MEDICAL SOCIETY OF THE STATE OF NEW YORK 2015 HOUSE OF DELEGATES

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

Presented by: Nameer Haider, MD, Chair

Mister Speaker and Members of the House of Delegates:

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 101  Scheduled Medications
2. Resolution 108  Lombardi Program “Nursing Home Without Walls”
3. Resolution 110  Changes to Article 81 of New York’s Mental Hygiene Laws
4. Resolution 116  Filming Patients for News or Entertainment
5. 2015 Governmental Affairs “B” Sunset Report

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

6. Resolution 100  Federal Agency Compliance with State Laws on Controlled Substances Databases
7. Resolution 103  Pharmaceutical Practices
8. Resolution 104  Meaningful Use Requirements
9. Resolution 105  Quality Improvement in Clinical/Population Health Information Systems
10. Resolution 106  Office Based Procedure
11. Resolution 107  Expansion of the Collaborative Partnership with MSSNY and the VA to Enhance Long Term Care
12. Resolution 109  Mandatory Reporting of Elder Abuse
13. Resolution 112  Automatic Link to Physician Profile Updating at Time of License Renewal

RECOMMENDED NOT FOR ADOPTION

14. Resolution 102  Remove Androgens from Scheduled Medications and I-Stop
15. Resolution 111  Treatment by the Office of Professional Medical Conduct (OPMC) Resulting from a Claim of Misconduct
16. Resolution 113  Medical Society Dues as Part of Biennial Registration
17. Resolution 114  Simplify Healthcare System Administrative Costs

REFERRED TO COUNCIL

18. Resolution 115  Assure Access to Federally-Funded GME Residency Positions for Graduates of U.S. Medical Schools
(1) RESOLUTION 101  SCHEDULED MEDICATIONS

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 101 **BE ADOPTED.**

Resolution 101 directs MSSNY to work with New York State to improve the I-STOP program by including a link to patient prescription histories that will appear at the time of prescribing as well as at the pharmacy where said prescription is filled.

Your Reference Committee heard testimony in support of this Resolution. Your Reference Committee was informed that the I-Stop law contains provision (now PHL Section 3343-a(1)(c)) which in pertinent part states that “To the extent practicable, implementation of the electronic transmission of prescriptions for controlled substances shall serve to streamline consultation of the registry by practitioners and reporting of prescription information by pharmacists”. Your Reference Committee agrees that the Prescription Monitoring System should be interoperable with EHR and stand-alone e-prescribing software and consequently recommends the adoption of the Resolution as written.

(2) RESOLUTION 108  LOMBARDI PROGRAM “NURSING HOME WITHOUT WALLS”

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 108 **BE ADOPTED.**

Resolution 108 directs the MSSNY to: (1) work to assure the continuity of the Long Term Home Health Care Program (LTHHCP) in managed care contracts; (2) work with the AMA to assure that the federal waiver authority which authorized the LTHHCP does not expire in September of 2015; and (3) urge the state Department of Health to conduct a study to evaluate the clinical and cost-effectiveness of LTHHCP as opposed to the Medicaid Long Term Care to determine the efficacy of one or both models in the evolving health care system.

Your Reference Committee heard testimony which supports this Resolution. Your Reference Committee was informed that the Lombardi Long Term Home Health Care Program (LTHHCP), in effect since 1977, which has enabled the provision of home care services paid for by Medicaid for individuals who would otherwise require nursing facility care is in jeopardy. In 2011, the Medicaid Redesign Team recommended the transition of all Medicaid beneficiaries from fee-for-service into Medicaid managed care and managed long term care plans (MLTCs) or “Care Coordination Models” (CCMs). The ensuing, mandatory transition of long term care patients into MLTCs/CCMs was instituted with the understanding that the LTHHCPs would continue to be a vital part of the long term care infrastructure serving these patients as either: (i) securing designation as MLTCs, (ii) securing designation of “Care Coordination Models (CCMs),” or (iii) contracting with MLTC and/or CCM. A number of impediments followed. MLTCs are effectively “insurance companies” with like requirements for financial reserves, escrow, etc., whereas LTHHCP is a provider based service delivery and care coordination model which does not maintain reserves and escrow as would a licensed insurance company. Next, DOH implemented “CCMs” as insurance models (basically, MLTCs except in name only), rather than a provider-based care coordination models like LTHHCP, as the Legislature intended. As a result, the CCM model has been prohibitively difficult to implement and it is believed that to date no LTHHCP, has been so designated. Ensuing legislative efforts advanced by MSSNY with broad-based state association support to statutorily provide for CCM-equivalent status for LTHHCP were rebuffed by the Executive which has held firm to an insurance-only model. Lastly, LTHHCPs, as robust models, must also meet both state and federal comprehensive Conditions of Participation for governance, quality, care coordination and service delivery. Upon
implementation of the mandatory MLTC enrollment policy, MLTCs took to market aiming for the lowest cost provider options, which were not held to these same standards. As a result of each of these “hurdles,” since the commencement of mandatory transfer of LTHHCP patients to MLTC, LTHHCPs have been largely consigned to serve as a la cart contractors for MLTCs for any individual services or functions requested by MLTCs, rather than enabled to effectively remain as long term care “medical homes” for their patients; although there are some (but few) cases where the entire LTHHCP delivery/care management package is maintained under MLTC contract. As such, direct LTHHCP enrollment has declined from roughly 30,000 statewide, to less than 5,000 in just two years, with mandatory MLTC enrollment policy in place and working toward 100% completion in all but the most rural regions of the state. While LTHHCPs are not Medicaid-limited providers, and may also serve Medicare and private pay individuals, the limitations on private and Medicare-based long term coverage de facto make Medicaid the primary payor for long term care. The state Medicaid master plan currently has in place a federal waiver for the LTHHCP which will expire in September of 2015. While the LTHHCP is rooted in Article 36 of the public health law as a standalone program apart from the waiver, if the waiver is allowed to expire the program will still-further diminish under Medicaid. Consequently, approval of this resolution will seek to assure the continuation of the program while urging that a study of its cost-effectiveness as compared to Medicaid Long Term Care model. Your Reference Committee, concerned for the quality of care received by the elderly, urges adoption of this Resolution.

