2024 HOUSE OF DELEGATES
MEDICAL SOCIETY OF THE STATE OF NEW YORK
Report of Recommendations for Sunset of Policy Adopted 2014

Referred to: Reference Committee on Governmental Affairs - A …, Chair

Mister Speaker, Your Reference Committee recommends that the policies contained in the 2024 Governmental Affairs A Sunset Report be acted upon in the manner indicated and that the remainder of this report be filed:

ITEMS RECOMMENDED FOR SUNSET

150.966 Hospital Closures
MSSNY will ask the New York State Legislature to enact laws that require hospitals which are going to be closed or significantly change the level of clinical services, to develop a clinical impact statement and that the statement be presented at a public hearing run by the Health Department; that this clinical impact statement be used to document the diminution in services and outline ways that the community can be compensated or continue to receive these services in another venue; and that the public should have a chance to comment on this document, with the Health Department as the final arbiter if the removal of the services creates a danger to the community. (HOD 2014-111)

RECOMMEMDATION: Sunset, as more recent policy on this topic 150.959 was adopted in 2021.

160.990 Laser Surgery:
MSSNY has adopted the position that laser treatments should be prohibited by those not licensed as MD, DO, DMD, DDS, DPM-trained and will include this as a priority item in its 1997 legislative program. (HOD 1996-80; Reaffirmed HOD 2014)

RECOMMENDATION: Sunset. MSSNY has adopted more recent policy (115.983) on the use of laser use by non-physicians.

160.992 Mandated CME for Re-registration of Medical Licensure:
The Society strongly reaffirmed its opposition to any linkage between legislatively mandated CME with re-registration of medical licenses. (HOD 1993-15; Reaffirmed HOD 2014)

RECOMMENDATION: Sunset. MSSNY has adopted more comprehensive overlapping policy also being re-affirmed 315.996.

165.930 Health Insurance Eligibility Electronic Verification System:
MSSNY will seek legislation requiring all health care plans doing business in New York State to issue health insurance cards containing magnetic strips, which can be used with an electronic verification system which would be furnished to physicians free of charge by the health care plans. (HOD 2000-272; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET, as the policy refers to an obsolete technology.

165.991 Responsibility To Patients in Managed Care Plans:
MSSNY will seek legislation requiring that any health plan using managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques; health plans shall also be subject to legal action for any harm to enrollees resulting from failure to disclose, prior to enrollment, any coverage provisions, review requirements, financial arrangements, or other restrictions that may limit services, referrals or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient. (HOD 1995-59; Reaffirmed HOD 2014)

RECOMMENDATION. SUNSET, as similar MSSNY policy 165.968 has been more recently re-affirmed by MSSNY.

195.985 Repealing Restrictions on Private Medicare Contracting:
MSSNY will support and lobby on behalf of related bills HR 2497 (Representative Archer) and S.1194 (Senator Kyl), which would amend Title XVIII of the Social Security Act to clarify the right of physicians and other health care providers to enter into private contracts with Medicare beneficiaries for: a) the provision of health services for which no payment is sought under the Medicare program; b) the right to privately contract with beneficiaries without physicians having to opt out of the program for two (2) years. MSSNY will introduce a resolution to the 1999 Annual Meeting of the AMA House of Delegates calling for the Association to support and lobby on behalf of related bills HR 2497 and S.1194. (HOD 1999-271; Reaffirmed HOD 2014)

RECOMMENDATION. Sunset, as it contains references to obsolete legislation, and is substantially similar to 195.987, which is being recommended below to be retained.

265.927 Patients' Out of Pocket Financial Responsibility for Emergency Room Services Provided
MSSNY opposes efforts, including legislation and regulation, to prevent an out-of-network physician who provides emergency care to a patient from receiving their full charge and that no patient out of network deductible/co-pay should apply. (HOD 2004-74; Reaffirmed HOD 2014) **GOV A**

RECOMMENDATION: Sunset, as MSSNY has adopted numerous more recent policies, such as 120.885, 120.887, 120.903 and 265.821, to advocate for fair payment for out of network services through the state and federal IDR process.

265.971 Guaranteed Trust Corporation for Health Insurance
MSSNY will seek legislation or regulation requiring the information of a Guaranteed Trust Corporation for health insurance in New York State. (Council 2/4/99; Reaffirmed HOD 2014*)*

RECOMMENDATION. Sunset, as this policy goal was achieved through legislation enacted in 2023.

305.997 ICD-10

The Medical Society of the State of New York will continue to work with the AMA and the federation of medicine to advocate for legislation, regulation or other policy mechanism that would prevent implementation of the ICD-10 code sets. (Amended and adopted Council 11/20/2014. From HOD 2014-263

RECOMMENDATION. SUNSET, as ICD-10 has long been in use since this policy was adopted.

ITEMS RECOMMENDED FOR ADOPTION AS AMENDED

130.988 Medical Savings Accounts:
MSSNY vigorously supports the introductions of Medical Savings Accounts (MSAs) in New York State and will support legislation ~~such as that embodied in State Assembly Bill 6249A and its companion Senate Bill 69A~~ calling for the establishment of tax-favored Supplemental Insurance Accounts (which essentially embody the MSA concept), subject to subcommittee interaction with State legislators for an opportunity to: (a) provide additional MSSNY input and possible suggested modifications to the aforementioned Assembly/State bills; (b) exchange views with hopeful enlistment of legislative support.

MSSNY supports expansion of the subcommittee charge to timely interact with representatives of the insurance, banking and business sectors as well as the Council on Affordable Health Insurance for educational purposes and for an in-depth investigation and assessment of: (a) the economic ramifications of MSAs; (b) the level of insurer/consumer interest in MSAs; (c) alternatives or modifications to the basic MSA concept as may be appropriate, necessary and feasible.

MSSNY vigorously supports the right of individuals to select their own health insurance plan and to receive the same tax-exempt treatment for individually purchased insurance as for employer-purchased coverage. (Council 12/19/96)

MSSNY will seek state and federal legislation that would enable individuals to create medical savings accounts for health care purposes which would encompass the concepts of utilization of pretax dollars, tax-free accumulations, and non-penalized withdrawals for health care and other related purposes. (HOD 1995-85; Policy Reaffirmed HOD 2014)

RECOMMENDATION: Retain, but modify as above to delete reference to outdated legislation.

ITEMS RECOMMENDED FOR RE-AFFIRMATION

20.993 Admissibility of Blood Alcohol Samples as Legal Evidence:
MSSNY supports the principle of permitting a blood alcohol sample drawn in the course of medical treatment of an injured driver to be admissible as legal evidence in any criminal or civil proceeding against such individual, provided that an appropriate chain of custody and quality of analytical results is maintained. (Council 5/14/92; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

40.999 Protection from Criminal Prosecution for Good Faith Clinical Judgment:

MSSNY has adopted the position that physicians, acting in good faith while exercising clinical judgment in the delivery of medical care, should be exempt from criminal prosecution as a result of untoward outcomes as a result of said judgment, and intends to initiate appropriate legislation to assure such protection. (HOD 1995-64; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

65.989 Driving While Intoxicated, Impaired or Distracted by All Substances

The Medical Society of the State of New York will advocate to ensure that when the ability to drive is impaired by recreational intake of drugs which are not listed as controlled substances under New York's Public Health Law, those persons are still subject to penalties under New York law which prohibits driving while intoxicated or driving while ability impaired. The Medical Society of the State of New York will continue to support programs that educate the public on the dangers of driving while intoxicated, or impaired. (HOD 2014-62)

RECOMMENDATION: Retain, the Policy is still relevant.

65.999 Testing in the Work Place for Drug and Alcohol Abuse:

MSSNY recognizes the right of employers to require drug and alcohol testing within certain limitations, as follows: (1) Drug and alcohol testing of applicants for employment in order to prevent drug and alcohol abusers from entering the work place. Patients taking medication which artificially triggers a positive test should have due process to be retested to exclude illegal drug or alcohol. (2) Drug and alcohol testing of employees for cause, provided that such testing is done under qualified medical supervision and that economic and other assistance is given in the rehabilitative process. (3) Random drug and alcohol testing of employees whose jobs may have an impact on public safety, under conditions as in number 2 above. (4) Drug and alcohol tests must be performed by New York State certified laboratories where adequate quality control processes are in effect and where a full chain of custody procedure is maintained on each specimen. In addition, each positive test result must be confirmed by means of gas chromatography/mass spectrometry or an equally accurate test. (5) Confidentiality must be maintained at all stages of the process. (6) Drug testing is appropriate when implemented in conjunction with a program for rehabilitation and treatment of employees who are psychologically or physically dependent. (Council 12/21/89; Reaffirmed HOD 2014*)*

RECOMMENDATION: Retain, the Policy is still relevant.

70.948 Point of Care Dispensing

The Medical Society of the State of New York will seek legislation that permits in-office physician dispensing of prescription medication to the patients. (HOD 2014-113)

RECOMMENDATION: Retain, the Policy is still relevant.

70.971 Administration of Prescription Drug Programs Insuring Patient Access to Necessary Medication:

MSSNY will:

1. express its concern to the New York Department of Health and the Department of Health and Human Services that the programs concerning prescription drugs be administered in such a way that patients will not be denied access to necessary medication; and
2. oppose any third party payer reducing reimbursement beyond or below a physician's and/or other health care practitioner's cost; and
3. support activity to ensure that all fair administrative costs be considered for reimbursement; and
4. coordinate with the Pharmacists Society of the State of New York in a concerted effort to insure proper access to pharmaceutical drugs for all patients in New York State. (Council 1/25/01; Reaffirmed Council 1/22/04)
5. vigorously advocate for fair and reasonable reimbursement for chemotherapy and other vaccines. (Council 1/22/04 addition) Policy 70.971 Reaffirmed HOD 2014

RECOMMENDATION: Retain, the Policy is still relevant.

70.978 Contact Lens Prescription, Expiration Date for:
MSSNY has adopted the position that there is danger to the public health and safety by allowing prescriptions for contact lenses to be filled without time limitation and without any requirement for proper ophthalmic follow-up care and that the same strict standards that regulate the dispensing of oral and topical medications, medical devices and appliances also apply to the dispensing of contact lenses to the residents of New York, and that contact lens prescriptions have an expiration date of one year after the date they are written. (HOD 1996-180; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

85.993 Opposition to Medical Resident Education Fee:
MSSNY will continue to strongly oppose any legislation that includes an annual fee for medical residents. The Division of Governmental Affairs of MSSNY will continue to strongly oppose any New York State budget that includes an annual fee for medical residents; and will report to the MSSNY-RPS any further action attempted by the State of New York regarding this issue as soon as possible. (HOD 1997-86; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

95.979 Testimony in Professional Liability Cases:
MSSNY takes the position that a physician who provides expert medical testimony in bad faith and/or who provides expert medical testimony that has no recognized scientific validity, is guilty of professional misconduct, and should be reported to the appropriate Office of Professional Medical Conduct.

MSSNY shall encourage all national specialty organizations to enact rules and disciplinary methods, utilizing the American Association of Neurological Surgeons as a model, to promote fair and honest expert testimony. (HOD 2000-82; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

95.987 Expert Medical Witness - Ethical Guidelines of MSSNY Members: MSSNY declares as an "Ethical Consideration" that physicians should aspire to the following objectives

in providing expert medical testimony: (1) In order to have the requisite skill, knowledge and expertise to offer expert medical testimony, medical experts should devote the greater part of their professional activities to practicing their specialties rather that testifying in litigation cases; (2) That when medical experts do offer testimony in litigation cases, their testimony should be objective, represent generally accepted facts reflecting the consensus of the scientific community, consist of verifiable scientific truths and be limited to testimony in his/her sphere of professional medical expertise.

MSSNY defines an "Ethical Consideration" as a principle intended to be aspirational in character and which represents objectives toward which every member of the profession should strive. An Ethical Consideration is intended to provide principles upon which a physician can rely for guidance in specific situations. Being aspirational in character, while every member of the profession should strive toward the attainment of the objective, the failure to attain the objectives of the Ethical Consideration does not subject the individual to disciplinary action. MSSNY will seek appropriate legislation that would require individuals to satisfy the requirements of paragraphs 1 and 2 above in order to be qualified to provide expert medical testimony. (Council 9/22/94; Reaffirmed HOD 2000-82; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

117.981 Patient Consent for Uploading Patient Records to the SHINY-NY And RHIOs

The Medical Society of the State of New York (MSSNY) will seek legislation or regulation that requires patient consent for uploading patient records to Regional Health Information Organizations (RHIOs) and the Statewide Health Information Network of New York (SHINY-NY).

The MSSNY will seek legislation or regulation to tighten access to patient records so as to restrict access without patient consent, ie "break the glass," only when the patient is not in a conscious or rational state of mind or their legal representative is unable to provide consent and the healthcare provider documents the life-threatening reason for having to access the patient record.

MSSNY will seek to educate patients and patient advocacy organizations concerning the data contained within the SHIN-NY database. (Amended and adopted Council 11/20/2014; from HOD 2014-105)

RECOMMENDATION: Retain, the Policy is still relevant.

117.982 Exemption Criteria for Electronic Health Record Adoption and Cloud-Based Electronic Health Record Packages

The Medical Society of the State of New York will ask that the American Medical Association (AMA) not give up the fight for Electronic Health Records (EHR) exemptions and continue to petition the Centers for Medicare and Medicaid Services (CMS) to:
(a) Grant solo physician practices and physicians nearing the age of retirement an exemption from the disincentives associated with not using Electronic Health Records (EHR); and
(b) Provide government EHR adoption subsidies for any small and/or solo physician practices that demonstrate a need for these subsidies, beyond the present incentive payment structure; and

(c) Provide cheaper alternatives to commercial EHR systems, either through a lowest-bid Request for Proposal (RFP) process with commercial vendors, or the development of a low-cost or free, CMS-based and administered, cloud-based system for physicians in solo practice and physicians nearing the age of retirement.

The Medical Society of the State of New York will urge the American Medical Association (AMA) request the Centers for Medicare and Medicaid Services (CMS) grant a "temporary waiver" for physician practices that are, in good faith, in the process of obtaining and attempting to implement meaningful use of an Electronic Health Records system, but due to technical issues beyond their control will be unable to meet the October, 2014 attestation deadline. (HOD 2014-107)

RECOMMENDATION: Retain, the Policy is still relevant.

117.994 Medical Smart Cards:
MSSNY will urge the American Medical Association to study and develop a "white paper" on the issue of medical smart cards and aligned technology, including the role of organized medicine in smart card development, the emergence of regional health information organizations (RHIOs), the opportunity for State and Specialty Societies to obtain grants to educate and inform members of opportunities in this and similar emerging technology and to enumerate the implications which these technologies have for physicians, patients and healthcare, in general. (HOD 2009-92; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

120.941 Affordable Care
The Medical Society of the State of New York will advocate for regulation and legislation which provides that insurers give reasonable credit for out of network expenses based on Fair Health toward a participant's annual deductibles and out of pocket maximums. MSSNY will submit a resolution to the annual meeting of the American Medical Association seeking federal regulation and legislation to provide that insurers give reasonable credit for out of network expenses toward a participant's annual deductibles and out of pocket maximums. (HOD 2014-253)

RECOMMENDATION: Retain, the Policy is still relevant.

120.943 Physicians and Health Care Institutions as Providers of Health Insurance
In the case where a provider or health care institution provides such insurance it should be held to the highest standards and oversight to prevent conflicts of interest that impair quality care; and any institution in the business of health care insurance have on its governance board and/or advisory boards, community providers as long as they are not employees of the institution providing such insurance. (HOD 2014-112)

RECOMMENDATION: Retain, the Policy is still relevant.

120.945 Access to Timely Care
The Medical Society of the State of New York will advocate for legislation or regulation to assure the right of a patient to have insurance coverage which permits them to be treated by an out of network physician of the patient's choice if the plan network is inadequate to enable a patient to

be treated by a needed specialist within 14 days of the patient's request, with payment based upon usual and customary rates. (HOD 2014-60)

RECOMMENDATION: Retain, the Policy is still relevant.

120.987 Multiple Product Lines:
MSSNY through the American Medical Association will seek Federal Legislative action to challenge health insurers who mandate the commitment of physicians to all (or multiple) product lines under a single contractual agreement as a condition for their participation with such organizations. (Council 12/18/97; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

120.990 Physician Notification of Insurance Payments Made Directly to Patients:
MSSNY will seek legal or regulatory action to require that insurance carriers be mandated to notify physicians of the amount and date of insurance claim payments made directly to their subscribers, regardless of the physician's participation status in the plan. (HOD 1998-52; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

130.934 MSSNY Single Payer Healthcare Survey
MSSNY, with input from the medical student section, design and conduct an objective poll by email of the collective opinion of MSSNY members and non-members ascertaining both their knowledge of the single payer health care system and their support or opposition of such a system in the State of New York. (HOD 2014-109)

RECOMMENDATION: Retain, the Policy is still relevant.

130.937 Exclusion of Physicians from the New York State Health Benefit Exchanges
The Medical Society of the State of New York will continue to advocate to the Governor's office, New York State Health Insurance Exchange officials, the New York State Legislature and New York's Congressional delegation that all plans sold inside and outside of New York's Health Insurance Exchange have robust physician networks that enable patients to have sufficient choice of treating physicians and enable patients to continue to be covered for care provided by physicians with whom there are long-standing treatment relationships. The Medical Society of the State of New York will take efforts to prevent hospitals from directing their physician employees to not refer patients to private-practice physicians. The Medical Society of the State of New York will continue its ongoing public relations efforts to assure the public and policymakers are aware of the problems of narrow insurer networks. (HOD 2014-57)

RECOMMENDATION: Retain, the Policy is still relevant.

130.942: Repeal PPACA Restrictions on Physicians
MSSNY supports federal legislation to repeal provisions in PPACA that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. MSSNY

will forward this resolution to the AMA for consideration at its next annual meeting. (HOD 2013-54; Reaffirmed HOD 2014-53)

RECOMMENDATION: Retain, the Policy is still relevant.

130.984 Malpractice Reform To Reduce The Number Of Frivolous Suits:
Medical Society of the State of New York will seek legislation amending the New York State Civil Practice law and Rules to require that the Certificate of Merit currently required in a malpractice action be signed by a physician actively practicing in the same specialty of medicine or surgery of a defendant who is the subject of the lawsuit and that the identity of such physician be provided to the defendant at the time such Certificate of Merit is executed. (HOD 1996-61; Reaffirmed HOD 1997-62, HOD 2000-76; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

130.985 All Self-Insured Programs To Have Same Standards As Other Insurers:
Medical Society of the State of New York will petition the appropriated legislative bodies and regulatory agencies to mandate that all self-insured programs be held to the same requirements, coverages and other standards as those to which HMOs, commercial insurers and governmental insurers are held; and will petition the American Medical Association to urge appropriate legislative bodies and regulatory agencies to pursue similar legislation/regulation at the Federal level. (HOD 1997-61; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

130.986 Timely Return of Properly Endorsed This Party Payor Contracts to Participating Physicians:
The Medical Society of the State of New York will seek appropriate legislative or regulatory action to require that upon receipt of physician-signed contracts by the health maintenance organization or insurance plan for participation in such plans, the HMO or insurance plan must be required to return a fully executed contract to the physician within 30 days of completion of such organization's credentialing of the physician. Such legislation shall require the HMO or insurer to provide notice to the physician within 120 days of submission of the physician's signed contract of any additional information necessary to the completion of the physician credentialing process; and shall require that HMOs or insurers shall have no more than 30 days from receipt of all necessary credentialing information to complete the credentialing process. (HOD 1997-59; Reaffirm HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

150.984 Outpatient Medical Services:
MSSNY is seeking legislation to provide that practitioners whose practices are supported, sponsored by and financially beneficial to hospital controlled satellite diagnostic and therapeutic facilities be held to the same self-referral standards to which the community-based practitioners are held. (HOD 1993-77; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

150.985 Incident Reports:
MSSNY is working with the Hospital Association of New York State to ensure that a copy of a hospital incident report which has been forwarded to the New York State Department of Health be sent to any physician whose name is included in such incident report. MSSNY is seeking to ensure that physician identifying information included in hospital incident reports submitted to the New York State Department of Health remain confidential and not be publicly disclosed, as well as seeking to ensure that all information developed by review of incidents required to be reported including, but not limited to "Statements of Deficiency" be covered under existing New York State confidentiality statutes and not be subject to disclosure through the Freedom of Information Law (FOIL). (HOD 1992-40; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

160.974 Physicians Should Not Be Penalized For Non-Participation In Government Medicine
It is the policy of the Medical Society of the State of New York that medical licensure in New York State shall not require participation in Medicare, Medicaid, or any other governmentally sponsored health insurance program. (HOD 2012-60; Reaffirmed HOD 2014-53)

RECOMMENDATION: Retain, the Policy is still relevant.

160.985 Destruction of the Doctor-Patient Relationship and the Practice of Medicine by Insurers:
MSSNY will seek legislation to discourage activities by insurers and other third parties that weaken or destroy the doctor-patient relationship including, but not limited to, the profusion of telephone based evaluation and referral by non-physicians.

Where managed care plans and insurers utilize nurses for "on-call" triage purposes, such nurses shall be licensed in New York State and provide, establish and maintain appropriate medical documentation of their activities as well as timely follow-up documentation to the patient's primary care physician regarding the nurse's assessment and recommendation; and that where MCOs provide triage services they must assume the liability for adverse events which may ensue. (HOD 1998-75; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

160.987 Statutory Authority for Licensure:
MSSNY supports the statutory transfer of authority for license restoration from the Education Department to the Board for Professional Medical Conduct. (Council 2/6/97; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

160.988 Licensure Restoration Process:
MSSNY supports the following recommendations of the Office of the Professions, New York State Education Department, to improve and streamline the license restoration process: An in-depth license restoration application to be developed with the burden being placed on the physician to explain why he or she should have the license back.

The establishment of a minimum waiting period of three years between the time a physician's license is revoked and the time that a physician may reapply for license restoration. The minimum waiting period is currently one year.
A graduated application fee for restoration is to be set so the physician covers the administrative cost of the restoration. There is currently no fee or charge.
The need for a personal appearance in every case is to be eliminated, but to permit the state board the option of calling for a personal appearance. (Council 2/6/97; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.848 Medicare Advantage Insurer Abuses
The Medical Society of the State of New York will ask the Attorney General to review the practice of managed care plans requesting medical records which are not for quality or utilization review but for business/reimbursement enhancement and that the Attorney General review situations whereby managed care plans, under the guise of doing a health assessment, have personnel visit an insured at home for a medical exam and discussion of the insured's medical history. MSSNY will urge the Attorney General to ensure that managed care plans which conduct these home "assessment" visits for the purpose of garnering added funds from the plans' overall administrator (ie, the employer, county state, CMS, etc.) be certain that the plans insureds/patients have a clear understanding of who is coming into their home and the purpose for the examination and history being conducted by the managed care plan's staff and further that managed care plans obtain clear and explicit consent from patients for these visits. (HOD 2013-252; referred, amended, adopted Council 4/13/2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.932 Health Care Plans:
MSSNY will seek regulation and/or legislation that once a health care plan has sold its product to a consumer, the health care plan is not permitted to limit the territory it covers during the policy term. (HOD 2000-254; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.938 Patient's Choice:
MSSNY will seek New York and Federal legislation which requires a health care plan to permit patients to access, without restriction, any and all providers participating with the plan who provide medical or diagnostic services. (HOD 2000-63; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.939 Insurance Company Participating Provider Networks:
MSSNY will pursue a legislative remedy to ensure that when any health care plan entity publishes a list of participating providers as part of an advertising campaign to enroll new members for a future time period (or upcoming coverage period), that said list accurately reflect the physicians who will be participating during the time period the insurance will be in effect and not merely the physicians who are currently participating as of the time of the advertising campaign. (HOD 2000-62; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.951 Quarterly Financial Disclosures:
MSSNY will seek the introduction of legislation and/or regulation to require HMOs and insurance companies to provide quarterly: a standard financial report, a statement of financial reserves, and a statement of outstanding debt including "disputed" and "undisputed" claims to the Medical Society of the State of New York and that MSSNY shall seek the introduction of legislation and/or regulation to require HMOs and insurance companies to report to the State all transfers of funds in excess of $250,000 not in the ordinary course of business within 15 days of such transfer and that such legislation and/or regulation should require HMOs and insurance companies to provide, upon request by MSSNY, an independent audit of a quarterly report when in the quarter for which the report was issued, such plan has transferred funds in excess of $250,000 not in the ordinary course of business. (HOD 1999-59; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.960 Capitation:
The Medical Society of the State of New York will seek legislation or regulation which (a) defines acceptable financial risk arrangements between physicians and managed care plans to minimize the potential for the reduction or limitation of appropriate access to medically necessary services; and (b) ensures that managed care plan enrollees be entitled to know the type of financial risk arrangement health plans have in place for their providers. (HOD 1998-72; Reaffirmed HOD 1999-268; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.961 Enforcement of Disclosure Laws Under Managed Care Bill of Rights:
That the Medical Society of the State of New York petition the state legislature, Attorney General, and the Governor to (a) strictly enforce the current law and (b) increase the fine to a sufficient level to encourage compliance and (c) clearly stipulate that such fines shall not be paid from money budgeted for the provision of health care. (HOD 1998-61; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.962 State Control Over Changes in Health Insurance Coverage and Reimbursement:
MSSNY will seek the enactment of legislation that
(a) requires that physicians receive specific notice of the compensation terms proffered by managed care plans, including a detailed statement of the precise terms by which monies will be paid and
(b) requires that physicians be routinely informed of the method by which the amount of a withhold or a bonus will be calculated, the date upon which payment will be made and a description of the records relied upon to calculate the withhold or bonus and
(c) requires scrutiny of managed care plans financial statements by appropriate state agencies when a managed care plan fails to return funds withheld from physicians in a given year to determine if the retention of funds by the managed care plan is, indeed, justified and
(d) if retention of funds is determined to be unjustified, said agencies direct the managed care plan to return the withhold with appropriate interest and penalties, and
(e) inform beneficiaries when benefits are changed. (HOD 1998-60; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.971 Retrospective Denial of Insurance Claims:
MSSNY will seek legislation which would amend subdivision (4) of section 4903 of the public health law and subdivision (d) of section 4903 of the insurance law which require health maintenance organizations and insurers to "make a utilization review determination involving a health care service which has been delivered within 30 days of receipt of the 'necessary information'" to further require that in no event shall such determination be made later than 90 days from the submission of the claim. (HOD 1997-97; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.975 Retroactive Denials:
MSSNY working through the Committee on State Legislation will strongly support the introduction of appropriate legislation to require all health insurers in this State, including HMOs, to be precluded from retroactively denying reimbursement to physicians for patients' admissions to hospitals. (HOD 1997-78; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

165.977 Financial Incentives Based Upon The Non Provision Of Services:
MSSNY will seek legislation which would prohibit the use of any financial incentives which inhibit the provision of medically necessary care. (HOD 1997-68; Reaffirmed HOD 2014*)*

RECOMMENDATION: Retain, the Policy is still relevant.

165.983 Redefining the Roles, Obligations and Responsibilities of Insurance Companies which Utilize Capitation as a Means of Physician Reimbursement:
MSSNY will seek legislation requiring managed care organizations to assume appropriate risk while at the same time:
(a) providing an adequate proportion of premium dollars dedicated to medical care;
(b) providing for equitable physician reimbursements;
(c) reducing excessive MCO profit margins. (Council 12/19/96; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

175.972 OPMC Inform Physicians of Untended Consequences
Utilizing legislative, regulatory or other relief against the Office of Medicaid Inspector General, the Medical Society of the State of New York will seek a prohibition from removing a physician from the State Medicaid program solely on the basis that the physician entered into a consent order with the Board of Professional Medical Conduct. (HOD 2014-100)

RECOMMENDATION: Retain, the Policy is still relevant.

175.996 "Pill Mill" Centers:
MSSNY is seeking regulatory or statutory reform mandating that physicians affiliated with Medicaid "Pill Mill" Centers where there is undisputed evidence of Medicaid abuse be subject to

an expedited license review and suspension as may be required by the appropriate agencies. MSSNY is seeking to ensure that suspension of any physician's license be based on direct and verifiable identification of the clinic(s) in question by the appropriate enforcement and investigative agencies and established community organizations, and not solely upon indirect and tangential criteria. Such unacceptable criteria would include, but not be limited to, Medical Management Information Services (MIS) computerized billing records or superficial and unreliable "spot check" site visits productive of only anecdotal and ultimately inadmissible evidence as gathered by the funding agency of the Medical Assistance Program. (Council 1/19/92; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

180.980 SHIN-NY Connectivity

The Medical Society of the State of New York will work with the New York eHealth Collaborative and the State Health Information Network – New York (SHIN-NY) to make sure that physicians do not have to pay any of the costs associated with connecting to, accessing or downloading data from the SHIN-NY network.

The Medical Society of the State of New York will oppose any state requirement or mandate to participate in the SHIN-NY as a condition of physician licensure. (HOD 2014-104)

RECOMMENDATION: Retain, the Policy is still relevant.

180.981 Correct Record Access

MSSNY supports action to assure that the imbedded costs of EHR technology, interoperability and additional administrative expenses associated with patient record access are added separately to the rate of payment currently received by the physician from the patient's health payer. In order to govern privacy and security of record transfer through the SHIN-NY, the State of New York should promote patient record access in accordance with rules developed through the Statewide Collaboration Process (SCP) which are delineated in the document entitled *"Privacy and Security Policies and Procedures for Qualified Entities and their Participants in New York State, Version 3.0*. (HOD 2014-106)

RECOMMENDATION: Retain, the Policy is still relevant.

180.990 FBI Raids:

MSSNY will take all necessary steps to ensure that government investigators not be permitted to remove records of patients from a physician's office without copies being made prior to removal.

MSSNY's position is that if patient records are seized and there is no provision made for copying of records at Government expense, copies must be made on side and left for the affected practitioners' use in ongoing care of their patients.

State and Federal legislation must be sought which would provide immunity for physicians from any physicians from any suit or administrative proceedings where it can be shown that absence of the patient records contributed to an alleged negligent act or where the patient records seized contain information relevant to defending against an alleged negligent act.

MSSNY will seek passage of State and Federal legislation that would ensure that FBI investigations regarding physicians should be done in a matter that is sensitive to the health of patients and the viability of the medical practice under investigation, and that physicians not be required to pay any fees to receive copies of their patient records which have been seized by the FBI. (HOD 2000-73; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

180.991 Privacy and Confidentiality:
MSSNY will seek legislative/regulatory relief to prevent insurance companies and other managed care organizations from selling, trading, transmitting, or in any way communicating, individually identifiable health information to third parties. Such legislative/regulatory relief should include a provision that patients be permitted to opt to provide individually identifiable information to third parties. (HOD 2000-69; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

190.996 Amendments to the "Certificate of Merit" in Medical Liability Cases:
MSSNY will seek legislation which would provide that physicians who provide consultation to attorneys for purposes of executing the certificate of merit required in medical malpractice actions (CPLR, Section 3012-a) and who routinely, arbitrarily and falsely assert that a basis for such medical malpractice actions exist, shall be guilty of unprofessional conduct and shall be subject to all appropriate disciplinary penalties pursuant to the Public Health Law. (HOD 1999-86; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

190.997 Expert Witness Disclosure:
MSSNY supports legislation which would require the disclosure and pre-trial deposition of expert witnesses in medical liability cases. (HOD 1998-85; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

190.998 Certificate of Merit in Liability Cases:
It is MSSNY's position that (a) a plaintiff's attorney, when initiating a medical liability action, certify that he or she has consulted with a physician licensed to practice in New York State who has reviewed the relevant medical records, and that said physician is of the opinion that there were departures from good medical practice that caused injury to the patient; (b) that it is solely the responsibility of the plaintiff's attorney to select the physician consultant commensurate with the above requirements; and (c) that the name of the consulting physician be made available. (HOD 1998-73; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

190.999 Reinstatement of Panel System:
MSSNY will seek the reinstatement of the medical malpractice panel system which was eliminated in the 1991 legislative session. (1992 State Legislation Program; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

225.997 Physicians as Reviewers:
The MSSNY, in total cognizance of the rights and privileges of licensed practicing physicians, seeks legislation to require that all peer review activities, conducted under the auspices of the PRO, the New York State Department of Health, Office of Professional Medical Conduct, and/or any other authority commissioned to perform physician peer review, be performed by physicians currently engaged in that specialty or not more than five years removed from the practice of the same specialty. In addition, the physician conducting peer review should submit evidence of board certification by a specialty or subspecialty as recognized by the American Board of Medical Specialties.

MSSNY is seeking legislation that would include the performance of peer review within the definition of the practice of medicine. (HOD 1990-39; Reaffirmed; HOD 1991-62; Reaffirmed HOD 1996-52; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

260.963 Medical Errors Data
MSSNY will urge that the New York State Department of Health provide to MSSNY statistical data identifying the five (5) most common medical errors that occur in New York.

MSSNY will study the medical error data provided by the DOH and, through the Committee on Interspecialty, the MSSNY Bioethical Issues Committee, and other appropriate MSSNY committees, develop systems and/or surgical/medical protocols which will result in the reduction of erroneous medical outcomes and ultimate prevention of medical errors.

MSSNY will urge the Medical Liability Mutual Insurance Company (MLMIC) to include in risk management seminars for their insured physicians education with respect to a reduction of medical error rates in the State of New York. (HOD 2000-87; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

195.975 Medicare and 'Off-Label' Uses of Drugs:
MSSNY opposes the imposition of any limitation, including under the new Medicare "Part D" drug benefit, on the "off-label" prescribing practices of physicians, whether by statute, regulation or operating practice of any private contractor administering such benefit. (HOD 2004-67; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

195.983 Medicare "Fraud and Abuse":
MSSNY will urge the appropriate federal and state agencies to acknowledge that the characterization of any billing errors as "fraud" to be libelous and offensive.

MSSNY objects to the heavy handed techniques of search and seizure, with guns drawn and without formal charges levied, as tactics of a totalitarian police state;

MSSNY will demand that Congressional inquiry address these concerns, which give the perception that the physicians are "*GUILTY UNTIL PROVEN INNOCENT*," with open public hearings at the earliest opportunity.

MSSNY objects to and rejects "statistical analysis" that attempt to claim that a physician's billing or practice is aberrant by use of flawed methodologies, and will advocate to stop the use and extrapolation of this data as "fraud and abuse.

MSSNY will seek legislation, in concert with the AMA, directing the Health Care Financing Administration (HCFA) to remove the notations of fraud reporting announcements from all mailings to Medicare beneficiaries in order to prevent erosion of the physician/patient relationship. (HOD 2000-255; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

195.987 Opposition To Limitations on Medicare Contracts:
MSSNY will support corrective legislation concerning the Section 4507 of the Balanced Budget Act to allow Medicare beneficiaries to enter into private contracts for provision of medical care without any significant preconditions being imposed either on the patient or on those providing the care. MSSNY will specifically seek to abolish the requirement that the physicians providing care under a private contract must forego participating in the Medicare program for two years. (HOD 1998-261; Reaffirmed HOD 00-82; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

210.996 Opposition to Inclusion in the National Practitioners Data Bank: MSSNY supports the mandatory and prompt notification of residents by the appropriate hospital authority when they are named along with a hospital and/or others in the hospital in malpractice suits.

MSSNY opposes the inclusion in the National Practitioner Data Book of information on liability payments made on behalf of residents named in malpractice suits for incidents which occur during the *required* activities of their residency training.

MSSNY should seek the immediate suspension of the policy whereby information on residents named in malpractice suits for incidents which occur during the required activities of their residency training is documented in the National Practitioner Data Bank when liability payments are made on their behalf. (Council 2/4/99; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

210.998 Expunging Disciplinary Actions and Other Adverse Data from the National Practitioner Data Bank and State Databases:
MSSNY will support legislation requiring the National Practitioner Data Bank and state databases to expunge data relating to a physician five (5) years after the completion of any disciplinary penalty and five (5) years after any payment relating to a malpractice claim. (HOD 1999-96; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

230.999 Maximizing Involvement of Physicians and Physician Organizations in Review Process:

MSSNY is continuing to evaluate the physician discipline process as revised by Chapter 606 of the laws of 1991, and, if determined to be necessary, to make recommendations on additional legislative refinements that will further the principles of maximizing the involvement of licensed physicians and recognized physician organizations in the process pursuant to which professional conduct of physicians is reviewed, so as to expedite and simplify this process, thus making it more fair to the accused physician and to the public. (HOD 1991-9; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

250.992 Amendment to OPMC Reporting Requirement Associated with Physician Profile Updates

Under New York State Law, failure of a physician to update his/her profile within six (6) months of license renewal, can be considered as professional misconduct and reportable to the OPMC for immediate action. The Medical Society of the State of New York will seek regulation/ legislation to allow a 60-day grace period for physicians to comply after receipt of a warning letter, and if a physician still does not comply after the 60 days grace period, then and only then should it be considered a reportable event. MSSNY, county and specialty societies will immediately begin to notify their members about the importance and urgency of updating their individual profiles in a timely and expeditious manner.

In an effort to ensure that physicians comply with the requirement of updating their profile, MSSNY will request there be notification with a direct link to www.nydoctorprofile.com which must be completed prior to submission of the registration renewal when a physician renews his/her license online and for those physicians who may still renew their registration via paper, a copy of their updated profile must be included and sent together with the registration renewal. (HOD 2014-102)

RECOMMENDATION: Retain, the Policy is still relevant.

260.981 Public Health Law - Obliged Disclosure

MSSNY will seek to amend the New York State Civil Practice Law and Rules to mandate disclosure of the name, or names, of a prosecution's expert witness prior to trial for purposes of deposition. (HOD 1994-85; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

265.925 Pay Physicians for Emergency Room Call

MSSNY urges hospitals to compensate physicians for being "on emergency room call" unless they choose to work voluntarily. (Council 6/3/04; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

265.965 Physician Appeal's Mechanisms for Down Coded or Denied Claims

MSSNY will seek legislation and/or regulation to ensure that physicians have an appropriate appeals mechanism which third party payors should make available to physicians when claims have been denied or "down coded" by such payors. Such legislation and/or regulation should require (a) all payors to notify the physicians of the appropriate appeals mechanism to be

utilized when a claim is denied or "down coded" and (b) all third party payors to provide physicians with a clear and accurate explanation on all claims that have been denied or "down coded". (HOD 2000-66; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

265.966 Circumvention of the Prompt Payment Law in New York State

MSSNY will seek amendment to the present Prompt Payment legislation to impose penalties on those carriers that have been determined to be circumventing the Prompt Payment law by "forcing claims to payment" to meet the prescribed deadlines and then demanding refunds well after the claims have been paid. (HOD 2000-65; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

265.970 Prompt Payment Law

MSSNY will seek legislation to amend the Prompt Payment Law so as to allow relief for physicians through a class action suit. (Council 9/30/99; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

265.980 Enhancements to HMO Prompt Payment

MSSNY will petition the Governor of the State of New York to modify the current Prompt Payment Law to provide for the imposition of a penalty of up to 20% of the amount billed, payable directly to the physician by the payor, for any clean claim not paid within the 45-day time frame. The Prompt Payment Law should also be modified to include payment to the physician of punitive damages for clean claims not processed or paid within 45 days when it can be shown that an intentional "pattern of abuse" exists on the part of the HMO, ERISA plan, or insurance company. When an intentional pattern of abuse is found to be exhibited by an HMO, ERISA plan, or insurance company in not paying physicians' claims within the prescribed 45-day limit, that the HMO's license be subject to suspension or revocation. The Prompt Payment Law be further amended to reflect that in the event suspension or revocation of license is not forthcoming, that the New York State Insurance Department be granted the legislative authority to mandate that these efficient HMO, ERISA plan, or insurance companies be required to increase their monetary reserves by 25%, and that managed care plans be required to provide written proof of "unclean claims." (HOD 1999-72; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

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)

RECOMMENDATION: Retain, the Policy is still relevant.

265.998 "No Fault" Accident Victim

MSSNY continues to support legislation and all other means to amend the "no fault law" to ensure that physicians and hospitals are paid regardless of the involvement of alcohol as

possible cause of the accident which resulted in the injury being treated. (HOD 1992-34; Reaffirmed HOD 2014)

RECOMMENDATION. Retain. The policy is still relevant.

270.969 Physician Liability and Patient Protection under the False Claims Act

The Medical Society of the State of New York together with the AMA will advocate for changes to the False Claims Act to ensure that physician liability under the False Claims Act is limited to those instances where the practitioner had actual knowledge that a claim presented is false and that this resolution be forwarded to the American Medical Association for consideration at its next Annual meeting. (HOD 2014-52)

RECOMMENDATION: Retain, the Policy is still relevant.

270.990 Protection from Discovery of Information Collected for Performance Improvement Activities

MSSNY will pursue legislation that would protect information collected for and action taken related to quality improvement activities in a physician's office in accordance with the New York State Department of Health's *Clinical Guidelines for Office-Based Surgery* from discovery, similar to that which already exists for Article 28 institutions. (HOD 1999-101; Reaffirmed HOD 2014*)*

RECOMMENDATION: Retain, the Policy is still relevant.

270.992 MSSNY's Support for Physicians in their Quest to be Considered Independent Contractors

MSSNY will communicate to all appropriate physicians or state medical societies its support of the activities of such physicians seeking to establish their right to act collectively in defining the terms and conditions of such physicians' relationships with managed care companies, insurers and/or other entities utilizing physician services. Such support be communicated in the *News of New York* and all other appropriate communication vehicles. (HOD 1999-84; Reaffirmed HOD 2014*)*

RECOMMENDATION: Retain, the Policy is still relevant.

270.993 Disruptive Visits to Medical Offices by Government Investigators and Agents

MSSNY will support legislation and/or other appropriate means to ensure that State and Federal investigators and/or agents give a physician written notice prior to a visit to a medical office so that such visit may be scheduled upon mutual agreement at a time when patients are not present in the medical office in any circumstance which lawfully permits a visit to a medical office without notice, such as a search warrant, arrest warrant or subpoena, investigators and/or agents should be required to initially identify themselves to appropriate medical staff in a quiet and confidential way that allows the physician an opportunity to comply in a manner that is least disruptive and threatening to the patients in the medical office at the time. (HOD 1999-57; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

295.997 Office Based Surgery

MSSNY will promote the implementation of the report of the Public Health Council Task Force on Office-Based (Ambulatory) Surgery as guidelines and guidelines only, and will promote legislation to preserve the privacy and confidentiality of the office-based practice. MSSNY will oppose legislation regulating office-based procedures until we have had sufficient experience with the guidelines. (HOD 2000-93; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

310.997 Arbitration in Cases of Third-Party Audits

MSSNY will seek legislation or regulation for the development of an independent arbitration panel to handle requests for refunds by third-party payers arising from audits of physicians' practices. (HOD 1998-265; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

315.996 Identification and Reporting - Licensure Mandated CME

MSSNY has reiterated its opposition to all mandated courses tied to licensure. Inasmuch as there is a mandated course of identification and reporting of child abuse and maltreatment for physicians and other medical personnel, it is the Society's position that all other professionals and personnel possibly involved in child abuse cases, including all judges, attorneys, court personnel, social service workers and others be mandated to complete course work or training in child abuse and family violence as a licensure or job requirement. (HOD 1993-62; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the Policy is still relevant.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 50

Introduced by: NASSAU COUNTY

Subject: 340B REGULATIONS

Referred to: Reference Committee on Governmental Affairs A

Whereas, 340B regulations were developed for the not for profit hospitals in 1992 by the Public Health Service Act; and

Whereas, these regulations allow hospitals and other facilities to acquire medications at 50% of its usual price for the benefit of underinsured and uninsured patients and to free up funds for hospitals to provide charity care; and

Whereas, these regulations were designed primarily for institutions in relatively underserved communities; and

Whereas, there is ample evidence that many institutions have utilized these regulations to increase their profits and have not provided low or no cost care to underserved communities; and

Whereas, qualifications to determine which institutions receive the benefits of 340 B regulations are determined by private data vendors and pharmacy benefit managers at significant profit with little or no governmental oversight; and

Whereas, only 24% of participating hospitals in New York are in underserved communities and generate 2.8 times as much from 340 B as they spend on charity care; and

Whereas, less than ⅔ of 340B institutions nationally provide charitable care at or above the national average; and therefore be it

RESOLVED, that 340B regulations be revisited by Congress and other appropriate regulatory bodies; and be it further

RESOLVED, that there be strict rules and transparency regarding use of funds generated by 340 B regulations; and be it further

RESOLVED, that there be definitive governmental oversight for entities involved in 340B benefits; and be it further

RESOLVED, that institutions receiving 340 B benefits provide significant care to patients commensurate to the degree of funding resulting from 340 B regulations; and be it further resolved

RESOLVED, that the AMA consider this resolution at their 2024 annual spring meeting.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 51

Introduced by: NASSAU COUNTY

Subject: DISCIPLINARY ISSUES FOR EMPLOYED PHYSICIANS

Referred to: Reference Committee on Governmental Affairs A

Whereas, physicians are increasingly employed by large, often corporately structured entities; and

Whereas, most physicians are not currently unionized; and

Whereas, employment contracts are often one sided and do not allow for any due process on behalf of the physician against meritless and at times erroneous accusations; and

Whereas, some entities have utilized its legal and human resource divisions in manners that are not equitable; and

Whereas, due to non competes and 'at will employment' contracts can result in major and potentially irreparable career damage for what may be minor transgressions; therefore be it

RESOLVED, that transparency be integral to the evaluative process regarding any behavioral issues involving employed physicians; and be it further

RESOLVED, that the organized medical staff is to be represented on any decision-making body or committee tasked with evaluation of alleged behavioral or professional departures by any physician; and be it further

RESOLVED, that the organized medical staff be given significant input to include voting towards any resolution of alleged behavioral issues; and therefore it be further

RESOLVED, that all punitive actions rendered are equivalent and equitable and do not demonstrate subjectivity on the part of the employer.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 52

Introduced by: New York County Medical Society

Subject: Statute of Limitations for OPMC Web Site

Referred to: Reference Committee on Governmental Affairs A

Whereas, The New York State Department of Health has two different websites on which the public can view actions of the Office of Professional Misconduct (OPMC) – the New York State Physician Profile (www.nydoctorprofile.com) and the OPMC's own site (https://apps.health.ny.gov/pubdoh/professionals/doctors/conduct/factions/PhysicianDetailsAction.action?finalActionId=4321); and

Whereas, Actions by the OPMC are (by statute) removed from the New York State Physician Profile after 10 years, but remain on the OPMC's own site in perpetuity (the OPMC site has no statutory or regulatory limit); and

Whereas, Even though the information sources are different (physicians report their own data on the Profile), fairness may require that the same standard be applied to both sites; and

Whereas, After a disciplinary episode, many physicians improve their practices and may even reshape their lives, and a day may eventually come when the negative information, though accurate concerning the past, does not paint a realistic picture of the physician as he or she is in the present; and

Whereas, A check of processes in other states shows that almost all fifty states list "recent disciplinary action" or date–specific disciplinary actions with New York being one of the few states where data is visible in perpetuity (https://projects.propublica.org/graphics/investigating-doctors)); and

Whereas, There might be just one justifiable exception – behavior so egregious that the license has been revoked -- ought to remain in perpetuity on both sites); therefore be it

RESOLVED, That the Medical Society of the State of New York seek legislation or regulation such that the New York State Department of Health apply a ten-year time limit to data on the publicly visible web page of the Office of Professional Medical Conduct, apart from actual license revocation, conforming to the ten-year limit on data on the New York State Physician Profile.

References:

1. https://apps.health.ny.gov/pubdoh/professionals/doctors/conduct/factions/PhysicianDetailsActin.action?finalActionId=4321
2. www.nydoctorprofile.com

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 53

Introduced by: Medical Society of the County of Kings & Lisa Eng, DO

Subject: OPMC Should monitor all practitioners who are forward facing patients, i.e. physicians, physician assistants/associates, special assistants, nurse practitioners and midwives

Referred to: Reference Committee on Governmental Affairs A

Whereas, the NYS Health Department's Office of Professional Medical Conduct (OPMC) and the state Board for Professional Medical Conduct (board) are responsible for investigating and adjudicating complaints against physicians, physician assistants and specialist assistants; and

Whereas, nurse practitioners, nurse midwives and certified midwives are monitored by NYS Education Department Office of the Professions, Board of Regents and complaints can be filed with them or Office of Professional Discipline (OPD). The midwifery board is composed of 7 licensed midwives, 1 educator of midwifery, 2 licensed physicians who are also certified as obstetrician/gynecologist by a national certifying body, 1 licensed physician who practices family medicine including obstetrics and 1 licensed physician who practices pediatrics; Nurse practitioners are under the auspices of the Nursing board and their board is composed of 11 licensed registered professional nurses and 4 licensed practical nurses and

Whereas, April 9, 2022 as part of the state budget, Gov. Hochul signed a law granting NPs to practice independently with more than 3600 hours of experience no longer need a formal relationship with a medical doctor to practice, and can evaluate patients; diagnose, order and interpret diagnostic tests; initiate and manage treatments; and prescribe medications; and

Whereas, the path to becoming a Doctor of Nursing Practice (DNP) can be obtained completely online. The Master of Science in Nursing (MSN) is also attainable completely online; The steps to a DNP are: obtain BSN, pass the NCLEX, get RN license, complete MSN degree then complete DNP course; therefore be it

RESOLVED, all practitioners of medicine who are independent or supervised or in a collaborative practice arrangement should be monitored, investigated and disciplined by OPMC as there has already been precedent for PAs and SAs to be monitored by them; and be it further

RESOLVED, there should be one oversight board in NY State for all patient forward practitioners; and be it further

RESOLVED, there should be a majority of physicians of primary care and specialty care on the oversight board with representation by NPs, CNM/CM and PA's .

References:

https://www.op.nysed.gov/professions/midwifery/questions-answers
https://www.regents.nysed.gov/committees/committee-professional-practice
https://www.op.nysed.gov/professions/nurse-practitioners/professional-practice/practice-requirements

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK

House of Delegates

Resolution 54

Introduced by: Joseph Current, Medical Student, as an individual

Subject: Title Misappropriation of Healthcare Professionals in Clinical Settings

Referred to: Reference Committee on Governmental Affairs A

Whereas, currently there are mid-level practitioners who seek to be identified as a “doctor” and wear badges in clinical settings that make reference to the mid-level clinician as an equal team member to the physician when displayed to the patient-population; and

Whereas, historically, the term “doctor” has a connotation in the clinical setting that is equivalent to a licensed physician with credentials from successfully completing a prescribed course of study from a school of allopathic or osteopathic medicine (MD, DO, or equivalent); and

Whereas, there exists key differences in the length, rigor, and focus of medical training and scope of practice of medical professionals with different titles; and

Whereas, professional medical associations support transparency by arguing that the use of unclear provider identifiers can mislead patients into perceiving that they are being treated by a physician when they are being treated by a nonphysician, which cost a trusting patient greatly and create liability exposure for all physicians who have treated said patient; and

Whereas, there have been legal conclusions that reserve certain titles for physicians in other states, for example, to prevent non-physicians from identifying as “anesthesiologists” if they are not licensed as a practicing anesthesiologist; and

Whereas, using terminology to title medical professionals can mislead patients, breaking inherent trust between patients and providers, influencing patients’ treatment decisions in a clinical setting, and violating the Lanham Act; and

Whereas, in the United States, per the Lanham Act, false advertising that “misrepresents the nature, characteristics, qualities, or geographic origin” of goods and services (15 U.S.C § 1225(a)) is prohibited; therefore be it

RESOLVED, that the Medical Society of the State of New York supports legislation to require proper verbal and badge identification of medical professionals based on their training and credentials (i.e. MD, DO, RN, LPN, DC, DPM, DDS, etc.), including but not limited to reserving titles such as “doctor,” “attending,” “resident,” “fellow,” “anesthesiologist,” etc. only for practicing physicians carrying an MD/DO degree and license to practice medicine.

References:

1. https://www.justia.com/consumer/deceptive-practices-and-fraud/false-advertising/#:~:text=Regulations%20of%20False%20Advertising,laws%20on%20behalf%20of%20consumers.
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9462903/
3. https://www.acep.org/patient-care/policy-statements/use-of-the-title-doctor-in-the-clinical-setting
4. https://www.anesthesiologynews.com/Multimedia/Article/01-23/Title-Misappropriation-in-Anesthesia/69201

6. https://www.ama-assn.org/practice-management/scope-practice/court-anesthesiologist-title-restricted-mds-dos

Existing MSSNY Policy:

110.992 Standardization of Identification for Medical Professionals
MSSNY will work with appropriate health care entities to ensure that licensed physicians and other health care practitioners wear a picture identification badge which shall be conspicuously displayed and legible, and which clearly details to the patient, the name and professional title authorized pursuant to Education Law (Physician, Physician Assistant, Nurse Practitioner, etc) of their physician and any other health care practitioner's.

