

MEDICAL SOCIETY OF THE STATE OF NEW YORK 2016 HOUSE OF DELEGATES

Report of the Reference Committee on Governmental Affairs and Legal Matters (B)

Presented by: Michael Goldstein, MD, Chair

Madame Speaker and Members of the House of Delegates:

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 109 New Review of For-Profit Health Insurance By Institute of Medicine
2. Resolution 118 Task Force on Home Care Services
3. 2016 Division of Governmental Affairs B SUNSET Report

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

4. Resolution 100 Unionization of Employed Physicians
- Resolution 101 Employed Physicians
5. Resolution 102 Employed Physicians
6. Resolution 103 Unionization Of Independent Physicians
7. Resolution 104 Formation Of A MSSNY Clearinghouse
8. Resolution 105 UCR-Based Out of Network Policies
- Resolution 106 Protecting Physician Choice in Mode Of Practice
9. Resolution 107 Protection Of Clinical Decision Making And Ownership Of Medical Practices
10. Resolution 108 Board Certification In Advertisements Or Marketing Materials To The Public
11. Resolution 111 Electronic Health Records, A Failure Of Health Care Reform
12. Resolution 115 Resolving E-Prescribing Problem
13. Resolution 116 Clinical Practice Guidelines As Safe Harbors

RECOMMENDED NOT FOR ADOPTION

14. Resolution 110 Health Savings Accounts
15. Resolution 117 "De-Fiscalizing" Lobbying

REFERRED TO COUNCIL

1 1. RESOLUTION 109 - NEW REVIEW OF FOR-PROFIT-HEALTH INSURANCE BY
2 INSTITUTE OF MEDICINE
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4 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 109 BE ADOPTED.**
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6 Resolution 109 directs the MSSNY to request the Institute of Medicine to report again on the for-
7 profit enterprise in health care.
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9 Your Reference Committee heard testimony which supports this Resolution. Your Reference
10 Committee was informed that throughout our history, medical institutions and insurers have
11 largely been "charitable," nonprofit establishments existing primarily to serve the community. But
12 in recent years, the number of for-profit health care facilities and insurers has grown at a quick
13 pace. The ethical implications of the growing commercialization of health care have become a
14 matter of heated controversy. Those favoring the trend toward health care for profit claim that an
15 increased role for entrepreneurs and competition in the delivery of health care will result in a
16 more efficient and effective health care system. For others, the pursuit of profit is antithetical to
17 the values central to medicine. This is not a new dynamic. Frankly, it is similar to that which
18 served as the foundation for the development and issuance in 1986 of the Institute of Medicine's
19 Report entitled *For-Profit Enterprise in Health Care*. The study took three years to complete and
20 consists of the committee report itself and a group of 15 papers, most of which conveyed
21 original research, that were prepared at the committee's request or as part of its work. It is a very
22 interesting and though-provoking document. Your Reference Committee agrees with the
23 sponsors of the Resolution that a second study should be prepared and should now incorporate
24 what the committee back in the mid -eighties lacked, data which show the experience and
25 influence of for profits interests in the financial underpinnings of our health care systems and the
26 implications for patient access to quality care.
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29 2. RESOLUTION 118 - TASKFORCE ON HOME CARE SERVICES
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31 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 118 BE ADOPTED.**
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33 Resolution 118 urges the MSSNY and the Home Care Association of New York State (HCA) to:
34 (1) form a taskforce to collaborate and assess issues relating to: (a) community physician
35 involvement in the development of care plans for home care services; (b) the transmission of
36 clinical information; (c) non-reimbursement resulting from delayed requests for physician orders;
37 (d) and administrative inefficiencies; and (2) that the results and recommendations of the
38 taskforce and collaboration between MSSNY and HCA be reported to the Long Term Care
39 Subcommittee of the Quality Committee for further action, such as: educational, regulatory or
40 legislative changes.
41

42 Your Reference Committee received testimony in support of this Resolution. At the most recent
43 meeting of the Long-Term Care Sub-Committee, the Home Care Association of New York State
44 presented on issues and challenges facing both home care agencies and physicians in the
45 course of working with one another to deliver home care services to the elderly and disabled.
46 Strong collaboration between the physicians ordering the medical care and the home care
47 agency staff providing home care services is necessary to achieve synergies, eliminate
48 inefficiencies and assure reimbursement for the care provided. Members of the LTC sub-
49 committee testified in furtherance of this collaboration. Your Reference Committee agrees with
50 these sentiments and therefore recommends that the Resolution be adopted.
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1 3. 2016 Division of Governmental Affairs B SUNSET REPORT

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3 **THE REFERENCE COMMITTEE RECOMMENDS THAT THE 2016 DIVISION OF**
4 **GOVERNMENTAL AFFAIRS B SUNSET REPORT BE ADOPTED.**

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7 4. RESOLUTION 100 - UNIONIZATION OF EMPLOYED PHYSICIANS

8 And

9 RESOLUTION 101 - EMPLOYED PHYSICIANS

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11 **THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE**
12 **RESOLUTION 100 BE ADOPTED IN LIEU OF RESOLUTIONS 100 AND 101.**

13
14 **RESOLVED, that the Medical Society of the State of New York form an Employed Physician**
15 **Section dedicated to addressing the interests of physicians employed in hospitals or other**
16 **settings; and be it further**

17
18 **RESOLVED, that the Medical Society of the State of New York (MSSNY) with its legal**
19 **counsel explore all avenues of representation of employed physicians including potential**
20 **affiliation with an existing union, formation of a union either directly or through an entity**
21 **affiliated with MSSNY, and any other manner of representation; and be it further**

22
23 **RESOLVED, that the efforts of the Medical Society of the State of New York (MSSNY) to**
24 **form an Employed Physician Section and to explore all avenues of representation of**
25 **employed physicians be initiated before the 2017 meeting of the MSSNY House of**
26 **Delegates.**

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28 Resolution 100 directs MSSNY to: (1) seek acceptable union partners and publicize union
29 membership as an option worth considering; and (2) initiate these organizational efforts
30 before the 2017 meeting of the MSSNY House of Delegates.