(3) RESOLUTION 110

CHANGES TO ARTICLE 81 OF NEW YORK’S MENTAL HYGIENE LAWS

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 110 BE ADOPTED.

Resolution 110 asks MSSNY to seek immediate changes to Article 81 of the New York Mental Hygiene Law, which would allow courts to grants full guardianship to nursing homes for incapacitated residents only when the health and well-being of a patient is in jeopardy and no family member is capable of making such a decision, and not when motivated strictly by nursing home concerns.

Your Reference Committee heard support of the Resolution and was moved by the examples of the manipulative actions which have been reported in the press where certain nursing home administrators seek guardianship status through Article 81 of the Mental Hygiene Law to collect arrears. Guardianship transfers a person’s legal rights to make some or all decisions to someone appointed by a court. It is aimed at protecting people unable to manage their affairs because of incapacity. Legally, it can supplant a power of attorney and a health care proxy. A New York Times article published in January entitled To Collect Debts, Nursing Homes Are Seizing Control Over Patients noted that “in a random, anonymized sample of 700 guardianship cases filed in Manhattan over a decade, Hunter College researchers found more than 12% were brought by nursing homes”. While some of these cases might have been for legitimate reasons, the Times stated that “lawyers versed in the guardianship process agree that nursing homes primarily use such petitions as a means of bill collection–a purpose never intended by the Legislature when it enacted the guardianship statute in 1993”. However, Section 81.06 (7) provides that “the chief executive officer, or other designee of the chief executive officer, of a facility in which the person alleged to be incapacitated is a patient or resident may bring a proceeding under [the guardianship law]. The overriding issue is whether a guardianship petition is the best means for assuring that bills are paid. Your Reference Committee, therefore, recommends adoption of this Resolution.
(4)  RESOLUTION 116  FILMING PATIENTS FOR NEWS OR ENTERTAINMENT

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 116 BE ADOPTED.

Resolution 115 urges the MSSNY to: (1) adopt policy which states that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique) do not substitute for the need to obtain consent from a legally authorizing person prior to publication of any material related to the treatment of a patient and (2) bring a Resolution to the 2015 Annual meeting of the AMA House of Delegates which states that efforts to disguise a patient (such as blurring the face, changing the voice or any other technique) do not substitute for the need to obtain consent as outlined in AMA policy E-5.045 for publication of any material related to the treatment of a patient.

Your Reference Committee received much testimony in support of this Resolution. Your Reference Committee is very troubled by the circumstances that form the basis for this Resolution. As noted in the AMA’s Ethical policy E-5.045, “filming patients in a healthcare setting without consent is a violation of the patient’s privacy. Consent is therefore an ethical requirement for both initial filming and subsequent broadcast for public viewing. Because filming cannot benefit a patient medically and may cause harm, filming should be done only if the patient being filmed can explicitly consent.” Your Reference Committee was informed that legislation (A.5161, Braunstein) has been introduced which would require a medical facility to obtain express prior written consent before filming and/or broadcasting a patient's medical treatment and would make it a felony for anyone to film a patient without their consent. The bill has been referred to the Assembly Health Committee. Your Reference Committee agrees with the sponsors of this Resolution and recommends that the Resolution be adopted.

(5)  2015 Division of Governmental Affairs SUNSET REPORT

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that the 2015 DIVISION OF GOVERNMENTAL AFFAIRS B SUNSET REPORT BE ADOPTED.

Your Reference Committee did not hear any testimony on this item and agrees with the recommendations of the report.

(6)  RESOLUTION 100  FEDERAL AGENCY COMPLIANCE WITH STATE LAWS ON CONTROLLED SUBSTANCES DATABASES

RECOMMENDATION A:

Mister Speaker, your Reference Committee recommends that the first Resolved of Resolution 100 BE AMENDED BY ADDITION.

