MSSNY polled its members on February 10, as to whether they wanted MSSNY to support or oppose legislation that would repeal and replace the Medicare SGR payment formula.

A bipartisan group of House and Senate lawmakers announced a proposal (HR 4015, Burgess), The SGR Repeal and Medicare Provider Payment Modernization Act. If passed, this would repeal and replace the Medicare SGR physician payment formula, provide modest payment increases and implement a value-based incentive/penalty program starting in 2018.

However, it does not yet establish the “offsets” necessary to pay for the proposal, which are estimated to cost over $125 billion. Given the political difficulty associated with finding the money to pay for this proposal, which could involve cutting funding to many groups, including other health care providers, Congress is seeking physicians to advocate for this legislation.

MSSNY expressed to members of Congress and the media that there are both positive and negative aspects to this proposal. However, since the legislation has been revised numerous times, there is likely to be little opportunity to make significant changes to the latest proposal.

The legislation includes provisions that would:

- Repeal the SGR immediately, thereby eliminating the annual threat of 20% Medicare physician payment cuts.
- Provide positive annual payment updates of 0.5% for five years, from 2014-2018. However, the bill provides for a “freeze” between 2019 and 2023.
- Create a Merit-Based Incentive Payment System (MIPS), which would consolidate the existing EHR meaningful use incentive/penalty program, PQRS program, and Value Based Modifier into one quality program, which also incorporates clinical practice improvement activities. The program would require up or down Medicare physician payment adjustments starting in 2018, based upon a composite “performance score” in these four performance categories.
- Impose negative payment adjustments on Medicare payment for physicians who fall below a performance threshold in the MIPS, capped at 4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021.
- Provide physicians with higher performance scores above the threshold with proportionately larger bonus payments.

Two-Midnight Rule: Only Doctors Can Sign Off On Inpatient Admissions

Hospital nurses, medical residents and physician assistants can all write the orders to admit Medicare beneficiaries to the hospital. But newly clarified CMS rules say a physician must sign off on the admitting paperwork and “accept responsibility” for the decision before the patient is discharged.

The rules were published (http://tinyurl. com/kzt6b4) as part of the ongoing effort to define the CMS’ new two-midnight policy, which says admitting physicians must have good reason to believe that a patient will require two nights in the hospital to qualify for Medicare’s higher-paying hospital rates. Otherwise, the care is considered outpatient, which pays less.

CMS officials said during a national conference call on Tuesday, February 4, that Medicare’s recovery auditors will not be allowed to audit inpatient claims under the two-midnight rule until after Sept. 30. However, the agency said its administrative contractors, which process the bills and do some auditing work before payment, will continue to probe small numbers of cases and “educate” hospitals on whether the claims broke the new rules.

For example, the new regulations say that a nurse can document a physician’s “verbal order” to admit a patient in the medical record, even though the nurse lacks the authority to admit a patient independently. An admitting physician must countersign the decision before the patient leaves the hospital. If it later turns out that the doctor disagrees with the decision to admit and refuses to sign the order, the hospital can still send the bills through Medicare’s Part B system for outpatient care, according to the rules.

Likewise, a medical resident, physician assistant or nurse practitioner may write the inpatient admitting order as a proxy for the physician. But that applies only when a physician “approves and accepts responsibility for the admission decision by countersigning the

(Continued on page 2)
Two-Midnight Rule
(Continued from page 1)
order prior to discharge.” Decisions to admit patients to the hospital have been fraught territory for hospital officials, who complain that Medicare rules have been unclear even though providers are subject to extensive data-mining and auditing after the fact.

The result was that growing numbers of patients were placed in hospital beds but classified as outpatient observation cases, which can protect the hospital from auditing but exposes patients to copayments and bills for post-acute rehabilitation care that would otherwise have been covered fully by Medicare.

The two-midnight policy, announced last fall as part of the 2014 Medicare inpatient payment rates, was intended to reduce the number of long observation stays by clarifying that any patient sick enough to get at least two nights of hospital care is now presumed to have had a legitimate hospital stay.

CMS DELAYS IMPLEMENTATION OF TWO-MIDNIGHT RULE

The Centers for Medicare and Medicaid Services will delay the implementation of the two-midnight rule for an additional six months, according to Kenneth Raske, president of the Greater New York Hospital Association. The delay is seen as “a major victory for hospitals in New York and across the country, which have already lobbied tirelessly for delay and repeal.” According to the article, “the two-midnight rule could cost hospitals across the country as much as $2 billion because of lower payments from the federal government.”

February 10, 2014 SGR Survey
(Continued from page 1)
ments up to 3x the annual cap for negative payment adjustments.

• Set an annual target for the HHS Secretary to identify “misvalued services” at 0.5% of the estimated amount of fee schedule expenditures from 2015-2018.

• Provide a 5% added incentive payment for physicians who participate in risk-based Alternative Payment Models. These physicians would also be exempted from the MIPS program.

• Provide $40 million in funding annually for technical assistance in the MIPS program or for participation in the APM program to small practices of 15 or fewer professionals

• Require the creation of “appropriate use criteria” for advanced diagnostic imaging.

• Prohibit new liability causes of action based upon standard deviations in the ACA or Medicare.

• Permit physicians who opt out of Medicare to engage in private contracting with their patients to no longer be required to renew their opt-out status every two years.

To read a more detailed summary of the proposal, including more information on the above, please click here: http://origin.library.constantcontact.com/download/get/file/1115032643020-49/Section+by+Section+Summary.pdf.
Council Notes: January 30, 2014

• Troy Oechsner, Deputy Superintendent for Health with the Department of Financial Services (DFS), spoke at length about the out of network insurance proposal in the governor’s budget. Insurers would be required to offer at least one out of network policy based on 70% of UCR, which is vastly better than the policies based on 140% of Medicare now being offered. Mr. Oechsner said that the proposed bill for out of network coverage would provide greater transparency of coverage to patients, and broader availability of a patient’s right to go out of network if the insurer’s network is insufficient. If the insurance company objects to excessive costs for emergency care and urgent care “surprise bills” for hospital care by non-participating physicians, partial payment would be made and the disputed amount would be subject to an arbitration process (which is really an external review). President Elect Dr. Andrew Kleinman noted that in arbitration cases, the Fair Health database is consulted and the amount awarded is the exact amount of what is asked by either side, not the average of the two figures. Dr. Kleinman noted the process by which baseball arbitrations are decided and that it tends to make both parties’ demands more reasonable. The Council applauded the responsiveness the DFS has shown to the medical society and looks forward to working with them as this proposal is refined.