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32 Resolution 101 directs MSSNY to: (1) form an Employed Physician section dedicated
33 specifically to meeting the needs of MSSNY's employed members; and (2) work with its
34 legal counsel to explore all avenues available to become the recognized negotiating agent
35 for employed physician members in NYS.

36
37 Your Reference Committee heard testimony in support to each of these Resolutions and concurs
38 with the intention of the sponsors. Physician unions are not a new phenomenon. They have
39 existed for decades. For example, the Committee on Interns and Residents (CIR), which primarily
40 represents residents employed by hospitals, was founded in 1957. Doctors Council was formed
41 as the result of a merger between Doctors Association and Public Health Physician Association in
42 1978 and the Federation of Physicians and Dentists (FPD) was founded in 1981. The AMA in
43 1999 created a national labor organization called Physicians for Responsible Negotiation (PRN)
44 to represent employed physicians.

45
46 In 1998, a Task Force was created as a result of action taken by the House of Delegates which
47 passed a Resolution calling upon MSSNY to "pursue any and all remedies to enable physicians in
48 NYS to engage in collective bargaining with third party payors". The Task Force conducted legal
49 research and interviewed several unions with a view toward determining whether to create or
50 affiliate with a union. It ultimately recommended that MSSNY affiliate with PRN. PRN had some
51 early success and was allowed pursuant to a NLRB decision to facilitate an election at Lutheran
52 General Hospital in the Chicago area to determine whether the 170 residents at the hospital

1 wished to be represented by PRN. PRN, however, ran into great difficulty in organizing
2 physicians who were employed by hospitals as a result of a US Supreme Court ruling in 2001 in
3 which it was decided that hospital nurses are not eligible to become union members if they
4 supervise other employees. Shortly thereafter, PRN announced it would close down its effort to
5 organized employed physicians since physicians who are employed by health care facilities bear
6 the same disqualifying characteristics as do employed nurses.

7
8 The determination of whether a specific employee is a supervisor is identified under the facts of
9 each case. To this day, unions including Doctors Council and CIR among others continue to
10 represent the interests of residents and employed physicians. Hospitals continue to oppose these
11 efforts and wage legal battles over whether employed physicians are able to be organized into a
12 collective bargaining unit. Your Reference Committee felt that the health system landscape has
13 changed dramatically since the issuance of the Task Force reports. As health care economics
14 and the private practice environment shift in response to market and policy forces, physicians in
15 growing numbers are opting for direct employment with hospitals, health systems, and other
16 entities. Data from the Physicians Foundation's 2014 Survey of America's Physicians show that
17 only 35% of physicians describe themselves as independent practice owners, down from 49% in
18 2012 and 62% in 2008. In addition, 53% of physicians describe themselves as hospital or medical
19 group employees, up from 44% in 2012 and 38% in 2008. Moreover, the testimony received
20 supports a renewed focus on MSSNY representation of employed physicians. Since both
21 Resolutions 100 and 101 seek similar relief, your Reference Committee has combined them into
22 one substitute resolution which incorporates each facet of both Resolutions. In addition, for those
23 physicians who do not qualify for protection under the National Labor Relations Act, your
24 Reference Committee agrees that MSSNY should create a separate Employed Physicians
25 section to address other grievances and concerns raised by employed physicians.

26 27 28 5. RESOLUTION 102 - EMPLOYED PHYSICIANS

29 30 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 102 BE AMENDED BY** 31 **ADDITION.**

32
33 RESOLVED, that MSSNY examine governance structures of hospitals, physician group
34 practices, federally qualified health centers, clinics, urgent care practices and other health
35 care delivery facilities and physician employment contracts to determine the most effective
36 way to provide a grievance mechanism to resolve disputes between physicians and their
37 employers.

38
39 Resolution 102 directs MSSNY to examine the most effective way to provide a grievance
40 mechanism to resolve disputes between physicians and their employers.

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42 Your Reference Committee received testimony in support of and in opposition to this Resolution.
43 As health care economics and the private practice environment shift in response to market and
44 policy forces, physicians are opting for direct employment with hospitals, health systems, and
45 other entities in growing numbers. Data from the Physicians Foundation's 2014 Survey of
46 America's Physicians show that only 35% of physicians describe themselves as independent
47 practice owners, down from 49% in 2012 and 62% in 2008. In addition, 53% of physicians
48 describe themselves as hospital or medical group employees, up from 44% in 2012 and 38% in
49 2008. Your Reference Committee agrees with the sponsors of this Resolution that MSSNY
50 (perhaps through its Employed Physicians Section) should review the governance structures and
51 employment contracts used by health system stakeholders to identify best practices for the
52 resolution of grievances and complaints.

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3 6. RESOLUTION 103 - UNIONIZATION OF INDEPENDENT PHYSICIANS
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5 **THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE**
6 **RESOLUTION 103 BE ADOPTED IN LIEU OF RESOLUTIONS 103**
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8 **RESOLVED, That the Medical Society of the State of New York (MSSNY) explore with**
9 **legal counsel the legal ability to and cost associated with physicians unionizing under the**
10 **legal theory that physicians have *de facto* become part-time employees of insurance**
11 **companies; and be it further**
12

13 **RESOLVED, That the Medical Society of the State of New York explore whether any**
14 **established unions that represent employed physicians will support efforts to unionize**
15 **physicians in independent practice; and be it further**
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17 **RESOLVED, That the Medical Society of the State of New York explore ways to enhance**
18 **integration of independently practicing physicians through all legal means including IPAs,**
19 **ACOs in order to enhance their leverage in negotiations with managed care plans and**
20 **health insurers; and be it further**
21

22 **RESOLVED, That the Medical Society of the State of New York initiate its exploration of**
23 **the legal ability and cost associated with unionizing physicians in independent practice,**
24 **whether any unions will support efforts to unionize physicians in independent practice**
25 **and efforts to enhance integration of independently practicing physicians before the 2017**
26 **meeting of the MSSNY House of Delegates.**
27

