Narrow networks and high-deductible health plans are root causes of today’s surprise medical bills epidemic. Don’t let Congress rubber stamp insurers’ preferred solution. Take action now! Visit www.freeroots.com to show support for policies that protect your patients and practice. The Medical Society of the State of New York is taking action on quickly-moving federal legislation on “surprise” billing, which refers to bills that patients incur when they access out-of-network emergency care or receive unanticipated out-of-network services at an in-network hospital or facility. We have joined with other physician organizations, to promote a fair and balanced solution for surprise billing – the bipartisan Ruiz-Roe framework that is modeled on New York’s successful law. That’s why Congress must hear from you about the grave consequences for patients if the insurer-championed rate-setting approach prevails! Click here to access a simple tool that will match you to your members of Congress and enable you to urge them to take the right approach to surprise billing.

MSSNY’s Statement re Creation of Maternal Mortality Review Board

“The Medical Society of the State of New York thanks Governor Andrew Cuomo and the Legislature for passing and signing into law the creation of a Maternal Mortality Review Board. The creation of a maternal mortality review board will assist the state in developing and creating new strategies to improve maternal health and lessen the impact of maternal mortality and morbidity. Under this law, the review board would allow multidisciplinary experts to conduct a review process of causes of maternal death, factors leading to death, preventability and opportunities for intervention. It requires the board to report aggregate findings and recommendations in order to share best practices on the prevention of maternal deaths. The law embraces national best practices on maternal health and ensures accountability and sustainability of a maternal review board. It ensures that the board is diverse, multi-disciplinary and includes experts who serve and are representative of the diversity of women in medically underserved areas of the state. It also ensures confidentiality protections regarding the board’s proceeding and requires the board to report on its aggregate findings and recommendations,” stated Dr. Arthur Fougner, MSSNY President.

USPSTF Proposes Screening All Adults for Illicit Drug Use

On August 13, the U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation that providers screen all adult patients for illicit drug use, marking the first time the task force has proposed such a recommendation. According to STAT News, the draft recommendation is intended to help combat the U.S. opioid epidemic. A federal survey in 2017 found one in 10 U.S. residents older than age 18 reported using drugs or prescription drugs illicitly, and other research has shown more than 70,000 U.S. residents in 2017 died from a drug overdose, STAT News reports. USPSTF in 2008 had concluded that there was insufficient evidence to recommend that providers screen all adult patients for illicit drug use. However, based on new evidence, USPSTF on August 13 proposed that providers screen all patients ages 18 and older for illicit drug use if the providers can offer or refer patients to services to accurately diagnose and effectively treat substance use disorders. USPSTF in the draft recommendation defined illicit drug use as the use of illicit drugs or prescription drugs in amounts and for durations to

(Continued on page 2)
Those with Employment Coverage Persistently High Spending Averaged Almost $88,000 in Health Spending in 2017 Prescription Drugs Accounted for almost 40 Percent of Costs

Among people with three consecutive years of coverage from a large employer, just 1.3 percent of enrollees accounted for 19.5 percent of overall health spending in 2017, finds a new KFF analysis. These “people with persistently high spending” – people in the top five percent of spending in each of the three years from 2015 to 2017 – had average health spending of $87,870 in 2017. That compared to average per person spending of $5,870 among all large group enrollees during that period.

Spending on retail prescription drugs accounted for almost 40 percent of spending for those with persistently high spending in 2017, more than twice the percentage for enrollees overall. People with persistently high spending averaged over $34,100 in spending on retail prescription drugs (not including rebates) in 2017, compared to $1,290 for enrollees overall, the analysis finds. This underscores the importance of prescription drugs in treating people with chronic illnesses as well as the fact that some drugs have very high prices.

The analysis also finds a close association between having persistently high spending and being diagnosed with certain chronic health conditions such as HIV, multiple sclerosis, cystic fibrosis, rheumatoid arthritis, diabetes with complications, and a number of cancers. While not everyone with these conditions has persistently high spending, there are large shares of people with persistently high spending who have these diseases.

Overall, health spending is highly concentrated: a small share of people

(Continued on page 5)

USPSTF Proposes Screening All Adults

(Continued from page 1)

RECOMMEND QUESTIONS NOT DRUG TESTS

According to the draft recommendation, USPSTF found new evidence showing screening tools can allow providers to detect whether a patient is using drugs illicitly and whether a patient might need to be assessed further. However, Karina Davidson, co-chair of USPSTF, noted that the task force is not recommending providers use drug tests to screen their patients. Instead, USPTF said providers could ask their patients a series of questions to determine whether they are using drugs illicitly.

Based on the evidence, USPSTF concluded “with moderate certainty” that screening adult patients for illicit drug use has a moderate net benefit when providers can offer or refer patients to services to diagnose and treat substance use disorders. USPSTF did not endorse a particular screening tool or treatment, which means providers who follow the recommendations can decide how they will screen and treat their patients.

USPSTF gave a “B” grade to the draft recommendation. Under the Affordable Care Act, insurers are required to cover preventive services that receive a “B” grade or higher from USPTF without cost sharing.

USPSTF did not extend the draft recommendation to adolescent patients between the ages of 12 and 17. The task force said there was insufficient evidence to determine whether screening tools and treatments are safe and effective for adolescents. According to STAT News, the long-term effects of certain treatments on the developing brains of adolescents are unknown, which is why treatments such as buprenorphine are approved only for use among patients 16 and older.

USPSTF in the draft recommendation called for additional research on screening tools and treatments for adolescents who use drugs illicitly.

USPSTF is accepting comments on the draft recommendation through Sept. 9.

Gary LeRoy, president-elect of the American Academy of Family Physicians (AAFP), agreed, saying it is crucial for providers to have substance use disorder care available on site, because there is a possibility that patients will not receive appropriate care if they leave the provider’s facility. LeRoy noted many providers likely already are screening patients for illicit drug use, though they might not be using a specific assessment tool. “We may not be checking boxes on a screen, but we’re mentally checking boxes saying something is wrong,” he said.

Be Sure to Listen to MSSNY’s Latest Podcast:

MSSNY proudly announces our latest podcast entitled The Mental Health Needs of Women in the Military. Dr. Frank Dowling, MSSNY Secretary, discusses the history and challenges faced by women in the military with Dr. Malene Ingram, Colonel, US Army Reserves and Marcelle Leis, CMS (Ret.) USAF/ANG and Lance Allen Want, Lt. Col. (Ret.) USA. Listen here: www.buzzsprout.com.