• Moe Auster, VP Legislative and Regulatory Affairs, reported on recent efforts to repeal the flawed Medicare SGR formula and to establish a new physician payment system. Specifically, the Senate Finance proposal would repeal SGR, put a 10-year freeze on payments, and have some portion of physician payments be increased or cut starting in 2017, based upon quality assessment. There is a similar proposal in the House, but the House proposal will also provide modest positive updates for three years. Mr. Auster noted the split in the medical community about how to address the SGR—the AMA and several primary care specialty societies applaud the Senate Finance and House proposals, while some specialty societies oppose it. Congress is expected to act within the next month. “We finally have an opportunity to get the SGR monkey off our backs,” said Mr. Auster. “We need to continue to work to advocate to Congress to make needed changes that would protect the viability of smaller physician practices.” Following Mr. Auster’s presentation, Dr. Unterricht voiced his own strenuous objections to the AMA position. “We have essentially had a Medicare freeze for the last 10 years, which has resulted a 35-50% reduction in payments after adjustment for medical inflation,” noted Dr. Unterricht.

• Regarding ICD-10, although legislation has been introduced to delay the October deadline, Mr. Auster said the passage of the bill was unlikely, but efforts were continuing to urge CMS to delay implementation. Socio-Medical Economics VP Regina McNally said that CMS has engaged an outside contractor to educate physicians regarding ICD training. MSSNY, in tandem with CMS, is exploring the possibility of conducting educational sessions on a county-wide basis.

• MSSNY Council discussed the legislative and possible regulatory push for CME on Medicare payment and reimbursement. We continue to discuss this issue in the 2014 legislative session.

• Steven Sherman, MD, President of the First District asked for and received Council support for the Breast Cancer Patient Education Act (S.931/H.R.1984), an education campaign to inform breast cancer patients of the availability and coverage of breast reconstruction. In 2010, the State of New York passed legislation making it mandatory for all hospitals to provide cancer patients with information about reconstructive surgery. However, this legislation does not exist on the federal level.

• Dr. Howard Grossman, Chair of Physicians for Compassionate Care, an organization comprised of 600 physicians who have voiced support for of medical marijuana, presented information that supports a highly-regulated construct. Dr. Unterricht urged Dr. Grossman to have Compassionate Care physician supporters join MSSNY as members and consider bringing a resolution on the marijuana issue to our House of Delegates.

Troy Oechsner Addresses MSSNY Council Meeting

MYSSNY PAC

Advocacy Requires Funding—Join Now!

The Legislative Session is well underway and the proposed Budget is being closely examined by the Assembly and Senate with a view towards passage on or before April 1, 2014. There are a number of proposals that would affect the way you practice medicine and could impact upon your ability to sustain your practice financially. One proposal would require all urgent care practices to be accredited and impose special equipment and staff requirements. Another proposal would require Office Based Surgery practices accreditating bodies to conduct and report the results of surveys and investigations requested by the Commissioner of Health. Other proposals would enable specifically traded corporations to operate limited service clinics in pharmacies and other retail clinics likely staffed by nurse practitioners. The entities would not be encumbered by self-referral prohibitions so that patients can be directed to make purchases at the establishment where they receive health care to enable the bottom line for the corporation shareholders.

Third and Fourth District 15th Annual Retreat

Left to right: William Latreille, MD, retreat host; Congressman William Owens; Andrew Kleinman, MD, MSSNY President Elect; and MSSNY Immediate Past President Robert Hughes, MD.

On January 24-26, the Third and Fourth District held their 15th Annual Branch Retreat, hosted by MSSNY Board Trustee William Latreille, MD, at Lake Placid. The weekend agenda included a presentation on the “Legal Ramifications of a Pain Contract” by MSSNY Counsel Michael Schoppmann, a physician leadership training course and two clinical presentations. Harold Sokol, MD (3rd District Councilor) and John Kennedy, MD (4th District Councilor) gave Council updates. Congressman William Owens and Assemblywoman Janet Duprey provided legislative updates. Elizabeth Dears-Kent presented the attendees with a detailed outline of MSSNY’s 2014 Legislative Program; Joseph Sellers, MD, reported on the PACT activities; John Kennedy, Vice Chair of the AMA Delegation and Immediate Past MSSNY President kept the physicians informed of AMA activities.

Drs. Kleinman & McLaughlin Testify

(Continued from page 1)

with whom the physician was participating. Dr. McLaughlin highlighted multiple issues faced with regard to the implementation of the ACA in New York. She faced a “double whammy” of having a county-wide education campaign to inform breast cancer patients of the availability and coverage of breast reconstruction. In 2010, the State of New York passed legislation making it mandatory for all hospitals to provide cancer patients with information about reconstructive surgery. However, this legislation does not exist on the federal level.

• Dr. Howard Grossman, Chair of Physicians for Compassionate Care, an organization comprised of 600 physicians who have voiced support for medical marijuana, presented information that supports a highly-regulated construct. Dr. Unterricht urged Dr. Grossman to have Compassionate Care physician supporters join MSSNY as members and consider bringing a resolution on the marijuana issue to our House of Delegates.

Troy Oechsner Addresses MSSNY Council Meeting

NYSS’s Deputy Superintendent for Health Troy Oechsner spoke at the January 30 Council Meeting. Mr. Oechsner outlined several important physician issues, including a provision in Governor Andrew Cuomo’s proposed budget, which would remove the consumer from the insurance dispute-resolution process, leaving it up to the doctor and the insurer to settle disputes when the doctor is out-of-network.

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The road to hell is often paved with good intentions. One of the issues that bears its head at both formal and informal meetings with physicians is the large number of unfunded mandates that we are responsible for. Some are valuable; others seem to be forced upon us at the whim of the latest hot button issue. Long after the hubbub dies down and the “flavor of the month” has changed, the mandate remains for physicians to work through their schedule.

I have compiled a list (that is growing as I write this) of requirements mandated by hospitals, insurers, boards and licensing bodies. The following CME requirements involve over 40 to 50 hours a year, some of which only accept (to the exclusion of all others available) one particular course:

- ISTOP time costs and (CME requirements coming soon)
- HEP-C CME
- Child abuse courses
- Infection control CME courses
- CPR courses
- Naloxone courses
- Smoking Cessation courses
- Risk Management courses for excess coverage
- Hospital mandated courses on Risk Management (in addition to HIPAA, IT and others)
- CME mandated for hospital privileges
- CME mandated for insurance company panels

In addition to the educational course listed above, physicians must also spend considerable time on the following obligatory tasks:

- Prior authorization forms for each procedure, required by many insurance companies
- ADA compliance forms for each insurance company
- CAQH updates every 3 months and when data changes
- Must supply corrected information to NYS Physician Profiling Law within 30 days of change and when re-registering
- Filling out Home Health Care forms
- Supplying unfunded foreign language translators required for Medicare and Medicaid patients
- Reporting PQRS measures, even after the program ends or there is a penalty involved. (The costs of reporting far exceed the potential bonuses.)