Any picture identification badge for physicians and other health care practitioners should be provided at no cost to the physician and health care provider. (HOD 2012-105; Reaffirmed HOD 2022; Reaffirmed HOD 2023 in lieu of Resolution 60)

115.981 Non-Physician Post-Graduate Medical Training
(1) MSSNY recognizes that the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians; thus these terms should be reserved to describe physician roles. MSSNY will work with relevant stakeholders to define appropriate labels for postgraduate clinical and diagnostic training programs for non-physicians that recognizes the rigor of these programs but prevents role confusion associated with the terms "resident," "residency," "fellow," or "fellowship."

(2) MSSNY objects to the American Board of Medical Specialists (ABMS), the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS) and their member boards having designated seats for Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Anesthesia Assistants, or any other healthcare professional that are independent from the public member seats.

(3) MSSNY will work with relevant stakeholders to assure that funds to support the expansion of postgraduate clinical training for non-physicians does not divert funding from physician GME. This resolution will be immediately forwarded to the American Medical Association. (HOD 2021-AMA #1, referred to Council, adopted 4/15/21)

115.987: Healthcare Provider Representation and Patient Protection
MSSNY endorses the enactment of legislation that would establish requirements for all licensed health care providers who deliver direct care in an Article 28 licensed hospital, ambulatory surgical center, diagnostic and treatment center, or private physician's office that is accredited (OB), to wear identification badges that in addition to current State Education Department identification requirements, also contain large bold lettering indicating the practitioner's licensure (i.e. PHYSICIAN, RN, NP, PA, etc.). (HOD 2013-113; Reaffirmed HOD 2023 in lieu of Resolution 60)

Existing AMA Policies:

Protection of the Titles "Doctor," "Resident" and "Residency" H-275.925
Our AMA will: (1) advocate that all health professionals in a clinical health care setting clearly and accurately communicate to patients and relevant others their qualifications, degree(s) attained, and current training status within their training program; (2) develop model state

legislation for implementation to this effect; (3) support state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO); and (4) expand efforts in educational campaigns that: a) address the differential education, training and licensure/certification requirements for non-physician health professionals versus physicians (MD/DO) and b) provide clarity regarding the role that physicians (MD/DO) play in providing patient care relative to other health professionals as it relates to nomenclature, qualifications, degrees attained and current training status.

Professional Nurse Staffing in Hospitals H-360.986

The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;

(2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;

(3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;

(4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and

(5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured.

Truth in Advertising H-405.964

1. AMA policy is that any published lists of "Best Physicians" should include a full disclosure of the selection criteria, including direct or indirect financial arrangements.

2. Our AMA opposes any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician **providers' state issued licenses.**

Definition of a Physician H-405.969

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.

2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

Non-Physician Title Misappropriation D-405.977

Our AMA will: (1) actively oppose the American Academy of Physician Assistants' (AAPA's) recent move to change the official title of the profession from "Physician Assistant" to "Physician Associate"; and (2) actively advocate that the stand-alone title "Physician" be used only to refer to doctors of allopathic medicine (MDs) and doctors of osteopathic medicine (DOs), and not be used in ways that have the potential to mislead patients about the level of training and credentials of non-physician health care workers.

Clarification of the Title "Doctor" in the Hospital Environment D-405.991

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

"Doctor" as a Title H-405.992

The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title "Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 55

Introduced by: David Zuckerman & Nassau County Medical Society

Subject: Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas

Referred to: Reference Committee on Governmental Affairs A

Whereas, the most common visa that international medical graduates (IMG) use to participate in US graduate medical education programs is the J-1 visa[1]; and

Whereas, the J-1 visa traditionally requires a mandatory two-year foreign residency after completion of their graduate medical education , forcing many IMGs who may wish to begin practice inside the US to undergo a long and painful transition out of the country before reapplication under a new visa[2]; and

Whereas, the Conrad 30 waiver program is a federal exemption to the J-1 visa residency requirement, which allows up to 30 IMGs per State under a J-1 visa to avoid the two-year foreign residency requirement after graduation if they practice in a federally designated medically underserved area or with a medically underserved population[3]; and

Whereas, New York is granted significant latitude in the composition and distribution of Conrad 30 recipients, including which medical specialties are considered for visa waivers and where waiver recipients may practice medicine, even outside of federally designated shortage areas under the Conrad FLEX program[4]; and

Whereas, New York is expected to need an increase of 8% more primary care physicians compared to the current workforce due to an aging, growing and increasingly insured population (post-Affordable Care Act) over the next decade[5]; and

Whereas, some studies have suggested that US residency-trained IMG physicians may yield superior patient outcomes relative to their US medical graduate peers[6]; and

Whereas, 40 of New York's 62 counties are designated as primary care health professional shortage areas by the Department of Health and Human Services[7]; and

Whereas, 37 of New York's 62 counties have been designated as a mental health professional shortage area (HPSA) by the Department of Health and Human Services[8]; and

Whereas, reapproval or expansion of the Conrad 30 waiver program is unlikely to meaningfully harm the economic competitiveness of native New York physicians or physician practices due to requirements that waiver recipients be employed by health systems that have been unsuccessful in attracting US medical graduates to the same position[9]; and

Whereas, for the past five years, New York has maximally utilized the existing per-year per-State cap of 30 J-1 visa waivers, suggesting a need for additional visa waivers to meet healthcare gaps inside the State[10]; and

Whereas, the Conrad State 30 and Physician Access Reauthorization Act would extend and expand the Conrad 30 waiver exemption program, allowing for approximately ~50% additional waivers to be granted on a per-year basis over the next decade[11]; and

Whereas, New York State recently proposed legislation that would require State agencies to report to the Secretary of State how many unused Conrad 30 waivers they retained at the end of each fiscal year to ensure utilization of all available waivers[12]; and therefore be it

RESOLVED, Our MSSNY: (1) supports reapproval and expansion of the Conrad 30 visa waiver program; (2) supports maximal and equitable geographic allocation within the State of New York of any additional waiver recipients; (3) supports the preferencing of physicians entering training in underserved fields in the allocation of additional J-1 Visa waivers.

References:

1. https://www.ama-assn.org/education/international-medical-education/immigration-information-international-medical-graduates
2. https://internationalaffairs.uchicago.edu/twoyearreq
3. https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups
4. https://cbkimmigration.com/health-care-workers/conrad-flex-program/
5. https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/New%20York.pdf
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9334519/#REF5
7. https://www.ruralhealthinfo.org/charts/5?state=NY
8. https://www.ruralhealthinfo.org/charts/7?state=NY
9. https://www.irvine-legal.com/irvine-articles/2019/10/21/conrad-30-overview-by-state-j-1-waivers-for-physicians
10. https://www.niskanencenter.org/the-bipartisan-immigration-policy-that-helps-rural-americans-get-access-to-local-physicians/
11. https://www.collins.senate.gov/newsroom/collins-klobuchar-rosen-tillis-introduce-bipartisan-legislation-to-build-healthcare-workforce-in-rural-and-medically-underserved-areas
12. https://stefanik.house.gov/2024/1/stefanik-helps-introduce-bill-to-address-doctor-shortage

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 56

Introduced by: Medical Society of the County of Kings & Lisa Eng, DO

Subject: International Medical Graduates as a Solution to Physician Shortage

Referred to: Reference Committee on Governmental Affairs A

Whereas, by 2025, it is projected that the demand for physicians in the United Stated will exceed the supply by 46,000 to 90,000. This comprises a shortage of:

- 12,500 to 31,100 primary care physicians
- 5,100 to 12,300 medical specialists
- 23,100 to 31,600 surgical specialists
- 2,400 to 20,200 other specialists

and

Whereas, This shortage of physicians is likely to have a considerable impact on the health of the population. Most scientists believe that it will persist even with the introduction of purportedly compensatory scenarios such as: advanced nurse practitioners (APRNs), retail health clinics, delayed physician retirement, more efficient delivery of services; and

Whereas, The supply of primary care physicians is linked to the achievement of better health outcomes. These include overall health, life expectancy, better perception of self-rated health, and mortality from all causes, cardiovascular disease, stroke and in infancy. This relationship has been evident with repeated trials over the previous thirty years in the United States; and

Whereas, Research suggests that increasing the number of primary care physicians by one per 10,000 people is associated with a 5.3% reduction in average mortality (which is presently 49 per 100,000 per year) [1]; and

Whereas, A stand-alone solution is unlikely to be sufficient in addressing the issue of physician shortage. The training of new doctors takes up to a decade. It is, therefore, important, that several measures to resolve this shortage in supply are initiated from today and going forward.; and

Whereas, Tennessee has passed an innovative solution and perhaps much more rooted in common sense than others. "International medical graduates (IMGs) play a large role in the U.S. healthcare system, comprising 1 in 4 physicians (24.7%) in the U.S. Despite their critical role in boosting the U.S. physician supply and mitigating physician shortages in underserved areas[1], and

Whereas, IMGs face substantial barriers to licensing compared to domestic graduates, hindering their efforts to practice medicine in the U.S. This new groundbreaking law enacted in Tennessee may help reduce these barriers and expand opportunities for IMGs to practice medicine in the U.S. This Perspective first summarizes existing barriers facing IMGs, then highlights significant

changes of Tennessee's new law from current programs before discussing potential concerns about the new policy; and

Whereas, There are two major requirements for IMGs to be licensed to practice in the U.S.

First, all IMGs, regardless of their U.S. citizenship status, must complete a U.S.-based residency even if they have previously completed a residency and/or practiced medicine in another country. While the mandated US-based residency training intends to standardize training quality, it presumes that IMGs received substandard training overseas and causes duplicative clinical training with unclear benefit to their skills and competencies. Moreover, a fraction of IMGs has difficulty completing training due to financial or social instability, with some abandoning training altogether.

Second, even after completing a US-residency program, noncitizen IMGs often experience difficulties in securing necessary visas to practice medicine because few hospitals are willing to sponsor H1B visas due to filling fees, especially after the 2016 Medicare cuts to graduate medical education.[2] Historically, noncitizen IMGs enter the U.S. through the J-1 medical trainee visa program and are only able to remain in the country after their post-graduate medical training through the Conrad 30 waiver program or another J-1 waiver program.[3] These exemptions allow IMGs to convert their J-1 to a H1B visa in exchange for an obligation to practice in health professional shortage areas (HPSAs) or medically underserved areas, and

Whereas, Together, these two barriers have led to substantial underutilization of IMGs' medical skills. Recent evidence indicates that up to 40% of immigrants with medical and doctorate degrees work in jobs not requiring those degrees.[4] The "deskilling" of highly skilled immigrants, including IMGs, costs $39 billion in lost wages annually and $10 billion in unrealized taxes among the entire labor force each year,[5] and

Whereas, The significance of Tennessee's New Law should be understood and appreciated. In April 2023, Tennessee, through SB 1451 that aimed to mitigate the state's physician shortage, drastically reduced these barriers and became the first state in the nation to allow IMGs who are licensed in another country to be provisionally licensed and practice in the U.S. without requiring completion of a U.S.-based residency. Applicants must

- be certified by the Educational Commission for Foreign Medical Graduates (ECFMG)
- pass US licensing exams (USMLE Step 1 and Step 2)
- have completed at least a three-year residency program at an accredited international program
- practice under the supervision of a Tennessee-licensed physician for two years before receiving an unrestricted license, and

Whereas, Tennessee's new law offers a new "provisional licensing" pathway for IMGs (PLIMGs) to attain fully licensed physician status, similar to the programs for IMGs in Canada and the United Kingdom, both of which have implemented PLIMG programs in the past three decades. Similar bills pending in Arizona, Idaho, Missouri, and Nevada seek to emulate the PLIMG pathway to address the perceived or objectively assessed physician shortage in their states, and

Whereas, Tennessee's new law also removes major restrictions imposed by previous immigration policies and allows greater flexibility for individual hospitals to hire IMGs, especially noncitizens." [2]; and

Whereas, The two most fundamental differences between NPs and PAs are the training they receive and the environments where they work. Nurse practitioners are trained in the advanced practice of nursing. An NP degree can be obtained online after nursing school with little working experience and the Doctor of NP (DNP) can be obtained immediately after the NP degree online as well. On the other hand, physician assistants have more intense training, and PA school is much more competitive. The PA curriculum more closely resembles that of a physician, and they receive more training in diagnosing pathology, and

Whereas, In NYS after 3600 hours an NP can work independently and without physician collaboration or supervision [3]; Legislators in New York are advocating for a bill that would make permanent a state executive order that has allowed physician assistants to practice without a supervising physician since March 2020. This only extends to PAs who have more than 8,000 hours of experience and work for hospitals, large healthcare organizations or in primary care, and

Whereas, The time has come to allow an International Medical Graduate who has already attained their medical degree (MD) in another country and has been providing care for a minimum of three years in a postgraduate setting – would have more fundamental knowledge, training, and experience than the minimum that is required of an NP and PA to work independently, and

Whereas, the State could consider the equivalent requirement of an H1B visa – i.e. employer willing to sign for a minimum of two years in a medically underserved area (MUA or HPMS) or under-represented specialty, which would truly help to reduce physician shortages upon implementation and going forward,
therefore be it

RESOLVED, MSSNY seek legislation or regulation and advocate to NYS DOH, the Governor's Office, and NYS legislature for adoption of a measure similar to Tennessee to allow us to quickly but thoughtfully begin to fill an unmet need with qualified, well-trained physicians; and be it further

RESOLVED, that MSSNY should have a seat at the table for any discussions, legislation, or regulation for fast-tracking of entry to the US system in NYS of IMG's, working with US Immigration and NYS DOH and DOE; and be it further

RESOLVED, There should be a clear pathway for licensure of IMG physicians in NYS.

References:

1. https://www.news-medical.net/health/Physician-Shortage.aspx#:~:text=By%202025%2C%20it%20is%20projected,5%2C100%20to%2012%2C300%20medical%20specialists
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10688565/
3. https://www.hipaaexams.com/blog/nurse-practitioner-doctor-differences

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 57

Introduced by: 3rd & 4th Districts

Subject: ERISA preemption for health insurers

Referred to: Reference Committee on Governmental Affairs A

Whereas health insurers are able to deny coverage for any test or treatment prescribed by a physician; and

Whereas such denials, in most case, effectively preclude the insured patient from having said test or treatment; and

Whereas the insured patient may be harmed by failing to have the test or treatment prescribed by their doctor; and

Whereas an insured patient should be able to sue for damages resulting from such a denial of care; and

Whereas most insurers, because they provide their service as part of an employer-sponsored health plan, are regulated under the Employee Retirement Income Security Act of 1974 (ERISA); and

Whereas Section 514(a) of ERISA preempts an individual's rights under state law of filing a claim for injury or wrongful death, and

Whereas the injured party has no alternative but to sue their physician(s) for their injuries even though the decision to withhold care was rendered by the insurer, be it therefore

Resolved that the Medical Society of the State of New York, through its delegation to the American Medical Association, advocate for federal legislative and/or regulatory changes that remove the preemption provided by the Employment Retirement Income Security Act (ERISA) to insurance companies that currently prohibit injured patients from filing malpractice claims against their insurance companies

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References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 58

Introduced by: Hemant Kalia MD MPH and Josephine McAllister MD

Subject: Site of Service Differential Payment System Reform in NY State

Referred to: Reference Committee on Governmental Affairs A

Whereas, Patients receive outpatient medical services in a variety of settings, including physician offices, hospital outpatient departments (HOPD), and ambulatory surgical centers (ASC); and

Whereas, The choice of outpatient site has no discernible effect on patient care; and

Whereas, Equal pay should be provided for equal work; and

Whereas, The unsustainable and growing payment differential between HOPDs and physician practices is inequitable and endangers patient access to their choice of care provider; and

Whereas, Medicare physician reimbursement has declined 26% from 2001 to 2023, resulting in either the closure of physician offices, or forcing these practices to join larger health systems; so be it

RESOLVED, MSSNY will advocate for site of service differential payment reform in NY state; and be it further

RESOLVED, that MSSNY advocates that the AMA study this issue and present its findings back to the MSSNY House of Delegates.

References:

Mostashari, Farzad MD. The Paradox of Size: How Small, Independent Practices Can Thrive in Value-Based Care. Ann Fam Med. 2016 Jan; 14(1): 5–7.

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https://www.ama-assn.org/system/files/issue-brief-pay-variations-outpatient-sites.pdf

AMA Directive on The Site-of-Service Differential D-330.902: https://policysearch.ama-assn.org/policyfinder/detail/The%20Site-of-Service%20Differential%20D-330.902?uri=%2FAMADoc%2Fdirectives.xml-D-330.902.xml

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 59

Introduced by: Ninth District Branch
(Dutchess, Orange, Putnam, Rockland and Westchester Counties)

Subject: Payment for pre-certified/preauthorized procedures

Referred to: Reference Committee on Governmental Affairs A

Whereas, many insurers require pre-certification/preauthorization for diagnostic and surgical procedures; and

Whereas, many insurers require extensive pre-approval/preauthorization documentation submission and approval process, and have ample opportunities to consider and request additional documentation to decide on approval or denial of the pre-certification request; and

Whereas, Current Procedural Terminology (CPT) codes defining the procedures/testing to be performed are routinely required under pre-certification/preauthorization process; and

Whereas, pre-certification/preauthorization process is both time and labor intensive; and

Whereas, certain Gold Card program waiving pre-certification/preauthorization requirement is under consideration by the NY State legislature; and

Whereas, insurers not infrequently deny payments for such pre-certified/preauthorized procedures; and

Whereas, such pre-certification/preauthorization process and post-procedure claim denial cause significant administrative burden on physician practice; therefore be it

RESOLVED, that MSSNY seek through legislation and/or regulation mandatory insurer payment without further review or delay to contracted physician(s) for pre-certified and preauthorized services at the contracted rates; and be it further

RESOLVED, that MSSNY seek through legislation and/or regulation mandatory insurer payment without further review or delay for waived pre-certification and preauthorization requirement under the “Gold Card” program; and be it further

RESOLVED, that the MSSNY Delegation to the American Medical Association (AMA) introduce a similar resolution at the next meeting of the AMA House of Delegates for adoption.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 60

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland and Westchester Counties)
Subject:	Regulation Against Insurance Company Denials Following Insurer Peer-to-Peer Prior Authorization
Referred to:	Reference Committee on Governmental Affairs A

Whereas, the Medical Society of the State of New York (MSSNY) is dedicated to promoting the highest standards of medical care and advocating for the well-being of patients and physicians; and

Whereas, the prior authorization process is a crucial component of the healthcare system, designed to ensure appropriate utilization of medical services, control costs, and enhance patient safety; and

Whereas, MSSNY recognizes the importance of peer-to-peer prior authorization, which involves direct communication between the treating physician and a medical director or reviewer from the insurance company to discuss the medical necessity and appropriateness of a proposed medical procedure; and

Whereas, despite the existence of peer-to-peer prior authorization, there continue to be instances insurance companies deny coverage for procedures after a medical director has authorized the treatment, causing unnecessary delays in patient care and potential harm to patients; and

Whereas, these denials may occur after the procedure is performed requiring the physician to perform an appeal for medical necessity in which they justify the observed benefits of their clinical care; and

Whereas, such denials can lead to increased administrative burdens on healthcare providers, resulting in wasted time and resources that could be better utilized in direct patient care; and

Whereas, MSSNY acknowledges the current regulatory framework that ensures insurance companies honor peer-to-peer prior authorizations and provides a fair appeals process for healthcare providers facing unwarranted denials; and

Whereas, current New York State regulation requires a timely peer-to-peer review with a physician in the same, or similar specialty, with the requesting physician; and

Whereas, insurance carriers may claim that a same specialty reviewer is unavailable due to unforeseeable circumstances and provide peer reviewers in an unrelated medical specialty thus circumventing current regulation, therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) advocate for legislation or regulation that prevent insurance companies from denying coverage for medical procedures after receiving prior authorization through peer-to-peer consultations; and be it further

RESOLVED, that MSSNY supports the enforcement of current guidelines and standards for peer-to-peer prior authorization processes to enhance transparency, efficiency, and consistency in the evaluation of medical necessity, including the requirement for a same specialty peer reviewer; and be it further

RESOLVED, that MSSNY advocates for the enforcement of mechanisms within the regulatory framework to hold insurance companies accountable for unjustified denials, including penalties for repeated violations; and be it further

RESOLVED, that a similar resolution be brought to the AMA.

References:

Existing MSSNY Policy:

120.925 Peer-to-Peer Reviews by Insurers
The Medical Society of the State of New York will seek legislation to change peer to peer review by insurers to include evidence-based criteria publicly available and to be conducted by a physician of the same specialty and responded to the physician practice on a timely basis via fax or electronically. This legislation should also limit peer to peer and prior authorization reviews to only those cases that do not fall within the evidence-based criteria.
(HOD 2017-252; Reaffirmed HOD 2020-270; Reaffirmed HOD 2023-106)

165.849: Lack of Transparency in Insurers' Final Audit Findings
MSSNY should draft legislative proposals regarding third–party insurers' medical records audits, or work to amend existing proposals, to require that when a final audit finding is accompanied by a refund demand, the insurer must at least state: (a) the identity and medical qualifications of the insurer reviewer; (b) the standards of medical practice and medical record documentation that the reviewer used; (c) the source(s) of any utilization statistics or peer group activities cited; (d) a detailed, patient–by–patient analysis of the alleged insufficiencies in the documentation, including alleged insufficiencies in the documentation of history, exam, and medical decision making; and (e) the full text of the insurer's most recent in-house policy regarding each service under review. (HOD 2013-258; reaffirms Policies 165.861 and 165.992; Reaffirmed HOD 2023)

310.996 Third-Party Payer Use of Unsubstantiated Demand and Refund Letters:
MSSNY will seek amendment to the New York State Insurance Law to address the issue of payer demand letters, and to reflect the following provisions: 1) the physician should have the right to due process, should have access to all pertinent carrier documents, and should have the right to review the post-payment audit sample with appropriate carrier personnel; 2) in post-payment reviews, carriers should not retroactively apply new policy to old claims; 3) where the amount in dispute exceeds $1,000, physicians should have the right to have an independent entity not employed by the third-party payer (such as a Peer Review Organization or the American Arbitration Association) review the results of the carrier's post-payment review; and 4) third-party payers should not seek repayment through the claims offset process until the physician has exhausted all appeals, and until an accurate overpayment amount has been established. (HOD 2000-279; Reaffirmed HOD 2010-259; Reaffirmed HOD 2020)

130.950 Credentials for Doctors Reviewing Appeals to Insurers
MSSNY will advocate for a change in law or regulation which requires physicians who hear appeals regarding payment for imaging studies be licensed and actively practicing clinical medicine in New York State and that such company physician be of a specialty satisfactory to the appealing physician for a particular case. (HOD 2012-111; Reaffirmed HOD 2022)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 61

Introduced by: Ninth District Branch
(Dutchess, Orange, Putnam, Rockland and Westchester Counties)

Subject: Inappropriate use of the federal IDR process

Referred to: Reference Committee on Governmental Affairs A

Whereas, the Federal independent dispute resolution (IDR) process was created to prevent patients from receiving unexpected medical bills from out-of-network providers (surprise billing); and

Whereas, patients with insurance select plans knowing that out-of-network fees may not be covered; and

Whereas, patients have the right to request services from physicians for non-emergent procedures; and

Whereas, those physicians may or may-not be in-network for each patient; and

Whereas, patients sign informed consents for non-emergent procedures performed in emergency, inpatient, outpatient or ambulatory settings, which clearly state the physician is out-of-network; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) work with the American Medical Association (AMA) to seek through legislation and/or regulation to codify that the Federal IDR process may not be utilized to negotiate payment for non-emergent procedures when a patient has signed a consent form stating they understand the physician is out-of-network and accept the charges; and be it further

RESOLVED, That MSSNY work with the AMA to seek through legislation and/or regulation that if the insurance company accesses the IDR process in such a situation that they be subject to a fine to be paid to the physician in addition to any costs incurred by the physician over and above the original fee; and be it further

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

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 62

Introduced by: New York County Medical Society

Subject: Combating Consolidation in Healthcare

Referred to: Reference committee on Governmental Affairs A

Whereas, Documented by numerous studies, only a few of which are cited below, the healthcare legislation of the last 15 years introducing value-based payment models has resulted in the worst possible outcome -- higher costs and declining quality of care; and

Whereas, This feat has primarily been accomplished through the myriad incentives that value-based payment models have created encouraging health system consolidation, and massive private equity acquisitions of physician practices and hospitals, resulting in reduced competition and higher prices; and

Whereas, For example, insurers have vertically integrated (merging with, or acquiring, pharmacy benefit managers (PBMs), retail and specialty pharmacies) in such a way as to be able to shift profits to their affiliates, dodging Obamacare's Medical Loss Ratio requirements; and

Whereas, For another example, physicians and hospitals have been bought out by private equity organizations, as they can no longer handle today's regulatory burdens, requiring more management expertise to survive the value-based care environment; and

Whereas, Medical costs are significantly higher for medical practices and hospitals that are part of health systems or private equity groups, than for independent medical practices and solo community hospitals; and

Whereas, This issue is beginning to be recognized by Congress - Senators Elizabeth Warren (D., Mass.) and Mike Braun (R., Ind.) have urged the Department of Health and Human Services to examine the vertical integration of healthcare companies that results in sky-high drug prices therefore, be it (www.warren.senate.gov/imo/media/doc/2023.11.21%20Letter%20to%20HHS%20OIG%20regarding%20MLR%20evasion.pdf);

RESOLVED, That the Medical Society of the State of New York request that the AMA urge Congress to enforce antitrust laws and to remove the incentives for health systems and private equity firms to buy up physician practices and hospitals that result in monopolistic pricing of healthcare services; and be it further

RESOLVED, That the Medical Society of the State of New York request that the AMA urge Congress to examine the cost-benefit analysis approach used by current value-based physician and hospital payment programs, eliminate programs that are spurring consolidation, and halt the implementation of new alternative payment models that are likely to increase consolidation.

References:

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Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 63

Introduced by: Phillip Gioia, MD, MPH, Cayuga County Delegate

Cayuga County Delegation

Subject: Ask NYS to Expand Medicaid 1332 Waiver to Immigrants

Referred to: Reference Committee on Governmental Affairs A

Whereas, New York State submitted a 1332 innovation waiver only requesting funding to increase the qualifying poverty level from 200% to 250% of the Federal Poverty Level (FPL), excluding immigrants; and

Whereas, Center for Medicare and Medicaid Services (CMS) has responded that it is allowable to spend surplus money to expand health coverage to New Yorkers, regardless of immigration status; and

Whereas, Colorado and Washington State have both requested and been approved for a Federal 1332 Waiver that utilizes the federal surplus pass-through account to fund health insurance coverage for undocumented immigrants; and

Whereas, The Senate acted to require the state to do this when they passed last session's S2237A, but the Assembly failed to pass the corresponding bill A3020A; and

Whereas, This waiver is essential for the health of communities across New York State, as well as for the financial health of safety net hospitals that care for the majority of immigrants without insurance; therefore be it

RESOLVED. That the Medical Society of the State of New York (MSSNY) ask New York State (NYS) to amend the May 12, 2023, State Innovation 1332 Waiver to expand the Essential Plan to New Yorkers regardless of immigration status, and/or fund comprehensive health insurance for all low-income New Yorkers regardless of immigration status in the 2024 Executive Budget.

References:

MSSNY Position Statements:
95.969 Healthcare is a Fundamental Human Good
https://www.positionstatements.mssny.org/table-of-contents/95-000-ethics/
265.806 Complexity of US Healthcare System – MSSNY & AMA Communications
https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/ Health insurance coverage for all immigrants improves access to care.
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2809604 Providing insurance to immigrants costs the health care system less than half the corresponding cost for US-born adults ($3800 vs $9428 per person per year).

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 64

Introduced by: NASSAU COUNTY

Subject: ADDITIONS TO MEDICARE BENEFITS

Referred to: Reference Committee on Governmental Affairs A

Whereas, traditional Medicare covers over 50% of the eligible population; and

Whereas, dental care in this population is often ignored due to lack of coverage; and

Whereas, vision and dental issues negatively impact other comorbidities common in this population including increased cardiac and cerebrovascular events; and

Whereas, many people qualified for Medicare elect nontraditional insurance products -i.e. Medicare part C or Advantage which include these benefits; and therefore be it

RESOLVED, that CMS be urged to provide adequate dental and vision care to those on traditional Part B Medicare at minimal cost to the insured; and be it further

RESOLVED, that this resolution be adopted by the AMA at its 2024 spring annual meeting.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 65

Introduced by: NASSAU COUNTY

Subject: MEDICARE COVERAGE FOR NONPAR PHYSICIANS

Referred to: Reference Committee on Governmental Affairs A

Whereas, not all physicians participate in the Medicare program; and

Whereas, certain specialties as well as physicians in certain geographic regions have opted out of CMS insurance products due to reimbursement rates well below the level needed to provide adequate care; and

Whereas, traditional Medicare provides freedom of physician choice for its insured; and

Whereas, many non-governmental insurance products exist that provide out of network benefits albeit at some potential cost to the insured beyond the level of reimbursement; and

Whereas, certain services such as mental health care are critical to good health and covered under Medicare; and

Whereas, these services are difficult, if not impossible, to find within the participating provider panels; and therefore be it

RESOLVED, that CMS allow patients to seek care from any physician regardless of their participating status; and be it further

RESOLVED, that patients be reimbursed at least to the extent that they would be if the physician were a participating Medicare provider; and be it further

RESOLVED, that supplemental policies reimburse the usual 20% of the approved Medicare amount.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 66

Introduced by: New York County Medical Society

Subject: AMA Task Force to Design an Alternative to the Merit-based Incentive Payment System (MIPS)

Referred to: Reference Committee on Governmental Affairs A

Whereas, MIPS is an administratively costly program that has failed as a strategy to improve the quality of care and has had many negative unintended consequences; and

Whereas, Based on 2019 data, before full program implementation, MIPS required a considerable investment in time and financial capital -- approximately 200 hours and $12,811 (IQR, $2,861-$17,715) annually per physician; thus, this is likely an underestimate of today's costs[1]; and

Whereas, A November 2023 JAMA study of 49,901 surgeons revealed that 78% of surgeons participating in MIPS in 2021 received quality scores qualifying them for a median positive payment adjustment of $1,341 (IQR, $210-$3120).[2] These adjustments do not compensate for the financial costs of participation and the significant diversion of physicians from patient care; and

Whereas, Independently practicing physicians had significantly lower MIPS performance scores than physicians affiliated with better resourced health systems[3]; and

Whereas, Physicians caring for more medically and socially vulnerable patients received significantly lower MIPS scores despite providing high-quality care, punishing them for factors outside of their control.[4] Thus, MIPS will serve to increase healthcare disparities by transferring resources from poorer patients to the most affluent; and

Whereas, A 2022 study demonstrated that the MIPS program is ineffective at measuring and incentivizing quality improvement[5]; and

Whereas, MIPS is inconsistent with physician professionalism, is perceived as manipulative and fails to harness what motivates physicians most – mastery, purpose and autonomy;[6] therefore, be it.

RESOLVED, The Medical Society of the State of New York requests the AMA to create a task force to design an alternative to MIPS, as the evidence of the program's tremendous costs, ineffectiveness, and harmful effects is overwhelming; and be it further

RESOLVED, The Medical Society of the State of New York requests the AMA to advocate for eliminating MIPS If a workable alternative is not feasible, as no program is preferable to an ineffective or harmful one.

References:

1.Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. JAMA Health Forum. May 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527

2. Maganty A, Shah AA, Hill D, Golla V. Financial Implications of the Merit-Based Incentive Payment System for Surgical Health Care Professionals. *JAMA Surg.* Published online November 22, 2023. doi:10.1001/jamasurg.2023.5638

3. Johnston KJ, Wiemken TL, Hockenberry JM, Figueroa JF, Joynt Maddox KE. Association of Clinician Health System Affiliation With Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA.* 2020;324(10):984–992. doi:10.1001/jama.2020.13136

4. Khullar D, Schpero WL, Bond AM, Qian Y, Casalino LP. Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System. JAMA. Sep 8 2020;324(10):975-983. doi:10.1001/jama.2020.13129

5. Bond AM, Schpero WL, Casalino LP, Zhang M, Khullar D. Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes. *JAMA.* 2022;328(21):2136–2146. doi:10.1001/jama.2022.20619

6. Khullar D, Wolfson D, Casalino LP. Professionalism, Performance, and the Future of Physician Incentives. JAMA. 2018;320(23):2419-2420. doi:10.1001/jama.2018.17719

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 67

Introduced by: Medical Society of the County of Kings & Lisa Eng, DO
New York County Medical Society
Richmond County Medical Society

Subject: Medicare "Dis" Advantage

Referred to: Reference Committee on Governmental Affairs A

Whereas, Medicare Advantage- MC/MCAID patients are being recruited heavily and given Over The Counter (OTC) cards giving monthly credit for supplies, gifts and food. Meanwhile if you have MA and have earned a good income and paid your Social Security and Medicare obligations via deductions to your paycheck while working, you are subjected to exorbitant co-pays for services for which the Insurance companies previously paid. For example, since last January UHC AARP patients and other lines of MAdvantage - supplemental business (Not MCAID for the 20 %) have had to pay for TRUS prostate ultrasound and Pelvic ultrasound co- pays. This will increase in 2024 to $130 for each as per UHC. The copays vary for commercial insurance also and it is impossible to keep track of how much to collect. The senior patients often state that they can't afford to pay for these necessary services, and this often affects the physician-patient relationship. In the end physicians lose significant collectables which were previously part of the insurance payment for ultrasounds; and

Whereas, approximately 28 million U.S. residents are signed up for Medicare Advantage plans across the nation. This means that about 44% of all 64 million people eligible for Medicare are enrolled in Medicare Advantage plans – a number called the "Penetration Rate." In NYS the penetration is about 48%. As of December 2021, Minnesota's Aitkin County boasted the top penetration rate in the 50 U.S. states, with 81% of all Medicare-eligible citizens are enrolled in Medicare Advantage plans; and

Whereas, these plans often have smaller networks of doctors and hospitals than traditional Medicare, which can limit the choice of providers available to patients. This can be frustrating for doctors who want to provide the best possible care for their patients by providing referrals but are constrained by the limitations of the plan. When a Medicare Advantage plan offers a limited network, receiving a referral to the best specialist may be more difficult than anticipated; and

Whereas, these plans put the patients' financial risk in the hands of the doctor. The Medicare Advantage plan carrier will pay the doctor a set amount of money upfront based on a diagnosis. So, the only way the physician will make a profit is if they stay under budget. This encourages doctors to provide cost-effective care that may create pressure to prioritize cost over care. The complex billing and reimbursement process with Medicare Advantage plans is also a common downfall in the eyes of a physician. In addition to needing to stay under budget when providing care, Medicare Advantage plans often have different payment structures and rates than traditional Medicare, which can make it difficult for doctors to understand how they will be paid for their services.

Whereas, these plans often require prior authorization for certain treatments or procedures. This means that doctors must get approval from the insurance company before they can perform certain tests, procedures, or treatments. Obtaining prior authorization can be extremely time-consuming and can delay the delivery of care, which can be frustrating for both the doctor and

the patient. There can be high out-of-pocket costs and the plan benefits change annually and constant need for referrals and approvals; therefore be it

RESOLVED, MSSNY should consider a task force with CMS to examine the aggressive marketing and practice of MA and MAPD plans to recruit patients without truthfully letting them know the pros and cons in a manner and language they can understand; and be it further

RESOLVED, MSSNY, AMA and NYS DOH should consider looking into the Shared Savings contracts between the MA insurers with physicians and consider if this is fee splitting, collusion and undue enrichment of the health plans and the provider in a manner that punishes or discourages care for the patient in the best manner with appropriate testing, appropriate services and medications; and be it further

RESOLVED, MSSNY in the interest of patient protection consider an education program directed at patients to fully understand where every dollar from CMS goes – how much and what contract incentives there may be for their provider groups or individuals.

References:

Why Medicare Advantage Plans Are Bad (medicarefaq.com)

Evaluation of Spending Differences Between Beneficiaries in Medicare Advantage and the Medicare Shared Savings Program | Health Policy | JAMA Network Open | JAMA Network

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 68

Introduced by: Phillip Gioia, MD, MPH, Cayuga County Delegate
Fifth & Sixth District Medical Societies

Subject: MSSNY Supports The AMA work to Improve Medicare

Referred to: Reference Committee on Governmental Affairs A

Whereas, The percentage of excess payments in MA (Medicare Advantage) accounting for all of the discussed factors excluding induced utilization amounts to anywhere from 22-26%. In 2022, this would be $88- 104 billion; and

Whereas, With induced utilization by MA, the overpayment amount to MA increases to 31-35%, or $124-$140 billion in 2022; and

Whereas, Improved Medicare with caps on spending and long-term care would cost less than MA; and

Whereas, Medicare for All with improved/negotiated payments for providers and coverage for all would with expanded services would save money by cutting corporate excess profits and fraud; and

Whereas, Administrative costs and profits of MA will cause decrease payments to healthcare providers; therefore be it

RESOLVED, That the Medical Society of the State of New York supports the American Medical Association in its work to eliminate Medical Advantage plans and use the savings to better pay healthcare providers and provide better benefits to patients. - and be it further

RESOLVED, That MSSNY ask the AMA to advocate for Medicare for All for further savings, better payments to healthcare providers, and better coverage for all age groups.

References

MSSNY Position Statements https://www.positionstatements.mssny.org/195-910-medicare-advantage-plan-transparency/ supports legislation and administrative rulemaking that would prohibit the use of the term “Medicare” for a private insurance entity for health care and support legislation such as the “Save Medicare Act” and similar legislative efforts.

MSSNY Policy- 130.929 Health System Improvement Standards

MSSNY Policy- 130.926 Collective Bargaining by Physicians

Sec. 612 of Medicare for All Act. “(d) Physician Practice Review Board.—Each director of a regional office, in consultation with representatives of physicians practicing in that region, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for physician-delivered items and services. The use of mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-

effectiveness assessments." https://www.congress.gov/bill/118th-congress/senate-bill/1655/text?s=1&r=1&q=%7B%22search%22%3A%22Medicare+for+all+Act%22%7D
https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html

https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf?eType=EmailBlastContent&eId=275f581c-67c5-4eff-846f-4424e8459a3f Report on Medicare Advantage costs, plans to save

Congressional Budget Office, "Budgetary Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act," December 10, 2019, https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf , 10-11.

https://www.nytimes.com/2023/02/21/opinion/medicare-social-security.html?searchResultPosition=3 Paul Krugman believes that Medicare is sustainable

https://jayapal.house.gov/2023/05/17/jayapal-dingell-sanders-introduce-medicare-for-all-with-record-number-of-house-cosponsors/#:~:text=The%20Medicare%20for%20All%20Act%20of%202023%20also%20includes%20universal,based%20care%20over%20institutional%20care. Also see https://PNHP.org

https://jamanetwork.com/journals/jama/article-abstract/2801097 Salve Lucrum: The Existential Threat of Greed in US Health Care, Donald M. Berwick, MD, MPP1

https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/ "A quarter of adults with health care debt owe more than $5,000. And about 1 in 5 with any amount of debt said they don't expect to ever pay it off."

https://www.thebalancemoney.com/medical-bankruptcy-statistics-4154729 "The KFF found that wage increases are not keeping up with rising health care costs—medical insurance premiums increased 54% while earnings have increased by only 26% since 2009."

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 69

Introduced by: Phillip Gioia, MD, MPH, Cayuga County Delegate

Subject: Advocate for a Single Payer Health Plan for All with Better Care and Lower Costs

Referred to: Reference Committee on Governmental Affairs A

Whereas, The United States of America ranks 11th in health outcomes among the top 11 industrial nations yet spends the most per capita for health; and

Whereas, The Medical Society of the State of New York has advocated for access to health care for all and a better working environment for physicians; and

Whereas, The NY District of the AAP has advocated for a single payer health plan for our state for many years; and

Whereas, State health plans will be difficult to administer and finance with current laws and regulations such as ERISA for large and multistate corporations; and many states fail to promote health care for their poor children and families; and

Whereas, Economies of scale and negotiations for products and services will be most favorable with a national health plan; therefore be it

RESOLVED, The Medical Society of the State of New York and/or The American Medical Association advocate to support modifications to the federal ERISA and other Federal Laws to help implement any state health plans; and be it further

RESOLVED, That MSSNY advocate for better healthcare for all with a health plan for the United States of America covering all in a sustainable way.

References:

https://jamanetwork.com/journals/jama/article-abstract/2801097 Salve Lucrum: The Existential Threat of Greed in US Health Care, Donald M. Berwick, MD, MPP1

Sec. 612 of Medicare for All Act. "(d) Physician Practice Review Board.—Each director of a regional office, in consultation with representatives of physicians practicing in that region, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for physician-delivered items and services. The use of mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments." https://www.congress.gov/bill/118th-congress/senate-bill/1655/text?s=1&r=1&q=%7B%22search%22%3A%22Medicare+for+all+Act%22%7D

https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/ "A quarter of adults with health care debt owe more than $5,000. And about 1 in 5 with any amount of debt said they don't expect to ever pay it off."

https://www.thebalancemoney.com/medical-bankruptcy-statistics-4154729 "The KFF found that wage increases are not keeping up with rising health care costs—medical insurance premiums increased 54% while earnings have increased by only 26% since 2009."

https://www.commonwealthfund.org/publications/issue-briefs/2023/feb/reforming-erisa-help-

states-control-health-care-costs ERISA's effect on limiting state health plans.
From the National Academies of Science, Engineering and Medicine (NASEM) - Many physicians and healthcare providers are stressed daily by the administrative burdens of multiple payers that require records, billing constraints, reports, prior authorizations, formulary restrictions, and limited referrals and subspecialty care. Many record systems exist without adequate integration and functionality to easily deliver and document high quality care, and communicate to colleagues, patients, families, preventive services, and community institutions to best promote the health of our patients. Actions now for health system transformation are needed also to help the government and the providers of care to deal with current and future environmental and health threats to children and their families, as recommended by NASEM.
https://nap.nationalacademies.org/catalog/26657/emerging-stronger-from-covid-19-priorities-for-health-system-transformation

https://en.wikipedia.org/wiki/Wendell_Potter Nation on the Take, & Deadly Spin books

http://mikemagee.org/code-blue-review/ an insider physician advocates for change.

https://www.nimhd.nih.gov/news-events/research-spotlights/medicaid-expansion-benefits-young-adults.html#:~:text=Overall%2C%20researchers%20found%20that%20the,the%20number%20of%20uninsured%20patients. Shows benefits of Medicaid Expansion for the young and minority groups.

https://www.commonwealthfund.org/medicaid-expansion?redirect_source=/topics/current-issues/medicaid-expansion also risks for contraction of Medicaid with COVID-19 emergency end.

https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html reasons to avoid Medicare Advantage and REACH for in a national plan

https://www.rand.org/pubs/research_reports/RR2424.html more care, less costs with NY Health Act

Health and Sustainability: An Introduction by Tee L. Guidotti Oxford University Press 2015

Existing MSSNY Policy:
MSSNY Policy- 130.929 Health System Improvement Standards

MSSNY Policy- 130.926 Collective Bargaining by Physicians

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 70

Introduced by: Brien Maney, Zucker School of Medicine at Hofstra/Northwell

Subject: Expanding MSSNY's Position on Healthcare Reform Options

Referred to: Reference Committee on Governmental Affairs A

Whereas, Our MSSNY supports basic health insurance coverage for all New Yorkers (120.919); and

Whereas, Our MSSNY recognizes that "the current health care delivery system model has proven ineffective at the goals of cost containment, improved access, and improved outcomes" (110.994); and

Whereas, Over one million New Yorkers remain uninsured leading to reduced access to care, extraordinary financial burdens placed on patients, lower quality of care, and a system of perpetual inequities[1-4]; and

Whereas, unified financing refers to any system of healthcare financing that provides uniform and universal access to healthcare coverage that is high quality and affordable, which can include single payer or multi-payer systems based on managed competition between private insurers; and

Whereas, evidence shows that single payer proposals can address salient challenges in our medical system[5-11] and can ensure equitable, universal, and timely access to high quality care by simplifying our fragmented system and placing decision making power back in the hands of physicians and patients[12,13]; and

Whereas, evidence suggests that single payer health insurance can improve financing for physicians in rural areas through removal of systemic biases[14,15], reduce prior authorization burden[16], reduce administrative expenses[17], and can improve health equity through reducing disparities in health insurance coverage and health care access, with greatest relief to lower-income households[18,19]; and

Whereas, evidence suggests that a single-payer system in New York State will expand health care coverage without increasing overall spending, reduce administrative costs, decrease health care payments for 90% of New Yorkers, and maintain current physician payment rates[20]; therefore be it

RESOLVED, That our Medical Society of the State of New York (MSSNY) adopts a neutral stance regarding single-payer health insurance; and be it further

RESOLVED, That our MSSNY evaluate all nationwide and statewide healthcare system reform proposals based on our stated principles as in MSSNY policy; and be it further

RESOLVED, That our MSSNY support a unified financing healthcare system that meets the principles of freedom of choice, freedom and sustainability of practice, and universal access to quality care for patients.

References:

1. "Narrowing New York's Health Insurance Coverage Gap." The Citizens Budget Commission (CBC), Jan. 2022, https://cbcny.org/research/narrowing-new-yorks-health-insurance-coverage-gap
2. "The State of U.S. Health Insurance in 2022." *State of U.S. Health Insurance in 2022: Biennial Survey | Commonwealth Fund*, 29 Sept. 2022, www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey.
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10. Wallace, Zachary S, et al. "Treatment Delays Associated With Prior Authorization for Infusible Medications: A Cohort Study." *American College of Rheumatology*, Sept. 2019, onlinelibrary.wiley.com/doi/abs/10.1002/acr.24062.
11. "2022 AMA Prior Authorization (PA) Physician Survey." *AMA*, 2023, www.ama-assn.org/system/files/prior-authorization-survey.pdf.
12. Morra, Dante, et al. "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers." *HealthAffairs*, Aug. 2011, www.healthaffairs.org/doi/abs/10.1377/hlthaff.2010.0893?journalCode=hlthaff.
13. Markowitz W, McLeod-Sordjan R. Values-Based Foundation for a U.S. Single Payer Health System Model. Front Sociol. 2021 Apr 28;6:627560. doi: 10.3389/fsoc.2021.627560. PMID: 33996990; PMCID: PMC8113613.
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Existing MSSNY Policy:

Lowering Health Care Costs - 110.982
MSSNY will continue to work together with the AMA to advocate for measures that help reduce healthcare costs including but not limited to the following areas:

(a) ensuring a health care delivery environment where physicians can have a meaningful choice of whether to be in private practice or health system-employed;

(b) ensuring meaningful patient choice of health insurance coverage options in all regions of New York State;

(c) increasing patient access to needed prescription medications and reducing PBM interference;
(d) reducing litigation;

(e) reducing administrative and regulatory burdens that interfere with patient care delivery.

MSSNY will continue to work together with the AMA to advocate for measures that help reduce healthcare costs including reducing obesity and managing chronic conditions.

MSSNY will continue to work together with the AMA to more fully educate legislators, the media and the public generally of data showing that spending on physician services represents only a small component of overall health care costs. (HOD 2020-63; referred to Council; substitute resolution amended and adopted by Council 1/14/21)

Health Care Reform Based Upon Evidence Not Ideology - 110.994
In recognition that the current health care delivery system model has proven ineffective at the goals of cost containment, improved access, and improved outcomes, MSSNY should actively engage in pursuit of a new health care delivery system model that is primarily based upon

evidence which supports these stated objectives, and not reforms based just upon political or economic ideology. (HOD 2007-103; Reaffirmed HOD 2017)

MSSNY Statement on Increased Health Insurance Deductibles - 120.918
MSSNY supports health insurance coverage that is affordable and usable for patients in terms of premium, deductible, coinsurance and/or copayment. (HOD 2017-59, referred to Council, substitute adopted June, 22, 2017)

Access to Timely Care - 120.945
The Medical Society of the State of New York will advocate for legislation or regulation to assure the right of a patient to have insurance coverage which permits them to be treated by an out of network physician of the patient's choice if the plan network is inadequate to enable a patient to be treated by a needed specialist within 14 days of the patient's request, with payment based upon usual and customary rates. (HOD 2014-60)

Health Coverage Coalition for the Uninsured - 120.970
MSSNY approves the conclusions of the Health Coverage Coalition for the Uninsured and express its concern that additional issues of significance should be also addressed by HCCU including but not limited to the burdensome cost associated with the administration of current health care coverage, the need for redress of the medical liability problem, and the need to obtain leverage in the health care market through collective negotiation. (Council 3/5/07; Reaffirmed by Council 11/29/2012 in lieu of 2012-260; Reaffirmed HOD 2022)

Healthcare Delivery System Including Single Payer Insurance - 130.931
MSSNY will continue to consider the feasibility of other payment methodologies including single payer and will also continue to work collaboratively with physicians who both support and oppose such proposals in order to assess the strengths and weaknesses of such proposals. MSSNY will continue to advocate that physicians are ensured direct input and ongoing involvement on all aspects of any single payer system or other system that may be considered by the New York State Legislature or United States Congress. Among the critical aspects that should be considered and included: the ability of patients to receive needed quality care and medications in a timely manner; whether the administrative burden to physicians of participation and facilitating needed patient care in such a system are an improvement from, or worsening of, existing systems; and whether the payment methodology is and will continue to be fair to physicians regardless of practice setting or specialty.(Adopted Council Nov, 2017 [sub res for 2017-62 & 63]; Reaffirmed HOD 2019 in lieu of resolution 69; 2019-70 Referred to Council, amended and adopted 11/2019; Reaffirmed HOD 2020-61; HOD 2021-57 and 2021-58 reaffirmed by Council 3/9/22 in lieu of resolutions; Reaffirmed HOD 2023 in lieu of Resolutions 66 and 67)

Long Term Care – The Impending Crisis - 130.935
The Medical Society of the State of New York recognizes the crisis of long term health care financing and will look for innovative programs which would balance individual responsibility for long term health care costs and society's role in making long term health care insurance available to all. It is the position of the Medical Society that people should be allowed to purchase long term care insurance with continued positive and no negative tax implications and those who exhaust private insurance benefits be automatically enrolled in the Medicaid program without a need to spend down their assets.

The Medical Society of the State of New York work will work with the AMA to support a public option to cover the long term health insurance needs of all Americans through a Long Term

Health Insurance Trust Fund financed with fees paid by all Americans during their lifetime. (HOD 2014-115)

Reducing Prior Authorization Burden and Separate Payment When Not Part of a Patient Encounter - 120.897

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.

MSSNY Support of Universal Health Insurance - 120.919

The Medical Society of the State of New York will advocate for legislation to ensure that all New Yorkers have at least basic health insurance coverage. (HOD 2017-64)

MSSNY Preparation for the New York Health Act - 130.927

MSSNY will create a Task Force to evaluate potential legislative changes in health care reimbursement and coverage methodology. (HOD 2020-61)

Health System Improvement Standards 130.929

MSSNY will advocate for health care reform proposals that would achieve the following goals:

- Reduce the number of uninsured;
- Reduce barriers to insured patients receiving needed health care including assuring full transparency of patient-cost sharing requirements, preventing unjustified denials of coverage, assuring comprehensive physician networks including through fair reimbursement methodologies, and providing meaningful coverage for out-of-network care;
- Reduce administrative burden on physicians;
- Prevent imposition of new costs or unfunded mandates on physicians;
- Provide needed tort reform; and
- Provide meaningful collective negotiation rights for physicians.

This resolution will be transmitted to the American Medical Association for consideration at its next House of Delegates meeting. (HOD 2019-71)

MSSNY Single Payer Healthcare Survey - 130.934

MSSNY, with input from the medical student section, design and conduct an objective poll by email of the collective opinion of MSSNY members and non-members ascertaining both their knowledge of the single payer health care system and their support or opposition of such a system in the State of New York. (HOD 2014-109)

Universal Health Care: - 130.969

MSSNY opposes funding universal health insurance through decreased reimbursement, or any tax on physicians. (HOD 2007-105; Reaffirmed HOD 2017)

MSSNY Openness to Health Care System Reform: 130.972

MSSNY policy on health care system reform be that of consideration and study of all and any new proposals in the health care arena likely to benefit the general public and the medical profession. (HOD 2005-202; Reaffirmed HOD 2015)1

Health System Reform – MSSNY Principles - 130.987

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); Reaffirmed HOD 2021):

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.)