28 Resolution 103 directs MSSNY to (1) encourage established unions of employed physicians to
29 support independent physicians' efforts to unionize under the legal theory that physicians have
30 *de facto* become part-time employees of insurance companies with regard to the treatment and
31 care of their insured; and (2) initiate these organizational efforts before the 2017 meeting of the
32 MSSNY House of Delegates.
33

34 Your Reference Committee heard much testimony in support of this Resolution. While it is clear
35 that non-supervisory physician and resident employees are able to collectively negotiate with
36 their employers, self-employer and independent practice physicians have less of a clear pathway
37 toward collective negotiation even though the insurance industry exerts significant control over
38 physician activities. The goal of antitrust policy is to promote free market competition to foster the
39 efficient allocation of society's resources. The Sherman Act was enacted to prevent horizontal
40 agreements among rivals and vertical agreements among firms along the supply process that
41 restrict trade. The courts have determined that some activities are by their very nature
42 unreasonable restraints of trade and these constitute per se violations of the Sherman Antitrust
43 Act. Physicians in a group practice may collectively negotiate fees with an insurer without being
44 subject to charges of price fixing because a group practice is viewed as a single entity. In
45 addition, the Department of Justice and the Federal Trade Commission have established
46 "antitrust safety zones" which allow joint negotiations only among physicians who have
47 sufficiently integrated their practices such that they are no longer viewed strictly as competitors.
48 Generally speaking, however, independent, self-employed physicians are not considered
49 employees for the purpose of the National Labor Relations Act. In *Ameri-Health-New Jersey*
50 *HMO and United Food and Commercial Workers Union, Local 56, AFL-CIO*, the union argued
51 that, based on Ameri-Health's control over the day-to-day operations of the medical practices,
52 the physicians were not independent contractors but rather *de facto* employees. The NLRB

1 applied the common law agency test for distinguishing between employees and independent
 2 contractors and determined that the physicians were more akin to independent contractors.
 3 Factors relevant to this decision included the extent of control exerted by the HMO, whether the
 4 HMO had any financial ownership of the physicians' practices, the extent of the physician's right
 5 to determine the size of their practice and with whom they would contract and the market share
 6 of Ameri-Health. Importantly, the decision recognized that AmeriHealth's market share of insured
 7 patients was only 10% and that almost all of the physicians involved in the lawsuit had also
 8 contracted with other insurance companies, including competing HMOs. This decision dates
 9 back to 1999. Clearly, the competitive landscape has changed significantly even since the
 10 issuance of this decision further tilting the power dynamic toward insurers with insurer
 11 consolidation causing regional markets to continue to be dominated by a dwindling number of
 12 health insurance companies. According to a 2014 report from the American Medical
 13 Association, 82% of the enrollees in the commercial managed care market in New York State
 14 were enrolled in just 5 health insurance companies. And the same report demonstrated that most
 15 regions of New York State had only two insurers dominating their markets. Insurer-physician
 16 contracts are typically non-negotiable. Additionally, they generally contain strict controls over
 17 utilization management, reimbursement amounts, financial incentives and access to specialists.
 18 They also may contain termination-without-cause clauses or ambiguous contract terms. The
 19 typical insurer-physician contracts are actually contracts of adhesion because physicians lack
 20 choice and the ability to negotiate terms. Your Reference Committee heard testimony in support
 21 of and in opposition to unionization of physicians. Your Reference Committee also heard
 22 testimony in support of efforts to integrate physician practices into IPAs and other entities. Your
 23 Reference Committee therefore recommends adoption of a substitute Resolution which seeks to
 24 achieve the objectives of the sponsor while also allowing for an analysis of the legal merits of
 25 and costs involving litigation testing the theory of whether physicians in private practice could be
 26 considered to be *de facto* employees. It also will enable MSSNY to move forward with efforts to
 27 enable greater integration of independent physician practices through all legal means including
 28 IPAs and ACOs.

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31 7. RESOLUTION 104 - FORMATION OF A MSSNY CLEARINGHOUSE

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33 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 104 BE AMENDED BY**
 34 **ADDITION AND DELETION.**

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36 RESOLVED, that MSSNY ~~collaborate with~~ **identify** regional physician groups, **IPAs and ACOs**
 37 which have already adopted New York State payment reform principles **having entered into**
 38 **value based payment contracts**, and are accepting new physicians, so that MSSNY can
 39 disburse information to its members who need **to develop a relationship with other physician**
 40 **practices in order to gain leverage in value based payment negotiations with health**
 41 **insurers, managed care plans and governmental payors a mechanism by which they can**
 42 **participate in the forthcoming Value-Based Payment Plan standard.**

43

44 Resolution 104 urges MSSNY to collaborate with regional physician groups which have already
 45 adopted NYS payment reform principles and are accepting new physicians so that MSSNY can
 46 disburse information to its members who need a mechanism by which they can participate in the
 47 forthcoming value-based payment plan standards.

48

49 Your Reference Committee heard testimony in support of this Resolution. Across the country,
 50 states are seeking to transform how health care is paid for by shifting from a volume-centric to a
 51 value-based payment (VBP) model. In June 2015, New York State released its report entitled *A*
 52 *Path Toward Value-Based Payment: Roadmap for Medicaid Payment Reform*, outlining the

1 state's plans to move 80-90 percent of managed care payments to providers from fee-for-service
 2 to VBP by 2020. The VBP plan is intended to enable providers to sustain the costs of care
 3 coordination, patient engagement initiatives, infrastructure, including information technology
 4 investments, and workforce training and redeployment that must accompany the shift of 25
 5 percent of acute care utilization to community-based settings. The Roadmap classifies VBP by
 6 levels of financial risk that a provider will assume, breaking it down into levels from 1 to 3. The
 7 levels are structured so that as providers move up a level, they will assume greater financial
 8 responsibilities for costs that exceed the benchmark and may be able to recoup a greater
 9 proportion of savings. This is significant. Only larger groups of physicians will have the
 10 experience and leverage to negotiate Level 2 and Level 3 VBP arrangements with insurers. A
 11 delegate described his history with a downstate IPA that saved his practice noting that there are
 12 several successful IPAs across NYS and that MSSNY can serve its members best by assuring
 13 they are made aware of the existence of these IPAs. Your Reference Committee believes that
 14 MSSNY can assist independent physician practices to align with other IPAs and ACOs in order
 15 to leverage better payment under VBP agreements by maintaining a database accessible to
 16 MSSNY member physicians with information concerning the relevant contact information for
 17 existing IPAs, ACOs and group practices in their community.