The following CME requirements involve over 40 to 50 hours a year, some of which only accept (to the exclusion of all others available) one particular course:

- Reporting PQRS measures, even after the program ends or there is a penalty involved. (The costs of reporting far exceed the potential bonuses.)
- Reporting to NCQA and HEDIS for the benefit of the insurance company
- Taking hospital-mandated courses on Risk Management (in addition to HIPAA, IT and others)
- Attending Hospital Departmental Grand Rounds, M&M conferences
- Fulfilling OAS accreditation requirements
- Attesting to Meaningful Use requirements
- Entering information into Immunization Registry (Physician must enter in all immunizations in data base for every child under 19; and having to go back and enter previous immunizations.)

- And worst of all, fulfilling MOC requirements and increasing pressure for MOL requirements.

As far as practice requirements, additional burdens (in chronological order of when mandated was passed):

- 2009- Must screen for elevated lead levels if provide care to children or pregnant women and must report to health office
- 2010- Mandate to provide counseling on palliative care options
- 2011- Mandate to offer HIV test
- 2012- Dense Breast Tissue – radiologists required to ascertain whether woman has a dense breast, and make that information part of the report to the patient
- 2013- SAFE Act- mandated reporter requirements
- 2015- eRX mandate becomes effective

Reporting actions we must take with certain presentations:

- Inform patient that he/she has tested positive for Lyme disease and conduct additional tests as necessary or refer to another physician
- Multiple infectious disease must be reported to NYS DOH, NYC DOHMH and the CDC
- Mandatory eye report for legally blind patients
- Cancer report within 180 days
- Where self-referral is not prohibited, must provide notice to patient of financial relationship.

On the radar:

- Expansion of the OAS accreditation mandate along with mandated data sharing requirements
- Establishment of a mandate on Urgent Care facilities to be licensed and accredited
- I ask you in earnest, how do we find time to see our patients, engage them, diagnose them, and treat them while fulfilling all of the above requirements? You tell me.

RACHEL RUOTOL, MD, HONORED BY NASSAU COUNTY EXECUTIVE

MSSNY member Rachel Ruotolo, MD, of Long Island Plastic Surgical Group, was honored by the Nassau County Executive Edward Mangano and Legislator Rose Marie Walker for her work in treating children with cleft lip and palate birth defects.

Dr. Ruotolo, a pediatric plastic and craniofacial surgeon in Garden City, has helped hundreds of pediatric patients with cleft lip and cleft palate birth defects from Long Island and over 50 countries around the world. Many of her patients were in attendance at the event, which took place at Nassau County’s Ceremonial Chamber.

“I feel truly blessed to be able to make a difference in the lives of these children and their families,” said Dr. Ruotolo. “They’ve helped to raise awareness about this condition, and together we can better educate families who are going through similar situations.”

Dr. Ruotolo has been a partner at Long Island Plastic Surgical Group since 2010. She received her undergraduate degree from Duke University and MD from George Washington School of Medicine, where she graduated with distinction. She completed her general surgery and plastic surgery training at the Hospital of the University of Pennsylvania and pursued specialty training in Pediatric Congenital and Craniofacial Surgery during a fellowship at Medical City Children’s Hospital in Dallas, Texas. Dr. Ruotolo serves on the board of Child Abuse Prevention Services, Long Island’s leading non-profit resource on the prevention of child abuse and neglect.

MEMBERS IN THE NEWS

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The Executive Budget contains a comprehensive proposal to address several issues relative to out of network care, to provide greater transparency of a health insurer’s out of network (OON) coverage, broader availability of a patient’s right to go out of network if the insurer’s existing network is insufficient, provisions to assure that OON benefits are more comprehensive, and provisions to address payments for emergency care and “surprise bills” by OON physicians. Many of the provisions are similar to Senator Hannon’s legislation (S 2551), but there are also some important differences.

The Executive Budget proposal would:

• Require health insurers to describe its OON coverage in a manner that is balanced with the “usual and customary cost” of OON health care services, including examples of anticipated out-of-pocket costs for frequently billed OON health care services, and an internet site that enables patients to determine what out of pockets they can reasonably expect to face based upon the OON coverage provided by the insurer;

• Define “Usual and customary cost” as the “average payment” for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent”. This would appear to imply FAIR Health;

• Requiring health insurers issuing a “comprehensive, geographical” OON coverage of a health insurer’s out of network coverage, broader availability of a patient’s right to go out of network if the insurer’s existing network is insufficient, and provisions to assure that out of network benefits are more comprehensive.

However, it is more limited than the Senate proposal in that it would require insurers issuing a group health insurance policy to “make available” coverage for out of network care at the “70% of usual and customary cost of out of network health care service.”

Moreover, it would make all bills for emergency care and other “surprise bills” for hospital care by non-participating providers subject to an arbitration process.

(See article below)

Governor’s Budget Proposal Include Out Of Network Reform Provisions

The bill contains provisions similar to Senator Hannon’s S 2551 to provide for greater transparency of a health insurer’s out of network coverage, broader availability of a patient’s right to go out of network if the insurer’s existing network is insufficient, and provisions to assure that out of network benefits are more comprehensive.

However, it is more limited than the Senate proposal in that it would require insurers issuing a group health insurance policy to “make available” coverage for out of network care at the “70% of usual and customary cost of out of network health care service.”

Moreover, it would make all bills for emergency care and other “surprise bills” for hospital care by non-participating providers subject to an arbitration process.

(See article below)

The proposed budget would authorize the establishment of limited service clinics within retail establishments owned by publicly traded corporations. These clinics would be staffed by nurse practitioners and would be authorized to provide a limited set of services with no self-referral prohibitions placed on the health professionals from directing patients to make purchases at the retail establishments at which the nurse practitioners or other health professionals are employed. If read in tandem with this proposal, an exclusion on OON practitioners summarized below, a NP could be allowed to “collaborate” with a hospital and placed by the hospital in a retail clinic owned by a publicly traded corporation to provide services in the clinic with no requirement for physician collaboration.

DEFINITION

Urgent Care would be defined as the treatment of acute episodic illness or minor traumas that are not threatening or potentially disabling, including monitoring or treatment of prolonged periods. Any physician who holds their practice out to be an “urgent care” facility must be accredited. The Commissioner is authorized to promulgate regulations redefining these provisions. It is expected that the recommendations of the Public Health and Health Planning Council (PHHPC) reported in Capital Update earlier this month will constitute the body of such regulations.