(Continued on page 16)
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- Warren Buffett, CEO, Berkshire Hathaway

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**PRESIDENT’S COLUMN**

**Surprise Bills Struggle Continues**

"Great results, can be achieved with small forces."

– Sun Tzu, The Art of War

As Congress is about to return to DC, the insurers must be feeling pretty smug. Both the Senate and House are prepared to hand them quite a victory. Both Senate Bill S1895 and House HR3630 suggest that the way to resolve billing for out of network services is to pay the median In Network payment rather than New York’s baseball style arbitration. Yes, the Democrats who are usually aligned against the insurers and Republicans who normally favor market-based solutions both feel the urgency of a political solution to the issue in the run up to 2020. They are also counting on physicians to tell their woeful tales, “full of sound and fury, signifying nothing.”

So let’s look at where we are on this issue from a patient’s perspective. All the proposed solutions would hold patients harmless for any cost other than their own plan’s normal financial obligation – period, end of story. What should give patients pause, however, is the knowledge that many specialists are not necessarily in their network and that allowing consultants to bill at their own rate provides a far wider pool for coverage, especially in emergency situations. Additionally, patients are also not aware that it is the insurers which have forced many physicians out of the network as a cost control measure. A reasonable person would ask why, if insurers wished to pay physicians at in network rates, do they not open the doors to the networks rather than narrow them? Perhaps we should be asking legislators the same question.

“In the midst of chaos, there is also opportunity.”

–Sun Tzu, The Art of War

After my last weekly column, I received an email from a surgeon whose practice was treading water. Turning over all payment decisions to insurers would put this physician out of business. In the midst of a looming doctor shortage, is this what Congress truly wants? We should call them on this.

Last week, I read with great surprise that many physicians out of the country are looking to practice in the U.S. Perhaps we should be asking insurers which have forced them on this.

**MSSNY-PAC**

**Gearing Up for the 2020 Legislative Session**

While the legislative session between January and June is when bills are actually passed, “off-session” is the ideal time to ramp up grassroots activity, contacting your legislators and working to promote the needs of our patients and our profession. Advancing or defeating legislation is a full-year process and we must maximize our time and energy. Please take the time to sit down with your local legislators and their staffs to discuss the issues facing your practice and how that impacts the ability of your patients to get the care they need.

MSSNY and county society leadership and the Legislation and Physician Advocacy Committee will officially begin meeting in September to discuss and craft strategies for 2020. At the meetings, attendees will hold an initial discussion of items to be included in MSSNY’s 2020 Legislative Program, as well as an initial discussion of the Resolutions referred to the Committee from the MSSNY 2019 House of Delegates. From this meeting, the staff will take recommendations and develop a draft program for 2020 that will be reviewed and finalized when the committee meets again in October. Once finalized, this program will serve as the guide for MSSNY and the physician community’s legislative activity during the upcoming session.

We know that there will be many

(Continued on page 17)
Permitted Uses of Safe and Sick Leave

(Continued from page 2)

health emergency.

An employee may use safe and sick leave for an employee who becomes a victim of domestic violence, sexual assault, stalking, or human trafficking to:

• obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program for relief from a family offense matter, sexual offense, stalking, or human trafficking;

• participate in safety planning, relocate, or take other actions to increase their safety and that of family members from future family offense matters, sexual offenses, stalking, or human trafficking, including enrolling children in a new school;

• meet with an attorney or social service provider to obtain information and advice and prepare for or participate in any criminal or civil proceeding, related to family offense matters, sexual offenses, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, or discrimination in employment, housing, or consumer credit;

• file a domestic incident report with law enforcement or meet with a district attorney's office; and

• take other actions necessary to maintain or improve the employee's or employee's family member's physical, psychological, or economic health or to protect those associating or working with the employee.

Under the ESSTA, employees are also entitled to take sick leave to care for a covered family member, a category that is broad in scope. This category includes an employee's child. The child must be biological, adopted, foster, step, legal ward, a son or daughter of a spouse or registered domestic partner, or a child to which the employee stands in loco parentis. It also includes the parent of an employee, who must be biological, adopted, foster, step, legal guardian, or a person that was in loco parentis when the employee was a minor. Also falling within this class are: 1) a parent-in-law, through a spouse or registered domestic partner; 2) spouse; 3) registered domestic partner; 4) grandparent; 5) grandchild; 6) sibling; and 7) blood relatives. The ESSTA also covers any other individual whose close association with the employee is the equivalent of a family relationship.

Under the ESSTA, employees can use the full amount of sick leave for a qualifying family member.

Finally, employers may require the use of sick leave when an employee qualifies for leave under the Family and Medical Leave Act (FMLA) and New York State’s Paid Family Leave (NYPFL). However, employers must recognize that the ESSTA is broader than the FMLA or NYPFL because it covers siblings, blood relatives and any other individual whose close association with the employee is the equivalent of a family relationship. Also, the ESSTA and NYPFL cover registered domestic partners, but the FMLA does not.

Madelin T. Zwerling is an attorney at Garfunkel Wild, P.C., which she joined in 2011, and a member of the Employment Law Practice Group, which provides legal advice on a full range of employment matters. She may be reached at mzwerling@garfunkelwild.com or (516) 393-2510.

Veterans’ Care Claims Inappropriately Denied

Veteran Affairs (VA) claims processors inappropriately processed claims for emergency care received at non-VA hospitals, resulting in denied or rejected claims for tens of thousands of veterans, according to a recent VA Office of Inspector General (OIG) report. VA’s OIG noted that denied or rejected claims can leave veterans on the hook for the total costs of their care.

United: “Average Price for Treating Primary Care Conditions in ED? $2,032”

Each time a patient enters the emergency department with a condition that can be treated in a primary care setting, it comes at an average cost of $2,032 to the healthcare system, according to an analysis published by UnitedHealth Group.

UnitedHealth said the average cost is 12 times higher than visiting a physician office, which costs an average of $167. It also said the $2,032 price tag is 10 times higher than an urgent care visit, which costs an average of $193. “In other words, visiting either a physician's office or an urgent care facility instead of a hospital would save an average of more than $1,800 per visit — creating a $32 billion annual savings opportunity system wide,” according to UnitedHealth.

