To the House of Delegates, Ladies and Gentlemen:

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

Jerome Craig Cohen, MD, FACP, Chair ................................................................. Broome
Frank G. Dowling, MD, Ex-Officio ................................................................. Secretary
Robert Allan Frankel, MD .................................................................................. Kings
Timothy Francis Gabryel, MD ............................................................................ Erie
Kira A. Geraci-Ciardullo, MD MPH................................................................. Westchester
Robert B. Goldberg, DO .................................................................................. New York
Robert Alan Hesson, MD .................................................................................. Tompkins
Nina I. Huberman, MD, MPH ........................................................................... Bronx
William R. Latreille, Jr., MD, FACP, AME, Ex-Officio ..................................... Speaker
Bonnie L. Litvack, MD ....................................................................................... President
Philip Schuh, CPA ............................................................................................ Executive Vice President
Sandra Bennett .................................................................................................. Staff
Barry B. Cepelewicz, MD, Esq........................................................................ General Counsel

At the 2020 annual meeting of the House of Delegates, the following resolutions were referred to the House Committee on Bylaws for review and report back to the House of Delegates in 2021.

As the 2020 HOD was held virtually, the Reference Committee on Bylaws did not meet to hear testimony. Instead, testimony was submitted online. No transcript was prepared, but the comments were assembled and reviewed by the Committee. The Committee wishes to thank the individuals who submitted testimony.

Resolution 2020-1, Addition to MSSNY Mission Statement
Resolution 2020-2, MSSNY Council Representation

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**Resolution 2020-1, Addition to MSSNY Mission Statement, provided as follows:**

RESOLVED, That the following language be added to the Mission Statement of the Medical Society of the State of New York: “To improve the health and well-being of our community through promoting wellness, fostering collaborative relationships, providing personal and professional development of physicians and engaging in healthcare advocacy.”

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This requested addition to the MSSNY mission statement was triggered by advice given to a member of this Committee when his county proposed a non-scientific, non-health-based program at a county meeting. An outside lawyer cautioned that organizations must act within their mission statements, or risk losing tax exempt status. Our MSSNY counsel did concur that there is a possibility that if a tax-exempt entity does not act in a manner that is consistent with its mission statement it could lose its tax-exempt status. The Committee agreed that the cleanest solution would be to change the MSSNY mission statement to reflect the importance of doctors.
gathering together to participate in activities that support each other, including gatherings of a
social nature. Members of the House Committee on Bylaws noted that this is a well-worded,
timely statement. It is the intent of the Committee that this addition be added at the end of the
current MSSNY mission statement. It was remarked that county medical societies should
consider such an addition as well.

**RECOMMENDATION:**
The House Committee on Bylaws recommends that Resolution 2020-1, Addition to MSSNY
Mission Statement, be adopted by the House of Delegates.

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**Addendum:**
Upon approval of this recommendation, the entire Mission Statement will read as follows:

To advance the health of the residents of our State by promoting a favorable environment
for medicine through advocacy, education and professional community for New York
State physicians.

To improve the health and well-being of our community through promoting wellness,
fostering collaborative relationships, providing personal and professional development of
physicians and engaging in healthcare advocacy.

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**Resolution 2020-2, MSSNY Council Representation, provided as follows:**

RESOLVED, That the Medical Society of the State of New York amend its Bylaws, Article IV,
Section 1, as follows (deletions struck out and additions underlined):

**ARTICLE IV. COUNCIL**
There shall be a Council which shall exercise all the rights and duties of the House of Delegates,
consistent with the Bylaws of the State Society, when the House of Delegates is not in session.
The Council, therefore, is in fact the executive committee of the House of Delegates.

**SECTION 1. COMPOSITION**
The Council shall be composed of the president, president-elect, vice-president, immediate past-
 president, secretary, assistant secretary, treasurer, assistant treasurer, speaker, vice speaker,
chairman of the Board of Trustees and 15 councilors elected by the House of Delegates,
including one councilor for each of the five boroughs of New York City.¹

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This is a very complex, controversial, confusing issue, with many ramifications and many
moving parts. The issues that this Resolution raises deserve significant study. One consideration
is that we need a better definition of what our Council is. Should Council be comparable to a
Senate, with representation based on geography (thus serving as protection for smaller districts)?

¹ Bylaws on MSSNY website say 15; number acknowledged at Council currently is 16.
Or should Council be comparable to a House of Representatives, with representation based on membership numbers?

Currently, the Bylaws do not assign specific Councilors to specific Districts. It has been the custom for many decades that the First District is assigned 3 Councilors, the Second District is assigned 2 Councilors, and the other Districts are assigned 1 Councilor each. It has also been the custom that each Councilor would come from the same District. If adopted, this Resolution would increase the number of Councilors assigned to the First District from 3 to 5, designate each such Councilor to one of the NYC boroughs, and enshrine this change in the Bylaws.

Another consideration is this: should the composition of the Council reflect the composition of the HOD, since it acts in its stead when the HOD is not in session? But this begs the question of whether representation in the HOD truly reflects only membership numbers when the assembly district aspect of representation is considered.

It was also pointed out that the MSSNY Bylaws, under Duties of the President (Article 6, Section B, paragraph 8), give the President the authority to assign Councilors to an area. This is the only place in the Bylaws that addresses where and how Councilors are assigned.

Yet another objection is that assigning a Councilor solely to Richmond County with only 150 active members (as of 1/12/21), or solely to New York County with 926 active members, would be unfair to Nassau County with 3617 active members, or to other entire Districts with thousands of members. On the other hand, would it be fair or practical to give each County and Borough its own Councilor? Should Franklin County, with 10 active members, get its own Councilor?

Finally, this caveat was raised during the Committee’s discussion: when hard numbers are fixed in the Bylaws, those numbers are then frozen. However, membership figures are fluid and change over time. Therefore, it may not be prudent to establish a permanent Bylaws change based upon the current membership data.

**RECOMMENDATION:**
The House Committee on Bylaws recommends that Resolution 2020-2, MSSNY Council Representation, not be adopted (nine in agreement, one abstention).

Respectfully submitted,

Jerome Craig Cohen, MD, Chair
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021-1

Introduced by: MSSNY Membership Committee
Bronx County Medical Society Inc.
Suffolk County Medical Society Inc.

Subject: Create MSSNY IMG/Ethnic Medical Associations Section

Referred to: House Committee on Bylaws

Whereas, Resolution 2020-201, Membership Expansion and Representation of Diverse Physician Organizations, was referred to the Membership Committee by the Council; and

Whereas, Resolution 2020-201 asks that ethnic medical associations be eligible for representation in the MSSNY HOD if they meet certain criteria which are analogous to those established many years ago for specialty societies; and

Whereas, These criteria are no longer realistic (especially the criterion that at least 25% of dues-paying physician members of the petitioning organization also be members of MSSNY) and present barriers to reaching a viable solution; and

Whereas, MSSNY should reflect the diversity of the House of Medicine and must find new ways to bring diversity, equality and inclusion into the House of Delegates; and

Whereas, One solution is to change the IMG/Ethnic Medical Associations Committee to section status, entitled to a number of delegates based on the number of IMG MSSNY members (as in YPS1) as well as a Councilor; therefore be it

RESOLVED, that the following additions (underlined) and deletions (struck through) be made to the MSSNY Bylaws:

Article IV, House of Delegates
Section A, Composition
(p) delegate representing the IMG/Ethnic Medical Associations Section; and

Section A, last paragraph:
The IMG/Ethnic Medical Associations Committee is authorized to be represented in the House of Delegates by a minimum of one delegate and, according to the rolls of the Medical Society of the State of New York sixty days prior to the annual meeting, one additional delegate for each additional 400 members over 100, up to a maximum of three delegates.

1. * The Young Physicians Section is authorized to be represented in the House of Delegates by a minimum of one delegate and, according to the rolls of the Medical Society of the State of New York sixty days prior to the annual meeting, one additional delegate for each additional 400 members over 100, up to a maximum of three delegates.
Article V, Council
Section A, Composition, Third Paragraph
Four councilors shall be elected annually by the House of Delegates, each for a term of three years. Two Three councilors, one representing the young physicians section, and one representing the organized medical staff section, and one representing the IMG/Ethnic Medical Associations Section shall be elected every third year by the House of Delegates for a term of three years.

Section A, Sixth Paragraph
Except for the councilor representing the medical student section, the councilor representing the resident and fellow section, the councilor representing the young physicians section, and the councilor representing the Organized Medical Staff Section, and the councilor representing the IMG/Ethnic Medical Associations Section, Councilors shall be assigned to specific county societies as liaison for the Council in accordance with the provisions of Article VI, Section B, paragraph 8.

Article VIII, Special Sections
Section E IMG/Ethnic Medical Associations Section
Membership in the MSSNY IMG/Ethnic Medical Associations Section shall be open to those paid members of the Medical Society of the State of New York who have obtained their medical school education outside the United States, or who are members in good standing of an ethnic medical association. Conduct, rights and privileges of IMG/ Ethnic Medical Associations Section membership shall be governed by the Bylaws of the MSSNY. The IMG/ Ethnic Medical Associations Section may establish its own bylaws so long as they are not in conflict with the Bylaws of the Medical Society of the State of New York and are approved by the MSSNY Council.

The IMG/Ethnic Medical Associations Section shall hold meetings in order to conduct such business as may be necessary. They shall establish a Governing Council to be elected by the constituents of the IMG/ Ethnic Medical Associations Section. Any paid member of the Section may participate in meetings of the Section.

The IMG/Ethnic Medical Associations Section is authorized to be represented in the House of Delegates by a minimum of one delegate and, according to the rolls of the Medical Society of the State of New York sixty days prior to the annual meeting, one additional delegate for each additional 400 members over 100, up to a maximum of three delegates. The method of electing the delegates representing the IMG/Ethnic Medical Associations Section shall be determined by the Council.

The IMG/Ethnic Medical Associations Section is authorized to be represented on the MSSNY Council by one Councilor with voice and vote. The IMG/Ethnic Medical Associations Section Councilor shall be elected by the constituents of the IMG/Ethnic Medical Associations Section. The duties of the IMG/Ethnic Medical Associations Section Councilor shall be as outlined in the MSSNY Bylaws, Article IV, Sections A and B.

Fiscal Note: $5,000 - $10,000 per annum, based on budget line set for other MSSNY sections.
WHEREAS, in NYS medical assistants are trained in certified programs where they learn basic skills; and

WHEREAS, a medical assistant is expected to learn under the direction of a supervising physician how to assist a physician in a particular office based on physician and patient needs of that office; and

WHEREAS, medical assistants are under indirect supervision of physicians at all times and their supervising physician is responsible for their actions; and

WHEREAS, healthcare leadership is expected to control expenses in delivering health care; therefore be it

RESOLVED, that MSSNY seek regulation/legislation that a medical assistant’s scope of practice be expanded after proper training and assessment of competency to include the following and be defined by the designated supervising physician who is already responsible for the actions of and expense of a medical assistant:

- Placement and removal of casts under the direct supervision of the physician or licensed professional
- Drawing up of medications under the direct supervision of the physician or licensed professional
- Application of topical medications under the direct supervision of the physician or licensed professional

Existing MSSNY Policy:

115.984 **Expanded Clinical Roles for Medical Assistants in New York State**
MSSNY will work with New York State approved medical assistant teaching programs to develop suitable rules defining clinical work guidelines that can be incorporated into current New York State regulations. (HOD 2017-105; Reaffirmed HOD 2018 in lieu of resolution 113)

115.994 **Certified Medical Assistants/Medical Assistants - Preservation of Physician Autonomy in Employment and Assignment of Duties**:
MSSNY will develop and promote regulation and/or legislation that allows Certified Medical Assistants and Medical Assistants to continue to perform the usual duties of their position under the direct supervision of their physician employers if the physician has evaluated and approved their ability to do so, making this a part of the Annual Legislative Agenda until this goal has been attained. (HOD 1996-68; Reaffirmed HOD 2014; Reaffirmed HOD in lieu of 2017-105; Reaffirmed HOD 2018 in lieu of resolution 113)
Whereas, Medical care for the treatment of the same condition or the performance of the same procedure is rendered by a range of healthcare providers -- not only general physicians, physician specialists and physician subspecialists, but also chiropractors, nurse anesthetists, optometrists, physician assistants, nurse practitioners and other providers; and

Whereas, A patient seeking care from a health professional expects the medical service to be competently performed -- and non-physician healthcare professionals have argued that their care is equivalent to that of a physician, and have successfully sought legislation based on that theory; and

Whereas, For that reason, these non-physician healthcare professionals ought to be held to the same standard of care in medical malpractice cases as are physicians, but they are not; rather, the non-physician provider is judged by the standard of a reasonable person in the same profession; and

Whereas, The existence of different standards of care for different professions, results in different outcomes in liability cases for the same medically negligent care, so that injured patients do not receive equal justice for the harm they have suffered;

Whereas, For example, a patient who is harmed by the failure to diagnose and treat glaucoma suffers the same harm regardless of whether he or she is treated by an optometrist, an ophthalmologist or a glaucoma subspecialist, yet each of these three professionals is held to a different standard of care; therefore be it

RESOLVED, That the Medical Society of the State of New York seeks legislation declaring that in the case of an allegation of medical malpractice committed by an allied health professional practicing without direct supervision of a licensed physician, the standard of care is to be based on the nature of the negligent care, with a uniform minimally acceptable standard of care for the treatment of a specific diagnosis, not the licensee’s profession.
WHEREAS, New York State has experienced closing and consolidation of hospitals at an accelerated level for the last 40 years. Since the early 2000s the Medicaid Redesign Team I and II submitted their reports, commonly known as the “Berger Commission” after its chairman Peter Berger – MRT I recommended closure of five city hospitals and the merger and downsizing of at least five others; and

WHEREAS, in 1997 the state deregulated hospital reimbursement rates which left healthcare providers to negotiate their own prices with insurance companies, which left the least powerful hospitals with diminished returns and struggling with their overhead; and

WHEREAS, the state distributed public funds, known as the Indigent Care Pool to both public and private voluntary hospitals instead of targeting the institutions that truly served the most vulnerable populations, hospitals with large endowments and owning much real estate, were able to be designated as “safety net hospitals” and receive such funding, thereby leaving less funding for the most vulnerable; and

WHEREAS, nearly one in five Americans depend on a rural hospital for their care, and a record number 20 rural hospitals closed their doors in the US during the year 2020, and over 136 rural hospitals have closed since 2010 including at least two rural NY hospitals, and several other rural hospitals are at risk for closure; and

WHEREAS, there are more hospitals proposed for closure, many of whom if they were not open during Covid’s peak would have worsened the morbidity and mortality for disenfranchised and marginalized people in the community due to lack of access and overcrowding of the remaining hospitals; and

WHEREAS, these hospitals remain essential and are in the neighborhoods that experience the greatest disease burdens, highest numbers of uninsured and people living below poverty therefore there is no way for these hospitals to be “profitable” or even breakeven; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) and the medical community stand with urban, suburban, and rural safety net hospitals and their communities and against those that would take advantage of vulnerable populations that do not have the financial resources or political clout to spend on staying open against the monolithic health systems that are profitable and powerful; and be it further

RESOLVED, that MSSNY in collaboration with other stake holders will seek legislation or regulation to prevent any further hospital closures in NY State until stake holders including community based groups and physicians in the neighborhoods served by each hospital have been able to have real input into the closure decision making process, and a review with an
equity lens of closures, downsizing, or repurposing of hospital beds and services with the foremost concern regarding the health needs of the communities each hospital serves has been conducted; and be it further

RESOLVED, a coalition of community-based stake holders should occupy at least 50% of the positions on boards, committees or task forces that review hospital closures, downsizing and repurposing of beds, and such boards or committees should include representation from the County Medical Society and MSSNY; and be it further

RESOLVED, that MSSNY affirms that some individual hospitals which serve communities that face inequities will not make profit and MSSNY asserts that use of financial profitability as a principle rationale for such closures is filled with ethical conflict, particularly when viewed with an equity lens; and be it further

RESOLVED, that MSSNY asserts that payment parity must be the same across all hospitals, i.e. CPT and DRG codes must be paid the same regardless of site, because such payment parity is a significant health equity issue for safety net hospitals.