DEFINITIONS

Urgent Care would be defined as the treatment of acute episodic illness or minor traumas. The minimum characteristics/services that a provider must have in order to be considered an “urgent care” provider include:

Accepts unscheduled, walk-in visits typically with extended hours on week-days and weekends.

• XRay and EKG

• Phlebotomy and Lab Services (CLIA waived tests)

• Administration of oral (PO), sublingual (SL), subcutaneous (SC), intramuscu- lar (IM), intravenous (IV), respiratory, medication and IV fluids

• Urgent care facilities include: fastest expansion over time, service; broaden the definition of reportable events and extend reporting timeframes.

The term “Urgent Care” would be restricted to those providers offering urgent care services as defined and approved by the Department. The term “Urgent Care” is to be used in the name and in signage at the provider site and in materials. Commercial terms (e.g. “Convenient Care,” “FastMed,” etc.) could still be used in a provider’s name, but would need to add “Urgent Care.” For example, “FastMed Urgent Care.” The word “emergency” or its variations, such as “Emergency Care” or “Emergent-care,” “cannot be used by urgent care providers or other providers unless licensed by the State as an emergency department.

Providers offering specialized services (e.g. orthopedic services) typically do not offer the defined scope of urgent care services as the model of urgent care described in this report and would not be permitted to use the term “Urgent Care.” They are more appropriately characterized as specialty care with walk-in appointments.

Providers offering the defined scope of urgent care services required, but limiting their practice to a specific population of patients, such as a pediatric or geriatric population, may be allowed to use the term “Urgent Care” but need to specify the specific population served in their name, such as “Pediatric Urgent Care” or “Geriatric Urgent Care.”

Private physician offices, including those affiliated with an Article 28, wanting to provide Urgent Care Services as a private physician office if they obtain accreditation by an accrediting organization approved by the Department OR they can become an Article 28 through a full CON review.

OBS ACCREDITATION

A provider that wants to provide an Urgent Care Service that requires more than minimal sedation or local anesthesia must seek Office Based Surgery accredi- tation (in addition to any OON care accreditation requirements for equivalence with OBS accreditation). This is consist- ent with current private practice OBS requirements.

Urgent care facilities would be required to provide CHIRM-recognized primary care providers and Federally Qualified Health Centers to patients seen at these clinics who do not have a primary care provider; prominently display signage that states the type of facility and where applicable, post signage to indicate that pre- scripts and over-the-counter supplies, etc., can be purchased from any business and do not need to be purchased on-site; and utilize an EHR and e-prescribe.

OVERVIEW OF OFFICE BASED SURGERY TO BE ENHANCED

The proposed article 7 bill would standardize and limit procedures in an OBS setting; broaden the definition of adverse events; broaden the definition of reportable events and extend reporting timeframes.

Significantly, the proposal would establish a registration process for OBS facilities and to submit certain procedure and quality data as determined by the Department.

The Governor’s Bill would be autho- rized to promulgate these new provisions through regulation.

Also recommended is the clarification in the OBS statute that neuraxial and major upper and lower extremity regional nerve blocks are included in the OBS definition; assure that office based anesthesia is defined to include general anesthesia, neuraxial anesthesia, major upper and lower extremity regional nerve blocks, and moderate sedation, the recommendations would limit OBS/OBA expected procedural time to six hours and limit post-procedural time to meet safe and appropriate discharge to six hours.

ADVERSE REPORTING

With the new accreditation and adverse reporting, the budget proposal would:

• Require all physician practices performing procedures (including non-invasive procedures) utilizing more than minimal sedation to become accredited and file adverse-event reports.

• Require all podiatry practices perform- ing procedures (involving the foot as well as the ankle) utilizing more than minimal sedation to become accredited and file adverse-event reports.

(Continued on page 8)
NY State of Health: The Official Health Plan Marketplace
December 2013 Enrollment Report

New York opened its Health Plan Marketplace, the NY State of Health, on October 1, 2013, allowing New Yorkers to shop for and enroll into quality, affordable, comprehensive health plans. Health plans offered through NY State of Health are on average 53 percent less expensive than coverage New Yorkers purchased directly last year. In addition, many New Yorkers are eligible for additional financial assistance to help further lower the cost of health plan premiums purchased through the Marketplace. New York also successfully launched its Small Business Marketplace providing attractive health plan options to small employers and their employees.

Sixteen health insurers are offering health plan coverage to individuals and ten health insurers also offer plans to small businesses through New York's Marketplace. NY State of Health features a state-of-the-art website where New Yorkers can shop and enroll in coverage; a first class customer service center that is answering questions and enrolling people into coverage; and more than 6,000 certified enrollment experts who are available to provide in-person assistance in the community at convenient times and locations across the State.

INDIVIDUAL MARKETPLACE

As of December 24, 2013, 464,318 New Yorkers had completed applications and 230,624 people had enrolled into a health plan through NY State of Health’s Individual Marketplace for coverage in January 2014. This report offers a snapshot of the 230,624 New Yorkers who enrolled through December 24, 2013. Enrollment in NY State of Health has continued and by January 10, 2014, 285,164 people had enrolled.

Marketplace Enrollment, by Program

New Yorkers from every region in the State have enrolled in QHPs through the Marketplace, with 37 percent of enrollees in New York City and 63 percent of enrollees in other areas of the State. Counties with the largest enrollment are Kings, Queens, Suffolk, Manhattan, Nassau, Erie, Westchester, and Monroe. The enrollment percentages in New York State regions align closely with the regions’ population percentage of the state as a whole.

ENROLLMENT BY ISSUER

Each of the sixteen issuers offering coverage through NY State of Health enrolled members into Qualified Health Plans (QHPs) by the end of December 2013. (Note that the table below shows issuers by their d/b/a, or “doing business as,” since they differ depending on geographic region of the State.) Six issuers each enrolled 10 percent or more: Empire (18%), Healthfirst (16%), Excellus (14%), Emblem (12%), MetroPlus (11%), and MVP (10%). Six percent of enrollees are enrolled in Excellus and the remaining 13 percent of enrollees were spread across nine issuers, each of which enrolled one to two percent of QHP enrollees.

A REVIEW OF WHO IS ENROLLING INTO QUALIFIED HEALTH PLANS IN NY STATE OF HEALTH

Many individuals and families are eligible for financial assistance to reduce the cost of coverage purchased through the Marketplace. Financial assistance is available in two forms:

1) Tax credits will reduce the cost of premiums for most single adults earning less than $45,960 and for families of 4 earning less than $94,200.
2) Cost-sharing reductions will lower co-payments, deductibles, and out of pocket maximums for single adults earning less than $28,725 and for families of 4 earning less than $58,875, who enroll in Silver QHPs. These tax credits and cost-sharing reductions are estimated at the time of application and applied immediately.