Single Payer Reimbursement System – Opposition To: 130.996

MSSNY is opposed to universal health care proposals with single-payor reimbursement systems. It reaffirms the position reflected in its Universal Health Plan (UHP) Proposal for improving the U.S. Health Care System which call for: (1) Retention of the present multiple payor system with tighter oversight mechanisms to enhance administrative controls and cost efficiencies; (2) Free-market competition as a stabilizing factor in choosing among a multiplicity of health insurers offering a standard and appropriate benefits package. (HOD 1992-13; Reaffirmed HOD 2014; Reaffirmed Council Nov 2017 [res 2017-62 & 63]; Reaffirmed HOD 2019 in lieu of resolution 69)

2024 HOUSE OF DELEGATES
MEDICAL SOCIETY OF THE STATE OF NEW YORK
Report of Recommendations for Sunset of Policy

Referred to: **Reference Committee on Governmental Affairs – B**
Dr. Bruce Molinelli, MD, Chair

Mister Speaker, Your Reference Committee recommends that the policies contained in the 2024 Governmental Affairs B Sunset Report be acted upon in the manner indicated and that the remainder of this report be filed:

ITEMS RECOMMENDED FOR SUNSET

70.972 Require Pharmacies to Print the Expiration Dates of Medications on All Prescription Labels
MSSNY will support legislation to require that expiration dates of prescribed drugs be listed on the package for consumers, and to provide for enforcement of such provisions by the New York State Attorney General, and MSSNY will ask its delegation to propose a similar resolution to the American Medical Association. (HOD 2000-162; Reaffirmed HOD 2014-65)
RECOMMENDATION: Sunset as New York State now requires expiration dates of all prescriptions on labels.

70.982 Optometrists Prescribing Drugs
MSSNY opposes legislation which would permit optometrists to administer or prescribe drugs for treatment of patients. (HOD 1992-39; Reaffirmed HOD 2014)
RECOMMENDATION: Sunset as the legislature passed a bill in 2021 to allow optometrists to prescribe.

110.989 Long Term Care-Scope of Problem
The Medical Society of the State of New York (MSSNY) will urge the New York State Department of Financial Services to develop an educational program on long term health care financing and MSSNY will request that the New York State Department of Financial Services promote and make this program available to all New Yorkers. (HOD 2014-165)
RECOMMENDATION: Sunset, as DFS currently offers a range of educational information to consumers including long term care financial issues. Consumer Home Page | Department of Financial Services (ny.gov)

160.993 Self-Incriminating Questions on Application Forms by Licensing, Certifying and Credentialing Bodies
MSSNY takes the position that questions regarding past history of referral and treatment for alcohol and other drug disorders and mental and emotional illness should not be used on application forms by licensing, certifying, and credentialing bodies because it is not believed that such questions are pertinent to a physician's current ability to practice medicine but merely infringe on privacy matters. MSSNY is urging that such bodies instead ask a question regarding the applicant's current ability to practice medicine, such as: "Is your ability to practice medicine currently impaired by any physical, mental, emotional, alcohol or substance abuse disorder?" (Council 7/23/92; Reaffirmed HOD 2014)
RECOMMENDATION: Sunset, as New York no longer requires this information be disclosed.
Medscape Registration

ITEMS RECOMMENDED FOR REAFFIRMATION

70.973 Insurance Companies, Pharmacies and Pharmaceutical Benefits Management Companies (PBMs) Should Not Require a Diagnosis in Order for Patient Prescriptions to Be Filled
MSSNY will advocate for legislative/regulatory relief, requiring pharmacies, any health plan and pharmaceutical benefits managers to fill prescriptions even if their patient's diagnosis is not divulged to them. (HOD 2000-83; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

25.999 Practice Standards
MSSNY has adopted policy that maintains that all physicians, including practitioners of alternative medicine, should be held to the same standards of practice and that this policy be utilized in educating our legislators and the general public regarding the problem. (HOD 1995-66; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

10.990 Low Beam Headlights
In an effort to reduce multi-vehicle accidents, MSSNY encourages the use of low beam headlights on all present vehicles. The Society favors the installation on all vehicles sold in the United States by foreign and domestic manufacturers of a system which will automatically turn on low beam headlights with the ignition switch. (HOD 1987-77; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

35.997 Limited License Practitioner - Physician Relationship
Whether a physician should have professional relations with chiropractors must be the individual choice of the physician, based on what the physician believes is in the best interest of the patient. As with any limited license practitioner, a physician should be mindful of state laws which prohibit a physician from aiding and abetting a person with limited license in providing services beyond the scope of his license. (Council 1/26/89; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

35.998 Hospital Privileges for Chiropractors - Opposition to.
MSSNY vigorously opposes the enactment of legislation which would permit the practice of chiropractic by chiropractors in hospitals. (HOD 1988-72; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.
70.993 "Look-Alike" Drugs
MSSNY encourages federal legislation prohibiting the manufacture, sale, distribution or gift of substances which look like controlled substances ("Look-alikes"). MSSNY supports stricter legislation controlling the advertising and sale of "Look-Alike" medications. (Council 12/13/84; Reaffirmed HOD 2013*)*
RECOMMENDATION: Retain, the policy is still relevant.

70.994 Qualitative Labeling of All Drugs
MSSNY strongly supports efforts to promote qualitative drug labeling of all drugs, requiring the active and inactive ingredients of all drugs (over-the-counter as well as prescription) to be listed on the label or package insert for the drug. (Council 12/13/84; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

70.995 Generic Drug Labeling
All generic medications should have an identifying number or symbol. (Council 12/13/84; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

90.997 Polystyrene and Polyvinyl Chloride Products for Packaging
MSSNY opposes the use of polystyrene and polyvinyl chloride products for all retail food packaging in New York State. (HOD 1989-40; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

90.999 Radioactive Waste, Disposal of Low Level
MSSNY supports low-level radioactive waste disposal providing it contains the following principles: (1) A disposal site must be promptly identified; (2) Low level wastes should be segregated from high level wastes; (3) Long term monitoring of such disposal must be included (4) The costs of such disposal must be borne by those disposing of the wastes; (5) The environment and the health, safety and welfare of those inhabiting nearby areas must be protected. (HOD 1985; Modified and Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

115.987 Healthcare Provider Representation and Patient Protection

MSSNY endorses the enactment of legislation that would establish requirements for all licensed health care providers who deliver direct care in an Article 28 licensed hospital, ambulatory surgical center, diagnostic and treatment center, or private physician's office that is accredited (OB), to wear identification badges that in addition to current State Education Department identification requirements, also contain large bold lettering indicating the practitioner's licensure (i.e. PHYSICIAN, RN, NP, PA, etc.). (HOD 2013-113) **RECOMMENDATION: Retain, the policy is still relevant.**

117.984 Electronic Health Record Problems

MSSNY will work with New York's congressional delegation, as well as encourage the AMA to work proactively with MSSNY, to assure that additional federal financial incentives are provided to encourage physicians to adopt EHR, and to assure that physicians who use cloud based electronic health record systems are indemnified for security breaches caused by defects in such systems. (HOD 2013-105)
RECOMMENDATION: Retain, the policy is still relevant.

130.938 Affordable Long Term Care Insurance

MSSNY's Long Term Care Committee should meet regularly with state officials to work toward the creation of affordable long term care insurance options with a clearly defined premium and benefit structure. (HOD 2013-115 and 116)
RECOMMENDATION: Retain, the policy is still relevant.

130.939 Initiation of the Physician Patient Relationship

MSSNY should establish as policy that the doctor patient relationship is formed when the physician first evaluates the patient and a consensual relationship has been initiated.
(HOD 2013-101)
RECOMMENDATION: Retain, the policy is still relevant.

135.994 Support of Three Point Legislative Plan for Home Care

MSSNY backs the *Three Point Plan to Support and Ensure Success Of State Redesign Efforts* (transition support, regulatory relief, and stable fiscal environment) and supports efforts to keep MSSNY's Long Term Care Subcommittee members informed of the progress being made in this endeavor. (HOD 2013-114) **RECOMMENDATION: Retain, the policy is still relevant.**

135.996 Home Health Care Services in New York State

The MSSNY Council adopted a position statement of Home Health Care Services in New York State which called on the State to develop a Home Care Policy Plan and to address the critical manpower shortage in home care. The position statement endorsed the following principles: (1) Home care enhances the quality of life, promoting independence and the availability of choice; (2) Home care should be accessible and available to all persons regard-less of their financial ability to pay; (3) Home care should maintain reasonable standards of quality care and be fully integrated with all the other components of the health care delivery system; (4) All orders emanating from home care agencies that pertain to the care and management of the individual patient should be under the direct supervision and control of the attending physician. This alludes to all orders for any type of medical care rendered to patients, particularly to those confined to the home. It is the responsibility of the individual physician to see that such orders are completely executed. (Council 7/21/88; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

135.997 Tax Deduction for Long Term Home Health Care

MSSNY supports legislation which would provide a New York State and federal tax deduction for individuals rendering home care to family members with a long-term illness. (HOD 1988-79; Reaffirmed HOD 2013) **RECOMMENDATION: Retain, the policy is still relevant.**

135.998 Elderly - Home Health Care

MSSNY supports the concept that reimbursement for home health care for the elderly be provided on a twenty-four hour a day basis, seven days a week, if required for the adequate care of the patient and to prevent the institutionalization of such patient for reasons not requiring institutional care. (HOD 1980-37; Reaffirmed HOD 2013) **RECOMMENDATION: Retain, the policy is still relevant.**

135.999 Home Health Care Services

MSSNY encourages the stimulation of physician interest in, and acceptance of home care as an integral part of the overall continuum of medical care. We also emphasize the need for medical schools and internship programs to educate medical students, interns, residents, and practicing physicians in the value and proper use of home health care programs. Hospital boards and medical staffs should encourage community interest in support of home health care programs. Community health planning agencies should have representation from organizations concerned with providing home care services; and practicing physicians should involve themselves in developing home health care programs along with community health planning agencies.

MSSNY supports the concept that all home health agencies, voluntary or proprietary, should be subject to the same controls, regulations, and standards. MSSNY also supports the concept that the physician is responsible for monitoring the home health care of his patients, or for the transferal of this responsibility to another physician. (Council 9/14/77; Reaffirmed HOD 2013)

RECOMMENDATION: Retain, the policy is still relevant.

145.999 Hospice Care

Hospice is provided at home or in freestanding hospice centers, nursing homes and other long term care facilities. Hospice is a concept of patient and family centered, designed to meet the physical, psychological, spiritual, and social needs of terminally ill patients and their families. This care shall be rendered by a physician-led inter-disciplinary team.

The goals of hospice care are: 1) Manages the patient's pain and symptoms; 2) Assists the patient with the emotional, psychosocial, and spiritual aspects of dying; 3) Provides needed drugs, medical supplies and equipment; 4) To support the family on how to care for the patient (5) Provides bereavement care and counseling to surviving family and friends. (Council 6/21/79; Modified and Reaffirmed HOD 2013)

RECOMMENDATION: Retain, the policy is still relevant.

150.998 Attending Physicians and Residents, Guidelines For

MSSNY adopted the following statement as part of its official position. It is a supplement to the *Guidelines for Attending Physicians and Residents Established by the New York Academy of Medicine.* Because optimum care of hospitalized patients often entails technically sophisticated treatment modalities, reliance on the expertise of specialists and consultants, and frequent clinical assessments and judgments by house officers or other designees of the attending physician, it is imperative to specifically indicate the authority and responsibility for decisions about treatment and management. Ethically and legally, the patient's freely selected attending physician possesses this authority and responsibility. Such action will strengthen the patient-physician relationship essential to the continuity of a patient's care. The patient's own physician clearly retains ultimate responsibility for patient management but close cooperation between his/her own physician and the involved house officers and specialist consultants is essential to provide the highest quality of patient care. Features of this cooperation should include at least the following:

(1) Ongoing discussions and review of the patient's course by the attending and other involved physicians.
(2) Explicit approval and/or supervision by the amending of invasive, hazardous, or complex diagnostic or treatment procedures.
(3) Explicit approval by the attending physician of the indications or requests for consultations, and of the choice of consultant.
(4) Recognition by the attending physician to contribute to the education, training and learning experience of the house staff.
(5) Conscientious efforts by the house staff and other involved physicians prompted to inform the attending physician of unexpected changes in the patient's condition or needs for treatment.
(6) Although there is recognition by both attendees and house officers that they share responsibility for writing orders, recording observations, or formulating analyses or treatment goals in the progress notes, the ultimate authority for patient care is the patient's attending physician.*

These guidelines will best serve the goal of optimum care for the patient and will enhance the quality training for young physicians. The attending physicians, hospital administrations, and house officers have the obligation to respect these guidelines and the attending physician shall candidly inform the patient of the roles of the various physicians in that patient's care. In such explanations, the patient's right freely to select his/her own physician must be maintained. No assignment of attending physician shall be made without prior discussion of available options with the patient and then only with his/her full knowledge and freely given consent. (HOD 1982-51; Reaffirmed HOD 2013)

The *Guidelines* of the New York Academy of Medicine are available, upon request, at the Society Headquarters in Westbury.

NB: Per General Counsel, this position statement was cited in the dissenting opinion in Somoza v. St. Vincent's Hospital 596 N.Y.S. 2d 789 (App. Div., 1st Dept., April 22, 1993). The majority decision nevertheless held that a hospital and a hospital resident may be held legally responsible where the hospital resident carries out the order of a private attending physician but knows, or should know, that the physician's orders "are so clearly contraindicated by normal practice that ordinary prudence require inquiry into correctness of the order." The ruling, according to the majority decision, is an exception to the general rule followed by the courts which holds that the hospital and the hospital staff cannot be held legally responsible for the actions of a private attending physician as long as the hospital staff properly carries out the attending physician's orders. **RECOMMENDATION: Retain, the policy is still relevant.**

160.998: Licensure Based on Professional Standards
It is the position of the Medical Society of the State of New York that physician licensure be based solely upon professional standards, including training, education, ability, competence and moral fitness. The Society vigorously opposes any attempts to establish nonprofessional standards, such as acceptance of third-party payment, as a condition of medical licensure. (HOD 1989-6 ; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

235.999: **MSSNY's Non-Support of NYS Advisory Committee on Physician Re-credentialing Report**
The Report of the New York State Advisory Committee on Physician Re-credentialing entitled "Phase One: General Principles, Proposed Process, Recommendations" was released in January of 1988. MSSNY does not endorse this report or its recommendations. Historically, quality assurance (optimal patient care) and physician competency have been the foundations upon which the policies and positions of the MSSNY have been developed. Over the past decade, the assurance of quality and maintaining of competence, a responsibility, which rightly belongs within the purview of the profession (all professions), has been gradually assumed to a large extent by agencies external to the profession. Perhaps well intentioned, the regulatory mechanisms developed by these external agencies have had a deleterious effect on the delivery of medical care but have had little impact on physician clinical performance.

MSSNY agrees with the statement, made on several occasions in the report, that the re-credentialing process broadly outlined in the report "is not designed to measure medical competence." Indeed the report does little more than discuss those well-known methods used to evaluate those various, individual components which taken collectively are used to define knowledge and cognitive skills, not performance. We agree with the report that there does not exist a single methodology for measuring competency and agree that employment of a combination of methodologies to measure competency would be logistically and economically unrealistic. The evaluation of competence in the health professions has not yet reached maturity. Measurement of changes in practice as a consequence of additional education, assessment of the validity of examinations and the determination of goals for competence are all necessary parts of the ongoing development of competence evaluation. As stated in the beginning of this statement, MSSNY is committed to quality assurance and maintaining competence of health professionals. However, we do not need further government intrusion to do what already is being done. Accordingly, the MSSNY subscribes to the following recommendations of the "Health Policy Agenda for the American People":

(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected

programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education.
(2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers and should make efforts to ensure that acceptable programs of continuing education are available to practitioners.
(3) Health professions organizations and faculty of programs of health professions education should develop standards for competence. Such standards should be reviewed and revised periodically.
(4) When reliable and cost-effective means of assessing continuing competence are developed, they should be required for continued practice. This should be done without government interference or control. (HOD 1988-25; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

240.983: Allow Physicians to Receive "Dual Use" Supplies for In-Office Blood Collection
MSSNY will propose and support new legislation allowing physicians to receive a limited supply of dual use supplies proportionate with the number of specimens received by the lab each month and will transmit a copy of this resolution to the American Medical Association (AMA) for consideration at its next House of Delegates. (HOD 2013-120) **RECOMMENDATION: Retain, the policy is still relevant.**

260.917: Pharmacy Practice of Medicine
MSSNY will work to oppose legislation or regulation that would enable retail clinics owned by publicly traded corporations to be established in the State of New York. (HOD 2013-109 and 110)
RECOMMENDATION: Retain, the policy is still relevant.

260.950: Further Integration of Mental Health and General Health
MSSNY supports the position of executive deputy commissioner within the New York City Department of Public Health be filled by a board-certified psychiatrist. (HOD 2002-164; Modified and Reaffirmed HOD 2013) **RECOMMENDATION: Retain, the policy is still relevant.**

260.951: Physician Use of Health Commerce System
MSSNY will continue to work with the New York State Department of Health in promoting and helping facilitate the use of the Health Commerce System to provide urgent information to physicians throughout the state. (HOD 2002-163; Modified and Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

275.999: **Consultation**
Physicians should obtain consultation whenever they believe that it would be helpful in the care of the patient. When a patient is referred to a consultant, the referring physician should provide a history of the care and such other information as the consultant may need, and the consultant should advise the referring physician of the results of the consultant's examination and recommendations relating to the management of care. A physician selected by a patient is encouraged to advise the patient's regular physician of the finding or recommendations. (HOD 1984-62; Reaffirmed with modifications in lieu of HOD 2013-117) **RECOMMENDATION: Retain, the policy is still relevant.**

280.999: **Second Opinion**
MSSNY makes recommendations for and lends positive support to procedures and programs that promise improvement in quality care for patients. To clarify the terminology involved in Second Opinion Programs, the MSSNY offers the following statement: When a second opinion is requested on issues of medical necessity or feasibility of a specific treatment recommendation, this opinion must be provided by a physician or surgeon who has completed Accreditation Council for Graduate Medical Education (ACGME) approved residency training in the diagnosis and treatment of the disease or condition for which a specific treatment has been proposed. This should be termed a **second opinion**. An opinion relative to surgical technique on the other hand must be provided by a surgeon who has completed ACGME approved residency training in the specific treatment proposed. This option should be termed a **second surgical opinion**. If an opinion is desired regarding the relative merit of all treatment options, including the proposed treatment, such an opinion should be termed a **consultation**. These opinions

may be obtained from any physician who has completed ACGME approved residency training in the treatment of the disease process or condition involved. In keeping with the opinion of the AMA Judicial Council (Report A, A-85) the consultant should be provided with a history of the case and such other information as the consultant may need. (HOD 1987-15; Reaffirmed HOD 2013)
RECOMMENDATION: Retain, the policy is still relevant.

35.996 Holistic Medicine
MSSNY will inform the Board of Regents of the State of New York it has adopted the position that the practice of holistic medicine by Chiropractors is ***not*** part of the authorized practice of Chiropractic, and request that it issue an Order for such Chiropractors to desist and refrain from such practice of medicine. (The Council directed that the word "not" be highlighted by boldface type to indicate stronger emphasis of the intent of the resolution). (Council 3/27/97; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

110.997 The Need for Patients to be Informed as to the Difference Between Physicians and other Types of Health Care Providers so as to Allow the Patient to Make a Choice of a Physician or Other Health Care Provider Based on Informed Consent
MSSNY will seek State and Federal legislation mandating that patients be notified whenever a health care provider other than a physician will provide care to a patient. (HOD 1998-57; Reaffirmed HOD 1999-83; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

70.981 Generic Substitutions
MSSNY will seek legislation to provide that where there is generic substitution because the physician has not designated "DAW" the pharmacist filling the prescription include on the label the words "Substituted for (brand name)." (HOD 1994-152; Reaffirmed 2010-97; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

110.998 Non-physician Practitioners in Today's Health Care Delivery Systems
(A) Scope of Practice: While the Medical Society is certainly concerned about system costs, our primary focus is and must be on quality. We believe, therefore, that non-physician professionals should be used in a manner commensurate with their training. It is clear, furthermore, that how we pay non-physician practitioners will directly affect how they practice. The medical community firmly believes that non-physician practitioners lack the education and training necessary to practice independently of physicians. A serious danger to the well-being of the citizens of this state will result if health care professionals, competent within their own fields, are permitted to work in areas beyond their competence and training and/or without an appropriate relationship with a physician. Moreover, to the extent that some advocate the expansion of the services performed by non-physician practitioners in the pursuit of system economies, but without an adequate educational base, costs will inevitably increase, not decrease. Therefore, while the Medical Society is committed to ensuring the efficient and responsible integration of these professionals into health care delivery teams, we should be moving toward an integrated system, not reversing statutorily created interrelationships which foster cohesion in our health delivery processes rather than fragmentation. Consequently, MSSNY strongly opposes any expansion of the scope of practice of non-physician practitioners which would undermine the quality of health care and compromise public safety.

(B) Practice Setting and Distribution: Certain interests recommend increasing the number of non-physician practitioners to address perceived provider shortages in underserved areas of the state. MSSNY, for a variety of reasons, questions the reasonableness of this conclusion. Generally, it is difficult to entice physicians to practice in such locations where they must be on call constantly, have few professional colleagues with whom to interact and where their spouses may not be able to find suitable jobs in such settings. Non-physician practitioners face similar, If not the same disadvantages. Furthermore, government should always be alert to initiatives which could result in the establishment of a two-tiered system of health care and, in effect, deny physician services to the elderly, poor and chronically ill. In light of the efforts of managed care organizations to significantly constrict staffing levels,

and in view of the persuasiveness of managed care in New York State, we submit that government should carefully examine future work force requirements generally.

(C) Manner and Extent of Compensation: In certain government forums, non-physician practitioners are advocating that they should receive the same amount of compensation paid to physicians for certain services. MSSNY specifically opposes any policy which would implement "parity" of payment between physician and non-physician providers. MSSNY supports the implementation of a differential payment structure based upon the provider's level of training, skill, expertise, responsibility and practice costs. Such a payment structure must necessarily recognize the inherent distinctions which exist between the extent of physician education and training as compared to that of non-physicians. Such distinctions in education, training, legal recognition and scope of practice demonstrate beyond argument the lack of any "equivalency" of service despite the claims by some non-physician practitioners. As noted above, the education of a nurse practitioner can be completed in as few as thirty-one months consisting of two years of junior college and nine months of advanced nurse practitioner certification program, or in as much as six years including four years of college and two years in a combined masters and certificate training program. By contrast, generalist physicians have at least eleven years of education and training, including four years of college, four years of medical school, three years of residency and often, additional years of fellowship training. A differential payment structure which recognizes and compensates those with greater skill, knowledge and training is absolutely necessary to assure that dedicated, talented and intelligent individuals are attracted to the profession of medicine. Obviously, young women and men are motivated to pursue the long and arduous work of medical licensure for a variety of reasons, not the least of which is the unique opportunities which the profession offers to serve society in a very direct and personal way. However, we must also recognize the necessity of fair and adequate compensation for those who pursue this course. Without such a structure, there would be inadequate training required of physicians today.

MSSNY strongly supports the provision of payment to a physician for all services provided by non-physician practitioners under the physician's supervision and direction regardless of whether such services are performed when the physician is physically present, so long as the ultimate responsibility for such services rests with the physician. Such a payment relationship is completely consistent with the functional relationships required by NY law which clearly prescribe that the physician is ultimately responsible for services provided by nurse practitioners and certified nurse midwives with whom the physician is collaborating, and physician assistants who the physician is supervising. As a result, MSSNY opposes direct reimbursement to non-physician practitioners. (Council 1/19/95; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

120.961 Impediments to Obtaining Pre-authorizations for Medically Indicated Diagnostic Tests

MSSNY will take appropriate steps including, if necessary, seeking the enactment of legislation and regulation, to eliminate unnecessary impediments imposed by health insurance companies to obtaining pre-authorization, including reducing the need and time for obtaining pre-authorization. (Council 3/3/08; Reaffirmed HOD 2014-58) **RECOMMENDATION: Retain, the policy is still relevant.**

130.935 Long Term Care – The Impending Crisis

The Medical Society of the State of New York recognizes the crisis of long-term health care financing and will look for innovative programs which would balance individual responsibility for long term health care costs and society's role in making long term health care insurance available to all. It is the position of the Medical Society that people should be allowed to purchase long term care insurance with continued positive and no negative tax implications and those who exhaust private insurance benefits be automatically enrolled in the Medicaid program without a need to spend down their assets.

The Medical Society of the State of New York work will work with the AMA to support a public option to cover the long-term health insurance needs of all Americans through a Long Term Health Insurance Trust Fund financed with fees paid by all Americans during their lifetime. (HOD 2014-115)
RECOMMENDATION: Retain, the policy is still relevant.

130.936 Affordable Care Act and NYS Medical Tort Reform

As part of its advocacy efforts to achieve comprehensive medical liability tort reform, the Medical Society of the State of New York should educate the public that patient access to necessary care is being threatened by the confluence of decreased payment from health insurers resulting from implementation of the Affordable Care Act and the exorbitant cost of medical liability insurance. (HOD 2014-51)
RECOMMENDATION: Retain, the policy is still relevant.

130.973 Method of Financing Long Term Care

MSSNY supports a change in the financing of long-term care to remove it from the County Medicaid budget and turn it over to the state budget as it is with most other states. (HOD 2004-259; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

130.991 Financial Disclosure Requirements by Health Maintenance Organizations (HMOs), Revision of

MSSNY supports legislation and/or regulation to require that all managed care entities or organizations incorporate into their annual financial disclosure statements all disbursements made by such entities or organizations for all administrative purposes, marketing, physician, hospital, pharmacy, and ancillary health care provider services, as well as any surplus funds, profits or dividends declared. (HOD 1994-56; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

130.992 Reimbursement for Medically Necessary Emergent Services Provided by Non-participating Managed Care Physicians and Hospitals

MSSNY will seek appropriate legislation which would require all managed care entities operating in the State of New York to reimburse physicians and hospitals for medically necessary emergency services provided in good faith to managed care subscribers, without consideration of participation status. (HOD 1994-84; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

150.977 Prohibit Institutions from Mandating In-House Testing

MSSNY will seek measures to prohibit mandatory in-hospital pre-operative testing when those tests, including but not limited to blood and urine, EKGs, chest X-rays, etc are performed in a qualified physician's office or in a state-and/or CLIA-accredited facility. (HOD 1998-126; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

150.978 For Profit Hospitals and Nursing Homes

MSSNY will vigorously support current law prohibiting for-profit businesses from entering the New York hospital and nursing home market. (Council 12/18/97; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

150.986 Physical Examination for Physicians (Annual)

MSSNY continues to meet with the Department of Health and other interested parties to clarify existing issues pertaining to the physical examination requirements under Section 405.(b)(10) of the Health Department regulations. MSSNY takes the following position with regard to the physical examination requirements:
(1) Physicians should have the option of going to his/her personal physician for the physical examination;
(2) If the physician opts to have the physical examination performed by the personal physician, the medical records pertaining to the physical examination should be retained in the office of the personal physician.
(3) The attestation form which the hospital must retain to document the physical examination should be standardized.
MSSNY should be involved in the development of an attestation form. (HOD 1991-91; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

160.968 Retirement of a Physician Medical Licensure

The Medical Society of the State of New York will seek legislation which provides non-disciplinary retirement of a physician license so long as there are no pending disciplinary matters. (HOD 2014-103)
RECOMMENDATION: Retain, the policy is still relevant.

160.981 Development of Legislation Regarding Physical Therapists (PTs)

MSSNY will seek through legislation, regulation, or whatever means necessary, the adoption of the following amendment to the New York Education Law:

(1) Needle electromyography is the practice of medicine and shall be performed and interpreted only by physicians licensed in the State of New York who are appropriate to perform and interpret such tests by virtue of specialty and training; and

(2) Physical therapists shall be limited in the scope of electro-diagnostic practice to the role of technicians utilized to perform nerve conduction studies under the direct supervision of a licensed physician who is appropriate to perform or interpret such tests by virtue of specialty and training; and

(3) Non-licensed individuals as defined by the NYS Department of Education may not perform needle electromyography under any circumstance, whether or not the individuals are supervised by a licensed provider of any type.

MSSNY will request that the State of New York Insurance Department and the State of New York Workers' Compensation Board, as they relate to the care of individuals sustaining automobile and work-related injuries, respectively, adopt these resolutions in whole into their prevailing and future statutes. (Council 11/2/00; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

160.982 Enforcing Licensing Statutes:

MSSNY will seek support of the appropriate regulatory bodies to enforce licensing statutes to ensure that HMOs do not permit non-physician practitioners to perform services beyond the scope of their licensure. (Council 3/13/00; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

160.989 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) **RECOMMENDATION: Retain, the policy is still relevant.**

160.995 Cryotherapy

It is the position of the Medical Society of the State of New York that cryotherapy be performed only by individuals licensed to practice medicine and surgery or by those who have been specifically authorized by law to perform these services. (HOD 1991-46; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

160.996 Diathermy

It is the position of the Medical Society of the State of New York that diathermy be performed only by individuals licensed to practice medicine and surgery or by those who have been specifically authorized by law to perform these services. (HOD 1991-48; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

165.948 Community Rating for Medical Coverage

MSSNY will work with the American Medical Association to secure passage of federal legislation to: (a) replace the current tax exclusion of employer-provided coverage with a refundable tax credit for each individual who receives coverage as a benefit of employment, or who purchases health insurance in the private market; (b) expand the definition of health benefits under Section 106 of the Internal Revenue Code to include employers' contributions to their employees' purchase of individual health insurance; (c) eliminate the restrictions on the availability of MSAs; and, (d) enable the creation of risk pooling

cooperatives to foster an environment in which individually owned insurance could be purchased economically. MSSNY will support all legislative/ regulatory efforts to examine the need to implement effective state insurance reform that would facilitate the purchase of individual and group coverage for all New Yorkers at an affordable cost. (HOD 1999-68; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

160.994 Therapeutic Ultrasound
It is the position of the Medical Society of the State of New York that therapeutic ultrasound be performed only by individuals licensed to practice medicine and surgery or by those who have been specifically authorized by law to perform these services. (HOD 1991-47; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

165.954 Prudent Layperson – 911 Calls
MSSNY reaffirms its support of the prudent layperson standard for emergency medical service and opposes triage by 911 dispatch which divert 911 (Emergency Dispatch) calls to non-emergency facilities, other than birthing centers or those facilities identified by the local REMAC (Regional Medical Advisory Committee) because of geographic constraints. (Council 10/28/98; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

165.955 The Need for Patients to be Informed as to the Difference Between Physicians and Other Types of Health Care Provides so as to Allow the Patient to Make a Choice of a Physician or Other Health Care Provider Based in Informed Consent

MSSNY shall seek enactment of State and Federal legislation mandating that patients be notified whenever a health care provider other than a physician will provide care to a patient. (HOD 1998-57, Reaffirmed HOD 1999-83; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

165.959 Channeling of Eye Examinations to Optometrists
It is the position of MSSNY that third-party payors not be permitted to shift patients from ophthalmologists to optometrists, that third-party payors not designate optometrists as primary eye care providers; and that MSSNY will issue a letter to all third-party payors operating in New York State, putting forth organized medicine's strong opposition to channeling enrollees to optometrists and other non-physicians and opposing the exclusion of ophthalmologist from refractive eye examinations, routine eye examinations, or primary eye care.

MSSNY will coordinate efforts with medical specialty societies to introduce legislation prohibiting third-party payors from mandating or encouraging that routine and refractive examinations be performed by optometrists rather than by ophthalmologists. (HOD 98-79; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

165.973 Patient Access to Physicians No Longer On Plan
MSSNY will seek legislation which would enable enrollees to a managed care plan to continue to receive care from the enrollee's current physician for up to one year or the balance of their policy period, whichever is longer, where the physician has left or has been terminated by the plan provided that the termination is not related to imminent harm to patient care, a determination of fraud or a final disciplinary action and provided further that the physician continues to accept reimbursement from the managed care plan at the rates applicable prior to the termination or departure of such physician from the plan and adheres to the plan's quality assurance and utilization review requirements. (HOD 1997-93; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

165.976 Substituting Nurse Practitioners For Licensed Primary Care Physicians
MSSNY will seek legislation prohibiting the substitution of licensed primary care physicians with nurse practitioners and will continue its public opposition to replacing physicians with physician extenders. In

recognition of a patient's right to receive high quality medical care from appropriately trained health care professionals, and the lack of any credible studies which indicate that services provided by nurse practitioners are equal to those rendered by physicians, MSSNY will communicate to all appropriate state agencies and state officials its opposition to the Oxford Health Plan agreement with Columbia University and Presbyterian Medical Center and to similar activities engaged in by other managed care entities operating in New York State. (HOD 1997-71; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

165.978 Referrals to Allied Health Providers
It is the position of MSSNY that managed care organizations in the State of New York should be required to designate only MDs and DOs as primary care providers for any individual or group of patients. MSSNY will continue its public opposition to replacing physicians with physician extenders; and will communicate its opposition to the assignment of primary care status to any professional provider other than an MD or DO in managed care entities and workers compensation programs operating in New York State. (HOD 1997-64; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

165.984 Prior Authorization for Procedures Under Managed Care: Limits on Time Requirements
MSSNY supports the requirement that managed care organizations implement and comply with written procedures to assure that entities that conduct utilization review: (1) provide adequate access to its review staff by a toll-free or collect call phone line, at a minimum, from 8:00 a.m. of each standard business day; (2) establishment of written procedures for receiving or redirecting after-hour calls either in person or by recording; and (3) having a mechanism to receive timely call backs from providers. (HOD 1996-76; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

175.990 Standing Orders
Since (a) the Medicaid Program does not currently recognize a standing orders protocol which is widely accepted by other insurers and (b) it becomes inefficient and burdensome for physicians to provide original signatures on all laboratory test requisitions, MSSNY will urge the Office of Medicaid Management of the NYS Department of Health to:

- Eliminate the requirement for original physician signatures, except the first signature, on each laboratory test requisition and allow standing orders for such tests involving chronic patient conditions (which may include, but not be limited to, diabetes (Glucose, Hemoglobin A1C/Glycohemoglobin), chemotherapy (CBC, Platelets), heart conditions (Prothrombin Time, Digoxin) substance abuse monitoring by a licensed treatment facility, any other condition deemed chronic in the reasonable judgment of a physician, etc.);
- Allow the initial standing order containing an original physician signature to be valid for up to six months, after which time it must be renewed;
- Enable physicians to designate staff members to sign the laboratory test requisitions on their behalf so long as the physicians formally acknowledge ultimate responsibility for the ordered tests;
- Develop a similar protocol for electronically ordered laboratory tests
- Interact the MSSNY, the Advisor on Practice Parameters Partnership and the NYS Clinical Laboratory Association (NYSCLA) to develop a listing of acceptable chronic conditions for the application of standing orders;
- Interact with MSSNY and NYSCLA to develop an appropriate mechanism for the implementation of a standing orders protocol for laboratory test requisitions. (Council 2/4/98; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the policy is still relevant.

175.992 Site of Service Differential Payment Policy
MSSNY reaffirms its position calling for the elimination of the highly objectionable Medicaid site of service differential payment policy for similar services provided in physicians' offices as compared to hospital settings; particularly as the state-proposed Medicaid Managed Care Demonstration unfolds. (Council 12/19/96; Reaffirmed HOD 2013; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

265.924 Gross Receipts Tax
MSSNY opposes the imposition of taxes and cuts in payment that hinder the ability of physicians to provide needed care to patients. (HOD 2004-81; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

265.973 Physician Responsibility for County Nursing Service
MSSNY will seek federal and state legislative or regulatory relief requiring Medicare and other insurers based in this state to hold Nursing Service Agencies responsible for their billing practices and for the care decisions they make that either deviate from physician instructions, are devoid of related physician input, or are violative of HCFA guidelines. Physicians will be held harmless when their Home Health Certification and Plan of Care Forms (HCFA 485 form) differ from by the actual services rendered by the Nursing agencies, and MSSNY shall pursue every available avenue at both the state level and nationally through our representation with the American Medical Association to protect physicians from being held responsible for care provision and billing beyond their control pertaining to Nursing services. (HOD 1999-273; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

265.986 Physician Due Process in Managed Care
Should a physician participant in one plan of an Insurance Company be denied access to other newly evolved plans that Insurance Company offers, the reason for such must be provided in writing and an appeals process be established to review that decision in a timely fashion. (Council 12/18/97; Reaffirmed HOD 2014) **RECOMMENDATION: Retain, the policy is still relevant.**

265.992 Reimbursement of Alternative Therapies By HMOs
MSSNY will support legislative action to prevent insurance coverage by managed care companies for unproven alternative therapies and unlicensed practitioners. (HOD 1997-163; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

270.970 Internet Review of Physicians
The Medical Society of the State of New York (MSSNY) will ask the American Medical Association (AMA) to seek federal legislation and/or regulation which would amend internet privacy laws so that websites hosting reviews of physicians will be required to: obtain the name of the person posting the review; keep this information on file; and inform the posting party that a physician requesting this information from the website host must be provided with the name of the person writing the review; and websites hosting reviews of physicians be required to post a warning against libelous and other legally inappropriate statements. (HOD 2014-206) **RECOMMENDATION: Retain, the policy is still relevant.**

290.989 Support of Athletic Trainer Legislation
The Medical Society of the State of New York supports efforts which encourage athletic trainers to obtain continuing educational development. (HOD 2014-152)
RECOMMENDATION: Retain, the policy is still relevant.

310.999 Medical Director to be Required for All Third Party Payors
The Medical Society of the State of New York will seek whatever legislative or regulatory action is necessary to insure that all health insurance companies that are licensed in the State of New York and performing utilization review have a physician medical director who is licensed by the State of New York, who is accessible and identifiable to the treating physician; and will seek regulatory action which assures that plan medical directors are held accountable for their medical review determinations. (HOD 1997-58; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

317.997 Immunity For Physicians Serving Volunteer Ambulance Corps
MSSNY will seek passage of state legislation that would extend the “Good Samaritan” protection to physicians working on volunteer ambulance corps. (HOD 1997-116; Reaffirmed HOD 2014)
RECOMMENDATION: Retain, the policy is still relevant.

317.998 Volunteer Physician Services

MSSNY strongly encourages those who wish to use the services on a voluntary basis to cover the cost of medical liability insurance as a part of their arrangement with the volunteering physician. (HOD 1996-53; Reaffirmed HOD 1998-65 & 98-69; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the policy is still relevant.

325.985 Timely Authorizations

MSSNY will urge the New York State Department of Insurance and the New York State Workers Compensation Board to require insurance companies to provide a mechanism for authorizing requests for medical or surgical services in a timely fashion and that such an approval mechanism be available 24 hours a day, seven days a week. A response to a requested authorization will be returned within 24 hours for in-hospital care and 7 days for outpatient care. (HOD 1999-272; Reaffirmed HOD 2014*)*

RECOMMENDATION: Retain, the policy is still relevant.

75.992 Prohibition of Inappropriate Pill Splitting

It is the position of MSSNY that the New York State Insurance Department and all other appropriated state agencies prohibit insurance companies from requiring pill splitting. (HOD 2000-160; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the policy is still relevant.

110.999 Primary Care Services, Access To

It is the position of MSSNY that a patient's access to primary care services provided by a physician should not be limited by the specialty or subspecialty designation of the physician, but should be determined by the training, competence, and experience of the physician to provide primary care services, and that health plans should allow physicians with the appropriate qualifications to elect to provide primary, specialty and subspecialty care services. (Council 12/15/94; Reaffirmed HOD 2014)

RECOMMENDATION: Retain, the policy is still relevant.

ITEMS RECOMMENDED FOR ADOPTION AS AMENDED

None.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 100

Introduced by:	Realba Rodriguez, MD and Alan Diaz, MD-past FDB president As Individuals, Delegates to Bronx County
Subject:	Telehealth a needed tool for Medicine not a commodity
Referred to:	Reference Committee on Governmental Affairs B

Whereas, The Medical Society of the State of New York in existing policy: 117.961 asserted that MSSNY will support legislation protecting [fair payments for] Telehealth services (HOD 2021-100) ,and

Whereas, Telehealth Medicine was proven to be a vital tool during the pandemic helping to provide continuity of care and procedural order during this period, and

Whereas, There is a plethora of data substantiating the cost effectiveness of Televisits upon the health care system, and

Whereas, Both patients and physicians will benefit greatly from the continuance of this form of medical encounter(s), and

Whereas, Telehealth services were extended beyond May 5 2023 only to end December 31, 2024, therefore be it

RESOLVED, that MSSNY will in addition to existing policy, lobby in conjunction with the AMA, seeking legislation in order to permanently extend and keep Televisits as a viable alternative to patient care for all Physicians.

References:

Existing MSSNY Policy:
117.961 Telehealth Services

117.961 Telehealth Services The Medical Society of the State of New York will 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. (HOD 2021-100)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 101

Introduced by: Health Information Technology Committee

Subject: Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits **Permanently**

Referred to: Reference Committee on Governmental Affairs B

Whereas, Medicare is set to end reimbursement for telehealth on 12/31/24; and

Whereas, The decision for a telehealth type visit should be made **between a doctor and a patient** and not determined by a third-party insurance payor; and (Definition of Telehealth in Appendix 1)

Whereas, "Telehealth offers patients and providers significant benefits as a lower cost, easier way to access quality care"[1]; and

Whereas, The COVID-19 health pandemic heightened awareness and dramatically increased the need for use of telehealth; and

Whereas, Telehealth has been shown in surveys to benefit both physicians and patients (Appendix 2) and physicians would be able to maintain continuity of care to those patients who are unable to make in-person visits; and

Whereas, Licensed health care professionals in the VA system can practice their profession "using telemedicine at any location in any state regardless of where the professional or patient is located if the covered health care professional is using telemedicine to provide VA [Department of Veterans Affairs (VA)] medical or health services"[2]; and

Whereas, Physicians would be able to render care to those patients seeking their follow-up medical care and expert opinion without the need to travel to the physician;[3,4] and

Whereas, Telehealth would benefit patients as it would increase patient access to a greater number of physicians **particularly for the homebound**, increase choice of patients for their physicians and has been shown to increase patient satisfaction;[3,4] and

Whereas, "The rise of telehealth during pandemic boosted mental health treatment rates"[5] in a society where "90% of US adults say the U.S. is experiencing a mental health crisis";[6] and

Whereas, "An American Medical Association (AMA) survey released shows physicians have enthusiastically embraced telehealth and expect to use it even more in the future and "Nearly 85% of physician respondents indicated they are currently using telehealth to care for patients, and nearly 70% report their organization is motivated to continue using telehealth in their practice";[3,4] (Appendix 3); therefore, be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) request that the AMA advocate for making telehealth reimbursement permanent for Medicare and for all health insurance providers.

References:

1. Manocchia A. Telehealth: Enhancing Care through Technology. RI Med J; 2020; 103(1):18-20.
Available at: https://pubmed.ncbi.nlm.nih.gov/32013298/

2. H.R.2123 - Veterans E-Health and Telemedicine Support Act of 2017. Bill Summary available at: https://www.congress.gov/bill/115th-congress/house-bill/2123?s=1&r=7

3. Kelly, S. Rise of telehealth during pandemic boosted mental health treatment rates. Available at: https://www.healthcaredive.com/news/telehealth-mental-health-JAMA-pandemic/639905/

4. McPhillips, D. 90% of US adults say the United States is experiencing a mental health crisis, CNN/KFF poll finds. Available at: https://www.cnn.com/2022/10/05/health/cnn-kff-mental-health-poll-wellness/index.html

5. AMA Telehealth Survey report. Available at: https://www.ama-assn.org/system/files/telehealth-survey-report.pdf

6. AMA survey shows widespread enthusiasm for telehealth. Available at: https://www.ama-assn.org/press-center/press-releases/ama-survey-shows-widespread-enthusiasm-telehealth

Existing MSSNY Policy:

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.
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)

117.960 Reciprocal Telehealth Coverage

The MSSNY will advocate for opportunities to enable reciprocal telehealth arrangements with other states so that New York State physicians can continue to provide care via telehealth across state borders, when appropriate, for existing patients. (HOD 2021-105, referred to Council, adopted 3/9/22)

117.961 Telehealth Services
The Medical Society of the State of New York will 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. (HOD 2021-100)

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.

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)

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)

160.989 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)

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)

Existing AMA Policy:

1)

COVID-19 Emergency and Expanded Telemedicine Regulations - D-480.963

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

2)
In 2019, prior to the pandemic, the AMA developed the policy below on telehealth reimbursement and then reaffirmed it in 2022. However, the AMA does not request that coverage and reimbursement for telehealth be made **permanently or indefinitely.**

Reimbursement for Telehealth - D-480.965
Our AMA will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians."

APPENDIX INCLUDING BACKGROUND INFORMATION

LIST OF ITEMS IN APPENDIX:

1. Definition of Telehealth

2. Benefits to Society For Telehealth

3. AMA Telehealth Survey Report

Appendix 1
Definition of Telehealth

The Health Resources and Services Administration (HRSA) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration.

Telehealth is comprised of two forms:

1) two-way, synchronous, interactive client-provider communication through audio and video equipment (sometimes referred to as telemedicine), and

2) asynchronous client-provider interactions using various forms of technology (e.g., web-based client portals, e-mail messages, text messages, mobile applications, symptom management tracking, sensors, peripherals, client education modules, or electronic medical record data).

Appendix 2

Table 2. BENEFITS TO SOCIETY FOR TELEHEALTH ACCESS ACROSS STATE LINES

BROAD SOCIETAL BENEFITS FOR PATIENT TO BE ABLE TO SEE PHYSICIANS VIRTUALLY ACROSS STATE LINES – TELEHEALTH ACROSS STATE LINES
"MOST PHYSICIANS FEEL TELEHEALTH ALLOWS THEM TO PROVIDE MORE COMPREHENSIVE QUALITY CARE" AMA Telehealth Survey
"TELEHEALTH OFFERS ACCESS TO CARE AND CONVENIENCE THAT CONTRIBUTES TO IMPROVED PATIENT SATISFACTION" AMA Telehealth Survey
"TELEHEALTH HAS INCREASED PROFESSIONAL SATISFACTION" AMA Telehealth Survey
"PHYSICIANS FEEL TELEHEALTH ENABLES THEM TO PROVIDE HIGH-QUALITY CARE FOR MANY TYPES OF SERVICES" AMA Telehealth Survey
DOCTORS AND PATIENTS CAN CONNECT TO EACH OTHER REGARDLESS OF PHYSICAL LOCATION
IMPROVEMENT FOR PHYSICIANS AS PHYSICIANS WILL HAVE A GREATER PATIENT POPULATION THAT CAN SEEK CARE FROM THEM – A "WIN-WIN" SITUATION FOR PATIENTS AND DOCTORS
IMPROVE COST EFFECTIVENESS FOR PATIENTS TO RECEIVE NECESSARY MEDICAL CARE
IMPROVE HEALTH EQUITY, DECREASE HEALTH DISPARITIES
INCREASE PATIENT COMPLIANCE WITH FOLLOW-UP VISITS
IMPROVE ACCESS TO MENTAL HEALTH SERVICES AND PRIMARY CARE SERVICES

IMPROVED HEALTH, SAFETY, COMFORT AND CONVENIENCE OF PATIENTS BY DECREASING NEED FOR PATIENTS TO TRAVEL FOR MEDICAL CARE AND FOLLOW-UP CARE
IMPROVE AND INCREASE ACCESS TO HEALTH CARE FOR PATIENTS IN PHYSICIAN UNDERSERVED AREAS AND RURAL AREAS
DECREASED RISK FOR INFECTIOUS RESPIRATORY ILLNESS WHILE TRAVELLING (COVID-19 IS STILL CIRCULATING, PLUS THERE IS THE ANNUAL FLU)
SAVE TIME BY NOT TRAVELLING TO HEALTHCARE PROVIDERS
DECREASE CARBON FOOTPRINT, HELP ENVIRONMENT, AND COMBAT CLIMATE CHANGE – INCLUDING LESS USE OF GASOLINE TO FLY OR DRIVE ACROSS STATE LINES
OPPORTUNITY TO REMAIN IN A FAMILIAR AND COMFORTABLE ENVIRONMENT WHILE RECEIVING HEALTHCARE
IMPROVED FOLLOW-UP FOR LONG TERM CHRONIC CONDITION MANAGEMENT
POTENTIAL FOR OVERALL IMPROVEMENT IN HEALTHCARE FOR PATIENTS AND FOR SOCIETY
BROAD SOCIETAL BENEFITS FOR PATIENT TO BE ABLE TO SEE PHYSICIANS VIRTUALLY

Appendix 3

AMA Telehealth Survey Report
Key Trends and Findings

Telehealth Use Trends

CLINICAL OUTCOMES

85% of physician respondents indicate they currently use telehealth. For those that report a decrease in use indicate now doing a mix of in-person and virtual care.

- 60% of clinicians agree or strongly agree telehealth enabled them to provide high quality care.
- Of those using telehealth, 93% (⬆ 13%) are conducting live, interactive video visits with patients and 69% are doing audio-only visits.
- 56% of respondents are motivated (agree and strongly agree) to increase telehealth use in their practices.
- 8% (⬇ 4%) of respondents said they were using remote patient monitoring technologies with patients in their homes; the commonly used tools include smartphones (camera), blood pressure cuffs, pulse oximeters, and body weight scales. 76% (⬆ 7.6%) report data is usually shared manually (e.g. verbally over the phone or via email).

PATIENT EXPERIENCE

- More than 80% of respondents (⬆ 12%) indicate patients have better access to care since using telehealth.
- 62% of respondents feel patients have higher satisfaction since offering telehealth.
- 63% (⬆ 12.2%) of respondents report 75% or more of virtual visits are conducted with patients they have an existing relationship with.

PROFESSIONAL SATISFACTION

- A majority of respondents indicated that telehealth has improved the satisfaction of their work 54.2%.

COST

- 44% of respondents indicated that telehealth decreased the costs of care (strongly agree or agree)

Note: Trend comparisons refer to the COVID-19 Healthcare Coalition Physician Survey fielded in 2020.