Existing MSSNY Policy

240.996 Fee Differentials:
MSSNY affirms the principle of equitable reimbursement to rural area physicians by all health insurance carriers in order to encourage establishment of physician practices in these traditionally medically underserved areas of the State. MSSNY encourages the retention and recruitment of physicians in rural and other underserved areas of New York State by removing the disincentive of lower fee schedules for physicians practicing in such areas. (HOD 1991-41; Reaffirmed HOD 2014)

285.992: Specialty Society Committees to Eliminate Health Care Disparities
MSSNY strongly encourages all state specialty medical societies to form a Committee to Eliminate Health Care Disparities. These committees should share ideas and work together with MSSNY’s Committee to Eliminate Health Care Disparities as a coalition. MSSNY also strongly encourages all state specialty medical societies to incorporate, within their CME courses, lectures and other academic activities, relevant information about access to care, health literacy, cultural competency, workforce diversity, management options, compliance, outcomes and other factors that relate to healthcare disparities in their respective specialties, including race, ethnicity, sexual orientation and gender identity. In addition, MSSNY should develop a scientific accuracy rating system and report for all proposed New York State legislation impacting clinical services to include whether or not the legislation adheres to specialty practice guidelines and appropriateness criteria. (HOD 2013-163)

Pay-for-Performance Principles and Guidelines H-450.947
GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS
Safe, effective, and affordable health care for all Americans is the AMA’s goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA’s “Principles for Pay-for-Performance Programs” and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care
– The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

– Evidence-based quality of care measures must be the primary measures used in any program.
  1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
  2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
  3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
  4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

– Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
– Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
– PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
– PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
– Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
– Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship
– Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
– Programs must not create conditions that limit access to improved care.
  1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
  2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

– Programs must neither directly nor indirectly encourage patient de-selection.

– Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation
– Physician participation in any PFP program must be completely voluntary.
– Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
– Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
– Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
– Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
  1. Programs should provide physicians with tools to facilitate participation.
  2. Programs should be designed to minimize financial and technological barriers to physician participation.

– Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
– Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
– Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
– Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.
Physician Data and Reporting
– Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

– The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
  1. Programs should use accurate administrative data and data abstracted from medical records.
  2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
  3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

– Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

– Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

– Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting. 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives. 2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

– If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

– The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

– PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards– Programs must be based on rewards and not on penalties.

– Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

– Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

– Programs must finance bonus payments based on specified performance measures with supplemental funds.

– Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

– Programs must not reward physicians based on ranking compared with other physicians in the program.

– Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

– Programs must not financially penalize physicians based on factors outside of the physician’s control.

– Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

(2) Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA’s “Principles and Guidelines for Pay-for-Performance.” (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07). (HOD 2007-94; Modified and Reaffirmed HOD 2017)
Whereas, Contracts between a health insurance plan and/or a hospital delivery system are subject to review and or renewal from time to time; and

Whereas, Patient access to a hospital and/or a healthcare delivery system is subject to disruption in the event that contract terms may not be agreed upon; and

Whereas, In the event that a contract is not renewed, substantial risk is passed onto subscribers of the non-renewed contract which places an employer and the subscriber at risk: and

Whereas, In order to protect the consumer, patient, employer and physicians with whom relationships have been established, safeguards must be put in place to preserve networks that are subject to such contract disruptions; and

Whereas, A contract dispute between a major New York City hospital system and a major health insurance carrier led to a non-renewal of a participating provider contract agreement between them\(^1\) and

Whereas, Those insured by that insurer experienced unilateral disruption in the continuity of their care, and will no longer be in network for their care at the aforementioned New York City hospital system; and

Whereas, A large number of patients will now have to discontinue care with their current providers; and

Whereas, These kind of contract disputes are not uncommon; and

Whereas, The employers who signed contracts with the insurance company must continue with the health insurance plan until the next renewal period; and

Whereas, This situation is harmful to patient care; therefore be it

RESOLVED, That the Medical Society of the State of New York will seek legislation that will allow employers to cancel their contract with an insurance company within 30 days when that insurance company no longer has a participation agreement with a provider or hospital system that is available to their subscribers.

120.953  **Transparency in Insurance Contracts:**
MSSNY will seek legislation and/or regulation that would enforce health insurance plans to clearly and transparently declare what exactly is covered and not covered in each of their plans in a plain, simple and concise summary, with carefully documented exclusions to coverage, in a standardized format to be approved by the New York State Superintendent of Insurance. Also such legislation and/or regulation should state that once these limitations of coverage are outlined they cannot be changed without first notifying the insured of these changes in a timely manner, sufficient enough to allow an insured the ability to change policies without disruption to healthcare coverage. (HOD 2010-260; Reaffirmed HOD 2020)
Whereas, Insurance companies enter into contracts with individuals, doctors and hospitals; and

Whereas, patients enter into doctor-patient relationships; and

Whereas, this relationship is entered into for the benefit of good patient care; and

Whereas, patients choose their doctors for many reasons, not the least is the doctor’s reputation and expertise; and

Whereas, it is the intention of physicians to provide services in a cost-effective manor; and

Whereas, an insurance company should not be allowed to disrupt the doctor patient relationship by limiting access to care based on monetary reasons, to increase their profitability; therefore, be it

RESOLVED, That the Medical Society of the State of NY seek legislation and/or regulation to require insurance companies to equally cover a patient’s outpatient procedure regardless of whether it is hospital based or freestanding ambulatory surgical center; and be it further

RESOLVED, that the MSSNY AMA Delegation bring this matter to the attention of the AMA for further action.

Existing MSSNY Policy:

130.987 Health System Reform - MSSNY Principles: MSSNY is sensitive to the compelling circumstances generating the movement towards health care system reform in New York State and nationally. The Society is cognizant of the need to control health care costs while advocating the provision of health insurance coverage to the entire population of this state, including our 2.5 million citizens who are currently uninsured. While cost controls are the primary factor influencing the reform process, MSSNY believes that access and quality are equally essential objectives which must not be compromised by any planned system restructuring. In fact, cost control cannot be achieved if either access or quality is not satisfactorily addressed.

MSSNY believes that eventual stability of the state health care delivery system must be fundamentally predicated upon: (1) Universal access to high quality care for all New Yorkers; (2) Redirection of economies derived from renovation of a flawed system with its significant inefficiencies and frequent misallocation of resources to a more cost-effective service delivery structure; (3) Finance reform in conjunction with a price competitive market-based pluralistic system; (4) Meaningful physician input concerning relevant key aspects of any system reform.
Consequently, MSSNY believes that the following principles should be embodied in any reform of the state health care delivery system: (1) All New Yorkers regardless of health and income status should have access to high quality, affordable and basic health care; (2) Comprehensive health care reform should be achieved through a collective partnership encompassing the consumer, business, labor, health provider, health insurance and government sectors which would build on the positive elements of our current pluralistic health care system; (3) An independent health care access oversight authority comprised of pertinent private and public sector representatives should be established to monitor and assess the quality of care provided under the reform; (4) Health system reform should provide sufficient tax and financial incentives to create an environment of consumer cost consciousness which would compel vigorous price competition among health care insurers; (5) Competition among insurers should be predicated on required offering of the standard benefits program developed under the auspices of the proposed independent health care access oversight authority; (6) Individuals should have the right and responsibility to obtain, at minimum a standard benefits package, and finance a portion of cost of their care according to their means. State government and employer contributions should supplement the purchase of such insurance as appropriate, with tax incentives provided to employees and employers for the purchase of the lowest priced comparable coverage among insurers (as identified by the independent authority). Coverage beyond the standard package may be procured at additional cost, but without tax relief for the purchaser; (7) State financing, coupled with the necessary federal Medicaid/Medicare waivers, should be provided for the purchase of a standard benefits package by the indigent, elderly, uninsured and unemployed; (8) Health insurance system reform should be designed to: (a) Aid small business in the provision of health insurance to their employees; (b) Promote community rating; (c) Eliminate preexisting condition exclusions; (d) Guarantee renewability and portability; (e) Control premium increases; (f) Guarantee consumer choice of insurer, inclusive of programs providing freedom of choice of physicians; (9) Medical liability tort reform, including limitations on non-economic damages, should be enacted in concert with health care system restructuring to mitigate the costly practice of defensive medicine, while continuing to protect the legitimate interests of the patient community; (10) Practice parameters should be developed by physicians experts as useful educational tools for assuring the delivery of quality care and providing an affirmative defense in legal actions premised upon physician negligence; (11) Electronic claims processing (unrelated to a single payor authority) in conjunction with the development of a uniform claim form should be achieved in an effort to mitigate the current high administrative costs of health insurance operations; (12) Reimbursements for a defined service should be the same regardless of the site of that service (office, home, hospital settings, etc.) thereby establishing ambulatory care payment parity; (13) The residents of New York State should assume greater responsibility for their health by the imposition of financial sanctions directed toward mitigating unhealthy behaviors, taking appropriate preventive measures, and making conscientious cost effective determinations concerning the utilization of health care services; (14) The system must be structured to induce all insurers to function in the most cost-effective manner possible so as to ensure the mitigation of administrative costs, and application of the maximum amount possible of the premium dollar to health care benefits; (15) All providers of health care should be committed to adhering to the highest standards in the provision of patient care and interaction with health insurers. (16) Organized medicine, as represented by MSSNY, should be authorized to represent physician interests in negotiating the establishment of fees with insurers and other payors. (17) MSSNY is committed to organize physicians into an integrated risk-sharing entity in order to offer an alternative to capitated plans and to permit private practicing physicians to compete effectively in the managed care/managed competition arena in both the public and private payor market. (Council 6/3/93; Reaffirmed HOD 01-256; Reaffirmed HOD 2011 and also Reaffirmed AMA Substitute Resolution 203, Health System Reform Legislation (below):

RESOLVED, That our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
Health insurance coverage for all Americans;
Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps;
Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials;
Investments and incentives for quality improvement and prevention and wellness initiatives;
Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors’ access to care;
Implementation of medical liability reforms to reduce the cost of defensive medicine; and
Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens; and be it further

RESOLVED, That our American Medical Association advocate that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation; and be it further

RESOLVED, That our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States; and be it further

RESOLVED, That our American Medical Association support health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients; and be it further

RESOLVED, That it is American Medical Association policy that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians; and be it further

RESOLVED, That our AMA actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician; and be it further

RESOLVED, That our AMA actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals; and be it further

RESOLVED, That our AMA actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: 2

Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services;
Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system;
Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk adjusted;
Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate;
Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; and
Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest; and be it further

RESOLVED, That our American Medical Association continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA’s position based on AMA policy; and be it further
RESOLVED, That our American Medical Association use the most effective media event or campaign to outline what physicians and patients need from health system reform; and be it further

RESOLVED, That national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a “call to action” with the Federation to advance this goal; and be it further

RESOLVED, That creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform; and be it further

RESOLVED, That effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform; and be it further

RESOLVED, That our American Medical Association reaffirm AMA policy H-460.909 Comparative Effectiveness Research.

(Note: Also Filed for Information is the Final Report of MSSNY’s Subcommittee on Health System Reform, chaired by Dr. Robert Scher, which was adopted by the MSSNY House of Delegates.)

265.844 Office Based Surgery Reimbursement
The Medical Society of the State of New York will seek legislation to require health plans to provide facility fee reimbursement to physicians and/or medical practices that obtained State-mandated accreditation for their office-based surgical suite(s). The new legislation should mandate that facility fee reimbursement paid to physicians and/or medical practices issued by the health plan be fair and equitable, which means that payment by plans be no less than 50% of the rate paid to Ambulatory Surgical Centers (ASCs) or Hospitals for the room use of the ER, OR, OPD or Clinic, which will enable the plans to realize cost containment savings by paying physicians and/or medical practices, rather than paying the full ASC or Hospital room use rate. (HOD 2017-255; Reaffirmed HOD 2018-53)
Whereas, the Medical Society of the State of New York (MSSNY) and the American Medical Association (AMA) have previously affirmed that administrative simplification, including automation and standardization of electronic transactions, is a high priority in order to provide affordable, timely, and effective care; and

Whereas, the National Standards Group (NSG) at the CMS Office of Burden Reduction is empowered to enforce administration simplification requirements to ensure standardization throughout the ecosystem of payers, providers, and clearinghouses; and

Whereas, violations of administrative simplification requirements by health plans and payor business associates, including clearinghouses, are prevalent and have an adverse effect on healthcare practices and patients via higher costs and resulting in limited access to affordable healthcare; and

Whereas, NSG at the CMS Office of Burden Reduction has stated that the enforcement mechanism against health plan violations is based on the idea of ‘voluntary compliance’, the only program of this type in the Federal Government where compliance is ‘voluntary’; and

Whereas, the NSG at the CMS Office of Burden Reduction has failed to impose any financial penalties in the past 7 years on health plans for violation of HIPAA administrative simplification requirements. At the same time, HHS/CMS imposed numerous penalties on providers and the healthcare producer industry, including for violations of HIPAA privacy rules which are governed by the same rules as the HIPAA administrative simplification requirements, financial penalties for failure to implement EMR, Meaningful Use (MU) and PQRS penalties, MACRA MIPS penalties, “Open Payments” Sunshine Act violation penalties, and numerous other financial penalties; and,

Whereas, physicians strongly disapprove of the failure by the NSG at the CMS Office of Burden Reduction to resolve complaints related to payments via non-compliant methods including virtual credit cards and for imposing fees for receiving EFT payments by health plans and clearinghouses, and

Whereas, physicians strongly disapprove of the NSG at the CMS Office of Burden Reduction practices of closing complaints without good-faith investigation and under false pretenses, and ignoring overwhelming evidence that contradicts health plan assertions; therefore be it

RESOLVED, that Medical Society of the State of New York (MSSNY) takes the position that the American Medical Association (AMA) must advocate (1) that there is parity in the enforcement of the HIPAA Privacy Rule and HIPAA Administrative Simplification requirements; (2) that the CMS imposes penalties on health plan violations of HIPAA with the same rigor it imposes penalties on healthcare providers for violations of MIPS and other requirements; and be it further
RESOLVED, that MSSNY takes the position that the AMA must advocate that the CMS investigates all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparently in its processes and decisions as required by the Administrative Procedure Act (APA); and be it further

RESOLVED, that MSSNY takes the position that the AMA must advocate that the CMS resolves all complaints related to the non-compliant payment methods including opt-out virtual credit cards and illegal EFT fees and, be it further

RESOLVED, that MSSNY strongly disapprove of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans.