Of those who have enrolled in qualified health plans to date, 68 percent have enrolled with financial assistance and 32 percent are paying the full premium. The Marketplace is open to all New Yorkers – including those who are currently uninsured as well as those who have insurance but are interested in applying for other new coverage. Of those who have enrolled to date, nearly half were uninsured at the time of application with higher rates among those who qualify for financial assistance.

QUALIFIED HEALTH PLAN ENROLLMENT

The Marketplace offers Qualified Health Plans at 4 different metal levels: Bronze, Silver, Gold and Platinum. Catastrophic plans are also available to adults below age 30 and adults with cancelled insurance policies. Bronze level plans generally have the lowest premiums and highest out of pocket costs (e.g., deductible or copayment required when receiving services). Platinum level plans have, on average, the highest premiums but have the lowest out-of-pocket costs. Silver and gold level plans fall in the middle.

Cost-sharing reductions are available to eligible individuals for Silver level plans purchased through the Marketplace. These cost-sharing subsidies reduce individuals’ out-of-pocket costs, deductibles, and out of pocket maximums. American Indians and Alaskan Natives are eligible for additional cost-sharing reductions at all metal levels.

Seventeen percent of enrollees are enrolled in Platinum level plans, 12 percent are in Gold level plans, 12 percent are in Silver level plans, 39 percent are in one of three Silver level Cost-sharing Reduction plans, and 18 percent are in Bronze level plans, and 2 percent are in Catastrophic level plans. A total of 156 American Indian/Alaskan Natives are enrolled into a Qualified Health plan.

INCOME

Eligibility for financial assistance is based on household income. The Marketplace collects income data only when consumers indicate that they would like to apply for financial assistance. As such, the income data shown below in Figure 4 is for enrollees in subsidized Qualified Health Plans.

Consumers eligible for subsidized QHPs are eligible for Advance Premium Tax Credits (APTC) up to 400 percent of the federal poverty level (FPL) to reduce monthly premium costs. Consumers eligible for subsidized QHPs are eligible for Cost-sharing Reductions (CSR) if their income is at or below 250 FPL to reduce out of pocket costs for covered services. The income levels corresponding to FPL are available through the US Department of Health and Human Services: http://aspe.hhs. gov/poverty/13poverty.cfm

Nearly half (48 percent) of enrollees in subsidized QHPs have income at or below 200 percent FPL. One quarter (25 percent) of subsidized QHP enrollees have incomes between 200-250 percent FPL. The remaining 27 percent of QHP enrollees have income above 250 percent FPL.

AGE

Marketplace enrollees include a mix of New Yorkers across all age groups. Approximately 30 percent of New Yorkers enrolled in a Qualified Health Plan are under the age of 35, 15 percent are between ages 35 and 44, and 34 percent are over the age of 45.

As expected because of New York’s public program eligibility levels, a very small share of QHP enrollment (4 percent) is for children below age 18. Children over 400 percent of FPL are not eligible for financial assistance and may choose the Marketplace’s enrollment option for the care of their families.

Figure 2: Enrollment, by Issuer
Issuer | % of Qualified Health Plan Enrollment
---|---
Affinity Health Plan | 1%
BlueCross BlueShield of Western New York | 1%
BlueCross BlueShield of Northern New York | Less than 1%
CDPHP Inc. | 1%
EmblemHealth | 12%
Empire Blue Cross Less than | 1%
Empire Blue Cross Blue Shield | 18%
Excellus BlueCross BlueShield | 6%
Fidelis Care | 14%
Health Republic Insurance of New York | 16%
Healthfirst | 2%
Independent Health | 2%
MVP Health Care | 10%
MetroPlus Health Plan | 11%
North Shore-LIJ Insurance Company Inc. | 2%
Oscar | 2%
Today’s Options of New York Less than | 1%
UnitedHealthcare | 12%
Univera Healthcare | Less than 1%
Total | 100%

Figure 3: Qualified Health Plan Enrollees, With and Without Financial Assistance

<table>
<thead>
<tr>
<th>Program</th>
<th># Enrollees</th>
<th>% of Total Qualified Health Plan Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Health Plan, with Tax Credits and Cost-Sharing Subsidies</td>
<td>75,516</td>
<td>50%</td>
</tr>
<tr>
<td>Qualified Health Plan, with Tax Credits only</td>
<td>27,275</td>
<td>18%</td>
</tr>
<tr>
<td>Qualified Health Plan, without Financial Assistance</td>
<td>49,458</td>
<td>32%</td>
</tr>
<tr>
<td>Qualified Health Plan Enrollees</td>
<td>152,249</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 4: Percentage of QHP Enrollees Who Were Uninsured at Time of Application, Among Those Enrolled With and Without Subsidies

<table>
<thead>
<tr>
<th>Program</th>
<th># Enrollees</th>
<th>% of Total QHP Enrollees</th>
<th>% of Uninsured at Time of Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Health Plan, with Tax Credits and Cost-Sharing Subsidies</td>
<td>46,682</td>
<td>75,516</td>
<td>62%</td>
</tr>
<tr>
<td>Qualified Health Plan, with Tax Credits only</td>
<td>14,009</td>
<td>27,275</td>
<td>51%</td>
</tr>
<tr>
<td>Qualified Health Plan, without Financial Assistance</td>
<td>6,534</td>
<td>49,458</td>
<td>13%</td>
</tr>
<tr>
<td>Qualified Health Plan Enrollees</td>
<td>67,225</td>
<td>152,249</td>
<td>44%</td>
</tr>
</tbody>
</table>

New York City | 37%
Mid-Hudson/ | 21%
| Capital/North Country | 20%
| Central | 15%
| Western | 7%
| Total | 100% |
to enroll in full-pay Child Health Plus plans or may enroll in full-pay Qualified Health Plans.

**WEBSITE**

As of December 24, 2013, 518,322 people had created accounts in NY State of Health. This number is higher than the number of people who have applied for coverage because some individuals have not yet completed their applications and because individuals can also create more than one account in the system.

The Marketplace has experienced very high volumes of website visitors. To date, there have been 2,229,123 unique visitors to the website who have viewed 48,145,253 web pages. While the traffic to the site has been high, the website has been operating quite smoothly with an average system response time of 3.8 seconds for each web page.

**Public Programs**

**MEDICAID**

**ELIGIBILITY AND ENROLLMENT**

Through December 24, 2013, 61,625 individuals enrolled in Medicaid through NY State of Health.