3

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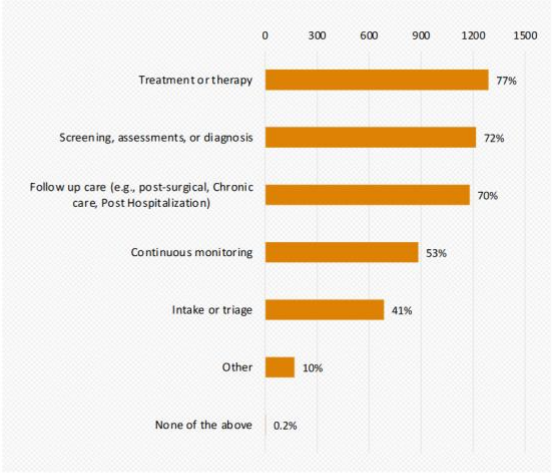
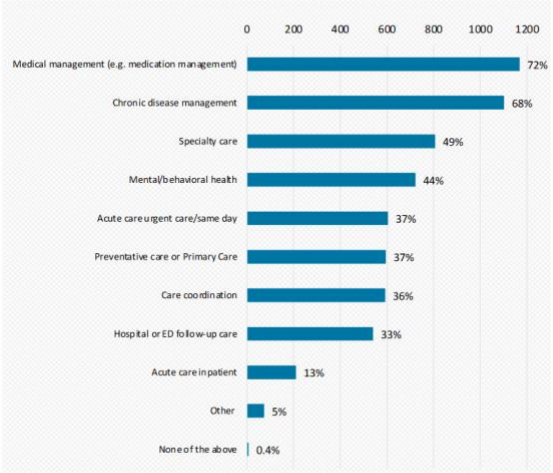
Telehealth is currently being used across many aspects of clinical care and used to deliver a variety of services



What aspects of care do you provide via telehealth? (select all that apply) N=1,682



What services do you or your practice/organization currently provide via telehealth? N=1,630

11

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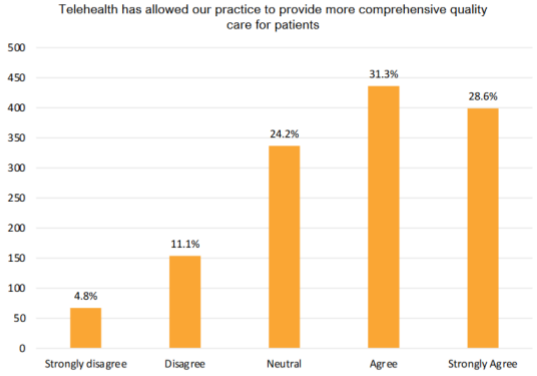
Physician Sentiments

Most physicians feel telehealth allows them to provide *more comprehensive quality care*

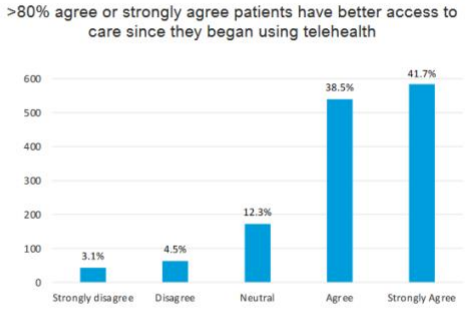


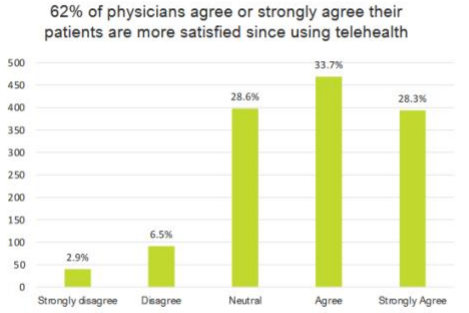
To what extent do you agree or disagree with the following statements? Telehealth has allowed our practice to provide more comprehensive quality care for patients. N=1,393
Is there any additional insight or thoughts you would like to share regarding the impact of telehealth on you, your practice, or your organization?

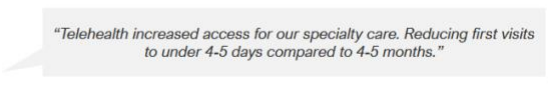
209
210

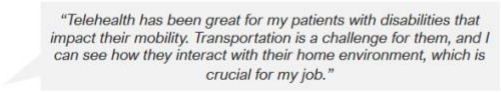
Physician Sentiments

Telehealth offers *access to care* and convenience that contributes to *improved patient satisfaction*









To what extent do you agree or disagree with the following statements? Patients have better access to care since our practice began using telehealth. N=1,402
To what extent do you agree or disagree with the following statements? Patients have higher satisfaction since our practice began using telehealth. N= 1,392
Is there any additional insight or thoughts you would like to share regarding the impact of telehealth on you, your practice, or your organization?

211
212

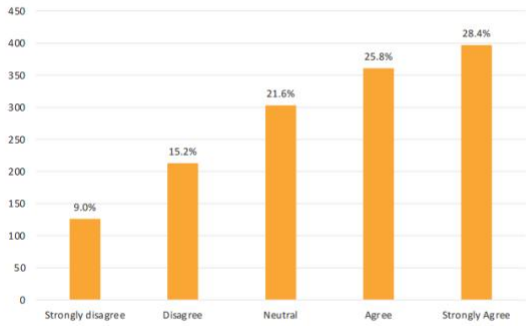
Physician Sentiments

Telehealth has *increased professional satisfaction*

"I am a wife, mother, and in a dual physician partnership, and telehealth allows me to balance my professional and family obligations without leaving my profession for family reasons in the middle of my career."

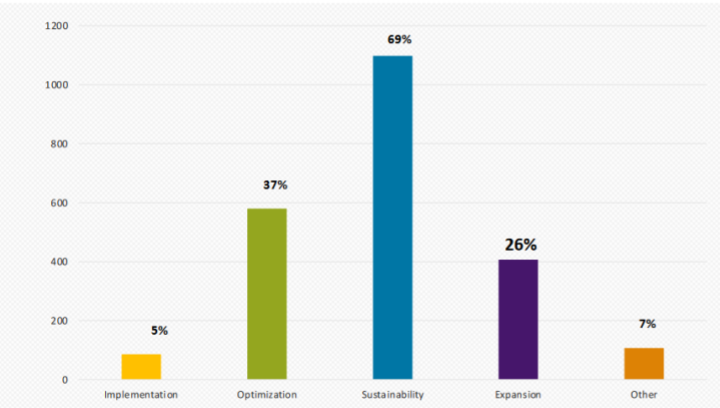
"The option of providing care via telehealth has increased my professional satisfaction and actually has delayed my decision to retire in a time when many in our field are retiring prematurely and exacerbating the physician shortage."

Over 50% of physicians indicate telehealth has increased their professional satisfaction



Is there any additional insight or thoughts you would like to share regarding the impact of telehealth on you, your practice, or your organization?
To what extent do you agree or disagree with the following statements? Telehealth has increased my professional satisfaction. N=1,400

Most are focused on *sustaining* telehealth at their practice or organizations



Implementation = just getting started in implementing telehealth

Optimization = looking to improve existing telehealth operations

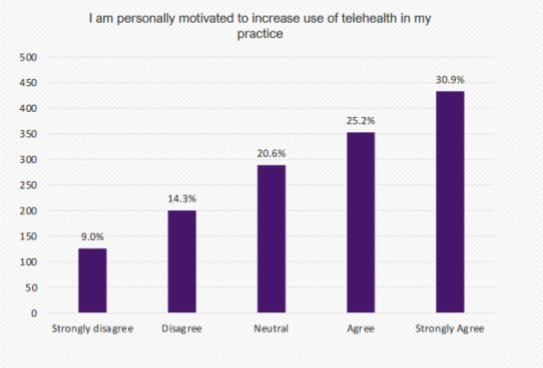
Sustainability = interested in continuing to offer telehealth services that seamlessly integrate with in-person care

Expansion = looking to expand telehealth offerings for other services, additional locations, or more comprehensive virtual care

At what stage is your organization's telehealth program? (select all that apply) N=1,585

Future plans

Looking ahead, organizations are interested in continuing to offer telehealth and increase use

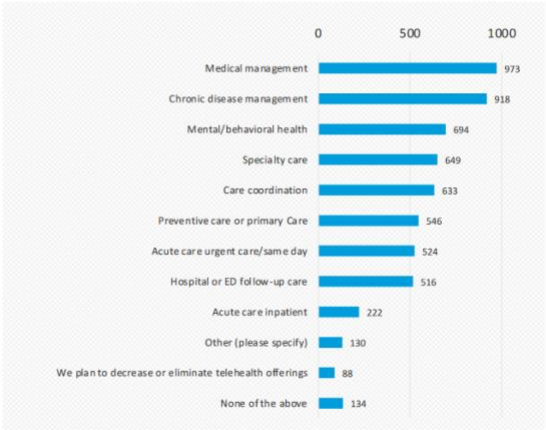


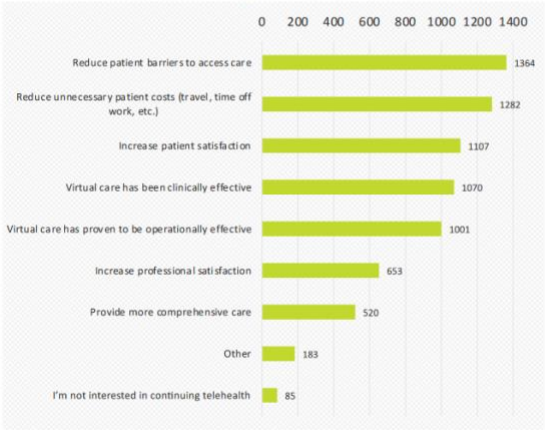
To what extent do you agree or disagree with the following statements? I am personally motivated to increase use of telehealth in my practice. N=1,401
To what extent do you agree or disagree with the following statements? My organization's leadership is motivated to continue use of telehealth in my practice. N=1,322

217
218

Future plans

Practices plan to offer a variety of services via telehealth in the future for a variety of reasons





What telehealth services does your practice or organization plan to offer in the future? (select all that apply) N=1,599
Which of the following are reasons why you are interested in continuing to provide care via telehealth? (select all that apply) N=1,591

219
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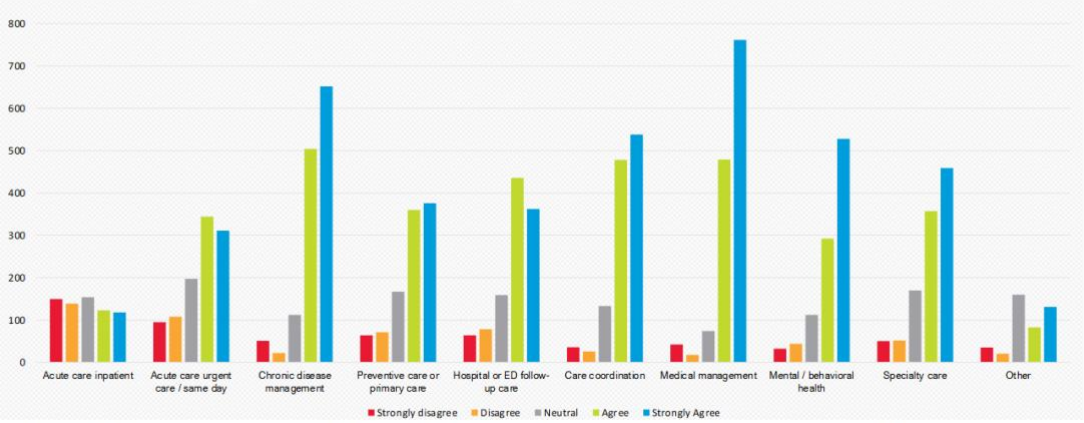
Physician Sentiments

Physicians feel telehealth enables them to provide *high-quality care* for many types of services



To what extent do you agree or disagree with the following statement: Telehealth enables me to deliver high-quality care for… N=1,453

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MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 102

Introduced by: New York County Medical Society

Subject: Understaffing in Retail Pharmacies

Referred to: Reference Committee on Governmental Affairs B

Whereas, Patients today face obstacles - sometimes even dangers - with retail pharmacies, including wrong medications, wrong instructions, long waits on phone or in line, and lack of medication in stock; and

Whereas, Physicians also have logistical problems with pharmacies including mis-transcribed prescriptions, not following “brand or generic” instructions, and ignoring rules on opioid treatment; and

Whereas, Experts believe that one key factor in these problems is extreme understaffing in the pharmacy retail stores, which has led to recent walkouts by overworked pharmacy technicians and licensed pharmacists; and

Whereas, Currently, the New York State Education Department’s website states that in each retail pharmacy, there must be four pharmacy technicians for each licensed pharmacist; therefore be it

RESOLVED, That the Medical Society of the State of New York initiate discussions with the New York State Department of Education and the New York State Department of Health concerning serious patient safety issues in pharmacies and severe understaffing; and be it further

RESOLVED, That the Medical Society of the State of New York work with New York State regulatory bodies to establish a specific number of licensed pharmacists that would be required to be present during “open hours” in each retail pharmacy store.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 103

Introduced by: New York County Medical Society

Subject: Addressing Problems in Retail Pharmacies

Referred to: Reference Committee on Governmental Affairs B

Whereas, Physicians and patients face difficulties working with retail pharmacies that can have serious impact on patients; and

Whereas, There are inefficiencies and confusion related to patients filling prescriptions as prescribed by doctors; and

Whereas, Problems range from no notice of formulary changes to patients' difficulty getting refills while traveling; and

Whereas, While there are problems filling prescriptions, pharmacies are sending physicians "robo faxes" about refills aimed at generating income for chains, but not related to the patient's current needs; and

Whereas, There are enough issues related to pharmacy care that require an examination from the State of New York; therefore be it

RESOLVED, That the Medical Society of the State of New York form a committee to advise and enter into dialogue with the New York State Department of Health on the wide range of pharmacy problems; and be it further

RESOLVED, That the Medical Society of the State of New York seek legislation or regulation aimed at correcting pharmacy routines and systems that create inefficiency, confusion, unfairness and sometimes even danger for patients.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 104

Introduced by: New York County Medical Society

Subject: Out-of-Stock Drugs at Pharmacies

Referred to: Reference Committee on

Whereas, Patients today face obstacles in filling prescriptions when retail pharmacies lack stock of their specific medications; and

Whereas, Physicians and patients have no way of knowing in advance that a particular pharmacy does not have the required medications in stock (in particular, certain specialty medications); and

Whereas, Delay in filling a prescription can be dangerous for the patient and result in costly hospitalizations; therefore, be it

RESOLVED That the Medical Society of the State of New York seek legislation requiring pharmacies that have websites (exempt small independent pharmacies that do not have websites) to post on their websites lists of medications that are out of stock so physicians can be alerted when prescribing electronically, and patients can obtain their medication without delay.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution: 105

Introduced by: Medical Society of the County of Kings & Alex Shteynshlyuger MD

Subject: Transparency at the pharmacy counter – Let patients own their prescriptions

Referred to: Reference Committee on Governmental Affairs B

Whereas, insurance companies routinely interfere with the patient-doctor relationship by failing to cover the medication, dose, and duration as prescribed.

Whereas, pharmacies often fail to inform patients about the actual medication, dose, and duration prescribed if not covered by the health plan.

Whereas, pharmacies often fail to inform patients about the option of purchasing the prescribed medications out-of-pocket and to provide the associated out-of-pocket costs when insurance does not cover or covers only part of the prescribed regimen

Whereas, prescriptions are written for three months, but insurance may only allow dispensing of one month's supply; a prescription may only be prescribed for 2 weeks, but insurance mandates 3-month prescription; a prescription may be written for 2 weeks, but insurance may only allow five days worth of medication.

RESOLVED, MSSNY would advocate legislation that would mandate that pharmacies, whether physical or mail-order, must inform the patient about the actual dose, duration, and number of units prescribed (number of pills, days of treatment, grams of cream, etc); inform patients about the option of purchasing the prescribed medications out-of-pocket and to provide the associated out-of-pocket costs when insurance does not cover or covers only part of the prescribed regimen; provide a reason for dispensing deviation from the prescribed dose, duration and number of units; whenever relevant pharmacy must include reference to insurance imposed limits or pharmacy impose limits.

RESOLVED, MSSNY advocates that the AMA would advocate legislation that would mandate that pharmacies, whether physical or mail-order, must inform the patient about the actual dose, duration, and number of units prescribed (number of pills, days of treatment, grams of cream, etc); inform patients about the option of purchasing the prescribed medications out-of-pocket and to provide the associated out-of-pocket costs when insurance does not cover or covers only part of the prescribed regimen; provide a reason for dispensing deviation from the prescribed dose, duration and number of units; whenever relevant pharmacy must include reference to insurance imposed limits or pharmacy impose limits.

References:

Existing MSSNY Policy:

195.962 Undue and Burdensome Regulations Inflicted by Medicare Part D Pharmacy Benefit Plans
70.959 Pharmacy Benefit Managers' or Payors' Interference with the Course of Good Treatment and Requiring the Provision of Dangerous Quantities of Medicine

RELEVANT AMA POLICY

AMA Response to Pharmacy Intrusion Into Medical Practice H-35.961
Price of Medicine H-110.991

Author's Priority Statement

Failure to obtain and take the prescribed course of treatment often leads to therapeutic failure and imposes significant financial costs and health consequences on patients. Patients should be able to obtain the prescription as written and to pay out of pocket if necessary, without interference from pharmacies, insurance companies, and PBMs (Pharmacy Benefit Managers).

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 106

Introduced by: John Kraus, Med Student

Subject: Requiring payers to compensate medical offices for complex and timely prior authorizations

Referred to: Reference Committee on Governmental Affairs B

WHEREAS, the administrative burden of insurance preauthorization's on physician practices is excessive and diverts time and resources away from patient care; and

WHEREAS, nearly 853 hours consumed by prior-authorization tasks per physician annually. The time burden is so great that about one-third of physicians have staff members who work exclusively on prior-authorization duties; and

WHEREAS, insurance companies can cause delays in the preauthorization process, causing physician practices to spend additional time on administrative tasks; and these delays can negatively impact the quality and timeliness of patient care; and

BE IT RESOLVED, that MSSNY shall advocate for legislative and regulatory measures that require insurance companies to compensate physician practices for excessive delays in the preauthorization process

BE IT FURTHER RESOLVED that MSSNY shall advocate for legislative measures in which a physician practice experiencing a delay attributable to the insurance company, such as waiting on hold for an excessive time to speak with an agent or a peer for a "peer to peer" review, the physician's office shall be entitled to bill the insurance company for its time commensurate with time cost associated by office staff completing these claims. This compensation shall be paid out if the claim is ultimately approved.

References:

1. https://www.beckersasc.com/asc-news/how-time-consuming-is-prior-authorization-for-
2. physicians-practices.html#:~:text=Physicians and staff spend an, that surveyed 1,001
3. practicing physicians.
4. https://www.ama-assn.org/practice-management/prior-authorization/survey-quantifies-time-burdens-prior-authorization
5. https://www.ama-assn.org/press-center/press-releases/toll-prior-authorization-exceeds-alleged-benefits-say-physicians
6. https://fixpriorauth.org/stories
7. Salzbrenner SG, Lydiatt M, Helding B, Scheier LM, Greene H, Hill PW, McAdam-Marx C.

8. Influence of prior authorization requirements on provider clinical decision-making. Am J Manag Care. 2023 Jul;29(7):331-337. doi: 10.37765/ajmc.2023.89394. PMID: 37523751; PMCID: PMC10403277.

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 107

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland and Westchester Counties)
Subject:	Enhancing Transparency of Cost of Drug to Pharmacy and Price Comparison Accessibility
Referred to:	Reference Committee on Governmental Affairs B

Whereas, the Medical Society of the State of New York (MSSNY) is dedicated to promoting the highest standards of medical care and advocating for the well-being of patients; and

Whereas, the rising costs of prescription drugs have become a significant concern for both patients and healthcare providers, impacting the ability to access necessary medications; and

Whereas, transparency in drug pricing is essential for informed decision-making, allowing patients and prescribers to make cost-effective choices that align with the principles of quality care; and

Whereas, pharmacies play a crucial role in the distribution of prescription medications, and there is a need to ensure that prescribers have access to accurate and up-to-date information on insurance contracted drug prices across various pharmacies; and

Whereas, pharmacies charge widely disparate prices, including co-pays, for the same medication based on insurance contract and method of payment resulting in patients foregoing medications due to cost that could have been satisfactorily obtained at a neighboring pharmacy; and

Whereas, there are available third-party applications that easily allow the comparison of cash-price of a selected drug across neighboring pharmacies; and

Whereas, there is currently no easily accessible mechanism for physicians to compare insurance contacted out of pocket costs of drugs across neighboring pharmacies; and

Whereas, the lack of a standardized mechanism for prescribers to easily compare out-of-pocket costs of a drug between local pharmacies may contribute to the inefficiencies in the healthcare system and hinder the ability to provide affordable and accessible care; therefore be it

RESOLVED that the Medical Society of the State of New York (MSSNY) supports legislation and/or regulation that enhances transparency in pharmacy drug costs and establishes a mechanism for prescribers to easily view the out-of-pocket insurance cost of drugs and price comparisons between local pharmacies at point of prescribing; and be it further

RESOLVED that MSSNY urges lawmakers and regulatory bodies to collaborate with relevant stakeholders, including prescribers, pharmacists, and patient advocacy groups, to develop and implement policies that ensure the availability similar accurate, real-time informational tools on drug prices for patients.

References:

Existing MSSNY Policy:

70.936 High Drug Prices and Pharmacy Parity

The Medical Society of the State of New York will urge legislation prohibiting pharmacies from charging higher prices (from pharmacy benefit managers or insurance plans) than the actual pharmacy price of the medication. MSSNY will further advocate for patients to have a choice of receiving maintenance prescriptions from either a mail order pharmacy or a brick-and-mortar pharmacy without any financial penalty. (HOD 2018-102 and 105)

227.999 Cost of Drug Disclosure During Direct Advertising:

MSSNY has adopted the position that pharmaceutical companies include in the consumer advertisement of any pharmaceutical the suggested retail price of such pharmaceutical. (HOD 2001-51; Reaffirmed HOD 2003-252; Reaffirmed HOD 2013; Reaffirmed HOD 2023)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 108

Introduced by: San San Wynn, MD

Subject: Chemotherapy sensitivity test to provide precise personalized cancer treatment

Referred to: Reference Committee on Governmental Affairs B

Whereas hematologist/oncologists must have the ability to provide chemotherapy sensitivity test to choose chemotherapy for particular cancers to avoid unwanted preventable side effects of chemotherapy; and

Whereas many cancer patients have no specific mutations to for targeted chemotherapy; and

Whereas with this chemotherapy sensitivity test many cancer patients will be benefited & insurance should cover for the test; and

Whereas presently insurance does not cover this much needed testing; therefore be it

Whereas the testing for chemotherapy sensitivity reduces harm to already vulnerable patients suffering with malignancy; therefore be it

RESOLVED, MSSNY support coverage by all health plans for chemotherapy sensitivity without any out-of-pocket cost to the patient.

References:

https://link.springer.com/article/10.1007/s00423-023-03133-7

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8234301/

https://pubmed.ncbi.nlm.nih.gov/21788567/

https://pubmed.ncbi.nlm.nih.gov/21788567/

Existing MSSNY Policy: none

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 109

Introduced by:	Medical Society of the County of Kings & Niraj Acharya, MD New York County Medical Society Richmond County Medical Society
Subject:	Medicaid to pay Medicare for coinsurance for dual eligible patients
Referred to:	Reference Committee on Governmental Affairs B

Whereas, Medicaid has stopped paying 20% Medicare coinsurance for dual eligible patients (with Medicare & Medicaid) while simultaneously prohibiting physicians from billing dual eligible patient for the 20% coinsurance; and

Whereas, Physicians are already paid inadequately with even 100% Medicare fee schedule rates;

therefore be it

RESOLVED, that the MSSNY works with NY State Dept. of Health for NYS Medicaid to resume paying 20% Medicare coinsurance for all dual eligible patients.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 110

Introduced by: Caleb Atkins, DO, Jefferson County, as an individual
Fifth and Sixth District Medical Societies

Subject: Enhanced Funding for Rural and Safety Net Residency Training Sites

Referred to: Reference Committee on Governmental Affairs B

Whereas, Smaller residency programs serve smaller communities which lack access to primary care (1); and

Whereas, Having more doctors that train in programs that serve rural communities is closely tied to the number of physicians who will work in those communities (2); and

Whereas, The New York State Council on Graduate Medical Education supports initiatives to create residency training programs in rural communities since only 4% of residents plan to practice in a rural area after completing training (3); and

Whereas, NYSDOH believes initiatives to add residency slots to targeted sectors where physician workforce shortages exist can improve our ability to increase access to high quality care (3); therefore be it

RESOLVED, That the Medical Society of the state of New York will lobby the New York State legislature to enhance Medicaid funds allocated to rural and safety net hospital residency programs that serve rural communities to assist in their expansion of residency slots

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References:

1. Rural access to primary care in New York State: 2019 Report. https://www.pcdc.org/wp-content/uploads/Resources/Rural-Access-to-Primary-Care-in-New-York-State-_-2019-Report.pdf
2. Recipe for more rural physicians: More exposure in residency training. American Medical Association. Published September 27, 2022. Accessed February 23, 2024. https://www.ama-assn.org/medical-residents/transition-resident-attending/recipe-more-rural-physicians-more-exposure
3. New York State Council on Graduate Medical Education Report of Activities, November 2019.https://www.health.ny.gov/professionals/doctors/graduate_medical_education/reports/docs/report_of_activities_november_2019.pdf

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 111

Introduced by: 3rd & 4th Districts

Subject: Scope of Practice for Medical Assistants

Referred to: Reference Committee on Governmental Affairs B

Whereas medical assistants are valuable adjuncts in providing healthcare; and

Whereas it is becoming increasingly desired by many practices that medical assistants be allowed to administer immunizations; and

Whereas the scope of practice of medical assistants has traditionally been determined by the their supervising physicians/employers; and

Whereas it is increasingly common that a medical assistant's employer is not the same as their supervising physician; and

Whereas MSSNY policy 115.994 indicates that "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"; be it therefore

RESOLVED that MSSNY update policy 115.994 to read as follows: MSSNY will develop and promote regulation and/or legislation that allows Medical Assistants to continue to perform the usual duties of their position, including the administration of immunizations, if their supervising physician has evaluated and approved their ability to do so in a directly supervised setting, making this a part of the Annual Legislative Agenda until this goal has been attained.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 112

Introduced by: NASSAU COUNTY

Subject: Advocating for the Addition of Osteopathic Distinction/ "DO" Option on Customizable License Plates in New York State

Referred to: Reference Committee on Governmental Affairs B

Whereas, the Osteopathic medical profession plays a vital role in healthcare delivery in New York State[1]; and

Whereas, personalized license plates provide a unique opportunity for individuals to express their professional identities, interests, and affiliations, contributing to a sense of pride and community; and

Whereas, as of June 2023, Medical Professionals, including Acupuncturists, NYSCA Chiropractors, DCH Doctors of Dental Surgery, Medical Doctors (MDs), New York State Dental Association DDSs, New York State Dental Association DMDs, Nurse Practitioners, Optometrist/Ophthalmic Dispenser/Opticians, Podiatrists, Pharmacists, Physical Therapists, Physician Assistants, Psychologists, Registered Nurses, Respiratory Therapists, and Veterinarian Visiting Nurses all have custom options identifying themselves in registered vehicles through a custom DMV[2]; and

Whereas, the Vision Statement of NYSOMS is “advocating on behalf of all Osteopathic physicians in New York State, disseminating information that is beneficial to Osteopathic physicians, students, and the public”[3]; and

Whereas, the current options for customizable license plates in New York State do not include a specific designation for Osteopathic physicians (DO), limiting their ability to showcase their professional identity on their vehicles; and

Whereas, allowing a "DO" option on customizable license plates would provide Osteopathic physicians with an opportunity to proudly display their professional affiliation, contributing to public awareness and recognition of the Osteopathic medical profession; therefore be it

RESOLVED, that MSSNY shall engage in proactive dialogue with the appropriate bodies, including the New York State Department of Motor Vehicles (DMV) and legislative representatives, to advocate for the inclusion of a "DO" option on customizable license plates.

References:

1. AOA Physician Masterfile, May 31, 2022; AOA OMP Reports 1995-2020. <https://osteopathic.org/wp-content/uploads/2022-AOA-OMP-Report.pdf>
2. New York State Department of Motor Vehicles: Plates-Professions. New York DMV. (2014, February 21). https://dmv.ny.gov/plates/professions <https://dmv.ny.gov/plates/professions>
3. NYSOMS: Mission and Vision. NYSOMS.org. (n.d.). https://www.nysoms.org/mission-and-vision <https://www.nysoms.org/history>

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 113

Introduced by: New York ACEP

Subject: Mandating Emergency Department Patient Management

Referred to: Reference Committee on Governmental Affairs B

Whereas, New York State Emergency Departments (ED) have been strained beyond capacity with increasing volumes of critically ill patients, increasing numbers of admitted patients boarding in the ED, increasing numbers of patients with psychiatric illness being held pending availability of psychiatric hospitalization, and patients seeking non-urgent care who are unable to access healthcare elsewhere; and

Whereas, regulatory bodies may impose mandates, which may be unfunded, upon EDs requiring screening and testing for conditions in all patients, without regard for specific indications, and without engagement of relevant stakeholders,

Whereas, compliance with such mandates is often unindicated, overly burdensome, and diverts human, lab, and other resources away from patients and ED operations; therefore be it

RESOLVED, that Medical Society of the State of New York (MSSNY) create a position statement to be sent to the New York State Department of Health and Office of Mental Health which calls for engagement with relevant stakeholders including designees from bodies who represent Emergency Medicine providers, whenever mandates or regulations appertaining to ED operations are being considered; and be it further;

RESOLVED, That the MSSNY position statement request that with any new mandates or regulations, there be appendant provision of resources and/or funding to the Emergency Departments sufficient for compliance.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 114

Introduced by: Ninth District Branch
(Dutchess, Orange, Putnam, Rockland and Westchester Counties)

Subject: Discharge summaries from Skilled Nursing Facilities

Referred to: Reference Committee on Governmental Affairs B

Whereas, physicians are encouraged to see patients after they are discharged to coordinate care and prevent re-hospitalization; and

Whereas, many patients are transferred to skilled nursing facilities after discharge from the hospital; and

Whereas, hospitals are required to provide discharge summaries to the patient's physician; and

Whereas, patients can experience significant medical incidents while at a skilled nursing facility; therefore be it

RESOLVED, that MSSNY seek through legislation and/or regulation that Skilled Nursing Facilities shall be required to provided discharge summaries of a patient's clinical course while admitted to a skilled nursing facility to a patient's physician for the purpose of continuity of care.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 115

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland and Westchester Counties)
Subject:	Definition of medical necessity in terms of patient autonomy
Referred to:	Reference Committee on Governmental Affairs B

Whereas, patients have the right to determine what medical interventions will be performed on their bodies (patient autonomy); and

Whereas, patient autonomy is a cornerstone of Medicine and informed consent; and

Whereas, patients pay for or are provided with health insurance with the expectation that their health care will be paid for subject to good and accepted standards of care by the physician or other provider of their choice; and

Whereas, when a course of treatment is recommended and is discussed with a patient with their physician (provider) and is accepted by the patient and physician (provider), the course of treatment shall be defined as medically necessary and reasonable; and

Whereas, health insurers profit from the delivery of health care, and this profit motive creates a unresolvable conflict of interest in determining what is medically necessarily and therefore should not be determined by the insurer; and

Whereas, preauthorization harms patients by denying timely access to care without any evidence of improvement in outcomes. Preauthorization only serves to limit health care expenditures to the benefits of the health insurer and employers who pay for care; therefore be it

RESOLVED, that MSSNY through legislation and/or regulation advocate that if a physician determines a treatment is medically necessary, and the patient desires to proceed with the prescribed treatment, then under the doctrine of patient autonomy under NY State and Federal Law, no insurer in NY State shall be allowed to give themselves the right to deny coverage for the prescribed treatment; and be it further

RESOLVED, that MSSNY seek through legislation and/or regulation that there shall be no preauthorization requirement allowed by CMS or NY State Health Insurers for medically necessary interventions; and be it further

RESOLVED, if the insurers wish to deny coverage for medically necessary interventions, then the insurer must prove that the intervention is 1) not FDA approved, 2) not CMS approved and 3) not reasonable as defined by lack of ANY published peer reviewed data to support the intervention without delaying the timing of the intervention; and be it further

RESOLVED, that MSSNY seek through legislation and/or regulation that the use of third party companies paid for by insurers to determine the level of evidence required shall be invalidated since the third parties by association with insurers also have an unresolvable conflict of interest; and be it further

RESOLVED: MSSNY shall forward this or a similar resolution to the AMA for application to apply to ERISA plan and CMS payers

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References:

Existing MSSNY Policy: None

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 116

Introduced by: New York County Medical Society

Subject: Formation of a Physician Patient Coalition

Referred to: Reference Committee on Governmental Affairs B

Whereas: There has been a rapid transformation in our healthcare system from a private practice to an institution based model; and

Whereas: There are greater regulatory and administrative hurdles that reduce the efficiency and raise the cost of providing medical care in this new environment; and

Whereas; There is increased frustration by patients and physicians regarding the role of the physician and how they interact with their patients; and

Whereas; There are patient issues regarding scheduling follow up visits and obtaining prompt appointments for semi-urgent conditions; and

Whereas: The patients blame the physicians for all of the problems that they have in this institution based system; and

Whereas: Many of the problems the patients face are beyond the control of the physician; therefore be it

RESOLVED, That the Medical Society of the State of New York engage and interact with patient advocacy groups to find common ground regarding healthcare issues; and be it further

RESOLVED, That when there is common ground that MSSNY and the patient advocacy groups work together to advocate for mutually agreed upon legislative and institutional reforms in our healthcare system

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References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution: 117

Introduced by: Medical Society of the County of Kings & Alex Shteynshlyuger MD

Subject: Physician victims of hacking

Referred to: Reference Committee on Governmental Affairs B

Whereas healthcare system is highly dependent on electronic transactions, which are mandated under HIPAA. In fact, many health plans refuse to continue traditional non-electronic methods with many refusing to pay claims by check if a provider is not enrolled in EFT and instead forcing costly virtual credit cards.

Whereas every interaction between health plans, insurance companies and providers involves an electronic standard: eligibility verification, claim submission, electronic remittance advice, ACH EFT, prior authorization, healthcare electronic attachments, claim denial appeals, prior authorization appeals, and many more.

Whereas, electronic fraud and sabotage are prevalent and can affect any organization even when reasonable measures are taken to prevent it. Multiple organizations including hospitals, medical societies, the FBI, federal government, and insurance companies and vendors including United Healthcare and Change Healthcare have been victims of electronic fraud and sabotage in the form of electronic attacks, system infiltration, hacking, and other criminal activities.

Whereas there are legal timeline limits on counterparty activities such as claim submission, prior authorization, appeals that may result in loss of rights by physicians and patients.

Resolved that the MSSNY advocates and asks the AMA to advocate for state and federal laws and regulations that protect patients and doctors rights to due process when criminal activities result in temporary or permanent damage to electronic systems, limitations on physician ability to electronically transfer consistently with CAQH transaction uptime rules by extension of the deadline by at least 90 days or 4 times longer than the loss of transaction availability based on calendar day requirements of greater than 90% uptime.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 118

Introduced by: NASSAU COUNTY

Subject: Helium Shortages in the USA

Referred to: Reference Committee on Governmental Affairs B

Whereas, Helium has many industrial uses including in semiconductor chip manufacturing, and nuclear power plant cooling, it also is necessary for MRI magnets to operate; and

Whereas, approximately 40 million MRI scans are done yearly and every one of those magnets require helium for cooling; and

Whereas, in 2020, the Bureau of Land Management said it was to auction off the federal system to comply with the 2013 Helium Stewardship Act, which requires helium assets to be privatized. There was an auction in 2023 with bids being unsealed in Jan 2024, showing industrial gas company Messer as the highest bidder and the United States the world's largest producer of helium; and

Whereas, transfer of federal control to Messier is likely to cause regulatory and logistical issues that could result in a temporary shutdown of production as the facility spans three states with its own laws. Additionally, helium needs to be enriched and that is not part of the federal sale, so either Messer will need to lease such capacity or build its own, which is likely to lead to significant delay; and

Whereas, in recent years there have been helium shortages that have already started to effect basic science research that utilizes helium; and

Whereas, the compressed gas association that represents industries that rely on helium have urged the Biden Administration to delay privatization that could disrupt the supply of helium; and

Whereas, the other major producers of helium are Russia and Qatar, however global events are such that reliance on those sources is dubious; and

Whereas, according to the NY Times (Feb 3, 2024), Premier Inc, a major supplier of helium to hospitals and health care systems is talking about guidelines to start rationing helium; therefore be it

RESOLVED, in the interest of protecting patients' ability to access MRI imaging, the Medical Society of the State of New York urge the delay of the sale and privatization of the Federal Helium Reserve until issue of supply chain shortages, both current and potential future, can be resolved; and be it further

RESOLVED, that a copy of this resolution be transmitted to the AMA for consideration at its House of Delegates

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References:

Existing MSSNY Policy:

2024 HOUSE OF DELEGATES
MEDICAL SOCIETY OF THE STATE OF NEW YORK
Report of the Recommendations for Sunset of Policy Adopted 2014
Charles Lopresto, MD, Chair
MSSNY Public Health and Education Reference Committee

Mister Speaker, Your Reference Committee recommends that the policies contained in the 2024 Public Health and Education Sunset Report be acted upon in the manner indicated and that the remainder of the report be filed.

ITEMS RECOMMENDED TO BE REAFFIRMED

10.981 Child Safety Seats:
MSSNY will seek and support legislation that mandates that automobile rental agencies provide child safety seats whenever needed, free of charge. (HOD 1998-167; Reaffirmed HOD 2014).

RECOMMENDATION: REAFFIRM. Policy is still relevant.

10.982 Expanded Use Of Safety Helmets:
MSSNY will pursue legislation which would require the use of helmets for all cyclists, inline skaters, skateboarders, alpine skiers, snowboarders, scooters and roller skaters, regardless of age. (HOD 1997-176; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRM. Policy is still relevant.

10.983 In-Line Skating Injuries:
MSSNY supports the use of full protective equipment for in-line skating and supports appropriate efforts to educate adults and children about in-line skating safety, such as encouraging physicians to educate their patients about the importance of safety equipment use, and working with organizations like the American Academy of Pediatrics to promote widespread distribution on information and educational materials about in-line safety, including the use of protective equipment, to both medical and non-medical audiences. MSSNY will urge state consumer protection agencies to require the availability of all safety equipment at the point of in-line skate purchase or rental and will support legislation requiring the mandatory use of full protective equipment for children 16 years of age and younger. (Council 12/14/95; Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRM. Policy is still relevant.

15.965 Expansion of HIV Prevention Programs in Prisons:
MSSNY will urge the New York state Department of Corrections to develop and implement comprehensive HIV prevention and education programs specifically designed for the prison population. (HOD 1997-157; Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

20.898 Blood Alcohol Level and Driving:
MSSNY supports efforts to lower the current drinking level standard from 0.08% to the more desirable alcohol level of 0.05%. (HOD 1997-182; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRM. Policy is still relevant.

20.900 Sales Tax Increase on Alcohol and Cigarettes:
MSSNY supports an increase in the tax on alcohol and cigarettes in order to discourage alcohol and cigarettes use. (HOD 1993-124; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

20.995 Deleterious Effects of Alcohol Consumption:
MSSNY supports programs which warn the public about the risk associated with the consumption of alcohol as it affects both men and women. (HOD 1991-120; Modified and affirmed HOD 2014)

RECOMMENDATION: REAFFIRM. Policy is still relevant.

30.988 Maintaining Tax Exempt Status for Youth Service Organizations
The MSSNY will oppose any New York State legislation that would remove the property tax exemptions currently granted to non-profit youth service organizations, such as 4H, Boy Scouts, Girl Scouts, and religious groups for the purpose of maintaining wilderness camps throughout New York State for the purposes of providing outdoor experiences for any of our youth. (Amended and adopted Council 11/20/2014. From HOD 2014-209)

RECOMMENDATION: REAFFIRM. Policy is still relevant.

30.990 Dangers of Youth Football
The Medical Society of the State of New York will promote the New York State Department of Health's "When in Doubt...Take Them Out!" sports related concussion prevention campaign and the Sports Concussion Tool Kit developed by the American Academy of Neurology to its members. (HOD 2014-151)

RECOMMENDATION: REAFFIRM. Effective 12/2/2019, tackle football programs in NYS are required to provide informational packets about concussions, and sub-concussive blow, and injuries that might occur because of the blows, to parents and guardians participating in football programs. The NYS DOH continues its "When in Doubt...Take Them Out!" sports-related concussion prevention campaign which is designed to empower coaches, parents, athletes, and school administrators to effectively prevent, recognize, and respond to concussions. The campaign includes a fact sheet for coaches and parents, a poster, a magnet, and a clip board for coaches.

30.995 Immunization of Adolescents:
MSSNY endorses the immunization recommendations for adolescents as set forth by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and will urge NYS to adopt ACIP immunization requirements for adolescents as a condition for school attendance so that the state will be able to participate in the movement toward universal protection. (HOD 1996-157; Reaffirmed HOD 2014; Reaffirmed HOD 2016-163)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

75.976 Cannabis for Seriously Ill Patients
The Medical Society of the State of New York (MSSNY) adopts as policy the following principles:
1) That the use of cannabis may have a role in treating patients who have been diagnosed with serious, debilitating illnesses, when all other treatments have failed; or when clinical trials have shown to demonstrate comparable efficacy to currently accepted treatments.
2) The Medical Society of the State of New York recognizes the risk of smoking cannabis and encourages the use of alternate delivery systems.
3) Physicians who recommend cannabis for patient use, subject to the conditions set forth above, shall not be held criminally, civilly or professionally liable.
The Medical Society of the State of New York supports continued high quality clinical trials on the use of cannabis for medical purposes. (HOD 2014-161)

RECOMMENDATION: AFFIRM. Policy is still relevant.

75.986 Herbal Supplements:
(1) MSSNY will work with the American Medical Association to educate physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's database of adverse event information on these forms of alternative/complementary therapies;

(2) MSSNY, in conjunction with the AMA, supports efforts to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA post-marketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement;
(3) MSSNY will work with the AMA to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements;
(4) That the product labeling of dietary supplements and herbal remedies contain the following disclaimer as a minimum requirement: "This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease." This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product;
(5) That in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label; and
(6) MSSNY will continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies. (HOD 2004-151; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRM. While some of the objectives of this policy have been obtained, it is still input for MSSNY to continue to have a position regarding herbal supplements and to ensure that safety of herbal and dietary supplements is important.

85.980 Nutrition, Physical Activity and Weight Management Curriculum in Medical Schools:
MSSNY encourages all New York State medical schools to develop a nutrition, physical activity and weight management curriculum at both the basic science level and the clinical level; (2) that MSSNY also encourage New York State medical schools to integrate nutrition and physical activity education into their residency programs and encourage the development of bariatric medicine fellowship programs. (HOD 2004-161; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRM. Policy is still relevant.

85.994 Hepatitis Vaccinations for all Medical Students:
MSSNY supports efforts to require all medical students to be vaccinated for Hepatitis A and B unless they have already been vaccinated; and will also require everyone entering a US residency training program to be vaccinated for Hepatitis A and B if they have not yet received vaccination. (Council 3/27/97; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. While Hepatitis A and B are on the child and adult immunizations schedule, there may be medical students and/or residents who have not receive this immunization. Therefore, it is important to maintain this policy.

85.997 Animals in Biomedical Research:
MSSNY supports the humane use of animals in biomedical research and advocates support of regulatory policies to protect animals from unnecessary uses in biomedical research. (HOD 91-49; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.
95.981 Cloning:
It is the policy of MSSNY that there should be a moratorium by the medical and research communities on cloning human beings. Congress should permit human, animal or cellular cloning related research that is not directed at producing a human being. (Council 5/21/98; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

95.985 Physician Participation in Capital Punishment:

MSSNY has adopted the following policy statement relative to Physician Participation in Capital Punishment:

(1) An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life, when there is hope of doing so, should not be a participant in a state execution. "Physician participation in execution" is defined generally as actions which would fall into one or more of the following categories: (a) An action which could automatically cause an execution to be carried out on a condemned prisoner; (b) An action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (c) An action which could automatically cause an execution to be carried out on a condemned prisoner.

(2) Physician participation in an execution includes but is no limited to the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications which are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

(3) In the case where the method of execution is lethal injection the following actions by the physicians would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; consulting with or supervising lethal injection personnel. (4) The following actions do not constitute physician participation in execution:

(a) Testifying as to competence to stand trial testifying as to relevant medical evidence during trial, or testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case; (b) Certifying death provided that the condemned has been declared dead by another person; (c) Witnessing an execution in a totally non-professional capacity; (d) Witnessing an execution at the specific voluntary request of the condemned person, providing that the physician observes the execution in a non-physician capacity and takes no action which would constitute physician participation in an execution; and (e) Relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to relieve pain or anxiety in anticipation of the execution. (HOD 1995-71; Modified and reaffirmed HOD 2014).

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

105.998 Discrimination, Prevention of Selective in Insurance Plans:

MSSNY will introduce or support legislation to forbid insurance companies from using as criteria for issuance of coverage or premium rating for health, life and disability policies information derived from genetic screening. (HOD 1996-172; Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. In 1996 the Health Insurance Portability and Accountability Act (HIPAA) was created which prevents employers from denying health insurance based on genetic information. The Americans with Disabilities Act of 1990, and the Equal Employment Opportunity Commission of 1995, also provide some protection. Bills have been introduced in the NYS Legislature that would not allow life insurers, long-term care insurers and others to use genetic information when issuing policies, determining premiums, etc.

120.992 Insurance Companies To Cover Screening Mammography:

MSSNY will seek requiring all health insurance products to cover mammography whenever the patient's physician deems it medically appropriate. (HOD 1997-255; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

125.994 Use of CT Scans for Early Detection of Lung Cancer:

The Medical Society of the State of New York supports screening for lung cancer with low dose computed tomography for patients who meet current nationally recognized guidelines. (HOD 2014-157)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

130.997 Maternal and Infant Care:
MSSNY supports universal access to maternal and infant care; to family planning, pre-pregnancy related health care evaluation, pregnancy diagnosis, nutritional support, substance abuse counseling, full pregnancy related services, labor and delivery, postpartum evaluation, neonatal care, and infant care. (HOD 92-56; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant

255.999 Opposition to Protests Which Impede Access to Health Care:
MSSNY is vehemently opposed to any interference with patients' access to desired health care services by demonstrators or protesters. (HOD 1990-30; Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

260.909 Protecting Public Health from Elevated Radon Exposure:
The Medical Society of the State of New York supports policy that limits exposure to radon and its decay products which are known to cause primary lung cancer in non-smokers and potentiate the likelihood of lung cancer in smokers.

The Medical Society of the State of New York supports legislation that protects public health by ensuring that New York State is committed to reducing sources of excess radon emissions, and monitoring radon gas exposure levels to confirm that these radon gas levels do not exceed the recommended levels set by the Environmental Protection Agency. (HOD 2014-154)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

260.941 Adequate Cell Phone Service Throughout New York State:
MSSNY will continue to support all appropriate efforts of the state and municipalities to eliminate cell phone dead zones in all service areas of New York State in the interest of public safety. (HOD 2004-158; Reaffirmed HOD 2014)

RECOMMENDATION. REAFFIRM. This policy is still relevant as there are still places in New York State that does not have any cell service.

260.943 Government to Support Community Exercise Venues:
MSSNY encourages towns, cities and counties across New York State to make recreational physical activity more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational and fitness facilities; and encourage municipalities to provide tax breaks and grants toward these community projects in the same way that they support the building and maintenance of highways, shipping harbors, railroad lines, and airports. (HOD 2004-152; Modified and reaffirmed HOD 2014)

RECOMMENDATION. REAFFIRM. This policy is still relevant.

260.974 Calcium, Optimal Intake of:
MSSNY supports efforts to educate both patients and the public about the need for optimal dietary calcium intake in all age groups to prevent osteoporosis. (HOD 1996-159; Modified and Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

260.975 Scented Inserts in Magazines and Mailings, Prohibition of:
MSSNY will advocate to prohibit the unsolicited distribution of scented inserts and other odor-emanating materials in magazines and through the mail because of the deleterious effects it has on the health of many individuals. (HOD 1996-171; Modified and Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

260.977 Domestic Violence As A Public Health Threat
MSSNY recognizes domestic violence as a public health threat in the State of New York and supports legislative, regulatory, and other efforts in the State that will lead to protection of domestic violence victims, and abatement of domestic violence. (HOD 1995-163; Modified and Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

260.988 Prisoners - Medical Care For:
MSSNY affirms the position that each person arrested and detained, even overnight, has the right to needed medication, medical attention and protection against exposure to contagious disease. (HOD 1993-71; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

260.992 Breast Feeding:
MSSNY supports the following initiatives in regard to breast feeding of infants:
(1) Educating its members about the process and benefits of breast feeding.
(2) Encouraging innovative and educational programs for use in medical training about the clinical benefits and process of breast feeding.
(3) Cooperating with other professional medical groups to encourage breast feeding education programs at national and regional meetings of pediatricians, obstetricians, and family physicians.
(4) Encouraging all of its members, regardless of specialty, to offer professional and emotional support for their patients who are breast feeding mothers.
(5) Continue to support the law that women may not be charged with indecent exposure or lewd behavior as a result of breast feeding in public. (HOD 1993-27; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

290.998 Physician Coverage at Interscholastic Events:
The physician assigned and/or designated by the managing authority (i.e., New York State Public High School Athletic Association, school district, specific school or the New York State Education Department) of the interscholastic competition shall have the final decision-making authority concerning the entry/re-entry of an athlete to competition at the particular contest. (Council 10/19/95; Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

300.963 Local Tobacco Ordinances, State Preemption of:
MSSNY supports the right of local jurisdictions to enact tobacco control regulations that are stricter than those contained in state statutes and strongly opposes efforts to preempt this right through state legislation. (HOD 1996-158; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

300.966 Tobacco Subsidies
MSSNY supports efforts to enact federal legislation which would discontinue the subsidies to tobacco farmers. (HOD 1993-86; Modified and reaffirmed HOD 2014).

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

300.968 Pharmacies - Commendation for Not Selling Tobacco Products
MSSNY publicly commends pharmacies that do not sell tobacco products and asks its members and patients to patronize pharmacies that do not sell tobacco products. (Council 10/29/92; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

300.969 Tobacco Industry "Health Education"
MSSNY continues to reject the tobacco industry as a credible source of health education material, and encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry. (Council 10/29/92; Modified and reaffirmed HOD 2014*)*

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

300.973 Warning Labels on Cigarette Packs
MSSNY supports having: (1) Warning labels on cigarette packs which appear on the front and the back and occupy at least twenty-five percent of the total surface area on each side; and (2) In the case of cigarette advertisements, labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (3) Warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets. (Council 5/14/92; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

300.979 Tobacco Marketing Aimed at Women, Children and Minorities
MSSNY denounces marketing of tobacco products specifically aimed at woman, children and minorities. (HOD 1990-31; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

320.999 Physical Activity Increase for US Adults and Children
MSSNY supports The US Department of Health and Human Services recommendation for every adult to have 150 minutes of moderate to vigorous activity a week and for children to have 60 minutes in the course of each day. (HOD 1995-172; Reaffirmed HOD 1999-151; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION. Policy is still relevant.

REAFFIRMATION WITH MODIFICATION

5.993 Unintended Pregnancies:
~~Women~~ **Individuals** with an unintended pregnancy are less likely to seek early prenatal care and could expose the fetus to harmful substances such as tobacco, alcohol and other drugs. Harmful exposure and the lack of early prenatal care can lead to low birth weight newborns due to premature birth and/or growth retardation in utero. Low birth weight is the most important risk factor for infant morbidity and mortality, and infant mortality is commonly used as a health status indicator of the population. Unfortunately, this country has an infant mortality rate that is higher than most industrialized countries.

The Medical Society of the State of New York supports requiring any prescription drug plans offered by insurance companies and health maintenance organizations to cover the cost of prescriptive contraceptives. Furthermore, the Medical Society supports direct access for women to obstetric and gynecologic services. (White Paper on *Women's Health Initiatives* Council 11/2/00; Modified and reaffirmed HOD 2014).

RECOMMENDATION: REAFFIRMATION WITH MODIFICATION. Policy is still relevant, however there was a slight change in wording from women to individuals.

15.979 Physicians' Duty to Treat HIV Seropositive Patients:
MSSNY ~~**endorses the position**~~ **supports the concept** that a physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is HIV seropositive. Physicians who are unable to provide the services should make referrals to physicians or facilities equipped to provide such services. Persons who are HIV seropositive should not be subjected to discrimination based on fear or prejudice. (Council 1/31/91; Modified and reaffirmed HOD 2014**)**

RECOMMENDATION: REAFFIRMATION WITH MODIFICATION. Policy is still relevant; there was a slight amendment indicating a change in phrase.

20.991 Advertising Ban:
In the interest of promoting better health in our communities, the Medical Society of the State of New York ~~takes the position towards~~ **supports** banning alcohol advertising on billboards near all schools and public housing and at sporting events. Billboard advertisements should not be placed less than five city blocks or 1,500 feet from all schools and public housing. (HOD 1992-100 & 1992-101; Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. Policy is still relevant, and the modification reflects the support of the advertising ban.

65.988 Availability of Treatment Slots for Substance ~~Abusers~~ USE:
The Medical Society of the State of New York ~~will urge the New York State Department of Health to commission a study analyzing the projected substance abuse treatment slots needed from drug crime sentencing to ensure the system will be equipped to handle the increased volume and if there is a shortage of substance abuse treatment slots projected, the Medical Society of the State of New York will lobby~~ **supports efforts** to increase **the number of substance use** treatment slots available to meet the need. (HOD 2014-114)

RECOMMENDATION: REAFFIRMATION WITH MODIFICATION. Policy is still important but was updated to take a more proactive position to support efforts to increase the number of treatment slots; language was also to reflect changes in terminology.