RESOLVED, That the Medical Society of the State of New York working with the AMA request that the Veterans Administration and other federal health programs comply with applicable State laws which require checking databases of controlled substance prescriptions so as to better coordinate controlled substance prescribing with other physicians; and be it further
RECOMMENDATION B:

Mister Speaker, your Reference Committee recommends that the second Resolved of Resolution 100
BE AMENDED BY ADDITION.

RESOLVED, That the MSSNY working with the AMA request that VA and other federal
pharmacies comply with state laws with regard to their respective requirements for entering
data on prescription fills into controlled substance tracking databases.

RECOMMENDATION C:

Mister Speaker, your Reference Committee recommends that Resolution 100 BE AMENDED BY
ADDITION.

RESOLVED, That the MSSNY work with the NYS Department of Health to address any
technological obstacles that exist to impede the transfer of data from VA practitioners and
other federal health programs to the NYS Prescription Monitoring Program.

RECOMMENDATION D:

Mister Speaker, your Reference Committee recommends that Resolution 100 BE ADOPTED AS
AMENDED.

Resolution 100 directs MSSNY to request: the Veterans Administration and other federal health programs
to comply with I-STOP PMP requirements so as to better coordinate controlled substance prescribing; and
(2) VA pharmacies to comply with the requirements of I-STOP.

Your Reference Committee heard testimony in support of this Resolution. Your Reference Committee was
informed that the I-Stop law contains provision (now PHL Section 3343-a(1)(c) which in pertinent part
states that “The registry shall be interoperable with other similar registries operated by federal or state
governments, to the extent deemed appropriate by the commissioner”. Your Reference Committee was
further informed that the Veterans Administration is fully supportive of exchanging prescribing data with
state Prescription Monitoring Programs and has worked to eliminate technical and legal impediments
which have prevented the sharing of this information. In December of 2011, the President signed into law
provisions which amended privacy laws applicable to the VA in order to authorize VA practitioners to
share patient data with PMPs. Regulations were promulgated to enable the sharing of controlled substance
prescription information including the national code number, quantity dispensed, number of refills ordered,
certain patient demographics and prescriber DEA and NPI numbers with state PMPs. The VA is actively
developing and testing software to facilitate the transmission and receipt of this information. Several sites
in other states have served as beta test sites. While the VA is actively working towards activation of
transmissions to the remaining states, there remain some internal VA obstacles that need to be addressed as
well as a NYS specific obstacle concerning NYS’s use of the UPHN Lite system to receive data instead of
a direct pharmacy-to-vendor transmission system. Consequently, your Reference Committee believes the
intent of this Resolution should be supported with two amendments; the first which recognizes a role for
the AMA in the resolution of this matter and the second, which recognizes the need for additional work on
the state level to eliminate obstacles which currently exists to impede the transfer of data. Your Reference
Committee recommends adoption of the amended Resolution.
RESOLUTION 103

PHARMACEUTICAL PRACTICES

RECOMMENDATION A:

Mister Speaker, your Reference Committee recommends that the first Resolved of Resolution 103 BE AMENDED BY ADDITION AND DELETION.

RESOLVED, That the Medical Society of the State of New York (MSSNY) seek set as a policy the statement legislation requiring that all pharmaceutical insurers must operate with complete transparency so as not to monopolize the industry, that all medications dispensed by participating local independently-owned pharmacies be reimbursed fairly on a contractual pre-arranged percentage basis, and that any attempt by the pharmaceutical insurer to monopolize the pharmacy industry be referred to the New York State Attorney General for investigation as to the possible anti-trust law violations; and be it further

RECOMMENDATION B:

Mister Speaker, your Reference Committee recommends that the second Resolved of Resolution 103 BE AMENDED BY ADDITION AND DELETION.

RESOLVED, That MSSNY shall take action to immediately refer to the NYS Attorney General any evidence of collusion with by a pharmaceutical manufacturer to create a shortage of any medication in order to manipulate the price of said medication, be immediately referred to the NYS Attorney General.

RECOMMENDATION C:

Mister Speaker, your Reference Committee recommends that Resolution 103 BE ADOPTED AS AMENDED.

Resolution 103 urges MSSNY to (1) seek legislation requiring all pharmaceutical insurers to operate with complete transparency, that all medications dispensed by participating local independently-owned pharmacies be reimbursed fairly on a contractual pre-arranged percentage basis, and that any attempt by the pharmaceutical insurer to monopolize the pharmacy industry be referred to the New York State Attorney General for investigation as to the possible anti-trust law violations; and (2) take action to immediately refer to the NYS Attorney General any evidence of collusion by a pharmaceutical manufacturer to create a shortage of any medication to manipulate the price of the medication.