With the implementation of the Affordable Care Act, New York expanded Medicaid eligibility levels to 138 percent of the Federal Poverty Level for all eligible New Yorkers. Since New York’s eligibility levels were largely met this new federal standard, this expansion affected single- and childless adults whose eligibility had been at set at 100 percent FPL. The new expansion population represents 20% of new Medicaid enrollees through the Marketplace.

**AGE**

Just over half (51 percent) of Medicaid enrollees are under the age of 35, 37 percent are between age 35 and 54, and 20 percent are over the age of 55.

**CHILD HEALTH PLUS**

**ELIGIBILITY AND ENROLLMENT**


Children in households with incomes up to 400 percent FPL can enroll in subsidized insurance through Child Health Plus. Child Health Plus eligibility begins where Medicaid eligibility ends (154 percent FPL for children over age 1). There is no CHIP premium for children in households with incomes below 160 percent FPL, and a sliding scale premium for those in households with incomes between 160 and 400 percent FPL. Households with income above 400 percent FPL have the option to purchase Child Health Plus coverage at full premium.

**AGE**

Children are eligible for Child Health Plus up to the age of 19. Less than one-third (27 percent) of Child Health Plus enrollees are between the ages of 1 and 5, 55 percent are between the ages of 6 and 12, and 33 percent are between ages 13 and 18. Children under age 1 reflect only 4 percent of CHIP enrollees, likely because infants have a higher Medicaid eligibility (up to 254 percent FPL).

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2 Note that the data here reflect only the share of enrollment that were also enrolling individuals into Medicaid during this period.

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**Report Of The House Committee On Bylaws**

To the House of Delegates, Ladies and Gentlemen:

The Members of the House Committee on Bylaws are as follows:

Steven M. Kaner, MD .......................... Chair Kings Sunny, MD .......................... Vice-Chairing William A. Dolan, MD .......................... Monroe Joyce S. Garber, MD .......................... Onondaga Louis W. Giordano, MD .......................... Broome Robert B. Goldberg, DO .......................... New York William R. Latreille, MD .......................... Franklin Richard M. Peer, MD .......................... Erie Nathan P. Reed, MD .......................... Albany Philip A. Schuh, CPA .......................... Executive Vice President Donald R. Moy, Esq .......................... General Council

At the annual meeting of the House of Delegates Resolutions 2013-1 and 2013-2 were referred to the House Committee on Bylaws. A transcript of the testimony was prepared and provided to the members of the House Committee on Bylaws for review and consideration. Your chair wishes to express his thanks to all the members of the House of Delegates who provided testimony regarding the resolutions. In addition, the Committee received a report from MSSNY’s Long Range Planning Committee pertaining to Resolution 2012-206, consideration of MSSNY’s Mission Statement. Your Committee recommends that the recommendations contained in the Long Range Planning Committee report be adopted.

Resolution 2013-1 was referred to the House Committee on Bylaws

**RESOLUTION 2013-1**

**DELETE ARTICLE XI, SECTION 3 OF MSSNY’S BYLAWS**

Introduced by: Fifth and Sixth District Branches

**Whereas,** the MSSNY Bylaws identify a Professional Medical Liability Insurance and Defense Board as a standing committee (Article XI); SECTION 3. PROFESSIONAL MEDICAL LIABILITY INSURANCE AND DEFENSE BOARD, which hear appeals from adverse decisions by the Medical Liability Mutual Insurance Company (MLMIC) regarding a member’s coverage or rating; and

**Whereas,** in 2010, MSSNY discontinued the activities of the PMLIIB, and those appeals are handled by MLMIC’s claims committee; therefore, be it

RESOLVED, That Article XI, Section 3 of the Bylaws of the Medical Society of the State of New York be deleted.

The Committee heard testimony in support of this resolution. The Committee did not hear any testimony in opposition to the resolution. Accordingly, the House Committee on Bylaws recommends that Resolution 2013-1 BE ADOPTED

Resolution 2013-2 was referred to the House Committee on Bylaws

**RESOLUTION 2013-2**

**HOD REPRESENTATION FOR SMALL COUNTIES**

Introduced by: Fifth and Sixth District Branches

**Whereas,** MSSNY Bylaws Article III, Section 1 (House of Delegates Composition) states:

The number of delegates to which each component county medical society is entitled shall be determined by one of the following:

1. Each component county medical society shall be entitled to as many delegates as shall be State assembly districts in such county at the time of election, but each county medical society shall be entitled to elect at least one delegate:


a. Any component county medical society which, according to the rules of the Medical Society of the State of New York two months prior to the annual meeting, shall have had up to 99 members, shall be entitled to 1 delegate.

b. When the (one) delegate from a component county medical society having a total membership of up to 99 is unable to attend the House of Delegates and be credited as a delegate from a specific county medical society, then in that event, that county medical society shall be entitled to designate one member from another county medical society within its specific district branch to be credited as a delegate to the House.

**Whereas,** Under the assembly district method county medical societies with small numbers of members may be allocated two or more delegates, and

**Whereas,** County societies are not always able to recruit any members to serve as delegates, and

**Whereas,** Small county medical societies have correspondingly small operating budgets and often cannot afford to send even one delegate to the HOD; therefore, be it

RESOLVED, that the Bylaws of the Medical Society of the State of New York be amended to allow any county medical society which is not able to send any delegates to the MSSNY HOD to designate one member from another county medical society within its specific district branch to be credited as a delegate to the House.

The second paragraph to subparagraph (b) of Article III, Section 1 states as follows:

“When the (one) delegate from a component county medical society having a total membership of up to 99 is unable to attend the House of Delegates and be credited as a delegate from a specific county medical society, then in that event, that county medical society shall be entitled to designate one member from another county medical society within its specific district branch to be credited as a delegate to the House.”

The Committee heard testimony at that times, county medical societies with more than 99 members have been unable to send delegates to the House of Delegates, but have not been permitted to designate one member from another county medical society within its specific branch to be credited as a delegate to the House because the above provision is only available to a county medical society having a total membership of up to 99 members. Your committee believes that this is not equitable. Your committee believes that this provision should be available to each county medical society, regardless of size, that is unable to send any delegates to the House of Delegates from the specific county medical society. It is emphasized that this provision should only be available to a county medical society that is unable to send any delegate. If a county medical society is able to send one or more of its delegates, but not its full allotment of delegates, this provision is not available. For example, this provision would not be available to a county medical society that is entitled to 2 delegates, but which is only able to send 1 delegate.