Existing MSSNY Policy:

120.897 Reducing Prior Authorization Burden and Separate Payment When Not Part of a Patient Encounter
The Medical Society of the State of New York (MSSNY) will seek legislation or regulation that:
- restricts insurers from requiring prior authorization for generic medications,
- ensures the legislation or regulation contains disincentives for insurers demanding unnecessary prior authorizations, including payments to physicians’ practices for inappropriate prior authorizations,
- ensures the legislation or regulation requires that payment be made to the physician practice for services related to prior authorization when those services do not coincide with a visit,
- ensures that the legislation or regulation contains a requirement for an independent external review organization to review disputes involving prior authorizations and require insurer payments be made to the practice when the review organization agrees with the physician practice. This resolution will be forwarded to the AMA for national support. (HOD 2020-252 and 2020-262)

RELEVANT AMA POLICY

Administrative Simplification in the Physician Practice D-190.974

Police, Payer and Government Access to Patient Health Information D-315.992
Whereas, insurance companies are having a dramatic negative impact on private practice with onerous prior authorization requirements including waiting periods for prior authorizations extending up to 6 weeks and which require separate authorizations for bilateral procedures with the same disease process. Such requirements result in needless and potentially dangerous delays of necessary care, placing an undue burden on physician, staff and patient alike; and

Whereas, insurers also create onerous referral requirements that change even across same insurers service lines; and

Whereas, even when records are sent, insurance companies claim they are not received and continue to place an undue burden on practices; and

Whereas, insurance companies are using the pandemic to assure the death of private practice by using such tools as 100% audits and unreasonable medical documentation requests to insure nonpayment; and

Whereas, payments are subject to clawbacks and retrospective audits that further take physicians away from patient care; and

Whereas, delays in care lead to disease progression and impair the ability of the physician to obtain optimal results, exacerbating morbidity in an already high risk patient population; therefore, be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) work with the NYS Department of Financial Services and other appropriate entities to create common sense guidelines and metrics regarding on time payments for both E&M and procedure codes; and be it further

RESOLVED, that the NYS Department of Insurance list these metrics by Insurance provider and plan and make them subject to public reporting; and be it further

RESOLVED, that the NYS Department of Financial Services make outliers subject to intensive review and potential penalty; and be it further

RESOLVED, that all insurance plans must pay for a third party to review the satisfaction of the patients and physicians in their payment process and that these surveys also be available for public review including placement on the exchange website as a quality indicator; and be it further
RESOLVED, that an ad hoc committee work with the NYS Department of Financial Services and the Insurance Industry to provide for fair and reasonable standards for chart auditing, prior authorization and any other impediment to prompt treatment of the patient and prompt payment of the doctor and this should be submitted to the NYS Department of Insurance and other appropriate entities to be made into law or statute; and be it further

RESOLVED, that any actions taken beyond the gold standards that have been established require that an application be made to the NYS Department of Financial Services for approval in advance of implementation and that the appropriate stakeholders have an adequate period to review these changes; and be it further

RESOLVED, that this resolution be submitted to the American Medical Association for report in A2022 to determine what concrete steps we can take on the Federal level to best curb the out of control, abusive practices of the insurance industry in the sphere of prior authorization, clawbacks, onerous document requests, failure to document receipt of requested records and retrospective audits that will result in the end of private practice, lead to further consolidation, the destruction of physician autonomy and the sanctity of the physician patient relationship.
Whereas, [Physicians] swear to fulfill, to the best of [our] ability and judgment, this covenant:

[Physicians] will apply, for the benefit of the sick, all measures that are required… and
[Physicians] will remember that [we] do not treat [an illness or injury], but a sick human being, whose illness may affect the person’s family and economic stability. [Our] responsibility includes these related problems, if [we are] to care adequately for the sick [or injured]; and

Whereas, the 2001 revision of [the American Medical Association (AMA)] Principles of Medical Ethics added two new principles: 1) To regard responsibility to the patient as paramount, and 2) To support access to medical care for all people; and

Whereas, the Medical Society of the State of New York (MSSNY) and AMA this year will consider and previously have “Resolved” to oppose the arbitrary and capricious use by private insurance companies of Prior Authorizations resulting in delays in care, excessive administrative burdens, and dwindling payments to physicians; and

Whereas, the MSSNY and AMA this year will consider and previously have “Resolved” to oppose the arbitrary and capricious use by private insurance companies of Utilization Reviews, at times conducted by non-physicians or non-specialty-specific clinicians, resulting in denials of medically necessary care and excessive costs of appeal; and

Whereas, the MSSNY & AMA this year will consider and previously have “Resolved” to oppose the arbitrary and capricious use by private insurance companies of untimely Drug Formulary Changes including, e.g. “Fail-First & Step” therapies, resulting in harm to patients, delays in achieving best practice, and excessive costs to physicians and patients; and

Whereas, the MSSNY & AMA this year will consider and previously have “Resolved” to oppose the inadequate and opaque Conflict Resolution, Appeal, and Challenge procedures employed by private insurance companies resulting in uncompensated expending of time and resources; and

Whereas, while these unethical and unprincipled actions and procedures by private insurance companies are in keeping with their fiduciary duty to prioritize Profits over People, nonetheless they represent clear violations of our Oath and Principles of Professional Conduct; and

Whereas, the Medicare for All Act of 2021 [H.R. 1976] will require coverage to everyone for all medically necessary care, transparency (through input from all stakeholders) in establishing the definition of medical necessity and content of drug formularies, and mandates collective
bargaining to ensure all payment rates shall be reasonable and related to the cost of efficiently providing care, thus assuring an adequate and accessible supply of services; therefore be it

RESOLVED, the MSSNY undertake to relieve the private insurance companies of their unethical and unprincipled fiduciary duty to prioritize Profits over People by endorsing the Medicare for All Act of 2021, Putting People First, and calling on the United States Congress to immediately pass the Act and the President to promptly sign it into law; and be it further

Resolved, the MSSNY forward to the AMA a resolution to undertake to relieve the private insurance companies of their unethical and unprincipled fiduciary duty to prioritize Profits over People by endorsing the Medicare for All Act of 2021, Putting People First, and calling on the United States Congress to immediately pass the Act and the President to promptly sign it into law.

HR-1976
Medicare for All Act of 2021
This bill establishes a national health insurance program that is administered by the Department of Health and Human Services (HHS).

Among other requirements, the program must (1) cover all U.S. residents; (2) provide for automatic enrollment of individuals upon birth or residency in the United States; and (3) cover items and services that are medically necessary or appropriate to maintain health or to diagnose, treat, or rehabilitate a health condition, including hospital services, prescription drugs, mental health and substance abuse treatment, dental and vision services, and long-term care.

The bill prohibits cost-sharing (e.g., deductibles, coinsurance, and copayments) and other charges for covered services. Additionally, private health insurers and employers may only offer coverage that is supplemental to, and not duplicative of, benefits provided under the program.

Health insurance exchanges and specified federal health programs terminate upon program implementation.

However, the program does not affect coverage provided through the Department of Veterans Affairs or the Indian Health Service.

The bill also establishes a series of implementing provisions relating to (1) health care provider participation; (2) HHS administration; and (3) payments and costs, including the requirement that HHS negotiate prices for prescription drugs.

Individuals who are age 18 or younger, age 55 or older, or already enrolled in Medicare may enroll in the program starting one year after enactment of this bill; other individuals may buy into the program at this time. The program must be fully implemented two years after enactment.
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 58

Introduced by: Larry A. Melniker, MD, as an individual Delegate, Kings County

Subject: Prioritizing People First: Upholding our Oath & Code of Conduct by Endorsing the New York Health Act [A.6058/S.5474]

Referred to: Reference Committee on Governmental Affairs - A

Whereas, [Physicians] swear to fulfill, to the best of [our] ability and judgment, this covenant:

[Physicians] will apply, for the benefit of the sick, all measures that are required... and [Physicians] will remember that [we] do not treat [an illness or injury], but a sick human being, whose illness may affect the person's family and economic stability. [Our] responsibility includes these related problems, if [we are] to care adequately for the sick [or injured]; and

Whereas, the 2001 revision of [the American Medical Association (AMA)] Principles of Medical Ethics added two new principles: 1) To regard responsibility to the patient as paramount, and 2) To support access to medical care for all people; and

Whereas, the Medical Society of the State of New York (MSSNY) and the AMA this year will consider and previously have “Resolved” to oppose the arbitrary and capricious use by private insurance companies of Prior Authorizations resulting in delays in care, excessive administrative burdens, and dwindling payments to physicians; and

Whereas, the MSSNY and AMA this year will consider and previously have “Resolved” to oppose the arbitrary and capricious use by private insurance companies of Utilization Reviews, at times conducted by non-physicians or non-specialty-specific clinicians, resulting in denials of medically necessary care and excessive costs of appeal; and

Whereas, the MSSNY and AMA this year will consider and previously have “Resolved” to oppose the arbitrary and capricious use by private insurance companies of untimely Drug Formulary Changes including, e.g. “Fail-First & Step” therapies, resulting in harm to patients, delays in achieving best practice, and excessive costs to physicians and patients; and

Whereas, the MSSNY & AMA this year will consider and previously have “Resolved” to oppose the inadequate and opaque Conflict Resolution, as well as, Appeal & Challenge procedures employed by private insurance companies resulting uncompensated expending of time and resources; and

Whereas, while these unethical and unprincipled actions and procedures by private insurance companies are in keeping with their fiduciary duty to prioritize Profits over People, nonetheless they represent clear violations of our Oath and Principles of Professional Conduct; and

Whereas, the New York Health Act [A.6058/S.5474] will require coverage to everyone for all medically necessary care, transparency (through input from all stakeholders) in establishing the definition of medical necessity and content of drug formularies, and mandates collective
bargaining to ensure all payment rates shall be reasonable and related to the cost of efficiently providing care, thus assuring an adequate and accessible supply of services; therefore be it

RESOLVED, the MSSNY undertake to relieve the private insurance companies of their unethical and unprincipled fiduciary duty to prioritize Profits over People by endorsing the New York Health Act, Putting People First, and calling on the New York State Legislature to immediately pass the Act and the Governor to promptly sign it into law; and be it further

RESOLVED, the MSSNY forward to the AMA a resolution to undertake to relieve the private insurance companies of their unethical and immoral fiduciary duty to prioritize Profits over People by endorsing the New York Health Act, Putting People First, as a model for healthcare reform in the United States.

A.6058/S.5474
S5474 (ACTIVE) - SUMMARY
Estabishes the New York Health program, a comprehensive system of access to health insurance for New York state residents; provides for administrative structure of the plan; provides for powers and duties of the board of trustees, the scope of benefits, payment methodologies and care coordination; establishes the New York Health Trust Fund which would hold monies from a variety of sources to be used solely to finance the plan; enacts provisions relating to financing of New York Health, including a payroll assessment, similar to the Medicare tax; establishes a temporary commission on implementation of the plan; provides for collective negotiations by health care providers with New York Health.
Whereas, The coverage and utilization of telehealth expanded rapidly during the COVID-19 pandemic; and

Whereas, CMS (Medicare and Medicaid) and many commercial health insurance companies have voluntarily expanded telehealth coverage during the pandemic, and

Whereas, Our AMA has drafted model legislation that requires health insurance companies to offer telehealth coverage and to reimburse for those services “on the same basis and to the same extent” that the insurer would have if the same service were rendered in-person; and

Whereas, New York State has been a champion of patient access which was facilitated by the expansion of telehealth services, and

Whereas, There are ongoing discussions across the nation regarding whether to require health insurance companies to offer telehealth coverage and whether to require health insurance companies to provide payment parity for telehealth services; and

Whereas, Physicians have recognized that telehealth can improve clinical outcomes, patient experience, costs, and professional satisfaction; and

Whereas, Physician advocates must request continued telehealth coverage and payment parity legislation in the absence of research that can be used to respond to the assertion that such legislation will definitively and significantly increase health insurance premiums; therefore, be it

RESOLVED, That the Medical Society of the State of New York support legislation that will protect telehealth benefits by CMS and all private health insurance plans including ERISA plans after the end of the pandemic and request that AMA assist in these efforts.

References:
2. AMA Telemedicine Model Bill, 2017
4. American Medical Association Telehealth Research & Key Resources: Research Findings, https://www.ama-assn.org/practice-management/digital/telehealth-research-key-
Relevant MSSNY Policy

265.842 Study and Promotion of Telemedicine Payment Parity
MSSNY will work with individual legislators throughout the state to introduce legislation that would require parity of payment between services provided in-person and via telemedicine. (HOD 2017-109; Reaffirmed HOD 2019 in lieu of res 105)

265.869 Development of a Transparent and Fair Payment Process for ERISA Plans
MSSNY will introduce a resolution at the AMA House of Delegates seeking legislation through the Congress or through regulation by the Department of Labor which would require ERISA Plans develop and administer a transparent and fair process, similar to States prompt payment laws and CMS regulation, for the payment of claims to providers. (HOD 2014-61; Reaffirmed HOD 2015 in lieu of res 62)

265.981 ERISA Plans Should be Held Accountable to the Same Reimbursement Requirements as other Insurance Carriers in the 1997 Prompt Payment Legislation:
The Medical Society of the State of New York supports legislation that would require ERISA plans to pay medical insurance claims in a timely manner as other insurance carriers in New York State are required to do. (HOD 1998-87; Reaffirmed HOD 2014)

195.920 Elimination of the Medicare Face-to-Face Requirement
The Medical Society of the State of New York will work with the AMA to advocate simplification of the Medicare requirements for a “Face to Face” visit by a physician with a patient as a precondition for Medicare home health coverage, including advocating for alternatives for such “face to face” visits such as by telehealth. This resolution will be forwarded to the 2017 AMA House of Delegates. (HOD 2017-50)

110.987 Collaborating with Federal and State Agencies to Ensure the Provision of Long Term Care Services
Through its Long Term Care Subcommittee of the Quality Improvement and Patient Safety Committee, MSSNY will work with all relevant federal and state agencies to ensure that long term care services, including home care services, physician home visits, telehealth and palliative care, are integrated into and paid for through new initiatives underway which seek to restructure the health care delivery system, such as the Delivery System Reform Incentive Payment (DSRIP) Program, Medicare Shared Savings Accountability Care Organizations and the Fully-Integrated Dual Advantage (FIDA) Program. (HOD 2015-107)

Relevant AMA Policy

Insurance Coverage Parity for Telemedicine Service D-480.969
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states’ efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state’s medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
Whereas, Federal Medicaid rules limits a laboratory standing order’s validity to six months which 
necessitates practitioners to reorder laboratory studies every six months for regular and routine 
laboratory studies that often are required for a patient’s lifetime (such as standard of care 
monitoring of HemoglobinA1Cs every three to six months for diabetics); and

Whereas, there is no documented benefit to limiting laboratory orders to six months and 
expiration of standing lab orders has led to patient and physician dissatisfaction; and

Whereas, burnout is a harm negatively impacting the American medical work force and has 
deleterious implications on patient care quality, outcomes and patient satisfaction; and

Whereas, ‘busywork’ that is not perceived as meaningful contributes to burnout; and

Whereas, reordering laboratory studies only for the sake of a regulation leads to unnecessary 
and not meaningful work, the kind of activity that contributes to burnout among practitioners and 
increases the cost of healthcare because of the time and labor required for each practice to 
reorder routine laboratory studies; therefore be it

RESOLVED, That MSSNY directs New York AMA representatives to present this resolution to 
the AMA for action at the Interim 2021 meeting; that the AMA advocates to CMS to allow 
standing laboratory orders to be valid for 15 months, and, be it further

RESOLVED, that MSSNY advocate for all insurances to allow any standing laboratory order to 
be valid for up to 15 months before a new order is required.
Whereas, the American Association of Medical Colleges projects that the United States will face a shortage of between 54,100 and 139,000 physicians by 2033 (1); and

Whereas, The Center for Health Workforce Studies at the University at Albany also projects that New York State will have a shortage of between 2,500 and 17,000 physicians by 2030 (2); and

Whereas, there has been a sharp increase in the growth of midlevel practitioners, such as Physician Assistants, Nurse Practitioners, Certified Registered Nurse Anesthetists, over the past few years, who all have less rigorous education and training standards than licensed physicians and unlicensed resident physicians touted as a possible solution for the impending physician shortage (3); and

Whereas, there is current discrepancy in New York State regulations that allows graduates of LCME or COCA accredited medical schools to obtain a New York State medical license after completion of one year of graduate medical education, however medical school graduates who have obtained ECFMG certification are required to complete three years of graduate medical education (4); and

Whereas, there are many well qualified physicians who have obtained ECFMG certification who are unable to practice medicine in New York because they are only able to complete one or two years of graduate medical education largely due to a shortage of residency training programs; and

Whereas, allowing ECFMG certified physicians to obtain a New York State medical license after completing one year of graduate medical education would both help close the projected shortage of physicians in New York; therefore be it

RESOLVED, That the Medical Society of the State of New York pursue changes in New York State regulations that would allow physicians who have successfully obtained ECFMG certification to obtain a New York State medical license after the successful completion of one year of graduate medical education.

Existing MSSNY Policy:

85.991 Preservation of Opportunities for US Graduates and IMGs Already Legally Present in This Country:

In the event of reductions in the resident workforce in the State of New York, the Medical Society of the State of New York will advocate for a mechanism of resident selection which promotes the maintenance of resident physician training opportunities for all qualified graduates
of United States Liaison Committee on Medical Education and American Osteopathic Association accredited institutions.

MSSNY adopts and will publicize the position that if hospitals reduce the number of residency positions they offer, MSSNY will continue to advocate for equal consideration in the candidate selection process of IMGs who are already legally present in this country.

MSSNY will ask the AMA to urge the Educational Commission for Foreign Medical Graduates (ECFMG) to reduce the number of examinations it offers abroad, in the light of decreased availability of residency position; and make it clear to graduates of international medical schools that the opportunity for residency training and practice in the United States are becoming extremely limited.

This information should be included in the initial application materials given to the candidates prior to the examination. (HOD 1997-228; Reaffirmed Council 3/19/98; Reaffirmed HOD 2014 with recommendation for development of more relevant policy)

85.975 **Federation Credentials Verification Service (FCVS):**
That the Medical Society of the State of New York supports beginning the process, by the Federation Credentials Verification Service (FCVS), of compiling documents needed for medical licensure of International Medical Graduates, after 2 ½ years of medical residency, upon receiving certification by the Residency Program Director that the IMG will be competent to be licensed, pending satisfactory completion of the final 6 months of training; and that one month before the end of the Residency Program, FCVS send all necessary documentation for licensure of an International Medical Graduate to the New York State Education Department in order that the license be ready immediately upon completion of the 3 year Residency Program. (Council 1/26/06; Reaffirmed HOD 2016)

References:

1. https://www.aamc.org/media/45976/download
WHEREAS, the Supplemental Nutrition Assistance Program (SNAP) is the largest federal nutrition assistance program (1) and New York State’s largest food assistance program, helping more than 2.5 million New Yorkers each month (2); and

WHEREAS, during the COVID-19 pandemic, the US Department of Agriculture (USDA) made online groceries available for SNAP recipients in 48 states (3); and

WHEREAS, online SNAP purchasing is currently limited to a very small number of approved retailers due to technological and financial barriers, with the majority of states having only Amazon and Walmart (4) as online SNAP vendors, and New York only having four online SNAP grocery vendors: Aldi, Amazon, Walmart and ShopRite (5); and

WHEREAS, the Center for Digital Democracy investigation found that the USDA’s privacy protection requirements for participating online SNAP retailers were “weak and ineffective,” leaving SNAP recipients susceptible to “an often manipulative and nontransparent online grocery marketplace” from retailers including both Amazon and Walmart (6); and

WHEREAS, a report led by the Center for Digital Democracy showed that online SNAP retailers may be locking low-income consumers into online shopping patterns that favor highly processed foods and those that are high in sugar, hydrogenated oils, and other synthetic ingredients (6); and

WHEREAS, retailers use “highly sensitive geolocation data,” to track how SNAP recipients shop, how they live, where they go, how long they stay, what they buy, and what they do not (6), and

WHEREAS, Predatory marketing practices have been linked to increased health disparities for communities of color (7), and

WHEREAS, on July 16, 2020, a joint letter from Berkeley Media Studies Group, Center for Digital Democracy, Color of Change, and UnidosUS was submitted to the USDA Secretary of Agriculture urging the USDA to strengthen and expand safeguards in the SNAP Online Purchasing Pilot due to concerns of exacerbating disparities in racial and health equity and advocating for oversight hearings for the SNAP online purchasing program (8), therefore, be it
RESOLVED, that the Medical Society of the State of New York will advocate for policy that would facilitate expansion in the number of vendors that participate in the online Supplemental Nutrition Assistance Program in New York State.

1. https://www.benefits.gov/

Existing MSSNY Policy:

320.989 **Decreasing the Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition-Poor Foods and Nutrition-Dense Foods:**

MSSNY supports:
- efforts which seek to decrease the price gap between calorie-dense, nutrition-poor (CDNP) foods and naturally nutrition-dense (ND) foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity such as the Farmer’s Market Nutrition Program (FMNP) as a part of the Women, Infants, and Children (WIC) program;
- novel application of FMNP to existing programs such as the Supplemental Nutrition Assistance Program (SNAP) and apply program models that incentivize the consumption of ND foods in wider food distribution venues than solely in farmer’s markets as part of WIC. (HOD 2010-168; Amended and reaffirmed HOD 2020)

320.991 **Promoting Healthy Foods:**

MSSNY will (1) continue to advocate for a healthy diet for all; (2) support legislative efforts to establish New York State nutritional standards within the educational system; (3) recommend to hospitals, schools, nursing homes, patients and its physician members that foods should meet the accepted nutritional standards; and, (4) together with the American Medical Association, promote and advocate legislation that promotes the availability of fruits, vegetables and whole grain foods. (HOD 2008-150; Reaffirmed HOD 2018)
Whereas, The SARS Covid19 pandemic has resulted in an increase in overt and an exacerbation of mental illness in both children and adults; and,

Whereas, MSSNY will continue to educate practicing physicians to help them recognize and counsel those in psychological need and detect, refer, and treat depression, anxiety, OCD, PTSD, substance abuse, and other conditions arising from, or exacerbated by, the pandemic; and,

Whereas, MSSNY will support the establishment of clinical guidelines for diagnosis, referral, and appropriate treatment for these mental illnesses; and

Whereas, MSSNY supports funding to school districts, not-for-profit agencies, and communities to implement high quality, effective evaluation, intervention, and short- medium- and long-term treatment for children and adults across the spectrum of pandemic related mental illness, and

Whereas, while some insurance plans and managed care organizations pay for some treatment of mental illness, others do not and some plans offer coverage for treatment which is generic rather than specifically directed toward the most appropriate therapy; and

Whereas, MSSNY has supported New York State’s mental health parity law; and therefore be it

Resolved, that MSSNY support legislation to assure that there is coverage for a full continuum of services to treat mental health-illnesses brought on by the COVID-19 pandemic, and be it further

Resolved, that the Medical Society supports legislation that will eliminate the outpatient and inpatient limits and equalize co-payments and deductibles for mental health coverage.

Existing MSSNY Policy:

320.995  Weight Management Guidelines

Physician Education
The Medical Society will work towards educating its physician members and will work with its various county medical and specialty societies to bring weight management before them. The Medical Society will educate physicians via its website, through continuing medical education courses, and through other media outlets the Medical Society may have available to them. Additionally, the Medical Society will enter into a discussion with medical schools regarding the
training of medical students with great emphasis on nutrition, weight management and healthy lifestyles.

**Community Awareness**
The Medical Society will work with state agencies, particularly the Department of Health, in creating awareness for the general public on weight issues. The Medical Society will also contact representatives within the business community and will work with the New York State Community Health Partnership to promote physical activity and lifestyles within communities. The Medical Society will also attempt to enlist the support of the fast food industry to “down size” the portions and to increase the availability of nutrition information for food purchase within a fast food restaurant.

**Educational Institutions**
The Medical Society recommends that increased physical activity be incorporated into the daily schedule at all schools in accordance with the recommendations of “Healthy People 2010”. Additionally, the Medical Society will seek to preserve “recess” for all schools to help ensure that children receive physical activity. Furthermore, the Medical Society will work towards the goal of advocating proper nutrition within the schools and will support legislative efforts to afford good nutritional choices, especially in vending machines and in the lunchroom or cafeteria.

**Legislative Initiatives**
While some insurance plans and managed care organizations pay for programs related to weight, many in New York State do not. Therefore, the Medical Society will seek legislation requiring insurance and managed care plans for paying for nutritional visits, bariatric programs, and certain medications. The Medical Society will also seek coverage for surgical management, including bariatric surgery and reconstructive surgery, related to weight loss and management. The Medical Society will also support efforts to require the Medicaid program to pay for medications related to weight loss. Furthermore, weight management problems have both medical and psychological disease origins. Serious mental illnesses can exacerbate the obesity condition and the conditions related to bulimia and anorexia nervosa. Therefore, the Medical Society of the State of New York will support legislative efforts to assure that there is coverage for a full continuum of services to treat these illnesses. Additionally, the Medical Society supports legislation that will eliminate the outpatient and inpatient limits and equalize co-payments and deductibles for mental health coverage.

**Position Paper:**
Weight Management: Promotion of Healthy Lifestyles
Public Health and Education Report 1 Presented by Sheila Bushkin, MD and the members of the Rural and Preventive Medicine Committee
(HOD 2003; Reaffirmed HOD 04-170; Reaffirmed HOD 2005-165; Reaffirmed HOD 2015; Reaffirmed HOD 2019 in lieu of res 257)

**260.949 Post Disaster Mental Health Consequences of Concern:**
MSSNY will educate practicing physicians to help them a) reach out to those potentially harmed by the natural, made-made or terrorism-related disasters b) counsel those in psychological need, c) detect, refer, and treat post-traumatic stress disorder, depression, substance abuse, and other conditions arising from the events. (HOD 2002-165; Modified and Reaffirmed HOD 2013)
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 105

Introduced by: Loren Wissner Greene, MD, As an Individual Delegate, New York

Subject: Reciprocal Telehealth Arrangements

Referred to: Reference Committee on Governmental Affairs - B

Whereas, Many elderly or disabled or immuno-compromised patients are reluctant to return to in office care; and

Whereas, Many independent and small practices cannot afford to obtain licensure in all the states where their patients now reside; and

Whereas, Not all New York residents have been vaccinated as some are too young and some do not wish to be vaccinated and some do not want to mask; and

Whereas, Coronavirus variants continue to circulate and even infect vaccinated people; therefore, be it

RESOLVED, That the Medical Society of the State of New York advocate for reciprocal telehealth arrangements so that New York State physicians can provide continuing care by telehealth across state borders for existing patients.

Existing MSSNY Policy:

110.987 Collaborating with Federal and State Agencies to Ensure the Provision of Long Term Care Services

Through its Long Term Care Subcommittee of the Quality Improvement and Patient Safety Committee, MSSNY will work with all relevant federal and state agencies to ensure that long term care services, including home care services, physician home visits, telehealth and palliative care, are integrated into and paid for through new initiatives underway which seek to restructure the health care delivery system, such as the Delivery System Reform Incentive Payment (DSRIP) Program, Medicare Shared Savings Accountable Care Organizations and the Fully-Integrated Dual Advantage (FIDA) Program. (HOD 2015-107)

110.983 Covid 19 Emergency and Expanded Telemedicine Regulations

The Medical Society of the State of New York will continue to advocate for a continuation of coverage for the full-spectrum of technologies that were made available during the Covid-19 pandemic and that physicians be reimbursed by all government and private payers for time and complexity. MSSNY will advocate that the current emergency regulations for improved access to and payment for telemedicine services be made permanent with respect to payment parity and use of commonly accessible devices for connecting physicians and patients, without reference to the originating site, while ensuring qualifications of duly licensed physicians to provide such services in a secure environment.
Study and Promotion of Telemedicine Payment Parity
MSSNY will work with individual legislators throughout the state to introduce legislation that would require parity of payment between services provided in-person and via telemedicine. (HOD 2017-109; Reaffirmed HOD 2019 in lieu of res 105)

MSSNY will propose that all New York insurance carriers provide coverage for New Yorkers’ telemedicine visits with any physician licensed and registered to practice in New York State.

MSSNY will forward a resolution to the AMA HOD at its next meeting in order to address these issues on a national level. (Amended and Adopted, Council 6/4/2020; HOD 2020-168 & Late F)

Licensure Requirement for Providing Medical Advice Through Telemedicine:
MSSNY will urge the New York State Board of Medicine to require full New York State licensure for an individual providing medical advice through the technology of Telemedicine from in or out of state for patients under treatment in New York State. Such medical advice requiring full licensure would entail the performance of an act that is part of a patient care service initiated in this state and affecting the diagnosis or treatment of the patient. Excluded from this full licensure requirement would be traditional informal physician-to-physician consultations (“curbside consultations”) that are provided without expectation of compensation. MSSNY will recommend further monitoring and study of the areas of Telemedicine encompassing confidentiality of patient information, professional liability, coding and reimbursement, and will seek the development of legislation and/or regulation requiring the full New York State licensure of Medical Directors and physicians employed by managed care systems or other health insurers in or out of state who make decisions which affect medical care. (Council 10/24/96; Reaffirmed HOD 2014)
Whereas, New York City retirees now are being mandated to change from traditional Medicare to Medicare Advantage plans; and

Whereas, Medicare Advantage plans may have restrictive networks; and

Whereas, Medicare Advantage plans further privatize patients' Medicare, without discussion or agreement by the persons concerned, all in the interest of saving money for the employer; and

Whereas, Forcing use of Medicare Advantage plans does not consider the retiree's personal health concerns, including the ability to find continued care with their own doctors or hospitals; therefore be it

Resolved, That the Medical Society of the State of New York advocate for legislation such that no person should be mandated to change from traditional Medicare to Medicare Advantage plans.

Existing MSSNY Policy:

195.922 Seamless Conversion and Medicare Advantage Plans
The Medical Society of the State of New York will prepare a simple, easy to read modifiable model letter for physician members to provide their Medicare enrollees and a poster which can be downloaded for printing by physicians for their offices. MSSNY will work with appropriate stakeholders to collaborate with senior groups, including the AARP, to raise awareness among physicians and seniors on the implications of the practice of seamless conversion and to advocate with legislators and CMS to implement an immediate moratorium on the practice of seamless conversion. This resolution will also be submitted to the AMA for its consideration. (Adopted Council 9/15/16)
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 150

Introduced by: Edward W. Powers, III, MD, As an Individual Delegate, New York

Subject: Electric Scooters

Referred to: Reference Committee on Public Health and Education

Whereas, Effective April, 2020 the law allows people to operate bicycles with electric assist (e-bikes) on some streets and highways in New York State; and

Whereas, Effective August, 2020 the law allows people to operate electric scooters (e-scooters) and bicycles with electric assist (e-bikes) on some streets and highways in New York State; and

Whereas, A study published by JAMA has found that the United States experienced a surge in injuries due to e-scooter use; and

Whereas, There has been an increase in fatalities related to e-transportation vehicles (note the recent death of actor Lisa Barnes killed in a hit-and-run electric scooter accident); and

Whereas, It is a common occurrence to see people on e-scooters and e-bikes at high speeds running red lights, going the wrong way down streets, swerving into traffic and just missing pedestrians, and riding along sidewalks; and

Whereas, Hit and run fatalities on e-transportation vehicles are not classified as felonies; therefore be it

RESOLVED, That the Medical Society of the State of New York advocate for safety measures and stricter penalties for hit-and-run e-scooter and e-bikes offenses.

Existing MSSNY Policy:

10.968 Bicycle Safety Infrastructure
The Medical Society of the State of New York will encourage law enforcement to enforce the rules of the road, and will collaborate with county medical societies to ensure that future infrastructure projects consider the safety of bicyclists. (HOD 2018 – 151 and 152)
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 151

Introduced by: Sandhya Malhotra, MD - Delegate, Queens County
Sheila Bushkin, MD – Delegate, Washington County
As individuals

Subject: Requiring Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians

Referred to: Reference Committee on Public Health and Education

Whereas, Accredited Continuing Education is recognized as essential for the continuing professional and personal development for physicians in order to improve the health and wellbeing of patients as well as the community; and

Whereas, Accreditation Council Medical Education (ACCME) current policies and guidelines do not require an accredited provider of Continuing Education (CE) providing education for physicians to be organizations for (or led by) physicians; and

Whereas, many such non-physician led accredited CE provider entities are engaged in providing accredited CE to physicians; and

Whereas, ACCME policies require that all accredited CE identify professional practice gaps for the development of CE activities; and

Whereas, to ensure that all accredited CE for physicians addresses the needs of physician learners that CE for physicians is planned and developed with physician involvement; therefore, be it

RESOLVED, that MSSNY collaborate with other stakeholders to petition the Accreditation Council for Continuing Medical Education (ACCME) to require physician participation in the planning and development of accredited continuing education for physicians; and be it further

RESOLVED, that MSSNY brings this resolution to the AMA for adoption as policy.
MEDICAL SOCIETY OF THE STATE OF NEW YORK  
House of Delegates

Introduced by: Schoharie County Medical Society  
Medical Society of the County of Kings

Subject: Fifteen Month Prescribing

Referred to: Reference Committee on Public Health and Education

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Whereas, burnout is a harm negatively impacting the American medical work force and has deleterious implications on patient care quality, outcomes and patient satisfaction; and

Whereas, ‘busywork’, that is not perceived as meaningful, contributes to burnout; and

Whereas, New York Medicaid limits a prescription’s validity to six months which necessitates practitioners to rewrite maintenance prescriptions every six months for medications that patients often take for years or decades; and

Whereas, there is no documented benefit to limiting prescriptions to six months; and

Whereas, rewriting prescriptions only for the sake of a regulation leads to unnecessary work not perceived as meaningful, thus contributing to burnout among practitioners in addition to increasing the cost of healthcare because of the time and labor required to process prescription refills; and

Whereas, other states have extended the validity of a prescription to 15 months ( see Illinois 2019 ) without reported negative financial or patient impact but with positive impact on physician and other practitioners’ efficiency and wellbeing; therefore be it

RESOLVED, That MSSNY advocate for the New York Legislature to change the law to allow prescriptions for non-controlled substances to be refilled for 15 months.

Existing MSSNY Policy

70.991 Physician’s Right to Dispense Drugs and Devices: MSSNY supports the position taken by the AMA House of Delegates in June, 1986 to support the physician’s right to dispense drugs and devices when it is in the best interest of the patient and consistent with the AMA’s Ethical Guidelines. (Council 4/23/87; Reaffirmed HOD 2013)
Whereas, The NY Prescription Monitoring Program (PMP) was passed into law in 2013, to make prescribers of controlled substances and pharmacists aware of a patient’s controlled substance prescription history and require dispensing Pharmacist input data into the registry.

Whereas, The goal of PMP is to prevent patients from “Doctor shopping”; i.e., obtaining multiple contemporaneous opioid prescriptions for the purposes of recreational use, drug diversion or addiction.

Whereas, it has been noted that patients maintained on Methadone to treat opioid addiction often do not have Methadone prescriptions documented in the PMP likely because the Methadone may be dispensed in a clinic setting which is one of the exemptions in the PMP law.

Whereas, Patients maintained on Methadone for opioid addiction may develop acute pain resulting in consultation with acute care providers.

Whereas, some patients with a history of opioid addiction may not disclose this information to the acute care provider either accidentally or intentionally.

Whereas, acute care providers may check the PMP and prescribe opioids after seeing no documentation of Methadone prescriptions due to a loophole in the PMP, possibly resulting in a relapse or possible overdose due to 2 opioids being taken at once; therefore, be it

RESOLVED; That MSSNY would work with the State Legislature and the NY Bureau of Narcotic Enforcement (BNE) to close the existing loophole by requiring Methadone dispensers to report each prescription to the PMP to prevent opioid addiction relapses and overdose.

Existing MSSNY Policy:

117.968 **All Dispensers Report to the Prescription Monitoring Program**
The Medical Society of the State of New York will continue to work with the American Medical Association to update federal regulations which enable physicians to review medication information currently not required to be reported to New York’s I-STOP database, such as medications dispensed as part of opioid treatment programs and the Veterans Administration. (HOD 2019-51)

65.991 **Recommendations to Address the Prescription Drug Abuse and Diversion Issue**
The Medical Society of the State of New York adopted the following consensus statement: There have been several New York State legislative proposals from state legislators and officials to combat the abuse of prescription drugs. The Medical Society of the State of New York and the above referenced specialty societies believe that any solution to the abuse of prescription drug problem must be multipronged.
This approach includes increased law enforcement efforts to prevent and punish inappropriate diversion of prescription medications. It includes the need for increased accessibility of treatment for patients suffering addictions so as to reduce the likelihood of inappropriate diversion of prescribed medications. It includes improvement in and better use of the existing database that is currently maintained by the New York State Health Department on all controlled substance prescriptions. And it includes the need for additional resources for associations representing prescribers so that they can educate their members about the existence of the database and the circumstances of patients presenting themselves in health care settings that should trigger a prescriber to check the database.

New York State has for many, many years collected information on prescription drugs and has a Prescription Monitoring Program (PMP)—an electronic monitoring system that is operated by New York State’s Department of Health Bureau of Narcotics Enforcement (BNE). The issue is not the need to create a new database. The issue is how the information that already exists within the database can be best used and improved upon in order to inform physicians and other non-physician prescribers, as well as pharmacists dispensing these medications, so as to prevent or reduce “doctor-shopping,” diversion and abuse. Physicians have indicated that the present system which is operated on the Health Commerce System (HCS) is very difficult to use, has a significant lag in the reporting of such data, and requires a password that expires if the physician does not go onto the HCS within a certain period of time. In addition, no information at all is given about an individual patient unless their prescription usage hits a too high threshold of obtaining multiple prescriptions from multiple doctors and filling them at multiple pharmacies in a short timeframe. Specifically, no information at all is available unless a patient has two or more prescriptions written by two or more physicians that are filled at two or more pharmacies over the last couple of months or so. Finally, since pharmacy data may be entered on a monthly basis, often the prescription information for the most recent few weeks is incomplete.

The Medical Society of the State of New York and the above referenced specialty societies note that as the State looks to identify ways to prevent misuse and inappropriate diversion, it will need to be careful that it does not “over correct” this problem. In fact, there is a body of recognized expertise that has concluded that physicians are not actually prescribing pain medications enough. As such, the medical community has serious concerns with proposals that would mandate reporting and checking a database each and every time a controlled substance prescription is written. The Medical Society and the above referenced specialty societies are greatly concerned that such proposals would add to the already tremendous administrative burden facing physician practices and worse, would potentially discourage physicians from writing prescriptions for controlled substances in situations where they are necessary. In addition, strict mandatory reporting may result in the unintended consequences of preventing patients with substance use disorders or chronic pain from seeking or staying in treatment or prevent them from reporting such behaviors to their treating physicians.

Therefore, the Medical Society of the State of New York and the above referenced specialty societies recommend that the following changes be made via regulation and/or statute:

**E-Prescribing of Narcotics**
- The Medical Society and the above referenced specialty societies support the implementation of E-prescribing for all controlled substances.
- The Medical Society and the above referenced specialty societies support the implementation of connecting the PMP Database with Health Information Exchanges.

**Improving the PMP Database**
The Medical Society of the State of New York and the above referenced specialty societies support physicians having access to the PMP for ANY controlled medication prescriptions as far back as database will allow.

- The Medical Society and the above referenced specialty societies are supportive of allowing a physician’s designee to have access to the PMP. The Medical Society and the above referenced specialty societies support authorizing pharmacists to have access to the existing PMP database which would better enable pharmacists to provide relevant information to the prescribing physician.

- The Medical Society and the above referenced specialty societies support the use of improved technology to allow easier usage of the PMP.

Physician Access to PMP and Physician Education

- MSSNY and the above referenced specialty societies support the principle that if a physician believes a patient is attempting to access a prescription for any reason other than treatment of an existing medical condition such physician has the obligation to decline to write the prescription or check the current data base before a script is written or submitted electronically.

- The Medical Society and the above referenced specialty societies support developing regulatory guidance with the input of appropriate physician organizations to treat acute pain and for chronic pain management care provided that this guidance is developed in consultation with physicians and appropriate physician organizations and that such guidance is mindful of the need for individualized medical evaluation and decision making. Such guidance may include information relative to the clinical conditions which would indicate physician recourse to the PMP database.

- The Medical Society and the above referenced specialty societies support voluntary education programs for providers on pain management, substance abuse and dependence, diversion and on the use of the PMP as a tool for prescribing, with the caveat that the prescribing authority remains independent of any educational requirement.

Patient Education

- The Medical Society and the above referenced specialty societies believe it is imperative that NYS educate the public regarding the dangers of prescription misuse and diversion and the requirement to inform all prescribers of any controlled drugs they are taking.

Prescription Drugs

- The Medical Society and the above referenced specialty societies support elevating Hydrocodone to Schedule II and Tramadol to Schedule III. Importantly, this will limit the duration of Hydrocodone prescriptions to 30 days.

Prevention Methods

- The Medical Society and the above referenced specialty societies support data sharing of information through the PMP with other states.

- The Medical Society of the State and the above referenced specialty societies support drug take-back programs for all prescriptions.

Additionally, the Medical Society of the State of New York opposes any legislation requiring physicians to do patient background checking prior to prescribing controlled substances.

The Medical Society of the State of New York submitted a resolution to the AMA House of Delegates opposing federal legislation which would require physicians to do background checking prior to prescribing controlled substances. (HOD 2012-161 and 162)

References:
Whereas, under 42 CFR §8.7(h), CMS requires every nursing home to designate a physician to serve as medical director who is responsible for the implementation of resident care policies and the coordination of medical care the facility; and

Whereas, while the New York State Department of Health (NYSDOH) survey teams can verify that a physician is named medical director, this does not allow for adequate regulatory oversight to ensure that the intent of the regulation is being fulfilled across many care communities at all times; and

Whereas, a system is necessary to ensure active involvement of medical directors in nursing homes and provide an efficient process for other sites of care (hospitals, etc.) to engage with the medical director to improve transitions of care; and

Whereas, nursing home medical directors have a key role in the oversight of medical care including implementing effective antibiotic stewardship programs and improving staff compliance with infection control procedures; and

Whereas, the NYSDOH should consult and actively engage with nursing home medical directors in an emergent clinical situation (i.e., a pandemic), and therefore needs an active, up to date medical director registry; therefore be it

RESOLVED, that MSSNY collaborate with the New York State Department of Health to create an active/up to date registry for nursing home medical directors and associate medical directors, that can easily be accessed by physicians, hospitals, and/or health systems.

Existing MSSNY Policy: none found
Introduced by: Daniel Torres Leyva, MD, As an Individual Delegate, NYS Rheumatology Society

Subject: Physician Burn Out

Referred to: Reference Committee on Public Health and Education

Whereas, physician burn out and awareness of burn out is a problem that is being faced through all medical specialties; and

Whereas, physicians are becoming disillusioned with medicine; and

Whereas, productivity is decreasing and ultimately patient care is being affected; therefore, be it

RESOLVED, Medical Society of New York will continue to reinforce CME on recognizing burn out, as well as surveys to measure physician stress; and be it further

RESOLVED, Medical Society of New York will collaborate with major hospital systems to introduce physicians’ wellness programs and activities; and be it further

RESOLVED, surveys will be re administered at the House of Delegates Meeting in 2022 to see if there has been an improvement in either physician burn out or at least burn out awareness.

Existing MSSNY Policy:

MSSNY Physician Stress and Burnout Task Force

MSSNY will:
Develop CME programs on physician stress and burnout, as well as the peer support model, recruiting a cadre of doctors to do such CME presentations;
Seek grants or other funding to support CME, study of burnout, and program activities in an enduring way;
Continue collaboration with other organizations on burnout reduction and wellness efforts;
Develop a peer support model to all county societies, hospitals/hospital systems, and practices through grants or other funding (Adopted, Council 1/19/17)
Distribute to MSSNY membership burnout survey data coupled with a preliminary plan for interventions; beginning with distribution of survey results at the 2017 House of Delegates and CME presentations during the weekend;
Develop a program to assist doctors when they need to reach out for help to sustain their wellness before it progresses to mental health or substance use disorder, charging the MSSNY legal team and staff to devise a solution which meets the needs of our members and maintains the legal and financial integrity of the MSSNY organization. (Adopted, Council 3/7/17)

The Medical Society of the State of New York has, since March 2017 has addressed the issues of burnout and physician wellness and resiliency.

MSSNY has:
• Created a standing Committee on Physician Wellness and Resiliency, chaired by Charles Rothberg, MD. The committee meets on a regular basis and its planning committee meets once
a month to discuss on-going educational programming and initiatives on reducing physician’s burnout.

- Conducted numerous CME programs at the MSSNY House of Delegates since 2017. Over the last year, webinars were conducted on *Steps to Physician Wellness and Resiliency* and *Mental Health and COVID-19 for Health Professionals*. Both programs are available on-line at [https://cme.mssny.org/](https://cme.mssny.org/).

- MSSNY will conduct the *Steps to Physician Wellness and Resiliency* on Sept. 17, 2021, as part of the CME programs at MSSNY HOD.

- MSSNY has obtained grants, through the Physicians’ Foundation that has allowed it to participate in the American Medical Association’s Practice Transformation Initiative (PTI) and most recently, The Telehealth Initiative. Part of the PTI, is to assess physician burnout and the partners in this program have conducted various surveys, identify an intervention and then resurvey physicians upon completion of the intervention.

- In 2020, MSSNY developed its Peer to Peer (P2P) program for all physicians, residents and medical students. This program pairs a stressed physician with a colleague to help them obtain support, empathy and if needed, referral.

- MSSNY has been working closely with institutions in New York State to implement the P2P program and has held many meetings with administrators, hospital personnel, and county medical societies on the P2P program.

Therefore, since MSSNY is addressing the issue of physician burnout, based on the number of activities above, this resolution should be reaffirmed.
Whereas, there are known healthcare disparities within New York City, and
Whereas, each borough has a population that would be a significant city on their own, and
Whereas, these large populations are made up of at least 22 culturally different groups that have unique health needs, and
Whereas the Office of the Borough President of Richmond County has had a physician who monitors the health and wellbeing of the residents and has proven to be effective; therefore, be it
RESOLVED, That the Medical Society of the State of New York (MSSNY) work with New York City Government and the NYC Department of Health to establish a Chief Medical Officer role for each borough that reports to the both the Borough President and the Chief Medical Office in the City Department of health to identify and resolve health care disparities which vary greatly from borough to borough.
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 157

Introduced by: New York State Academy of Family Physicians
Suffolk County Medical Society

Subject: Support Physicians Providing Gender Affirming Care for Youth

Referred to: Reference Committee on Public Health and Education

WHEREAS, the recommended curriculum guidelines for family medicine residents on Lesbian, Gay, Bisexual and Transgender Health, endorsed by the American Academy of Family Physicians (AAFP), includes expectation to apply knowledge of the "developmental and psychosocial challenges faced by transgender children and adolescents as they approach puberty, and the availability of puberty-blocking medications to delay development of secondary sexual characteristics"¹ and;

WHEREAS, in 2016 the American Academy of Family Physicians reaffirmed policies against discrimination of transgender by opposing state and federal laws compromising the safety and health of transgender people, through discriminatory state laws on bathroom use², and

WHEREAS, there were an estimated 150,000 youths between 13 and 17 years of age who identified as transgender in 2017, per the 2017 Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy³ and;

WHEREAS, adolescents and adults who identify as transgender have high rates of depression, anxiety, eating disorders, self-harm, and suicide, due to multifactorial issues of “internal conflict between one’s appearance and identity, limited availability of mental health services, low access to health care providers with expertise in caring for youth who identify as [transgender], discrimination, stigma, and social rejection”⁴ and;

WHEREAS, the American Academy of Pediatrics released a policy statement in 2018 recommending “that youth who identify as [transgender] have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space” and that “that pediatricians have a role in advocating for policies and laws that protect youth who identify as [transgender] from discrimination and violence”⁵ and;

WHEREAS, at least four states have introduced or proposed legislation in the past year, that would criminalize clinicians for offering medical or surgical care to assist youths with gender transition and⁶, and

WHEREAS, several medical professional organizations has previously issued statements against interference in the doctor-patient relationship through the criminalization of providing medical care; therefore be it⁶

RESOLVED, that the Medical Society of the State of New York supports physicians in New York who provide gender affirming care to people including transgender youth, and be it further

RESOLVED, that the Medical Society of the State of New York opposes the criminalization of providing gender affirming care for youth.
Citations:


Existing MSSNY Policy:

**120.969 Removing Barriers to Care for Transgender or Gender Variant Patients:** MSSNY supports public and private health insurance coverage for treatment of gender dysphoria, and opposes categorical exclusions of coverage for treatment of gender dysphoria when prescribed by a physician. (HOD 2008-171; amended and reaffirmed HOD 2018)

**285.987 MSSNY Policy on Gender Equity in Medicine**
MSSNY supports institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; and will advocate for pay structures based on objective, gender-neutral criteria. MSSNY will encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; promote training to identify and mitigate implicit bias in compensation determination; recommend elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice.

MSSNY will create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act, which took effect in 2009, restoring protection against pay discrimination, establish educational programs to help empower all genders to negotiate equitable compensation. (HOD 2019-217)

**285.988 Advancing Gender Equity in Medicine**
MSSNY will promote pay structures based on objective, gender-neutral criteria; and/or develop educational programs to help empower physicians of all genders to negotiate equitable compensation. It will advocate for training to identify and mitigate implicit bias in compensation decision making for those in positions to determine salary and bonuses, with a focus on how subtle differences in the evaluation of physicians of different genders may impede compensation and career advancement.

MSSNY will collect and analyze comprehensive demographic data and produce a report on gender equity, including, but not limited to, membership; representation in the House of Delegates; reference committee makeup; and leadership positions within MSSNY, and disseminate this report to the House of Delegates and the MSSNY membership beginning with the Annual Meeting in 2020 and continuing yearly thereafter, with recommendations to support ongoing gender equity efforts. (HOD 2019-216)

285.989 Discriminatory Policies that Create Inequities in Health Care
The Medical Society of the State of New York opposes policies that are discriminatory and create greater health disparities in medicine. MSSNY will be a voice for New York’s most vulnerable populations, including sexual, gender, racial and ethnic minorities, who suffer the most under such policies, and which further widen the gaps that exist in health and wellness in our nation. (HOD 2018-155)

105.996 Medical Spectrum of Gender
The Medical Society of the State of New York (MSSNY) will partner with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity as a complex interplay of gene expressions and biologic development. A copy of this resolution will be sent to the AMA for its consideration. (HOD 2017-164)
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 200

Introduced by: The Suffolk County Medical Society

Subject: September 11th as a National Holiday

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, September 11, 2001 took over 3,000 lives in an act of terrorism against the United States of America; and

Whereas, thousands of responders, both uniformed and civilian, employed and volunteers, served at Ground Zero and the vicinity, the morgues, and land fill operations on 9/11/2001 and the following months, risking their lives, being exposed to debris, powdered cement, fumes, vapors, dust, and a variety of other irritants, as well as many severe psychological stressors including exposure to body parts, human remains, and the devastation to the WTC site itself, who now live with World Trade Center related medical and mental health conditions; and many whose lives were prematurely shortened because of the impact of these toxic exposures; and

Whereas, The effects of the 9/11 attack has forever altered the world in every aspect of life from mental, emotional, medical, business, security, education, etc.; and

Whereas, Every American and every individual has felt the impact from lost loved ones, who were taken away too early, or from the increased security and vigilance needed to protect this country; and

Whereas, Every life lost on that day represents the freedoms we were attacked for; and

Whereas, Patriot Day, 9/11, is already recognized as a day of remembrance; and

Whereas, The terror attack on US soil on September 11, 2001 should never be minimized or forgotten; and

Whereas, The United States Congress holds the authority to create a Federal Holiday according to Title V of the United States Code (5 U.S.C. 6103); therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) urge and support that September 11th be recognized as a national holiday, for which purpose is in part to honor, remember, and recognize all who died on 9/11/2001 and who died from 9/11 related health conditions since 9/11/2001, with all authorities that may influence this decision and will directly petition Congress for this change; and be it further

RESOLVED, that MSSNY will forward this resolution to the AMA for action on a national level.

Existing MSSNY Policy – None found
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 201

Introduced by: Alan K. Klitzke, MD, FACNM, FACR, As an Individual Delegate, Organized Medical Staff Section

Subject: UN International Radionuclide Therapy Day Recognition

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, the General Assembly of the United Nations advocates for proclaiming International days of recognition to highlight specific values of worldwide human interest; and

Whereas, the United Nations General Assembly documents describe the purpose of proclaiming “International Days” as follows: “International days are occasions to educate the general public on issues of concern, to mobilize political will and resources to address global problems, and to celebrate and reinforce achievements of humanity”; and

Whereas, the year marks the 80th year from the first recorded use of radioiodine therapy to treat human disease; and

Whereas, Saul Hertz, MD (1905 - 1950) discovered the medical uses of radionuclides, and his breakthrough work with radioactive iodine (RAI) created a dynamic paradigm change integrating the sciences of physics, biology, physiology and medicine; and

Whereas, Radioactive iodine (RAI) is the first and remains the Gold Standard of targeted cancer therapies; and

Whereas, In early 1941, Dr. Hertz administered the first therapeutic treatment of (Cyclotron-produced) radioactive iodine (RAI) at the Massachusetts General Hospital, which led to the first series of twenty-nine patients with hyperthyroidism being treated successfully with RAI; and

Whereas, Dr. Hertz expanded the successful use of RAI of treating hyperthyroidism and Graves’ disease to the treatment of thyroid cancer in 1946; and

Whereas, this work generating and utilizing radioactive material for medical therapy leaves an enduring legacy, impacting countless generations of patients, numerous institutions worldwide and setting the cornerstone for the field of Nuclear Medicine, and has for all future generations, augmented and forever altered the approach to medical therapies, arguably marking the advent of what we now recognize as modern medicine; and

Whereas, this novel work arguably marks the advent of what we now recognize as modern medicine, utilizing molecular medicine and the ever evolving promise of targeted molecular therapies for the treatment of human disease; and

Whereas, to appropriately recognize and honor this groundbreaking scientific and medical breakthrough on its 80th year anniversary, and to honor Dr. Saul Hertz and to remember and celebrate this extraordinary accomplishment; therefore be it

RESOLVED, that the Medical Society of the State of New York advocate directly with the United States Mission to the United Nations and with Ambassador Linda Thomas-Greenfield to create
and introduce a United Nations General Assembly (UNGA) Resolution for the creation of a new International Day recognition, with the suggested name of “International Radionuclide Therapy Day”; and be it further

RESOLVED, that MSSNY bring forth a similar Resolution to the American Medical Association House of Delegates for AMA advocacy for creation of an International Day of recognition of; “International Radionuclide Therapy Day.”

Existing MSSNY Policy: None found

A few References for interest:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357704/
https://endocrinology.endocrine.org/january-2016-thyroid-month-the-saga-of-radioiodine-therapy/
Radioactive Iodine in the Study of Thyroid Physiology. VII. The Use of Radioactive Iodine Therapy in Graves’ Disease. (Dec. 1946)
http://saulhertzmd.com/home
### TABLE I

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<th>SERIES NO.</th>
<th>CASE NO.</th>
<th>DOSE OF THYROID A-T (Gm.)</th>
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*CENTRAL MORPHIC TYPE

### TABLE II

**ANALYSIS OF 20 CASES "CURED" BY RPD + KI
ON BASIS OF EXAMINATION MARCH 1936**

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<th>SERIES NO.</th>
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*B.D. ISOTOPE FIGURES WERE NO LOS OF RADIO FROM THYROID DURING DECONS. THEY ARE THEREFORE EXCESSIVE. THEY WERE NOT CORRECTED FOR CASES.
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 202

Introduced by: Nassau County Medical Society
Subject: IMG Membership
Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, the current membership structure excludes a significant number of International Medical Graduates (IMGs) because of Educational Commission for Foreign Medical Graduates (ECFMG) certification requirements; and

Whereas, Certification requires passing the USMLE examinations which entails a 3 year “journey” and also, for many, a significant cost; and

Whereas, ECFMG requirement then becomes an impediment to membership for many physicians who would otherwise join our Society; and

Whereas, passage of Step 1 and Step 2 CK of the USMLE examination demonstrates a level of desire, education, and proficiency; therefore be it

RESOLVED, that the Medical Society of the State of New York either, re-evaluate its requirements for membership for IMGs or develop a distinct membership class geared to the needs of these physicians.

From MSSNY Membership Division
The criteria for the Post Medical Graduate category are as follows. It does require ECFMG certification (as does the AMA).

1. Post-Medical Graduate Candidates eligible for this category must
   • Reside in New York State.
   • (a) Hold a medical school diploma from a US or Canadian school, OR
      (b) Hold a medical school diploma and certification by the Educational Commission for Foreign Medical Graduates.
   • Have not yet entered residency training or been employed as a physician in New York State.
   • If residing in Bronx, Chautauqua, Erie, New York or Westchester Counties, must join the county medical society as well.
   • Maximum time in this category is three years.

The AMA offers membership to international medical school graduates (IMGs) who are currently ECFMG-certified and are waiting to match into a U.S. residency program (GME position).
Annual membership dues rate: $45

Existing MSSNY Policy:

160.999 Licensure as a Prerequisite for Membership in the Medical Society of the State of New York:
At the present time there is no official State Society policy as to the requirement of licensure as prerequisite for membership. (Council 12/16/76; Modified and reaffirmed HOD 2013)

200.997 International Medical Graduates (IMGs):
MSSNY continues to discourage any form of discrimination toward International Medical Graduates (IMGs) and is expanding its efforts to identify and address the issues of major concern to IMGs. In order to encourage IMGs to join the mainstream of organized medicine, MSSNY is sending a loud and clear message that it vigorously opposes discrimination, will work diligently to establish equity in all professional standards including, but not limited to, licensure, reciprocity, academic and medical staff appointment, jobs, promotions, and hospital privileges, and that it will afford IMGs the same opportunities as non-IMGs to become involved in the policy making processes at all levels of organized medicine. (HOD 1992-62; Reaffirmed HOD 2014)

200.982  **Pilot Project for International Medical Students**
MSSNY will conduct a pilot project in those counties wishing to participate which will offer member benefits and services free of charge to international medical students engaged locally in New York State-approved clinical rotations until such time as they are eligible for student or another membership category in these societies. Benefits would include invitations to county and state medical society meetings, without vote unless and until formal membership is obtained. (Council, May 10, 2018)

200.988  **Supporting International Medical Graduates**
The Medical Society of the State of New York opposes laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion. MSSNY opposes policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
A copy of this resolution will be immediately forwarded to the American Medical Association. (HOD 2017-207)

200.996  **Credentials and Election of New Members:**
MSSNY urges county medical societies to find ways of meeting existing credentialing requirements that do not place the burden of compliance on the applicant, and to use online resources for reviewing applicants’ credentials.

MSSNY urges county medical societies to review their credentialing requirements and to remove any that are unnecessary and, as such, may be a barrier to membership. It is recommended that requirements for membership be outlined in a general way in county society bylaws, but that processes for determining eligibility be contained in a “policies and procedures” document that is easier to amend.

MSSNY urges county medical societies to review any materials they send to applicants for language. (e.g. “Submit proof of Board Certification” implies that such certification is a requirement for membership) or requirements (e.g. photographs) that might serve as a serious barrier to completing the application.

MSSNY offers an on-line application for membership and encourages county medical societies to do the same. Applicants should not be required to submit any documents, physical signatures or other materials with their applications (other than dues payment), as this renders the on-line concept useless.

MSSNY encourages county medical societies to accept payment of dues by credit card.

County medical societies are reminded that Article XVIII, Section 2 of the MSSNY Bylaws provides as follows: “...all county medical societies shall utilize a universal membership application form which shall be approved by the Council. Component county medical societies shall act upon the receipt of a membership application in a timely manner not to exceed sixty days.”

MSSNY recommends that a new goal be established that allows for processing of new members at all three levels of the federation within 60 days.

MSSNY will assist any county medical society in amending its bylaws or revising its credentialing and election procedures so as to remove any requirements which can act as a barrier to membership for qualified individuals or interfere with the speedy processing of new members.

**White Paper:**
Recommendations of Ad Hoc Subcommittee re Resolution 2002-203 - Improve Member Services by Streamlining Membership and Dues Processing Systems Throughout MSSNY and the County Medical Societies (HOD 2003; Modified and Reaffirmed HOD 2013)
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 203

Introduced by: Nassau County Medical Society

Subject: Physician-Scientist Committee

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, the MSSNY lacks a physician-scientist committee devoted to the fostering and growth of physician-scientists; and

Whereas, physician-scientists have an instrumental role in making discoveries and bringing them into real-life treatments; and

Whereas, physician-scientists can merge and unite two worlds with different languages and dynamics, medicine and science; and

Whereas, physicians involved in academic medicine have a distinctive role creating new medical knowledge, not fulfilled by other practitioners; and

Whereas, physician-scientists are considered “an endangered species”; and

Whereas, physician-scientists are a minority (MD/PhDs representing 3% of all American Medical Graduates); and

Whereas, the physician-scientists work-force at the National Institutes of Health (NIH) reported in 2018 that the physician-scientist population is decreasing and most of them are near retirement; therefore be it

RESOLVED, that the Medical Society of the State of New York creates a “Physician-Scientist Committee” devoted to growth, development, and promotion of academic medicine and science among physicians and medical students.

Existing MSSNY Policy: no specific policy found.

MSSNY’s Current List of Committees Includes:

**COMMITTEE DESCRIPTIONS OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK**

Division of Governmental Relations Committees

**COLLECTIVE NEGOTIATION & INTEGRATION AD HOC WORKGROUP**
Reviews models of physician practice that currently enable physicians to negotiate collectively, such as through financial or clinical integration, as well as develops models for physicians to negotiate collectively should legislation be enacted into law permitting such joint negotiations.

**EMPLOYED PHYSICIANS**
A forum for discussing issues of concern to employed physicians and identifying ways to solve common problems.

**FEDERAL CANDIDATE EVALUATION**
Makes recommendations regarding potential Congressional candidate endorsements by MSSNYPAC.

**HEALTH INFORMATION TECHNOLOGY (HIT)**
Guides physicians in the selection, adoption and use of electronic medical record technology, including assessing and recommending changes to governmental policies that impact upon the use of EHR technology.

**LEGISLATIVE AND PHYSICIAN ADVOCACY**
Sets priorities among the many advocacy goals of MSSNY, including development of the MSSNY Legislative Program. Committee members serve as a resource for all physicians across the state regarding legislation under consideration in Albany and Washington, including facilitating physician grassroots involvement both at home in our capitols.
LONG TERM CARE SUBCOMMITTEE
A subcommittee of the Quality Improvement and Patient Safety Committee. Looks at issues affecting nursing home and long term care facility issues and how to improve existing conditions affecting patients and physicians/directors of those facilities. Works closely with the Home Care Association to improve transition from hospital to home care where possible

MSSNYPAC OFFICERS & EXECUTIVE COMMITTEE
MSSNYPAC supports the election of candidates to New York State government who support the principles of the medical profession and the interests of those it serves. Officers govern the body of members, and an Executive Committee consisting of these officers and representatives from various MSSNY member sections make policy and strategic decisions. President’s Circle level members provide guidance to the Executive Committee.

SCOPE OF PRACTICE TASK FORCE
Coordinates with specialty societies to facilitate advocacy regarding the numerous pieces of legislation that would endanger patients through inappropriate proposed expansions in scope of practice for various non-physician practitioners. The Task Force will work with MSSNY’s Legislative & Physician Advocacy Committee and MSSNY staff on allocating efforts to assist specialties in advocating for or against these issues, including where appropriate, developing suggestions for joint public relations activities including social media.

STATE CANDIDATE EVALUATION
Makes recommendations regarding potential State Legislative candidate endorsements by MSSNYPAC.

Division of Science and Public Health Committees

ADDITION AND PSYCHIATRIC MEDICINE
Evaluates and considers issues in psychiatric medicine and problems related to alcohol and drug abuse, including therapeutic care and prevention. Participates in an advisory capacity with other agencies in promoting educational material. Advises individual physicians and organizations.

BIO ETHICS
Serves primarily in an educative and consultative role regarding bioethical concerns and issues, and recommends MSSNY policy.

COMMITTEE TO ELIMINATE HEALTH DISPARITIE
Mission is to eliminate healthcare disparities by obtaining evidence on racial and ethnic health care disparities, identifying causes, and proposing effective strategies. Provides physician awareness and education, patient/ public education, youth-focused mentoring and education programs on the vital role of minority physicians, and improved data collection on race and ethnicity.

EMERGENCY PREPAREDNESS AND DISASTER/TERRORISM RESPONSE
Assists MSSNY in responding to NYS public health emergencies. Provides educational programming for physicians and public health officials.

HEART, LUNG, CANCER
Examines diseases related to heart and pulmonary systems, and cancer. Focus is on prevention, early diagnosis, treatment and rehabilitation processes. Encourages and supports research and education activities that enhance and improve patient care and physician expertise and knowledge.

INFECTIOUS DISEASES
Examines and discusses all aspects of infectious diseases including HIV, hepatitis, and STDs. Develops policy on immunizations and other harm reduction efforts. Educates physicians, conducts relevant programs, develops recommendations, and provides expertise when MSSNY interacts with state agencies and elected officials.

MEDICAL EDUCATION COMMITTEE
Consists of medical schools deans, physicians in private practice, students and residents. Focuses on issues related to medical education, both osteopathic and allopathic; general medical issues; physician workforce; and others that affect medical education and medicine in general.

PHYSICIAN WELLNESS & RESILIENCE COMMITTEE
Stress is a serious problem with serious consequences faced by many physicians throughout their professional careers. It is a critical challenge for the medical profession and the overall healthcare system. This committee provides a resource, and addresses ways to help colleagues understand the issues and develop skills to manage their own stress.

PREVENTIVE MEDICINE AND FAMILY HEALTH
Addresses the spectrum of health issues across the entire life cycle, from preconception to end-of-life care. Supports educational programs for the general public and for physicians; addresses the various methodologies to promote health and prevent diseases or conditions related to physical and mental health; formulates the development of policy around family health topics; and provides advocacy for these policies and for legislative or regulatory issues.

QUALITY IMPROVEMENT AND PATIENT SAFETY
Committed to the improvement of patient care and enhanced outcomes. Looks at topics related to physicians and other health care professional to ensure effective strategies to improve health outcomes while enhancing overall quality

Division of Socio-Medical Economics Committees

COMMITTEE ON HEALTH INSURANCE:
Maintains an effective liaison with health plans and their oversight organizations (i.e. the NYS DOH, DFS, and CMS). Explores ways to improve the patient–physician relationship based on the interactivity between patients and their health plans. Deals with issues related to all different insurers and addresses aspects of these programs that impact both the medical community and program recipients.

COMMITTEE ON WORKERS’ COMPENSATION AND NO-FAULT INSURANCE:
Addresses relevant aspects of the State Workers’ Compensation program, including schedule of medical payments, performance of carriers, the arbitration process, and related legislation. Identify and recommend solutions to prevent or reduce accidental injuries which occur in transportation, recreation, work or the home. Considers issues relating to physical medicine
and rehabilitation, the injured and disabled, and allied health professionals involved in rehabilitation. Interacts with the NYS Insurance Department concerning issues pertaining to No-Fault Auto.
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 204

Introduced by: Medical Society of the County of Erie

Subject: Promotional Period for Membership (“18 months for 12 months”)

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, current MSSNY policy allows members who join after July 1st of a given year to pay one year’s dues for eighteen months of membership; and

Whereas, this creates and perpetuates financial hardship by giving new members six months free instead of requiring members who join during the year to pay a pro rata portion for the remainder of the year; and

Whereas, MSSNY and the Counties would benefit by pro rating the membership dues based on the date that a member joins during a given year and then require full dues payment for the commencement of the new billing year; therefore, be it

RESOLVED, that any new member who joins MSSNY mid-way during a given year be required to pay the pro-rated amount for the rest of that year; and be it further

RESOLVED, that any new member who joins during a given year and pays pro-rated dues for that given year, that member will be required to pay full dues for the subsequent year.

Existing MSSNY Policy:

207.965 Creation of Strategic Membership Plan
The Medical Society of the State of New York will continue working with representatives of county medical societies to develop short, medium and long-range plans which should include:
- Membership growth initiatives
- Unified communications and member relations strategy
- County medical society collaboration strategies
- Fiscal sustainability strategies
- Recommendations for an equitable system of MSSNY membership dues and privileges (HOD 2018-208, 211, 213)

MSSNY Bylaws
ARTICLE III - DUES

The annual dues shall be determined by the House of Delegates.

Annual dues are due and payable on the first day of January each year. The dues year shall coincide with the calendar year, January 1 to December 31.

Any member, except a member who is eligible and has applied for life membership, whose component county medical society and Medical Society of the State of New York dues are unpaid after February 1 of any current year or whose assessments are unpaid by the specified time is not in good standing and shall be deemed to be in arrears.
A member whose dues are unpaid after March 1 of any current year or whose assessments are unpaid one month after the specified date may be dropped from the roles of membership of his component county medical society and the Medical Society of the State of New York upon reasonable notice to such member by his component county medical society or the State Society. In the case of nonpayment of dues, the reasonable notice to be provided shall commence on February 1, or as soon as possible thereafter, upon the determination that such member is in arrears.

**Dues and State Society assessments of a member elected or reinstated after October 1 shall be credited to the succeeding year,** but no member dropped for nonpayment of assessments shall be reinstated until he has, in addition, paid his assessments for the year in which he was dropped.

………………………………………

Notwithstanding the terms of Articles II and III of these Bylaws, the House of Delegates or the Council may establish schedules for the prorated payment of dues for new members who have never previously been members of the Medical Society of the State of New York. Such prorated dues payments established by the House of Delegates or the Council may only be exercised by the new members in the year that they apply for membership.
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 205

Introduced by: Medical Society of the County of Kings

Subject: MSSNY Membership Dues Multiyear Discount Program and Other Innovative Membership Levels

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, membership in a society such as the Medical Society of the State of New York (MSSNY) and the Medical Society of the County of Kings (MSCK) should be affordable, renewable, and a value to its members; and

Whereas, membership growth and retention is the ideal of any organization; and

Whereas, MSSNY’s membership is consistently declining statewide as the economics of medical practice has evolved; and

Whereas, physicians are increasingly members of hospital faculty practices or large groups and membership to medical associations may or may not be part of the incentive packages; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) consider a discounted Medical Society County of Kings and MSSNY combined dues rate for Kings County of $250 per annum for full membership as a two-year trial, to retain existing full dues paying members (with the exception of residents) and drive new membership, and be it further

RESOLVED, that MSSNY consider a level of affiliate membership, that is free and will give physicians and MSSNY a means of communication to all physicians in the State of New York; and be it further

RESOLVED, that MSSNY consider creative membership options including, but not limited to, discounts for multiyear renewals, for example, 10% for 2 years or 20% for 3-year prepaid renewals.

Existing MSSNY Policy: NA
Whereas, Scalp Cooling (Cold Cap Therapy) has been cleared by the FDA for use during chemotherapy treatment to reduce the likelihood of chemotherapy-induced alopecia in cancer patients with solid tumors such as ovarian, breast, colorectal, bowel, and prostate cancers. And

Whereas, the National Comprehensive Cancer Network® (NCCN) has given Scalp cooling a Category 2A designation indicating uniform NCCN consensus that the intervention is appropriate; and

Whereas, peer-reviewed studies have shown Scalp Cooling (Cold Cap Therapy) prevented hair loss in 53-66.3% of patients with breast cancer receiving adjuvant chemotherapy, compared to a control group where all patients experienced significant hair loss; and

Whereas, Scalp cooling treatment (Cold cap Therapy) in peer reviewed studies was well-tolerated with no scalp metastases observed; and

Whereas, Minimizing hair loss during cancer treatment helps patients to preserve personal identity and self-esteem and appear normal as opposed to sick; and

Whereas, Protecting privacy and gaining the ability to choose whether to disclose a cancer diagnosis is significant to many patients; and

Whereas, scalp cooling patients can give patients a sense of control in what can be an overwhelming experience; and

Whereas, the American Medical Association (AMA) has issued two (2) separate Category III CPTcodes for "mechanical scalp cooling": 0662T and 0663T, effective July 1, 2020; and

Whereas, Aetna, issued a policy statement in 2017 stating that they consider scalp cooling medically necessary as a means to prevent hair loss during chemotherapy but insurance coverage for scalp cooling is not yet standard in the United States; and

Whereas, reimbursement varies depending on plan, coverage, and location with some insurance companies covering up to $2000.00 for wigs but denying coverage for Scalp cooling in similar price range ($1500.00-$3000.00); and

Whereas, this significant out of pocket expense puts this treatment out of range for many; and

Whereas our MSSNY and our AMA advocate for health equity; therefore, be it

RESOLVED, That our MSSNY seek by legislation and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy; and be it further
RESOLVED, that our MSSNY work with consumer groups to challenge insurers on Scalp Cooling (Cold Cap) Therapy medical necessity denials and encourage appeals to independent third party reviewers, and be it further.

RESOLVED, that our MSSNY transmit a similar resolution to the AMA.

Citations:


2. References

Number: 0290
Policy Effective Date 10/13/1998
Last Review: 7/1/2021

Aetna considers scalp cooling (i.e., using ice-filled bags/bandages, cryogel packs, or specially designed products (e.g., Chemo Cold Cap, DigniCap, ElastoGel, Paxman Scalp Cooling System and Penguin Cold Cap)) medically necessary as a means to prevent hair loss during chemotherapy. Note: Cooling caps and other products for scalp cooling are considered incidental to the chemotherapy administration and are not separately reimbursed. Cooling caps and other scalp cooling products purchased by the member are considered supplies that are generally excluded from coverage under plans that exclude supplies. See benefit plan descriptions.
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 - 251

Introduced by: Ninth District Branch

Subject: Prohibition of Insurer Processing Fee on Claims

Referred to: Reference Committee on Socio-Medical Economics

Whereas, physician professional medical bills are traditionally submitted by paper claims, processed by health insurers, and paid by mail with paper Explanation of Benefits (EOB) and paper checks; and

Whereas, many insurers, including government payers, have transitioned to and mandated electronic billing over recent years; and

Whereas, such claim processing has always been the services undertaken by government and private insurance payers without any costs to physicians and other providers, and

Whereas, the costs of processing paper claims and paper (EOB) delivery are higher than electronic claim processing and payment; and

Whereas, some health insurers and/or their claim processing subsidiaries have begun to charge a processing fee for electronically submitted claims and making electronic payments, and

Whereas, these very same insurers cannot and do not charge their other vendors or professional service providers a fee simply because they process the invoices and make electronic payment; and

Whereas, mandated electronic claim submission has largely been unilaterally imposed by insurers; and

Whereas, health insurers are already making record profits in recent year; therefore be it

RESOLVED, That MSSNY, through legislation and/or regulation, advocate for the prohibition of health insurers charging physicians and other providers fees to process claims and make payments, and be it further

RESOLVED, That the MSSNY AMA Delegation introduce a similar resolution at the next meeting of the AMA House of Delegates for federal actions.

Existing MSSNY Policy: None found
Whereas, Some New York insurers impose unfair, abusive, arbitrary and capricious rulemaking
of their own devising (not sanctioned by CMS or the AMA), whereby they delay payment on
a certain “clean” claims; and
Whereas, Most frequently such affected claims are successfully appealed which is evidence
that the automatic “first-pass” denial was merely a stalling tactic, or an apparent ploy to
circumvent the Prompt Pay law; and
Whereas, These denials or delays in payment are against claims submitted with the “modifier-
25” which denotes that there were two separate diagnoses, and/or that the medical visit went
“above and beyond” what was required for the surgical procedure as accepted by the CPT
treatise accepted by CMS and others; and
Whereas, Another ploy by insurers is to automatically deny a claim if there has been another
claim of this type with Modifier 25 within the past 28 days; therefore be it
RESOLVED, That the Medical Society of the State of New York work for a legislative proposal
that mandates that the CPT language be followed for claims submitted in the State of New York
that comply with the provisions and description(s) of service according to the accepted CPT
volume in use for the year of service.

MSSNY Policy:

165.907 Clarification of the New York State Current Procedural Terminology Uniformity Law:
MSSNY should take all the steps, including legislation, necessary to assure that health plans comply with and abide by the American Medical Association coding policy statements that are contained in the yearly AMA CPT coding manual. (HOD 2007-61; Reaffirmed HOD 2017)

165.862 Clarification of Chapter 551 Law - Insurance Law Sections 3224-b and 4803(a):
MSSNY will:
A. Initiate a legal review of the provision of the Chapter 551 Law (Insurance Law Sections 3224-b and 4803(a)) that states that “all accident and health insurers and Article 43 corporations ("insurers") and health maintenance organizations are required to accept and initiate the processing of physicians’ claims utilizing the American Medical Association’s (AMA’s) current
procedural terminology (CPT) codes, reporting guidelines and conventions and the Centers for Medicare & Medicaid Services (CMS) Health Care Common Procedure Coding system (HCPCS);  

B. Review (1) whether that section of the law specifically requires insurers to use the AMA CPT coding manual (particularly that manual’s Introductory Section and its narrative policy sections), and (2) whether the law also requires insurers to use all other standard coding conventions as well;  

C. Seek legislation and/or regulatory relief, in regard to the provision in the Chapter 551 Law (Insurance Law Sections 3224-b and 4803(a)) that contains the phrase “codes, reporting guidelines and conventions,” mandating that insurers incorporate all AMA CPT guidelines and conventions, as well as codes, in their payment policies.  (HOD 2011-54)

265.871: Revision of AMA Current Procedure and Terminology (CPT) to reflect EHR/EMR documentation and work processes  
MSSNY recommends that the AMA review the CPT coding guidelines with the aim of developing a new model of payment that reflects 21st century EHR technology, and that the AMA make immediate revisions to the current CPT practice performance reporting process aimed at preparing the infrastructure for new models of paying for the delivery care.  (HOD 2013-268)

265.987 AMA-CPT Coding:  
MSSNY endorses AMA-CPT as the standard accepted coding system in New York and that proper use of CPT by insurance carriers requires adherence to all of its rules and guidelines; and will recommend that the Insurance Superintendent and the New York State Legislature require health insurance carriers processing claims from New York physicians, including Workers’ Compensation and No-Fault Carriers, to adhere to all CPT rules and guidelines, including code modifiers.  MSSNY will request that the Insurance Superintendent make the necessary revisions of the inappropriate bundling edits in the software which erroneously processes claims from physicians and disallows legitimate claims for services.  (HOD 1997-285; Reaffirmed HOD 2000-251, HOD 2000-257, HOD 2000-268, HOD 2003-268 & 278 and HOD 2005-254 & 276; Reaffirmed HOD 2013)
Whereas, insurance companies frequently issue denials of hospital stays despite incomplete data (often based on the first day’s data only – not the whole hospital stay); and

Whereas, an insurance company denial often requires an attending physician to intervene by calling the insurance company that can include several minutes on hold and time explaining the case to a reviewing doctor; and

Whereas, often the denial is overturned following the physician’s phone call; and

Whereas, physicians are not compensated for their time consumed with their intervention:

therefore be it

RESOLVED, When an insurance company’s denial is overturned only after a physician’s call to the insurance company reviewer, then the insurance company must fairly compensate the physician for the time needed for the intervention.

Existing MSSNY Policy

265.859 Payment for Physicians’ Work: Appealing Insurance Company Denials for Payment

The Medical Society of the State of New York, by legislation or regulation, will seek payment for physicians’ time and effort which is involved in preparing appeals for reversal of denials of payment for medical care, procedures and medications by insurers and other third party payers on behalf of their patients. (HOD 2015-259)
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 254

Introduced by: Medical Society of the County of Kings
Schoharie County Medical Society

Subject: CPT Denials / Service / Preauthorization Denials

Referred to: Reference Committee on Socio-Medical Economics

Whereas, the Medical Society of the State of New York (MSSNY) and the American Medical Association (AMA) have previously affirmed that physicians and physician practices should be fairly compensated for work involved in administrative work; and

Whereas, AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise, update, or modify CPT codes, descriptors, rules and guidelines; and

Whereas, studies have shown that wrongful adverse determinations by health plans are common, including denial of prior authorization, denial of payment for previously provided service; and

Whereas, good public and economic policy must align costs, benefits and incentives; currently, all costs in appealing wrongful denials are incurred by physician practices and all financial savings and benefits from wrongful denials accrue to health insurance plans leading to perverse incentive that disadvantage patients and endanger their health; and

Whereas, compensation for work performed by physician practices is accomplished via CPT codes; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) advocates that the American Medical Association (AMA) supports creation of CPT codes to provide adequate compensation for administrative work involved in successfully appealing wrongful pre-and post-service denials (visits, tests, procedures, medications, devices, and claims); and be it further

RESOLVED, that compensation should encompass all appeals of adverse determination, including primary, secondary, and tertiary internal and external appeals, reconsiderations, and ERISA plan appeals; and be it further

RESOLVED, that our MSSNY advocates that the AMA will include fair compensation based on CPT codes for appeal of wrongfully denied services in any Model Legislation and as a basis for all advocacy, including those for Prior Authorization reforms and that CPT codes must fully reflect the aggregated time and effort expended by physician practices.

Existing MSSNY Policy:

120.897 Reducing Prior Authorization Burden and Separate Payment When Not Part of a Patient Encounter
The Medical Society of the State of New York (MSSNY) will seek legislation or regulation that:
-restricts insurers from requiring prior authorization for generic medications,
- ensures the legislation or regulation contains disincentives for insurers demanding unnecessary prior authorizations, including payments to physicians’ practices for inappropriate prior authorizations,
- ensures the legislation or regulation requires that payment be made to the physician practice for services related to prior authorization when those services do not coincide with a visit,
- ensures that the legislation or regulation contains a requirement for an independent external review organization to review disputes involving prior authorizations and require insurer payments be made to the practice when the review organization agrees with the physician practice. This resolution will be forwarded to the AMA for national support. (HOD 2020-252 and 2020-262)

120.898  **Prior Authorization Reform**
The Medical Society of the State of New will advocate for practicing physician representation in peer-to-peer reviews and development of prior-authorization criteria and also to prohibit the use of prior authorization for medically necessary services and imaging performed during pre-approved surgeries or other invasive procedures. (HOD 2020-270)

265.871:  **Revision of AMA Current Procedure and Terminology (CPT) to reflect EHR/EMR documentation and work processes**
MSSNY recommends that the AMA review the CPT coding guidelines with the aim of developing a new model of payment that reflects 21st century EHR technology, and that the AMA make immediate revisions to the current CPT practice performance reporting process aimed at preparing the infrastructure for new models of paying for the delivery care. (HOD 2013-268)

**RELEVANT AMA POLICY**
Prior Authorization and Utilization Management Reform H-320.939
Remuneration for Physician Services H-385.951
Prior Authorization Reform D-320.982
MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2021 – 255

Introduced by: Medical Society of the County of Kings
Subject: Prior Authorization – CPT Codes for Fair Compensation
Referred to: Reference Committee on Socio-Medical Economics

Whereas, the Medical Society of the State of New York (MSSNY) and the American Medical Association (AMA) have previously affirmed that physicians and physician practices should be fairly compensated for work involved in prior authorizations; and

Whereas, AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise, update, or modify CPT codes, descriptors, rules and guidelines; and

Whereas, studies have shown that costs involved in prior authorizations provide perverse disincentives and lead to sub-optimal healthcare outcomes, especially for marginalized and economically vulnerable communities; and

Whereas, good public and economic policy must align costs, benefits and incentives; currently, all costs are incurred by physician practices, and all financial savings and benefits from prior authorization accrue to health insurance plans leading to perverse incentives; and

Whereas, compensation for work performed by physician practices is accomplished via CPT codes; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) advocates the creation of CPT codes by the American Medical Association (AMA) CPT® Editorial Panel to provide adequate compensation for administrative work involved in prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physician practices to advocate on behalf of patients and to comply with insurer requirements. CPT codes must fully reflect the aggregated time and effort expended; and be it further

RESOLVED, that the MSSNY will include fair compensation methodology based on CPT codes for prior authorization in any model legislation and as a basis for all advocacy for Prior Authorization reforms; and be it further

RESOLVED, that our MSSNY advocates that the AMA includes fair compensation methodology based on CPT codes for prior authorization in any model legislation and as a basis for all advocacy for Prior Authorization reforms.

Existing MSSNY Policy:

120.897 Reducing Prior Authorization Burden and Separate Payment When Not Part of a Patient Encounter
The Medical Society of the State of New York (MSSNY) will seek legislation or regulation that:

- restricts insurers from requiring prior authorization for generic medications,
-ensures the legislation or regulation contains disincentives for insurers demanding unnecessary prior authorizations, including payments to physicians’ practices for inappropriate prior authorizations,
-ensures the legislation or regulation requires that payment be made to the physician practice for services related to prior authorization when those services do not coincide with a visit,
-ensures that the legislation or regulation contains a requirement for an independent external review organization to review disputes involving prior authorizations and require insurer payments be made to the practice when the review organization agrees with the physician practice. This resolution will be forwarded to the AMA for national support. (HOD 2020-252 and 2020-262)

120.898  **Prior Authorization Reform**
The Medical Society of the State of New will advocate for practicing physician representation in peer-to-peer reviews and development of prior-authorization criteria and also to prohibit the use of prior authorization for medically necessary services and imaging performed during pre-approved surgeries or other invasive procedures. (HOD 2020-270)

**RELEVANT AMA POLICY**

Prior Authorization and Utilization Management Reform H-320.939
Remuneration for Physician Services H-385.951
Prior Authorization Reform D-320.982
Whereas, in 2017, The NYS state Workman Compensation Board (WCB) developed evidence-based Medical Treatment Guidelines (MTG) for common work injury problems such as Neck and Low Back pain, Knee and Shoulder; and

Whereas, the goal of the MTG is to provide evidence-based, high quality treatment for injured workers, while reducing delays in care by reducing Preauthorization requirements. In situations where the guidelines are being followed, i.e. physical therapy for lower back injury, does not require pre-authorization under the guidelines; and

Whereas, A second goal of the MTG is to restore the injured worker to preoperative function and return to work in a timely fashion while limiting their pain and impairment, and

Whereas, some insurers, physical therapists and occupational therapist do not recognize or follow the guidelines, limiting access of injured workers to appropriate care in a timely fashion; therefore, be it

RESOLVED, that MSSNY shall work with WCB to educate all insurers, physical therapists and occupational therapists regarding the MTG; if necessary, provide education for insurers, physical therapists and occupational therapists that repeatedly fail to follow the MTG; and be it further

RESOLVED, that MSSNY shall work with the WCB to set up an online reporting system to easily accessible to injured workers and their representatives, physical therapists and occupational therapists to address failures of insurers to accept and follow MTG; and be it further

RESOLVED, that MSSNY shall work with the Workers’ Compensation Board to change existing laws in order to prevent employers/insurers, physical therapists and occupational therapists from “opting out” of the Medical Treatment Guidelines for the benefit of the injured worker, physical therapists and occupational therapists trying to provide timely quality care.

Existing MSSNY Policy:
None found