Your Reference Committee heard testimony in support of this Resolution. Drug shortages remain a significant public health issue. The number of prescription drug shortages in the United States quadrupled between 2005 and 2010. Over the past few years, the President and Congress have taken steps to expand early notification of interruptions and discontinuations enhancing the Food and Drug Administration’s (FDA’s) ability to address drug shortages. In October of 2011, an Executive Order was issued which directed the FDA to “use all appropriate administrative tools” to require drug manufacturers to provide advanced notice of manufacturing discontinuances that could lead to shortages. On July 9, 2012, President Obama signed into law the Food and Drug Administration Safety and Innovation Act (FDASIA) which among other things gives the FDA authority to further enhance the safety of the drug supply chain by expanding early notification requirements to all drug manufacturers. In addition, the FDA was directed to establish a task force on drug shortages to develop and submit to Congress a strategic Plan to prevent and mitigate drug shortages. The Task Force’s report issued in October of 2013 notes that product disruptions can be triggered by many factors including a natural disaster, a business decision to permanently discontinue production or a failure in product or facility quality. The report identified four key areas where
there is a role for others outside of the FDA to reduce the incidence of drug shortages. In this context the report notes that a shortage offers a unique opportunity for a ‘gray market’ to develop where there is downstream distribution of approved drug products at significantly marked up prices. In this instance large-scale buyers are willing to pay any price to obtain the product which is in short supply. Your Reference Committee believes that action must be taken to minimize gray market activities and further believes that the state Attorney General is in the best position to do so. Amendment is proposed to be made in the body of the second Resolved to make it more readable. Consequently, your Reference Committee recommends the adoption of the amended resolution.

(8) RESOLUTION 104 MEANINGFUL USE REQUIREMENTS

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that the FOLLOWING SUBSTITUTE RESOLUTION 104 BE ADOPTED IN LIEU OF RESOLUTION 104.

RESOLVED, That the Medical Society of the State of New York work with the American Medical Association to assure that the Centers for Medicare & Medicaid Services and the National Coordinator for Health Information Technology: (1) adopt a more flexible approach for meeting Meaningful Use; (2) expand hardship exemptions for all meaningful use stages; (3) improve quality reporting; and (4) address physician EHR usability and interoperability.

Resolution 104 urges that a more lenient approach to meaningful use be considered by the overseeing government agencies.

Your Reference Committee heard testimony in support of this Resolution. It is clear to the members of the Reference Committee that even physicians who have had EHRs and other health IT in place for several years are struggling to keep up with the rapid pace of MU requirements. An AMA-RAND study released in 2013 cited EHRs as a major source of dissatisfaction for physicians. The report found that physicians want to embrace technology, but they’re frustrated that regulatory requirements are forcing them to do clerical work, distracting them from paying close attention to their patients. Physicians also raised concerns about interoperability in the study saying that the inability of EHRs to "talk" to each other prevents the transmission of patient medical information when it is needed. If changes are not made, the prescriptive nature of the MU program will stifle innovation and fuel the growing frustration among physicians. In the end it is the patient who will suffer most. The AMA has adopted a MU blueprint which contains four tangible recommendations to improve EHR use. These recommendations have been contained in the body of the substitute resolution to address the call for more specificity to be included in the body of the proposed resolution. Consequently, your Reference Committee recommends the adoption of a complementary substitute resolution in lieu of the original Resolution 104 which comports with the policy goals articulated by the AMA.

(9) RESOLUTION 105 QUALITY IMPROVEMENT IN CLINICAL/POPULATION HEALTH INFORMATION SYSTEMS

RECOMMENDATION A:

Mister Speaker, your Reference Committee recommends that Resolution 105 BE AMENDED BY ADDITION AND DELETION.
RESOLVED, That the Medical Society of the State of New York ask the American Medical Association to invite other expert physician associations, such as the American Academy of Pediatrics (AAP), the AMIA (formerly the American Medical Informatics Association), and the American College of Preventive Medicine (ACPM) and others into the AMA consortium to further the quality improvement of EHRs and Population Health as discussed in the consortium letter of January 21, 2015 to the National Coordinator of Health Information Technology.

RECOMMENDATION B:

Mister Speaker, your Reference Committee recommends that Resolution 105 BE AMENDED BY ADDITION.

RESOLVED, That the Medical Society of the State of New York support efforts of the AMA to secure specific changes to the EHR certification process to enhance security of information contained in an EHR, prioritizes functionality testing, decouples EHR certification from the meaningful use program and supports greater standardization and greater transparency of standards which support interoperability of EHRs.

RECOMMENDATION C:

Mister Speaker, your Reference Committee recommends that Resolution 105 BE ADOPTED AS AMENDED.

Resolution 105 urges MSSNY to ask the AMA to invite other expert associations such as the American Academy of Pediatrics (AAP), the AMIA (formerly the American Medical Informatics Association), and the American College of Preventive Medicine (ACPM) and others to the AMA’s consortium to further the quality improvement of EHRs and Population Health as discussed in the consortium letter of January 21, 2015 to the National Coordinator of Health Information Technology.