Accordingly, the House Committee on Bylaws recommends that subparagraph (b) of Article III, Section 1 of MSSNY’s By-laws be amended as follows (additions underlined, deletions lines through):

(b) Any component county medical society which, according to the rules of the Medical Society of the State of New York two months prior to the annual meeting, shall have had up to 99 members, shall be entitled to 1 delegate.

When one (1) delegate from a component county medical society having a total membership of up to 99 is unable to attend the House of Delegates and be credited as a delegate from a specific county medical society, then in that event, that county medical society shall be entitled to designate one member from another county medical society within its specific district branch to be credited as a delegate to the House.

Any component county medical society having 100 to 199 members shall be entitled to 2 delegates. Any component county medical society having 200 to 349 members shall be entitled to 3 delegates.

Any component county medical society having 350 to 499 members shall be entitled to 4 delegates. Therefore, any component county medical society having 500 to 749 members shall be entitled to 5 delegates. Any component county medical society having 750 to 999 members shall be entitled to 6 delegates.

Any component county medical society having 1,000 or more members shall be entitled to at least 7 delegates and 1 additional delegate for each additional 300 members.

Each component county medical society shall be entitled to designate at least 1 delegate, but no county medical society shall be entitled to designate more than 30 delegates.

If a county medical society is unable to send any delegates to the House of Delegates to be credited as a delegate from the specific county medical society, then and in that event, such county medical society shall be entitled to designate at least 1 delegate from another county medical society within its specific district branch to be credited as a delegate to the House. The provision is only available in the case where a county medical society is unable to send any delegate whatsoever from the specific county medical society, and that in the event, such county medical society shall be entitled to send at least 1 delegate from the specific county medical society.

Accordingly, the House Committee on Bylaws recommends that resolution 2013-2 BE ADOPTED AS AMENDED

**CONSIDERATION OF MSSNY’S MISSION STATEMENT**

Introduced by: New York County Medical Society

**Whereas,** MSSNY’s Mission Statement has been operating quite smoothly with an average system response time of 3.8 seconds for each web page.
MSSNY News of New York
March 2014

**Role of Surgeon General**

"The role is not to be a legislator or a judge. The role is to be a public health educator."

Vivek Murthy, President Obama’s nominee for surgeon general, on his role should he be confirmed

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**Governor’s Budget Proposal**

(Continued from page 5)

- Add “observation of longer than 24 hours within 3 days of OBS” and “unannounced emergency department visit within 72 hours” to list of reportable adverse events.
- Extend reporting time to 3 days/72 hours.

The proposal would require that attributing bodies:
- Share the outcomes of survey and complaint/referral investigations and other requested data with DOH upon request;
- Survey OBS/OBA practices and carry out complaint/incident investigations upon DOH request; and
- Utilize American Board of Medical Specialties (ABMS) certification, hospital privileges, or other equivalent determination of competency in assessing credentialing of practitioners to perform procedures and/or provide sedation/anesthesia.

**WORKFORCE**

*NURSE PRACTITIONERS AUTHORIZED TO PRACTICE IN COLLABORATION WITH OTHER NPS*

The proposed budget would allow Nurse Practitioners to practice for six months in collaboration with an NP who has been in practice for more than three thousand six hundred hours (1 year) if: (a) the collaborating physician retires, moves, dies, or becomes disqualified to practice and (b) the NP has demonstrated to the Department that she has made a good faith effort to find another collaborating physician but cannot.

Also, NPs with more than 3600 hours of practice (1 year) would be authorized to collaborate either with a physician or a hospital.

**NO FAULT**

DFS SUPERINTENDENT CONFERRED GREATER AUTHORITY TO INVESTIGATE NO-FAULT FRAUD

The Governor’s proposal would provide the Superintendent of Financial Services greater authority to investigate No-fault fraud by various health care providers by enabling the DFS Superintendent to make an examination, “including an audit or unannounced inspection” of a provider of health care services “when the superintendent deems it expedient for the protection of the people of this state”.

**PUBLIC HEALTH**

**CHP**

MSSNY’s Committee on Physician’s Health (CHP) Program would continue to be funded at $900,000.

**NYS BUDGET BILL INCLUDES PROVISIONS TO REMOVE SEPARATE, WRITTEN CONSENT FROM HIV LAW**

Governor Andrew Cuomo Article 7 Health and Mental Hygiene Budget Bill has included draft provisions to remove the requirement for separate, written consent when offering an HIV test. The provisions indicate that there needs to be informed consent and the person ordering the test shall at a minimum advise the individuals that the HIV-related test is being performed.

Under the bill’s provisions, the physician must note the notification in the patient chart and must provide the patient with information that HIV causes AIDS; that there is treatment for HIV; that the health care provider believe the individual has been exposed to HIV; that the individual has the right to confidential counseling; and that the individual can adopt safe practices to protect themselves in their lives from becoming infected; that testing is voluntary and that it can be done anonymously at a public testing center; that the law protects the confidentiality of HIV-related test results and prohibits discrimination based on an individual’s HIV status and that the law allows an individual’s informed consent for HIV-related testing to be valid for such testing until such time it is revoked by the patient. Should the provisions of the bill pass the New York State Legislature, there would be protocols put in place to ensure compliance with this section. The change amends the Public Health Law, Section 2781 and Chapter 308, Laws of 2010.

In 2010, New York State Legislature changed its HIV law to comply with some of the 2006 Centers for Disease Control and Prevention “Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings” that expanded requirements to offer an HIV test to persons between the ages 13-64. The 2010, New York State law which changed requirements for pre- and post-test counseling and allowed for the use of rapid HIV testing, still required separate written consent from the patient. For over 25 years, the Medical Society of the State of New York advocated that HIV testing be part of routine medical care and believed that separate, written informed consent remained the biggest barrier for patients to get tested for HIV. The Medical Society supports this provision of the Article 7 Health and Mental Hygiene Budget Bill and urges its members to communicate with their legislators about this issue. The HIV provisions of this bill must now pass the legislature as part of the 2014-15 NYS Budget.

**AIDS INSTITUTE RELEASES GUIDANCE ON THE USE OF PEP TO PREVENT HIV TRANSMISSION**

The New York State Department of Health AIDS Institute (NYSDOH AI) supports the addition of pre-exposure prophylaxis (PrEP) to the menu of evidence-based interventions to prevent HIV transmission. To promote effective use of this biomedical intervention, DOH has announced the release of a new guidance document for the use of pre-exposure prophylaxis (PrEP). Go to http://bit.ly/1bPhqWT for information.

The document includes a series of tables and checklists that can be easily used at the point of care.
CME Program Now Available
For Viewing

A continuing medical education archived webinar program on MERS-CoV is now available for physicians to view. The “Middle East Respiratory Syndrome-Coronavirus” is a Physicians’ Emergency Response Exercise that the Medical Society of the State of New York and the New York State Department of Health originally conducted in November 2013. The program was funded by a DHHS grant, entitled the New York State Hospital Preparedness Program.

