<tr>
<td>HealthNow New York Inc.²</td>
<td>1,101</td>
<td>1,102</td>
<td>256</td>
<td>23.23%</td>
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<tr>
<td>Independent Health Benefits Corporation²</td>
<td>458</td>
<td>455</td>
<td>227</td>
<td>49.89%</td>
</tr>
<tr>
<td>MVP Health Services Corporation²</td>
<td>96</td>
<td>94</td>
<td>46</td>
<td>48.94%</td>
</tr>
<tr>
<td>Nippon Life Insurance Company of America</td>
<td>67</td>
<td>66</td>
<td>23</td>
<td>34.85%</td>
</tr>
<tr>
<td>Oscar Insurance Corporation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>Oxford Health Insurance Company, Inc.</td>
<td>11,252</td>
<td>11,111</td>
<td>5,637</td>
<td>49.73%</td>
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<tr>
<td>UnitedHealthcare Insurance Company of New York²</td>
<td>3,383</td>
<td>3,385</td>
<td>847</td>
<td>25.02%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>31,582</strong></td>
<td><strong>31,560</strong></td>
<td><strong>12,241</strong></td>
<td><strong>38.79%</strong></td>
</tr>
</tbody>
</table>

¹Closed internal appeals can exceed filed internal appeals in 2017 because closed internal appeals also include internal appeals filed prior to 2017.

**Grievances—HMOs 2017**

<table>
<thead>
<tr>
<th>HMO</th>
<th>Filed Grievances</th>
<th>Closed Grievances¹</th>
<th>Reversed Grievances</th>
<th>Upheld Grievances</th>
<th>Reversal Rate (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitol District Physicians Health Plan</td>
<td>287</td>
<td>291</td>
<td>162</td>
<td>129</td>
<td>55.67%</td>
</tr>
<tr>
<td>Community Blue (HealthNow)</td>
<td>50</td>
<td>49</td>
<td>12</td>
<td>37</td>
<td>24.49%</td>
</tr>
<tr>
<td>Empire HealthChoice HMO, Inc.</td>
<td>840</td>
<td>772</td>
<td>266</td>
<td>506</td>
<td>34.46%</td>
</tr>
<tr>
<td>Excellus Health Plan</td>
<td>61</td>
<td>53</td>
<td>10</td>
<td>43</td>
<td>18.87%</td>
</tr>
<tr>
<td>HIP Health Maintenance Organization</td>
<td>979</td>
<td>918</td>
<td>376</td>
<td>542</td>
<td>40.96%</td>
</tr>
<tr>
<td>Independent Health Association, Inc.</td>
<td>184</td>
<td>179</td>
<td>78</td>
<td>101</td>
<td>43.58%</td>
</tr>
<tr>
<td>MVP Health Plan, Inc.</td>
<td>141</td>
<td>141</td>
<td>47</td>
<td>94</td>
<td>33.33%</td>
</tr>
<tr>
<td>Oxford Health Plans (NY), Inc.</td>
<td>657</td>
<td>742</td>
<td>227</td>
<td>515</td>
<td>30.59%</td>
</tr>
<tr>
<td>UnitedHealthcare of New York, Inc.</td>
<td>326</td>
<td>317</td>
<td>137</td>
<td>180</td>
<td>43.22%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,525</strong></td>
<td><strong>3,462</strong></td>
<td><strong>1,315</strong></td>
<td><strong>2,147</strong></td>
<td><strong>37.98%</strong></td>
</tr>
</tbody>
</table>

¹Closed grievances can exceed filed grievances in 2017 because closed grievances also include grievances filed prior to 2017.