Your Reference Committee heard testimony in support of this issue. Clearly, physicians are expressing a growing concern and level of frustration with their EHRs and the inability of EHR technology to function reliably or even interoperatively with other health system stakeholders. The letter sent by the AMA and signed onto by another 35 medical associations has elevated this discussion within the Office of the National Coordinator. Staff at the AMA has assured that while not initially consulted on the letter, they have reached out and are regularly speaking with AMIA and will be working to get their input on a more regular basis. Moreover, they will also be reaching out to the Federation on this and other HIT issues including MU very soon. Your Reference Committee recommends a slight amendment of the Resolved to recognize without naming the inclusion of other physician associations in these efforts. Moreover, while it would have been a good idea to include additional associations such those noted in the sponsor’s Resolution, your Reference Committee also recognizes and supports the efforts of the AMA and others to improve the EHR certification process. Therefore, your Reference Committee has added a second Resolved to the body of this Resolution which calls for specific changes to the certification process to enhance the security of information contained in an EHR, prioritizes functionality testing, decouples EHR certification from the meaningful use program and supports greater standardization and greater transparency of standards which support interoperability of EHRs.

(10) RESOLUTION 106 OFFICE BASED PROCEDURE

Mister Speaker, your Reference Committee recommends that the FOLLOWING SUBSTITUTE RESOLUTION 106 BE ADOPTED IN LIEU OF RESOLUTION 106.
RESOLVED, that the Medical Society of the State of New York reaffirm Policy 295.995.

295.995 Payment for Office Based Surgeries MSSNY will support legislation or regulation which assures payment of a facility fee which reflects the additional costs of accreditation and maintenance of an office-based surgical practice. (HOD 2012-114)

Resolution 106 calls upon MSSNY to seek legislation so that the insurers and governmental payers provide equal payment for the same procedures whether performed at a licensed AAASF practice or an Article 28 hospital based facility.

Your Reference Committee heard testimony in support of this Resolution. Your Reference Committee was informed that MSSNY already has policy (295.995 Payment for Office Based Surgeries) which seeks to achieve the objective as proposed in Resolution 106. It is intended that such payment be in addition to the payment received for the procedure performed in the OBS facility. As the sponsors of these Resolutions note, in 2007, legislation was approved which required OBS practices to receive accreditation by one of three nationally recognized accrediting bodies to assure that these practices meet nationally recognized standards for patient safety and quality of care. Physicians expend significant monies to assure that their practices comply with accreditation standards. Inexplicably, health plans have not reimbursed such facilities a fee for the use of the facility, despite the fact that they have demonstrated high quality care at a lower cost that care provided in more costly article 28 ambulatory surgery centers. MSSNY already has moved proactively to have legislation introduced which would accomplish this goal. Consequently, your Reference Committee urges the adoption of the substitute resolution.

(11) RESOLUTION 107 EXPANSION OF THE COLLABORATIVE PARTNERSHIP WITH MSSNY AND THE VA TO ENHANCE LONG TERM CARE

RECOMMENDATION A:

Mister Speaker, your Reference Committee recommends that the FOLLOWING SUBSTITUTE RESOLUTION 107 BE ADOPTED IN LIEU OF RESOLUTION 107.

RESOLVED, That MSSNY, through its Long Term Care Subcommittee to the Quality Improvement and Patient Safety Committee, work with all relevant federal and state agencies to assure that long term care services including home care services, physician home visits, telehealth and palliative care are integrated into and paid for through new initiatives underway to restructure the Health Care Delivery System such as the Delivery System Reform Incentive Payment (DSRIP) Program, Medicare Shared Savings Accountable Care Organizations and the Fully Integrate Duals Advantage (FIDA) Program.

RECOMMENDATION B:

Mister Speaker, your Reference Committee recommends that A TITLE CHANGE BE MADE TO RESOLUTION 107 TO READ AS FOLLOWS:

Collaborating With Federal and State Agencies To Assure The Provision Of Long Term Care Services

Resolution 107 urges MSSNY to: (1) seek legislation or regulation to establish programs to enhance the quality of care for both veterans and non-veterans; (2) report the results of these efforts to the MSSNY
Long Term Care Subcommittee of the Quality and Safety Committee for future action; and (3) forward the resolution to the AMA to request that they encourage other states to establish similar partnerships and programs in collaboration with the AMA and the Administration for Veterans Affairs.

Your Reference Committee heard testimony to support this resolution. The Veterans Access, Choice, Accountability Act (VACAA) of 2014 was enacted to expand the number of options Veterans have for receiving care to ensure Veterans have timely access to high-quality care. Veterans Choice Program (VCP) provides primary care, inpatient and outpatient specialty care, and mental health care for eligible Veterans when the local VA Medical Center (VAMC) cannot provide the services due to the lack of available specialists, wait times exceeding thirty days or where the veteran lives more than forty miles from the closest VA Hospital. MSSNY widely announced the enactment of this program in November 2014 and more than 300 physicians indicated their willingness to provide care through this initiative to eligible veterans in their community. $10B is appropriated to pay for the care to be provided by community based non-VA clinicians. MSSNY is working with the State to create a database which can serve to connect eligible veterans with community based physicians interested in providing care to veterans when treatment is not available through the VA. This is a voluntary program and is not being done in partnership with the VA. It is also not focused on the provision of long term care services as appears to be the focus of the proposed Resolution. Your Reference Committee believes that there are many new innovative programs now being launched such as the Delivery System Reform Incentive Payment (DSRIP) Program, Medicare Shared Savings Accountable Care Organizations and the Fully Integrate Duals Advantage (FIDA) Program which should integrate long term care services including home care services, physician home visits, telehealth and palliative care into the types of services for which they will provide payment. These programs are all being implemented by health system stakeholders on the state level. Consequently, while MSSNY independently took steps to collect the names of physicians who will provide care to veterans through the Veterans Choice program, that initiative is not really a vehicle which will accomplish the overarching objectives believed sought by the sponsors. Consequently, your Reference Committee recommends the adoption of the substitute resolution which we feel will effectuate the meaningful changes sought by the sponsors of this Resolution.