The educational objectives of the webinar are:
- Obtain information about local, state and national chain of command in a public health emergency and learn how to access resources;
- Understand the importance of planning for medical surge and triage of patients, as well as staff and family considerations, in the office-based practice setting during a health emergency;
- Develop an understanding that all public health emergencies can potentially have mental health implications for survivors and others connected with the event;
- Acquire skills for the management of patients in a public health emergency.

MERS-CoV objectives:
- Become familiar with the epidemiology and clinical features of the MERS-CoV;
- Understand the physician’s role in the public health response to an infectious diseases outbreak.

The archived webinar has been accredited for 3.0 AMA/PRA Category 1 credits™. Physicians must register for this program at http://tinyurl.com/mK28qyt. Registration includes name, email address, county you practice in and the MSSNY ID# if a member of MSSNY. All physicians may take this program free of charge.

Following the viewing of the webinar, all physicians must complete a post-test and an evaluation in order for CME credits to be awarded.
**New York Revises Request for $10 Billion Medicaid Adjustment**

New York has revised its request for a $10 billion Medicaid adjustment, which would allow using that money in related health-care programs, after federal officials concluded capital investment and some other programs are ineligible. The application was first filed 18 months ago, prompting Gov. Andrew Cuomo and Health Commissioner Dr. Nirav Shah last week to publicly blame the federal delay for threatening financially distressed New York hospitals.

HHS Secretary Kathleen Sebelius said in a letter responding to Cuomo that they’ve begun drafting “a potential agreement” based on New York’s revisions, but there are “outstanding issues.” Sebelius wrote that the so-called Medicaid waiver, intended to improve care for patients while lowering system costs, “will not, nor should it, determine the future path for particular New York hospitals.”

New York now proposes spending most of the $10 billion over five years on more primary care and alternative care, like home visits by nurses to women with high-risk pregnancies, along with transitional subsidies for hospitals that will lose patients. The major New York goal is to reduce avoidable hospitalizations by 25%, according to the state Health Department.

Among the items in the state’s initial application that federal officials rejected as “unfundable” are capital investment, rent subsidies for hospitals that will lose patients. The major New York goal is to reduce avoidable hospitalizations by 25%, according to the state Health Department.

We cannot possibly recount all the volunteer work that is done by our Alliance members across the state for our physician families, our communities and for countless not-for-profit organizations, but we can acknowledge them and offer our sincerest thanks.

**OBITUARIES**

CAVANAGH, James Joseph; Rockville Centre NY. Died December 14, 2013, age 81. Nassau County Medical Society.


DE WEES, James A.; Rochester NY. Died November 14, 2013, age 93. Monroe County Medical Society.

GOLDBERG, Ivan Kenneth; New York NY. Died November 26, 2013, age 86. Monroe County Medical Society.


HIRSCHBERG, Stephen E.; Yonkers NY. Died October 07, 2013, age 91. Medical Society County of Westchester.

HAMBRICK, George W. Jr.; Charlottesville VA. Died December 29, 2013, age 94. Medical Society County of Queens.

LESTER, Louis J.; Great Neck NY. Died December 14, 2013, age 98. Nassau County Medical Society.


MAHON, William M.; Islip NY. Died December 14, 2013, age 91. Nassau County Medical Society.


OBERSTEINER, Howard L.; Westbury NY. Died December 14, 2013, age 98. Nassau County Medical Society.

QUESADA, Hector Antonio; Bardonia NY. Died December 20, 2013, age 95. Nassau County Medical Society.

ROSI, Mario Brando; Stony Brook NY. Died December 07, 2013, age 84. Suffolk County Medical Society.

THALLINGER, Merrell E.; Norwich NY. Died December 01, 2013, age 84. Medical Society County of Chenango.

THOMAS, Elapumkal A.; Syracuse NY. Died December 11, 2013, age 84. Onondaga County Medical Society.

WECHTER, Joseph A.; Lancaster NY. Died November 18, 2013, age 86. Erie County Medical Society.

ZITRIN, Charlotte M.; Great Neck NY. Died December 03, 2013, age 95. Nassau County Medical Society.
Hepatitis C Testing Requirement

Now in Effect in NYS

A requirement to offer a Hepatitis C screening test to individuals born between 1945 and 1965 became effective on January 1, 2014. Chapter 425, Laws of 2013 was signed by Governor Cuomo on October 23, 2013 and amended the public health law to require hospitals and primary care physicians to offer Hepatitis C screening test to individuals born between 1945 and 1965. The law was previously signed by Governor Cuomo in 2011.

PHYSICIAN EMPLOYMENT OPPORTUNITIES

INTERNET MEDICINE/PRIMARY CARE PHYSICIANS

Established Bronx-based multi-specialty group of 80 providers is expanding and has multiple openings for full-time and part-time Internal Medicine/Primary Care Physicians and Nurse Practitioners for Ambulatory Care, Home Visits, Urgent Care, and Inpatient Services. Offices located in medically underserved areas and within hospital campuses in the Bronx, Brooklyn, Queens and Staten Island. Competitive salary and benefits package, including malpractice coverage, health insurance, 401k, paid time off, and increased evening and weekend privileges.

We look forward to hearing from qualified candidates interested in joining us. Interested please e-mail your resume to: recruitment@lesseendm.com

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Spacious luxury office on 56th street between Park and Lexington. This spacious office offers a reception area (including an esthetician, therapist, etc.) and is part of a three-office suite. Newly renovated and centrally located in the heart of Midtown. 24-hour downstairs 3 rooms, 1 kitchen and reception area. Newly renovated $2300/Mo Available in March. For more information, please email: Stephanie Middelton at stephanie@middeltonnutrition.com

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P: (914) 548-4543 E: jmp@MainStreetGroup.com
Info & Photos: www.1234CentralParkAvenue.com

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Fully furnished orthopedic office: Commack for sublease. It is perfect for a solo practice and is handicap accessible. Square footage: 3,600 with reception area, office space staff with 3 labs, 5 exam rooms, 1 office and a kitchen. Conveniently located on Commack Road near the LIRR. The office is suitable for other medical or therapeutic specialties. Please call Cherry at 631-803-4300 for additional information.

PHYSICIAN ASSISTANT NEEDED FOR NYC MULTI-SPECIALTY PRIVATE PRACTICE

Part-time Upper East Side - Park Avenue 60’s

Excellent opportunity for a Certified Physician Assistant to join a well-established private practice. Must have 1-2 years experience. Salary commensurate with experience.

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