UnitedHealth said the 10 most common conditions treated in the ED that could be treated in a primary care setting are bronchitis, cough, dizziness, flu, headache, low back pain, nausea, sore throat, strep throat and upper respiratory infection. UnitedHealth projects 18 million of the 27 million ED visits made by privately insured Americans each year are avoidable.
40% of Physicians Refuse New Patients Who Use Opioids for Chronic Pain

Researchers found that more than 40% of physicians refuse “to take on new patients who need opioids to control pain.” The study surveyed 194 primary care clinics in Michigan. The findings were published in JAMA.

CMS’ 2020 Proposed Rule Released that Will Reduce Paperwork

On July 29, CMS proposed major policy changes to ensure clinicians spend more time providing high-value care for patients instead of filing cumbersome paperwork. As part of CMS’s annual changes to the Medicare Physician Fee Schedule and Quality Payment Program, the agency’s proposals are aimed at reducing burden, recognizing clinicians for the time they spend with patients, removing unnecessary measures and making it easier for them to be on the path towards value-based care. This proposed rule builds on the Trump Administration’s efforts to establish a patient-driven healthcare system that focuses on better health outcomes, and is projected to save 2.3 million hours per year in burden reduction.

For the full press release describing this announcement, please visit here.

For a fact sheet on the CY 2020 Physician Fee Schedule proposed rule, please visit here.

To view the CY 2020 Physician Fee Schedule and Quality Payment Program proposed rule, please visit here.

THE CURE FOR THE COMMON DIAMOND BUYING EXPERIENCE.

Whether you are looking for an engagement ring, diamond studs, tennis bracelet, diamond pendant, or something unique, our goal is to offer MSSNY members a different and a better way to buy.

As manufacturers of rough diamonds and one of the few select clients of the De Beers Company, we are in the position to offer you uncommon access to our world-class, in-house inventory of GIA-certified diamonds and diamond jewelry.

By buying close to the source, you’ll save money, yet not sacrifice on quality. Additionally, one of our diamond experts will guide you through the entire process to ensure it’s a smooth and a pleasant one. We invite you to set up a complimentary, no-obligation consultation either in-person in our 5th Avenue offices, or via phone or video chat.

Contact our concierge directly at info@premiergemconcierge.com or call us at 212-319-5151.

Also, feel free to visit www.jewelryatwork.com using login code 2656 to see diamond jewelry options and let us help you Celebrate Your Life with Diamonds™.

Four Things to Know About UnitedHealthcare’s Enrollment

UnitedHealth Group’s health insurance arm, UnitedHealthcare, recorded a total medical enrollment of 49.5 million as of June 30, according to recent financial documents.

Four things to know about UnitedHealthcare’s medical enrollment:
1. UnitedHealthcare’s commercial enrollment totals 27.4 million.
2. The insurer enrolls 5.2 million members in its Medicare Advantage plans.
3. Medicaid enrollment accounts for 6.4 million of UnitedHealthcare’s members.
4. Internationally, 6.1 million people are enrolled in UnitedHealthcare coverage.

“While demand remains strong for primary care physicians, specialists are increasingly needed to care for an older and sicker population.”

Travis Singleton, Executive Vice President of Merritt Hawkins, discussing finding from a new report from the physician recruiting firm
11 Neurological Surgery, P.C. (NSPC)
Physicians Named to 2018 Castle Connolly “Top Doctors: NY Metro Area” List

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Jonathan L. Brisman, M.D.
Neurovascular Neurosurgery
Castle Connolly “Top Doctor”

Lee Tessler, M.D.
Brain Tumors
Castle Connolly “Top Doctor”

Brian J. Snyder, M.D.
Pain & Parkinson’s Surgery
Castle Connolly “Top Doctor”

Stephen T. Onesti, M.D.
Spine Surgery
Castle Connolly “Top Doctor”

Vladimir Y. Dadashev, M.D.
Spine Surgery
Castle Connolly “Top Doctor”

John A. Grant, M.D.
Pediatric Neurosurgery
Castle Connolly “Top Doctor”

Benjamin R. Cohen, M.D.
Spine Surgery
Castle Connolly “Top Doctor”

John Pile-Spellman, M.D.
Endovascular Neuroradiology
Castle Connolly “Top Doctor”

Roger W. Kula, M.D.
Chiari Neurology
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Sundeep Mangla, M.D.
Endovascular Neuroradiology
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September 2019 • MSSNY’s News of New York • Page 7
If your practice is using an EHR to capture patient data and coordinate care, you may be eligible for free support and assistance achieving Promoting Interoperability (formerly Meaningful Use) Program objectives through the Medicaid Eligible Professional Program, a New York State Department of Health initiative.

The New York eHealth Collaborative Healthcare Advisory Professional Services (HAPS) team is ready to assist providers in achieving the various stages of Promoting Interoperability.

Find out more at nyehealth.org/support

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**10 Biggest Healthcare Stocks of 2019**

Healthcare is a fast-growing sector, and the 10 biggest healthcare stocks combined generate nearly $600 billion in annual revenue, according to *The Motley Fool*.

Each of the companies that earned a spot among the 10 biggest healthcare stocks have market caps of at least $110 billion. Companies that occupy the top five spots have market caps exceeding $210 billion.

Here are the 10 biggest healthcare stocks of 2019, according to *The Motley Fool*:

1. Johnson & Johnson: $372 billion market cap
2. Pfizer: $246 billion
3. UnitedHealth Group: $232 billion
4. Merck: $220 billion
5. Novartis: $212 billion
6. Abbott Laboratories: $150 billion
7. Medtronic: $132 billion
8. Thermo Fisher Scientific: $120 billion
9. Amgen: $114 billion
10. Eli Lilly: $11 billion

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**Fourth Annual DoctHERS Symposium in Buffalo on September 21**

The Jacobs School of Medicine and Biomedical Sciences’ Medical Alumni Association is proud to present the 4th Annual DoctHERS Symposium.

**When:** Saturday, September 21, 2019

**What time?:** 8:00 a.m. - 12:00 p.m.

**Where?:** The Westin Buffalo, 250 Delaware Avenue, Buffalo, NY 14202

**Cost:** $25 general admissions; students and residents are free

Join for a morning of networking, information, enrichment and resources for pay, promotions and equity in the workplace and support for females in the healthcare profession. Dr. Rose Berkun, MSSNYPAC Co-Chair, is the Chair of the program and is a Clinical Assistant Professor of Anesthesiology Jacobs School of Medicine and Biomedical Sciences.