(12) RESOLUTION 109 MANDATORY REPORTING OF ELDER ABUSE

RECOMMENDATION A:

Mister Speaker, your Reference Committee recommends that Resolution 109 BE AMENDED BY ADDITION AND DELETION

RESOLVED, That MSSNY advocates for mandatory elder abuse reporting by healthcare workers professionals and all healthcare agencies involved in elderly care in the State of New York.

RECOMMENDATION B:

Mister Speaker, your Reference Committee recommends that Resolution 109 BE ADOPTED AS AMENDED.

Resolution 109 urges MSSNY to advocate for mandatory elder abuse reporting by healthcare professionals in the State of New York.

Your Reference Committee heard testimony in support of and in opposition to this Resolution. It appears from recent studies that there is an under reporting of elder abuse in NYS. However, elder abuse takes many forms. In a recently published study entitled Under the Radar: New York State Elder Abuse Prevalence Study, the highest rate of mistreatment occurred for major financial exploitation. Other forms
of abuse also occur including neglect, emotional and physical abuse. Healthcare professionals are not the only members of society best suited to report elder abuse. There is currently no requirement for physicians or other clinicians to report elderly abuse and there is no central, statewide repository of data on cases of elder mistreatment. Section 473 of the Social Services law does provide immunity for anyone who reports suspected elder abuse to a state agency. Elder abuse cases can come to the attention of several agencies capable of providing investigation and intervention services. In addition to Adult Protective Services, which operates in every county in the state, New York State also has several not-for-profit programs that specialize in investigating cases of elder abuse and responding to the needs of elder abuse victims. Each service system has its own data collection system. There is no simple answer to the question of whether mandatory reporting of elder abuse benefits or harms an individual victim or older victims overall. This will depend on the individual victim, agency expertise, local law enforcement and adult protective services response, and level of family and community support. Requiring health care workers to report elder abuse will at least assure that the appropriate agency will investigate and, where warranted, take action to protect the vulnerable elderly. Your Reference Committee received much testimony in opposition to further mandates but agreed with supporters of the resolution that physician concern for the wellbeing of their patients should outweigh concern regarding a mandate which has the best interests of patients at its core.

(13) RESOLUTION 112 AUTOMATIC LINK TO PHYSICIAN PROFILE UPDATING AT TIME OF LICENSE RENEWAL

RECOMMENDATION A:

Mister Speaker, your Reference Committee recommends that Resolution 112 BE AMENDED BY ADDITION.

RESOLVED, That the Medical Society of the State of New York request, through regulation/legislation if needed, that the New York State Education Department and the New York State Department of Health (DOH) create an automatic link from the online state education license renewal site to the state DOH physician profile site to enable a physician who is re-registering with the state to also update his/her physician profile in a seamless manner.

RECOMMENDATION B:

Mister Speaker, your Reference Committee recommends that Resolution 112 BE ADOPTED AS AMENDED.

Resolution 112 urges MSSNY to seek legislation or regulation to require the State Education Department and NYS Department of Health to create an automatic link from the online state education license renewal site to the state DOH physician profile site to enable a physician who is re-registering with the state to also update his/her physician profile in a seamless manner.

Your Reference Committee received testimony in support of this Resolution. State law requires that “except for optional information provided on physician profiles, physicians shall notify the department of any change in profile information within 30 days of such change. Any change in optional information must be reported to the department within 365 days of such change”. The state Education Department’s current re-registration website is not linked with the physician profile site maintained by the state Department of Health. The re-registration cycle is every two years. Consequently, in the event that there is a change in the mandatory element(s) of a physician’s profile, the physician cannot always wait for his/her re-registration to make the changes to the physician’s profile. However, that doesn’t negate the need for an automatic link between the sites. The state should at every opportunity promote access to a means through which
physicians can update the information contained on their physician profile. Consequently, your Reference
Committee recommends adoption of a slightly revised version of the Resolution.

(14) RESOLUTION 102 REMOVE ANDROGENS FROM SCHEDULED
MEDICATIONS AND I-STOP

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 102 BE NOT ADOPTED.

Resolution 102 directs MSSNY to have androgens removed from scheduled medications and from I-STOP
regulation.

