MEDICAL SOCIETY OF THE
STATE OF NEW YORK

2014 Legislative Program

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The Medical Society of the State of New York’s Division of Governmental Affairs wishes to express its gratitude to the following County Medical Societies and Specialty Societies for their invaluable assistance in the preparation of our 2014 Legislative Program.

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New York State Radiological Society           New York Chapter, American College of Surgeons
New York Society for Surgery of the Hand           New York State Thoracic Society
PROLOGUE

The practice of medicine is again on the precipice of tremendous change. The state’s focus of enhancing population health through innovative practice models and significant payment “reform” presents an opportunity to improve delivery of care, but also raises concerns that these new practice models may interfere with the physician’s sacred duty to provide each of their patients the care that best meets their needs.

Through this Legislative Program, MSSNY sets forth its priorities, designed to assure that patients can access the physician of their choice, while protecting the ability of physicians to deliver high quality care, in the face of greatly increasing practice overhead costs and burdensome and intolerable practices of the health insurance industry. In addition, we will advocate on behalf of our patients, and make sure they are fully informed of the credentials of all members of the health-care team they come in contact with. Patients must be protected from those who would blur the lines between physicians and non-physicians and damage the integrity of the physician-led care team.

The importance of physicians and their practices to the State of New York goes far beyond the medical services they provide. Medical practices are businesses which provide a valued service to society and employ about 330,000 New Yorkers. Physicians are also valued employees who contribute daily to the financial stability of the hospitals and clinics they serve. We must advocate to assure that physicians, in all care settings, are supported and incentivized, rather than penalized, for practicing in New York State. There must be no further drain of physicians from New York.

I believe that this Legislative Program sets forth a vision which will support physician care delivery in both institutional and private practice settings. I urge your consideration of these priorities as you ponder the legislative and regulatory measures and policy changes which will impact upon the practice and the business of medicine and the well-being of our patients in the future.

SAM L. UNTERRICHT MD
MSSNY PRESIDENT
BROOKLYN, NY
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## IMPROVING PUBLIC HEALTH IN NEW YORK STATE IN THE 21ST CENTURY

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PRESERVING PATIENTS’ ABILITY TO RECEIVE TIMELY QUALITY CARE

The stability of New York’s already fragile health care delivery system is further threatened by the confluence of factors that are making it difficult for physicians to remain in practice to deliver care to their patients. Physicians are being squeezed between extraordinary overhead costs, led by the startlingly high cost of medical liability insurance, and decreasing payments from health insurers and Medicare. Moreover, physicians face administrative burdens like never before. Completing and updating credentialing forms, complying with state practice mandates and federal government reporting mandates, and complying with time-consuming pre-authorization requirements for needed medical care and referrals all consume hours upon hours that take time away from taking care of patients.

In a recent survey by MSSNY of member physicians, only 35% indicated that they would recommend to their children or other family members that they become physicians and only 22% indicated that they would recommend to medical students that they practice in New York State. Little wonder nearly 83% indicated that the time they spend obtaining authorizations from health insurers for needed patient care had increased in the last three years, and nearly 60% indicating it had increased significantly. At the same time nearly 65% indicated that their compensation had decreased in the last 5 years, with 32% indicating it had decreased significantly.

It’s certainly understandable why many physicians are choosing the route of becoming employees – lessening their paperwork burden and providing more time to actually be a doctor. Moreover, many physicians, particular older physicians, have indicated that they are simply “fed up” and are strongly considering retiring early or moving to other states with more favorable practice and business environments. The survey showed that nearly 1/3 of the respondents indicated that they were seriously considering retiring from practice in the next two years, and over 37% indicated that they plan to reduce the services they deliver over the next two years.

“HELP! We are all drowning in administrative/insurance/regulatory hassles. Overhead has doubled since I started practice in 1993. As a primary care MD, there is no way to continue in this environment.”
– Internist, Rochester, 2013 MSSNY Survey Comments

“I spend less and less time managing patients’ health and more and more time managing administrative things – especially insurance companies’ refusal to allow certain prescribed drugs and refusing to pay me for services I have already rendered to patients...What an outrage!”
– Nephrologist, New York City, 2013 MSSNY Survey Comments

These problems will become even more acute as hundreds of thousands of New Yorkers are anticipated to receive health insurance coverage for the first time as a result of the implementation of the ACA and New York’s Health Insurance Exchange. Will our health care system be truly able to meet this demand?

MSSNY supports the concept that a physician should be free to define a business model to practice medicine that is most appropriate to that physician and his/her patients, whether that be as part of a solo or small practice, as part of a large group, or as an employee of a hospital. Legislation is needed to preserve the ability of physicians to have a meaningful choice as to which practice environment suits them best, so as to protect the sanctity of the physician-patient relationship and to assure patients receive needed care in the most appropriate care setting. Efforts to expand health insurance coverage will not enhance the availability of timely quality care for patients unless steps are taken to assure the viability of physician practices to provide this needed care.

THE NEED TO REFORM NEW YORK’S LIABILITY SYSTEM

Many New York physicians must pay extraordinary medical liability premiums to be able to continue to deliver care to their patients. While physicians in many other states have seen their premiums reduced in the last several years, liability premiums for New York physicians continue to rise. Physicians in New York face far greater liability insurance costs and exposure than their colleagues in other states. By way of example, a neurosurgeon practicing on Long Island must pay an astounding $331,295 for just one year of insurance coverage and an OB/GYN practicing in the Bronx or Staten Island must pay $192,412. Something has got to give.
There were over $760 million in medical liability payments in New York State in 2011, nearly 250% higher than the state with the second highest total (Pennsylvania, $316 million) and nearly 350% higher than California ($222 million) and Florida ($203 million).