**2019 SYMPOSIUM REGISTRATION**

Registration for the 2019 DoctHERS Symposium will be open soon! [Learn more about DoctHERS here](#)

**KEYNOTE SPEAKER**

Susan R. Bailey, MD, President-Elect, American Medical Association,

Allergist in private practice, Fort Worth, TX,

Distinguished Fellow of the American College of Allergy, Asthma, and Immunology

“Leadership and the Urgency of the Moment in Medicine”

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**Use your EHR to its fullest potential**

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If your practice is using an EHR to capture patient data and coordinate care, you may be eligible for free support and assistance achieving Promoting Interoperability (formerly Meaningful Use) Program objectives through the Medicaid Eligible Professional Program, a New York State Department of Health initiative.

The New York eHealth Collaborative Healthcare Advisory Professional Services (HAPS) team is ready to assist providers in achieving the various stages of Promoting Interoperability.

Find out more at nyehealth.org/support
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Visit The Medical Society of The State of New York website to enroll in a signature membership.

Enroll online through the special LA Fitness website linked from your employee benefits page. Offer valid until 8/12/2020. Must pay initiation fee plus first and last month's dues to join and a recurring annual fee ("Annual Fee") of $49.00 per year. Monthly dues must be paid by one account and deducted by automatic transfer from checking, savings, Visa, MasterCard, American Express, Discover card. Facilities may vary; extra charge for some amenities and leagues. Offer is not available in combination with other discounted rates. ©2019 Fitness International, LLC. All rights reserved.
Practical Considerations Regarding Your Employee Handbook: Part One

By Madelin Zwerling, JD

Your medical practice is growing and, upon focusing on your practice’s human resources capacities, you realize that there is a greater need to provide clearer and more comprehensive guidelines for your employees to follow concerning workplace norms and behavior. You recognize that having an employee handbook will helpfully inform your employees and supervisors of the rules and policies of the workplace in a uniform way, and provide for clarity concerning expectations and standards that must be followed and adhered to by employees. A handbook will place your employees on notice of your practice’s policies, expectations and benefits. That said, what steps you should take depends, in part, on whether you have an existing employee handbook.

Many, if not most, medical practices have an employee handbook. If you do not fall within that category, however, and are first attempting to draft such a handbook, you must first decide which policies to include. Some policies are required or recommended for all employers such as an anti-harassment policy. Other policies are optional and their inclusion in a handbook largely depends on the employer’s policies and procedures. Accordingly, employers seeking to create a handbook for the first time should evaluate which policies they currently have and which policies they should implement. Employers should only include policies they intend to follow because failure to follow written policies can cause employee confusion, significantly damage morale and recruitment efforts and create legal liability. For example, depending on relevant state law and the specific facts at issue, failure to follow policies could strengthen a plaintiff’s claim of discrimination if it is rooted in an employer’s failure to follow the employer’s own written policies. Likewise, uneven enforcement of a written policy can lead to discrimination claims.

On the other hand, if you are creating a handbook from existing policies, you should consider conducting an audit to confirm that all existing policies are up-to-date and are all consistent with one another. It should go without saying that all policies must adhere to current law. Even more, should an employment lawsuit arise, a failure to update a policy may result in an obsolete policy being used as proof of your practice’s disregard for the law. Thus, you should ensure that all policies are current with respect to the law, especially if your practice expands into new geographic areas where the law may be different, as well as your actual business practices. You should also confirm that all policies are internally consistent and do not contradict each other. For example, the complaint procedures in an equal employment opportunity policy, anti-harassment policy and anti-retaliation policy should be consistent with one another: 1) increase the likelihood that employees will use the proper and desired procedure; 2) decrease the risk of confusing employees; and 3) increase the likelihood that the employer will respond properly and in a timely fashion. As a safeguard, have at least one person read the handbook in its entirety before you distribute it to your employees.

A revised handbook should indicate that it supersedes any prior handbooks so that employees are clear about which policies are current. Employers should distribute or post revised handbooks, reissue acknowledgment forms and collect signed acknowledgments from all employees. Additionally, when an employer distributes an updated handbook, it should keep copies of any older versions. If the employer is ever involved in litigation, it should be able to point to the written policies in effect at the time of the challenged employment action. Best practice is to keep individual policies for the longest statute of limitations period applicable under federal or state law.

Madelin T. Zwerling is an attorney at Garfunkel Wild, P.C., which she joined in 2011, and a member of the Employment Law Practice Group, which provides legal advice on a full range of employment matters. She may be reached at mzwering@garfunkelwild.com or (516) 393-2510.

QPP Tip of the Month: Understand the New Requirements for the MIPS Promoting Interoperability Category

The Merit-based Incentive Payment System (MIPS) Promoting Interoperability category (formerly known as the Advancing Care Information category) changed significantly from previous years. Some of the key changes include:

• Revised to contain a single set of objectives and measures for reporting;
• Required use of 2015 edition certified electronic health record technology (CEHRT); and
• A new scoring methodology for the category that eliminates the base, performance, and bonus score components.

Notably, the category features hardship exceptions, which allow reweighting to 0 percent and have the 25 percent weight reallocated to the quality category (for a final weight of 70 percent of the final MIPS score).

Physicians can submit an application by December 31, 2019 for reweighting for one of the following hardships:

• Insufficient internet connectivity
• Extreme and uncontrollable circumstances
• Lack of control over the availability of CEHRT
• MIPS eligible clinicians in small practices of 15 or fewer ECs
• Decertified EHR

For more information, see PAI’s Promoting Interoperability Overview resource and Pt Category Hardship and Reweighting Overview resource. PAI’s MACRA QPP Resource Center has additional resources on the QPP, MIPS, and Advanced Alternative Payment Models (APMs).

AAP Issues Policy Statement on Racism in Child and Adolescent Health

The American Academy of Pediatrics has issued a policy statement on the role of racism in developmental and health outcomes among children and adolescents.

Here are some of the many recommendations for clinicians, published in Pediatrics:

• Establish a “culturally safe medical home” for patients in which “providers acknowledge and are sensitive to the racism that children and families experience.” This should include screening patients for perceived and experienced racism.
• Evaluate patients reporting racism for mental health sequelae, including post-traumatic stress, anxiety, depression and grief. Make referrals for mental health care as appropriate.
• Educate clinicians and office staff about providing culturally and linguistically appropriate care (see second link below for Health and Human Services guidance).

The AAP’s policy statement offers numerous resources for clinicians. Separately in Pediatrics, researchers report evidence that infants of color generally receive worse neonatal intensive care — in particular, neonatal mortality rates are higher at minority-serving hospitals.
New York Insurer Opens Office in Hospital

CDPHP, a New York health insurer, opened a branch inside Ellis Medicine, a hospital in Schenectady, to connect patients directly with insurance staff if they have questions during treatment and post-discharge, according to the Albany Business Review.