65.990 Use of Naxolone to ~~Prevent~~ Treat Drug Overdoses:
MSSNY supports the use of intra-nasal Naxolone in the ~~prevention~~ **treatment** of drug overdoses. (Council 3/10/2014)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. Policy is still relevant, however, the word treatment better reflects what occurs when naloxone is administered.

65.995 Opioid Dependent Patients: Changes in Treatment Venue of ~~Stable~~ Patients:
MSSNY supports efforts ~~**of federal and state agencies**~~ to permit properly trained and qualified practicing physicians to engage in the independent treatment of opioid dependent patients. ~~who have attained behavioral and social stability under standard treatment.~~ (Council 9/7/00; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION WITH MODIFICATION. The policy is still relevant and was modify slightly to reflect all efforts to allow physicians to treat opioid dependent patients in different setting. The title was also changed to eliminate the word stable.

87.993 Concussion and Traumatic Brain Injuries in Youth:
MSSNY **will continue** to advocate for the immediate removal from play/practice of any youth suspected of having a concussion or Traumatic Brain Injury (TBI) and also that any youth suspected of sustaining a concussion or traumatic brain injury need written approval by a physician before they can return to play or practice. ~~**In addition**~~, MSSNY will **continue to** promote adoption of this policy within school settings and organized youth sports programs and support educational efforts to improve understanding of concussion and traumatic brain injuries in youth among coaches, trainers, athletes, school officials, parents and legal guardians. (HOD 2011-153; Reaffirmed HOD 2014-151).

RECOMMENDATION: REAFFIRM WITH MODIFICATION. This policy is still relevant, and a law called the Concussion Management and Awareness Act issued guidelines for return to school and certain school activities apply to all public-school students who have sustained a concussion regardless of where the concussion occurred. The law also requires that school coaches, physical education teachers, nurses, and certified athletic trainers complete a New York State Education Department (NYSED) approved course on concussions and concussion management every two years. Finally, the law requires that students who sustained, or are suspected to have sustained, a concussion during athletic activities are to be immediately removed from such activities. Students may not return to athletic activities until they have been symptom-free for a minimum of 24 hours and have been evaluated by and receive written and signed authorization to return to activities from a licensed physician. The policy was amended slightly to indicate that MSSNY still advocates for removal of any student suspected of having incurred a concussion.

260.938 Individuals with Autism and Intellectual Disability:
MSSNY **continues to support** ~~**will seek the passage of**~~ state and federal ~~**legislation increasing the**~~ funds **be** available for research and treatment of individuals with autism and for individuals with an intellectual disability. (HOD 2004-164; Modified and reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMANTION WITH MODIFICATION. The Autism Collaboration, Accountability, Research, Education and Support Act (CARES) of 2019 reauthorized and expanded the provisions first introduced in the Combating Autism Act of 2006. The Autism CARES Act ensures support for research, services, prevalence tracking, and other government activities. The new legislation increases the annual authorized federal spending on autism efforts to $369.7 million through 2024. The policy was amended to reflect that MSSNY continues to support funding for this.

285.998 Equality in the Provision of Quality Health Care:
The Medical Society of the State of New York (MSSNY) reaffirms its longstanding principle that it is unequivocally opposed to any form of discrimination in the provision of quality medical care to any individual because of race, color, religion, sex, sexual orientation, **ethnicity**, **age,** national origin, **gender identity, abilities,** or underlying disease process. The Society calls upon all component county medical societies as well as its entire membership to: a) be vigilant as to the existence of any such discrimination in the provision of health care in their respective areas; b) expend every effort towards eliminating such discriminatory practices wherever they may exist, regardless of the settings in which the health care is delivered.

It is the position of MSSNY that the withholding of the best available care to any individual on a discriminatory basis is abhorrent to the Society, its membership, and the medical profession at large. The Society, therefore, vigorously affirms that equality of medical care should be scrupulously and compassionately afforded across the entire patient community, without exception.

MSSNY's Committee **on Health Equity** ~~**to Eliminate Health Care Disparities**~~ will continue to work with the AMA**'s Health Equity Center** ~~**Commission to End Health Care Disparities**~~ to encourage other State Medical Societies and Specialty Societies to establish standing committees to help eliminate ~~**health care disparities**~~ **inequities** wherever they exist. (Council 1/20/00; Reaffirmed HOD 2004-174; Reaffirmed Council 9/9/04; Revised and reaffirmed HOD 2014).

RECOMMENDATION: REAFFIRMATION WITH MODIFICATION. This policy is still relevant but was modified to reflect the name change of MSSNY's Health Equity Committee and the AMA's Health Equity Center and to add age, gender identity and abilities.

290.996 Drug Free Schools:
MSSNY advocates drug free schools, continues to condemn the use among student athletes of any and all performance enhancing drugs, and ~~**will**~~ recommend**s** that the New York State Dept. of Education and all secondary school athletic associations **continue to support** ~~**adopt a policy**~~ **of including** educational programs on the dangers of drug use, and the use of nutritional supplements in athletics, in all interscholastic athletic programs, and advocates for closer self-scrutiny to monitor the effectiveness of programs.

~~**Further, MSSNY will urge these same agencies to seriously consider and investigate the feasibility of reasonable suspicion or reasonable cause drug testing of athletes on all New York State championship teams, modeled after established Olympic drug testing protocols, with disqualification of an entire team if any member of the team test positive.**~~ (Council 3/9/95; Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION WITH MODIFICATION. The policy stems from 1995, the first paragraph was amended to reflect where NY State schools currently are regarding drugs and supplements. Additionally, the second paragraph was recommended be eliminated this has been accomplished on an international level. The US Anti-Doping Agency (USADA) provides a program, with policies and procedures in accordance with the World Anti-Doping Code, the WADA International Standards, the United States Olympic & Paralympic Committee Anti-Doping Rules, and the USADA Protocol for Olympic and Paralympic Movement Testing.

300.955 Tobacco Tax Use:
MSSNY will support legislation that would increase the state tax on the sale of tobacco products, with the proceeds to be used for a comprehensive anti-tobacco campaign, expanded access to clinical care for uninsured New Yorkers, including care provided by private physicians, and other appropriate purposes. Included in the anti-tobacco effort would be an anti-tobacco advertising campaign**.** ~~, similar to those that were implemented as a result of "Question 1" legislation in Massachusetts~~. (HOD 1999-56; Reaffirmed HOD 2014)

RECOMMENDATION: REAFFIRMATION WITH MODIFICATION. This further details how MSSNY would like the increase on tobacco taxes to be used, but the policy was modifed to take out reference to Massachusetts' 2014 legislation.

POLICIES RECCOMMENDED TO BE SUNSET

10.978 Physician's Role in Driver Safety:
MSSNY affirms its active role in driver safety in New York State and (a) will support Department of Motor Vehicles regulations that promote reaffirmation and verification of the minimal driver standards at each renewal cycle; (b) support the role of the Medical Advisory Board of the Department of Motor Vehicles in its goal to establish "total driver qualifications" and a scale that measures medical conditions affecting driver safety (MCADS) for all drives in New York State; (c) encourage physicians to assess patients' physical and mental impairments that may affect driving abilities, and in situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, it is desirable and ethical for physicians to notify the Commissioner of Motor Vehicles and release clinically pertinent information to help determine whether or not the patient can continue to drive safely, consistent with the American Medical Association Council on Ethical and Judicial Affairs Report 1-I-99; and (d) support legislation that would allow a physicians, family members and caregivers to report impaired drivers to the Commissioner of Motor Vehicles for reevaluation and provide immunity from civil or criminal liability for reporting or not reporting when such is done in good faith. (HOD 2000-171; Reaffirmed HOD 2014).

RECOMMENDATION: SUNSET. This policy, when first drafted in 2000, stipulated certain items and information on the MVA website has subsequently been changed. Therefore, the recommendation is to sunset this policy until such a time when there can be new information obtained. The Preventive Medicine and Family Health Committee also agreed that they would develop a more current policy.

15.975 HIV Infection, Counseling for as a Part of Routine Health Maintenance:
MSSNY supports routine HIV counseling and testing at the discretion of the physician without written consent. (HOD 1996-164; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. This has been accomplished legislatively.

15.975 HIV Infection, Counseling for as a Part of Routine Health Maintenance:
MSSNY supports routine HIV counseling and testing at the discretion of the physician without written consent. (HOD 1996-164; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. This has been accomplished legislatively.

15.980 Responsibilities of HIV Positive Physicians and Other Health Care Workers:
(1) All persons (including physicians and other health care personnel) engaging in high risk behavior have a responsibility to withdraw from or modify these practices, to notify sexual or IV drug abuser partners, to seek counseling and to consider having a determination of their HIV antibody status.
(2) Physicians and medical students have the responsibility to prevent transmission of communicable diseases to their patients. Physicians and medical students should, whenever appropriate, determine their HIV status. If a physician's ability to practice medicine is impaired, either physically or mentally by HIV infection or any other disease, he/she should not practice medicine. If a physician or medical student is HIV seropositive but not impaired, he/she should not engage in any professional activity for which there is scientific evidence of disease transmission to the patient. Adequate disability insurance coverage should be available to physicians and medical students who voluntarily limit their medical activities to reduce the risk of infecting patients with HIV.
(3) Physicians should not take upon themselves responsibility for determining the limitations to be placed on their medical practice. This should be the judgment of a peer review group representing the institution or locale of the physician's practice. Physicians are entitled to confidentiality no less than others, and safeguards to assure this must be put in place.
(4) The risk of transmission of HIV in health care settings is so infinitesimally small that, pending review of an individual practitioner by an appropriate panel, the Medical Society of the State of New York believes that universal disclosure of HIV status by physicians is not required. (Council 5/10/90; Council 1/31/91; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. The policy was developed in 1990; and the concepts included in this policy are no longer relevant or applicable today.

15.982 Condoms, Use and Advertising of:
For sexually active persons, the only instance when condoms are unnecessary for reduction of infection risk is within a long-standing, mutually monogamous relationship in which neither partner uses IV drugs and neither partner is infected with HIV. This applies to any sexual activity where the exchange of semen and/or blood is possible, including vaginal, anal, and oral sex. Natural membrane condoms do not protect against infection from the HIV virus. Therefore, the FDA allows only latex condoms to be labeled for the prevention of STDs, including AIDS. (HOD 1990-27; Modified and reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. The policy was developed in 1990; and the concepts included in this policy are no longer relevant or applicable today.

70.985 Opposition to Legalization of Non-Prescriptive Drugs Such as Heroin and Cocaine:
MSSNY physicians oppose the legalization of the use of non-prescriptive, potentially dangerous drugs such as heroin and cocaine. Use of such drugs poses a serious threat to the health of the individual and society. Use of potentially dangerous drugs frequently leads to limited reasoning ability, unproductive and antisocial behavior, an increase in the development of neurologic, psychiatric, infectious, and other medical diseases and fetal health problems. These health considerations outweigh any potential reduction in crime or reduction in the transmission of infection which might be anticipated from the legalization of such drugs. (Council 12/13/90; Modified and reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. The policy needs to be updated to reflect more current terminology and usage patterns and the Addiction and Psychiatric Committee will develop a new resolution for 2024 HOD.

70.988 Opposition to Legalization of Drugs for Non-Medically Indicated Uses:
MSSNY is opposed to the legalization for non-medically indicated uses of the following substances: hallucinogens, narcotics, and cocaine and ~~its~~ their derivatives. (Council 1/25/90; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. The policy needs to be updated to reflect more current terminology and usage patterns and the Addiction and Psychiatric Committee will develop a new resolution for 2024 HOD.

85.995 Infection Control Course, Mandated:
MSSNY will seek legislation to eliminate the statutory requirement that physicians complete course work or training in infection control practices every four years. (HOD 1995-67; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. The Infectious Control course required by NY DOH has been here for 30 years; the odds of it being repealed are nil.

145.996 Maintaining and Developing High Quality Hospice and Palliative Care:
The Medical Society of the State of New York recognizes that there is a shortage of physicians in geriatrics, hospice, and palliative care. By submitting this resolution to the AMA House of Delegates, will urge the American Medical Association to work with the various national medical specialty organizations to petition the American Board of Medical Specialties to develop alternative pathways to board certification for physicians with high quality experience and additional education to sit for the boards in hospice, palliative care, and in geriatric medicine. (HOD 2014-163)

RECOMMENDATION: SUNSET. This policy dates to 2014 and it has been difficult to trace back whether this was adopted by the AMA's House of Delegates. This issue is still prevalent, so the Long-Term Care Subcommittee should consider putting forth a new resolution for the 2024 House of Delegates

185.998 Autopsies Performed by Medical Examiner:
MSSNY will seek appropriate changes in New York State legislation and/or regulations to mandate the Coroner or Medical Examiner to release a copy of his autopsy findings to the attending physician and/or the hospital QA Committee in which the patient has expired. (HOD 95-105; Reaffirmed HOD 1999-82; Reaffirmed HOD 2014)

RECCOMMENDATION: SUNSET. This policy is no longer needed.

260.908 DVT and Air Travel:
The Medical Society of the State of New York (MSSNY) will request that the American Medical Association (AMA) encourage the Federal Aviation Administration (FAA) and the airline industry to alert passengers to the flight-associated risk of deep vein thrombosis (DVT) and that they provide recommendations to passengers to reduce their risk of developing DVT.
(HOD 2014-153)

RECOMMENDATION: SUNSET. This policy asked for involvement of the AMA and the FAA, however, the CDC discusses this in its Travelers Health portion of it's website. Therefore, the policy is not needed.

260.910 Support for the Breast Cancer Patient Education Act:
The Medical Society of the State of New York supports the American Society of Plastic Surgeons' campaign to pass the Breast Cancer Patient Education Act (Council 1/30/2014)
Note: summary copies of the Act are available from the Executive Headquarters office.

RECOMMENDATION: SUNSET. This act was accomplished federally in 2015.

260.959 Avian Monitoring for Encephalitis Viruses:
MSSNY will support and encourager the ongoing efforts of the New York State Department of Health regarding monitoring for encephalitis viruses. (HOD 2000-165; Reaffirmed HOD 2014).

RECOMMENDATION: SUNSET. This has been accomplished; the Department of Health now has the Viral Encephalitis Laboratory offers a molecular test panel for health care providers to assist in the diagnosis of hospitalized viral encephalitis cases.

260.960 Pain Management:
MSSNY will communicate with the New York State Department of Health and recommend the following: (1) that the New York State Department of Health coordinate educational activities on pain management with the Medical Society of the State of New York and national medical specialty societies in structuring voluntary educational programs for physicians on pain management; and (2) that the New York Sate Department of Health avoid threatening, punitive measures in dealing with the question of inadequate pain management. (HOD 2000-164; Modified and Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. This policy is outdated as New York State has statutorily moved to require three hours of pain management course work every three years. The statue also articulates the components of this course work.

290.995 Athletic Helmets, Removal of:
MSSNY's official position on the removal of athletic helmets is as follows: (a) Athletic helmets should not be removed on the playing field, other than for rare circumstances of obstruction of emergency medical care; and (b) Shoulder pads should be removed at the time of helmet removal at an emergency facility following appropriate x-ray and clinical evaluation and with the removal done under the supervision of an experienced physician. (Council 7/18/96; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. Since this policy was first drafted in 1996, there are procedures and medical protocols that now exist that are standard practice. Therefore, this policy should be sunset.

290.997 Mixed Gender Competition:

MSSNY maintains that gender specific sports participation, both before and after puberty, provides maximum opportunity and safety for a student athlete. MSSNY takes the position that students and their parents should be encouraged to select those sports that allow them the best opportunity for success in high school and beyond. However, in instances when a particular activity is not available for both genders, it is reasonable that an athlete be permitted to try out in a mixed gender interscholastic setting provided the following conditions are satisfied:

(1) The parents and student provide consent for participation and acknowledge understanding of the inherent risks of interscholastic, particularly contact/collision, mixed gender competition for their student athlete.

(2) The student has passed the basic routine pre-participation medical examination and interval health history.

(3) The school district enforces a strict disciplinary policy for sexual harassment or misconduct.

(4) The coach uses the same criteria for selecting and eliminating athletes as final team members based on athletic performance and capability alone.

Under the above conditions, there is no need for the student wishing to compete in a mixed gender activity to complete any additional tests or adhere to any different standards than are presently enforced for members of the opposite sex. The same rules, regulations, standards of conduct and expectations are upheld for all athletes regardless of sex. No special privileges or exemptions are granted based solely on sex, with the exception of appropriate separation of athletes for locker room. (Council 3/9/95; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. Policy is no longer relevant as even the Olympics now have mixed gender competition. Additionally, Title IX prohibits sex (including pregnancy, sexual orientation, and gender identity) discrimination in any education program or activity receiving federal financial assistance.

300.942 e-Cigarettes to Be Treated the Same as Tobacco Products

The Medical Society of the State of New York will urge the American Medical Association to seek federal legislation that would place "e-cigarettes" and all nicotine delivery devices under the purview of the US Food and Drug Administration. (HOD 2014-160)

RECOMMENDATION: SUNSET. In May 2016 the FDA used its authority under the Family Smoking Prevention and Tobacco Control Act to deem e-cigarette devices and e-liquids to be tobacco products, which meant it intended to regulate the marketing, labelling, and manufacture of devices and liquids; vape shops that mix e-liquids or make or modify devices were considered manufacturing sites that needed to register with FDA and comply with good manufacturing practice regulation.

300.954 Tobacco Settlement Funds:

MSSNY will work with state legislators, the Attorney General and other appropriate elected officials to seek passage of legislation that will devote a significant portion of tobacco settlement funds to: a comprehensive tobacco use prevention and cessation program similar to those now in place in Massachusetts, California, and Florida; and the expansion of access to medical care for the uninsured. MSSNY will immediately monitor and comment on plans emerging within the State on the proposed uses of the tobacco settlement monies and report back to the House periodically and not less than at each annual meeting. (HOD 99-58; Reaffirmed HOD 2014)

RECOMMENDATION: SUNSET. This has been accomplished.

315.986 A Resolution on Gun Violence:

The Medical Society of the State of New York will continue its efforts to seek amendments to the New York SAFE Act which would ensure that only those who present a "serious and imminent danger to self or others" are reported under the act. (HOD 2014-156)

RECOMMENDATION: SUNSET. MSSNY adopted policy 260.895 New York Safe Act which supports a "red flag" concept in New York State as well as educating physicians in New York State about the NYSAFE Act as a mechanism to help physicians reduce the risk of suicide in patients. This policy was adopted by the MSSNY Council on January 24, 2012 and therefore, Policy 315.986 is no longer relevant. (Council January 24, 2019).

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 150

Introduced by: Sandhya Malhotra, MD, Queens County Delegate

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

Referred to: Reference Committee on Public Health and Education

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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, Accredited Continuing 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, accredited providers are not required to disclose to its physician learners whether any physicians were engaged in the planning and development of the CE activity; 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; and

Whereas, MSSNY adopted policy 50.985 Requiring Physician Participation in the Planning and Development of Accredited Continuing Medical Education for Physicians; therefore, be it

RESOLVED, that MSSNY collaborates with other stakeholders including the AMA to petition the ACCME to develop policies which 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.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 151

Introduced by: David Zuckerman, MS3

Subject: House Fires Due to Lithium-Ion Batteries

Referred to: Reference committee on Public Health and Education

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Whereas, There has been a 20-fold increase in adult and pediatric chemical burn injuries due to thermal runaway from lithium-ion batteries in electric scooters from 2016-2020[1]; and

Whereas, There are roughly 65,000 electric bikes used in Manhattan alone — more than any other place in the U.S. — and there have been approximately 100 fires due to electronic bike explosions in Manhattan, resulting in 13 deaths[2]; and

Whereas, A sizeable population in both New York state and nationwide utilizes these electronic scooters to commute to work and school, complete deliveries, and travel to the locations of other important activities[2]; and

Whereas, the FDNY chief fire marshal told lawmakers that the FDNY could "use more resources for inspectors that are currently stretched thin"[3]; and

Whereas, delivery companies can play a greater role in ensuring that their drivers use electronic bikes and scooters that comply with safety standards[3]; and

Whereas, Enforcing consumer product safety standards for rechargeable lithium-ion batteries used in micromobility devices such as electric bicycles and scooters can protect against the risk of fires; and

Whereas, New York State has passed legislation "prohibiting the sale of second-use lithium-ion batteries intended for use in a bicycle with electric assist, an electric scooter or a limited use motorcycle and provides penalties for violations"[4]; therefore be it

RESOLVED, That our MSSNY urges lawmakers to enforce stricter consumer product safety standards for rechargeable lithium-ion batteries used in devices like electric bicycles and scooters to protect against the risk of fires; and be it further

RESOLVED, That our MSSNY advocates for more resources allocated towards inspectors who can ensure prevention of the sale of second-use lithium-ion batteries; and be it further

RESOLVED, That our MSSNY advocates for more legislative oversight on delivery companies and encouraging them to ensure that their drivers comply with safety standards.

References:

1. Hsieh M, Lai M, Sim H, et al. Electric scooter battery detonation: A case series and review of literature. *Annals of burns and fire disasters*. 2021;34(3):264.
2. Calvan BC. As e-bikes proliferate, so do deadly fires blamed on exploding lithium-ion batteries. *AP News*. https://apnews.com/article/ebike-fires-lithium-ion-batteries-b5ab9acf9ca317a1b5b917097ac5210d

3. Frey K. FDNY chief fire marshal urges Congress to act on lithium-ion batteries. *Spectrum News*. https://ny1.com/nyc/all-boroughs/politics/2024/02/16/fdny-fire-marshal-urges-congress-to-act-on-lithium-ion-batteries
4. Prohibits the sale of second-use lithium-ion batteries, A5310, The New York State Senate, 2023-2024 sess (2023). https://www.nysenate.gov/legislation/bills/2023/A5310#:~:text=2023%2DA5310%20(ACTIVE)%20%2D%20Summary,motorcycle%3B%20provides%20penalties%20for%20violations.

Existing MSSNY Policy:

260.885 Electronic Powered Transportation Vehicles

The Medical Society of the State of New York will advocate for safety measures and stricter penalties for hit and run e-scooter and e-bikes offenses. (HOD 2021-150)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 152

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland and Westchester Counties)
Subject:	Safety concerns regarding inadequate labeling of food products upon ingredient changes with known major food allergens
Referred to:	Reference Committee on Public Health and Education

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Whereas, the Medical Society of the State of New York (MSSNY) is dedicated to promoting the highest standards of medical care and advocating for the well-being of patients and physicians; and

Whereas, there are millions of Americans who have food allergies and hypersensitivities; and

Whereas, the FDA has provided guidelines to the food industry consumers and stakeholders on the best ways to assess and manage allergen hazards in food; and

Whereas, the FDA has identified the following 9 items as major food allergens: milk, eggs, fish, crustacean shellfish, tree nuts, peanuts, wheat, soybeans and sesame; and

Whereas, Federal law requires that food manufacturers and sellers identify by label all of the food source of all major food allergens used to make the food; and

Whereas, there is no guidance by the FDA to ensure additional labeling requirements or notifications identifying when ingredients have been substituted with major food allergens prior to sale other than simply listing the ingredient among all the other ingredients; and

Whereas, a recent unfortunate death of a 25-year-old female due to anaphylaxis from ingesting a food item that contained a new ingredient consisting of a major food allergen which was not included in the list of ingredients on the label; and

Whereas, the cause of the mislabeling is still under investigation, the deadly ramifications of incorrectly marked ingredients is apparent especially with a food product which had been changed by the food manufacturer with the addition of a food allergen, but repackaged by the retailer without the newly added major food allergen ingredient change identified in the labeling; and

Whereas, there is an ongoing investigation to review the details of the miscommunication of a change of ingredient by the developer and the retailer when repackaging the food that now had a major food allergen as an ingredient; and

Whereas, the FDA ‘s guidelines do not suggest any “red flag” or “warning” notifications labeling, or any other method to accentuate a major food allergy addition to a previously formulated food product; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) advocate for legislation or regulation that any repackaging entity verify with the food manufacturer/distributor

as an ordinary and routine transaction of commerce that no major food allergen ingredient changes have occurred, and be it further

RESOLVED, that MSSNY advocates for laws requiring major food allergen ingredient changes be labeled and packaged with accentuated, obvious warning labeling identifying such change; and be it further

RESOLVED, that a copy of this resolution be transmitted to the AMA for consideration at its House of Delegates.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 153

Introduced by:	8th District of New York
Subject:	Biotin Supplement Packaging Disclaimer
Referred to:	Reference Committee on Public Health and Education

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Whereas, although the use of biotin supplementation has become widespread for its supposed stimulation of hair and nail growth, there is a sparsity in the scientific data supporting these claims; and

Whereas, the FDA defines the recommended daily allowance of biotin to be 30 mcg per day for an adult, the majority of biotin supplement brands have daily dosages ranging between 600-10,000mcg.

Whereas, there are no apparent negative side effects to taking megadosages of biotin, there is evidence supporting its interference with many laboratory tests. In particular, excess biotin may cause falsely low troponin levels, resulting in missed or delayed myocardial infarction diagnoses, or false thyroid function tests leading to false diagnoses of Graves' disease.; therefore be it

RESOLVED, that over-the-counter biotin supplements be required to provide a clear disclaimer on the bottle that states the possibility of lab test interference; and be it further

RESOLVED, that the Medical Society of the State of New York advocates for greater awareness among both patients and physicians in regards to biotin megadose interference.

References:

1. Gifford JL, Sadrzadeh SMH, Naugler C. Biotin interference: Underrecognized patient safety risk in laboratory testing. Can Fam Physician. 2018 May;64(5):370. PMID: 29760259; PMCID: PMC5951654.

2. Barbesino G. Misdiagnosis of Graves' Disease with Apparent Severe Hyperthyroidism in a Patient Taking Biotin Megadoses. Thyroid. 2016 Jun;26(6):860-3. doi: 10.1089/thy.2015.0664. Epub 2016 Apr 28. PMID: 27043844.

3. Li D, Rooney MR, Burmeister LA, Basta NE, Lutsey PL. Trends in Daily Use of Biotin Supplements Among US Adults, 1999-2016. *JAMA.* 2020;324(6):605–607. doi:10.1001/jama.2020.8144

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 154

Introduced by:	Roy Korn MD; MSSNY Preventive Medicine and Family Health Committee; MSSNY Addiction & Psychiatric Medicine Committee; The Schoharie County Medical Society
Subject:	Requiring stores that sell tobacco products to display NYS Quitline information
Referred to:	Reference Committee on Public Health and Education

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Whereas in New York State a store must have a license to sell cigarettes; and

Whereas, state laws already only allow only certain stores (not pharmacies) to sell to certain persons (those over age 20) in certain locations (not near schools); and

Whereas, the New York State Tobacco Control Program sponsors the NY Quitline phone number and website (https://www.nysmokefree.com/) which offers to persons who smoke the ability to get help with stopping by texting, calling, or chatting; free nicotine patches, gum or lozenges, and other tools for cessation assistance, therefore be it

RESOLVED that stores licensed to sell tobacco products must also display to the public easily visible information about the NYS Quitline including phone number, website, services and products they offer, and be it further

RESOLVED that MSSNY asks the AMA to advocate to states, territories, and reservations that they adopt similar legislation or directives promoting display of local or national quitlines where tobacco products are sold.

References:

https://www.nysmokefree.com/
https://www.health.ny.gov/prevention/tobacco_control/current_policies.htm

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 155

Introduced by: Phillip Gioia, MD, MPH, Cayuga County Delegate
Cayuga County Delegation
Fifth and Sixth District Medical Societies

Subject: Ask NYS to Maintain Public Health Funding and Infrastructure

Referred to: Reference Committee on Public Health and Educaiton

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Whereas, Since the beginning of the pandemic, 27 (47%) of New York's 58 Local Health Officials have departed their jobs due to retirements or other reasons related to the pandemic; and

Whereas, Between 2021 and 2022, there was a 6% decrease in budgeted full time equivalent positions in local health departments; and

Whereas, The Local Health Departments (LHD's) need increased funding for staff to support surveillance, inspection, outreach, communications, and enforcement activities to address communicable diseases, chronic diseases, emergency preparedness and response, community health assessments and, in full-service counties, environmental health including prevention of lead toxicity; and

Whereas, The LHD's must respond to emerging public health threats such as monkey pox, polio, measles and other vaccine-preventable diseases, the opioid crisis, drinking water/housing contamination, increasing rates of sexually transmitted diseases, vector-borne diseases, violence, and more; and

Whereas, New York City's LHD needs restoration of their Article 6 funding back up to the 36% that other counties receive; and

Whereas, Public health infrastructure is built on people – local health officials, preparedness coordinators, epidemiologists, public health nurses, sanitarians, social workers, public health educators and support staff; and their information systems; therefore be it

RESOLVED, That the Medical Society of the State of New York ask New York State to maintain or increase funding for local Health Departments and their infrastructure in the State Budget.

References:

MSSNY Position Statements: 130.997 Maternal and Infant Care community services

90.985 Addressing the Adverse Health Effects of Climate Change in New York State: Recommendations for Protecting New Yorkers' Health and Safety from Global Warming and Climate Instability https://www.positionstatements.mssny.org/table-of-contents/90-000-environmental-health/ need for LHDs to educate the public and adapt to the current environment

90.986 Air Quality and the Protection of Citizen Health LHDs to monitor health effects

90.995 Safe Disposal of Toxic Materials in Consumer Products LHDs to monitor health effects

90.999 Radioactive Waste, Disposal of Low Level LHDs to monitor health effects

117.975 Recommendations of White Paper: Improve EHR Satisfaction LHD interfaces to improve

320.990 Financing Obesity Programs in New York State LHDs to educate communities

260.936 Lead Poisoning LHD's to prevent Lead Poisoning

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 156

Introduced by: Phillip Gioia, MD, MPH, Cayuga County Delegate
Cayuga County Delegation

Subject: Establish a Tax on Sugar Sweetened Beverages for public physical and fiscal health

Referred to: Reference Committee on Public Health and Education

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Whereas, The New York State Department of Health reports that over 25% of all New Yorkers are obese; and

Whereas, The negative effects of obesity are disproportionately burdensome for residents with limited resources, African Americans, and Latinx New Yorkers; and

Whereas, Sugar Sweetened Beverages (SSBs) are associated with increased body weight, poor nutrition, diabetes, and obesity; and

Whereas, Sugar consumption leads to dental caries, which is one of the most common chronic diseases in adults and children in the United States according to Healthy People 2030; and

Whereas, In Philadelphia and elsewhere, sugar sweetened beverage (SSB) taxes are an effective policy tool for reducing sugary drink purchases among at-risk populations; and

Whereas, SSB taxes can be especially effective when some of the revenue collected is reinvested in the low-income communities that are especially at risk for obesity and other adverse health effects and for increased SSB consumption; and

Whereas, Revenue from the SSB tax and savings from disease prevention may be used to help reduce the currently predicted NY State Budget deficit; and

Whereas, Non-sugar sweeteners may lead to diseases and displace natural whole plant based foods in the diet; therefore be it

RESOLVED, That the Medical Society of the State of New York works with New York State to establish a tax on Sugar Sweetened Beverages (SSBs) and on non-sugar sweetened beverages (NSSB);and be it further

RESOLVED, That MSSNY ask the American Medical Association to ask Congress to reduce sugar subsidiaries for sugar and/or corn syrup; and to label non-sugar sweetened (NSS) foods and beverages to warn consumers of their side effects and lack of efficacy to control obesity and other chronic non-communicable diseases (NCDS).

References

MSSNY Position Statements- https://www.positionstatements.mssny.org/table-of-contents/125-000-health-screening-programs/ -

125.996 Screening Programs and Interventions Most Beneficial in Improving the Overall Public Health, Essential Behavioral Changes 2) recommended limiting the dietary intake of refined sugar

320.996 Overweight and Obesity Control as a Major Public Health Program

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

https://www.hsph.harvard.edu/prc/2022/01/20/choices-project-featured-in-webinar-2-9-is-now-the-time-for-a-sugar-sweetened-beverage-tax-in-new-york-city/ -All 12 tax models resulted in lower levels of sugary drink consumption, thousands of people for whom obesity would be prevented (referred to as "cases" throughout the reports), improved health equity, and hundreds of millions of dollars in health care cost savings.

Healthy People 2030 - https://health.gov/healthypeople/about/workgroups/nutrition-and-weight-status-workgroup - reduce sugar for everyone 2 years old or older

Ultra-Processed People: The Science Behind Food that Isn't Food – reviews and access documenting how non-sugar sweeteners lead to disease and not to weight loss for most people. https://mitpressbookstore.mit.edu/book/9781324036722

The World Health Organization (WHO) has released a new guideline on non-sugar sweeteners (NSS), which recommends against the use of NSS to control body weight or reduce the risk of noncommunicable diseases (NCDs). https://www.who.int/news/item/15-05-2023-who-advises-not-to-use-non-sugar-sweeteners-for-weight-control-in-newly-released-guideline

Whole foods, such as fruits and vegetables, usually have the best mix of nutrients for the body. https://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/artificial-sweeteners/art-20046936

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 157

Introduced by: Phillip Gioia, MD, MPH, Cayuga County Delegate
Cayuga County Delegation

Subject: Increase Taxes on Beer and Wine

Referred to: Reference Committee on Public Health and Education

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Whereas, The New York State taxes for beer are ranked 38th in the nation, for wine are 40th in the nation, and for liquor are 5th in the nation. (New York Sales Tax Handbook 2022); and

Whereas, These taxes have not been increased in a number of years; and beer and wine taxes have not been adjusted for inflation since 1951; and

Whereas, MSSNY Policy has called for increasing taxes on beer and wine in the past; and
Whereas, NY State is facing a financial short fall in its budget; and

Whereas, Taxes on beer and wine will generate revenue and decrease expenditures from disease, injuries, mental illness, disability and premature death; and

Whereas, Research has shown that a doubling of alcohol sales tax (that would still only barely place New York's tax in the top 10 among all states) can reduce alcohol-related mortality by 35%, automobile accident deaths by 11%,violence by 2%, and crime by 1.4%; therefore be it

RESOLVED, That the Medical Society of the State of New York advocate for New York State to increase taxes on alcoholic beverages or other substances; such as beer, wine, cider, liquor, mixed drinks, foods and vapes that contain significant amounts of alcohol now or in the near future.

References:

From the CDC "There is strong scientific evidence that increasing the unit price of alcohol by raising alcohol taxes is an effective strategy for reducing excessive alcohol consumption and related harms" -
https://www.cdc.gov/policy/hi5/alcoholpricing/index.html#:~:text=A%20systematic%20review%20and%20meta,sexually%20transmitted%20disease%2C%20and%20violence.

Existing MSSNY Policy:

20.997 Alcohol and other Drug Misuse Prevention/Control – (1): (e) Adjusting taxes on beer and wine to equate with those for distilled spirits and adjusting taxes on all alcoholic beverages for inflation experienced since 1951. (f) Devoting significant additional funds derived from increased taxes to the support of prevention and research.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 158

Introduced by: Daniel Young, MD, Broome County as an Individual
Broome County Medical Society
Fifth and Sixth District Medical Societies

Subject: Stop NYDOH from Requiring Inappropriate Inpatient Care

Referred to: Reference Committee on Public Health and Education

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Whereas, the NYS Department of Health 405.9 guidelines regarding hospital admissions are well intended; and

Whereas, Item #12 (i) pertains to protecting women's health by stating "Such examination shall include a screening uterine cytology smear on women 21 years of age and over, unless such test is medically contraindicated or has been performed within the previous three years, and palpation of breast, unless medically contraindicated, for all women over 21 years of age. These examinations shall be recorded in the medical record."; and

Whereas, Although it is well intentioned, hospitals do not have the means to perform uterine (or cervical) cytology, there is no upper age cutoff listed for the cytology, ill patients are in no condition to be undergoing these procedures and breast palpation exams are no longer recommended; therefore be it

RESOLVED, That the Medical Society of the State of New York advocate for a change to the NYS DOH 405.9 guideline by deleting item 12 (i) "Such examination shall include a screening uterine cytology smear on women 21 years of age and over, unless such test is medically contraindicated or has been performed within the previous three years, and palpation of breast, unless medically contraindicated, for all women over 21 years of age. These examinations shall be recorded in the medical record."

References:
https://regs.health.ny.gov/content/section-4059-admissiondischarge#:~:text=(1)%20The%20governing%20body%20shall,fees%20between%20a%20referring%20agency

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 159

Introduced by: Suffolk County Medical Society

Subject: Opioid Overdose Reversal Agents Where AED's Are Located

Referred to: Reference Committee Public Health and Education

Whereas, the number of overdose deaths in the US has continued to rise year by year for over 20 years, with nearly 110,000 dying by overdose in the year 2022, and opioids such as fentanyl alone or in combination with other substances involved in the majority of overdose deaths (1), and

Whereas, naloxone is a mu opioid competitive antagonist which is effective in reversing opioid overdose when administered intravenously or intranasally, has no abuse potential, has few side effects or adverse events when administered to someone who has overdosed, is easy to administer with little training required (2-6), and

Whereas, the World Health Organization and the CDC have recommended widespread availability of naloxone to reverse opioid overdoses (7,8), and

Whereas, expansion of the availability of naloxone is not associated with compensatory increases in substance use or risk taking (9,10), and

Whereas, one modelling study conservatively estimated that in Alleghany County, Pennsylvania, 16% of naloxone administrations occur within 200 yards of an AED location (11), which would suggest that an additional 1/7 opioid overdoses could be reversed and potential lives saved, Therefore Be It

RESOLVED, that MSSNY supports the expansion of naloxone availability through colocation of intranasal naloxone with AEDs in public locations, and Be It Further

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

References:

NIDA. Drug Overdose Death Rates. 30 June 2023. Accessed 20 October 2023 at: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

NIDA. Naloxone for Opioid Overdose: Life-Saving Science. National Institute on Drug Abuse website. https://nida.nih.gov/publications/naloxone-opioid-overdose-life-saving-science. March 30, 2017 Accessed October 20, 2023.

Rzasa Lynn R, Galinkin JL. Naloxone dosage for opioid reversal: current evidence and clinical implications. Ther Adv drug Saf. 2018;9(1):63-88. doi:10.1177/2042098617744161

Davis CS, Carr D. Legal changes to increase access to naloxone for opioid overdose reversal in the United States. Drug Alcohol Depend. 2015;157:112-120. doi:10.1016/j.drugalcdep.2015.10.013

Wermeling DP. Review of naloxone safety for opioid overdose: practical considerations for new technology and expanded public access. Ther Adv drug Saf. 2015;6(1):20-31. doi:10.1177/2042098614564776

Jauncey ME, Nielsen S. Community use of naloxone for opioid overdose. Aust Prescr. 2017;40(4):137-140
World Health Organization. Opioid Overdose. 29 August 2023. Accessed 21 October 2023 at: https://www.who.int/news-room/fact-sheets/detail/opioid-overdose#:~:text=WHO%20recommends%20that%20naloxone%20be,assisting%20ventilation%20and%20administering%20naloxone
Center for Disease Control: Lifesaving Naloxone. Updated 21 April 2023. Accessed at: https://www.cdc.gov/stopoverdose/naloxone/index.html
Bazazi AR, Zaller ND, Fu JJ, Rich JD. Preventing opiate overdose deaths: examining objections to take-home naloxone. J Health Care Poor Underserved. 2010 Nov;21(4):1108-13. doi: 10.1353/hpu.2010.0935. PMID: 21099064; PMCID: PMC3008773.
Jones JD, Campbell A, Metz VE, Comer SD. No evidence of compensatory drug use risk behavior among heroin users after receiving take-home naloxone. Addict Behav. 2017;71:104-106. doi:10.1016/j.addbeh.2017.03.008
Salerno JE, Weiss LS, Salcido DD. Simulation of the Effects of Co-Locating Naloxone with Automated External Defibrillators. Prehosp Emerg Care. 2018 Sep-Oct;22(5):565-570. doi: 10.1080/10903127.2018.1439128. Epub 2018 Mar 1. PMID: 29494776; PMCID: PMC6777719.

Existing MSSNY Policy:

65.990 Use of Naxolone to Prevent Drug Overdoses
MSSNY supports the use of intra-nasal Naxolone in the prevention of drug overdoses. (Council 3/10/2014)
65.980 Safe Injection Facilities Pilot Studies in New York State:
The Medical Society of the State of New York supports pilot studies to assess the role of Safe Injection Facilities in New York State as a component of expansion of drug user health programs and that any pilot study include New York City and two other areas outside of New York City. Such pilot studies on Safe Injection Facilities should include a publicly disclosed report of outcomes and should provide screening, support and referral for treatment of substance use disorders, co-occurring medical and psychiatric conditions, and also provide education on harm reduction strategies including, but not limited to, Naloxone training. (HOD 2018-154; Reaffirmed in lieu of HOD 2020-152)
65.992 Preventing Overdose Deaths – Community-based Naloxone Programs:
MSSNY and its respective specialty societies will continue to work with the New York State Department of Health to reduce overdose deaths and to expand Naloxone programs as part of its comprehensive overdose prevention programs. (HOD 2011-155; Reaffirmed HOD 2021)
Relevant AMA Policy:
Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications H-95.932

Topic: Drug Abuse	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2023
Action: Modified	Type: Health Policies
Council & Committees: NA	

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .
3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective

overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations.
Policy Timeline
BOT Rep. 22, A-16 Modified: Res. 231, A-17 Modified: Speakers Rep. 01, A-17 Appended: Res. 909, I-17 Reaffirmed: BOT Rep. 17, A-18 Modified: Res. 524, A-19 Reaffirmed: BOT 09, I-19 Reaffirmed: Res. 219, A-21 Modified: Res. 505, A-23

Oppose Tracking of People who Purchase Naloxone D-120.930

Topic: Drugs	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2021
Action: NA	Type: Directives
Council & Committees: NA	

Our AMA will: (1) oppose any policies, regulations, or laws that require personally identifiable information associated with naloxone prescriptions or purchases to be tracked, monitored, or utilized for non-clinical or non-public health care purposes; and (2) advocate for availability of naloxone as an over-the-counter medication.
Policy Timeline
Res. 219, A-21
Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program D-130.961

Topic: Emergency Medical Services	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2019
Action: NA	Type: Directives
Council & Committees: NA	

Our AMA will collaborate with the American Heart Association and other interested parties to include naloxone use in training in BLS instruction.

Policy Timeline

Res. 530, A-19

Improvement in US Airlines Aircraft Emergency Kits H-45.981

Topic: Aviation Medicine	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2022
Action: Modified	Type: Health Policies
Council & Committees: NA	

1. Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.
2. Our AMA will: (a) support the addition of naloxone, epinephrine auto injector and glucagon to the airline medical kit; (b) encourage airlines to voluntarily include naloxone, epinephrine auto injector and glucagon in their airline medical kits; and (c) encourage the addition of naloxone, epinephrine auto injector and glucagon to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).
3. That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits.

Policy Timeline

Res. 507, A-97 Amended: CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed in lieu of: Res. 502, A-16 Appended: Res. 524, A-18 Modified: Res. 508, A-22

Prevention of Drug-Related Overdose D-95.987

Topic: Drug Abuse	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2023
Action: Modified	Type: Directives
Council & Committees: NA	

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other safe and effective overdose reversal medications and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other safe and effective overdose reversal medications and other harm reduction measures in preventing opioid and other drugrelated overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug- related overdose; and (b) support the development of adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose; and (c) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

Policy Timeline
Res. 526, A-06 Modified in lieu of Res. 503, A-12 Appended: Res. 909, I-12 Reaffirmed: BOT Rep. 22, A-16 Modified: Res. 511, A-18 Reaffirmed: Res. 235, I-18 Modified: Res. 506, I-21 Appended: Res. 513, A-22 Modified: Res. 211, I-22 Appended: Res. 221, A-23 Reaffirmation: A-23 Modified: Res. 505, A-23

Substance Use Disorders During Pregnancy H-420.950

Topic: Pregnancy and Childbirth Policy Subtopic: NA
Meeting Type: Annual Year Last Modified: 2023
Action: Modified Type: Health Policies
Council & Committees: NA

Our AMA will:
(1) support brief interventions (such as engaging a patient in a short conversation, providing feedback and advice) and referral for early comprehensive treatment of pregnant individuals with opioid use and opioid use disorder (including naloxone or other overdose reversal medication education and distribution) using a coordinated multidisciplinary approach without criminal sanctions;
(2) oppose any efforts to imply that a positive verbal substance use screen, a positive toxicology test, or the diagnosis of substance use disorder during pregnancy automatically represents child abuse;
(3) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy;
(4) oppose the filing of a child protective services report or the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation;
(5) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual’s family structure, (b) the patient’s treatment status, and (c) current impairment status when substance use is suspected; and
(6) advocate that state and federal child protection laws be amended so that pregnant people with substance use and substance use disorders are only reported to child welfare agencies when protective concerns are identified by the clinical team, rather than through automatic or mandated reporting of all pregnant people with a positive toxicology test, positive verbal substance use screen, or diagnosis of a substance use disorder.

Policy Timeline
Res. 209, A-18 Modified: Res. 520, A-19 Modified: Res. 505, A-23

Medications for Opioid Use Disorder in Correctional Facilities H-430.987

Topic: Prisons Policy Subtopic: NA

Meeting Type: Annual Year Last Modified: 2021
Action: Modified Type: Health Policies
Council & Committees: NA

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

Policy Timeline
Res. 443, A-05 Reaffirmed: CSAPH Rep. 1, A-15 Appended: Res. 223, I-17 Modified: Res. 503, A-2

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 160

Introduced by: MSSNY Addiction and Psychiatric Medicine Committee

Subject: MSSNY Opposition to the Legalization of Non-prescription Drugs

Referred to: Reference Committee on Public Health and Education

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Whereas, the Medical Society of the State of New York had the following two policies regarding the legalization of non-prescriptive drugs and of drugs for non-medically indicated purposes:

MSSNY Policy 70.985 "MSSNY physicians oppose the legalization of the use of non-prescriptive, potentially dangerous drugs such as heroin and cocaine. Use of such drugs poses a serious threat to the health of the individual and society. Use of potentially dangerous drugs frequently leads to limited reasoning ability, unproductive and antisocial behavior, an increase in the development of neurologic, psychiatric, infectious and other medical diseases and fetal health problems. These health considerations outweigh any potential reduction in crime or reduction in the transmission of infection which might be anticipated from the legalization of such drugs."

MSSNY Policy 70.988 "MSSNY is opposed to the legalization for non-medically indicated uses of the following substances: hallucinogenics, narcotics, and cocaine and its derivatives" respectively; and

Whereas, these policies were up for their 10 year review; and

Whereas, the Addiction and Psychiatric Medicine Committee reviewed these policies and decided that they should be sunsetted and that a new resolution be brought forth to the MSSNY House of Delegates more in line with current policies and practices; therefore be it

RESOLVED, that the Medical Society of the State of New York is opposed to the legalization of hallucinogens, narcotics, cocaine, amphetamines and their derivatives for non-medically indicated uses. These drugs pose a serious threat to the health of the individual and society as their use frequently leads to cognitive impairment, an increase in the development of neurologic, psychiatric, infectious and other medical diseases as well as fetal health problems. The current scientific evidence indicates that these health considerations outweigh the potential reduction in crime or in the transmission of infections which might be anticipated from the legalization of such drugs.

References:

Existing MSSNY Policy:

MSSNY Policy 70.985 "MSSNY physicians oppose the legalization of the use of non-prescriptive, potentially dangerous drugs such as heroin and cocaine. Use of such drugs

poses a serious threat to the health of the individual and society. Use of potentially dangerous drugs frequently leads to limited reasoning ability, unproductive and antisocial behavior, an increase in the development of neurologic, psychiatric, infectious and other medical diseases and fetal health problems. These health considerations outweigh any potential reduction in crime or reduction in the transmission of infection which might be anticipated from the legalization of such drugs.

MSSNY Policy 70.988 "MSSNY is opposed to the legalization for non-medically indicated uses of the following substances: hallucinogenics, narcotics, and cocaine and its derivatives" respectively.

Fiscal Impact: none

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 161

Introduced by: 5th and 6th District Branches

Subject: Physician Access to Pseudoephedrine, Phenylpropanolamine, and Ephedrine Logbook Information

Referred to: Reference Committee on Public Health and Education

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Whereas, The Combat Methamphetamine Epidemic Act of 2005 requires that for pseudoephedrine, phenylpropanolamine, and ephedrine, each regulated seller ensure that customers do not have direct access to the product before the sale is made "behind-the-counter" and a written or electronic "logbook" listing sales is kept that identifies the products by name, quantity sold, names and addresses of purchasers, and the dates and times of the sales; and

Whereas, The logbook information may only be shown to local, state and federal law enforcement; and

Whereas, Immunoassay is a commonly used, quick, and cost-effective screening method in various settings, including hospital labs. On the other hand, gas chromatography-mass spectrometry (GC-MS) techniques, while more precise, are more labor-intensive and require advanced laboratory services, making them more expensive; and

Whereas, Pseudoephedrine may cause false-positive immunoassay urine drug tests for amphetamine;[1] and

Whereas, A patient may claim that a positive immunoassay for amphetamine is the result of the use of pseudoephedrine thereby requiring confirmation via more expensive testing methods; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) seek legislation or regulation to require regulated sellers of pseudoephedrine, phenylpropanolamine, and ephedrine registered within New York State to electronically transmit data on these medications to the Bureau of Narcotic Enforcement (BNE) and that data collected as a result of the submission process, securely reside within the Prescription Monitoring Program (PMP) Registry; and be it further

RESOLVED, That the MSSNY forward a similar resolution to the American Medical Association

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References:

[1] *Pharmacotherapy*. 2013; 33(5):e88-e89.

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 162

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland and Westchester Counties)
Subject:	Accelerate Integration of New York State iSTOP Data into the Multi-State NACP/Bamboo Health PMP Program for Opioid Monitoring
Referred to:	Reference Committee on Public Health and Education

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Whereas, the opioid epidemic continues to pose a significant public health threat in the state of New York, necessitating vigilant monitoring and regulatory measures to address the crisis; and

Whereas, the National Association of Boards of Pharmacy (NABP) and the Alliance for Patient Medication Safety (APMS) have jointly developed the National Association of Chain Drug Stores (NACP) and Bamboo Health Prescription Monitoring Program (PMP) to provide comprehensive multi-state data on controlled substance prescriptions to aid in the prevention of opioid misuse and abuse; and

Whereas, the Bamboo Health PMP Platform is accessible and fully integrated directly into most major EHR vendors, allowing Physicians to easily survey the database for prescriptions in multiple states at the point of prescribing of controlled substances; and

Whereas, the NACP/Bamboo Health PMP Platform has data from 48 states in the US, but still does not have NY state controlled-substance prescribing data included; and

Whereas, the New York State (NYS) I-STOP (Internet System for Tracking Over-Prescribing) program has been an instrumental tool in combating opioid abuse in New York state by providing real-time access to prescription data and promoting responsible prescribing practices; and

Whereas, the NYS ISTOP Platform remains a standalone NYS DOH website platform that requires a distinct access workflow and remains a barrier to efficient care in an integrated HER environment; and

Whereas, the integration of data from the NYS iSTOP program into the NACP/ Bamboo Health PMP has the potential to enhance NYS Physician's ability to monitor and respond to opioid prescribing patterns across multiple states, identify potential cases of over-prescribing, and further improve patient safety; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) advocate through legislation and/or regulation for the immediate integration of controlled substance prescribing data from the New York State iSTOP program into the NACP/Bamboo Health PMP for enhanced opioid monitoring through currently utilized EHR solutions.

References:

Existing MSSNY Policy:
70.923 Retire Current NYS I-STOP Prescription Drug Monitoring Program and Transition to the Multistate PMP System

The Medical Society of the State of New York will advocate to the New York State Department of Health for full integration access to multistate database in New York State Prescription Monitoring Program (PMP).
MSSNY will also advocate for integration of the state PMP into the electronic medical records of all prescribers, as required under the law, and that this integration be of no cost to the prescribers. (HOD 2023-156)

265.849 Development of a CPT Code for PMP Look-Up

Since 2013, New York State has required that physicians check the Department of Health (DOH) Prescription Monitoring Program (PMP) registry prior to prescribing or dispensing any Schedule II, III or IV controlled substances, a process which is not currently reimbursable but involves physicians' time and medical judgment in consideration of providing controlled prescription medications; the New York Delegation will submit a resolution to the 2016 Annual AMA House of Delegates, calling for the development by the AMA and CMS of a Current Procedural Terminology (CPT) code so physicians in all States can be appropriately paid for their time and effort in consulting the PMP registry. (HOD 2016-253)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 163

Introduced by: Medical Society of the County of Queens

Subject: "Crack is Whack" Act

Referred to: Reference Committee on Public Health and Education

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Whereas, The federal "Crack is Whack" Act prohibits federal funding for injection sites; and

Whereas, This Act states: No Federal funds may be used by any Federal agency to operate or control, or to pay the salaries of officers and employees of such an agency to operate or control, an injection center in violation of section 416 of the Controlled Substances Act (21 U.S.C. 856; commonly referred to as the "Crack House Statute"); and

Whereas, OPS (Overdose Prevention Sites) have been shown to be effective at reducing overdoses, refer patients for ongoing drug treatment, prevent communicable disease and decrease health care costs; therefore be it

RESOLVED, That MSSNY lobby, petition and educate our representatives in Congress to repeal or amend the federal "Crack is Whack Act" to exclude legitimate OPS.