Moreover, New York per capita medical liability payment of $38.99 far exceeded the second highest state Pennsylvania ($24.77) and third highest state New Jersey ($23.31)

Faced with similar problems, many other states have passed comprehensive medical liability reform legislation. According to the Texas Alliance for Patient Access, 90% of Texas physicians have seen a minimum 30% reduction in their premiums since the enactment of comprehensive reform there in 2003. In Los Angeles, California in a state where strong medical liability reforms were enacted in the mid-1970s, OB/GYNs pay less than 1/4 the premiums that OB/GYNs in Nassau and Suffolk County pay. Significantly, the reforms in each of these states included a cap on pain and suffering damage awards.
The problems of the medical liability adjudication system do not just impact physicians – they impact the cost of all health care. Several studies have shown that billions of dollars are unnecessarily spent each year due to the practice of defensive medicine, such as unnecessary MRIs, CT scans and specialty referrals. A 2009 study by the Congressional Budget Office (CBO) showed that enactment of medical liability reforms would reduce the federal deficit by $54 billion over 10 years largely due to reducing defensive medicine. The group Patients for Fair Compensation recently estimated that enactment of comprehensive medical liability reform could actually reduce defensive medicine costs by $650 billion.

Numerous scholarly articles have concluded that the current system for adjudicating medical liability claims routinely encourages lawsuits and facilitates awards in instances where there has been no negligence. Errors cannot be fixed if we cannot study them. The fear of retribution prevents health professionals from freely disclosing error. As a result, we cannot fully correct medical errors unless we remove the fear of retribution. As stated by noted patient safety expert Troyen Brennan:

*Any effort to prevent injury due to medical care is complicated by the dead weight of a litigation system that induces secrecy and silence. No matter how much we might insist that physicians have an ethical duty to report injuries resulting from medical care or to work on their prevention, fear of malpractice litigation drags us back to the status quo. To address the problem of iatrogenic injuries seriously, we must reform the system of malpractice litigation.*

Some modestly positive steps have occurred in New York to begin to constrain liability costs, including the establishment of a medical indemnity fund and Office of Court Administration demonstration projects to facilitate early negotiation of medical liability allegations. While promising, these programs have yet to produce tangible premium relief for physicians. We must do more. New York must follow the lead of the many, many other states who have passed legislation to bring down the gargantuan cost of medical liability insurance.

Similar action must be taken on the federal level. Among the measures which must be enacted include:

- **Creating Alternative Systems for Resolving Medical Liability Cases**
  - Neurologically Impaired Infants No-Fault fund
  - Promoting medical courts

- **Medical Liability Tort Reforms**
  - Reasonable limits on non-economic damages
  - Identifying and assuring qualified expert witnesses
  - Eliminating joint and several liability
  - Identifying a physician supplying a Certificate of Merit
  - Immunizing statements of apology or regret
  - Immunity for physicians providing pro bono care

- **Assuring Adequate Funding for Excess Medical Liability Insurance Program**

- **Requiring Hospitals to Provide Tail Liability Coverage for Employed Physicians**

**PREVENTING UNTENABLE EXPANSIONS OF LIABILITY**

At the same time that physicians and hospitals face these extraordinary costs, remarkably some interest groups continue to pursue legislation that would radically increase these costs. MSSNY will continue to strenuously oppose any measure to expand the damages recoverable in medical liability actions, including legislation that would:

- Create a “date of discovery” rule for New York’s statute of limitations for medical liability actions – Estimated to increase premiums by 15%.
- Expand “wrongful death” damages to permit “pain and suffering” – Estimated to increase premiums by 53%.
- Permit the awarding of pre-judgment interest in tort actions – Estimated to increase premiums by 27%.
- Eliminate the current statutory limitations on attorney contingency fees in medical liability cases – Estimated to increase premiums by over 10%.
- Prohibit ex-parte interview by defense counsel of the plaintiff’s treating physician.
• Require a non-settling defendant to choose before trial whether to reduce their liability by either 1) the amount paid by the settling defendant or 2) by the equitable share of the settling defendant as determined by the jury.

Enactment of any of these measures would have calamitous consequences on our health care system. Efforts to reform our medical liability adjudication system must be comprehensive!

“Some have argued that many other states have ‘date of discovery’ exceptions in their statutes of limitations. It’s an “apples and oranges” comparison. Well over half of these states with these ‘date of discovery’ rules also have enacted caps on non-economic damages in medical liability actions, thereby significantly reducing the impact of such a provision. To fail to address New York’s healthcare liability cost problem and then pass laws to exacerbate this problem would be unconscionable. We can’t place another huge financial burden on top of already fraying health care delivery system. Patient access to necessary care will become far worse.”

– MSSNY President Dr. Sam Unterricht, 6/26/13 letter to the Daily News

ASSURING FAIR PAYMENT FOR PATIENT CARE
The implementation of New York’s Health Insurance Exchange along with the ACA requirement for individuals to maintain health insurance coverage will result in hundreds of thousands of New Yorkers obtaining health insurance coverage for the first time. Certainly, the increased availability of coverage is a positive development for our patients, but what will be the quality of this coverage?

One likely outcome is that it will expand the already significant control that health insurance companies have over the delivery of health care. As noted above, the MSSNY survey showed that health insurance companies are increasing the hassles on physicians to deliver needed patient care at the same time that they are reducing payment for this care. And they are reducing the availability of coverage that enables a patient to be treated by a physician outside of the plan’s network. MSSNY has been working closely with leadership at the New York Health Exchange to advocate that there be a robust availability of insurance options, that the products sold through the Exchange maintain comprehensive physician networks, and that these policies provide coverage for patients to see the physician of their choice. And most importantly, patients must be able to obtain the timely and quality care they expect to receive when they purchase this coverage.

It is unclear whether these goals can truly be met in the absence of specific legislation particularly given early reports that insurers have shrunk networks for many products and are listing physicians as participants who may not have agreed to participate. Legislation must be enacted to assure that patients can obtain the necessary care they need without hassle from health insurers and that physicians and other care providers are paid fairly for providing this needed care.