The idea came to CDPHP’s CEO, John Bennett, MD, after a recent hospitalization revealed some of the difficulties patients face when navigating the healthcare system. CDPHP opened its office July 16, which is staffed with representatives tasked with answering questions about what insurance will pay for at Ellis Medicine, among other discussions.

Ellis Medicine CEO Paul Milton told the Albany Business Review he expects to see improved patient satisfaction and readmission rates among CDPHP members because of the partnership. In addition, since Ellis Medicine houses CDPHP’s first hospital office, CDPHP members may seek out the hospital for care. Read the full article here.

Morgagni Medical Society

The Morgagni Medical Society of New York is comprised of physicians of Italian heritage, who meet quarterly in NYC for social, educational and professional meetings. It is a nonprofit organization, and sponsors a medical school scholarship in conjunction with the Columbus Citizen’s Foundation. Members benefit from interesting people and speakers, exceptional dinners, opera night, exclusive club and venue events and can march with their families in the NYC Columbus Day parade. New members, both of Italian descent as well as Italophiles, have a great opportunity to share culture and profession. Visit https://www.morgagni-medicalsociety.com/ or email Morgagni.society@gmail.com for information. Join today!

Leo Saulle MD
President Morgagni Medical Society

Christina Del Pin MD
Treasurer/Secretary

Obituaries

CASSADY, Raymond J.; Jamesville NY. Died July 04, 2019, age 93. Onondaga County Medical Society

COHEN, Murray Leon; Newburgh NY. Died July 08, 2019, age 92. Medical Society County of Orange

EDELSTEIN, Bernard; New Hyde Park NY. Died July 03, 2019, age 87. Medical Society County of Queens

GORMAN, Kevin John; Grand Island NY. Died June 12, 2019, age 84. Erie County Medical Society

KAUFMAN, Sherwin Allen; New York NY. Died May 14, 2019, age 98. New York County Medical Society

SCHORR-REINER, Sophie; Hopkins MN. Died June 28, 2019, age 92. Medical Society County of Oneida

Are you a member of MSSNYPAC?
If not, why not? MSSNY Advocacy Needs Your Support
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DO YOU KNOW AN OUTSTANDING PHYSICIAN?

The Medical Society of the State of New York is accepting nominations for the 2018 ALBION O. BERNSTEIN, MD AWARD

This prestigious award is given to:

“…the physician, surgeon or scientist who shall have made the most widely beneficial discovery or developed the most useful method in medicine, surgery or in the prevention of disease in the twelve months prior to December, 2018.”

This award was endowed by the late Morris J. Bernstein in memory of his son, a physician who died in an accident while answering a hospital call in November, 1940.

The $2,000 award will be presented to the recipient during a MSSNY Council Meeting.

Nominations must be submitted on an official application form and must include the nominator’s narrative description of the significance of the candidate’s achievements as well as the candidate’s curriculum vitae, including a list of publications or other contributions.

To request an application, please contact:
Committee on Continuing Medical Education
Miriam Hardin, PhD, Manager,
Continuing Medical Education
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DEADLINE FOR NOMINATIONS: September 9, 2019
briefly at 10:30 a.m., he told the patient gastroenterologist saw the patient again criteria were met—However, when the patient when the appropriate discharge physician wrote orders to discharge the ent complications. The gastroenterologist used an argon plasma angiodysplasia in the cecum. The gas -cols, as well as vascular friability and ulcerosis in the sigmoid and descending consent discussion included the risks of the patient had alcoholic gastritis. He recommended that the patient undergo a colonoscopy after completing alcohol rehabilitation. He planned to follow the patient after discharge as an outpatient.

FOLLOW-UP TESTING
Several weeks later, the gastroen -terologist saw the patient. The patient advised him that he “hated doctors and hospitals.” He reported that his rectal bleeding had persisted since his dis -charge from the emergency department. He stated he had never had a colonos -copy but expressed concern that he might have colon cancer and was willing to undergo one. The physician advised him of the risks of a colonoscopy. The consent discussion included the risks of death, bleeding, perforation, the need for surgical repair, and a colostomy. The patient then consented to undergo a colonoscopy.

The colonoscopy revealed divertic -ulosis in the sigmoid and descending colons, as well as vascular friability and angiodysplasia in the cecum. The gas -troenterologist used an argon plasma coagulator (APC) to cauterize the sites of angiodysplasia. The patient’s colon was otherwise normal. There were no appar -ent complications.

When the patient was taken to the recovery room at 9:30 a.m., the phy -sician wrote orders to discharge the patient when the appropriate discharge criteria were met. However, when the gastroenterologist saw the patient again briefly at 10:30 a.m., he told the patient to wait for him to return to discuss the results of the colonoscopy. He then gave these same verbal orders to three of the recovery room nurses.

At 12:15 p.m., the gastroenterologist returned to the unit and found that this patient had already left the facility. The nurse manager of the unit explained that he was discharged because of the written order that all discharge criteria had been met. Further, the patient had demanded to leave the hospital. He had executed an AMA form and left, despite being advised he should remain to speak to his physician. Unfortunately, on the AMA form, the patient’s signature was neither witnessed, timed nor dated.

PATIENT EXPIRES
At 5:30 p.m., the gastroenterologist received a message from his answering service to call the patient or his daughter. He returned the call within ten minutes and the plaintiff’s daughter reported that her father was “gassy.” The physician advised the daughter that her father either had retained air in his colon, or he could have a perforation. He asked whether her father was in pain. The physician claimed that she denied this. During a deposition, the physician stated that he told the daughter to take her father to the ED promptly to be evaluated and to have an abdominal x-ray. The gastroenterologist also claimed the patient spoke to him during that call, and claimed the patient denied having any problems other than passing gas. The patient also was told by the physi -cian to go to the ED or call 911 if his discomfort became worse. Finally, the physician advised the patient’s daughter that he would check on her father later that evening.

At 7:30 p.m. that same evening, the physician called the patient. The patient was upset by his call and asked, “why are you calling me again?” The gastroen -terologist told the patient that he had promised his daughter that he would follow up with him. He again told the patient that if he was still having gas or any other pain, he had to be evaluated in the ED. The patient allegedly told him to “stop bothering me” and abruptly hung up the telephone.