Your Reference Committee received testimony in support of and in opposition to this Resolution. Anabolic
steroids are listed on the schedule III of section 3306 of the public health law. I-STOP does require that
prescribers must consult the Prescription Drug Monitoring database before prescribing any controlled
substance on schedule II, III or IV of PHL section 3306 for the purpose of reviewing a patient’s controlled
substance history. MSSNY led a very large prescriber and patient advocacy coalition in opposition to the I-
STOP law in its entirety. The requirement to consult the PMP database has been in effect since August 27,
2013. Many physicians feel that the program has well served the public’s interest in reducing drug
diversion. Statistics show that drug diversion has been reduced in NYS by 75% since the enactment of the
I-STOP initiative. Because of its great success, it is very difficult to re-open discussion of the I-STOP
consultation requirements. Moreover, it is difficult, however supportable, to differentiate why one
schedule III drug should not require consultation and another should. Why should anabolic steroids
prescribed to androgen deficient men be treated differently than anabolic steroids prescribed for other
purposes? Why should anabolic steroids be treated differently than medications prescribed for children
under the age of eighteen with ADHD? While anabolic steroids used as testosterone replacement drugs
have a positive impact on patient quality of health, they have been shown to be both addictive and abused
as have medications for the treatment of ADHD. They should remain on the list of schedule III drugs and,
therefore, within the ambit of the requirement for PMP consultation prior to prescribing. Your Reference
Committee therefore recommends that the Resolution be not adopted.

(15) RESOLUTION 111 TREATMENT BY THE OFFICE OF THE PROFESSIONAL
MEDICAL CONDUCT (OPMC) RESULTING FROM A
CLAIM OF MISCONDUCT

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 111 BE NOT ADOPTED

Resolution 111 urges MSSNY to adopt policy which states that physicians should have the right to know
the nature of all complaints lodged against them to the OPMC, even in the event that the complaints are
found to be of no merit by the OPMC after review of the case.

Your Reference Committee received testimony in support of and opposition to this Resolution. All
complaints received by OPMC are investigated. Most complaints (60%) are closed without the convening
of an investigation committee. Approximately 8% of complaints are referred to an Investigation
Committee. Public Health law does require OPMC to keep the name of the complainant confidential. The
very existence of an investigation is also confidential until completed. These provisions exist for the
protection of both the complainant and the physician under review. In the event that the Board for Professional Medical Conduct decides that it may present an investigation to an investigation committee, the law provides that the physician must be offered an interview. Changes were made to the law in 2009 at MSSNY’s request which require that the letter inviting the physician to an interview must identify to specific issues to be discussed during the interview. Therefore, the physician is aware of the nature of the complaint before the interview is conducted. During the interview, the physician, who may have counsel and a stenographer present, is afforded an ability to respond to the allegations. Subsequent to the interview, OPMC must send the interview report to the licensee so that the licensee can confirm the accuracy of the contents of the report or stipulate changes that should be made. Confidentiality during the initial investigation flows both to the complainant and the physician. In the case where the matter is dismissed before an investigation committee is convened, and there is no evidence of any misconduct there is no basis for OPMC to use that investigation in a future review so the physician is not in any way harmed by what is determined to be a baseless assertion. The physician would have no avenue of redress in any subsequent civil proceeding even if he/she suspected that the complaint was made under fraudulent or frivolous circumstances. Consequently, your Reference Committee recommends that the Resolution be not adopted.

(16) RESOLUTION 113  MEDICAL SOCIETY DUES AS PART OF BIENNIAL REGISTRATION

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 113 BE NOT ADOPTED.

Resolution 113 urges the MSSNY to seek legislation to include MSSNY and County Medical Society opt-out dues in the New York State Department of Education biennial registration billing and payment.

Your Reference Committee heard testimony in support of and in opposition to this Resolution. While the sponsors should be commended for identifying a mechanism through which MSSNY can increase membership, several issues must be considered. First and foremost, MSSNY would not want to cede control of its billing to another entity including the State Education Department. Once control is lost, we lose control of our message. Moreover, adding MSSNY/County dues to the $600 re-registration creates an even higher price point to the physician and could serve to deter even more physicians from becoming MSSNY members. Lastly, many specialty societies may be concerned about MSSNY having an exclusive billing arrangement with SED and could ask for one as well which could further marginalize membership in MSSNY.

(17) RESOLUTION 114  SIMPLIFY HEALTHCARE SYSTEM ADMINISTRATIVE COSTS

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 114 BE NOT ADOPTED.

Resolution 114 urges the MSSNY to: (1) advocate for enactment of a single administrative system to manage the delivery of healthcare services (2) recommend that the single administrative system advocated for by MSSNY should operate pursuant to a global budgeting process that would be supported by direct and collective negotiation between the payer(s) and representatives of providers and consumers; (3) advocate for adequate compensation for health care providers to ensure they are financially stable and
therefore able to deliver quality health care and that such compensation levels should be determined through bi-lateral negotiations between provider groups and the single administrative system; (4) advocate for a streamlined, uniform operating system that would standardize the many different rules and systems currently in place to guide authorization of and payment for services; (5) recommend that the single administrative health care system promote public health by improving surveillance of public health status and early identification of emerging health problems; (6) advocate that single administrative health care system develop and promote policies to encourage and assist patients in assuming a more active role towards maintaining healthy lifestyles; and (7) recommend that the delivery of quality health care be the top priority of the single administrative health care system.