PERMITTING PHYSICIANS TO COLLECTIVELY NEGOTIATE
Most regions of New York State are dominated by just one or two health insurance behemoths. The market power enables these insurers to dictate the specifics of physician’s contracts and tell them to “take it or leave it.” A few larger medical provider entities may have some ability to negotiate, but smaller physician practices cannot. And a physician who chooses to walk away from these one-sided contracts risks losing the ability to provide care to a large number of patients. As a result, most physicians cannot afford to walk away.

NEW YORK HEALTH INSURANCE ENROLLMENT
Source: AMA, Competition in Health Insurance, 2013 Update

With insurer consolidation over the last decade, regional markets continue to be further dominated by a small number of insurers. According to a 2013 report from the American Medical Association, only three health insurers
comprised two-thirds of New York’s insurance market. These trends are even more pronounced on regional levels, where the combined market share of the top two insurance carriers ranges from 1/2 to over 3/4 of that market.

**HEALTH INSURER PENETRATION – SELECTED NY MSAS**

Source: AMA, Competition in Health Insurance, 2013 Update

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<thead>
<tr>
<th>MSA</th>
<th>Insurer 1</th>
<th>Insurer 2</th>
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<tr>
<td>Albany-Schenectady-Troy</td>
<td>CDPHP (32%)</td>
<td>United (18%)</td>
<td>50%</td>
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<tr>
<td>Binghamton</td>
<td>Excellus (43%)</td>
<td>United (25%)</td>
<td>68%</td>
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<tr>
<td>Buffalo-Cheektowaga-Tonawanda</td>
<td>Independent Health (45%)</td>
<td>HealthNow (24%)</td>
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<td>New York-White Plains-Wayne, NJ</td>
<td>United (31%)</td>
<td>Emblem (26%)</td>
<td>57%</td>
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<tr>
<td>Rochester</td>
<td>Excellus (41%)</td>
<td>MVP (36%)</td>
<td>77%</td>
</tr>
<tr>
<td>Suffolk-Nassau</td>
<td>United (43%)</td>
<td>Emblem (23%)</td>
<td>66%</td>
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<tr>
<td>Syracuse</td>
<td>Excellus (55%)</td>
<td>United (20%)</td>
<td>73%</td>
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It is our patients who most often bear the brunt of this market dynamic because the physicians’ inability to negotiate result in the imposition of unnecessary barriers for patients in need of care. These barriers include: cumbersome pre-authorization processes that delay our patients from receiving needed care and testing; arbitrary limitations or cumbersome “step therapy” restrictions on necessary prescription medications; and roadblocks to limit patients’ ability to receive care from the specialist physician of their choice.

While the new Health Insurance Exchange marketplace could bring about greater competition among health insurers, it remains unclear if this existing market dominance will be significantly altered. Moreover, the new dynamics created by implementation of health care reform are causing some insurers to actually increase their already substantial focus on the “bottom line” at the expense of patient care in the regions they serve. Recent examples include one major insurer threatening to drop out of the Medicaid Managed Care program across upstate New York due to allegedly inadequate payments and several insurers including United and Emblem dropping scores of physicians from their Medicare Advantage networks despite the obvious disruptions this will cause to many longstanding patient-physician treatment relationships.

To address this inequity in negotiating power, MSSNY is urging the New York State Legislature to enact legislation that would permit independently practicing physicians to come together under close state supervision to collectively negotiate participation contracts with health insurance plans. The bill would enact in New York State a “State Action exception” to federal antitrust rules that was articulated by the US Supreme Court in a landmark 1943 decision that permitted collective action under close state supervision to vindicate legitimate public interests. While the Federal Trade Commission (FTC) does not favor “state action immunity” exceptions to federal jurisdiction, the exception is well recognized and has been enacted in a number of states.

The new dynamic created by this legislation will not increase the cost of health care but will re-distribute existing dollars away from insurance company profits to the provision of necessary care for patients. Moreover, reductions in cost would result from greater standardization of administrative procedures which often now vary from plan to plan. Perhaps most importantly, the bill grants broad powers to the State to prevent joint health care provider negotiations from going forward if it is believed that such negotiations would have an adverse impact on patient access to care, including concerns regarding increases in the cost of health care.

**TRANSPARENCY AND FAIR PAYMENT FOR OUT-OF-NETWORK CARE**

There has been much focus recently on “surprise” medical bills received by patients who believed they had insurance coverage for their needed health care. A major contributing factor to this problem is that many health insurers have drastically reduced their levels of coverage in policies for care provided by out-of-network physicians. As a result, the increased financial responsibility for patients seeking out-of-network care is both substantial and unexpected.

_They’re going to lower the reimbursement to the point where it’s unaffordable for most people to go out of network,” said Dr. Andrew Kleinman, a Westchester plastic surgeon...“patients pay for policies that promise out-of-network coverage, then discover the benefit is so low that most middle class people can’t afford to go out of network.” _

– March 11, 2012 Daily News
When he was Attorney General, Governor Andrew Cuomo required health insurers to discontinue the use of the grossly distorted Ingenix database for determining payments for out-of-network care when it was found Ingenix was manipulating the database resulting in lower out-of-network payments. The settlements with the insurers and the creation of the FAIR Health database by then AG, now Governor, Andrew Cuomo should have at last provided fairness in the adjudication of claims for out of network health care coverage. Instead, health insurers have created an even greater problem because they switched to methodologies for covering out-of-network health care services that appear on their face to adequately cover the cost of out-of-network care but, in fact, deceptively result in grossly insufficient payments.

The gross inadequacy leaves the patient with staggering out-of-pocket responsibilities. Moreover, businesses which believe they are paying for the right of their employees to have coverage to see the physician of their choice are in fact paying for almost no coverage at all. This problem was extensively documented in 2012 articles in the New York Times and Daily News.

The switch “certainly creates the appearance that insurers are trying to end-run the settlement and keep out-of-network payments low.”

– Department of Financial Services (DFS) Superintendent Benjamin Lawsky, April 24, 2012 New York Times

MSSNY supports legislation to require health insurers to clearly disclose to patients and employers the scope of their out-of-network coverage, set as a percentage of the likely costs of care as set forth in the FAIR Health database established by then AG, now Governor, Andrew Cuomo. MSSNY also supports legislation to require health insurers offering a policy for out-of-network coverage to assure that there is significant coverage of such costs.