When his daughter’s calls to the patient went unanswered the next day, she went to his home and found him dead. An autopsy revealed a perfora -tion of the ascending colon, 2 inches from the ileocecal valve, with evidence of peritonitis, and fecal soilage of the peritoneal cavity. The primary cause of death was determined to be acute peri -tonitis with perforation of the colon “due to a colonoscopy with an argon plasma coagulator (APC).”

LAWSUIT AND TRIAL
The patient’s daughter then com -menced a lawsuit against both the gastroenterologist and the hospital. MLMIC experts in internal medicine and gastroenterology reviewed the patient’s records. They opined that there were clear indications to perform the colo -noscopy. Although the GI expert had some concerns about the use of the APC, including the lack of documentation of the wattage used and the number of pulses delivered, he opined that the insured should be vigorously defended as he was experienced in using this device.

The expert in internal medicine expressed concern about the telephone conversations that the gastroenterolo -gist had with both the patient and the daughter, since his written documen -tation of these calls was untimed and undated. He questioned whether a jury would believe that this documentation was made prior to the decedent’s death. However, an outside expert gastroen -terologist retained by defense counsel believed that all aspects of the insured physician’s treatment met the standard of care.

THE TRIAL
In February 2015, this case went to trial. The plaintiff demanded $300,000 to settle the lawsuit. Prior to jury selec -tion, the judge ruled that he would not permit the AMA form to be entered into evidence. He also would not permit the defense to discuss the patient’s alco -holism or prior DWI conviction. Finally, the judge would not permit the defend -ant physician to testify regarding the substance of his second telephone conversation with the decedent, based upon what is called the “Dead Man’s Statute.”

The plaintiff’s counsel focused her case on the decedent’s discharge from the facility. Throughout the trial, the judge ruled in favor of the plaintiff’s attorney on any objections made by defense counsel. The defendant testified that if the decedent had not left the hospital before speaking with him, the perforation would likely have been diagnosed, and this would have increased his chances of survival. Fortunately, the defense coun -sel was still able to introduce the AMA form into evidence, by having the nurse manager of the post-procedure unit read the chart into the court record, without any objection from the plaintiff’s coun -sel. However, the judge did instruct the jury that the AMA form was not a valid release under the law. He further ruled

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that this form did not absolve the hospital from liability.

The plaintiff’s expert admitted that not only was the colonoscopy procedure indicated, but that perforations are known complications of this procedure that can occur in the absence of negligence. This expert also did not criticize the technique used by defendant. However, he did testify that the defendant clearly deviated from the standard of care by giving verbal rather than written orders to the nursing staff to keep the patient in the unit until the defendant returned. The expert also testified that the defendant physician failed to evaluate the decedent prior to his discharge and failed to refer the decedent to the ED after he was home. Finally, he testified that by advising the decedent’s daughter to allow the decedent to eat, the defendant had caused the decedent’s death.

The plaintiff testified about the telephone call with the defendant the day before her father died. She had a significantly different recollection of the content of that call than the physician. She testified that she told the defendant that her father was in severe pain, had pressure in his stomach, and was dia- phoretic. According to her testimony, she claimed the defendant told her that “it might be a good idea to give her father something to eat or drink.” Apparently, she then gave him fluids and food. She further denied that she was ever told by the defendant to take him to the ED. Finally, the expert insisted that decedent did not speak with the physician while she was present.

At the end of the plaintiff’s case, the defense counsel moved to dismiss the lawsuit based upon the failure of the plaintiff to prove causation. He stated that the plaintiff’s expert only offered his opinion on alleged departures from the standard of care but did not link them causally to decedent’s death. As a result, the trial court dismissed the lawsuit.

APPEAL AND REVERSAL

The plaintiff’s counsel appealed the dismissal. The New York State Supreme Court, Appellate Division, 4th Dept., reversed the trial court’s dismissal and ordered a new trial. The Court found that the defendant’s actions “substantially diminished the decedent’s chance of surviving the bowel perforation and subsequent infection.” The defense counsel then appealed the dismissal to the New York State Court of Appeals. However, the motion to appeal this decision was denied. The lawsuit was then re-tried in 2018 before a different judge.

The second trial ended in a defense verdict in favor of the defendant gastroenterologist. Further, although the jury did find negligence on the part of the hospital, they did not find that the facility proximately caused the decedent to die. Therefore, no damages were awarded to the plaintiff.

CASE STUDY I

A Legal & Risk Management Analysis

Donnaline Richman, Esq.
Fager Amsler Keller & Schoppmann, LLP
Counsel to MLMIC Insurance Company

INFORMED CONSENT

While the defendant eventually prevailed, this case presented a multitude of legal and risk management issues. The first issue identified in this case was an alleged lack of informed consent. The patient signed only an informed consent form from the hospital that did not specifically delineate the risks of a colonoscopy. Fortunately, the risk of perforation is a well-known and common complication of a colonoscopy. Therefore, the physician can testify that it is his regular practice to advise the patient of the risks, benefits and alternatives to a colonoscopy, including a few of the most severe and the most common risks. When having an informed consent discussion, the risks of the alternatives, including no treatment, must also be discussed. The gastroenterologist, however, did document that he had an informed consent discussion with the patient in his office notes. He stated he explained what the procedure entailed as well as providing the risks and benefits of the procedure.

EVIDENCE EXCLUDED

Another problem that arose was the validity of the AMA (leaving against medical advice) form. Although the patient signed this form before leaving the facility, the signature was not witnessed, timed or dated. At the first trial, the judge excluded this form from being admitted as evidence based on the Dead Man’s Statute (New York State CPLR § 4519). This statute provides that under certain circumstances, an interested witness cannot testify against a decedent about conversations held with the decedent. However, if the form had been properly dated, timed, and authenticated, it could have been introduced as a part of the medical record and entered as evidence as a valid declaration against the decedent’s interests. Instead, the counsel for the defendant was permitted only to use the telephone records of the defendant physician, which would provide evidence of the calls he made to the decedent. In fact, during the first trial, the judge appeared to give the plaintiff’s counsel every advantage, not only by not admitting the AMA form into evidence, but also by excluding evidence of the decedent’s alcoholism and felony DWI conviction. He ruled that this information could only be used to determine the decedent’s life expectancy and damages.

TESTIMONY

The plaintiff’s expert testified primarily about the fact that the defendant should have issued written orders to the nursing staff, rather than giving them verbal orders to have the patient remain on the unit until the defendant returned. The expert testified that this was a breach of the standard of care. While a written order is preferable, verbal orders are legally acceptable. However, the defense was able to counter a weakness in this case that the verbal orders contradicted and superseded the prior written order permitting discharge after appropriate recovery criteria were met. Written orders, other than standing orders for post-procedure care, are not commonly issued in many post-procedure units. Further, verbal orders are permissible pursuant to 10 NYCRR § 405.10(c)(8), the regulation that governs hospitals. They are to be used sparingly and authenticated by the physician within the time frame required by the hospital. Therefore, this expert’s testimony about verbal orders was easily contested.

What was of concern was that some of the documentation by the RNs was confusing. At least one note stated that the patient was complaining of gas 8/10 and abdominal pressure. This made little sense. If the 8/10 was intended to reflect the patient’s level of pain, the patient was not appropriate for discharge. Regardless, this patient was discharged by the nursing staff without first calling the physician. According to the head nurse, the patient allegedly met the discharge criteria as the written order had required. Thus, he was discharged despite a serious inconsistency between nursing documentation and discharge criteria. Because this patient had previously expressed very negative feelings about hospitals and doctors, it was most likely that he insisted on leaving the facility at the first opportunity, despite the physician’s request that he

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CMS Releases Proposed 2020 Medicare Rule; Significant Up & Down Specialty Impacts

CMS recently released a [1,700-page proposed rule](#) for the 2020 Medicare physician fee schedule (PFS). CMS notes that “with the budget neutrality adjustment to account for changes in RVUs, as required by law, the proposed CY 2020 PFS conversion factor is $36.09, a slight increase above the CY 2019 PFS conversion factor of $36.04.

On a positive note, the three-year review of Medicare GPCI would produce a slight upward adjustment to the Geographic Adjustment Factors for the four New York Medicare payment localities.

However, it should be noted that the proposed changes to Medicare payment proposed in this rule could produce some significant upward and downward adjustments to Medicare physician payment, based upon specialty, if CMS finalizes the proposal without modification. Please see Table 111 on pp.1187-1188 of the proposed rule for a possible specialty by specialty impact. For example, it predicts an overall +16% increase for Endocrinology, +15% for Rheumatology, +12% for Family Practice and Hematology/Oncology, +8% for Urology and Neurology, and +7% for Ob-GYN and Allergy/Immunology. On the other hand, it predicts an overall -10% decrease for ophthalmology, -8% for Radiology and Cardiac Surgery, and -7% for Anesthesiology, Emergency Medicine and Thoracic Surgery. The AMA notes that this impact table “should be viewed with caution” as they believe it may contain some errors.

For more information from CMS on the proposed rule, [click here](#). For a comprehensive AMA summary of the proposed rule, [click here](#).

The AMA provided state medical societies with an overview of 2 of the key components of this rule:

**CHANGES TO E&M CODING AND THE MIPS PROGRAM**

**Office Visits – Evaluation and Management** - While retaining the important modifications to reduce documentation burden, CMS will implement coding and payment modifications in 2021 that are based on the resources required to perform various levels of office visits. This will ensure that physicians treating the sickest patients are not unfairly penalized, while providing simpler solutions to coding and documentation.

Following CMS’ proposal last year to collapse payment for office visits, the AMA coordinated a response from 170 national medical specialty societies and state medical associations urging a different solution. The CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) convened a Workgroup, that adopted changes in February 2019, to document office visits on either medical decision making or time spent on the date of the encounter. According to AMA, CMS accepted most of the CPT framework and RUC recommendations. Among the key aspects of the Office Visit Proposed Rule:

- **Effective January 1, 2021**, CMS will adopt the CPT guidelines to report office visits based on either medical decision making or physician time.
- CMS adopted the RUC work recommendations for the office visit codes. The work value increases represent $3 billion in redistributed spending, resulting in a 3% reduction in the conversion factor.
- CMS adopted the RUC physician time recommendations. Coupled with the work value increases and some modifications in direct practice costs, these changes lead to an additional $2 billion in redistributed spending, resulting in an additional 2% across-the-board reduction.
- Two departures from the CPT and RUC recommendations that we will need to be addressed:
  - CMS would implement an add-on payment for office visits for primary care and patients with serious or complex conditions. This proposal redistributes an additional $2 billion, resulting in an additional 2% reduction to the Medicare conversion factor.
  - Although the surgical specialties participated in the RUC survey and their data and vignettes were incorporated into the RUC recommendations, CMS proposes not to apply the office visit increases to the global surgery packages.

**Merit-based Incentive Payment System (MIPS)** - The AMA noted that it is encouraged by results showing 95% of eligible clinicians successfully participated in MIPS in 2017, increasing to 98% in 2018 based on initial results. However, many physicians report that the current program is too costly and requires reporting for reporting’s sake, diverting time from patient care.

The AMA noted that, in the 2020 proposed rule, CMS embraced the AMA’s proposed concept for streamlining MIPS. The agency outlined a high-level framework and seeks feedback on an episode-based approach to MIPS, which it is calling the MIPS Value Pathways (MVP). The attached MVP diagram is included in the rule.

In the AMA’s view, an MVP-type approach could be a turning point for the program because an option that ties MIPS to episodes of care has the potential to be more clinically relevant, less burdensome, and a stepping stone to alternative payment models. The AMA does have concerns with several specific aspects of MVP that CMS has proposed, such as a return to the use of controversial population health administrative claims measures that the AMA successfully fought to eliminate from the initial MIPS program. CMS does not plan initial implementation of an MVP approach until 2021.

Mark Your Calendars for our Fall Conference in October

The Alliance is planning our annual Fall Conference on October 6-7 at the Homewood Suites in Schenectady. Pat Clancy, MSSNY Senior Vice President for Public Health and Education will speak to us on marijuana legislation and legalization.

**HELMETS FOR GIRLS LACROSSE**

We will also have a speaker or two on the issue of helmets for girls lacrosse. As you may know, the issue of the helmets has been a hot topic for the Alliance. Our Health Promotions Co-Chair, Cheryl Stier, has been advocating on the Alliance’s behalf by connecting with organizations to spread the word on the importance of this issue. She is currently working to finalize an “open letter” that will be sent to lacrosse organizations and other outlets – emphasizing the need for helmets in girls lacrosse and the seriousness of the concussions that occur when not wearing protective headgear. It will be a very informative meeting. Please consider joining us.

For additional information on Alliance activities, please contact Alliance Executive Director Kathy Rohrer at krohrer@mssny.org or 516-488-6100 x396.
remain. Finally, as noted, the patient had signed an AMA form, which clearly indicated he was going to leave regardless of whether he met discharge criteria.

**DIRECTED VERDICT**

Despite the latitude the judge initially permitted to the plaintiff’s counsel during the trial, the defense counsel moved at the end of the plaintiff’s case for a directed verdict (NYS CPLR § 4401) in favor of defendant.

This motion is made when a plaintiff has provided insufficient evidence to sustain a verdict after presenting their case. It requires that the judge consider the evidence the plaintiff has presented and, even when viewed in the most favorable light to the plaintiff, not find a rational basis to find in favor of the plaintiff. The judge granted this motion and dismissed the lawsuit against the defendant.

**APPEAL AND RETRIAL**

The plaintiff then appealed this decision to the New York State Supreme Court Appellate Division, 4th Department. The Appellate Court ruled against the defendant and stated that the plaintiff did present legally sufficient evidence to require a new trial. The defense counsel then made a motion to appeal this decision to the New York State Court of Appeals. This motion was denied. Therefore, the lawsuit was re-tried before a different judge. This judge did not allow the defendant’s evidence, including the AMA form, as the original judge did.

As often occurs in a lawsuit, there were serious weaknesses in the medical record documentation. For instance, the defendant’s documentation of his telephone calls made to the plaintiff’s home was generally good. However, it did not contain the times or dates of the calls. Therefore, they were open to allegations of being written after the decedent’s death. Fortunately, the plaintiff did not do so. In addition, the plaintiff’s testimony was not at all credible. She testified that the defendant advised her to give the decedent food and drink while simultaneously claiming that he was in severe abdominal pain and diaphoretic, yet she did not take him to the hospital. This testimony was rebutted by the defendant’s expert, who advised that a skilled gastroenterologist, such as the defendant, would not have advised a patient in severe pain to eat and would, as standard practice, advise the patient to be promptly taken to or go to the emergency department.

Finally, the decedent’s autopsy report was admitted into evidence. The plaintiff focused her case on the autopsy’s primary finding that perforation of the colon and peritonitis caused the patient’s death. However, the defense counsel was able to show that there were secondary findings of severe CAD with 90% stenosis, hypertension, and a pulmonary embolus, all of which could well have cause decedent’s death. These diagnoses created serious doubt that the defendant’s care caused the patient’s death.

At the end of the trial, the jury found in favor of the defendant. Additionally, the jury found that there was no proximate cause that the hospital contributed to the patient’s death by its actions, so no damages were awarded to the plaintiff from the facility.
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interest a Kaiser Health News piece, Doctors Argue Plans To Remedy Surprise Medical Bills Will ‘Shred’ The Safety Net. The author’s premise was that this was largely false. Our analysis is that this constitutes whistling past the graveyard. California, for example, right now is in the midst of doctor flight, with physicians harder and harder to find. Moreover, analysis of the California law to deal with surprise bills suggests its effect akin to pouring gasoline on this fire.

Sen. Lamar Alexander, one of the chief sponsors of S1895, suggests that it was CBO’s analysis of the proposals to solve the Surprise Bill Issue that was the deciding factor in going with a benchmark median Insurance In-Network payment. Others have looked at this and suggested CBO is flat out wrong here. First, a recent Georgetown Review of New York’s Surprise Bill Law found no effect on physician pricing since 2014. Does CBO really feel doctors’ payments are inconvenient? Medicine currently is the only US enterprise that regularly enjoys a cost of living decrease.

“The opportunity of defeating the enemy is provided by the enemy himself.”

–Sun Tzu, The Art of War

Contrary to KHN’s position, NY’s arbitration does not involve costly attorney fees or lengthy wrangling. In fact, DFS reports arbitration to be timely, with decisions’ favoring both insurers and physicians equally. Complaints used to be a torrent. Now they are a trickle. The fact that the loser pays the arbitrator’s fee has eliminated outlandish demands. It is certainly not the physicians who are gaming the system here. Presently, the payment playing field is so uneven that were this pinball, the screen would be flashing TILT. Insurers should be far more concerned that their continued profits and roadblocks to care are fueling the clamor for Medicare for All, as a recent Forbes piece suggests. CBO’s analysis also fails to appre-
ciate the implications of its findings. Hospitals and Health Systems do not exist in a vacuum. Rather, they are creatures of their own fiscal reality. Many are the result of keeping pace with movements of the health insurers themselves. If the insurers become more powerful still, then the US can look forward to more mergers and acquisitions to achieve some form of bargaining stability. Most in government acknowledge that this trend has not resulted in cost-savings but has been thus far a driver of escalating cost. If Congress truly wishes to contain costs, they should realize that it is not physicians, whom the late Uwe Reinhardt found account for no more than 20% of healthcare costs, driving this escalation.

So as we get ready to say goodbye to summer, feel free to use this piece and contact your Representatives and Senators. Post op-eds in your local papers. I will be a guest on an upcoming segment of Northwell’s Dr. Ira Nash’s Well Said to discuss this issue. Stay tuned.

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contentious items at the forefront this coming year. This includes the New York Health Act – policy that would create a single-payer system in New York – and legalization of recreational marijuana use, which was thought to be a fait accompli at the beginning of last year, but was not passed due to strong advocacy by MSSNY and many other organizations. Moreover, while New York already has the worst liability environment in the nation, liability expansion proposals will continue to be championed by the trial lawyer lobby. And of course, we will again face a lit-any of well-meaning but misguided practice mandate proposals.

This is a great time to join the Political Action Committee or increase your contributions. MSSNYPAC contributions are absolutely vital in helping to ensure access to decision-makers and helping to develop the relationships that are the crux of the political process. Physicians in New York continue to be outspent by many of our adversaries such as the trial lawyers. As such it makes it more difficult to fight adverse policies such as liability expansion or scope of practice expansion.

For more information and to join, please visit the PAC’s website at https://www.mssnypac.org/ (and encourage your friends and colleagues as well).

Further, expanding our grassroots advocacy network is imperative if we want to amplify our message and be heard above the din in Albany and across New York. If you know of a physician that wants to be more involved, please invite them to join the Physicians Advocacy Liaison (PAL) network by going to http://tiny.cc/JoinPAL.

Please help your colleagues to understand that we need all physicians to support these efforts. There is too much at risk.

Only together can we fight for physicians’ ability to practice and your patients’ best interests.

Sincerely,
Thomas Lee, MD
Co-chair, MSSNYPAC
Rose Berkun, MD
Co-chair, MSSNYPAC

MSSNY-PAC

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