Your Reference Committee heard testimony in support of and in opposition to this single payer Resolution. While this is a very important issue and received much debate, it is also very divisive to organized medicine. Your Reference Committee agrees with the sponsor that certain health system efficiencies could be created as a result of the implementation of a single payer system. Your Reference Committee was informed that in a report entitled Economic Analysis of the New York Health Act it is estimated that enactment of the NY Health Act would save over $70B in 2019 and that the savings would increase over time. However, as noted in the testimony, many physicians are very concerned that they will lose clinical autonomy under a single payer system. Physicians are also concerned that a single payer system will result in a significant and unwarranted reduction in payment for the services they render. Consequently, your Reference Committee believes that until such time as there is more of a consensus on this issue, your Reference Committee recommends against adoption of this Resolution.

(18) RESOLUTION 115

ASSURE ACCESS TO FEDERALLY-FUNDED GME RESIDENCY POSITIONS FOR GRADUATES OF U.S. MEDICAL SCHOOLS

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 115 BE REFERRED TO COUNCIL.

Resolution 115 urges the MSSNY to ask the AMA to work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, AHA, AOA, Commission on Osteopathic Medicine and other relevant parties to change the residency match program to assure that, in the initial round of the match, taxpayer supported residency programs will be available only to graduates of Liaison Committee on Medical Education (LCME) and American Osteopathic Association (AOA) accredited medical schools while subsequent rounds will be available to graduates of international medical schools.

Your Reference Committee heard much impassioned testimony in support of and in opposition to this Resolution. Your Reference Committee agrees that there is an increasing need for additional residency slots and that action must be taken to assure that graduating medical students have access to residency programs.

However, we are deeply concerned by the level of discord generated by this Resolution. We respectfully disagree that we should pit one medical student against another medical student. Medical students should not be discriminated against simply because they completed their medical training at an off-shore medical school not accredited by the Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA). And yet many medical students training at LCME or AOA accredited schools are now in jeopardy of not having access to residency slots, notwithstanding taxpayer support for the graduate medical education system. It is estimated that by 2016, the number of U.S. medical school graduates will
exceed the number of residency slots. In addition, to relieve the burgeoning need for residency program
slots, your Reference Committee believes that since our healthcare delivery system has encountered a
physician shortage and now requires additional primary and specialty care physicians, action should be
taken on the federal level to assure an adequate number of residency slots. This position is consistent with
that of the AMA D-305.967 in pertinent part calls upon the “AMA to strenuously advocate for increasing
the number of GME positions to address the future physician workforce needs of the nation”. And while
this will alleviate much of the current problem, some believe that Congress will not take timely action to
assure an adequate supply of residency slots. Your Reference Committee believes that the current
Resolution as written is too contentious and that other remedies must be explored. Consequently, your
Reference Committee recommends referral of the Resolution to Council.

(19) RESOLUTION 117 MONOPOLIZATION OF HEALTHCARE BY VERTICALLY
INTEGRATED HEALTH SYSTEMS

RECOMMENDATION:

Mister Speaker, your Reference Committee recommends that Resolution 117 BE REFERRED TO
COUNCIL.

Resolution 117 urges MSSNY to: (1) seek legislation or regulation that requires vertically integrated
hospital systems must prove to the Department of Health a need to employ an individual in the
marketplace and obtain a certificate of need for each of their employed physicians; and (2) assure that
the CON process include an evaluation of the employment agreement insofar as it be limited to fair
market value of physician services and not to include ancillary services.

Your Reference Committee received testimony in support and in opposition to this Resolution. Those
who support the Resolution believe that large hospital systems monopolize the marketplace to such an
extent that causes reimbursement to independent physicians to dramatically decrease and thereby serves
to make hospital employment more appealing to the independent physicians. Physicians in opposition to
this Resolution note that physicians should have a right to decide for themselves and without intrusion by
state government as to whether they wish to sell their practice to the hospital and become employed. They
further note that their decision to become employed is influenced by a number of factors, many of which
are outside the control of the hospital. Finally, they note that MSSNY is an organization which represents
all physicians including physicians employed by vertically integrated health systems and those who are
not. This Resolution may have a negative impact on MSSNY membership. Consequently, your Reference
Committee believe this is a Resolution which deserves much further scrutiny and, therefore, recommends
that it be referred to Council.
Your Chairperson is grateful to the Committee Members, namely, Steven Sherman, DO, Wayne Strouse, MD, Ernesto Diaz-Ordaz, MD, Celsa Tonelli, and Michael Pisacano, MD.

Your Reference Committee Chairman also wishes to express his appreciation to Elizabeth Dears Kent, Esq., Morris M. Auster, Esq., Pat Clancy, Barbara Ellman and Anna Cioffi for their help in preparation of this report.

Respectfully submitted,

____________________________________   ______________________________________
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____________________________________   ______________________________________
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____________________________________   ______________________________________
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