References:

https://www.congress.gov/117/bills/hr6741/BILLS-117hr6741ih.pdf

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK

House of Delegates

Resolution 164

Introduced by: The Medical Society of the County of Queens

Subject: Overdose Prevention Sites (OPS)

Referred to: Reference Committee on Public Health and Education

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Whereas, In 2021, 106,699 drug overdose deaths occurred in the United States. Opioids were involved in 80,411 overdose deaths in 2021 resulting in an age-adjusted rate of 32.4 per 100,000 standard population: and

Whereas, Drug overdose death rates have increased 500% since 2001; and

Whereas, OPS have been shown to save lives, decrease crime and decrease health expenditures; and

Whereas, OPS have been proven to decrease overdose, connect patients to drug treatment, decrease crime, decrease health care costs, improve harm reduction (reducing infectious disease) and reduce the burden on the criminal justice system; and

Whereas, OPS are associated with ingrained stigmata that have not been born out in studies; and

Whereas, ONPoint, the 2 Safe injection sites in NYC have recently showed evidence for preventing overdoses: and

Whereas, Europe, Australia and Canada have has OPS since 1986 and have studies for the efficacy of OPS: and

Whereas, MSSNY Policy 65.980 Safe Injection Facilities Pilot Studies in New York State The Medical Society of the State of New York supports pilot studies to assess the role of Safe Injection Facilities in New York State as a component of expansion of drug user health programs and that any pilot study include New York City and two other areas outside of New York City. Such pilot studies on Safe Injection Facilities should include a publicly disclosed report of outcomes and should provide screening, support and referral for treatment of substance use disorders, co-occurring medical and psychiatric conditions, and also provide education on harm reduction strategies including, but not limited to, Naloxone training. (HOD 2018-154; Reaffirmed in lieu of HOD 2020-152) is outdated as pilot program already exists and has data showing effectiveness in preventing drug overdose; therefore, be it

RESOLVED, That MSSNY promote and advocate for the further expansion and studies of OPS. and be it further

RESOLVED, MSSNY advocate for OPS on the local, state and federal levels, and be it further

RESOLVED, That MSSNY change Policy 65.980 to: MSSNY Policy 65.980 Safe Injection Facilities Pilot Studies in New York State, and be it further

RESOLVED, The Medical Society of the State of New York supports and advocates for the expansion and study pilot studies to assess the role of Safe Injection Facilities in New York State as a component of expansion of drug user health programs. and that any pilot study include New York City and two other areas outside of New York City. Such pilot studies on the expansion of Safe Injection Facilities should include a publicly disclosed report of outcomes and should provide screening, support and referral for treatment of substance use disorders, co-occurring medical and psychiatric conditions, and also provide education on harm reduction strategies including, but not limited to, Naloxone training.

References:

1. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse
2. https://nida.nih.gov/research-topics/stigma-discrimination#affect
3. Jennifer Ng, Christy Sutherland and Michael R. Kolber
Canadian Family Physician November 2017, 63 (11) 86
4. https://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en
5. Am Fam Physician. 2022;105(5):454-455

Existing MSSNY Policy: 65.980

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 165

Introduced by: Medical Society of the County of Kings

Subject: Public Safety Agencies Data Collection Enhancement

Referred to: Reference Committee on Public Health and Education

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Whereas, Clinical researchers and scientists are eager to study the causes and circumstances of accidental traumatic injuries, in order to promote the safety and general welfare of the public through primary & secondary prevention thereof; and

Whereas, Legislators and policymakers depend upon clinical researchers and scientists to provide valid evidence upon which data-driven legislation to protect the public may be developed and enacted. Historical examples include Standard 208 of the National Traffic and Safety Act in 1967, which required automobiles to have seatbelts, and banning tobacco advertisement on television and radio in 1971; both of which have saved millions of lives; and

Whereas, Currently, Public Safety Agencies, e.g., Emergency Medical Services and Police Departments, collect limited data on vehicular accidents and injury-related events by requiring only general descriptions of location, e.g., the road names or intersection where an accident occurs, or that a fall occurred “in the home;” and

Whereas, Regarding road or traffic accidents, details such as types of vehicles, including but not limited to micro-transit (scooters or motorized/electric bicycles); speed of the vehicles, and whether the event occurred in a crosswalk (zebra lines), bike lane, or main thoroughfare are relegated to non-mandatory “free-text” fields, which are not readily searchable; and

Whereas, Regarding falls in the home, more specific data on location and mechanism of injury, i.e., the kitchen, bathroom or stairs, as well as, the presence of obstacles or hazards, such as clutter, are relegated to non-mandatory “free-text” fields, which are not readily searchable; and

Whereas, In order to develop data-driven, evidence-based safety and preventative policies, more specific and granular information must be reliably and searchably collected by Public Safety Agencies across the state and the nation; now therefore be it

RESOLVED, the MSSNY shall actively collaborate with the National Emergency Medical Services Information System (NEMSIS) to develop a listing of necessary data points and variables to be added to the currently available information collection systems, in a mandatory and searchable fashion, to facilitate the required research; and further be it

RESOLVED, the MSSNY shall actively collaborate with the American College of Surgeons to add these variable fields to data collection systems of the National Trauma Data Bank (NTDB) and the Trauma Quality Improvement Program (TQIP), in a mandatory and searchable fashion, to facilitate the required research; and further be it

RESOLVED, the MSSNY shall lobby the New York State Legislature to mandate the collection of these data and fund the transition to and the ongoing collection of these data; and further be it

RESOLVED, the MSSNY forward similar resolution(s) to the American Medical Association for consideration at the 2024 AMA House of Delegates.

References:

See attached Appendix of initial specific datapoints for mandatory collection

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 166

Introduced by: MSSNY Infectious Disease Committee
MSSNY Heart, Lung, Cancer Committee
MSSNY Emergency Preparedness & Disaster/Terrorism Response Committee
MSSNY Preventive Medicine & Family Health Committee
MSSNY Quality Improvement & Patient Safety Committee
MSSNY Bio Ethics Committee

Subject: MSSNY Principles of Public Health During an Infectious Disease Outbreak

Referred to: Reference Committee on Public Health and Education

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Whereas, from the start of the COVID-19 pandemic, there have been 1,192,459 deaths from COVID in the United States as of January 17, 2024, and;

Whereas, there are currently 1,146,455 cases of COVID-19 infections in the United States as of January 11, 2024; and

Whereas. there have been 82,367 New Yorkers who have died of COVID-19 since the start of the pandemic in 2020; and

Whereas, according to the US Centers for Disease Control and Prevention, COVID 19 was the third leading cause of death in 2021 (416, 893 deaths) in the United States; and

Whereas, due to the COVID-19 pandemic, public health was launched into the public consciousness, and the public health systems did not speak with a unified voice in this country; and

Whereas, the science and medicine were called into question and false information on social media and across the internet continues; and

Whereas, the complex nature of infectious diseases means it is not easy to describe the pandemic in a sound bite or short phrase; and

Whereas, there is a reemergence of vaccine-preventable diseases occurring in New York State and other states, including measles, polio and pertussis; and

Whereas, the resurgence of vaccine preventable diseases is the result of several factors, including the anti-vaccine movement, vaccine hesitancy, and travel to foreign countries; and

Whereas, due to the continuation of COVID-19 cases, and now respiratory syncytial virus (RSV), and influenza, the critical role of public health continues to be spotlighted; and

Whereas, as physicians, we must focus on renewing and rebuilding our long underfunded and undervalued public health infrastructure, and critical importance medical science for patient health and safety; and

Whereas the medical community must continue to examine our response to COVID-19, challenge ourselves to move forward and grasp lessons learned and to recognize that thousands of people in the U.S. become infected with COVID every day and there is long-term health sequelae/ post-COVID conditions for those impacted by the disease; now therefore be it

RESOLVED, that the Medical Society of the State of New York believes in and supports these core principles:

1. Promotion of evidence-based medical science

2. Advocating for public health agencies, such as the Centers for Disease Control and Prevention, the New York State Department of Health, and the World Health Organization, to lead measures related to public health, especially in times of infectious disease outbreaks or pandemics.

3. Promotion of immunization as the number one preventive health measure for vaccine-preventable diseases.

4. Promotion of preventive or mitigation measures such as masking in healthcare facilities and, within society, social distancing and isolation and quarantine if needed.

5. Protection of physicians, healthcare workers, and public health workforce, which includes ensuring that a supply of protective gear is available, and that these groups receive the first round of any immunization needed.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 167

Introduced by: Young Physician Section

Subject: Excise Tax on Ammunition

Referred to: Reference Committee on Public Health and Education

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Whereas, MSSNY and the American Medical Association have enacted policy recognizing that gun violence in America is a public health crisis; and

Whereas, several specialty societies including the American Academy of Pediatrics, the American College of Emergency Physicians, the American College of Physicians, and the American College of Surgeons have also recognized that firearm death and injury in the USA is a public health crisis; and

Whereas, increasing excise taxes on tobacco products has been shown to reduce tobacco consumption and increase public health outcomes; and

Whereas, there is also evidence that excise taxes on alcohol also increases public health outcomes; and

Whereas, New York State currently imposes excise taxes on adult use cannabis, alcoholic beverages, cigarettes and tobacco products, medical cannabis, motor fuels, and opioids; therefore be it

RESOLVED, that the Medical Society of the State of New York support the creation of a New York State excise tax on ammunition; and be it further

RESOLVED, that the Medical Society of the State of New York support the creation of a federal excise tax on ammunition; and be it further

RESOLVED, that a copy of this resolution be transmitted to the AMA for consideration at its House of Delegates

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References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 168

Introduced by: 8th District of New York

Subject: Developing ERPO Guidance and Training for Physicians in NYS

Referred to: Reference Committee on Public Health and Education

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WHEREAS, firearm-related death in children and youth increased 87% since 2013, making it the leading cause of death for young people under the age of 19 years for the past five years consecutively; and

WHEREAS, firearms are among the most lethal suicide attempt methods and access to a firearm in the home increases the odds of suicide more than three-fold; and

WHEREAS, an Extreme Risk Protection Order (ERPO) is a civil order issued by a court that temporarily prohibits a person from purchasing or possessing firearms while the order is in place when someone is at risk of violence to themself or others; and

WHEREAS, the Red Flag Law provides procedural safeguards to ensure that no firearm is removed without due process while helping to prevent disasters, like the racist mass shooting in Buffalo and the Parkland, Florida school shooting; and

WHEREAS, New York State's "Red Flag" Law was amended in 2022 to include all health care practitioners as authorized to file an ERPO application due to their opinion that a person (the respondent) is likely to engage in behavior that would result in serious harm to themself or others by possessing a firearm; and

WHEREAS, although many NYS physicians treat patients who would qualify for an ERPO, many NYS physicians and health care practitioners are unfamiliar with ERPO and the ERPO filing process that could save lives; and

WHEREAS, the American Medical Association supports policies to create "state-specific guidance" for medical professionals and develop medical curricula training for ERPO procedures and reporting protocols (H-145.972 and H-145.976); and

BE IT RESOLVED, MSSNY will raise awareness and provide standardized education about ERPO to all medical professionals in the State of New York; and

BE IT FURTHER RESOLVED, MSSNY will collaborate with NYS law enforcement to develop policies and practices for medical professionals to follow when filing an ERPO, specifically addressing concerns over confidentiality and court time commitments.

References:

1. https://publichealth.jhu.edu/2023/cdc-provisional-data-gun-suicides-reach-all-time-high-in-2022-gun-homicides-down-slightly-from-2021

2. https://everystat.org/wp-content/uploads/2019/10/Gun-Violence-in-New-York.pdf

3. https://publichealth.jhu.edu/sites/default/files/2023-02/research-on-extreme-risk-protection-orders.pdf

4. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700250

5. Azrael D & Miller M (2016). Reducing suicide without affecting underlying mental health: Theoretical underpinnings and a review of the evidence base linking the availability of lethal means and suicide. In The International Handbook of Suicide Prevention, 2nd Ed (pp. 637-662).

6. Anglemyer A, Horvath T, & Rutherford G (2014). The accessibility of firearms and risk for suicide and homicide victimization among household members: A systematic review and meta analysis. Annals of Internal Medicine.

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 169

Introduced by: Ronald B. Menzin, MD

Subject: Urging NYS to Identify Physicians Involved in the Anal Rape of Federal Detainees, Preventing Them from Providing Care to Our Residents

Referred to: Reference Committee on Public Health and Education

Whereas, Dr Sondra S. Crosby and Leonard H. Glantz, JD have written in JAMA 1.9.2024 Volume 331, Number 2 103-104 that "Testimony given to the military commissions pretrial hearings at Guantanamo Bay highlighted serious legal and ethical problems with "rectal feeding." which is a form of medicalized rape[1]….Publicly available information does not specify the professional identities of the medical officers who authorized and performed the rectal feeding and hydration; however, according to the Chief of Medical Services, during the 5 years from 2002-2007, the CIA Office of Medical Services included physicians…who were directly involved in the program and were responsible for the health of detainees." and

Whereas, to quote from the same article, "Both ethical and legal standards require reasonable medical judgement and prohibit providing treatment that cannot benefit a patient. Furthermore, international human rights laws, and basic human decency, prohibit participation in cruel, inhuman, and degrading treatment that can institute torture.; and

Whereas, If any of the involved medical officers were physicians, they would have violated their fundamental ethical obligations by using their medical skills to intentionally inflict harm on individuals;" therefore be it

RESOLVED, that MSSNY insists that the State of NY and via the AMA, the federal government, identify the medical officers (including any who may have been physicians, physician assistants, and nurses) who participated in anal rape of federal detainees so that licensing agencies, or courts, could determine whether action is warranted against them. and be it further

RESOLVED, that MSSNY will not remain silent when a member of the noble profession of Medicine commits atrocities under the guise of medicine.

References: JAMA January 9, 2024 Volume 331, Number 2 Pages 103-104.

Existing MSSNY Policy: 95.973

Physician Involvement in Interrogation and in Torture:

The following definitions are for purposes of this statement:

Torture is defined as the intentional infliction of physical or mental harm for the purpose of gathering information, or to secure control or cooperation of a detainee, or for disciplinary or retaliatory purposes.

Interrogation is defined as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to

[1] Definition of rape under federal law 10 USC §920(a) and (g)(c).

individuals, the public or national security. Interrogations are distinct from questioning used by physicians to assess the physical or mental condition of an individual.

Coercive is defined as threatening to cause harm through physical injury or mental suffering.

Detainee is defined as a criminal suspect, prisoner of war, enemy combatant, or any other individual who is being held involuntarily.

Physicians who engage in any activity that relies on their medical knowledge and skills, regardless of jurisdiction or location, must continue to uphold principles of medical ethics. Physicians must not engage, directly or indirectly, in torture or in interrogations. Questions about the propriety of physician participation in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to individuals with obligations to protect the public interest, e.g. from terrorist attack. Precedent for this may be found in public health ethics in which physicians' expertise inform guidelines, policies, and procedure that lead to the imposition of relatively minor hardships on individuals for public welfare. However, when a physician is directly and clinically involved with an individual, the physician's obligations to the individual take precedent over public interests.

Physician involvement with interrogations during law enforcement or intelligence gathering should be guided by the following:

(1) Physicians must not directly or indirectly participate in torture or in the development of techniques of torture.
(2) Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others has access to information included in medical record. Treatment must never be conditional on a patient's participation in an interrogation.
(3) Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.
(4) Physicians must not monitor an interrogation with the intention of intervening in the interrogation, because this constitutes direct participation in interrogation.
(5) Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must be humane, respect the rights of individuals, and must not be coercive, for example, threaten or cause physical injury or mental suffering.
(6) When a physician has sound reason to believe that an interrogation constitutes torture, he or she must report this concern to the appropriate authorities. If the authorities are aware of the inappropriate interrogation but have not intervened to either stop the interrogation or prevent further inappropriate interrogations, physicians are ethically obligated to report such

interrogations to independent authorities that have the power to investigate and/or adjudicate such allegations. (Council 11/19/09; Reaffirmed HOD 2015-167)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 170

Introduced by: MSSNY Health Equity Committee
Bronx County Medical Society
Suffolk County Medical Society
MSSNY Young Physician Section

Subject: Addressing the Historical Injustices of Anatomical Specimen Use

Referred to: Reference Committee on Public Health and Education

Whereas, In the wake of the recent Harvard Anatomical Donation scandal, there is a clear need to reform rules and regulations surrounding the use of anatomical specimens in medical education, anthropological study, and related disciplines; and [1,2,3]

Whereas, America has a long and well-documented history of exploitation against American Indians, Alaska Natives, people of color, immigrants, those with disabilities, incarcerated people, non-Christian, and poor citizens, who historically have not been afforded the same rights as white, able-bodied Americans; and [4-7]

Whereas, Preserved and skeletal anatomical specimens from as far back as the 1800s are still held by medical schools and used for educational purposes today; and [8-12]

Whereas, The need for anatomical specimens has long since outpaced supply now and even more in the distant past; and [13]

Whereas, In the 1800s the theft of the bodies of minority populations like that of indigenous, enslaved, and free Black citizens was a common practice increasing supply of anatomical specimens without attracting scrutiny from legal entities; and [14-16]

Whereas, Some institutions have begun decommissioning, cremating, or returning remains of some slaves or minority populations; and [17-19]

Whereas, Other institutions have fought to hold on to remains like those of mother Bessie Wilborn, who had Paget's disease, whose skeleton still hangs at the University of Georgia against the wishes of her family; and [20-21]

Whereas, Despite laws such as the Native American Graves and Repatriation Act, which “requires federal agencies and institutions that receive federal funding to return Native American "cultural items" to lineal descendants and culturally affiliated American Indian tribes, Alaska

Native villages, and Native Hawaiian organizations", museums and institutions of higher learning have not complied with these laws; and [30, 31]

Whereas, Harvard holds human remains of 19 likely enslaved individuals and thousands of Native Americans according to a recent report [29-30]; and

Whereas, The Peabody Museum at Harvard stewards a collection of hair samples, and often names, taken from Indigenous people including clippings of hair from approximately 700 Native American children attending federal Indian Boarding Schools[29]; and

Whereas, the final manifestation of medical racism is the use of patient's bodies without their consent and the repatriation of these specimens is an important step toward healing minorities' distrust in medicine[21]; and

Whereas, today many states have presumed consent laws that still allow for bodies that haven't been claimed in as short as few days to be donated for dissection; and [27, 28]

Whereas, the majority of unclaimed bodies are non-white person, persons with mental health issues, or are the bodies of low- income individuals; and [26-28]

Whereas, the medical ethics community in America has expressed concern about presumed consent in the case of organ donation due to potential for damage the relationship of trust between clinicians caring for patients at the end of life and their families and loss of autonomy especially amongst those least capable of registering objections; and [25, 26]

Whereas, AMA Code of Ethics 6.1.4. cautions against the practice of presumed consent for deceased organ donation, but the AMA has no current policy on what constitutes ethical consent processes for donation of cadavers or body parts following death for educational purposes;

Whereas, AMA Code of Ethics 6.1.3 provides guidelines on financial incentives for cadaveric donations; however both opinions were developed in reports in 2002 and 2005 respectively, and do not consider the issues from a lens of medical racism; therefore be it

RESOLVED, That MSSNY advocate to AMSNY (Association of Medical Schools in the State of NY) for the return of human remains to living family members, or, if none exist, the burial of anatomical specimens older than 2 years where consent for permanent donation cannot be proven; and be it further

RESOLVED, MSSNY advocate that medical schools and teaching hospitals in NY State review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska Native remains and immediately return remains and skeletal collections to tribal governments; as required by laws such as the Native American Graves and Repatriation Act; and be it further

RESOLVED, MSSNY advocate that medical schools and teaching hospitals in NY State review their anatomical collections for remains of Black and Brown people and other minority groups, and return remains and skeletal collections to living family members, or, if none exist, then respectful burial of anatomical specimens or remains; and be it further

RESOLVED, That MSSNY seek legislation or regulation that requires the return of anatomic specimens of American Indian, Hawaiian Natives, Alaskan Natives and other minority groups; and be it further

RESOLVED, That MSSNY support the creation of a national anatomical specimen database that includes registry demographics; and be it further

RESOLVED, That MSSNY forward the above resolves and the following to the AMA for consideration at the next AMA HOD:

RESOLVED, That our AMA study and develop recommendations regarding regulations for ethical body donations including, but not limited to guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue; and be it further

RESOLVED, That our AMA continue to study and encourage research into the ethical implications of presumed consent as it relates to anatomical donations for research and medical education; and be it further

RESOLVED, That our AMA amend policy 6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors should be amended as follows:
Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:
(a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
(b) Has been developed in consultation with the population among whom it is to be carried out.
(c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.
Neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

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Existing MSSNY Policy:
None.

RELEVANT AMA POLICY
Improving Body Donation Regulation H-460.890

Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

Organ Donation and Honoring Organ Donor Wishes H-370.998
Our AMA:

continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members

when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

Medical Ethics and Continuing Medical Education H-300.964

The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making.
Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871

Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role.

6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors
Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:

(a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
(b) Has been developed in consultation with the population among whom it is to be carried out.
(c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.
Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 171

Introduced by: Ronald B Menzin, MD

Subject: Support for the Medical Aid in Dying Legislation [A.995-A / S. 2445-A] and Revision of the MSSNY Policy Position 95.989

Referred to: Reference Committee on Public Health and Education

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Whereas, public attitudes[1] to assisted dying are changing and it will be doctors that are prescribing and/or administering life-ending medications; and doctors' views[2] on assisted dying are also changing, partly by responding to the wishes and hopes of their patients and

Whereas, other countries[3] and states have enacted legislation to meet the wishes and needs of residents in Canada, the Netherlands, Switzerland, Belgium, and some US states, including for example New Jersey, by supporting voluntary assisted aid-in dying regulated and safeguarded practices that enable choices / options for their care during the end-stages of their lives; and

Whereas, the primacy of a personalized patient-doctor relationship is a key to ethical healthcare, and its fostering of patient-centric care, along with our Constitution's first amendment prohibition against government endorsement of a particular religion's codes/tenets - thereby allowing each of us equal and unfettered personal interpretations regarding this particular life-cycle event, and

Whereas, the NYS Assembly and Senate have before them legislation (A995a/S.2445a), sponsored by Assemblywoman Amy Paulin and Senator Brad Holman-Sigal; [4]and with consideration of the attachments included in this submission, along with the endorsements of like-minded organizations[5], therefore be it

RESOLVED, that the MSSNY will amend its position against medical aid in dying to allow physicians and their patients to benefit from the choices and regulations approved by such governing bodies as have legal and oversight responsibilities for these medical situations; and be it further

RESOLVED, that along with numerous other civic minded organizations, the MSSNY supports thoughtful consideration and ultimately the approval, of proposed legislation (A995a/S.2445a) and be it further

RESOLVED, that individual physicians will always retain their choice to opt-in or decline to engagement in the processes and procedures outlined in the Medical Aid in Dying

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[1] Polling. Voters support this option.
2.Polling. Doctors support this option.

[3] How Do Doctors Feel About Assisted Dying
[4] Crains article discussing Paulin/Holman-Sigal rationale for this legislation.
[5] NYCLU & New York State Bar Association

Legislation.

References:

Existing MSSNY Policy:
95.989 Physician-Assisted Suicide and Euthanasia

145.992 <u>Expanding Protections of End-Of-Life Care</u>
The Medical Society of the State of New York:

(1) recognizes that healthcare, including end of life care like hospice, is a human right.

(2) supports the education of medical students, residents and physicians about the need for physicians who provide end of life healthcare services.

(3) supports the medical and public health importance of access to safe end of life healthcare services and the medical, ethical, legal and psychological principles associated with end-of-life care.

(4) supports education of physicians and lay people about the importance of offering medications to treat distressing symptoms associated with end of life including dyspnea, air hunger, and pain.

(5) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to end-of-life care.
(6) supports shared decision-making between patients and their physicians regarding end-of-life healthcare.

(7) opposes limitations on access to evidence-based end of life care services.

(8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for receiving, assisting in, referring patients to, or providing end of life healthcare services.

A copy of this resolution will be forwarded to the AMA. (HOD 2023-166)

145.993 MSSNY Task Force on End of Life Care-Final Report
The final report of the MSSNY End of Life Task Force provides a review and recommendations of issues regarding end of life care. The report includes the following recommendations:

MSSNY will request the New York State Department of Health convene a group of stakeholders which will standardize community hospice programs around the state as well as the distribution of those programs.

MSSNY will work with the New York State Department of Health to develop culturally competent hospice guidelines.

MSSNY supports the development of a state central depository for eMOLST.
MSSNY will urge the New York State Legislature to create adequate reimbursement for end of life services.

MSSNY will request the NYS Department of Health and the AMA to develop educational resources for physicians, allied health professionals and patients on end of life care.

MSSNY will urge the AMA to work with all stakeholders to develop proper quality metrics to evaluate and improve palliative and hospice care.

MSSNY will request the NYS Department of Health to simplify the hospice re-certification process in the state.

MSSNY will offer end of life educational programming through live seminars, webinars and online. (HOD 2020-PHE reference committee report)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 172

Introduced by: Medical Society of the County of Queens
Young Physician's Section

Subject: Guiding Principles for the Healthcare of Migrants

Referred to: Reference Committee on Public Health and Education

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WHEREAS, there has been a recent increase in migrants and asylum seekers in the United States that has garnered New York City, New York State and National media attention [1], and

WHEREAS, this recent increase in migrants and asylum seekers has overwhelmed multiple areas of the United States, including southern border states such as Texas and Arizona, and has resulted in their coordinated transportation to cities that have "right to shelter" laws, such as New York City, Chicago, Denver and Washington D.C. [2,3], and

WHEREAS, from April 2022 to December 2023, more than 150,000 migrants have arrived in New York City, [1] and

WHEREAS, the Mayor of the City of New York declared an "Asylum Seeker State of Emergency" on 10/7/22, calling for increased aid from State and Federal governments [4], and

WHEREAS, the 2022-2023 New York City budgets did not account for this recent increase in migrants and asylum seekers, yet New York City has attempted to divert adequate resources to the New York City Health and Hospital System, which operates the Humanitarian Emergency Response and Relief Centers (HERRCs) which process the intake, screening, shelter, healthcare and other needs of migrants and asylum seekers [5], and

WHEREAS, the diversion of funds from the New York City budget to HERRCs and other associated costs of the recent increase in migrants and asylum seekers has resulted in a decreased funding of other New York City municipal services, such as public libraries, public schools and law enforcement [6], and

WHEREAS, New York State has declared a Disaster Emergency via Executive Order No. 28.7 in response to the recent increase in migrants and asylum seekers in New York State [7], and

WHEREAS, despite a $1 Billion addition to the New York State 2024 Budget allocated for response for migrants and asylum seekers, as well as mobilization of 1,500 National Guard Members and an Executive Order mobilizing additional resources, the New York State Governor is requesting additional support and resources from the Federal Government, including FEMA, the U.S. Department of Defense, and the National Parks Service [8, 9, 10], and

WHEREAS, New York City has become so financially overwhelmed with the recent increase in migrants and asylum seekers that it has requested discontinuation of its "right to shelter" statutes, and has reverted to litigating bus transportation companies for costs associated with the healthcare and housing of asylum seekers they have brought [11, 12], and

WHEREAS, Federal legislators are considering massive overhauls to immigration policy, but only at the expense of continued financial aid in the international conflict between Russia and Ukraine [13], and

WHEREAS, having adequate policy regarding the guiding principles of the healthcare for migrants and asylum seekers will allow organized medicine groups to adequately respond to future legislation or executive actions regarding the present migration crisis and future migration issues, and

WHEREAS, the First District Branch of MSSNY has “RESOLVED, that the First District Branch will collaborate together to write a resolution … to advocate for increased federal funding, and other federal solutions, to address the public health needs of the recent 2023 increase in asylum-seeking migrants.”, but has no other standing policy on migrants and asylum seekers, and

WHEREAS, the Medical Society of the State of New York does not have any present relevant policy regarding providing healthcare for migrant and asylum seekers, and

WHEREAS, the American Medical Association policy D-350.975 “Immigration Status is a Public Health Issue” does recognize “immigration status is a public health issue” and “will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities”, and AMA policy H-350.957 “Addressing Immigrant Health Disparities” addresses a limited scope of issues related to the healthcare of migrants, without reference to many important principles and priorities as identified by the World Health Organization [14, 15, 16, 17], and

WHEREAS, while the current migrant crisis being faced in the United States is causing recent local, state and national attention to this issue, other groups dedicated to the study and policy development of the healthcare of migrants at the international level report that this is indeed a part of a larger global migration trend, with the World Health Organization noting that from “2000 - 2017, the total number of international migrants rose from 173 million to 258 million, an increase of 49%” [16], and

WHEREAS, migrants face many unique health challenges and vulnerabilities including but not limited to; inadequate access to healthcare, increased need for mental health services, inadequate disease prevention, inadequate provision of care, lack of financial protection, discrimination, language and cultural barriers, increased risk of encountering communicable diseases, poor access to vaccination, inadequate continuity of care, inadequate health record portability, food insecurity, malnutrition, sexual and gender-based violence including abuse and trafficking and unsafe work conditions [16], THEREFORE, be it

RESOLVED, that our MSSNY advocate for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the “Colombo Statement”, and be it further

RESOLVED, MSSNY recognizes that migration status is a social determinant of health. and be it further

RESOLVED MSSNY affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration, and be it further

RESOLVED MSSNY recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families, and be it further

RESOLVED MSSNY recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard, and be it further

RESOLVED MSSNY recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by

1. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.

2. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.

3. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.

4. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.

5. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems and be it further

RESOLVED, that a copy of this resolution be transmitted to the AMA for consideration at its House of Delegates

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Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 200

Introduced by: NASSAU COUNTY

Subject: Chat GPT and Large Language Models in Medicine

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

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WHEREAS, Chat GPT and other generative artificial intelligence in the form of large language models (LLM) have become widely popular in medicine and other industries[1]; and

WHEREAS, There are many concerns regarding the use of LLMs, including worries about ethics, plagiarism, lack of originality in note writing, inaccurate content, limited knowledge, incorrect citations, and cybersecurity issues[2]; and

WHEREAS, Chat GPT has been listed as an author on research papers[3]; and

WHEREAS, At the same time, an LLM developed at NYU could accurately predict hospital readmissions and assess the likelihood of additional conditions accompanying a primary disease, as well as the chances of insurance denial[4]; and

WHEREAS, Chat GPT can successfully pass all three USMLE Step exams without prior training[5]; and

WHEREAS, There is still uncertainty regarding the possible benefits of LLMs in health care medical education[6]; therefore be it

RESOLVED, Our MSSNY will study and make recommendations regarding the use of LLMS in medical education and clinical practice; and be it further

RESOLVED, until further recommendations are made, MSSNY will discourage the use of LLMs in making diagnoses, managing patients' conditions, educating medical students, writing notes, and publishing research; and be it further

RESOLVED, that this resolution be forwarded to the American Medical Association.

References:

1. Boscardin CK, Gin B, Golde PB, Hauer KE. ChatGPT and generative artificial intelligence for medical education: potential impact and opportunity. Academic Medicine. 2024;99(1):22-27.
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5. Kung TH, Cheatham M, Medenilla A, et al. Performance of ChatGPT on USMLE: Potential for AI-assisted medical education using large language models. PLoS digital health. 2023;2(2):e0000198.

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Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 201

Introduced by: NASSAU COUNTY

Subject: Chat GPT and Large Language Models at the MSSNY House of Delegates

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

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WHEREAS, Chat GPT and other generative artificial intelligence in the form of large language models (LLM) have become widely popular in medicine and other industries[1]; and

WHEREAS, There are many concerns regarding the use of LLMs, including worries about ethics, plagiarism, lack of originality in note writing, inaccurate content, limited knowledge, incorrect citations, and cybersecurity issues[2]; and

WHEREAS, Chat GPT has been listed as an author on research papers[3]; and

WHEREAS, At the same time, an LLM developed at NYU could accurately predict hospital readmissions and assess the likelihood of additional conditions accompanying a primary disease, as well as the chances of insurance denial[4]; and

WHEREAS, Chat GPT can successfully pass all three USMLE Step exams without prior training[5]; and

WHEREAS, There is still uncertainty regarding the possible benefits of LLMs in health care medical education[6]; therefore be it

RESOLVED, Our MSSNY will establish a guideline that prohibits the use of LLMs in resolution writing for future MSSNY House of Delegate meetings.

References:

1. Boscardin CK, Gin B, Golde PB, Hauer KE. ChatGPT and generative artificial intelligence for medical education: potential impact and opportunity. Academic Medicine. 2024;99(1):22-27.
2. Sallam M. ChatGPT utility in healthcare education, research, and practice: systematic review on the promising perspectives and valid concerns. MDPI; 2023:887.
3. Stokel-Walker C. ChatGPT listed as author on research papers: many scientists disapprove. Accessed 2/2/24, https://www.nature.com/articles/d41586-023-00107-z
4. Jiang LY, Liu XC, Nejatian NP, et al. Health system-scale language models are all-purpose prediction engines. Nature. 2023:1-6.
5. Kung TH, Cheatham M, Medenilla A, et al. Performance of ChatGPT on USMLE: Potential for AI-assisted medical education using large language models. PLoS digital health. 2023;2(2):e0000198.
6. Biswas SS. Role of chat gpt in public health. Annals of biomedical engineering. 2023;51(5):868-869.

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 202

Introduced by: David Zuckerman, MS3

Subject: Opposition to Admissions Preference for Children of Alumni, Donors, and Faculty

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

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Whereas, our AMA in HOD Policy H-295.845 opposed the use of legacy admissions, defined as "a preference given by an institution to children of alumni and sometimes to applicants of varying relation to alumni,"[1] and

Whereas, less than 20% of medical school matriculants in 2023 belonged to families earning less than $75,000 per annum vs over 50% of American households[2]; and

Whereas, only 21% of medical school matriculants in 2023 belonged to "EO1/2" households, classified as those with a lower level than a bachelor's degree or any degree with a service, clerical, skilled and unskilled occupation despite 56% of American households with children possessing a lower level than a bachelor's degree[3,4,]; and

Whereas, American academic physicians definitionally hold a higher degree level than a bachelor's and earned an average of $347,000/annum in 2023, placing them at the 96th percentile of incomes[5]; and

Whereas, while data on medical school-specific applications remains highly opaque, undergraduate admissions data from Harvard suggests that children of donors and faculty comprised 11% of admitted students, nearly as large as the 14% of students admitted in connection to legacy preferences[6]; and

Whereas, the same study found that children of donors and faculty at Harvard garnered admissions rates six to seven times those of non-preferenced students[6]; and

Whereas, admissions preferencing for children of faculty significantly disfavored underrepresented minority applicants at Harvard, where less than 7% of admitted students with a Harvard faculty/staff parent identified as Black or Hispanic vs 23% of non-preferenced applicants[6]; and

Whereas, among medical school faculty, only 6% of full professors and 10% of total faculty are Black or Hispanic as compared to 38% of all young adults aged 18-24 years old, suggesting that preference for relatives of faculty in undergraduate medical education may act in a similar manner to undergraduate admissions as a defacto preference against URM applicants[7,8]; and

Whereas, in a 2023 survey of 39 allopathic medical school deans of admissions on barriers to increasing racial and ethnic diversity among medical students, several deans acknowledged that preference for children alumni, donors, faculty remained an obstacle to advancing diversity and that these practices favored applicants with racial and socioeconomic advantages[9]; and

Whereas, admissions deans in the same survey openly described several formal and informal processes which may favor children of alumni, faculty, and donors including 1) "[advantaging

applicants with social and political connections by] offering additional reviews, keeping an eye out for a given application, automatically granting interviews, and maintaining a database of preferred applicants" 2) "[Awarding] bonus points if you knew somebody, or your father was an alumni of the institution, or somebody was a donor, and that moved [you] up on the alternate of the wait list" and 3) "[That] the development office gets lots of inquiry for particular faculty, since they have produced so much for the institution. Imagine how difficult it would be to say, no [their relative] is not coming."[9]; and

Whereas, The Association of American Medical Colleges' (AAMC) framework for advancing health equity states its intent to "identify the subtle manifestations of structural racism that lead to exclusionary admissions processes in medical schools and residency programs."[10]; and

Whereas, AMA Policy H-65.952 states that the AMA recognizes that racial health inequity remains a serious threat to marginalized communities and encourages "the development of policy to combat racism and its effects."[11]; and

Whereas, AMA Policy H-350.970 states that the AMA "is committed promoting programs aimed at increasing the number of minority medical school admissions."[12]; and

Whereas, AMA Policy H-295.888 states that the AMA "will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants."[13]; and

Whereas, AMA Policy H-255.988 states that medical school admissions officers should select applicants on the basis of merit[14]; and

Whereas, MSSNY Policy 285.986 states that "MSSNY [will] work with medical schools in New York to ensure that underrepresented minority students are successfully recruited and supported to reinforce the pipeline of physicians and physician leaders to be representative of the population we serve"[15], therefore be it

RESOLVED, that our MSSNY affirm that the preferencing of alumni, donor, and faculty children in admissions is contrary to the goals of achieving a racially and socioeconomically diverse physician workforce, as well as the spirit of meritocratic admissions (New HOD Policy); and be it further

RESOLVED, that our MSSNY recognize that relation to alumni, donors, or faculty may be one reason among many for an applicant to express interest in a particular medical school, but otherwise oppose consideration of alumni, donor, and faculty relations in the evaluation of applicants (New HOD Policy); and be it further

RESOLVED, that our MSSNY will work with medical schools to deemphasize the consideration of alumni, donor, and faculty relation status in admissions (New HOD Policy); and be it further

RESOLVED, that our MSSNY will study the current prevalence and impacts of alumni, donor, and faculty relation status in NY state medical school admissions. (Directive to Take Action)

References:

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2. https://www.aamc.org/data-reports/students-residents/report/matriculating-student-questionnaire-msq
3. https://nces.ed.gov/programs/coe/indicator/cce/family-characteristics

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15. https://www.mssny.org/mssny-affirms-racism-is-a-public-health-crisis/

Existing MSSNY Policy:

285.986 Racism and Intersectionality in Medicine

“RESOLVED, that MSSNY affirms that racism is a public health crisis; and be it further…

RESOLVED, that MSSNY work with medical schools in New York to ensure that underrepresented minority students are successfully recruited and supported to reinforce the pipeline of physicians and physician leaders to be representative of the population we serve, and be it further…

RESOLVED, that MSSNY will request that all New York medical specialty organizations, medical schools, non-physician healthcare organizations and hospitals adopt similar resolutions”

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 203

Introduced by: New York County Medical Society

Subject: Medicaid Restructuring

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

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Whereas, New York State has had multiple commissions to study revising the Medicaid Program; and

Whereas, These commissions have had very little input from practicing physician; and

Whereas, The Medicaid system is still plagued with many issues including low reimbursement for physicians; and

Whereas, The New York Medicaid Program costs $108 billion dollars with $34.7 billion dollars of the NYS budget with an average cost of $9,531 per enrollee. There are 7.9 million New Yorkers enrolled; and

Whereas, Physician dealing directly with Medicaid patients and have first hand experience dealing with the problems of the system.

RESOLVED, That the Medical Society of the State of New York form a Commission to analyze the Medicaid system and propose solutions to improve it; and be it further

RESOLVED, That the report of this commission be forwarded to the Governor, the Legislature and publicized in the media.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 204

Introduced by: Connie L. DiMari, MD, as an Individual

Subject: An Assessment of the Unintended Consequences and Physician Support for Value–Based Payment Models — a Survey

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

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Whereas, Most CMS value-based payment (VBP) models have failed to improve the quality of care and meaningfully reduce cost[1]; and

Whereas, VBP programs such as the Hospital Readmission Reduction Program (HRRP), the Merit-based Incentive Payment System (MIPS), and the Medicare Shared Savings Program (MSSPP) have had many unintended serious consequences. By penalizing safety-net hospitals financially and physicians caring for greater numbers of disadvantaged patients with lower scores, HRRP and MIPS risk increasing healthcare disparities.[2,3,4] HRRP has resulted in increased mortality for targeted and non-targeted conditions.[5]; and

Whereas, The stated goal of the Center of Medicare and Medicaid Services is to have all beneficiaries in the traditional Medicare program cared for by providers accountable for costs and quality of care by 2030; and

Whereas, Although there may have been considerable response bias, a survey piloted through the New York County Medical Society found that 78% of physician respondents believe VBP will likely or somewhat likely harm patients, and 87% believe VBP will cause physicians to avoid high-cost patients. It is particularly concerning that 94% of physicians believe VBP will add to physician burnout, and physicians under 60 reported significantly less career satisfaction (50%) than those over 60 (85%); and

Whereas, The Medical Society of the State of New York and the American Medical Association have been steadily losing members, at least partially due to physicians' lack of faith that these organizations endeavor to understand their needs, value their opinions, and advocate effectively for their interests and patient care; therefore, be it

RESOLVED, That the Medical Society of the State of New York conducts a member survey to reveal value-based payment programs' impact on physicians and patient care to help guide future society advocacy efforts.

References:

1. Gondi S, Joynt Maddox K, Wadhera RK. "REACHing" for Equity - Moving from Regressive toward Progressive Value-Based Payment. *N Engl J Med*. Jul 14 2022;387(2):97-99. doi:10.1056/NEJMp2204749

2. Joynt KE, Jha AK. Characteristics of hospitals receiving penalties under the Hospital Readmissions Reduction Program. *JAMA*. Jan 23 2013;309(4):342-3. doi:10.1001/jama.2012.94856
3. Kim H, Mahmood A, Hammarlund NE, Chang CF. Hospital value-based payment programs and disparity in the United States: A review of current evidence and future perspectives. *Front Public Health*. 2022;10:882715. doi:10.3389/fpubh.2022.882715
4. Khullar D, Schpero WL, Bond AM, Qian Y, Casalino LP. Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System. *JAMA*. Sep 8 2020;324(10):975-983. doi:10.1001/jama.2020.13129
5. Wadhera RK, Joynt Maddox KE, Wasfy JH, Haneuse S, Shen C, Yeh RW. Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocardial Infarction, and Pneumonia. *JAMA*. Dec 25 2018;320(24):2542-2552. doi:10.1001/jama.2018.19232

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 205

Introduced by: Robert Hesson, MD and Radomir Stevanovic, MD, Tompkins County, as Individuals
Fifth and Sixth District Medical Societies

Subject: Physicians Outcomes' etc.

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

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Whereas, As there are approximately 10,000 complaints filed with the Office of Professional Medical Conduct per year; and

Whereas, As there is almost no data about the outcomes to those Physicians, both those exonerated and those sanctioned; therefore be it

RESOLVED, That Medical Society of the State of New York do a study regarding any another appropriate body to collect the outcomes to physicians referred to the OPMC.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution: 206

Introduced by: Medical Society of the County of Kings & Alex Shteynshlyuger MD

Subject: CMS violations of HIPAA and the Administrative Procedure Act – Let's sue them!

Referred to: Reference Committee Reports of Officers & Admin Matters

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Whereas CMS has been violating the rights of physicians under the APA (Administrative Procedure Act) when it comes to HIPAA Administrative Simplification requirements that govern **prior authorization**, claim submission, eligibility verification, electronic remittance advice, costly **virtual credit cards, EFT, modifier 25 use**. As a result of illegally adopted regulations and rulemaking that violates the Administrative Procedure Act requirements, physicians are forced to lose and pay tens of billions of dollars a year in administrative costs; because the enforcement mechanism adopted by CMS is legally unsound as it does not comply with the delegated rights, there is a lack of meaningful enforcement, and no resolution of problems for >10 years.

Whereas federal law requires that insurance companies pay directly to physicians with ACH EFT, CMS violates the APA by illegally promulgating major rules that allow health plans not to pay out-of-network physicians by EFT and instead send payments to patients.

Whereas, HIPAA Administrative Simplification requirements do not permit treating out-of-network physicians differently, CMS violates the APA by illegally promulgating major rules without the required notice-and-comment period and allowing health plans to discriminate against out-of-network physicians by denying HIPAA transactions, including prior authorization, electronic payments, and ERA (electronic remittance advice) information

Whereas, HIPAA Administrative Simplification law does not permit CMS to issue any HIPAA regulations that do not lower the costs or lower administrative burden; CMS routinely violates the governing law by illegally issuing regulations under HIPAA that raise the costs of healthcare and exponentially increase administrative burdens

Whereas, CMS issued "CMS Advancing Interoperability and Improving Prior Authorization Processes Final Rule" that explicitly allows **the imposition of UNLIMITED FEES on physicians** for doing prior authorization electronically, just as health plans imposed 2-3% EFT fees and 4-15% virtual credit card fees, a clear violation of HIPAA, which does not allow any regulations that do not LOWER the costs.

Whereas, HIPAA Administrative Simplification requirements do not permit health plans to impose fees on ACT EFT transactions or to force opt-out virtual credit cards on providers, CMS violates the APA by illegally promulgating major rules without the required notice-and-comment period and allowing health plans not to comply with HIPAA; by arbitrarily and capriciously closing valid complaints against health plans, insurance companies, TPA (third party administrators) "covered entities" against which complaints are explicitly allowed such as

clearinghouses and business associates; even after advising to file complaints against them and running a faux 'investigation' for 5 years.

Whereas, HIPAA Administrative Simplification requirements do not permit treating out-of-network physicians differently, CMS violates the APA by illegally promulgating rules and allowing health plans to discriminate against out-of-network physicians by denying medical practices, without reasoned explanation, access to **Provider Access API** (CMS Interoperability and Prior Authorization Final Rule) that communicate clinical information (including medical history, medication history) that health plan possesses to the treating physician; this includes Medicare participating physicians who happened to be out-of-network with PPO Medicare Disadvantage plan that has out-of-network benefits.

Whereas MSSNY and AMA policies advocate the resolution of such problems, and whereas HIPAA already makes all these practices illegal, the only way to resolve the issues that originate from illegally issued regulations is to declare them illegal in the court of law under HIPAA and the Administrative Procedure Act
Whereas the Texas Medical Society, won 4 times in a row, declaring CMS regulations governing the implementation of the No-Surprises Ac illegal under the APA, a shining example of successful advocacy.

Whereas Dr. Alex Shteynshlyuger, a MSSNY and AMA member, has been an advocate for administrative simplification on behalf of physicians nationwide, has filed >100 complaints with CMS and has been denied rights under the APA and HIPAA, and has a legal standing to sue CMS.

RESOLVED that MSSNY requests that the AMA Litigation Center and the Physician Advocacy Institute supports and initiate an APA lawsuit against CMS to declare regulations and arbitrary and capricious enforcement actions in response to physician complaints that impose >10 billion in annual costs on physicians illegal and void under HIPAA.

RESOLVED that MSSNY requests that the AMA engage any other relevant stakeholders, such as the American Hospital Association and the American Dental Association, in supporting a legal challenge to CMS.

Fiscal Note: $500,000 as per quote from the lawyers litigating the No-Surprises Act lawsuit filed by TMA.

References:

Existing MSSNY Policy:

120.891 Enforcement of Administrative Simplification Requirements – CMS
265.861 Forced Use of "Virtual" Credit Card Payments to Physicians
265.958 Authorized Assignment of Benefits:
265.804 Withdraw and Amend Virtual Credit Card Policy
120.990 Physician Notification of Insurance Payments Made Directly to Patients
120.897 Reducing Prior Authorization Burden and Separate Payment When Not Part of a Patient Encounter

RELEVANT AMA POLICY

CMS Administrative Requirements D-190.970
Standardized Preauthorization Forms H-320.944

Authorized Assignment of Benefits D-390.995
ERISA and Managed Care Oversight D-383.984
Virtual Credit Card Payments H-190.955
Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968

Author's Priority Statement

Healthcare is intertwined with electronic transactions, from prior authorization to electronic payments. Illegally adopted regulations that put physicians at a disadvantage and collectively cost physicians tens of billions of dollars year after year impose a real cost, threaten the viability of medical practices, and impose an undue administrative burden on physicians. The only viable solution is to challenge the illegal regulations, overturn them, and force CMS to write regulations that are consistent with the law as passed by Congress.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 207

Introduced by: Joseph R. Maldonado, Jr., M.D.