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20 8. RESOLUTION 105 UCR-BASED OUT-OF-NETWORK POLICIES

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And

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RESOLUTION 106 PROTECTING PHYSICIAN CHOICE IN MODE OF
 23 PRACTICE

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26 **REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE**
 27 **RESOLUTION 105 BE ADOPTED IN LIEU OF RESOLUTIONS 105 AND 106.**

28

29 **RESOLVED, that MSSNY continue to advocate strongly for preservation and expansion of**
 30 **usual, customary and reasonable (UCR) based out-of-network benefits available to our**
 31 **patients; and be it further**

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33 **RESOLVED, that MSSNY energetically and proactively educate physicians on the**
 34 **importance of a meaningful UCR-based out-of-network environment in order to maintain**
 35 **an acceptable practice environment for physicians desiring to practice in-network and**
 36 **those physicians who are employed by an institution; and be it further**

37

38 **RESOLVED, that MSSNY energetically and proactively educate physicians including the**
 39 **identification of access to other information including links to social media and to**
 40 **successfully implemented business strategies concerning how the meaningful UCR-**
 41 **based out-of-network environment may be a viable option for physicians who wish to**
 42 **maintain independent out-of-network practices; and be it further**

43

44 **RESOLVED, That MSSNY proactively educate patients, employer groups and insurance**
 45 **agents on a UCR- based out-of-network plan.**

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47 Resolution 105 urges MSSNY to: (1) continue to advocate strongly for preservation and
 48 expansion of usual, customary and reasonable (UCR) based out-of-network benefits available to
 49 our patients; (2) educate physicians on the importance of a meaningful UCR-based out-of-
 50 network environment in order to maintain an acceptable practice environment for physicians
 51 desiring to practice in-network and those physicians who are employed by an institution; and (3)
 52 educate patients, employer groups and insurance agents on a UCR-based out-of-network plan.

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2 Resolution 106 urges MSSNY to (1) proceed to energetically and proactively let physicians know
3 that out-of-network practice may be a viable alternative available to them; (2) proceed to remind
4 physicians that the existence of all these alternatives is a crucial condition for improving the
5 situation for physicians who do practice in network or as hospital employees; (3) develop an
6 encompassing system of providing information to physicians about all modalities of practice
7 available including by recruiting volunteer MSSNY members to counsel physicians on their
8 options one on one; (4) proceed to energetically and proactively use all of its communication
9 vehicles in order to let physicians know about modalities other than in network and hospital
10 employment that may still be a viable alternative for them; and (5) use MSSNY volunteers to
11 serve as mentors- including physicians who belong to Independent Doctors of New York, and
12 those who belong to the Out-Of-Network Preservation Group.

13
14 Your Reference Committee heard testimony in support of each of these Resolutions and concurs
15 with the intention of the sponsors to advocate to preserve and to expand out of network
16 opportunities for physicians in private practice. Notably, MSSNY has long advocated for a UCR
17 based reimbursement model for out of network physicians and succeeded in 2014 in requiring
18 insurers to describe coverage in a manner based on the percentage of the usual and customary
19 cost of out of network health care services rather than as a percentage of Medicare payment
20 rates. This provides important information to assure that the patient in real terms knows the
21 extent of their coverage limitations and out of pocket costs. Your Reference Committee
22 especially agrees that both physicians and patients need more education as to why a UCR
23 based out of network environment is both financially viable for physicians and conveniently
24 optimal for quality care for our patients. Your Reference Committee received testimony
25 concerning efforts from outside entities which seek to align with MSSNY and which seek to
26 proactively energize practicing physicians to maintain financially viable out of network practices.
27 Consequently, your Reference Committee recommends the linkage of MSSNY generated
28 educational material to other publications which including links to social media and to stories
29 concerning business strategies describing how UCR based out of network practice has worked
30 for certain physicians in lieu of the third and fifth Resolveds in Resolution 106. Your Reference
31 Committee recommends adoption of the substitute Resolution which incorporates other key
32 recommendations from each Resolution.

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35 9. RESOLUTION 107 - PROTECTION OF CLINICAL DECISION MAKING AND OWNERSHIP
36 OF MEDICAL PRACTICES

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39 **THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING:**

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41 **RECOMMENDATION A: THE REFERENCE COMMITTEE RECOMMENDS THAT THE FIRST**
42 **RESOLVED OF RESOLUTION 107 BE ADOPTED.**

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44 **RECOMMENDATION B: THE REFERENCE COMMITTEE RECOMMENDS THAT THE**
45 **SECOND RESOLVED OF RESOLUTION 107 BE ADOPTED.**

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47 **RECOMMENDATION C: THE REFERENCE COMMITTEE RECOMMENDS THAT THE THIRD**
48 **RESOLVED OF RESOLUTION 107 BE NOT ADOPTED.**

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50 **RECOMMENDATION D: THE REFERENCE COMMITTEE RECOMMENDS THAT**
51 **RESOLUTION 107 BE ADOPTED AS AMENDED.**
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2 Resolution 107 urges MSSNY to seek legislation and/or regulation: (1) to enable the sharing in
3 fees of professional services in a medical practice with other medical professionals licensed by
4 the New York Department of Education; (2) for medical practices sharing in fees which ensures
5 physicians maintain total control of all clinical judgment and clinical decision-making; and (3)
6 which ensures physician majority ownership in a medical practice sharing in fees with other
7 medical professionals licensed by the New York State Department of Education.