**Grievances—EPO/PPO Health Plans 2017**

<table>
<thead>
<tr>
<th>EPO/PPO Health Plan</th>
<th>Filed Grievances</th>
<th>Closed Grievances¹</th>
<th>Reversed Grievances</th>
<th>Upheld Grievances</th>
<th>Reversal Rate (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company²</td>
<td>195</td>
<td>205</td>
<td>36</td>
<td>169</td>
<td>17.56%</td>
</tr>
<tr>
<td>CDPHP Universal Benefits, Inc.</td>
<td>289</td>
<td>308</td>
<td>189</td>
<td>119</td>
<td>61.36%</td>
</tr>
<tr>
<td>CIGNA Health and Life Insurance Company²</td>
<td>282</td>
<td>276</td>
<td>57</td>
<td>219</td>
<td>20.63%</td>
</tr>
<tr>
<td>Empire HealthChoice Assurance, Inc.²</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Excellus Health Plan, Inc.²</td>
<td>1,199</td>
<td>1,225</td>
<td>330</td>
<td>895</td>
<td>26.94%</td>
</tr>
<tr>
<td>Group Health Incorporated²</td>
<td>507</td>
<td>519</td>
<td>104</td>
<td>415</td>
<td>20.04%</td>
</tr>
<tr>
<td>HealthNow New York Inc.²</td>
<td>381</td>
<td>375</td>
<td>42</td>
<td>333</td>
<td>11.20%</td>
</tr>
<tr>
<td>Independent Health Benefits Corporation²</td>
<td>540</td>
<td>551</td>
<td>223</td>
<td>328</td>
<td>40.47%</td>
</tr>
<tr>
<td>MVP Health Services Corporation²</td>
<td>44</td>
<td>43</td>
<td>8</td>
<td>35</td>
<td>18.60%</td>
</tr>
<tr>
<td>Nippon Life Insurance Company of America</td>
<td>295</td>
<td>273</td>
<td>92</td>
<td>181</td>
<td>33.70%</td>
</tr>
<tr>
<td>Oscar Insurance Corporation</td>
<td>8,424</td>
<td>8,307</td>
<td>2,013</td>
<td>6,294</td>
<td>24.23%</td>
</tr>
<tr>
<td>Oxford Health Insurance Company, Inc.</td>
<td>5,407</td>
<td>5,569</td>
<td>1,377</td>
<td>4,282</td>
<td>24.33%</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York²</td>
<td>5,407</td>
<td>5,569</td>
<td>1,377</td>
<td>4,282</td>
<td>24.33%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17,563</strong></td>
<td><strong>17,741</strong></td>
<td><strong>4,471</strong></td>
<td><strong>13,270</strong></td>
<td><strong>25.20%</strong></td>
</tr>
</tbody>
</table>

¹Closed grievances can exceed filed grievances in 2017 because closed grievances also include grievances filed prior to 2017.

¹Grievances and reversal rates include data from the health insurance company’s EPO, PPO and commercial business.

DFS Issues 2018 New York Consumer Guide to Health Insurers

Regarding IDR for out of network emergency care bill, of the 475 resolutions reached, the provider’s charge was found more reasonable in 61 claims, the plan’s payment more reasonable in 13 claims, a “split decision” in 102 claims, and a settlement in 67 claims.

The information in the guide is based on complaint, appeal and grievance information, as well as independent dispute resolution information data from 2017. The guide lists the following information:

**Rank:** Each health insurance company’s rank is based on the number of prompt pay complaints upheld, relative to the company’s premiums. A lower number results in a higher ranking. A higher ranking means that the health insurance company had fewer complaints relative to its size.

**Total Complaints:** Total number of complaints closed by DFS in 2017. Complaints typically involve issues about prompt payment, reimbursement, coverage, benefits, rates and premiums.

**Total Prompt Pay Complaints:** Total number of prompt pay complaints closed by DFS in 2017. Large health insurance companies may receive more complaints because they have more members and pay more claims than smaller health insurance companies.

**Upheld Prompt Pay Complaints:** Number of closed prompt pay complaints where DFS determined that the health insurance company was not processing claims in a timely manner. Prompt pay complaints upheld by DFS are used to calculate the prompt pay complaint ratio and ranking.

**Premiums:** Dollar amount generated by a health insurance company in New York State during 2017. Premiums are used to calculate the prompt pay complaint ratio so that health insurance companies of different sizes can be compared fairly. Premium data exclude Medicare and Medicaid.

**Prompt Pay Complaint Ratio:** Number of prompt pay complaints upheld divided by the health insurance company’s premiums.

A copy of the Consumer Guide to Health Insurers can be found [here](http://www.mssny.org/news-of-new-york/issue/2018-october/).
after the initial notification is submitted, the physician may submit a second notification of the need and intent to treat up to 100 patients.

On July 22, 2016, President Obama signed the Comprehensive Addiction and Recovery Act (CARA) into law. One of CARA’s important provisions expands access to substance use treatment services and overdose reversal medications—including the full spectrum of services from prevention to medication-assisted treatment (MAT) and recovery support—by extending the privilege of prescribing buprenorphine in office-based settings to qualifying nurse practitioners (NPs) and physician assistants (PAs) until Oct. 1, 2021.

Under the Drug Addiction Treatment Act of 2000 (DATA 2000), physicians are required to complete an eight-hour training to qualify for a waiver to prescribe and dispense buprenorphine. The following SAMHSA-supported continuing medical education (CME) courses can help physicians qualify to prescribe buprenorphine in an office setting (courses may require registration and include fees):

- The Buprenorphine Waiver Training at the American Academy of Addiction Psychiatry covers legislation, pharmacology, safety, patient assessment, and more. Complete all the modules and pass the post-test at the end.
- The American Society of Addiction Medicine offers the ASAM Buprenorphine Course for Office-Based Treatment of Opioid Use Disorders (link is external) in multiple formats that all provide the required 8 hours needed to obtain the waiver to prescribe buprenorphine in office-based treatment of opioid use disorders.
- The Providers Clinical Support System for Medication Assisted Treatment Self Study at the American Osteopathic Academy of Addiction Medicine (link is external), developed by the Providers’ Clinical Support System for Medication Assisted Treatment (PCSS-MAT) consists of a 4.25-hours webinar session and a 3.75-hours online session. For a list of trainings provided, visit the PCSS-MAT Calendar of Events.

CARA requires that NPs and PAs complete 24 hours of training to be eligible for a prescribing waiver. SAMHSA has created a list of recommended learning objectives for the trainings. Here are the Proposed Learning Objectives for the NP and PA Waiver Training – 2017 (PDF | 196 KB).

NPs and PAs are required to obtain no fewer than 24 hours of initial training addressing each of the topics in 21 USC 823(g)(2)(G)(ii)(IV) provided by one of the following organizations: The American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Medical Association, American Osteopathic Association, American Nurses Credentialing Center, American Psychiatric Association, American Association of Nurse Practitioners, American Academy of Physician Assistants, or any other organization that the Secretary of Health and Human Services determines is appropriate.

NPs and PAs may take both the eight-hour DATA-waiver course for treatment of opioid use disorder, designed by national experts, that physicians currently take, and the additional 16 hours course offered for free by SAMHSA through the Providers Clinical Support System.

The New York State Department of Health periodically offers buprenorphine training. Further information can be found in the brochure: “How You Can Help Patients with Opioid Addiction” here.
New York ...The Right Access to the Right Technology Can Help Solve Opioid Abuse

By Steve Marchbank, MD
Vice President – Strategic Product Solutions for Dr.First

Addressing the nation’s opioid crisis is no simple task. It’s a multi-factorial problem that must include multi-pronged solutions – including cooperation and collaboration among the medical and pharmacy communities, government, social programs, and regulatory agencies.

Prescription Drug Monitoring Programs (PDMPs) are one way that states are working with doctors to keep them informed about their patients’ opioid prescribing histories, especially as related to coordination of care with other providers. As of July 1, Maryland and Florida joined 40 other states including New York that now require prescribers to check PDMP databases before prescribing opioids.

These developments represent progress in the fight against the opioid crisis. Prescribers’ use of PDMP data may have contributed to a 22 percent decrease in opioid prescribing recently reported by the American Medical Association (AMA).

Information is power, and technology-enabled solutions support easier access to critical patient histories about opioids that can enable providers to improve outcomes and save lives.

HOW DID WE GET HERE?

In 2001, the Joint Commission rolled out pain management standards that included pain as the “fifth vital sign” in hospitals, and physicians were encouraged to order pain medications, including opioids, to keep patients as comfortable as possible – with an ultimate goal of “zero pain.” Then this liberal use of opioids spilled into ambulatory care, for everything from back pain to root canals to recovery from C-sections. At that time, there was also a widely cited article that suggested that addiction from short-term opioid use was rare. (citation: Porter J, Hick H. Addiction rare in patients treated with narcotics. N Engl J Med. 1980;302:123.)

Addiction to opioids occurs more rapidly and more readily than was once known, creating a perfect storm. When opioids are prescribed unnecessarily or treatment continues longer than needed, addiction issues can emerge quickly. Even worse, when patients with addiction issues can’t get prescription opioids, some may even turn to illegal street drugs such as heroin — which is increasingly laced with the dangerous agent fentanyl.

THE CHALLENGE OF PDMP MANDATES

While PDMP mandates make sense, some physicians believe that PDMPs are unnecessary because they trust their own judgment. Others feel they don’t have the time to check online PDMP registries. This is understandable when doing the database checks in a traditional manner. In the absence of a specific technology solution integrated directly into the workflow, verifying whether a patient is taking opioids requires doctors to go to a stand-alone PDMP website, log on, and enter patient demographic information. In states that require such checks, doctors also must document that they looked up the data. Altogether, this process can take 3 to 5 minutes per patient. If a doctor prescribes opioids or other controlled substances several times a day, that adds half an hour of daily work.

We must make it as easy as possible for clinicians to check PDMP data so that workflows aren’t adversely impacted for already time-pressed doctors. We also need more studies on the incidence and impact of PDMP-checking. The evidence needs to support the effort.

E-PRESCRIBING WORKFLOW TOOL

Many states outside New York already allow doctors to access PDMP data within e-prescribing tools such as DrFirst’s iPrescribe mobile application and its desktop versions, which are imbedded in EHRs. In those states, prescribers gain easy, fast access to this information in their e-prescribing workflow. With just a couple of clicks, they can check the PDMP data and prescribe the appropriate drug. In the background, the software automatically documents the fact that the doctor checked the registry.

When a physician discovers that a patient may be at risk of opioid addiction or may already be addicted, she can start a conversation with that patient. If the patient acknowledges that he may need help, the doctor can use DrFirst’s integrated HIPPA-compliance Backline application to securely message another clinician, a home health provider, or a social worker who can intervene.

Unfortunately, streamlined access to the New York I-STOP database has not yet been approved. As more studies are conducted which demonstrate a nexus between PDMP checking and patient outcomes, we hope that states like New York will take steps to authorize the automatic provision of PDMP data while in workflow to a prescriber.

If the evidence supports the use of PDMP databases, more prescribers will be encouraged to adopt and embrace this powerful tool — especially when they have an easy and efficient way to integrate it into their workflow.

A reduction in opioid prescribing alone will not end the opioid epidemic. The huge influx of illegal street drugs also must be addressed, and addicts must have easier access to treatment. But I’m convinced that, if all of us work together, the healthcare community can decisively reverse the trend of opioid addiction to improve outcomes and alleviate suffering.

In the recent vote of Record Date Policyholders, 6,635 out of 6,979 of the ballots were in favor of the Conversion & Amended/Restated Charter. MLMIC & NICO, a subsidiary of Berkshire Hathaway, are now proceeding to finalize the closing arrangements.

PRESIDENT’S COLUMN

President Philip Schuh, CPA testified in support of MLMIC’s acquisition by Berkshire Hathaway, during a recent New York Department of Financial Services (DFS) hearing examining the proposed transaction. Mr. Schuh noted that “MLMIC’s alliance with Berkshire Hathaway will fortify its finances and enable MLMIC to continue its mission to assure physicians, dentists and hospitals have access to quality medical malpractice insurance coverage and risk management services long into the future”.

He noted that “some physicians have expressed concerns that entities with enormous resources at their disposal could coerce a physician to give up their statutory right to these proceeds because of the fear of excessive litigation costs. He suggested that DFS impose a condition on the conversion approval “to assure a strict deadline for release of the funds from escrow following the closure of the transaction, whereby the funds will be awarded to the policyholder at the conclusion of such period if the process for resolving the dispute has not yet been completed.”

FINAL STEPS

In the recent vote of Record Date Policyholders, 6,635 out of 6,979 of the ballots were in favor of the Conversion & Amended/Restated Charter. MLMIC & NICO, a subsidiary of Berkshire Hathaway, are now proceeding to finalize the closing arrangements.
MSSNY-PAC

(Continued from page 4)

The challenge is that there is a loss of historical knowledge by those legislators who knew a lot of the dynamics regarding the various pieces of legislation that have been introduced year after year in Albany.

The opportunity is that there is the chance to shape the perspective of these new members of the Legislature on all the challenges physicians face in assuring their patients receiving the care they need.

With so much potential change on the horizon, MSSNYPAC has developed several tools to assist local physician leaders to have meaningful conversations with these candidates for State Legislature.

We have developed a candidate questionnaire that seeks these office-seekers’ perspective regarding whether they support or oppose key legislation, such as physician collective negotiation, medical liability reform, big box retail clinics, and various public health initiatives.

We have also developed a “scorecard” that tracks the voting and co-sponsorship records on key pieces of legislation that MSSNY has supported and opposed. This tool is available to MSSNYPAC members only by contacting jwilks@mssny.org.

LIST OF CHAMPIONS

We have also recommended a bi-partisan list of two dozen legislators for re-election for the upcoming November 6 election. Each of these legislators has demonstrated themselves to be champions of issues to preserve the ability of patients to continue to receive needed and timely physician care. It is an opportunity to educate physicians regarding the contributions these legislators have made to advance public health.

To read that list of legislators, click here.

WE NEED MORE THAN MANY

Many physicians across New York State have been part of our efforts to provide needed financial support to MSSNYPAC and to engage with candidates as they seek election or re-election.

However, not enough are.

Physicians must understand that there are many aspects of care delivery that are established in Albany. And many of these legislators would like to control even more.

Therefore, we need more physicians to join us in our efforts to help elect candidates who understand the concerns we face as seek to assure our patients receive the care they need. Please click here to join us in these efforts by joining MSSNYPAC today.

And if you have already joined us, please increase your contribution and urge your colleagues to join us.

The future you save may be your own.

OBITUARIES

BOOLEUKOS, George; Plattsburgh NY. Died April 03, 2018, age 89. Clinton County Medical Society

CLAUSEN, Jerry Lee; Manlius NY. Died August 03, 2018, age 78. Onondaga County Medical Society

GARBON, Antonio Aranda; Pittstown NJ. Died March 14, 2018, age 91. Richmond County Medical Society

LEMPERT, Philip; Ithaca NY. Died August 02, 2018, age 81. Tompkins County Medical Society

LIN, Tung-Hui; Savannah GA. Died August 06, 2018, age 94. Medical Society County of Oneida

MARCHIELLO, Peter J.; Flushing NY. Died March 24, 2018, age 94. Medical Society County of Queens

NEANDER, J. Michael; Oneonta NY. Died July 12, 2018, age 67. Otsego County Medical Society

SEGAL, Robert Lloyd; New York NY. Died August 02, 2018, age 92. New York County Medical Society

SHERMAN, Eugene; New York NY. Died March 06, 2018, age 91. New York County Medical Society

SILVERSTONE, Felix A.; Canton MA. Died April 30, 2018, age 98. Medical Society County of Kings

SINGER, Adolf; New York NY. Died March 06, 2018, age 93. Suffolk County Medical Society

THOMAS, Theodore F.; Sauquoit NY. Died March 11, 2018, age 93. Medical Society County of Oneida
For many years, Kaiser Family Foundation (KFF) has been tracking public opinion on the idea of a national health plan. Since the 2016 presidential primary and Bernie Sanders’ rallying cry for “Medicare-for-all,” KFF’s polls have shown a modest increase in support for the idea of a national health plan, and broad support for proposals that expand Medicare. Overall, about six in ten adults favor a national health plan or Medicare-for-all plan. There is robust support among Democrats, and even somewhat among Republicans, for expansions of the Medicare program through a Medicare buy-in or an “optional” Medicare-for-all proposal.

Yet, it is unclear how much staying power this support has once people become aware of the details of any plan. Public support quickly erodes when people hear further explanation about potential tax increases or increased government control and recent polling also shows many people falsely assume they would be able to keep their current health insurance under a single-payer plan, suggesting another potential area for decreased support.

MSSNY’s Statement on Regulated Marijuana

(Continued from page 1)

research into the use of cannabinoid products in the treatment of illness and the relief of pain.

The American Medical Association (AMA)’s Council on Science and Public Health recently developed a lengthy policy paper regarding the use of marijuana. It noted that studies had found substantial evidence that cannabis or cannabinoids have some therapeutic benefits, while also finding substantial evidence of a statistical association between cannabis smoking and health harms. For example, data from jurisdictions that legalized cannabis demonstrated concerns particularly around unintentional pediatric exposures resulting in increased calls to poison control centers and ED visits as well as an increase in traffic deaths due to cannabis-related impaired driving.

As a result of this report, the AMA adopted a position that: (1) cannabis is a dangerous drug and a serious public health concern; (2) the sale of cannabis for recreational use should not be legalized; (3) cannabis use should be discouraged, especially by persons vulnerable to the drug’s effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) states that have already legalized cannabis should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws that legalize cannabis use should consistently be evaluated to determine their effectiveness; (5) local, state, and federal public health agencies improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis use; (6) support public health-based strategies, rather than incarceration, for individuals possessing cannabis for personal use.

I will further note that, while the American Society of Addictive Medicine (ASAM) supports the “decriminalization” of marijuana, by reducing penalties for marijuana possession to civil offenses linked to contingencies, such as mandated referral to clinical assessment, educational activities, and, when indicated, formal treatment for addiction, ASAM does not support the legalization of marijuana. Instead, it recommends that jurisdictions that have not acted to legalize marijuana not do so until more can be learned from the jurisdictions that have legalized marijuana. They also recommend numerous limitations, including prohibiting sale to those under 25, prohibiting marketing and advertising to youth, assure that non-FDA approved products contain appropriate warning labels, and limit purchase to state operated outlets.
**CNBC.com** – 08/07/18  Digital health start-up Zocdoc is wrestling with a price change that could cripple doctors (MSSNY mentioned)

**AAPM&R** – 08/15/18  Members in the News  Dr. Van De Walle is the New York County Medical Society’s

**LIBN** – 08/20/18  Second Opinions  Provide First Line of Defense (MSSNY President Dr. Thomas Madejski quoted)

**The Buffalo News** – 08/28/18  Another Voice: WNY emergency rooms poised to help patients in crisis  (Erie County Medical Society Executive Director, Christine Ignaszak-Nadolny op-ed)

**Pharmacy Choice** – 08/28/18  150 Groups Send Letter on Proposed Changes to Physician Payment Rule (MSSNY mentioned)

**LocalSYR** – 08/28/18  Dealing with Addiction  CYN (MSSNY’s Dr. Brian Johnson interviewed)

**Crain’s Health Pulse** 08/29/18  Assemblyman, docs oppose CVS-Aetna deal (MSSNY President Dr. Thomas Madejski quoted)

**WKBW- Buffalo** – 09/05/18  Combating the doctor shortage in WNY (Erie County Medical Society mentioned)

**AP** – 09/06/18  At NY state 'listening session,' marijuana advocates urge making it legal, affordable (MSSNY Treasurer Dr. Joe Sellers quoted)

**The Troy Record**
**The Post-Journal**
**The Oneida Daily Dispatch**
**The Kingston Daily Freeman**
**The Post Journal**
**NewsTimes.com**
**Dariennewsonline**
**New Milford Spectrum**
**New Canaan News**
**Connecticut Post**
**StamfordAdvocate.com**
**Lexington Herald-Leader**
**Greenwich Time**
**US News & World Report**
**Recordonline.com**
**San Antonio Express-News**
**The Saratogian**
**MyrtleBeachOnline.com**
**TheState.com**
**The Daily Star**

**MSSNY IN THE NEWS**

**MSSNY IN THE NEWS**

Dr. Rehman Sworn in as Rotary Club President of Staten Island

Dr. Abdul Rehman, MSSNY member and past president of the Medical Society of the County of Kings (MSCK), was recently sworn in as president of the Rotary Club of Staten Island by Richmond County District Attorney Michael McMahon.

Dr. Rehman practiced medicine for 50 years and has been an active member of organized medicine for many years. In addition to serving as a delegate to both the MSSNY House of Delegates and the American Medical Association (AMA), he served as Chair of the MSCK Board of Trustees. He continues to play an active role on the Board and serves on numerous MSCK committees.

In addition to his own practice, Dr. Rehman served as President of the Professional Staff and Chairman of the Medical Board of The Brooklyn Hospital Center — where he worked from 1973 until his recent retirement. He was also an attending internal medicine physician at Staten Island University Hospital. In 2013, Dr. Rehman received the Louis R. Miller Business Leadership Award for his tireless community efforts to support a variety of charitable, cultural and educational institutions in Staten Island.

Dr. Rehman is currently a motivational speaker on the subject of spirituality and has published six books of poetry.

**MSSNY IN THE NEWS**

Dr. Abdul Rehman Sworn in as Rotary Club President of Staten Island

(Left to right) Dr. Abdul Rehman and Richmond County District Attorney Michael McMahon.

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