Subject: Study of a Hybrid live/virtual MSSNY HOD

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

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Whereas, the Medical Society of the State of New York (MSSNY) has reverted to a three day MSSNY HOD, and

Whereas, many county societies have experienced a decrease in membership and revenue, and

Whereas, travel, hotel room and dining costs have risen while MSSNY per diem reimbursement has remained unchanged placing the increased cost burden on counties, and

Whereas, county societies are no longer able to bear the additional costs of attending the MSSNY HOD, and

Whereas, MSSNY is not likely to increase revenues such that it will be able to adequately reimburse Delegates attending the MSSNY HOD; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) President establish a Taskforce in 2024 to explore the challenges and benefits of implementing a Hybrid model for participating in the MSSNY HOD in person as well as virtually and report back to HOD in 2025.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 208

Introduced by:	The New York County Medical Society and the Health Information Technology Committee
Subject:	Inclusion in Scheduling MSSNY HOD *Virtual* Reference Committee Meetings and Committee and Council Meetings So No Members are Barred From Live Participation Due to Religious Faith or Practices
Referred to:	Reference Committee on Reports of Officers & Admin Matters

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Whereas, The Medical Society of the State of New York (MSSNY) is an organization that encompasses a diverse group of physicians from a variety of ethnic backgrounds, religions, races, and nationalities; and

Whereas, The issue of religious tolerance affects MSSNY outreach and MSSNY's ability to attract new members and retain members; and

Whereas, MSSNY is strengthened by the diverse perspectives, experiences, interests and identities of its members and further strengthened by enabling all who want to engage and connect to do so; and

Whereas, A goal of MSSNY meetings is to hear all opinions and not sideline an entire group of members; and

Whereas, Certain religions have services on the religious holidays that would coincide with MSSNY meetings and certain religions prohibit the use of technology during religious holidays for strict observers of the religion; and

Whereas, MSSNY would not want to discriminate or even give the impression of religious discrimination or bias by treating any of its members disparately such that they cannot participate live, in real-time, during in-person or virtual meetings during the year or virtual Reference Committee hearings or serve as Reference Committee members (or Chairs) or provide live oral testimony if they author Resolutions; and

Whereas, All MSSNY members should feel that they have a place and can be seen and heard and fully partake in all aspects of the excellent organization; and

Whereas, There are many dates during the calendar year that MSSNY meetings can be held but religious practice, which occurs at publicly known times for all who are observant, cannot be moved, changed, or rescheduled; and

Whereas, MSSNY members should noy have to choose between religious observance or participating in MSSNY in-person or virtual committee or Council meetings or virtual MSSNY HOD Reference committee meetings; and

Whereas, MSSNY Reference Committee members and those testifying live should not be deprived of hearing the oral input of fellow members who wish to contribute but who would be silenced if the committee hearings or virtual reference committees occur during times of religious observance, i.e., those at the Reference Committee hearings would be deprived of

hearing the thoughts of those who are forced to submit only written testimony because of religious faith and practice; and

Whereas, Those who are observant of their religions should not be relegated a position where they are unable to participate in live Committee discussions or hear live testimony, unable to provide live testimony in real-time, unable to respond to live testimony with their own oral comments, unable to speak to resolutions they author and submit, and unable to see who and hear who testifies, and unable to serve on Reference Committees, etc. and are only offered the opportunity to submit isolated *written* testimony; and

Whereas, ALL MSSNY members, of any faiths, religious practices, and beliefs, deserve to:

- Be able to provide live verbal testimony at any MSSNY virtual Reference Committee hearing.
- Be able to hear the live testimony of their colleagues at the Reference Committee hearings.
- Be able to respond to the testimony of their colleagues by providing their own testimony.
- Be able to see who provides testimony and hear all of the testimony.
- Be able to speak as an author of a resolution.
- Be a full participant in the community of their peers; and
- Not be relegated to a second-class status providing merely written input, not in real-time, because of religious observance.
- Be able to participate in live MSSNY Committee and Council meetings.
- Be able to participate in virtual MSSNY Committee and Council meetings; and

Whereas, The matter of religious tolerance and sensitivity should not be dismissed and marginalized by simply removing any choice and offering only the opportunity to submit isolated written testimony independent of the live virtual Reference Committee hearings for individuals who are observant of their religion as there is no parity; and

Whereas, The NYC Government has publishes an annual list of ethnic and religious *weekday* holidays for the purpose of alternate side of the street parking that lists religious and ethnic observances of many faiths including Christianity, Islam, Hinduism, Jainism, Judaism (some of which the holidays start the night before) and that recognized list along with the Jewish Sabbath (from sunset Friday to sunset Saturday) can be used as a reference for ethnic and religious holidays; and

Whereas, There is no guidance within MSSNY policy regarding scheduling virtual Reference Committee hearings or Committee/Council meetings with respect to religious observance; and

Whereas, MSSNY has the <u>opportunity and capability to create an equitable and inclusive environment</u> where all MSSNY members can be a full participating member of the community and *all MSSNY members should be able to choose how they wish to submit testimony*; therefore, be it

RESOLVED, That as MSSNY is strengthened by its diverse community that MSSNY will demonstrate sensitivity to religious and ethnic inclusion, the varied and diverse religious and ethnic backgrounds of its members and will strive to schedule *virtual* HOD Reference Committee meetings, in person and virtual Committee and Council meetings, at times that do not overlap with religious observance and that would bar live participation or presentation of oral testimony due to religious faith and practice, as religious faith and practice are recurring events with known days of observance that affect an entire subset of MSSNY members and the dates of observance cannot be moved, changed or rescheduled.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 209

Introduced by: New York County Medical Society

Subject: RFP Process for MSSNY Contract Renewals

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

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Whereas, Members value the benefits and services provided by MSSNY; and

Whereas, Non–dues income continues to be an important part of MSSNY's overall financial health; and

Whereas, Duty of care is the Council's fiduciary responsibility and requires careful investigation when conducting the business of the organization; and

Whereas, Best practices in association management would dictate that MSSNY not automatically sign or re–sign any contract with vendor or sponsor without investigating other options; and

Whereas, Periodic reviews may introduce new opportunities or reinforce existing relationships; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) adopt policy that requests for proposals be issued and reviewed by the MSSNY Trustees before MSSNY signs or re–signs any multi-year sponsor agreement or membership benefits, and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) conduct an immediate review of all existing vendor contracts and issue Request for Proposals (RFPs) for any existing vendor contract at least once every five years.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 210

Introduced by: New York County Medical Society

Subject: Proper Role of Vendors and Endorsed Entities at MSSNY

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

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Whereas, the Medical Society of the State of New York (MSSNY) values its relationships with vendors and endorsed entities, and

Whereas, These vendor relationships bring value to MSSY members and ensure that members receive good service and good pricing from a vetted service provider, and

Whereas, Vendor relationships also provide necessary non-dues income to the organization, and

Whereas, Members value the benefits and services provided by these MSSNY associates and MSSNY values the relationships, and

Whereas, As important as these relationships are, good practice would dictate that the representatives of endorsed vendors should not be present during governance deliberations, and

Whereas, Although MSSNY should welcome reports and presentations from its endorsed vendors, it is inappropriate for those representatives to serve on MSSNY committees or be present at governance meetings; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) adopt policy that MSSNY endorsed vendors do not attend MSSNY Council or committee meetings outside of time given for a scheduled report or presentation.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 211

Introduced by: Joseph R. Maldonado, Jr., M.D.

Subject: Term Limits for Committee Chairs

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

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Whereas, the Medical Society of the State of New York (MSSNY) provides its members with the benefit of developing their physician leadership skills through engagement in its committees and taskforces, and

Whereas, many committees have chairpersons that have served for protracted periods, and

Whereas, often committee members resign because they believe they will never be able to serve as a committee chair thereby depriving those individuals the ability to develop their leadership skills and depriving the society of fresh and potentially excellent future leaders, and

Whereas, Presidents who make the committee appointments and chair appointments are often pressured into keeping existing chairs in their roles for prolonged terms, and

Whereas, the perpetuation of committee chairs for extended terms sends the message to other committee members that they may lack the ability to lead or that there is barrier to leadership development; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) adopt policy to limit committee chair appointments to a three-year term as chair.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 212

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland and Westchester Counties)
Subject:	Resolution for Equitable Dues Distribution to Alleviate County Stress
Referred to:	Reference Committee on Reports of Officers & Admin Matters

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Whereas, the Medical Society of the State of New York (MSSNY) recognizes the importance of supporting its members and ensuring fair representation; and

Whereas, proposed changes in the dues structure may disproportionately impact county medical societies, causing undue financial stress; and

Whereas, a more equitable distribution of dues would foster collaboration, unity, and shared responsibility among MSSNY members; therefore be it

RESOLVED, that the MSSNY modify its dues structure to provide a 50-50 dues split between the state and county medical societies, aiming to alleviate financial burdens on counties and promote a balanced, sustainable funding model; and be it further

RESOLVED, that MSSNY collaborates with county medical societies to assess the impact of the proposed changes and seeks consensus on an equitable distribution that benefits the entire medical community.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 213

Introduced by: David Zuckerman, MS3

Subject: MSSNY Committee Seats for Medical Students, Residents, and Fellows

Referred to: Reference committee on Reports of Officers & Admin Matters

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Whereas, MSSNY is generous with the opportunities and resources it provides its medical student members, residents, and fellows compared to other State medical societies; and

Whereas, Committees serve as entities through which medical students, residents, and fellows can explore their interests and meaningfully contribute to MSSNY's goals alongside more senior members; and

Whereas, Medical student, resident, and fellow involvement on committees can create familiarity with MSSNY-specific issues and proceedings, thereby cultivating its future leaders; and

Whereas, According to MSSNY's Bylaws, one of its purposes is to "contribute to the professional and personal development of member physicians by representing the profession as a whole and advocating health-related rights, responsibilities and issues"; and

Whereas, MSSNY Bylaws Article V Section F states that, "Any member of the Medical Society of the State of New York is eligible for membership on committees and commissions of the Council"; therefore be it

RESOLVED, Our MSSNY will allow for a minimum of one medical student member and one resident/fellow member on each committee starting at the conclusion of the 2025 House of Delegates.

References:

Existing MSSNY Policy:

MSSNY Bylaws: Article I. Name and Purposes

Purpose: To contribute to the professional and personal development of member physicians by representing the profession as a whole and advocating health-related rights, responsibilities and issues. These actions are designed to promote a favorable environment for medicine and improvement of the health of the residents of New York State

Article V. Council, Section F: Committees of the Council are grouped by the related nature of their purposes and functions. A commission is composed of the chairpersons of all committees within such a group.

Subject to the approval of the Council, the president shall appoint the chairpersons and members of all of its committees and the chairpersons of the commissions.

Any member of the Medical Society of the State of New York is eligible for membership on committees and commissions of the Council.

All chairpersons of such commissions and committees shall have the right to present their reports in person to the Council and to engage in the discussion of such reports. Members of such commissions and committees shall have the privilege of presenting minority reports, and both the majority and minority reports shall be published.

Any ex-officio member of a committee who enjoys that status by being a duly elected officer of the Medical Society of the State of New York shall have all the rights, responsibilities, and duties of any other member of the committee

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 214

Introduced by: New York County Medical Society
Dutchess County Medical Society
Medical Society of the County of Orange
Rockland County Medical Society

Subject: MSSNY Task Force on Elections

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

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Whereas, At the 2023 MSSNY House of Delegates, the House approved a resolution calling for a Task Force with representation from each District and each Section – which has diverse representation with respect to race, ethnicity, sexual orientation, and gender identity – that is tasked to improve the election process and ensure diversity in our leadership representation, with the Task Force report back to the 2024 House of Delegates; and

Whereas, The Task Force has not been appointed as of the beginning of 2024; and

Whereas, The Nominations Committee traditionally meets in January; therefore be it

RESOLVED, That the appointment of the Elections Task Force take place and work begin with no further delay.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 215

Introduced by: New York County Medical Society
Dutchess County Medical Society
Medical Society of the County of Orange
Rockland County Medical Society

Subject: New Policy for MSSNY's Nominations Committee

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

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Whereas, It is good association practice to insure participation and representation in the election process; and

Whereas, Younger members, the future of our organization, are often skeptical of election processes in which there is no choice or hurdles to nomination; and

Whereas, The recent history at the MSSNY House of Delegates indicates people "running from the floor" and an increased interest in being part of the leadership of MSSNY; and

Whereas, It is a perceived advantage in a contested election to be running as the Nominations Committee choice; and

Whereas, It is difficult for voters to make an informed choice without a proper mechanism to deal with contested elections, which are becoming much more usual than in the past; and

Whereas, The MSSNY Nominations Committee can serve as the entity that encourages leadership and participation by not focusing on a single list slate, but instead by confirming that all candidates meet qualifications to hold office, and

Whereas, When the Nominations Committee "vets" all interested candidates in advance, there will be no need for people to run "from the floor," and the process can be more efficient and more welcoming to all members, and

Whereas, When there is a choice for each position, voters feel that they are legitimate participants in determining MSSNY leadership as opposed to "rubber stamping" decisions made by others, therefore be it

RESOLVED, That the Medical Society of the State of New York adopt a policy such that the MSSNY Nominations Committee review the credentials of all nominated candidates for state office as received from the County Medical Societies and MSSNY members, with the goal of presenting contested slates for MSSNY elections.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 216

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland and Westchester Counties)
Subject:	Revision of Nomination and Election Processes for MSSNY Officers to Enhance Democracy
Referred to:	Reference Committee on Reports of Officers & Admin Matters

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Whereas, the Medical Society of the State of New York (MSSNY) values and prioritizes democratic principles within its organizational structure;

Whereas, continuous improvement and adaptation of organizational processes are essential for maintaining transparency, inclusivity, and fairness;

Whereas, it is crucial to ensure that the nomination and election of officers within MSSNY reflect the diverse perspectives and interests of its members; therefore be it

RESOLVED that MSSNY acknowledges the importance of revising its current nomination and election processes to align with democratic principles.

1. MSSNY will establish a special committee comprised of representatives from various segments of its membership to review and propose amendments to the existing nomination and election procedures.

2. The special committee shall conduct a comprehensive assessment of the current processes, seeking input from MSSNY members through surveys, town hall meetings, and other inclusive methods.

3. The special committee shall consider best practices in democratic nomination and election procedures within similar organizations and incorporate these insights into the revised MSSNY processes.

4. The revised processes should prioritize transparency, inclusivity, and fairness, ensuring that all eligible members have equal opportunities to participate in the nomination and election of officers.

5. MSSNY commits to providing clear and accessible information about the revised nomination and election procedures to its members through various communication channels.

6. The special committee shall present its proposed revisions to the MSSNY Board of Trustees for review and approval.

7. Upon approval, MSSNY will implement the revised nomination and election processes in the subsequent election cycle.

8. MSSNY encourages ongoing evaluation and feedback from its members to further refine and enhance the democratic nature of its nomination and election procedures.

This resolution shall take effect immediately upon passage; and be it further

RESOLVED, that by adopting this resolution, MSSNY reaffirms its commitment to democratic values and acknowledges the importance of continuously evolving its processes to better serve the needs and expectations of its diverse membership.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 217

Introduced by: Paul A. Pipia, M.D.

Subject: Election Reform and Candidate Interference with Committee Members

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

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Whereas, the Medical Society of the State of New York (MSSNY) members are asking for election reform, and

Whereas, The Nominations Committee Members and other general members of MSSNY have complained to the President of MSSNY that a potential candidate has called or has had others to call these members to influence their vote, and

Whereas, These same potential candidates have strongly advocated for Election Reform, and

Whereas, Lobbying the Nominations Committee Members to influence the nominations process goes against the concept of such reform; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) adopt policy that Candidates for election that contact or have someone else contact a Nominations Committee Member be barred from seeking a nomination for any position for a period of Two Years and loss of any current committee appointments as well as MSSNY elected offices; and be it

RESOLVED, That this barring come after an investigation of an Ad-Hoc Committee of 3 members that are not from the same District as the member and one appointed by the President, Speaker and Chairman of the Board of Trustees

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References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 218

Introduced by: New York County Medical Society
Dutchess County Medical Society
Medical Society of the County of Orange
Rockland County Medical Society

Subject: Protection of MSSNY Nonprofit Status and Abolition of "The Conference"

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

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Whereas, During the recent MSSNY Reference Committee on Bylaws it became known that a secret entity exists within MSSNY call "the Conference;" and

Whereas, Testimony suggested that this entity has been involved in influencing MSSNY elections and governance for years; and

Whereas, There is no reference to such an entity known as "the Conference" in either the MSSNY Bylaws or policies, and

Whereas, The Reference Committee on Bylaws meeting was recorded and is now discoverable by law; and

Whereas, MSSNY is a 501c6 not–for–profit entity; and

Whereas, The Foundation is a 501c3 not–for–profit entity, and

Whereas, Both MSSNY and the Foundation are responsible for adhering to both state and federal nonprofit laws; and

Whereas, The assessment and protection of the security, assessed risk and legal exposure for MSSNY is tantamount to the survival of the organization in the future; and

Whereas, "The Conference" or similar entities can be construed as a violation of both NY State and federal nonprofit laws, therefore be it

RESOLVED, That the entity known as "The Conference" shall immediately cease all activities and that this group be immediately dissolved, and be it further

RESOLVED, That MSSNY immediately undertake an independent and comprehensive investigation of the origins and effects of "The Conference" on past and present and future elections and its effects on the Society, and be it further

RESOLVED, That the results of "The Conference" investigation be concluded prior to the end of 2024 with the results reported back to members of the House of Delegates at that time, and be it further

RESOLVED, That no one ever involved in “The Conference” may in any way be involved or influence the Conference investigation; and be it further

RESOLVED, That anyone previously being a participant in “The Conference” must declare such participation in this entity as a conflict of interest in all further dealings of MSSNY; and be it further

RESOLVED, That MSSNY set policy such that officers, Councilors and Trustees of MSSNY will not engage in any secret meetings which could jeopardize the nonprofit status of MSSNY; and be it further

RESOLVED, That MSSNY set a policy that officers, Councilors, and Trustees of MSSNY sign annual affidavits that they will not put the nonprofit status of MSSNY in jeopardy through violation of New York State nonprofit laws.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 219

Introduced by: 3rd & 4th Districts

Subject: Establishment of a Steering Committee

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

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Whereas elections are held annually for all Medical Society of the State of New York (MSSNY) officers, councilors, trustees, and half of the delegation sent to represent MSSNY at American Medical Association (AMA); and

Whereas officers are elected for one-year terms only; and

Whereas ascension into the higher offices should strongly be considered as a prerequisite to becoming the Vice-President and, therefore, be ready to then ascend into the "Office of the President" (comprised of the President, President-Elect, and Immediate Past-President); and

Whereas pursuant to MSSNY by-laws, the Nominating Committee proposes to the MSSNY House of Delegates a slate of individuals to occupy all positions; therefore be it

RESOLVED that a Steering Committee be formed to research potential candidates for officers, councilors, trustees, and delegates to the American Medical Association and present its findings to the Nominating Committee, and be it further

RESOLVED that any potential candidate may present himself or herself to the Steering Committee for consideration, and be it further

RESOLVED that the Steering Committee would be charged only with the vetting of potential candidates and in no way would usurp the duties of the Nominating Committee

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References:

Existing MSSNY Policy:

2024 HOUSE OF DELEGATES
MEDICAL SOCIETY OF THE STATE OF NEW YORK
Report of Recommendations for Sunset of Policy Adopted 2014

Referred to: **Reference Committee on Socio-Medical Economics**
Maria LoTempio, MD, Chair

Mister Speaker, Your Reference Committee recommends that the policies contained in the 2024 Socio-Medical Economics Sunset Report be acted upon in the manner indicated and that the remainder of this report be filed:

Recommendation to be sunset:

165.928 **Rejection of Milliman & Robertson as Standard of Care:**
MSSNY formally rejects the Milliman & Robertson guidelines as a standard of care. (HOD 2000-273; Reaffirmed HOD 2014)
SME
Not able to locate current information that would require this to be reaffirmed. No longer needed.

165.950 **Require that HMO Subscribers Select a Primary Care Physician Within 30 Days or be Assigned One by the Plan, as per the Requirements of the NYS Medicaid Managed Care Guidelines Issued by the NYS Department of Health:**
MSSNY will seek regulatory or legal action to require that if HMO subscribers do not select a primary care physician within thirty days, they be assigned one by the plan, similar to the current guidelines utilized by the NYS Department of Health governing Medicaid Managed Care Plans; and such regulatory or legal action should also require that HMOs inform each enrollee of the name, address, and telephone number of the primary care physician to whom the enrollee has been assigned and of the enrollee's right to select a different primary care physician. MSSNY will seek regulatory or legal action to require that payment of the capitated amount to the primary care physician begin at the time of selection or assignment. (HOD 1999-62; Reaffirmed HOD 2014)

SME

This does not exist anymore as you have to select a primary care provider when signing up for insurance. This resolution was achieved.

130.932 **Encourage Use of NYS Record Release Form**
The Medical Society of the State of New York (MSSNY) recommends to physicians that their office staff utilize the New York State Authorization for Release of Health Information pursuant to HIPAA (OCA Office Form No. 960). (HOD 2014-250)
SME
This is current regulations and MR cannot be released without this form being signed. This resolution was achieved.

165.958 Crediting Capitated Payment:

MSSNY will advocate for legislation and/or regulations requiring managed care plans (a) to begin capitated payments to the physician starting from the date of which the patient enrolls in the managed care plan; (b) that the enrollee designate a primary care physician in a timely manner and (c) that the physician be notified of such selection. (HOD 1998-83; Reaffirmed HOD 2014)

SME

No longer relevant as resolution was achieved.

165.970 DEA Numbers Should Not Be Used As A Means Of Physician Identification:

MSSNY will advise and encourage New York State physicians not to release their DEA numbers except where required for prescribing narcotics and other Schedules II-V drugs; and will advise all MCOs of this policy. In the event that MCOs persist in using the DEA number as a means of physician identification, MSSNY will vigorously pursue appropriate legislative or regulatory relief and will ask the AMA to pursue similar legislation or regulatory relief. (HOD 1997-107; Reaffirmed HOD 2000-60; Reaffirmed HOD 2014)

SME

No longer relevant as resolution was achieved Current means to identify by physician identifier is the NPI.

175.988 New York State Department of Health Office of Medicaid Management Medicaid Fee Increase:

MSSNY and all of its component county medical societies will work together to affect ongoing changes in Medicaid fee schedules to make it a program more attractive to physicians, ultimately improving patient care. (HOD 2000-64; Reaffirmed Council 6/3/04; Reaffirmed HOD 2014)

SME

This was achieved for E/M in 2022 and for over 7000 CPT codes in 2023. Resolution achieved.

195.999 Mandatory Acceptance of Medicare Assignment:

MSSNY opposes mandatory assignment for payment for Medicare services. (HOD 1983-45; HOD 1990-46; Reaffirmed HOD 2014)

SME

Resolution achieved as you do not have to accept Medicare payments or be in network with Medicare.

240.993 Patient's Responsibility for Keeping Their Appointments

It is MSSNY's policy that it is the patient's responsibility to keep their follow-up and other assigned appointments. (Council 11/2/00; Reaffirmed HOD 2014)

SME

No longer relevant, offices can charge a no-show fee.

240.994 **Reimbursement for Missed Appointment**

MSSNY, consistent with the current opinions of the AMA Council on Ethical and Judicial Affairs, Section 8.01, reaffirms the position that "A physician may charge a patient for a missed appointment or for one not canceled 24 hours in advance if the patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his/her circumstances." (HOD 1996-263; Reaffirmed HOD 2004-274; Reaffirmed HOD 2014)

SME

No longer relevant, offices can charge a no-show fee.

265.960 **Reimbursement of Accutane**

MSSNY will urge the New York State Insurance Department to require insurance companies to reimburse for Accutane without forcing the physician to first prescribe unnecessary and potentially dangerous antibiotics. (HOD 2000-167; Reaffirmed HOD 2014)

SME

No longer relevant.

265.953 **Reimbursement for Baclofen Pump**

MSSNY will seek legislation to expand the Medicaid reimbursement formula for the Baclofen pump insertions to include the cost of the pump as an outlier in the DRG fee for this procedure. (HOD 2000-281; Reaffirmed HOD 2014)

SME

Per NYS website (link below, this is now covered) Resolution achieved.

https://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-09.htm#:~:text=For%20example%2C%20implantable%20infusion%20pumps,(s)%20that%20was%20provided.

Items recommended for Reaffirmation:

120.940 **Patient Educational Tools on Insurer Administrative Policies**

The Medical Society of the State of New York will develop a series of educational tools for members to give to their patients that will inform patients about policy and administrative problems caused by insurance plans making it more difficult for physicians to provide needed, quality health care and these Patient Educational Tools on insurer processes will state how insurers have interfered with physicians or otherwise constrain physicians from delivering what they believe to be the best quality care. (Amended and adopted by Council, 11/20/2014. From HOD 2014-257)

SME

120.942 Thoroughly Informing Patients and Physicians About Out-Of-Network Benefit Reduction and Cancellation

The Medical Society of the State of New York (MSSNY) will take all possible appropriate steps, utilizing all possible methods including public relations, to fully and thoroughly educate patients and the public about the emerging realities of out-of-network benefits, and the Medical Society of the State of New York will make every conceivable effort to communicate more fully and completely with its membership regarding what will transpire regarding out-of-network care since physicians too are under-informed. (HOD 2014-254)

SME

120.975 Home Visits:

MSSNY work to assure appropriate reimbursement for rendering care to homebound individuals. (HOD 2004-64; Reaffirmed HOD 2014)

SME

120.976 Geriatric Care:

MSSNY will work to assure appropriate reimbursement by all payors for care provided to the elderly. (HOD 2004-62; Reaffirmed HOD 2014)

SME

120.989 Routine and Refractive Eye Examination:

It is MSSNY's position that third-party payors make it abundantly clear to patients that *eyeglass riders, routine eye examinations, vision care services, vision benefits, vision aid benefits, vision care benefits, eyeglass benefits* and any such benefits, as desirable as they may be, do not substitute for a full medical eye examination on a regular basis by a qualified ophthalmologist, and that when eyeglass benefits are provided, that such benefits provide coverage for a refractive examination and prescription of eyeglasses by an ophthalmologist or optometrist of the patient's choice. MSSNY will coordinate efforts with medical specialty societies to introduce legislation requiring third-party payors to use uniform and precise language to describe benefits provided in eyeglass benefits and riders, and make it clear to patients that such examinations do not substitute for a full medical eye examination on a regular basis. (HOD 1998-78; Reaffirmed HOD 2014)

SME

120.997 Truth in Health Insurance:

MSSNY takes the position that all health insurance literature and contracts should be mandated to use a standardized form, written in laymen's terms (easy to understand language), wherein excluded diseases, diagnoses, and medical procedures are appropriately identified in policies of contract holders. As a means of allowing subscribers to make informed decisions concerning their health insurance choices, the Medical Society of the State of New York is urging the New York State Insurance Department to support legislation which would amend the insurance law in relation to the adoption of current procedural terminology for use by health insurers, as well as requiring insurers to release information on the mode of payment in addition to the actual reimbursement for services rendered to enrolled subscribers. (HOD 1992-37; Reaffirm HOD 2014*)*

SME

120.998 Reimbursement When Patients Refuse to Sign Health Insurance Forms:
MSSNY is urgently requesting the New York State Department of Insurance to draft measures which would ensure that health insurance companies be obliged to reimburse physicians for documented medical services performed in accordance with the patient's insurance plan whether or not the patient agrees to sign the insurance forms. (Council 7/23/92; Reaffirmed HOD 2014)
SME

130.933 Workers' Compensation and No-Fault Carriers to Use Diagnosis Codes Consistent with HIPAA Electronic Standards
The Medical Society of the State of New York (MSSNY) will seek legislation at the state level that requires all insurance carriers operating in New York State to utilize a consistent International Classification of Diseases (ICD) system. (HOD 2014-262)
SME

165.916 Patient Responsibility for Services Denied by Managed Care Organizations due to Coverage Parameters:
MSSNY encourages all managed care organizations licensed in this state, to adopt a policy allowing participating physicians to bill patients for those services that have been denied due to the company's internal coverage parameters, provided that the patient knew in advance that the procedure would not be covered and still chose to have the procedure performed. (Council 6/3/04; Reaffirmed HOD 2014)
SME

165.933 Downcoding:
MSSNY will seek legislative relief to (a) preclude down-coding and/or bundling of any medically necessary service by health care plans doing business in New York State and Computer Sciences Corporation/Medicaid; (b) prevent health care plans and Computer Sciences Corporation/Medicaid from the down-coding of medical services without first obtaining, at the expense of the health care plan, copies of patients' medical record and justifying the change in reimbursement; (c) prevent health care plans and Computer Sciences Corporation/Medicaid from requiring automatic and mandatory submission of medical record documentation for Evaluation and Management (E&M) codes at the time of claim submission. (HOD 2000-253; Reaffirmed HOD 2013; Reaffirmed HOD 2014)
SME

165.946 Information Included on Health Insurance Identification Cards:
MSSNY reaffirms its commitment to the positions embodied in Resolution 97-56, (Policy 165.981) and, in addition, MSSNY will work with payors to encourage the use of "smart cards" which would encode information, including but not limited to, the patient's eligibility data, co-pay, type of policy, effective policy dates, company address and appropriate phone number, I.D. number, group number, and the name of any entities with whom the MCO has subcontracted to pay for specific "carved-out" services. MSSNY will work with payors to encourage the use of a standard encryption format so that one machine is capable of reading data from all companies, and that the smart card reader be made available to all physicians at a reasonable price. MSSNY will seek through legislation or regulation a requirement that payors provide

immediately, upon application for enrollment, a temporary health insurance identification card providing information including but not limited to notice of effective date of eligibility. (HOD 1999-87; Reaffirmed HOD 2000-272; Reaffirmed HOD 2014)
SME

165.952 Managed Care Organizations' Restricting Practice of Credentialed Physicians:
MSSNY will seek legislation or regulation barring managed care organizations from limiting, by internal policy or refusal of payment, qualified physicians from practicing within the scope of their abilities, license and training. (HOD 1999-54; Reaffirmed HOD 2014)
SME

165.957 Re-credentialing of Physicians in Merged Managed Care Organizations:
The Medical Society of the State of New York will seek to assure, through whatever means appropriate, that when a contract between a managed care organization and credentialed physicians is transferred, merged or consolidated into another organization, the cost associated with re-credentialing of already credentialed participating physicians be borne by the new entity. (HOD 1998-207; Reaffirmed HOD 2014)
SME

165.966 Uniform Application Form, Uniform Encounter Form:
MSSNY supports the establishment and use of a uniform application and a uniform encounter form to be used by all HMOs, IPOs, HPOs and IPAs. (HOD 97-273; Reaffirmed HOD 2014)
SME

165.967 Managed Care Organizations to Standardize Pre-Certification:
MSSNY will encourage managed care organizations to standardize pre-certification procedures and time limits for HMOs to respond to pre-certification requests for patient care regardless of the time of day or day of week. (HOD 1997-254; Reaffirmed HOD 2014)
SME

SME

165.974 "Hold Harmless" Protection for Physicians Under Contract:
MSSNY will included in its policies and practices educating the physician on how such "Hold Harmless" clauses can serve to protect the physician or to increase risk exposure.
(HOD 1997-79; Reaffirmed HOD 2014)
SME

165.982 Changes in the Bundling of Medical Services by Managed Care Plans:
It is MSSNY's position that when a patient sees a physician for evaluation and management of an illness, whether primary care or consultation, and the physician also performs a procedure which helps in the diagnosis or treatment of that illness, the physician should be paid for both the evaluation and management code and the procedure code. When a physician sees a patient to perform a pre-scheduled procedure, cognitive services are considered part of the performance of the procedure and the physician should be paid only for the procedure. The supporting rationale for this policy is embodied in two separate functions; (a) the evaluation of the problem and decision to perform a procedure; and (b) the performance and interpretation of the procedure. These functions could often be performed on separate days, but, for reasons of good medicine, expedited care and patient/physician convenience, it is often preferable to perform the procedure on the same day as the evaluation and management visit. It would, therefore, be inappropriate under these circumstances to either unnecessarily require the patient to have the procedure performed on another day or to deprive the physician of equitable payment for the proper provision of both services on the same day. (Council 12/19/96; Reaffirmed HOD 2000-257 & 268; Reaffirmed HOD 2014)
SME

165.988 Specialty Rosters in Managed Care:
All managed care organizations should be required to maintain full rosters of medical specialists, representing all the specialties approved by the American Board of Medical Specialties and the American Osteopathic Board of Medical Specialties or otherwise provide access outside the managed care organizations to the full range of medical specialists as needed. (HOD 1996-78; Reaffirmed HOD 2014)
SME

165.992 Utilization Review Management:
MSSNY affirms the following position with regard to Utilization Review Management applicable to managed care entities who utilize down-coding, site of service payment reductions, and restrictive patient referral policies as a means of economic disincentives as follows: Physicians who are trained and/or Board Certified in their practice should be allowed to perform and be reimbursed for services if they are medically indicated. Any managed care plan implementing utilization review or management programs should establish an appeals process whereby physicians, other health care providers and patients may challenge policies restricting access to specific services and decisions to deny coverage for services. Such individuals must have the right to have reviewed any coverage denial based on medical necessity by a physician who is of the same specialty and has appropriate expertise and experience in the field. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services, or site of services, should be licensed to practice medicine and actively practicing in New York State and should be professionally and individually accountable for his or her decisions. The medical protocols and review criteria used by managed care plans in any utilization review or management program must be developed by practicing physicians. Managed care plans should be required to disclose to physicians, on request, the screening and review criteria, weighing elements, and computer algorithms used in the review process, as well as how they were developed. A physician of the same specialty must be involved in any decision by a utilization review or management program to deny or reduce coverage for services based on questions of medical necessity. A physician whose services are being

reviewed for medical necessity should be provided the identity and credentials of the reviewing physician on request. The reviewed physician should also have the opportunity to speak with a reviewer. (Council 9/22/95; Reaffirmed HOD 2000-79 & 80; Reaffirmed HOD 13-258; Reaffirmed HOD 2014)
SME

165.993 Emergency Services at Specialty Centers - Equity Coverage by Managed Care Entities:

It is the position of MSSNY that those managed medical care organizations that limit or restrict fiscal coverage to certain hospitals and physicians make an exception for emergent critical care case situations (such as extensive burns, neonatal spinal injuries, multi-organ/extensive trauma) that are sent to the appropriate specialty centers pursuant to guidelines established by organized medicine, and State or Federal policy, rules and regulations. MSSNY strongly opposes any attempt by a managed care entity or third party payer to delay, to deny payments, or to reduce payments when a patient is sent, on an emergent basis, to a designated specialty center and will disseminate this position to the membership and the New York State Health Maintenance Organization Council. (HOD 1994-274; Reaffirmed HOD 2014)
SME

165.994 Policy on Managed Care:

MSSNY affirms the following policy as adopted by the Council on January 23, 1986, and amended by the Committee on Interspecialty on January 13, 1994:
(1) No single pattern of health care delivery is necessarily suited to all patients or to all physicians; and that
(2) The traditional fee-for-service, the HMO, the HMO-IPA, and PPO concepts are valid and acceptable health care delivery systems; but
(3) There must be available multiple delivery mechanisms among which both the patient and the physician can truly exercise the right of free choice of how they will receive and disburse quality medical care; and that
(4) Any managed care plan is urged to cover in its basic policy all medically necessary procedures for all ICD-9 illnesses; medical, surgical, psychiatric and addictive. In the presence of such parity, cost factors may be dealt with by practice parameters, by utilization criteria and review, and by sliding scales of co-insurance and deductibles, not by limiting areas or specialties of care; and that
(5) Employers should contribute equitable amounts for each employee's health benefit plan, regardless of the plan selected; and that
(6) Fair market competition among all systems of health care delivery shall continue to be MSSNY policy (similar to AMA policy) with the potential growth of health care delivery systems being determined not by governmental intercession or entrepreneurial considerations, but by the number of people who prefer this mode of delivery. In addition, MSSNY recognizes both closed panel plans and open panel plans as valid and acceptable health care delivery modalities, consistent with the foregoing MSSNY policy statement.

MSSNY affirms the following AMA policy statements on managed care encompassing: (1) Case Management; (2) Financial Incentives and Disincentives; (3) Selective Contracting; (4) Physician Governance of Managed Care Program Policies:

1) **Case Management** (a) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of patient's care across different treatment settings. (b) With the increased specialization of modern health care,

it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. (c) The Primary goal of high-cost management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care. (d) Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations. (AMA Policy 285.998)

2) **Financial Incentives and Disincentives** (a) Any financial arrangements that may tend to limit the services offered to patients, or contractual provisions that may restrict referral or treatment options, should be fully disclosed to prospective enrollees by plans utilizing such arrangements. (b) Physicians must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians may satisfy their disclosure obligations by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. Physicians must also inform their patients of medically appropriate treatment options regardless of cost or the extent of their coverage. (c) Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create conflicts of interest because of financial incentives to withhold medically indicated services. Physicians must not allow such financial incentives to influence their judgment of appropriate therapeutic alternatives or deny their patients access to appropriate services based on such inducements. (d) Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care or expose the physicians to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk-sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians, and should be based over short periods of time. (e) Alternative private health benefit plans, with different schedules of deductibles, coinsurance and premiums, should be available to enrollees so that they are aware of the financial trade-offs associated with different plans. Both private and public third party payment systems should use deductibles and coinsurance as financial incentives for health care recipients to use health care resources in an appropriate manner. However, cost-sharing should not result in an undue financial burden for the health care recipient , and should not act to prevent access to needed care. (f) Physicians, other health professionals, and third party payors through their reimbursement policies, should continue to encourage use of the least expensive care setting in which medical and surgical services can be provided safely and effectively with no detriment to quality. (AMA Policy 285.998)

3) **Selective Contracting** (a) Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted. (AMA 285.998) (b) Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have that application judged on the basis of objective criteria that are available to both applicants and enrollees. (AMA CMS Report B, A-93) (c) Those managed care plans that contract with selected physicians to furnish care should utilize selection criteria based primarily on professional competence and quality of care. Any economic criteria used in such selective contracting should have a demonstrated positive

relationship to the quality and appropriateness of care and to professional competency. (AMA Policy 285.997) (d) Managed care plans that contract with selected providers should have an established appeals mechanism by which any provider willing to abide by terms of the plan contract could challenge a decision to deny the provider's application for participation in the plan. (AMA Policy 285.997) (e) All managed contracts should expressly require the managed care plan to provide meaningful due process protections, in order to prevent wrongful and arbitrary contract terminations that leave the physicians without means of redress. (AMA Policy 285.996) (f) Prior to initiation of actions leading to termination or non-renewal of a physician's participation contract for any reason, the physician shall be given notice specifying the grounds for termination or non-renewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. (AMA CMS Report B, A-43) (g) All "hold harmless" clauses in managed care contracts should be explicitly identified as such. Physicians should consider consulting with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician. (AMA Policy 285.995) (h) Physicians should have the right to enter into whatever contractual arrangements with managed care plans they deem desirable and necessary, but should be aware of the potential for some types of plans to create conflicts of interest because of financial incentives to withhold medically indicated services. (AMA Policy 285.998)

4) **Physician Governance of Managed Care Programs' Policies** (a) The medical protocols and review criteria used in any utilization review or utilization management programs must be developed by physicians. (AMA Policy 285.998)

In addition it is the position of MSSNY that quality assurance policies and any medical protocols be governed by practicing physicians. Credentialing of physicians is directly related to utilization review and quality assurance, and should, therefore, be operated in accordance with policies determined by physicians. (Council 3/10/94; Reaffirmed HOD 2014)
SME

175.991 Public Health Mandate Funding:
Fee schedules for immunizations under public funding mechanisms such as Medicaid should be modified to include additional reimbursement to help defray physicians' expenditures for compliance with State and City mandates which increase physicians' operating costs. (HOD 1997-268; Reaffirmed HOD 2014)
SME

175.995 Funding for Medicaid Services:
MSSNY has urged the Governor of the State of New York not to impose co-payments on Medicaid services, including nursing and therapy visits, paraprofessional services, prescriptions, and clinic visits. In addition, MSSNY has urged the Governor to: (1) Retain the existing Medicaid personal care program; (2) Retain Medicaid payments to hospitals for patients receiving alternative level of care services; and (3) Not to freeze Medicaid reimbursement rates for home health care providers. (HOD 1993-106; Reaffirmed HOD 2014)
SME

175.997 Utilization and Audits:
MSSNY is working with the New York State Department of Social Services and the New York State Department of Health to establish protocols against inappropriate utilization of Medicaid services and commensurate expenditures and to address the needs for: (1) Clear utilization of services parameters for dissemination to the physician community to guide physicians in the provision of health care under the Medical Assistance Program; (2) Development of more palatable and equitable methodologies to ensure appropriateness in audit investigations through mutually agreeable physician peer review activities and any disputes arising from such a peer review process. (Council 12/19/92; Reaffirmed HOD 2014)
SME

175.998 Fraud and Abuse Audit Control Activities:
MSSNY is cognizant of the realities surrounding health insurance audit and utilization review activities to ensure justifiable expenditures of private or public funds for claimed medical services. The Society is, nevertheless, deeply concerned by reports of inappropriate and inequitable Medicaid fraud and abuse investigations in New York State.
MSSNY asserts that any such fraud and abuse investigations motivated by established recoupment targets and bonus incentives by investigating state and federal entities is highly unethical, immoral, and contrary to the principles of fairness that are inherent in the American administrative and judicial system, and that have come to be rightfully expected by the medical community and the public at large. In acknowledging that not all individuals seek to fulfill the highest aspirations of their particular professions, MSSNY believes that any such individuals in medical practice who subscribe to substandard principles of medicine and ethics in interacting with health insurance programs should be treated accordingly. However, since MSSNY is confident that such practitioners comprise a decided minority of the state's medical community, the Society logically expects the New York State Department of Social Services (NYSDSS) Fraud and Abuse/Audit Control Divisions, the New York State Attorney General's Office, and the Office of the Inspector General to conduct legitimate Medicaid fraud and abuse investigation in an ethical and moral manner that ensures: (1) Equitable and meaningful due process for those medical professionals whose services are under review or investigation; (2) Appropriate classification of Medicaid audits so that cases basically involving the following are not unduly labeled as fraudulent activities and, thus, pursued accordingly: (a) Lack of adequate documentation of services; (b) Simple billing irregularities; or (c) Other billing errors (3) Physician safeguards against occurrences of unwarranted prosecutions by investigating agencies through: (a) Utilization of medical experts to corroborate substandard medical practices and justify Medicaid investigations; (b) Provision of pertinent guidelines to physicians for proper conformance with Medicaid requirements; (4) Retention of sufficient physician participation in the Medicaid program to guarantee access to quality health care for medically needy recipient (5) Physician immunity against harassment and victimization by overzealous reviewers to the detriment of their well-being, community standing, and professional careers; with such reviewers being answerable for their unwarranted actions; (6) Physician immunity against undue harassment and pursuit by reviewers on the basis of state budgetary constraints or bureaucratically devised recoupment targets and bonus plan incentives; (7) Physician entitlement to reasonable compensation by the investigating state or federal agencies for legal costs incurred by exonerated practitioners for compelled involvement in arbitrary fraud and abuse or audit control activities. In summary, it is the position of the Medical Society of the State of New York that no medical practitioner in the State of New York be subjected to the traumatic, intimidating and career-threatening activities of state and federal agencies, or any other health insurance entities, unless there is absolute and unimpeachable evidence of serious wrongdoing to warrant such focused pursuit. (Council 1/31/91; Reaffirmed HOD 2014)**SME**

175.999 Medicaid - Title XIX Recipients:
The position of the Medical Society of the State of New York is that all Title XIX (Medicaid) recipients must have equal access to high-quality health care along with freedom of choice as to the source from which they receive such care. This quality care should be delivered in an efficient manner by appropriately recognized and varying alternative mechanisms of medical care delivery. Reimbursement for medical service rendered to Title XIX (Medicaid) patients must be based on a realistic fee pattern, in keeping with current economic realities and with the physician mode of practice. Such fee patterns must be subject to periodic adjustments in the same manner as are all other recognized alternative mechanisms of medical care delivery. Further, there should be a: (1) Return of Medicaid patients to the offices of practicing physicians by revising the New York State Medicaid fee schedule to provide usual and customary fees, or to implement a realistically higher fixed fee schedule. (2) Well developed peer review system, administered by physicians at the local level and providing for an adequate appeals mechanism through physician ombudsmen. (3) Development of a program that would provide incentives to physicians for locating in underserved areas. (4) Unification of administrative and fiscal Medicaid responsibilities within a single Department at the State level. (Council 4/22/82; Reaffirmed Council 6/3/04; Reaffirmed HOD 2014)
SME

195.928 Point of Care Availability for Blood Glucose Testing
The Medical Society of the State of New York will call on the AMA to work with Centers for Medicare and Medicaid in order to maintain the CLIA exempt status of point of care glucose testing. (HOD 2014-252)
SME

195.929 CMS "Two Midnight" Policy
The Medical Society of the State of New York will ask the AMA to demand that the Centers for Medicare and Medicaid educate the public and produce documents that outline the potential negative financial consequences of the "two midnight" policy. (HOD 2014-255)
SME

195.930 Medicare Advantage Terminations Due to the Affordable Healthcare Act (ACA)
The Medical Society of the State of New York supports the information contained in the proposed rule by CMS, and supported by Congress, which states that Medicare Advantage Organizations notify their respective CMS Regional Account Managers no less than 90 (ninety) days prior to the effective date of planned termination(s) and MSSNY also supports CMS' belief that their approach and expectations described in the proposed rule will promote a more structured, efficient process that will minimize confusion and disruption for Medicare Advantage Organizations, enrollee care, providers and CMS. (HOD 2014-256)
SME

195.931 Application of Debt Collection Improvement Act of 1996
The Medical Society of New York will urge the American Medical Association to advocate for changes to the Debt Collection Improvement Act of 1996 so that CMS will be exempt from having to report to the Department of Treasury an outstanding debt arising from a Medicare/Medicaid overpayment when such original overpayment is $25 or less. (HOD 2014-63)
SME

195.991 Mandatory Enrollment of Medicare - Medicaid Patients in Managed Care Plans:

MSSNY strongly opposes mandatory enrollment of Medicare-Medicaid patients in managed care plans, and will actively use any available means to prevent forced enrollment and will bring this resolution before the next American Medical Association House of Delegates to be adopted as an official policy of the American Medical Association. (HOD 1997-103; Reaffirmed HOD 2014)

SME

180.994 Confidentiality of Patient and Physician Data:

MSSNY will continue to take whatever measures appropriate to discourage insurance companies and other health care agencies from publishing social security numbers and tax identification numbers whether it is stored, transmitted, or disposed of, in paper, electronic, or other media, and will become a strong proponent in efforts that may be underway to protect the confidentiality of patient and physician information whether it is stored, transmitted, or disposed of, in paper, electronic, or other media. (HOD 1998-88; Reaffirmed HOD 2014)

SME

195.995 Extrapolation Methodology in Medicare and Medicaid Postpayment Review:

MSSNY is:

(1) Petitioning the AMA to urge HCFA to adopt a policy that Medicare carriers just provide data which justify the statistical validity of their findings when any extrapolation technique is used in a Medicare post-payment audit and review process prior to any request for return of monies paid to physicians;

(2) Seeking statutory changes in the Medicare and Medicaid laws to prevent the application of the extrapolation methodology in order to ensure due process for physicians whose medical records and billing procedures are under review;

(3) Educating physicians in concert with local county medical societies about the potential abuses by Medicare and Medicaid administrators in carrying out reviews, and identifying legal resources which can be called upon by individual physicians for legal assistance and/or defense in cases of alleged Medicare/Medicaid fraud and abuse or overpayment. (HOD 1992-5 & 1992-76; Reaffirmed HOD 2014)

SME

225.991 IPRO Citations, Mandatory Purging of After Specified Time Period:

MSSNY will request the Centers for Medicare and Medicaid Services (CMS) to establish policy which would provide that Peer Review Organization (PRO) citations for matters that are not currently defined as quality issues, or those issues which are considered remote, be expunged. (HOD 1996-128; Updated and Reaffirmed HOD 2014)

SME

225.994 IPRO Reviewers:

MSSNY is taking all necessary and immediate steps to:

(1) Assure that IPRO disclose the names, qualifications and performance of its reviewers; (2) Assure that physicians in New York State be given information on the specific guidelines IPRO utilizes to assess the qualifications and performance of its reviewers;

(3) Require IPRO to utilize a board certified practicing physician of the same specialty from a like practice setting when PRO reconsideration determinations are conducted;

(4) Require IPRO to utilize the practice parameters as provided by the AMA and developed by its recognized specialty societies. (HOD 1991-62; Reaffirmed HOD 2014)
SME

235.995 Hospital Mergers Resulting in Physician Exclusions:
MSSNY will work with appropriate agencies to ensure that where one or more hospitals are merged, a physician credentialed to perform services at any one of the merging hospitals shall be entitled to receive equivalent credentials at any of the other merging hospitals, provided that such physician meets the qualifications for credentialing at such other hospital. (HOD 1999-77; Reaffirmed HOD 2014)
SME

235.997 Physician Credentialing:
MSSNY adopts as policy the position that the NCQA is not the appropriate organization to determine criteria for physician credentialing and will ask the AMA to adopt a similar policy and seek to develop its own national physician credentialing criteria through AMAP. (HOD 1997-87; Reaffirmed HOD 2014; Reaffirmed HOD in lieu of 2017-111)
SME

240.992 Patient Responsibilities:
MSSNY has adopted the following principles of patient responsibility:
(1) Good communication is essential to a successful physician-patient relationship. To the extent possible, patients have a responsibility to express their concerns clearly to their physicians and be honest.
(2) Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.
(3) In addition to explaining known medical background to their physician, patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
(4) Once patients and physicians agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with physician instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
(5) Patients generally have a responsibility to meet their financial obligations with regard to medical care or to discuss financial hardships with their physicians. Patients should be cognizant of the costs associated with using a limited resource like health care and should try to use medical resources judiciously.
(6) Patients should discuss end of life decisions with their physicians and make their wishes known. Such a discussion might also include writing an advance directive.
(7) Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients must take personal responsibility when they are able to avert the development of disease.
(8) Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.

(9) Patients should discuss organ donation with their physicians and make applicable provisions. Patients who are part of an organ allocation system and await needed treatment or transplant should not try to go outside or manipulate the system. A fair system of allocation should be answered with public trust and an awareness of limited resources. (10) Patients should not initiate or participate in fraudulent health care, and should report illegal or unethical behavior to the appropriate law enforcement authorities, licensing boards, or medical societies. (AMA Policy H-140.953 CEJA Rep. A, A-93; MSSNY Council 11/2/00; Reaffirmed HOD 2014)
SME

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)
SME

265.866 Use of Patient Satisfaction Surveys to Determine Payment for Medical Services

The Medical Society of the State of New York urges that health plans which use customer satisfaction surveys not use them to determine payment for medical services rendered but rather to educate providers in order to improve patient experiences. (HOD 2014-258)
SME

265.867 Cost Concerns Used to Downgrade Physician Designation and Listing on Insurance Panels

The Medical Society of the State of New York urges health plans to use cost analysis only as an educational tool for providers and not to downgrade physician designation or listing on insurance panels. (HOD 2014-259)
SME

265.868 Use of Guidelines as Absolute Over Clinical Judgment by the Provider

The Medical Society of the State of New York will seek through legislation, regulation or other relief, a prohibition against insurers using the existence of a clinical guideline to force an appeal. (HOD 2014-108)
SME

265.883 Physicians and Evidence-Based Medicine (EBM)

MSSNY, in its deliberations and advocacy, will support the development and use of high-quality evidence-based medicine as a guide to treating patients, provided, however, that the ultimate decision for care for each patient must rest with the physician determining the most appropriate care and treatment for their patient based on the patient's unique health care needs; and that evidence-based guidelines should not form the sole basis for health plan payment policies or liability. (HOD 2011-65; Reaffirmed HOD 2014-108)
SME

265.961 Accountability of Management Service Organizations

MSSNY will seek legislation which would (a) require that management service organizations that contract with health insurance entities to review, process and pay physician-submitted claims, grant authorizations and pre-certifications where appropriate, apply internal policy payment parameters frequently without physician input, be held accountable to the same State imposed standards, i.e. the Prompt Payment Law, as all insurance entities licensed in New York State, (b) mandate that the New York State Insurance Department have jurisdiction over management service organizations which contract with health insurance entities to review, process and pay claims.

It is MSSNY policy that insurance entities licensed in New York State that contract with management service organizations should be held accountable for the actions of these contracted organizations. (HOD 2000-88; Reaffirmed HOD 2014)

SME

265.976 Cost of Living Increases to Physician

MSSNY will seek the introduction of appropriate state legislation calling for the levels of physician payments by public and private health insurers to be annually adjusted with a cost of living increase tied to the Department of Labor cost of living index, with this increase remaining independent of adjustments made for any rising costs of providing services. (HOD 1999-255; Reaffirmed HOD 2014)

SME

265.982 Reimbursement Moratorium on Merged Health Maintenance Organizations

MSSNY will seek appropriate legislation which, in the event of a merger or consolidation of one or more health maintenance organizations, would impose a one-year moratorium after the announcement of a new fee schedule, thereby precluding the lowering of reimbursement to participating physicians for this one-year period. (HOD 1998-273; Reaffirmed HOD 2014)

SME

265.983 The Prudent Physician Paradigm

It is MSSNY's position that if a physician excises a clinically suspicious skin lesion, the insurer should be held liable for payment for the surgical procedure regardless of the subsequent pathology report.

MSSNY will request legislative or regulatory action that when a physician performs an indicated procedure based on a presumptive diagnosis, the third party payer reimburse the physician performing the procedure regardless of the final diagnosis. (HOD 1998-271; Reaffirmed HOD 2014)

SME

265.989 Changes In Reimbursement Rates And Payment Of Benefits Policies Of Insurance Carriers Without Recourse By Participating Physicians

MSSNY will actively seek, through legislation or whatever regulatory means necessary, the establishment of a mechanism whereby HMOs and other health insurers licensed in the State of New York be required to: (a) include in their annual financial reports to the Superintendent of Insurance any proposed changes in reimbursement schedules and withholds for physicians participation in their plans; (b) include in their participating physician agreements an

anniversary date indicating the duration that the contracted fees, withholds, and payment policies will remain in effect. (HOD 1997-270; Reaffirmed HOD 2014)
SME

265.990 Denial of Claims

MSSNY will seek to have legislation introduced that will require carriers to send a copy of their examiner's report to the treating physician with a provision that the denial cannot be issued until seven working days have passed from the time the report is mailed to the treating physician. (HOD 1997-263; Reaffirmed HOD 2014)
SME

265.991 Physicians Should Be Informed By the Third Party Payor of the Reason for the Denial of the Claim

MSSNY will seek the appropriate legislative or regulatory means to require that all third party payors, licensed to operate in New York State, be required to provide in a timely manner to the physicians with a rejected claim notice with an indication of the reason and the codes indicating why the claim was rejected. (HOD 1997-260; Reaffirmed HOD 2014)
SME

265.994 Determination of Where Medically Necessary Services Are to be Provided to Patients Enrolled in Managed Care Entities

MSSNY has adopted the position that in the event that a patient enrolled in a managed care program is referred to the emergency room of a local hospital following direct or verbal contact with a participating physician, this visit be covered and reimbursable whether categorized as emergent or not. (HOD 1994-262; Reaffirmed HOD 2014)
SME

265.995 Balance Billing - Benefits in Health System Reform

MSSNY supports the position that the practice of Balance Billing is in the best interest of: (1) Patients who will assume personal responsibility for a portion of their health care cost, and (2) Physicians and other providers who will be able to bill for an appropriate fee, yet still be subject to being monitored for such billing, and (3) Payers, government or other, who will have reduced financial liability, thus reducing the cost to third party payers.