We further note that MSSNY opposes efforts to create an across-the-board dispute resolution mechanism to determine payments for out-of-network emergency care, or other mechanism which permits insurers to grossly underpay for necessary emergency room care. While a dispute-resolution mechanism could be appropriate in circumstances where truly excessive billing is alleged, an across-the-board dispute-resolution process would likely further discourage many physician specialists from providing emergency on-call care.

REDUCING ADMINISTRATIVE HASSLES AND ASSURING FAIR PAYMENT

Health plans routinely engage in an array of tactics to inappropriately delay and deny needed care and treatments for patients when coverage for such care is requested, and delay and deny fair payment to physicians when needed care is delivered. These tactics adversely impact patients and exacerbate the already hostile practice environment facing physicians in New York that is making it harder and harder to remain in practice to deliver the care expected by our patients.

The ideal solution to these problems is the enactment of legislation that would permit physicians to jointly negotiate these issues with insurance companies. In addition, MSSNY supports a series of reforms to reduce these hassles, including legislation and/or regulation that would:

- **Reduce Administrative Burdens to Delivering Care**
  - Require health plans to use appropriate specialty care guidelines when reviewing medical necessity determinations;
  - Require medical necessity determinations be made by physicians practicing in the same or similar specialty as the physician recommending treatment;
  - Requiring use of uniform prior authorization forms;
  - Assure continuity in prescription drug coverage when formularies/prescription tiers change;
  - Assure inclusion of patient cost-sharing information on health plan ID cards; and
  - Assure greater transparency when a physician contracts with a rental-network entity (i.e. MagnaCare, MultiPlan) or “silent PPO.”

- **Assure Fair Payment for Providing Needed Patient Care**
  - Require insurer payment to physicians for advocating for patients to receive necessary imaging, medications or lab studies;
  - Require insurers to follow uniform code-review policies;
- Reduce from two years to two months the time frame in which health plans may recoup payments made to physicians;
- Prohibit health plan recoupment based upon lack of coverage where health plan previously confirmed eligibility of such patient;
- Prohibit health plans from using extrapolation to determine a refund demand amount; and
- Assure fair payment for facility fees for physicians to cover significant overhead cost of maintaining certification for office-based surgical practices.

**Fair Workers Compensation / No-Fault Reform**

MSSNY supports legislation to assure that injured workers and auto accident victims have adequate choice of physicians to treat their injuries, including:

- Assuring fair payments for medical care to injured workers – According to studies, New York Workers Compensation spends far less on medical care, on a percentage basis, than most other states;
- Reducing undue administrative burdens including streamlining burdensome claim forms;
- Preventing rigid implementation of the Workers Compensation Medical Guidelines;
- Limiting the use of Diagnostic Radiological Networks;
- Opposing inappropriate limitations on no-fault claims submissions; and
- Providing adequate coverage for necessary care provided to intoxicated drivers.

We are pleased that the Workers’ Compensation Board has contracted with an outside consultant to perform a complete system review of its claims adjudication process to better assure injured workers can receive timely quality care, and to incentivize physicians to participate in the program. We are hopeful that this process will at last produce needed changes in a program that has been reviled by many physicians as a result of its numerous administrative hassles and difficulty in receiving fair payment.

**Federal Health Care Reform**

The ability of physicians to continue to deliver care is impacted by a number of federal policies that can only be addressed by Congress. These issues include:

**The Need For Reform Of The Medicare Sustainable Growth Rate (SGR) Formula**

Unless action is taken by Congress, physicians face a draconian 24% cut in their Medicare payments on March 31, 2014. While Congress has passed several measures in recent years to prevent the imposition of similar scheduled cuts, the short-term fixes and recent tendency of Congress to retroactively fix the cuts after permitting them to go into effect has left many physicians concerned and doubtful whether their offices can sustain continued participation in the Medicare program. According to a recent Wall Street Journal article, the number of physicians who have opted out of the Medicare program nearly tripled between 2009 and 2012.

"Medicare has really been pushing its luck with physicians," said economist Paul Ginsburg, president of the nonpartisan Center for Studying Health System Change. "By allowing the SGR and its temporary fixes to persist, Medicare is risking a backlash by senior citizens who say, 'Hey, this program isn’t giving me the access to doctors I need.'"


These cuts are driven by the flawed SGR formula which penalizes physicians by lowering their payments when growth in the use of medical care exceeds the GDP. This is done despite the fact that service use is driven by factors outside physician control such as patient health needs, emerging technology and public policy changes.
Physician overhead costs have gone up dramatically in the last decade, and other health care providers have received annual increase. Medicare physician payments are on average at the same level as they were 10 years ago.

A permanent repeal of this grossly unfair SGR formula must be enacted.

**Enactment of the Medicare Patient Empowerment Act**

It is imperative that Congress consider alternative solutions to fix this SGR problem if we are to assure that seniors will continue to have access to their physicians. One such solution is legislation (HR 1310), the Medicare Patient Empowerment Act, that would permit Medicare patients to have the option to privately contract with the physician of their choice, regardless of such physician’s participation status in Medicare, with CMS providing the patient with a partial contribution towards the cost of such care (http://thomas.loc.gov/cgi-bin/query/z?c113:H.R.1310:).

**Repeal of the Requirement to Implement ICD-10 Coding**

Physicians across the country face huge costs associated with complying with a CMS mandate to change their disease coding systems from ICD-9 to ICD-10 on October 1, 2014. Implementing the new mandated ICD-10 code sets requires physicians and their office staff to contend with 68,000 outpatient diagnostic codes ─ a five-fold increase from the current 13,000 codes. This is a massive administrative and financial undertaking for physicians, requiring education, software, coder training, and testing with payers. Physicians will be responsible for all of these costs, which, depending on the size of a medical practice, are estimated to range from tens of thousands to millions of dollars. MSSNY has joined many other state and national specialty societies across the country in asking CMS for a further delay in this implementation. Legislation (H.R. 1701/S.972) to repeal this requirement must be enacted (http://thomas.loc.gov/cgi-bin/query/z?c113:H.R.1701:).

**Protecting Team Based Care**

MSSNY working together with the AMA and federation of medicine will advocate to oppose efforts by the federal government to displace state authority to determine the proper scope of practice for various non-physician practitioners, such as the recent attempt by the Veterans Administration to permit independent practice by nurse practitioners in its facilities.

**Fixing PPACA**

- Repeal of the Independent Payment Advisory Board (IPAB)
- Assuring taxes imposed on health insurers are not passed along to consumers and physicians
- Eliminating the Excise Tax on comprehensive health insurance coverage
- Assuring additional funding for health insurance cooperatives
ENHANCING QUALITY OF CARE

PHYSICIAN-LED TEAM-BASED CARE IS BEST FOR PATIENTS

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

Specifically, MSSNY opposes expansion or creation of a scope of practice for:

- Nurse practitioners independent practice;
- Nurse anesthetists independent practice;
- Naturopaths providing primary medical care;
- Oral and maxillofacial dental surgeons performing surgery unrelated to dental health;
- Optometrists prescribing certain therapeutic pharmaceutical agents;
- Pharmacists conducting medical assessments, ordering or interpreting lab tests;
- Psychologists prescribing privileges;
- Nurse practitioners to admit a patient to an inpatient mental health unit or to become a “psychiatric examiner” to evaluate a defendant’s fitness to stand trial;
- Podiatrists performing wound care or other procedures beyond scope of legislation enacted in 2012; and
- Any other scope-of-practice expansion that could negatively affect patient outcome.

MSSNY supports enactment of legislation or promulgation of regulation to:

- preserve the term “physician” for the exclusive use of MDs and DOs, or their foreign equivalents;
- define “surgery” and limit its performance to licensed physicians, dentists and podiatrists, as appropriate;
- assure that the advertisements of all health care professionals adequately inform the public of their professional credentials and require that all health professionals wear badges which identify their professional title;
- enable otolaryngologists to dispense hearing aids of fair market value;
- license medical assistants, anesthesia assistants and assistants in orthopedic surgery; and
- protect against pharmacists who inappropriately advertise what immunizations they are allowed to administer.

MSSNY will oppose legislation to:

- allow for profit retail clinics manned by nurse practitioners or physician assistants only in pharmacy and retail stores; and
- alter the corporate practice of medicine by allowing limited license providers to be business partners with physicians in a medical practice.

ENHANCING QUALITY OF CARE THROUGH PEER REVIEW

Current law impedes peer review by permitting attorneys access to statements made at a peer-review meeting by a physician who subsequently becomes a party to a malpractice action which involves the conduct which was the topic of discussion at the peer-review meeting. MSSNY will work to enact legislation which would extend existing confidentiality protections to all statements and information volunteered at peer-review quality assurance committees within hospitals and in office-based settings. MSSNY will also advocate to protect from discovery by OPMC any statements made or information obtained during the course of a peer-review proceeding.

ENHANCING CARE THROUGH E-PRESCRIBING

E-prescribing is one of several solutions advanced to improved patient safety and quality of care through clinical decision support and ready access to patient medication history. The I-STOP law also mandated the electronic submission of all prescriptions by March 27, 2015. The law requires that the Prescription Monitoring Program (PMP) registry be compatible with e-prescribing technology which for the first time will facilitate the electronic transmission of controlled substances. The federal regulations specifically require software with two-factor identification for e-prescribing of narcotics. These products are being certified and marketed. Not all physicians, however, are interested in purchasing e-prescribing technology. The law does provide certain exceptions to the e-prescribing mandate and allows for the issuance of a one-year renewable waiver to physicians who can demonstrate
economic hardship, technological limitations that are not reasonably within the control of the physician, or other exceptional circumstance. MSSNY will work to assure that the waiver process is available to physicians for whom purchase and implementation of e-prescribing technology is impractical.

Additionally, MSSNY will work to assure the simplification of the process by which a physician secures an exception to use a paper prescription. MSSNY will also work to assure that the technologies used as part of the prescription drug monitoring registry are compatible with all e-prescribing systems so that physician consultation with the PMP registry is streamlined. Moreover, MSSNY will work to enable registered nurses working with a physician to be authorized to send an electronic prescription to the pharmacy much like a prescription today is phoned into a pharmacy by a nurse upon the verbal order of a physician.

**Enhancing Quality of Care and Coordination Through Health Information Technology**

The State Health Information Network of New York (SHIN-NY) is a secure network for sharing clinical patient data across providers of health care in New York State through Regional Health Information Organizations (RHIOs). The SHIN-NY is coordinated by the New York e-Health Collaborative (NYeC) in conjunction with the New York State Department of Health, and the state’s 11 RHIOs. Currently, the two main capabilities of the SHIN-NY are Direct Messaging and Patient Record Look-Up. Direct Messaging functions like a highly secure email, giving clinicians the ability to seamlessly exchange authenticated, encrypted clinical data with one another. Patient Record Look-Up is comparable to a highly secure search engine, allowing healthcare providers to retrieve individual patient records from across the network once they receive patient consent. A network is only as good as the quality and quantity of its information, so the more healthcare providers sign on and begin sharing clinical data, the better the results available to all. MSSNY will work to enhance voluntary physician participation on the SHIN-NY.

All medical records, whether they are stored electronically or in paper files, are protected under the Health Insurance Portability and Accountability Act (HIPAA). In New York, a patient must grant consent (“opt in” authorization) before health care providers may access the patient’s electronic medical record. MSSNY will work to protect the patient’s right to privacy in the intraoperative exchange of patient health information.

MSSNY, however, is unalterably opposed to any effort to link physician participation on a compulsory basis such as linking participation on the SHIN-NY to the re-registration of a physician’s license. MSSNY will support a permanent funding stream to enable the SHIN-NY to operate provided no surcharge or fee is imposed on physician services. Moreover, physicians should not have to pay a user fee or additional interface fees in order to participate on the SHIN-NY. MSSNY will vigorously oppose the imposition of such fees. MSSNY will work collaboratively to ensure that the standards developed to make such technology operational in communities across New York State will, in an affordable and user-friendly manner, improve efficiency and accuracy in the delivery of healthcare in New York State. MSSNY will also work to assure that standard interfaces are used by EHR vendors to enable intraoperative communications and plug-and-play connectivity at no added cost to physicians.

**Elimination of Health Care Disparities**

MSSNY’s Committee to Eliminate Health Care Disparities works to ensure that all New Yorkers receive the best possible care. This work includes attracting a more diversified physician workforce, increasing the numbers of minority faculty teaching in medical schools, expanding medical school pipeline programs in rural and urban areas to address the shortage of physicians in medically underserved areas of New York State, and, where appropriate, support for legislation that addresses the root problems of health care disparities. According to an August 2013 report on *New York’s Primary Care Workforce*, by the Center for Health Workforce Studies, Blacks/African Americans and Hispanics/Latinos were underrepresented in the primary care workforce compared to their presence in the population. While 14% of the general population is Black/African American, only 8% of primary care physicians are Black/African American. And while 17% of the general population is Hispanic/Latino, only 6% of primary care physicians are Hispanic/Latino.

MSSNY’s committee, in conjunction with the American Medical Association, conducts *Doctors Back to School* programs, in which physicians go into middle and high schools in areas with high minority populations and talk to students about choosing medicine as a career. Cultural competence and health literacy are both extremely important aspects of providing optimum health care to minority populations. Securing private reimbursement for language services for patients with limited English proficiency is essential. The collection and aggregation of health care and demographic data on a regional and institutional level is also necessary to facilitate analysis by race and
MSSNY’s long-standing commitment to finding real solutions to improve access to high-quality medical care for all New Yorkers is reflected in the work of its Committee to Eliminate Health Care Disparities.

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

The DCIMS pay hospitals in New York, especially in the New York City area, as much as $18 million per year to secure these slots to the detriment of U.S. medical students, who cannot secure clinical rotations in their desired locations, or possibly even in New York State. Texas recently passed legislation prohibiting offshore medical schools from purchasing clinical clerkship slots. MSSNY supports the action of the Board of Regents to initiate a review and oversight of clinical training sites in New York and to establish a moratorium on the approval of new clinical rotation slots for students from DCIMS until the capacity in New York State has been determined. MSSNY supports the American Medical Association’s policy that U.S. hospitals should meet the core clinical training needs of U.S. LCME/COCA accredited medical schools before they provide clinical training for students of any foreign medical school. Moreover, MSSNY will work with the Associated Medical Schools of New York (AMSNY) to secure legislation to prohibit the sale of clerkship slots to medical schools that are not LCME or COCA accredited.

ASSURING ACCESS TO NECESSARY CARE FOR PERSONS LIVING WITH MENTAL ILLNESS
Mental illness is very common and its impact on individuals and families can be profound. In any year, one in ten Americans experience a mental illness serious enough to impact their life at home, school or work. Mental illness is the leading illness-related cause of disability, a major cause of death (via suicide), and a driver of school failure, poor overall health, incarceration and homelessness. However, recovery is real; people with mental illnesses can live full, productive and meaningful lives in their communities.

The struggle to enact mental-health parity legislation in New York State spanned more than a decade. As a result, however, MSSNY working with the Timothy’s Law coalition succeeded in eliminating arbitrary outpatient and inpatient limits which differed from health care coverage limits and equalized co-payments and deductibles for mental-health services, thereby assuring children and adults living with mental illness adequate access to the care they desperately need. It is important to assure that health plans continue to comply with our mental-health parity laws. MSSNY will work to assure that products offered through New York’s health benefit exchange will comply with federal and state mental-health parity laws.

The state is moving forward with a plan to close many inpatient mental health facilities as part of its initiative to recognize regional centers of excellence in the delivery of clinical services for the mentally ill. The state’s inpatient capacity includes fifteen adult hospitals that served 6,500 individuals in 2012-2013 fiscal year and four children’s psychiatric centers and six units for children and youth attached to adult facilities which collectively served 2,038 children in the 2012-13 fiscal year. It is important that there exists meaningful access in every community to clinically and culturally competent mental-health care that supports recovery. For children, access to necessary services near family and friends is extremely important. Youth sent far away where there is minimal or no connection with the family greatly limits or prevents needed family participation in treatment plans and makes transition back home extremely difficult. In addition, there is insufficient availability of intermediate length of stay beds for children and adolescents with complex behavior disorders whose needs cannot be adequately served by short stay acute care beds in the community hospital system. Finally, adequate comprehensive community based services must be in place and operating to address the increased needs created by the closure of state-run intermediate length-of-stay beds. Therefore, MSSNY will oppose the closure of facilities, particularly children's facilities, when there is sufficient need within a community to require the continued existence of access to inpatient services.
The SAFE Act enacted last year further stigmatizes the mentally ill and may serve to deter persons with mental illness from seeking treatment for fear of being reported to the state-maintained database. The law currently requires certain health care professionals including physicians to make a report to the local director of community services when the health care professional concludes “in their reasonable professional judgment” that a patient “is likely to engage in conduct that would result in serious harm to self or others.” This standard differs from the existing standard (MHL 33.13(c)(6)) currently used to allow the report to be made when a patient is receiving treatment in an OMH or OPWDD licensed or operated facility. In such instances a physician or psychologist may report to law enforcement or the individual threatened if a patient presents a serious and imminent threat to health and safety of self or others. We believe that the mandate in the SAFE Act is so broad as to result in the reporting of many patients who would not be subject to reporting under the MHL 33.13(c)(6) standard. This over-reporting includes many patients whose mental illness would never require hospitalization. We are concerned that the existence of two standards will cause significant confusion among health care professionals and could result in the reporting of persons who do not pose a serious and imminent threat to society. MSSNY supports an amendment to the SAFE Act which would assure that only those who present a “serious and imminent to self or others” are reported. Moreover, MSSNY supports an amendment to the Act which would clearly do away with the private right of action which will result in litigation over the question of whether the reporter exercised reasonable professional judgment in the exercise of their duty. MSSNY seeks an amendment which would assure that the decision of a mental health professional to disclose or not to disclose, if exercised without malice or intentional misconduct, shall not be the basis for any civil or criminal liability.

**ATTRACTING AND RETAINING PHYSICIANS IN NEW YORK STATE**

The Center for Health Workforce Studies reported recently that the in-state retention of new physicians has gradually declined from a high of 54% in 1999 to the lowest since the survey began of 44% in 2012. This is particularly troubling as demand for physician services continues to outpace physician supply, particularly in ophthalmology, urology, psychiatry, pathology, general internal medicine, general/family medicine, and otolaryngology. There are areas of the state and populations that are already underserved by the current physician supply. The implications of the forecasts for these areas and populations are dire. New York must do more to attract and retain physicians. New York must:

- Reduce the overhead burden shouldered by physician practices through meaningful civil justice reform;
- Enhance revenue to physician practices by leveling the playing field for physicians in their negotiations with health insurers and by assuring the offering of out-of-network coverage which significantly reimburses for the reasonable cost of services;
- Continue an adequately funded Excess Medical Liability program to assure that physicians will have the coverage needed to protect them from personal financial exposure to escalating medical liability awards;
- Prevent the imposition of costly and burdensome certificate of need (CON) requirements on physician offices and equipment purchases;
- Put additional resources toward the *Doctors Across New York* program to allow for more cohorts of awardees and modify eligibility to assure a more equitable balance of awards between institutionally based and private practice physicians;
- Create income tax credits for physicians who practice in specialty shortage areas;
- Continue Medicaid reimbursement of primary care rates at Medicare levels beyond 2015;
- Defeat any proposal to directly or indirectly tax medical services, medical devices or products or sites of service; and
- Defeat any proposal to increase the biennial physician registration fee.
IMPROVING PUBLIC HEALTH IN NEW YORK STATE IN THE 21ST CENTURY

By every single public health measure, New Yorkers are healthier, live longer and have lives that are less likely to be marked by injuries, premature death or ill health. Without a doubt, life expectancy has increased, infant mortality has declined and vaccines and antibiotics have prevented life-threatening illness. Life in the home, workplace and on the road has become safer. There have been unparalleled medical advances and investment in health care that has led to improved health outcomes. New York State must do more to invest in programs that emphasize the main causes of disease, disability and health disparities. This, combined with enhanced health care coverage and delivery, will ultimately lead to improved health outcomes for New Yorkers. In 2013, the New York State Department of Health, along with the Medical Society of the State of New York and other major public health stakeholders created a blueprint for 2013-17 for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups who experience them. The five priority action plans are: Prevent Chronic Disease; Promote a Health and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; and Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Disease and Healthcare Associated Infections.

IMMUNIZATIONS AND INFECTIOUS DISEASES

Disease prevention is the key to public health. Vaccines prevent disease in the people who receive them and protect those who come into contact with unvaccinated individuals. Vaccines are responsible for the control of many infectious diseases that were once common in the United States. The Medical Society continues to be very concerned about those individuals who opt out of immunizations, including parents who decide not to immunize their children. Immunization is a sound public health policy and one that this country has chosen to implement. Therefore, the Medical Society will continue to oppose any further religious, medical or philosophical exemptions to New York State immunizations law.

The Medical Society of the State of New York will place an emphasis this year on programs that will improve adult immunization rates and will advocate for use of the adult and child schedule for immunizations as developed by the Advisory Council on Immunization Practices (ACIP). The Medical Society supports universal state purchase for all vaccinations. The Medical Society also supports the administration of Human Papillomavirus (HPV) Vaccine to females and males as means of preventing the transmission of HPV, cervical cancer and HPV-associated disease to individuals. MSSNY will continue to advocate for early screening and testing for STDs and will support expansion of the law to allow for the use of expedited partner therapy (EPT) for all STDs as recommended by the Centers for Disease Control and Prevention. Early detection of the HIV infection means that infected patients will have the opportunity to live years longer when treatment is initiated prior to the development of symptoms. The Medical Society continues to support the routinization of HIV testing for individuals ages 13-64. The Medical Society will also seek state and private resources to educate physicians on the new requirement on primary care physicians, hospitals and clinics to offer a hepatitis C test to every patient born between 1945-1960.

I-STOP IMPLEMENTATION

The I-STOP law “duty to consult” went into effect August 27, 2013 and requires most practitioners in New York State to check New York's Prescription Monitoring Program (PMP) Registry prior to prescribing a controlled substance in Schedules II, III, and IV. This law requires prescribers to review information in the PMP database on their patients’ prescription history. The law also requires pharmacists to enter the prescription into a database called the PMP within 24 hours of filling the prescription. Prior to the effective date, the Medical Society worked closely with the New York State Department of Health and expended significant resources to ensure that physicians were educated in regards to the requirements of the new law and to provide information to all prescribers about the establishment of a Health Commerce System Account. The Medical Society regularly communicated its strong concern that physicians were unable to obtain an HCS account due to the overwhelming demands placed upon the registration system. The Medical Society was pleased that, as a result of its interaction with the department, there was notification that practitioners who were making a good faith effort to apply but were unable to establish an HCS were temporarily permitted to provide treatment to their patients in the same manner as they had been doing, including the prescribing of controlled substances without accessing PMP registry.

However, the Medical Society, 15 specialty organizations and several patient-advocacy organizations believe that the I-STOP law has the potential for creating another barrier for thousands of New Yorkers to receive the necessary...
medications needed to help them lead active, productive lives. Therefore, MSSNY will seek various changes to the law, including further exemptions of certain patient populations from the law’s requirements and for certain types of drugs.

The I-STOP statute also enabled the DOH Work Group to make recommendations for continuing medical education (CME) for prescribers and pharmacists on pain management issues. The workgroup has made a recommendation to the commissioner for two hours of continuing medical education for all prescribers who prescribe less than 100 M.M.E per day/per patient and eight hours for those who prescribe more than 100 M.M.E per day/per patient. The Medical Society of the State of New York, the specialty societies, the American Board of Medical Specialties (ABMS), and the American Osteopathic Association (AOA) provide CME on pain management issues making the recommendation duplicative of existing educational offerings.

MSSNY remains opposed to the implementation of a topic-specific CME mandate including a mandate which would require physicians to complete coursework and training on pain management. Most physicians have been board certified or recertified by the ABMS or AOA every seven to ten years and as a result have completed much CME training. Others have completed a risk-management course or other appropriate liability course which includes risk-mitigation components including appropriate prescribing practices. In addition, many physicians have been certified by the DEA to prescribe suboxone and have already taken eight hours of CME training that includes pain management and prescription medication abuse. Moreover, the Food and Drug Administration Amendments Act of 2007 empowered the FDA to require a Risk Evaluation and Mitigation Strategy (REMS) from manufacturers to ensure that the benefits of a drug or biological product outweigh the risks. Essentially, REMS is a safety strategy to manage a known or potentially serious risk associated with a medicine which enables a patient to have continued access to the medicine because their physician has been trained to manage its safe use. REMS may be required by the FDA as part of the approval of a new product or for an approved product when new safety information arises. In addition, the American Medical Association and the National Specialty Association have developed webinars and courses on topics related to responsible opioid prescribing. Consequently, MSSNY will oppose a pain management CME mandate on physicians.

**PREVENTION OF CHRONIC DISEASES**

The Medical Society of the State of New York believes that primary prevention of diseases is important to the health and well-being of all New Yorkers. The Medical Society will continue to support programs for prevention and management of chronic disease that includes prevention and cessation of tobacco use, obesity, diabetes, cardiovascular disease and asthma. The Medical Society is a strong proponent of a healthy lifestyle and has developed policies in support of good nutritional choices for all New Yorkers. Under the Affordable Care Act (ACA), there will be increased coverage for counseling offered to individuals for quitting smoking, losing weight, eating healthfully, and reducing alcohol use. MSSNY supports legislation to limit the promotion of tobacco products in the state by all tobacco companies; prohibit the sale of tobacco products to anyone less than 21 years of age; and prohibit smoking in all pediatric settings. The Medical Society supports an increase in the New York State Tobacco Control Program and will support efforts to increase funding for New York’s obesity prevention program. The Medical Society also supports a temporary ban on marketing of high stimulant/caffeine drinks to children/adolescents under age 18 until such time as the scientific evidence regarding the possible adverse medical affects can be determined.

**PUBLIC HEALTH PREPAREDNESS, ENVIRONMENTAL AND GLOBAL HEALTH**

Ensuring that New York State residents are prepared and can respond to a public health emergency is important, especially in light of the hurricanes, flooding, and the advent of significant flu outbreaks and other emerging infections such as the coronavirus. The Medical Society is committed to helping to prepare New York State residents and physicians for the next public health emergency and will continue to educate physicians on emergency preparedness. The Medical Society of the State of New York in 2013 revised its policy on hydraulic fracturing to include support for a moratorium on natural gas extraction until valid information is available to evaluate the process for its potential effects on human health and the environment and to support the planning and implementation of a health impact assessment to be conducted by a New York State School of Public Health. Moreover, MSSNY will advocate for the establishment of an industry-funded, independently arbitrated state trust fund for people that may be harmed as a result of hydraulic fracturing, and MSSNY will oppose any non-disclosure provisions related to the practice of hydraulic fracturing that interfere with any aspect of the patient-doctor relationship and/or the ready collection of epidemiological data for future health-impact studies. The Medical Society will also support measures that will provide for more walk-able and bike-able communities.
WOMEN AND REPRODUCTIVE HEALTH

The World Health Organization defines maternal death as the death of a woman while pregnant or within 42 days of the end of a pregnancy, from any cause related to the pregnancy or its management. According to the New York State Department of Health’s Prevention Agenda for 2013-17, dramatic racial, ethnic, socioeconomic and geographic disparities exist in New York’s maternal mortality rate. “In New York City, pregnancy-related mortality rates were seven times higher for Blacks and twice as high for Hispanics and Asian/Pacific islanders than for Whites. For New York State overall, the maternal mortality rate for black women was approximately 3.7 times the rate for White women. Additionally, some poorest neighborhoods had rates almost five times higher than affluent neighborhoods. Women without health insurance had pregnancy-related death rates almost four times higher, than those covered by Medicaid or private insurance.” Health reform holds the potential to greatly expand access to coverage for millions of currently uninsured women and to stabilize coverage for many more. MSSNY will continue to work with the Department of Health to reduce the incidents of maternal deaths. The Medical Society will support efforts to ensure that women have access to reproductive and sexual health care services to help to reduce unintended pregnancy and will also help to promote knowledge about screening and services available. The Medical Society of the State of New York will oppose any legislation that criminalizes the exercise of clinical judgment in the delivery of medical care. The Medical Society supports efforts to expand access to emergency contraception, including making emergency contraception pills more readily available. The Medical Society will continue to support sexual health education amongst adolescents.
CONCLUSION
Recognizing that our health care delivery system is currently the subject of unprecedented examination, analysis, and change the Medical Society of the State of New York wishes to reiterate its commitment to policies which will meaningfully enhance the delivery of affordable medical care of the highest quality. The proposals set forth in our 2014 Legislative Program are not an all-inclusive list of our goals, nor are they an exhaustive list of the health issues that will be addressed in Albany during the upcoming state legislative session. Whatever the issue, organized medicine will work to assure that the interests of our physician members and, most importantly, the interests of our patients are fully recognized and reflected in all health policies and health legislation adopted by the State of New York during the coming year. We can do nothing less.