8
9 Your Reference Committee heard testimony in support of this Resolution. Your Reference
10 Committee was informed that many ancillary health care professionals have collectively
11 advanced legislation (S. 5862, LaValle/ A.8153, Peoples-Stokes) to form multidisciplinary
12 partnerships limited liability companies, and professional service corporations with physicians.
13 This is currently prohibited by various laws including the corporate practice of medicine
14 doctrine. They argue that the advent of patient-centered medical homes, health homes and
15 accountable care organizations and value based payment are shifting health care delivery to
16 more collaborative models rendering existing legal prohibitions on the formation of limited
17 liability companies, partnerships and professional service corporations by allied health
18 professionals with physicians outdated. While the Reference Committee saw real value in
19 sharing fees with ancillary health care professionals including behavioral health care
20 professionals, a large amount of testimony was received in opposition to efforts to enable the
21 formation of business corporations by multi-disciplinary professionals. Current law (Sec.
22 6530(19)), however, prohibits physicians from sharing in the fees for a professional service
23 other than with a partner, employee, associate in a professional firm or corporation. This
24 Resolution seeks to afford ancillary non-employee health professionals the ability to share fees
25 with a physician practice to enable payment for care coordination without destabilizing existing
26 professional corporations or jeopardizing physician health care decision making. This will
27 enable physician practices to pay for behavioral care coordination without hiring new employees
28 and without disrupting legitimate existing structural corporate limitations.

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31 10. RESOLUTION 108 BOARD CERTIFICATION IN ADVERTISEMENTS OR
32 MARKETING MATERIALS TO THE PUBLIC

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34 **REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE**
35 **RESOLUTION 108 BE ADOPTED IN LIEU OF RESOLUTION 108.**

36
37 **RESOLVED, that the Medical Society of the State of New York support legislative and**
38 **regulatory efforts to require that physicians truthfully disclose their educational**
39 **background and board certification where applicable in all advertising to the public.**

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41 Resolution 108 urges MSSNY to amend MSSNY Policy 240.987 to read (new language
42 underlined), "MSSNY will advocate for proactive enforcement of New York State regulation that
43 gives patients the necessary information to make informed decisions about who is providing their
44 health care and also seek enactment of legislation to require all health care professionals in all
45 health care settings to wear identification tags that state their professional designation in large
46 block letters PHYSICIAN, NURSE, PHYSICIAN ASSISTANT, etc. and, to state which of the
47 American Board of Medical Specialties certifying board(s) he/she is certified with in any and all
48 advertisements or marketing materials to the public.

49
50 Your Reference Committee heard testimony in support and in opposition to this resolution. Your
51 Reference Committee was informed that MSSNY has for several years participated collegially
52 with other state and national specialty societies and the AMA in advancing Truth in Advertising

1 legislation to assure that patients are adequately informed of the credentials of the health care
2 professional treating them. Studies confirm increasing patient confusion regarding the many
3 types of health care providers – including physicians, nurses, physician assistants, technicians
4 and other varied providers. A survey conducted by the AMA’s Scope of Practice Partnership
5 revealed that: 54% of patients incorrectly believe an optometrist is a medical doctor; 35% of
6 patients believe a nurse with a “doctor of nursing practice” degree is a medical doctor; and 44 %
7 of patients believe it is difficult to identify who is a licensed medical doctor and who is not by
8 reading what services they offer, their title and other licensing credentials in advertising or other
9 marketing materials. Importantly, the legislation currently before the legislature would require: (1)
10 that advertisements for services to be provided by health care practitioners identify the type of
11 professional license held by the health care professional; (2) all advertisements to be free from
12 any and all deceptive or misleading information; and (3) health care practitioners to wear an
13 identification name tag during patient encounters that includes the type of license held by the
14 practitioner. Several of those who testified asked that the issue of identification name tags on
15 which MSSNY already has a policy should be treated separately from the issue of education
16 background and board credentials. Consequently, your Reference Committee recommends
17 adoption of the substitute resolution.

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20 11. RESOLUTION 111 - ELECTRONIC HEALTH RECORDS, A FAILURE OF HEALTH CARE
21 REFORM

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THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING:

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**RECOMMENDATION A: THE FIRST RESOLVED IN RESOLUTION 111 BE NOT
26 ADOPTED.**

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RECOMMENDATION B: THE SECOND RESOLVED IN RESOLUTION 111 BE ADOPTED.

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RECOMMENDATION C: THE THIRD RESOLVED IN RESOLUTION 111 BE ADOPTED.

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RECOMMENDATION D: THAT RESOLUTION 111 BE ADOPTED AS AMENDED.

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Resolution 111 asks MSSNY to: (1) urge the AMA to research the failure of Electronic Health
Records (EHRs) to achieve their stated goals and to ascertain the validity, value and accuracy of
various EHRs; (2) urge payers to issue a moratorium on penalties for those that do not utilize a
EHRs since they have not evolved adequately; and (3) adopt AMA policy H-478.993 that public
and private insurers should not require the use of electronic medical records.

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Your Reference Committee heard testimony in support of the Resolution. It was noted, however,
that the AMA has published a number of reports concerning issues which have served to impede
interoperability and disappoint physicians with regard to the functionality and usability of EHRs.
The AMA partnered with RAND on a prominent study that found cumbersome EHR systems are
taking a toll on physicians who feel increasingly demoralized by technology that interferes with
their ability to provide first rate medical care to their patients. Also, in order to leverage the power
of EHRs for enhancing patient care, improving productivity and reducing administrative costs, the
AMA published a framework of eight priorities for improving EHR usability. The AMA has also
issued a blueprint for the future of the Meaningful Use program with recommendations to
improve EHR functionality. Given the amount of work already conducted by the AMA on
improving EHR technology your Reference Committee recommends that the first Resolved be
not adopted. Moreover, your Reference Committee was informed that MSSNY’s HIT Committee
has conducted a survey of physicians on EHR usability and received similar results to those

1 produced by the AMA study. Your Reference Committee, therefore, agrees that until such time
 2 as EHR functionality and usability improves, physicians should not be penalized for not using
 3 EHRs. Moreover, we also agree that physicians should not be required by public or private
 4 payers to use EHRs. Consequently, your Reference Committee recommends the adoption of the
 5 remaining two Resolveds.

6
 7
 8 12. RESOLUTION 115 RESOLVING E-PRESCRIBING PROBLEM

9
 10 **THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE**
 11 **RESOLUTION 115 BE ADOPTED BE IN LIEU OF RESOLUTION 115.**

12
 13 **RESOLVED, that the Medical Society of the State of New York (MSSNY) urge the New York**
 14 **State Health Department's Bureau of Narcotic Enforcement (BNE) to issue rules**
 15 **permitting physicians to prescribe via paper/fax/phone in situations where the patient**
 16 **needs to comparison shop among pharmacies; and be it further**

17
 18 **RESOLVED, that the Medical Society of the State of New York (MSSNY) urge the New York**
 19 **State Department of Health's Bureau of Narcotics Enforcement (BNE) to make regulatory**
 20 **changes to enable pharmacies that do not have a particular medication in stock the ability**
 21 **to transmit the prescription to another pharmacy that has the needed medication in stock;**
 22 **and be it further**

23
 24 **RESOLVED, that the Medical Society of the State of New York (MSSNY) urge the AMA to**
 25 **work with the DEA and other appropriate federal agencies to enable the use of tokens in**
 26 **multiple care settings; and be it further**

27
 28 **RESOLVED, that the Medical Society of the State of New York (MSSNY) encourage**
 29 **member physicians to record incidents in which a patient is harmed by the law's ban on**
 30 **prescribing via paper/phone/fax and provide that data showing evidence of patient harm**
 31 **which has occurred as a result of e-prescribing to MSSNY for its ongoing dialogue with**
 32 **the New York State Health Department's Bureau of Narcotic Enforcement (BNE) and the**
 33 **New York State Legislature on e-prescribing issues.**

34
 35
 36 Resolution 115 urges the MSSNY to: (1) urge the New York State Health Department's Bureau
 37 of Narcotic Enforcement (BNE) to issue rules permitting physicians to prescribe via paper/fax/
 38 phone in situations where the patient is frail, elderly, speaks limited English, does not know the
 39 business hours of his/her preferred pharmacy, or needs to comparison shop among pharmacies;
 40 (2) urge the New York State Health Department's Bureau of Narcotic Enforcement (BNE) to
 41 provide physicians with guidelines for ascertaining in advance whether a particular pharmacy has
 42 a needed medication in stock; (3) urge the New York State Health Department's Bureau of
 43 Narcotic Enforcement (BNE) to clarify the law's requirements that physicians report electrical/
 44 technological failures (or temporary exigent problems) that have caused them to prescribe via
 45 paper/phone/fax, and that physicians report when they have provided a prescription by paper/
 46 fax/phone to be filled out of state, explaining: (a) Where - or to what agency, department or
 47 address - the physician must report the incident; (b) Via what portal, website or mechanism the
 48 physician must report; and (c) What information the physician must include in the report; (4) urge
 49 the New York State Health Department's Bureau of Narcotic Enforcement (BNE) to describe and
 50 explain the privacy safeguards that are built into key parts of the e-prescribing system such as
 51 the Surescripts network); (5) urge the New York State Health Department's Bureau of Narcotic
 52 Enforcement (BNE) to issue guidelines for a variety of e-prescribing situations, including: (a) The

1 prescription is to be sent to a mail-order pharmaceutical supplier; (b) The physician is ordering a
2 refill; and (c) The physician has two e-prescribing systems — e.g., one system belonging to the
3 group practice to which he/she belongs, and a second system belonging to himself/herself; (6)
4 encourage member physicians to record incidents in which a patient is (or might be) harmed by
5 the law's ban on prescribing via paper/phone/fax; and (7) use those records in its ongoing
6 dialogue with the New York State Health Department's Bureau of Narcotic Enforcement (BNE)
7 about e-prescribing issues.

8
9 Your Reference Committee received much testimony in support of this Resolution. The
10 sponsors have raised many important concerns regarding timely patient access to medically
11 necessary medications under the newly implemented e-prescribing mandate. However, new
12 information which addresses some of the concerns raised in some of the Resolveds has become
13 public since the development of this Resolution.

14
15 **With regard to the first Resolved**, your Reference Committee notes that current law now
16 addresses some of the issues raised in the first Resolved, particularly as the examples involve
17 the frail elderly or limited English speaking patients. In those instances where the physician
18 reasonably determines that it would be impractical for the patient to obtain substances
19 prescribed by electronic prescription in a timely manner and such delay would adversely impact
20 the patient's medical condition, a paper prescription can be written, provided that if it is for a
21 controlled substance, the quantity cannot exceed a 5 day supply. Moreover, e-prescribing
22 systems already provide for the business hours of pharmacies. However, that part of the first
23 Resolved which calls for changes to allow for comparison shopping among pharmacies should
24 be retained and adopted. In fact, Assemblyman Richard Gottfried has prepared draft legislation
25 that would allow for prescriptions to be sent to the cloud and to be retrieved from the cloud by the
26 pharmacist upon request by the patient. Consequently, that language should remain in the body
27 of a Resolution adopted by the House of Delegates.

28
29 **With regard to the second Resolved**, state and federal regulators have been consulting with
30 the healthcare industry and now recognize the problems presented when a pharmacy is out of
31 stock of the medication for which the e-prescription was transmitted. DEA and state rules
32 currently prohibit a pharmacy which doesn't have the particular medication in stock from
33 transferring an electronic prescription for a controlled substance to another pharmacy. Resolution
34 of this issue affects patient access to timely access to medically necessary care. Consequently,
35 to assure that the rules are modified to allow for an out of stock pharmacist to transmit the
36 prescription to another pharmacy which has the medication in stock language should remain in
37 the body of a Resolution adopted by the House of Delegates.

38
39 **With regard to the third Resolved**, MSSNY is urged to request that BNE clarify the reporting
40 requirements for physicians who have not received waivers who have issued paper prescriptions
41 because they have invoked one of three statutory exceptions (loss of technology or power,
42 patient harm or prescription to be filled out of state). On March 24th, BNE informed MSSNY that
43 each time a physician issues a paper prescription they must electronically send the following
44 information concerning each paper prescription issued: prescriber's name, address, email
45 address, phone number, license number patient's initials, and section of law cited for use of an
46 exception. Since the requested action contained in this Resolved has been provided, your
47 Reference Committee recommends that the language not be included in the body of a
48 Resolution adopted by the House of Delegates..

49
50 **With regard to the fourth Resolved**, your Reference Committee is informed that the DEA
51 interim final regulations promulgated in 2010 establish the privacy and security protocols for e-
52 prescribing systems. As noted on page two of the DOH FAQ's, security requirements can be

1 found on the Drug Enforcement Agency's (DEA) web page at:
2 http://www.deadiversion.usdoj.gov/ecomm/e_rx/ . Your Reference Committee respectfully
3 acknowledges the importance of information requested the fourth Resolved but given the fact
4 that BNE has already provided this information, your Reference Committee recommends that the
5 language not be included in the body of a Resolution adopted by the House of Delegates.
6

7 **With regard to the fifth Resolved**, BNE has maintained on its website a *Frequently Asked*
8 *Questions* page which has been regularly updated and which addresses the issues delineated in
9 the fifth Resolved. Page 23 of the FAQs, Q&A.129 makes it clear that a paper prescription may
10 be used where the pharmacy, including mail order pharmacies is out of state. Whether a
11 pharmacy must electronically receive a prescription is dependent upon whether it is registered
12 with the NYS Board of Pharmacy. Pharmacies located outside of NYS do not have to comply
13 with our e-prescribing law if they are not registered with the NYSBP; however, those that are
14 registered with NYSBP must comply. A refill is part of an original prescription and should be
15 distinguished from the reissuance of a prescription. Regulations prohibit refills for schedule II
16 and certain other substances. Some of those substances may be prescribed for a three or six
17 month supply provided that special codes are entered onto the prescription but prescriptions for
18 these substances do not allow for refill and a prescription must be re-issued for the substance
19 when the supply is exhausted. The e-prescribing mandate does not affect these rules.
20 Physicians using more than one e-prescribing system, particularly if they are going to e-prescribe
21 controlled substances must, according to DEA regulations which established the rules for e-
22 prescribing, utilize a system that has been certified for e-prescribing. To sign a controlled
23 substance prescription, the electronic prescription application must require the practitioner to
24 authenticate to the application using an authentication protocol that uses two of the following
25 three factors : (1) something only the practitioner knows such as a password or response to a
26 challenge question; (2) something the practitioner is, biometric data such as a fingerprint or iris
27 scan; or something the practitioner has, a device (hard token) separate from the computer to
28 which the practitioner is gaining access (21 CFR 1311.115). Software for e-prescribing has
29 unique hard tokens and cannot be shared between systems. While the issue of allowing tokens
30 to be shared is a focus of discussion on the federal level including at the National Strategy for
31 Trusted Identities in Cyberspace, we are not yet there. Consequently, physicians who provide
32 care in several distinct settings will need to carry multiple hard tokens to facilitate authentication
33 for purposes of prescribing controlled substance. Your Reference Committee respectfully
34 acknowledges the importance of the information requested by the fifth Resolved and
35 acknowledges that much of the information requested has been provided by BNE. However, the
36 problem presented by multiple tokens continues to persist. Consequently, your Reference
37 Committee recommends that language that urges the DEA to continue to work to permit one
38 token to be used in multiple care settings should be included in the body of a resolution adopted
39 by the House of Delegates.
40

41 **With regard to the sixth and seventh Resolveds**, MSSNY, since the enactment of I-STOP
42 (despite its clear and strong advocacy against the law) has been working and will continue to
43 work collaboratively with the Bureau of Narcotics Enforcement on the implementation of each
44 and every component of the Internet System for Tracking Over-Prescribing (I-STOP) program.
45 To the extent that MSSNY, through its physicians, is able to produce evidence of patient harm
46 resulting from the rules associated with the e-prescribing mandate, MSSNY will provide that data
47 to BNE in an expeditious manner. Consequently, your Reference Committee recommends
48 adoption of language to that effect in the body of a resolution adopted by the House of
49 Delegates.
50
51
52

1 13. RESOLUTION 116 CLINICAL PRACTICE GUIDELINES AS SAFE HARBORS

2
3 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 116 BE AMENDED**
4 **BY ADDITION.**

5
6 RESOLVED, that the Medical Society of the State of New York **seek legislation to** create a
7 demonstration project which establishes use of **the appropriate specialty medical society**
8 **developed** evidence-based clinical guidelines as a safe harbor **in any subsequent medical**
9 **liability litigation that may arise.**

10
11 Resolution 116 urges MSSNY to create a demonstration project which establishes use of
12 evidence-based clinical guidelines as a safe harbor.

13
14 Your Reference Committee heard testimony in support of this Resolution. Your Reference
15 Committee agrees that evidence based clinical guidelines could form a ceiling of reasonableness
16 as a safe harbor in medical malpractice litigation. More than 75% of all physicians are likely to be
17 named in a liability claim in their lifetime. Because of the ambiguity that can exist as to what is
18 reasonable medical care, medical liability litigation is often reduced to a battle of medical experts
19 resulting in unpredictable jury decisions that foster defensive medicine. Safe harbors are
20 designed to protect physicians from liability risk if they provide care that follows approved clinical
21 practice standards. If an adverse event occurs and a liability claim is asserted, safe harbors
22 operate by establishing a presumption of non-negligence if the named physician adhered to the
23 applicable guideline. They can also be a mechanism to facilitate rapid and accurate evaluation of
24 claims for their merit, taking some of the current ambiguity out of the adjudication system. While
25 the potential benefits associated with the use of physician developed clinical guidelines as safe
26 harbors in the liability setting is strong, producing reliable guidelines takes time and money and
27 even when developed may not necessarily be flexible in their application. Also, keeping
28 guidelines up to date may prove challenging. Moreover, legislative recognition for the use of
29 guidelines as a safe harbor would need to be enacted. In addition, your Reference Committee
30 was of the opinion that only guidelines developed by the appropriate specialty society should be
31 used as safe harbors for purposes of such a demonstration. Consequently, your Reference
32 Committee agrees with the sponsors of this Resolution that a demonstration project which tests
33 the impact of specialty medical society developed evidence-based clinical guidelines on the
34 medical legal environment is valuable and recommends amendment of the Resolution in order to
35 enable safe harbor protection to extend to the cases to which the safe harbor would apply.

36
37
38 14. RESOLUTION 110 HEALTH SAVINGS ACCOUNTS

39
40 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 110 BE NOT**
41 **ADOPTED.**

42
43 Resolution 110 urges MSSNY to: (1) support health savings accounts for all individuals,
44 regardless of health insurance status; (2) ask our state legislators to seek changes to the tax
45 code to allow income tax deductions for health savings accounts not linked to health insurance
46 policies; and (3) ask our AMA to support health savings accounts for all individuals, regardless of
47 health insurance status; and to seek changes in the tax code to allow income tax deductions for
48 health savings accounts not linked to health insurance policies.

49
50 Your Reference Committee heard minimal testimony in support of this Resolution. Your
51 Reference Committee was informed that as currently structured, a Health Savings Account is a
52 special purpose account used in conjunction with a High Deductible Health Plan. HSAs offer

1 consumers a different way to pay for health care. HSAs enable consumers to pay for current
 2 health expenses and save for future qualified medical expenses, including retiree health
 3 expenses, on a tax-free basis. However, in order to take advantage of HSAs, the patient must be
 4 covered by a High Deductible Health Plan (HDHP). An HDHP generally costs less than what
 5 traditional health care coverage costs, so the money that is saved on insurance can therefore be
 6 put into the Health Savings Account. If the patient loses the HDHP, they can continue to spend
 7 money from the HSA on medical services but they cannot contribute into the HSA when they do
 8 not have an HDHP. HSA contributions are exempt from both federal and New York State taxes.
 9 The sponsors of this resolution in effect want to enable individuals to remain uninsured and to
 10 pay for their care using a savings account. They seek positive tax treatment for contributions
 11 made to a savings account dedicated for payment of medical care. The thought process behind
 12 insurance of any type, whether it is for health care or for the home, car or life is the unpredictable
 13 nature of life itself. We cannot predict floods, tornados or sudden death; nor can we predict an
 14 unexpected serious illness and the medical bills that will accrue as a result. People without
 15 health insurance often find that medical bills add up quickly and these individuals can easily go
 16 into debt and could face bankruptcy. This can easily happen even if they put aside money in a
 17 savings account dedicated for health care needs. However, if these individuals had an HDHP,
 18 their costs to a large degree would be covered by the HDHP. They would be less likely to go into
 19 debt or face bankruptcy. Moreover, it is well established that people that have health insurance
 20 will be far more likely to visit the doctor on a regular basis. These routine checkups will allow a
 21 person to have a better understanding of their body and will help encourage a healthier lifestyle.
 22 While states are experimenting with Health Savings Opportunity programs, particularly in
 23 Medicaid, they are always linked to some form of health insurance. At the federal level, the AMA
 24 has historically expressed opposition to permitting the use of health savings accounts not linked
 25 to high-deductible health plans. However, their current policy positions express a stance of
 26 advocacy for HSAs in its campaign for health insurance market reform. Much has changed in the
 27 health insurance market in recent years, and de-linking HSA eligibility from high deductible
 28 health plans, can help address ever-increasing health care costs and make health care more
 29 affordable. This perspective, however, envisions some form of insurance policy associated with
 30 the health savings account. For the above stated reasons, your Reference Committee
 31 recommends that the Resolution be not adopted.

32
 33
 34 15. RESOLUTION 117 "DE-FISCALIZING" LOBBYING

35
 36 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 117 BE NOT**
 37 **ADOPTED.**

38
 39 Resolution 117 urges the MSSNY to: (1) proactively and publicly support public funding of
 40 political campaigns and oppose the continuation of private donations to politicians; (2) seriously
 41 consider and discuss curtailing the making of political contributions as a means of gaining entrée
 42 to or influencing politicians; (3) identify MSSNY members who have relationships with politicians
 43 and concentrate on using those relationships to reach out to the politicians in a non-fiscalized
 44 manner; and (4) recommend to physicians that during legislative visits on any topic money
 45 should be the last item on the agenda, so that medical and social perspectives may be covered
 46 first.

47
 48 Your Reference Committee heard testimony in support of and in opposition to this Resolution.
 49 Your Reference Committee was informed that our lobbying efforts are focused on the substance
 50 of health policy changes we either advance or work to defeat. At no time are these efforts linked
 51 to the work of the MSSNYPAC. At no time ever during a visit with an elected official is campaign
 52 contributions discussed. Indeed, the discussing of campaign contributions during a discussion of

1 health policy with a legislator is strictly prohibited. The law prohibits gifts of more than nominal
2 value given to a public official in any form including but not limited to money, service, loan, travel,
3 lodging, meals, refreshments, entertainment, discount, forbearance or promise, having monetary
4 value. Excluded from this prohibition are contributions made to candidate political action
5 committees. The work of MSSNYPAC is conducted by an Executive Committee that is distinct
6 from the work performed by our Committee on Legislative and Physician Advocacy which
7 develops and advocates in support of our annual legislative program. MSSNY's legislative
8 victories, and there are many, are secured as a result of the work of your physician leadership, a
9 seasoned lobbying team and grassroots advocacy by thousands of physicians who regularly
10 reach out to and interact with their elected representatives on a local level. MSSNY has a
11 number of legislative priorities on which it focuses much attention. Public financing of campaigns,
12 while an interesting political discussion, is not at the forefront of the many important public policy
13 issues threatening the viability of physician practice and quality of health care for the residents of
14 New York State. Moreover, Given the huge contributions by groups that have diametrically
15 opposed policy agendas, unilateral disarmament could prove disastrous to the physician
16 community. Therefore, for the reasons noted above, your Reference Committee recommends
17 that this Resolution be not adopted.

18
19
20

Your Chairperson is grateful to the Committee Members, namely, Gina Del Savio, MD, Mary Ann Millar, MD, Alan Diaz, MD, Kara Kvilekval, MD and Willie Underwood, MD.

Your Reference Committee Chairman also wishes to express his appreciation to Elizabeth Dears Kent, Esq., James P. McPartlon and Anna Cioffi for their help in preparation of this report.

Respectfully submitted,

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