MSSNY endorses the position that health system reform proposals include a provision that patients be free to contract with physicians of their choice to obtain medical services regardless of the insurance reimbursement. (HOD 1994-218; Reaffirmed HOD 2014)
SME

270.996 Social Security Number, Use as Provider Identifier

MSSNY will pursue legislation which will require the use of the physician's UPIN numbers and prohibit the use of a physician's social security number for identification purposes other than in tax-related documents.

MSSNY will also pursue legislation which will prohibit the publication of social security numbers in any form which has the potential to or will be available to the public. (HOD 1996-94; Reaffirmed HOD 2014)
SME

310.995 Independent Medical Examiners

MSSNY will legislation to create a pool of physicians in each specialty to act as Independent Medical Examiners (IMEs) for all third party payers doing business in New York State who request such a service in order to determine the need for further or continued medical treatment.

MSSNY will urge the Office of the Insurance Commissioner assign IMEs from the pool to conduct physical examinations and review medical records on a purely rotating basis so there is no bias in the selection of the IMEs; or, alternatively, select an independent organization, such as the Empire Foundation, to administer such an IME program with fees to be paid by the insurers. (HOD 2000-280; Reaffirmed HOD 2014)
SME

310.998 Third Party Audits of Physicians with Subsequent Billing of Physicians for Tests Deemed Inappropriate

MSSNY will urge the appropriate state and federal regulatory agencies to regulate third party payers' medical practice audits such that these audits focus on providing education and improving the quality of care, and not be used for financial or punitive activities. MSSNY will work to ensure outcomes of all medical practice audit processes would be governed by rules of due process which will be available for all physicians who participate in third party audits. (HOD 1998-255; Reaffirmed HOD 2014)
SME

325.958 Physician of Choice in Workers' Compensation Cases

The Medical Society of the State of New York (MSSNY) will seek a change to Section 13-b of the New York State Workers' Compensation Law to allow an employee with a Workers' Compensation related illness or injury, who is requesting a second opinion and/or medically necessary services, the right to obtain an independent evaluation and/or treatment from a physician who does not participate or accept Workers' Compensation, provided that the patient understands and acknowledges that he/she will not seek reimbursement from the Workers' Compensation program, or other health insurance plans they may have, and that such understanding between patient and physician is documented appropriately.

The Medical Society of the State of New York (MSSNY) will seek an additional change to the Workers' Compensation Law to allow a Workers' Compensation claimant to sign an approved document, such as an Advanced Beneficiary Notification (ABN), which clearly explains that the physician providing the second medical opinion and/or medically necessary services is not a Workers' Compensation authorized physician, and that the patient has agreed to pay the physician directly, without the expectation of reimbursement or the filing of a Workers' Compensation or other health insurance claim related to the care provided, and that a physician who evaluates a patient under such an arrangement may not be reported to OPMC for alleged violation of state law and that the recommendation generated from this opinion may not be used in a Workers' Compensation proceeding. (HOD 2012-266, referred, amended, adopted by Council 1/30/2014)
SME

325.968 Workers' Compensation Panels

MSSNY continue to work with the Workers' Compensation Board to encourage the enlistment of physicians to serve on arbitration panels. (HOD 2004-258; Reaffirmed HOD 2014)
SME

325.974 Modification of Workers' Compensation Law Sections 110A and 32

MSSNY will seek through legislation, regulation, or whatever means necessary, amendments to the NYS WC Law Sections 110A and 32 regarding the physician's ability to be listed as a *Party in Interest*. (Council 11/2/00; Reaffirmed HOD 2014)

SME

325.982 Augmentation of Damages in Workers' Compensation Arbitration Cases

MSSNY will urge the Workers' Compensation Board to amend its new streamlined appeals process, requiring that: (1) If a carrier makes misrepresentations to the Board concerning timely and proper receipt of bills, such misrepresentation be considered an act of bad faith, subjecting the carrier to judgment of treble damages; and (2) If a carrier fails to comply with a decision of the Board, such failure likewise be considered an act of bad faith, subjecting the carrier to judgment of treble damages**.** (HOD 2000-275; Reaffirmed HOD 2014)

SME

325.983 Timely Authorizations of Procedures

MSSNY will work with the appropriate agencies to require health care plans to provide adequate staffing/personnel to support the volume of incoming requests for authorizations via telephone in a timely fashion so that the waiting time for answering said calls does not exceed 5 to 10 minutes; MSSNY will work with the appropriate state agencies to require health care plans to accept requests for authorizations by electronic transmission in lieu of telephone requests, and MSSNY will work with the appropriate agencies to ensure that the response time to requests for authorization submitted via FAX not exceed 1 (one) business day. (HOD 2000-259; Reaffirmed HOD 2014)

SME

325.986 Hearing Outcomes in Workers' Compensation Cases

MSSNY will urge the New York State Workers' Compensation Board to enforce its current regulation that deems the physician as "an interested party," and requires the concurrent provision of notices of dates and time of pending hearings to physicians, claimants and representatives, as well as outcomes of any hearing of the Board within 15 days. (HOD 1999-270; Reaffirmed HOD 2014)

SME

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 250

Introduced by: Realba Rodriguez Bronx County
Alan Diaz MD past President FDB
As Individuals, Delegates' to Bronx County

Subject: Insurance Credentialing Demanding Physician Hospital Affiliation

Referred to: Reference Committee on Socio Medical Economics

Whereas, Primary Care Physicians have already limited time and availability and existing MSSNY policy (235.983) hasn't been actionable; and

Whereas, doing rounds in the hospital and returning to full waiting rooms, is a nonproductive proceeding; and

Whereas, the prevalence of independent physicians applying for privileges to a hospital has decreased; and

Whereas, those patients are being followed by hospitalists' who serve as the PCP during the hospitalization; and

Whereas, health insurances, without any rationale, are requiring physicians to have an affiliation/hospital privileges in order to participate in their network; and

Whereas, this model has become basically obsolete in the current health care model; therefore be it

RESOLVED, that MSSNY discuss and reissue with the Department of Financial Services that, health insurances should not haphazardly oblige a Physician to obtain hospital privileges in order to be paid for their work or participate in their network.

References:

Existing MSSNY Policy:

235.983 <u>Archaic Requirement that Primary Care Physicians Maintain Hospital Privileges</u>
MSSNY will call for an end to the insurance company requirement that physicians secure hospital admitting privileges as a condition to become participating (network) providers.

MSSNY will seek legislation or regulation that would prevent insurance companies from denying participating status to physicians who lack hospital admitting privileges. (HOD 2019-116)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 251

Introduced by: Ninth District Branch
(Dutchess, Orange, Putnam, Rockland and Westchester Counties)

Subject: Mandating Private Payer Coverage for Delegated Credentialing by Certified Verification Organizations and Extending Delegated Credentialing to Medicaid, Including Managed Medicaid Plans

Referred to: Reference Committee on Socio Medical Economics

Whereas, the Medical Society of the State of New York (MSSNY) is committed to advocating for policies that enhance the quality of healthcare delivery and ensure equitable access for patients; and

Whereas, credentialing is a critical process in healthcare that verifies the qualifications, training, and competence of Physicians, ensuring the highest standards of care for patients; and

Whereas, the process of credentialing by an insurance carrier frequently leads to extended delays in admission of physicians to that healthcare panel resulting in a delay in access to care for patients to the new Physician; and

Whereas, delegated credentialing, where a third-party certified verification organization (CVO) performs the credentialing process on behalf of insurance private payers, has proven to be an effective and efficient way to streamline the credentialing process while maintaining high standards; and

Whereas, private physicians groups have elected at their own expense to contract with CVO vendors to speed up admission of their physicians to insurance panels, thus removing the cost of credentialling from the private insurer; and

Whereas, many physician groups cannot afford the cost of contracting out for delegated credentialing, leading to variations in coverage and potentially hindering the efficient and timely delivery of healthcare services; and

Whereas, the Medical Society of the State of New York recognizes the importance of extending the benefits of delegated credentialing to all Medicaid programs, including managed Medicaid plans, to promote consistency and efficiency in credentialing processes across healthcare systems; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) advocates for the establishment of regulations mandating insurance private payers to provide coverage for the cost of performing delegated credentialing by certified verification organizations; and be it further

RESOLVED, that MSSNY supports efforts to extend delegated credentialing to all Medicaid programs, including managed Medicaid plans, to ensure a standardized and streamlined credentialing process for healthcare providers participating in these programs; and be it further

RESOLVED, that MSSNY will bring this issue to the AMA to promote equitable, efficient and standardized credentialing processes across the healthcare landscape.

References:

Existing MSSNY Policy:

235.992 <u>Eliminate Costly Monopoly for State Medical Licensure Credentialing by For-Profit Entity in New York and Enable Use of Alterative Credentialing Service</u>

The MSSNY will work with the New York state licensing board so that the costly for-profit FCVS service no longer has an exclusive monopoly on credentialing physicians and charging physicians hundreds of dollars to be licensed in New York; that the complimentary AMA Physician Credentialing service which is recognized and used for state licensure credentialing verification in over 40 other states is also offered as an alternative to state licensure credentialing verification ion New York; and ensure the complimentary primary verification obtained directly from medical schools and post-graduate residency training programs, which is used throughout the country and which previously has been used in New York to credential physicians for licensure, is another alternative accepted to credential physicians for state licensure in New York. (HOD 2012-116; Reaffirmed HOD 2022)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 252

Introduced by:	Realba Rodriguez MD Bronx County Alan Diaz MD past President FDB As Individuals, Delegates to Bronx County
Subject:	Do Not Penalize Primary Care Incentives if Patients Refuse Screening Tests.
Referred to:	Reference Committee on Socio Medical Economics

Whereas, Many year-end incentives; essentiall to the continued viability of a private practice are unjustifiably denied by insurance providers, and

Whereas, we as physicians struggle with the myriad of complex problems in drastically underserved patient populations, and

Whereas, the core services are often under-reimbursed as a matter of routine by predatory plan's; leaving many small practices struggling to remain an ongoing concern.

Whereas, these self-same insurance companies use random, and not representative, survey's to determine denial of payments, therefore be it:

RESOLVED, that MSSNY and the AMA lobby to propose legislation to the Department of Financial Services in order to revise the punitive practice that; health insurances hold Physicians responsible for the sole actions of their patients.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 253

Introduced by: New York County Medical Society

Subject: Making Care Primary – A Capitated Payment Model

Referred to: Reference committee on Socio Medical Economics

Whereas, Although the Institutes of Medicine has recognized capitation as encouraging the underuse of healthcare services, Making Care Primary (MCP) employs a capitated physician payment model designed for solo and small group practices.

Whereas, MCP entices participation with initial higher per-beneficiary payments and seemingly no risk in the transition to capitation and essentially admits that physicians participating in traditional Medicare are underpaid and overworked.

Whereas, "Our AMA strongly encourages all physicians contemplating entering into capitation agreements to exercise extreme caution, with attention to business skills and competencies needed to successfully practice under capitation arrangements and potentially uncontrollable market forces that may impact upon one's ability to provide quality patient care." (Contact Capitation Contracts H-385.932).

Whereas, A 2023 Gilfillan and Berwick review concluded capitated Medicare Advantage plans were higher in cost than traditional Medicare and did not improve quality.

RESOLVED, That the Medical Society of the State of New York remove from its website webinars or other materials advocating participation in MCP, or at a minimum, add a statement informing NYS physicians and patients of the conflicts of interest and the potential risks of participating in a capitated payment model.

References:

1. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academies Press (US); 2001.
2. Gilfillan R BD. Born on third base: Medicare Advantage thrives on subsidies, not better care", health affairs forefront. *Health Affairs Forefront*. March, 27,2023 2023;doi:10.1377/forefront.20230322.537535

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 254

Introduced by: NASSAU COUNTY

Subject: United Insurance Company Abuse of Physicians

Referred to: Reference Committee on Socio Medical Economics

Whereas, United Insurance Company is one of the major insurance carriers in New York State of which Oxford is a subsidiary; and

Whereas, health insurance products that can be regulated by New York (self-insured plans generally bought by large employers fall under a ERISA exemption) are under the Department of Financial Services (DFS); and

Whereas, in 2022, the Medical Society of the State of New York put forth a series of complaints to DFS that included many from Nassau County that United was engaging in abuse and unlawful practices as it pertains to record requests; and

Whereas, United Insurance company often asks for repeated and excessive copies of medical records which is extremely burdensome to physicians; and

Whereas, Oxford makes physicians send their medical records by US Mail to a PO Box in Atlanta despite clear NYS regulations that state that insurance companies must accept records electronically. This feature has been disabled for over 2 years, Oxford tells physicians they are working on the problem; and

Whereas, MSSNY Leadership, both physicians and staff, have worked diligently on this issue, constantly providing to the DFS examples of United not conforming to NYS regulations clearly demonstrating this is not just an occasional failing but a persistent and deliberate pattern of behavior; and

Whereas, DFS has had this issue in front of them for over 2 years without any action. Even the best of rules, without enforcement are meaningless; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) use all means available, regulatory, legislative, or legal, to force United to cease its demands for excessive records. United should also be obligated to allow electronic uploading of medical records.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 255

Introduced by: NASSAU COUNTY

Subject: PATIENT PORTAL ACCESS

Referred to: Reference Committee on Socio Medical Economics

Whereas, the state and federal government require health care entities to make medical records available to patients to view; and

Whereas, the record is to be available after the note or result is signed off by a healthcare provider who is often not the ordering clinician; and

Whereas, reports are signed well before the clinician has been able to review the report in the case of labs, pathology and radiology to name a few but not all instances; and

Whereas, one cannot assume that any given patient has the appropriate fund of medical knowledge to understand some of the data made available; and

Whereas, premature review by a patient can result in unnecessary anxiety, misunderstanding and possible maladaptive behavior by the patient; therefore be it

RESOLVED, that medical reports are to be reviewed by the ordering clinician prior to those reports being made available in the patient portal; and be it further

RESOLVED, that patients can be notified that a report is available but not yet signed off by the clinician so that they may call the clinician to review the result.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 256

Introduced by: David Zuckerman, MS3

Subject: Ensuring Transparent Use of Artificial Intelligence in Insurance Claims Processing

Referred to: Reference Committee on Socio Medical Economics

Whereas, artificial intelligence (AI) refers to the simulation of human intelligence or behaviors by non-human entities and machine learning (ML) refers to the learning of AI entities from previous events and application of this knowledge to future events[1]; and

Whereas, the in-network denial rate for private insurers has increased dramatically over the past five years with the 2022 national denial rate of 12% of in-network claims, which is more than 130% that of the 9% rate observed just six years prior in 2016[2]; and

Whereas, among health plans sold on the federal health insurance marketplace, this average denial rate increases to 17% with only 0.2% of these denials being appealed[3]; and

Whereas, in conjunction with the rise in national denial rates, AI- and ML-based claims processing techniques have been increasingly adopted by private insurers to expedite the processing of health insurance claims[4-6]; and

Whereas, a 2021 report by the consultancy firm McKinsey estimates that more than 50% of claims processing-related activities will be replaced by automation by 2030[7]; and

Whereas, a 2023 ProPublica investigation into the use of automatic claims processing by health insurer Cigna found that Cigna denied 300,000 requests for payments over a 2-month period using this method, spending an average of 1.2 seconds on each case, spawning subsequent lawsuits[8-9]; and

Whereas, in 2023 a class-action lawsuit against UnitedHealth and its subsidiary NaviHealth detailed its use of an AI algorithm to systematically deny claims of Medicare beneficiaries seeking coverage for long-term rehabilitation despite a reported 90% error-rate[10]; and

Whereas, when stratified by income, sex, and race/ethnicity, there are significant disparities in claim approvals regardless of processing methodology, which favor White, male, and non-elderly patients[11]; and

Whereas, a 2019 study analyzing a popular AI model used to evaluate patient health needs showed that the algorithm assigned lower risk scores to Black patients versus equally-sick White patients, due to the model's reliance on health care costs to calculate patient risk[12]; and

Whereas, in 2023 Pennsylvania introduced legislation requiring increased transparency surrounding the use of algorithmic claims processing by health insurers, intended to "minimize the risk of bias based on categories outlined in the Human Relations Act and other anti-discrimination statutes as applicable to health insurance in Pennsylvania"[13]; and

Whereas, the WHO's ethical guidelines on large multi-modal models (LMMs) use in healthcare state that "serious errors could arise, due to inaccuracies, mistakes [...] or 'hallucinations'. It is therefore important that most clerical and administrative functions not be completely automated"[14]; and therefore be it

RESOLVED, Our MSSNY supports:
(1) transparency standards which allow for the state agency auditing of AI algorithms used by New York State health insurers to approve and deny claims
(2) the modification of New York statute to explicitly preempt the utilization of race and race-based proxies in the algorithmic claims processing of health insurance

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References:

1. Poole, D.M., Alan; Goebel, Randy, Computational Intelligence: A Logical Approach. 1998, New York: Oxford University Press.
2. Choi, R.Y., et al., Introduction to Machine Learning, Neural Networks, and Deep Learning. Translational vision science & technology, 2020. 9(2): p. 14-14.
3. Karen Pollitz, et al., Claims Denials and Appeals in ACA Marketplace Plans in 2021, KFF (Feb. 9, 2023)
4. Raghupathi W, Raghupathi V. Big data analytics in healthcare: promise and potential. Health Inf Sci Syst. 2014 Feb 7;2:3. doi: 10.1186/2047-2501-2-3. PMID: 25825667; PMCID: PMC4341817
5. Davenport T, Kalakota R. The potential for artificial intelligence in healthcare. Future Healthc J. 2019 Jun;6(2):94-98. doi: 10.7861/futurehosp.6-2-94. PMID: 31363513; PMCID: PMC6616181.
6. Gervasi SS, Chen IY, Smith-Mclallen A, et al. The Potential For Bias In Machine Learning And Opportunities For Health Insurers To Address It. Health Aff. 2022;41(2):212–218.
7. Balasubramanian, R., Libarikian, A., & McElhaney, D. (2021, March 12). Insurance 2030—The impact of AI on the future of insurance. McKinsey & Company. https://www.mckinsey.com/industries/financial-services/our-insights/insurance-2030-the-impact-of-ai-on-the-future-of-insurance
8. Armstrong, P. R. M. (2023, December 11). How Cigna saves millions by having its doctors reject claims without reading them. ProPublica. https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims
9. Georgetown University. (2023, December 15). Kisting-Leung et al. v. Cigna Corporation et al. - Health Care Litigation Tracker. Health Care Litigation Tracker. https://litigationtracker.law.georgetown.edu/litigation/kisting-leung-et-al-v-cigna-corporation-et-al/
10. Ross, C., & Herman, B. (2023, December 12). UnitedHealth faces class action lawsuit over algorithmic care denials in Medicare Advantage plans. STAT. https://www.statnews.com/2023/11/14/unitedhealth-class-action-lawsuit-algorithm-medicare-advantage/
11. Lent AB, Garrido CO, Baird EH, Viela R, Harris RB. Racial/Ethnic Disparities in Health and Life Insurance Denial Due to Cancer among Cancer Survivors. Int J Environ Res Public Health. 2022 Feb 15;19(4):2166.
12. Ziad Obermeyer et al., Dissecting racial bias in an algorithm used to manage the health of populations.Science366,447-453(2019).
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14. Ethics and governance of artificial intelligence for health. Guidance on large multi-modal models. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO.

Existing MSSNY Policy:
120.953, Transparency in Insurance Contracts

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 257

Introduced by: Ninth District Branch
(Dutchess, Orange, Putnam, Rockland and Westchester Counties)

Subject: AI in Insurance Claims

Referred to: Reference Committee on Socio Medical Economics

Whereas, the Medical Society of the State of New York (MSSNY) is committed to upholding the principles of fair and equitable healthcare practices; and

Whereas, artificial intelligence (AI) technologies are increasingly being utilized in various sectors, including the insurance industry, to assess and make decisions on claims; and

Whereas, concerns have been raised regarding the potential bias, lack of transparency, and accountability in AI algorithms that may result in unjust denial of insurance claims; and

Whereas, the use of AI in the denial of insurance claims may adversely impact patient outcomes and contribute to disparities in healthcare access; therefore be it

RESOLVED, that the MSSNY advocates for the prohibition of the use of artificial intelligence in the denial of insurance claims; and be it further

RESOLVED, that MSSNY calls for a thorough examination and oversight of AI algorithms utilized in insurance claim processing to ensure fairness, transparency, and accountability; and be it further

RESOLVED, that MSSNY urges insurance companies to adopt policies that prioritize human review and intervention in the decision-making process for insurance claim denials; and be it further

RESOLVED, that MSSNY encourages collaboration with regulatory bodies, stakeholders, and experts in the field to establish guidelines for the ethical use of AI in insurance claim processing; and be it further

RESOLVED, that MSSNY shall communicate this resolution to relevant legislative bodies, regulatory agencies, and the public to promote awareness and action in addressing the ethical concerns associated with the use of AI in insurance claims denial.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 258

Introduced by: Bronx County Medical Society

Subject: Removing board certification as a requirement for billing for home sleep studies

Referred to: Reference Committee on Socio Medical Economics

Whereas, 25-30% of men at 9-13% of women in the United States suffer from sleep apnea; and

Whereas, there is a shortage of board certified Sleep physicians to address this unmet public health threat; and

Whereas, the Center for Medicare and Medicaid Services (CMS) require onerous requirements for centers and physicians to even provide basic at home sleep testing (1); and

Whereas, the American Academy of Sleep Medicine offers an alternative pathway for cardiologists not board certified in Sleep Medicine to seek accreditation in sleep apnea screening for OSA for $4500 for 5 years (2); and

Whereas, this pathway is not offered to other licensed physicians and pathways for grandfathering of sleep certification were closed years ago and no post graduate pathway has been made available except leaving practice for a one year fellowship; and

Whereas, it has never been demonstrated that board certification in sleep apnea results in improved outcomes; therefore be it

RESOLVED, that the Medical Society of the State of New York lobby the appropriate bodies in New York State government to remove Sleep Board Certification and facility accreditation as a requirement for the approval of and payment for home sleep studies, simply allowing this to be the purview of a competent licensed physician; and be it further

RESOLVED, that this resolution be brought to the American Medical Association (AMA) for consideration at the AMA Annual Meeting to lobby the CMS for a change in the Local Coverage Determination for home sleep studies.

References:

(1) https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34040
Physician and Technician Requirements for Sleep Studies and Polysomnography Testing:
1. The physician performing the service must meet one of the following:
    a. be a diplomate of the American Board of Sleep Medicine (ABSM);
    OR
    b. has a Sleep Certification issued by ONE of the following Boards:
    American Board of Internal Medicine (ABIM),
    American Board of Family Medicine (ABFM),
    American Board of Pediatrics (ABP),
    American Board of Psychiatry and Neurology (ABPN),
    American Board of Otolaryngology (ABOto),
    American Osteopathic Board of Neurology and Psychiatry (AOBNP),
    American Osteopathic Board of Family Medicine, (AOBFP)

American Osteopathic Board of Internal Medicine, (AOBIM)
American Osteopathic Board of Ophthalmology and
Otorhinolaryngology (AOBOO);
OR

c. be an active physician staff member of a credentialed sleep center or laboratory that have active physician staff members meeting the criteria above in a or b.

2. Technician Credentials

The technician performing the service must meet one of the following:
American Board of Sleep Medicine (ABSM),
Registered Sleep Technologist (RST);
Board of Registered Polysomnographic Technologists (BRPT),
Registered Polysomnographic Technologist (RPSGT)
National Board for Respiratory Care (NBRC)
Certified Pulmonary Function Technologist (CPFT)
Registered Pulmonary Function Technologist (RPFT)
Certified Respiratory Therapist (CRT)
Registered Respiratory Therapist (RRT)

(2) https://aasm.org/cardiology-practice-accreditation/

Existing MSSNY Policy: None

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 259

Introduced by: New York County Medical Society

Subject: Supporting Independent Practice – Payment Parity

Referred to: Reference Committee on Socio Medical Economics

Whereas, Once the reserve of physicians transitioning to retirement, there has been nearly a 90% increase in the locum tenens physician workforce since 2015. These mostly prime working-age temporary physicians, currently comprise 7% (50,000) of the US physician workforce.[1] Like traveling nurses, they earn 30-50% more than their employed colleagues and escape corporate medicine's bureaucratic pressures and increasing focus on physician productivity metrics. The reliance on temporary physicians can disrupt the **continuity** of patient care; and

Whereas, Concierge and other Direct Payment Contracting Practice models have also had considerable growth over the last few years and are expected to grow significantly in years to come.[2,3] They offer a reduced patient workload, often one-third of a typical practice, increased time to develop close personal relationships, and relief from time-consuming administrative tasks. These practices will not be accessible to most patients; and

Whereas, A recent survey by Elsevier Health revealed that half of US medical students no longer aspire to careers in direct patient care as they digest the complex medical landscape and that clinical careers no longer offer autonomy and flexibility.[4] The **availability** of primary care physicians, in particular, will likely continue to decline; and

Whereas, The current system pays hospital-based clinics more for many of the same services that independent community physicians provide. When small community practices are swallowed up by a hospital or private equity entity, the cost of care goes up.[5,6] Small independent practices have also been revealed to have significantly fewer preventable hospital admissions.[7] As consolidation into large physician groups clearly threatens the affordability of care, we should be supporting independent practice rather than undermining it; therefore, be it

RESOLVED, That the Medical Society of the State of New York will advocate for payment parity for physicians providing the same services (adjusted for local costs), allowing small independent practices to survive, thus helping to stem the loss of physicians to locum tenens, concierge practice and non-clinical careers, and helping to preserve the continuity, accessibility, availability, and affordability of care.

References:

1. Burned Out Doctors Turn to Temp Work by Gretchen Tarrant https://www.wsj.com/articles/the-rise-of-the-part-time-doctor-7025ec1d

2. Brekke G, Onge JS, Kimminau K, Ellis S. Direct primary care: Family physician perceptions of a growing model. Popul Med. 2021;3:21. doi:10.18332/popmed/140087
3. US Concierge Medicine Market Size, Share and Trends Analysis Report https://www.grandviewresearch.com/industry-analysis/us-concierge-medicine-market-report
4. Clinicians of the Future: Education Edition https://www.elsevier.com/promotions/clinician-of-the-future-education-edition
5. Beaulieu ND, Chernew ME, McWilliams JM, et al. Organization and Performance of US Health Systems. JAMA. 2023;329(4):325-335. doi:10.1001/jama.2022.24032
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Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 260

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland and Westchester Counties)
Subject:	Mandated Economic Escalators in Insurance Contracts
Referred to:	Reference Committee on Socio Medical Economics

Whereas, MSSNY is committed to advocating for the best interests of its members and ensuring access to quality healthcare for all patients; and

Whereas, the ever-changing landscape of healthcare economics poses challenges to sustaining the financial viability of medical practices; and

Whereas, adequate payment for medical care provided through commercial insurance contracts are integral to the financial well-being of healthcare providers; and

Whereas, the US Congress has directed CMS to repeatedly lowered the conversion factor utilized in the Medicare Physician Fee Schedule (PFS) resulting in significant decline in payment rates under traditional Medicare; and

Whereas, most commercial insurance contracts are based on a multiple of Medicare Payment rate for a specified service resulting in a potential decline in commercial reimbursement rates over time; and

Whereas, healthcare providers face increased costs of operation due to inflation in various aspects of practice, including but not limited to personnel, supplies, and overhead expenses; and

Whereas, the absence of an economic escalator in insurance contracts fails to account for the economic realities faced by medical practices, thereby hindering their ability to provide quality care to patients; therefore, be it

RESOLVED, that The Medical Society of the State of New York (MSSNY) advocates through legislation or regulation for the mandatory insertion of an economic escalator provision in all commercial insurance contracts to account for economic inflation or a decline in Medicare Physician Fee Schedule (PFS); and let it further be

RESOLVED, that MSSNY shall bring a similar resolution to the AMA to build a broader coalition advocating for the inclusion of economic escalators in insurance contracts across the US.

References

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK

House of Delegates

Resolution 261

Introduced by: Suffolk County Medical Society

Subject: Rollback on Physician Performance Measures

Referred to: Reference Committee on Socio Medical Economics

Whereas, There are increasing Initiatives from public and private payers that feature incentives purportedly aimed at “elevated performance standards” for physicians and facilitating public reporting; and

Whereas, this increased emphasis on “elevated performance standards” affects physicians’ pay, reputation, and job satisfaction, despite such measures being largely unproven; and

Whereas, the prioritization of such purported quality improvement measures places a financial and temporal strain on hospitals and administrators, and too often raises tensions between hospital administrators and physicians; and

Whereas, on average, physicians spend about 2.6 hours per week on quality improvement documentation, time that could be better utilized in patient care; and (NEJM)

Whereas, because of technological limitations, there is an omission of many aspects of quality that cannot be measured and claims data do not reliably capture many of the factors included in performance measurement, a problem compounded by variability in coding habits among physicians and institutions; and

Whereas, the reliability, validity, evidence, attribution, and meaningfulness of performance measures have been questioned; and (time out article)

Whereas, these largely unproven performance measures are a major driver of the systemic stressors that are resulting in moral injury and demoralization amongst physicians while also resulting in more patient dissatisfaction and destroying the patient-physician relationship, therefore be it

RESOLVED, that MSSNY will make public statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and be it further

RESOLVED, that MSSNY will seek legislation or regulation removing any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and be it further

RESOLVED, that MSSNY will forward this resolution to the next available AMA HOD for consideration and action on a national level, including but not limited to:

References:

-AMA statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and legislation and regulation seeking the same, and

-AMA seeking legislation or regulation mandating the removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare.

Existing MSSNY Policy:

120.891 Enforcement of Administrative Simplification Requirements – CMS

The Medical Society of the State of New York takes the position that the AMA must advocate that:

there is parity in the enforcement of the HIPAA Privacy Rule and HIPAAA Administrative Simplification requirements; and that the CMS impose penalties on health plan violations of HIPAA with the same rigor it imposes penalties on healthcare providers for violations of MIPS and other requirements;

the CMS investigates all valid allegations of HIPAA Administrative Simplification Requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA); and

the CMS resolves all complaints related to non-compliant payment methods including opt-out virtual credit cards and illegal EFT fees.

MSSNY strongly disapproves 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. (HOD 2021-55)

195.919 Reduce Physician Practice Administrative Burden

The Medical Society of the State of New York will work with the AMA and the federation of medicine to repeal the law that conditions a portion of a physician's Medicare payment on compliance with the Medicare Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM) programs. Should full repeal not be achievable, the Medical Society of the State of New York will work with the AMA and the federation of medicine to advocate for legislation and/or regulation which would significantly reduce the administrative burdens and penalties associated with compliance with the MIPS and APM programs. The New York delegation will introduce a resolution at the June AMA House of Delegates meeting calling for similar action. (HOD 2017-54; reaffirmed HOD 2018-52

150.988 Economic Credentialing and Medical Staff Privileges:

It is the position of MSSNY that:

(1) No hospital or ambulatory facility shall curtail, restrict, or terminate the medical staff privileges of any physician without adherence to established procedures set forth in the medical staff Bylaws, and only after the accordance of due process rights pursuant to the procedures specified in the Federal Health Care Quality Improvement Act of 1986, or in accordance with provisions of the hospital or ambulatory facility medical staff Bylaws; and (2) No hospital or ambulatory facility shall curtail, restrict, or terminate the medical staff privileges of any physician based upon economic criteria unrelated to the quality of patient care; and

(3) No hospital ambulatory facility shall solicit, require, or accept any payment as direct or indirect consideration for the awarding or granting by the hospital or ambulatory facility of the right to exercise medical staff privileges. This prohibition shall not apply to required payment of medical staff dues or medical society dues that may be required of all members of the hospital or ambulatory facility medical staff. (HOD 92-33; reaffirmed HOD 2014)

MSSNY's Hospital Medical Staff Section developed a MSSNY Policy Paper on Economic Credentialing and Exclusive Contracts which was approved by Council on July 23, 1992. The Policy Paper is available, upon request, at the Society Headquarters in Lake Success. MSSNY affirmed the concept that the credentialing of physicians for medical staff appointment or reappointment should be based solely on issues of competency, training and quality of patient care. The Society is seeking regulatory or legislative remedies to assure that only those with appropriate medical training, experience and ongoing clinical expertise will have the ability to establish standards of care and measure practice by these standards. MSSNY has communicated to the Hospital Association of the State of New York, its component associations and all other appropriate and interested parties its concern over the use of an individual physician's economic performance data which is being generated by hospitals in an effort to link charges, cost and clinical outcome as a major parameter, in and of itself, for the purposes of credentialing and re-appointing physicians. Hospital medical staff physicians and their leadership were informed by MSSNY to take precautions against any hospital initiative aimed at restructuring medical staff Bylaws which would emphasize economics and which could ultimately undermine quality of care. (HOD 1991-67; Reaffirmed HOD 2014; Reaffirmed in lieu of HOD 2020-66)

195.956 Medicare Contractor-Based PQRI:
MSSNY urge the Centers for Medicare & Medicaid Services (CMS) to (a) intensify its Physician Quality Reporting Initiative (PQRI) training efforts via sessions at the Medicare Administrative Contractor (MAC) level, rather than via national conference calls at the CMS level; (b) require the MACs to set up specialty-specific seminars, addressing the PQRI measures that are unique to each specialty area; and (c) integrate a mechanism to provide timely feedback during the course of the reporting year to physicians. (HOD 2009-96; Reaffirmed HOD 2019)

265.912 Reimbursement for Participation:
MSSNY adopts the American Medical Association's *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance*, H-450.947:
PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS
Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. **Ensure quality of care** – Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards. **2. Foster the patient/physician relationship** – Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
2. **Offer voluntary physician participation** – Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
3. **Use accurate data and fair reporting** – Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and

appeal results prior to the use of the results for programmatic reasons and any type of reporting.

4. **Provide fair and equitable program incentives** – Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

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.

<u>Physician Participation</u>

– 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.

<u>Physician Data and Reporting</u>

– 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)

RELATED AMA POLICIES

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998

Topic: Physician Payment | **Policy Subtopic:** NA
Meeting Type: Interim | **Year Last Modified:** 2020
Action: Reaffirmed | **Type:** Directives
Council & Committees: Board of Trustees

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (**MIPS**) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (**MIPS**) program as offered by proponents of the VVP to determine where improvement in the **MIPS** program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the **MIPS** program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the **MIPS** program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the **MIPS** program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.

Policy Timeline
Res. 247, A-18 Reaffirmed: BOT Rep. 13, I-20

Merit-based Incentive Payment System (MIPS) Update H-385.905

Topic: Physician Payment | **Policy Subtopic:** NA
Meeting Type: Interim | **Year Last Modified:** 2021
Action: Reaffirmed | **Type:** Health Policies
Council & Committees: NA

Our AMA supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in **MIPS** with incentive payments, or implements positive annual physician payment updates.

Policy Timeline
BOT Rep. 13, I-20 Reaffirmed: Res. 212, I-21

Reducing MIPS Reporting Burden D-395.999

Topic: Physician Payment | **Policy Subtopic:** NA
Meeting Type: Interim | **Year Last Modified:** 2020
Action: Reaffirmed | **Type:** Directives
Council & Committees: Board of Trustees

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (**MIPS**) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly **MIPS** data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.

Policy Timeline
Res. 236, A-18 Reaffirmation: A-19 Reaffirmed: BOT Rep. 13, I-20

MIPS and MACRA Exemption H-390.838

Topic: Physician Payment **Policy Subtopic:** Medicare
Meeting Type: Interim **Year Last Modified:** 2021
Action: Reaffirmed **Type:** Health Policies
Council & Committees: NA

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (**MIPS**) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Policy Timeline
Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) D-390.950

Topic: Physician Payment **Policy Subtopic:** Medicare
Meeting Type: Interim **Year Last Modified:** 2020
Action: Reaffirmed **Type:** Directives
Council & Committees: Board of Trustees

1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (**MIPS**) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding **MIPS** and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

Policy Timeline
Res. 242, A-16 Reaffirmed: BOT Rep. 13, I-20

Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911

Topic: Physician Payment **Policy Subtopic:** NA
Meeting Type: Interim **Year Last Modified:** 2017
Action: Appended **Type:** Health Policies
Council & Committees: NA

1. Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System (**MIPS**) or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model

(incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.
2. Our AMA will continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the **MIPS** payment adjustment as part of the Quality Payment Program (QPP).

Policy Timeline

Res. 218, A-16Appended: Res. 225, I-17

Support for the Quadruple Aim H-405.955

Topic: Physicians **Policy Subtopic:** NA
Meeting Type: Annual **Year Last Modified:** 2022
Action: Reaffirmation **Type:** Health Policies
Council & Committees: NA

1. Our AMA supports that the "Triple Aim"• be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
2. Our AMA will advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (**MIPS**).

Policy Timeline
Res. 104, A-16 Reaffirmation: A-22

Preserving Patient Access to Small Practices Under MACRA D-390.949

Topic: Physician Payment **Policy Subtopic:** Medicare
Meeting Type: Interim **Year Last Modified:** 2020
Action: Reaffirmed **Type:** Directives
Council & Committees: Board of Trustees

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA **MIPS** exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Policy Timeline
Res. 243, A-16 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT Rep. 13, I-20

Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries H-180.943

Topic: Health Insurance **Policy Subtopic:** Claim Forms and Claims Processing
Meeting Type: Interim **Year Last Modified:** 2018
Action: NA **Type:** Health Policies

Council & Committees: NA

1. Our AMA will oppose any Centers for Medicare and Medicaid Services (CMS) proposal that would require Qualified Clinical Data Registries (QCDR) measure owners, as a condition of measure approval for reporting in Merit-based Incentive Payment System (**MIPS**) and other Medicare quality payment programs, to enter into a free license agreement with CMS that would allow other QCDRs to use the owner's measures without a direct license with the measure owner.
2. Our AMA will oppose any CMS proposal that would require inclusion of CMS as a party in a QCDR measure licensing agreement between the QCDR measure owner and another.
3. Our AMA will support in situations where QCDR measures are shared between the original measure owner and another QCDR, that the latter QCDR:
A. must adhere to certain standards and terms set out by the QCDR measure owner on measure implementation and data capture, including data validity and reliability, plus fair remuneration for measure development and ongoing measure stewardship.
B. must have demonstrated clinical expertise in medicine, quality measure development and improvement by providing methods to ensure data quality, routine metric reporting, and quality improvement consultation.

Policy Timeline
Res. 232, I-18

Sequestration D-390.946

Topic: Physician Payment **Policy Subtopic:** NA
Meeting Type: Annual **Year Last Modified:** 2023
Action: Reaffirmation **Type:** Directives
Council & Committees: NA

Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in **MIPS** with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

Policy Timeline
Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmed: CMS Rep. 02, A-23 Reaffirmed: Res. 214, A-23

Pay-for-Performance Principles and Guidelines H-450.947

Topic: Quality of Care **Policy Subtopic:** NA
Meeting Type: Annual **Year Last Modified:** 2022
Action: Reaffirmation **Type:** Health Policies
Council & Committees: NA

1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

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- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

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- Physician participation in any PFP program must be completely voluntary.

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- 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.
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- 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.

- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

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."

Policy Timeline

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 Reaffirmation A-09 Reaffirmed: BOT Rep. 18, A-09 Reaffirmed in lieu of Res. 808, I-10 Modified: BOT Rep. 8, I-11 Reaffirmed: Sub. Res. 226, I-13 Appended: BOT Rep. 1, I-14 Reaffirmed in lieu of Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmation I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmation: A-18 Reaffirmation: A-22

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 262

Introduced by: Medical Society of the County of Kings & Niraj Acharya, MD
New York County Medical Society
Bronx County Medical Society

Subject: Medicaid Fee parity with Medicare for all E&M services

Referred to: Reference Committee on Socio Medical Economics

Whereas, Medicaid has started to pay 80% of Medicare fee schedule for office Evaluation & Management codes only; and

Whereas, Physicians provide E&M services in various different setting including office, ER, inpatient hospital, critical care units, nursing home, etc; therefore be it

RESOLVED, that the MSSNY works with NY State Dept. of Health to extend 80% of Medicare fee schedule reimbursement for all E&M services across all places of service provided to NYS Fee for Service all Medicaid and all Medicaid HMO patients.

References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution: 263

Introduced by: Medical Society of the County of Kings & Alex Shteynshlyuger MD

Subject: Payments by Medicare Secondary or Supplemental plans

Referred to: Reference Committee on Socio Medical Economics

Whereas there are more than 50,000 health plans in the United States.

Whereas patients have paid for health insurance either as a supplemental Medicare plan or through their job or union as an earned benefit prior to meeting eligibility for Medicare.

Whereas Medicare allowed amounts are not market based and fixed as an act of government edict; secondary payer does not vary whether a Medicare participating physician is in-network with the secondary payer

Whereas, secondary health plans and Medicare supplemental health plans engage in abusive, predatory, and anticompetitive practices by tying payment as a Medicare secondary plan to whether the Medicare-participating physician that provides care to Medicare patients is in-network with the secondary health plan.

Whereas, patients on Medicare are subjected to financial burdens when health plans fail to pay the balance (Medicare deductible and 20% coinsurance) that rightfully belongs to a secondary payer with adverse effects on their health and health equity.

RESOLVED: MSSNY will advocate that New York State enacts legislation that would mandate that all health plans, compliant with the Rutledge ruling Rutledge v. PCMA, cover Medicare secondary claims regardless of the provider participating in the secondary health plan.

RESOLVED: MSSNY will advocate that the AMA advocates national legislation that would mandate that all health plans, cover Medicare secondary claims regardless of the provider participating in the secondary health plan.

RESOLVED that the AMA will report on the status of this resolution and policies H-390.839 and D-390.984 at the 2025 Annual Meeting

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References:

Existing MSSNY Policy:
None

RELEVANT AMA POLICY
Requiring Secondary and Supplemental Insurers to Medicare to Follow Medicare Payments H-390.839

Managed Care Secondary Payers H-385.950

Payment by Health Insurance Plans of Medicare Deductibles and Copayments D-390.984

Author's Priority Statement

Failure by commercial plans to pay their liability as a Medicare secondary plan when a physician is not in network with the commercial plan is abusive and forces patients to pay for the services twice, to the physician after already paid through labor or premiums to the secondary plan.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 264

Introduced by: Medical Society of the County of Kings & Lisa Eng, DO

Subject: Modifier 25

Referred to: Reference Committee on Socio Medical Economics

Whereas, it is an injustice to physicians that Medicaid pays for 25 modifier for diagnosis not related to a procedure paid on the same visit, while Emblem Health instead is billing retroactively to re-claim payments which have been paid for the past several years. They as well as BC/BS, other insurances and HF are not paying for 25 modifier for patients which present the same insurance card as ones which the insurance occasionally pays the 25 modifier Office Visit ; and

Whereas, Appending the CPT modifier 25 to an E/M service code on a claim indicates the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service, as the AMA issue brief (PDF) explains "Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient's condition to be appropriately reported and, therefore, appropriately paid." The use of modifiers provides supplementary information for payer policy requirements. Payers, however, may not be aware or may not care that this is what the modifier is telling them. The use of modifier 25 "indicates that documentation is available in the patient's record to support the reported E/M service as significant and separately identifiable," the council report (PDF) adds.; and

Whereas, "Payment policies that deny or reduce payment for E/M services reported with a modifier 25 serve as a disincentive for physicians to provide unscheduled services, which may force patients to schedule multiple visits (with additional co-payments)," the letter states. "This jeopardizes quality patient care and safety, as well as threatens the patient-physician relationship."; and

Whereas, AMA April 25, 2023 editorial noted, The AMA and more than 100 other physician and health care professional organizations are raising serious concerns about The Cigna Group's recently announced policy requiring submission of office notes with all claims including evaluation and management (E/M) Current Procedural Terminology (CPT®) codes 99212, 99213, 99214 and 99215 and modifier 25 when a minor procedure is billed. *In May, Cigna announced it was delaying implementation of its planned modifier 25 policy. In addition to reevaluating the policy, Cigna reported that it intends to "optimize the provider experience and perform additional provider education in partnership with key national medical associations."*; therefore be it

RESOLVED, MSSNY seek regulation or legislation that all insurers follow at a minimum the CMS guidelines and not create greater obstacles to patients in obtaining appropriate and timely care; and be it further

RESOLVED, MSSNY seek that NYS DOH and Division of Insurance should prohibit unfair unfounded ungrounded unproven obstacles created by health insurance companies that accept federal dollars, when the sole purpose of such obstacles is not paying for or underpaying for medically necessary services; and be it further

RESOLVED, MSSNY seek that NYS DOH and Division of Insurance prohibit any insurer from and fine them for delaying care, by not reimbursing for 25, because the delays in care created by such denials may cause harm to patient, while the contracts between the insurer and patient provides for “hold harmless” clauses.

References:

Setting the record straight on proper use of modifier 25 | American Medical Association (ama-assn.org)

Seven quick tips for using modifier 25 | AAFP

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution: 265

Introduced by: Medical Society of the County of Kings & Alex Shteynshlyuger, MD

Subject: Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums

Referred to: Reference Committee Socio Medical Economics

Whereas, patients can sign up for health insurance without paying for up to 2 months, during which eligibility verification shows active coverage. Yet, health plans have a right to deny payment to physicians if a patient fails to pay premiums, which leaves physicians with uncollectible debt for physician professional services as well as expensive physician-administered and prior-authorized medications that cost thousands of dollars.

Whereas X12 is designated by CMS as a national standards organization that sets national standards for electronic eligibility transaction X12 270/271

RESOLVED, MSSNY will advocate for legislation to require that health plans inform healthcare providers whether the plan premium has been paid and whether the account is late on payment as part of benefit verification, whether by phone, fax, or electronic transaction, including but not limited to X12 270/271.

RESOLVED that MSSNY will advocate that the AMA seeks legislation or regulation to require that health plans inform healthcare providers whether the plan premium has been paid and whether the account is late on payment as part of benefit verification, whether by phone, fax, electronic transaction including but not limited to X12 270/271.

RESOLVED that MSSNY will advocate that the AMA seeks that X12 includes plan premium payment status as part of X12 270/271 standard transaction code updates.

RESOLVED that the AMA will report on the status of this resolution at the 2025 Annual Meeting

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References:

Existing MSSNY Policy:
None

Author's Priority Statement
Physicians are forced to provide services without knowing whether or not they will get paid. Health plans have the information but fail to share it with physicians, which puts physicians in a situation where they unknowingly take financial risks that threaten their financial viability with zero repercussions or risk to insurance companies.

Physicians deserve the right to know if there is a risk of non-payment and to choose whether to take such risk at their discretion.

MEDICAL SOCIETY OF THE STATE OF NEW YORK

House of Delegate

Resolution: 266

Introduced by: Medical Society of the County of Kings & Alex Shteynshlyuger MD

Subject: Full transparency - Explanation of Benefits

Referred to: Reference Committee Socio Medical Economics

Whereas, HIPAA Administrative Simplification Requirements mandate a national standard for the X12 835 electronic remittance advice (ERA), paper explanations of benefits (EOB) suffer from vague, incomplete, and often misleading information.

Whereas, EOBs often show vague descriptions of services, which precludes transparency and makes it difficult for the patient to determine if the charges are legitimate. Therefore be it

RESOLVED, MSSNY will advocate legislation and regulations that mandate that explanation of benefits, whether sent to the patient or the physician practice, include the actual CPT codes billed, DRG-codes, CPT descriptions, and optional consumer-friendly descriptions; and EOB must list the actual allowed amount, patient responsibilities (copay, deductible, coinsurance), non-covered and denied amounts with specific X12 reason codes in consumer-friendly explanations, what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal, including contact information for plan administrator, applicable laws governing the plan benefits, and contact information to submit external complaints. And further be it

RESOLVED, that MSSNY advocates that AMA **will** advocate legislation and regulations that mandate that explanation of benefits, whether sent to the patient or the physician practice, including the actual CPT codes billed, DRG-codes, CPT descriptions, and optional consumer-friendly descriptions; and EOB must list the actual allowed amount, patient responsibilities (copay, deductible, coinsurance), non-covered and denied amounts with specific X12 reason codes in consumer-friendly explanations, what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal, including contact information for plan administrator, applicable laws governing the plan benefits, and contact information to submit external complaints.

References:

Existing MSSNY Policy:

265.898 Universal Explanation of Benefits (EOB):

120.932 Insurance Simplification of Explanation of Benefits (EOBs)

RELEVANT AMA POLICY

Requiring Third Party Reimbursement Methodology be Published for Physicians H-185.975

Author's Priority Statement

While electronic remittance advice (ERA) has been adopted as a national standard and requires health plans to report information in a standard manner with sufficient detail, paper explanations of benefits that are sent to physicians and patients are not uniformly regulated and often use vague language that causes patient confusion and precludes patients and physician billing staff from understanding what is actually happening; why the claim was not fully paid, how to appeal an adverse determination, and what other recourse is available and appropriate.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution: 267

Introduced by:	Medical Society of the County of Kings & Alex Shteynshlyuger MD
Subject:	Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS
Referred to:	Reference Committee Socio Medical Economics

Whereas MSSNY adopted policy 265.804 "Withdraw and Amend Virtual Credit Card Policy" and policy 120.891, Enforcement of Administrative Simplification Requirements – CMS.

Whereas, the AMA adopted policies CMS Administrative Requirements D-190.970, Virtual Credit Card Payments H-190.955, Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968.

Whereas, the sneaky practices and associated costs of virtual credit cards and EFT fees have not abated.

Whereas, CMS has failed to enforce HIPAA administrative simplification requirements

RESOLVED, that MSSNY request that our AMA report at the Interim 2024 Meeting on the progress of implementation of AMA Policies D-190.970, H-190.955, and D-190.968.

References:

Existing MSSNY Policy:
265.804 "Withdraw and Amend Virtual Credit Card Policy"
120.891, Enforcement of Administrative Simplification Requirements – CMS

Relevant AMA Policy
CMS Administrative Requirements D-190.970
Our AMA will: (1) forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPPPA
Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA);

(2) forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees; (3) communicate its strong disapproval 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; and (4) through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.

2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.

3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at: (a) the issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services, (b) CMS enforcement activities related to this issue, and (c) physician access to a timely no fee EFT option as an alternative to VCCs.

Virtual Credit Card Payments H-190.955

Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.

2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.

3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

Author's Priority Statement

Administrative burdens and costs threaten the viability of medical practices and contribute to burnout throughout the healthcare system. Annually, virtual credit cards and EFT fees cost physicians upwards of $10 billion dollars. HIPAA administrative simplification requirements govern many electronic transactions, including payments, eligibility, and prior authorization, with a demonstrated lack of enforcement by CMS. Violations of HIPAA administrative simplification requirements cost physicians and hospitals upwards of $20 billion per year. It is important that the regulations be enforced and that physicians are freed from improperly imposed costs exceeding $20 billion a year. An update on the status of AMA advocacy is thus requested.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 268

Introduced by: Suffolk County Medical Society

Subject: Risk Reduction for Traumatic Urethral Catheterization Through Education and Proper Technique

Referred to: Reference Committee on Socio Medical Economics

Whereas, Traumatic urethral catheterization remains a major source of morbidity and mortality in the USA and worldwide, mostly in men; and

Whereas, Traumatic catheterization frequently results in urinary tract infection, including sepsis, and hemorrhage, and often permanent urethral damage; and

Whereas, Traumatic catheterization occurs for 2 reasons:

1. Anatomic considerations
2. Human factors, ie training, experience, temperament etc; and

Whereas, Reduction and elimination of traumatic catheterizations would reduce suffering of patients and their loved ones; and

Whereas, Reduction and elimination of traumatic catheterizations would save significant money expenditure for health care; and

Whereas, urologists are experts in placing urethral catheters, however, the use of the urology workforce as a foley catheter service is not feasible from a financial and availability perspective—there are not enough urologists; and

Whereas, Technology exists that is designed, tested and already in use in New York State that can enable non-urologists to atraumatic place urethral catheters in the majority of patients; and

Whereas, This urethral catheter device is a 16Fr silastic catheter that has a hydrophilic guidewire built into the catheter; and

Whereas, Non-urologist providers such as nurses, NPs, PAs, emergency medicine physicians, and hospitalists can be taught to use this device safely; and

Whereas, Peer reviewed and quality improvement both has shown a reduction in traumatic foley placement using this device; therefore be it

RESOLVED, that our MSSNY advocate for proper training for any medical provider that performs urethral catheterization

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References:

Existing MSSNY Policy:

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 269

Introduced by: Suffolk County Medical Society

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Existing MSSNY Policy: