Testimony Of
The Medical Society of the State of New York
Before The
New York State Assembly Committee
On Ways & Means and Senate Finance Committee
On the Governor's Proposed Public Health Budget
For State Fiscal Year 2015-2016

Good morning. My name is Elizabeth Dears, Esq. I am the Senior Vice-President/Chief Legislative Counsel for the Medical Society of the State of New York. On behalf of Andrew Kleinman, M.D., President of the Medical Society of the State of New York and the almost 25,000 physicians, residents and students we represent, let me thank you for providing us with this opportunity to present organized medicine's views on the proposed budget and how it relates to the future of the health care delivery system in New York State.

It must be noted that this proposed budget is being considered simultaneously with a number of market forces which are threatening the very viability of physician practices all across New York State. All the costs of running a medical practice, including the significant cost of medical liability insurance in New York State, and other normal business costs, such as rents, insurance, supplies, utilities, and local property taxes, continue to rise steadily every year, while government-mandated programs demand ever more expensive software and administrative costs. At the same time, medical fees have essentially either been kept at the same level or dropped significantly for the last two decades. Exacerbating these problems are new difficulties brought about by health care reform implementation, including the ridiculously low payments being offered by insurers to participate in New York Health Insurance Exchange products, and a significant increase in physicians' billing and collection costs due to huge, unaffordable deductibles, delays in the processing of payments and the 90-day "grace period."

Undoubtedly, more and more physicians will be forced to close their practices and join large hospital systems in order to continue to deliver care, which in turn will reduce patient choice, reduce competition, and drive up the cost of health care and health insurance. Worse still, many experienced but frustrated physicians have indicated they may simply retire and close their practices, further exacerbating the existing access-to-care issues.

The healthcare delivery system and the system through which it is financed continue to change. Government is shifting from fee-for-service to capitation. Payers are shifting risk to physicians and hospitals while at the same time shifting higher and higher levels of cost sharing to the insured. We have an influx of newly insured individuals and an increase in the number of Medicaid beneficiaries. And yet the type of coverage now being offered is far less robust with many plans offering products with much narrower networks – terminating physicians for reasons unrelated to the quality of care they provide- jeopardizing patient access to a physician of their choice and threatening the financial viability of physician practices.

It is through the context of this lens that we view the proposed budget. We urge you to listen to the concerns of New York's physicians – who are the ones predominately providing the care in our medical infrastructure - and to take action to assure that we create and preserve an economically sensible health care delivery system.

1.) Enact a One- Year Delay in the E-Prescribing Mandate

We urge your consideration of action to remedy the concerns of physicians and their patients regarding the March 27, 2015 effective date of the e-prescribing mandate enacted into law as part of the I-STOP legislation. While we recognize the important efficiencies and patient safety enhancements which can be achieved through electronic prescribing, it is quite concerning that many EHR vendors, including several with significant market share in New York State, are not yet certified for electronic prescribing of controlled substances (EPCS) and will not be certified in most cases until sometime in the first quarter of 2015. This is quite concerning for all prescribers, particularly large group and institutional prescribers whose systems must be tested and re-tested to remove operational flaws before the installation and implementation of software updates.

Nursing homes and assisted living providers face some unique challenges in ensuring safe and successful implementation of the NYS E-Prescribing law in these settings. Specifically, many of these providers have a system of medical orders for residents in which nurses interface with the prescriber (who is often not on-site) and the pharmacy to ensure medications are timely received by residents and properly recorded in their medication administration records. Nurses currently take telephone orders which are acted upon by the pharmacy immediately with a physician co-signature within 72 hours. The new law will disrupt this process, significantly changing the work flow and documentation flow among prescribers, nurses and pharmacies.

In addition, at least half of the state's nursing homes have no EHR system – let alone one capable of e-prescribing – nor the funds to implement one. Without compatible software linked with an EHR, the nursing home may not be aware of the communication between prescriber and pharmacy, leading to possible delays in treatment and transcription errors. Finally, nursing homes, pharmacies, EHR vendors and prescribers may be finalizing their individual parts of the process, but the interfaces among them will not be fully completed, tested and disseminated to safely proceed by March 27, 2015. Assisted living settings are even less likely to have electronic systems that are capable of communication with a pharmacy and prescriber. This circumstance can create the potential for miscommunication that ultimately jeopardizes the care of the resident.

We believe that prescribers who through no fault of their own cannot be compliant with the e-prescribing mandate by the March 27th effective date should be held harmless from penalty. Regrettably, the law does not provide providers with such protection. Consequently, we write to encourage you to take action to protect providers from liability if they are not compliant with the e-prescribing mandate on March 27th. The easiest and most uniform action would be to grant an extension of the effective date for a period of time. We recommend one year. In lieu of taking such action, we recommend that you issue a letter suspending enforcement of the law for a period of time. Similar action was taken when the NYS Immunization Information System (NYSIIS) was first implemented.

Moreover, there are a number of prescribers who write only a few prescriptions a year. As the waiver process is developed we encourage you to consider including as an example of an acceptable exigent circumstance which qualifies for a waiver those instances where the prescriber prescribes less than 25 prescriptions per year. The overall expense for low volume prescribers, including software, maintenance, updating and training personnel will be burdensome and could potentially be in the range of hundreds of dollars per prescription.

In addition, the implementation of one of the exceptions to the mandate is extremely burdensome to the physicians and other prescribers. Under this exception if a prescriber does not have their prescriber technology with them but he/she reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner he/she may call in an order for a 5 day supply. After they do so, they must follow up the oral request with an e-script *AND* they must call the Bureau of Narcotics Enforcement to tell them they have done so. This is too cumbersome and unwieldy for prescribers.

In addition, we encourage you to consider the following actions on behalf of prescribers for residents/ patients in nursing home and assisted living settings:

1. An ongoing or time-limited exclusion from E-prescribing requirements for prescriptions furnished in these settings; or
2. A one-year delay in the implementation of e-prescribing requirements for prescribers of medications to patients/residents in these settings under the Commissioner's waiver authority to provide sufficient time to establish, test and educate staff on new ordering systems and revise related work and documentation flows; and
3. Financial support for acquisition and deployment of EHR technology by nursing homes and assisted living facilities, which were not eligible for meaningful use incentives and most HEAL-NY technology funding.

Lastly, we encourage your consideration of a public education campaign which will educate the public as to the changes which will be encountered as they seek care from providers in all healthcare settings. For some patients, the elimination of paper prescriptions may be somewhat concerning if not confusing and disempowering. Patients need to be informed as to what will happen should their pharmacy not have on hand the specific controlled substance that has been e-prescribed for them. Currently, if they had a paper prescription and the pharmacy did not have the controlled substance they needed in stock, they would simply take the prescription to another pharmacy in their community. Once the e-script is received by the pharmacy, the pharmacist may not send it on to another pharmacy. Moreover, when medication is in short supply patients often need to shop around for the best price. The e-prescribing law will now prevent them from doing so. It would be helpful for the state to begin to make patients aware of the positive reasons for the change while at the same time addressing concerns they may have about accessing needed medications from the pharmacy of their choice.

2.) Continuation of an Adequately Funded Excess Medical Liability Program

We are grateful that Governor Cuomo has proposed to continue the Excess Medical Liability Insurance Program and to fund it at its historical level of $127.4M. We urge that the Legislature include this funding for the Excess program in the final budget adopted for 2014-2015. We note for your consideration, however, that the Excess program has historically been re-authorized every three years as HCRA is re-authorized. The Governor's proposed budget would only re-authorize the program for one year. While we are very appreciative that the program was re-

authorized and is proposed to be funded at historical levels, we are concerned by this seeming disconnection from HCRA. We ask that you re-authorize the program for a period which is consonant with the re-authorization of HCRA.

We are also concerned by the addition of express condition that physicians otherwise eligible for the Excess coverage must have received tax clearances from the department of tax and finance before they can obtain such coverage. Specifically, for each eligible physician, the pool administrator must receive from the commissioner of tax and finance a tax clearance which demonstrates that the physician has no past due tax liabilities. A new section of law, Tax Law Section171-w, is added to require the Commissioner of Tax and Finance to cooperate with any governmental entity that is required by law *or has elected to require* tax clearances to establish procedures by which the department shall receive a tax clearance request and transmit such tax clearance to the government entity. While the language attempts to frame the tax clearance review in terms of past due tax liabilities which are final, the commissioner is *also* required to, when the tax clearance request so requires, determine whether (i) the subject of the request has complied with applicable tax return filing requirements for each of the past three years; and/or (ii) whether a subject of such request that is an individual or entity that is a person required to register to collect taxes on behalf of the state pursuant to section one thousand one hundred thirty-four of this chapter is registered pursuant to such section. The Commissioner is required to deny the tax clearance if the individual has not complied with applicable return filing and/or registration requirements. We feel that the implementation of a tax clearance obligation as a condition for Excess coverage is unwieldy and cumbersome and could serve as an impediment to timely issuance of the Excess policy.

The Excess Medical Liability Insurance Program provides an additional layer of $1M of coverage to physicians with hospital privileges who maintain primary coverage at the $1.3 million/$3.9 million level. The cost of the program since its inception in 1985 has been met by utilizing public and quasi-public monies.

The Excess Medical Liability Insurance Program was created in 1985 as a result of the liability insurance crisis of the mid-1980's to address concerns among physicians that their liability exposure far exceeded available coverage limitations. They legitimately feared that everything they had worked for all of their professional lives could be lost as a result of one wildly aberrant jury verdict. This fear continues since absolutely nothing has been done to ameliorate it. The size of verdicts in New York State has increased exponentially and severity of awards continues to grow steadily each year.

The severity of the liability exposure levels of physicians makes it clear that the protection at this level is essential, especially today. Given the realities of today's declining physician income levels and the downward pressures associated with managed care and government payors, the costs associated with the Excess coverage are simply not assumable by most physicians in today's practice environment. Indeed, as mentioned earlier, the ability of a physician to maintain even the primary medical liability coverage is increasingly compromised as a result of escalating costs and decreasing reimbursement. Without Excess, however, many physicians will be unable to continue to practice.

It is important to note finally that the Excess program is not a solution to the underlying liability problem in New York State. That problem is caused by the failed civil justice system and the real solution is reform of that system.

Physicians in many other states have seen their premiums reduced in the last several years, while the liability premiums for New York physicians continue to rise. Physicians in New York face far greater liability insurance costs and exposure than their colleagues in other states. By way of example, a neurosurgeon practicing on Long Island must pay an astounding $338,252 for just one year of insurance coverage and an OB/GYN practicing in the Bronx or Staten Island must pay $186,639.

There were over $689 million in medical liability payments in New York State in 2013, nearly two time greater than the state with the second highest total (Pennsylvania, $356 million) and far exceeding states such as California ($274 million) and Florida ($199 million).

The problems of the medical liability adjudication system do not just impact physicians – they impact the cost of all health care. Several studies have shown that billions of dollars are unnecessarily spent each year due to the practice of defensive medicine, such as unnecessary MRIs, CT scans and specialty referrals.

New York must follow the lead of the many, many other states who have passed legislation to bring down the gargantuan cost of medical liability insurance. We stand ready to discuss any number of proposals that will meaningfully reduce medical liability premium costs for our physicians. Until that discussion occurs, however, we must take all steps necessary to protect and continue the Excess program so to assure that physicians can remain in practice in New York State.

3.) Allowing Physicians Practicing "Urgent Care" To Remain in Practice

The Proposed budget includes provisions which may adversely impact the ability of physicians to remain in practice as "urgent care" practices. Specifically, the budget would define "urgent care" to mean "the provision of treatment on an unscheduled basis to patients for acute episodic illness, minor traumas that are not life threatening or potentially disabling for monitoring or treatment over prolonged periods". Frankly, this definition is rather broad and could pertain at times to the private practice of any health care practitioner such as pediatricians, family physicians and orthopedists who have "after-hour" or weekend availability to avoid patients from having to go to a hospital emergency room.

Importantly, the proposal prohibits any individual or non-hospital established entity from holding itself out to be an urgent care practice or to display signage or advertise that they are an urgent care practice unless they are accredited by a nationally recognized accrediting agency as determined by the commissioner, obtains approval of the department of health and complies with regulations to be promulgated.

The Public Health and Health Planning Council (PHHPC) is specifically authorized to adopt and amend rules and regulations, subject to the approval of the Commissioner, to effectuate the purposes of this section including regulations to define the scope of services to be provided by urgent care practices and the minimum services which must be provided; standards for referral and continuity of care, staffing, equipment and maintenance and transmission of patient records.

Urgent care providers are engaged in the practice of medicine and possess a professional license as do other practicing physicians. Physicians who practice urgent care provide a valuable service to the communities in which they practice. They are open virtually every day of

the year and require no prior scheduled appointments. Consequently, when patients are unable to obtain care from their physician, they know that they can turn to urgent care practices to address their immediate health care needs. Many patients prefer to access the services of an urgent care physician than waiting for hours in a hospital emergency room setting.

Unfortunately, the imposition of the requirements envisioned by this proposal including the requirement for accreditation may threaten their very viability through imposition of huge new costs and for this reason, we oppose this provision. Accreditation is an exceptionally costly process. The Joint Commission has an accreditation process for all ambulatory care providers, including urgent care practices. The accreditation fees for one urgent care practice range from a low of $9,930 for a practice with up to 10,000 annual patient visits to a high of $28,240 for one urgent care practice with as many as 120,000 and more patient visits in a year. If the practice had more than one practice site, then additional fees are applied which will add between $1335 (for 1-2 additional sites) to $6,625 (9-10 additional sites) to the cost of a three year accreditation. And the cost of the accrediting survey and annual maintenance of accreditation are only two aspects. Staffing costs associated with preparation and maintenance of preparedness for accreditation typically runs into the tens of thousands of dollars. Many urgent care practices are small physician businesses which simply cannot absorb the costs necessary to secure and maintain accreditation. In our opinion, market forces should be the deciding factor in whether a physician owned urgent care practice should seek accreditation.

Other costs would be imposed on these sites as well by virtue of additional regulations to be advanced pursuant to this proposal by PHHPC. A report previously issued by PHHPC recommended that each urgent care site must have an x-ray machine and crash cart supplies and medications and that its staff must be ACLS and PALS certified. There are some physicians whose urgent care practices are located on a campus which houses an x-ray machine owned by another entity unaffiliated with the physician's practice so that any patient who needs an x-ray is immediately wheeled from the physician practice through a door where the x-ray machine is located in space owned by the other entity which subsequently bills the patient independently of the urgent care physician for the x-ray taken. The patient is made aware of this ahead of time. This urgent care practice will not be able to continue to be an urgent care practice if this recommendation is incorporated in the regulations. Moreover, ACLS and PALS certification is unnecessary since the urgent care practice is not an emergency room. We agree that a patient experiencing chest pain should go to the emergency room and not an urgent care for treatment. Should such a patient arrive in the urgent care practice, an ambulance would be called for proper transport to the closest ED. ACLS and PALS certification is, therefore, an additional and unnecessary cost on an urgent care practice.

Physician urgent care practices are among the small businesses which our communities and the state should protect. Physicians are the second largest industry in terms of business creation. Across New York, physicians employ more than 330,000 clinicians and non-clinical support staff. Physician urgent care practices are well known to their communities, particularly in the underserved rural and urban communities and are relied upon by patients who need acute episodic care when their own physician is not available. If they are unable to sustain financially, they will transform their business model and patients will be relegated to the most costly and inefficient of all care settings—the hospital owned emergency room.

4.) Amendment to the Office-Based Surgery Requirements of Public Health Law Section 230-d

The proposed budget also contains requirements which would impact upon physicians who perform certain surgery in their offices and who are already required by Public Health law Section 230-d to be accredited by one of three national accrediting agencies recognized by the commissioner of health and to report adverse events as defined in section 230-d (1) (b). Significantly, the proposal would establish a registration requirement for such OBS practices and would require such practices to submit certain procedure and quality data through their accreditation agency to the Department of Health.

We are concerned by the imposition of a registration process. We are unclear as to what is to be gained by such a process. Is it the intention to by virtue of the registration enable the Department of Health to conduct site surveys or subject the practices to other requirements imposed on other entities currently regulated by the Department of Health? Would such practices by virtue of being registered with the Department now be entitled to bill a facility fee in addition to a fee for the procedure performed? We need more information before we articulate a position on a registration requirement.

Moreover, the proposal would also establish a time limitation for the performance of office based procedures to six hours and a requirement for safe discharge within six hours thereafter. We feel that the surgeon should not be constrained by arbitrary time limitations. Moreover, should the physician and patient believe it appropriate, the patient should be allowed to stay overnight in a monitored setting.

The proposal also appears to inappropriately expand the scope of practice of chiropractors and podiatrists. It would include chiropractors within the definition of "licensee" thereby including chiropractic practices within the purview of the office-based surgery law; despite the fact that subdivision (3) of section 6551 in pertinent part prohibits a chiropractor from operating or reducing fractures or dislocations or prescribing, administering, dispensing or using in his practice drugs or medications. Moreover, while the law was amended to recognize the changes in the podiatric scope of practice as they relate to podiatrists who have obtained a privilege to perform podiatric standard or advanced ankle surgery, this proposal would remove reference to podiatrists who have attained such advanced recognition and would allow any podiatrist to fall within the definition of "licensee" thereby including all podiatric practices within the purview of the OBS law when only those with privileges to perform podiatric standard or advanced ankle surgery are permitted by law to do so.

The Article VII bill contains several provisions which empower the department to collect additional data concerning the procedures being performed and the type of anesthesia being used in OBS practices along with data concerning surveys and complaint/investigations.

Under Part L of the proposal, the department is specifically permitted to require licensees to report additional data such as procedural information as needed for the interpretation of adverse events and evaluation of patient care and quality improvement and assurance activities.

Under section 5 of Part H of the article VII bill, PHHPC is empowered to "review the type of procedures performed in outpatient settings, including OBS practices and ambulatory surgery services for the purpose of: (a) identifying the types of procedures performed and the types of anesthesia/sedation administered in such settings; (b) considering whether it is appropriate for such procedures or anesthesia/sedation to be performed in such settings; (c) considering

whether settings performing such procedures or administering such anesthesia/sedation are subject to sufficient oversight; (d) considering whether settings performing such procedures or are subject to an equivalent level of oversight regardless of setting; and (e) making recommendations to the department regarding the foregoing. It must be noted that the state has at least twice in recent years conducted a review of what was occurring in office based surgical practices. At that time, a number of unexpected deaths occurred in OBS settings. It was determined that there was a quality of care issue and that all OBS practices needed to demonstrate that they adhered to a standard set of quality of care standards. This review resulted in the enactment of the OBS law in 2007 which required these practices to be accredited. Moreover, the law required to reporting of adverse events; defined to mean (i) patient death within ninety days; (ii) unplanned transfer to a hospital; (iii) unscheduled hospital admission within seventy-two hours of office-based surgery, for longer than twenty four hour; or (iv) any other serious or life threatening event. The state has had data concerning adverse events but has not used such data to demonstrate a quality of care crisis. We need a better understanding of why the state needs this data. Accreditation is a rigorous and re-occurring review of the physician's practice. Accrediting agencies such as the AAAASF already maintain data on the number of procedures and the number of complications. The AAASF has over twelve million cases in their database. Since accrediting agencies have this information we oppose the collection of the additional data from office based surgical practices.

It is vital to note that the AAASF data show that nationwide, deaths occurred intraoperatively in office based surgical settings at the very low rate of 1 in 478,000 procedures. The data also demonstrate low infection rates of one in 2,400 procedures in office based settings. Should procedures now performed in office based settings move to hospital based settings, not only would they cost more but the complication rate would increase exponentially.

In addition, Part L of the proposal would require accrediting bodies to require all office-based surgical and office-based anesthesia practices to: (1) conduct quality improvement and quality assurance activities; (2) utilize American Board of Medical Specialties (ABMS) certification, hospital privileging or *other equivalent methods* to determine competency of practitioners to perform office-based surgery and office-based anesthesia; and (3) carry out surveys or complaint/incident investigations upon department request and report findings of surveys and complaint/investigations and date for all office based surgical and office based anesthesia practices to the department.

These proposed requirements are confounding.

Quality improvement and quality assurance activities have always been recommended. However, the results of such activity are not protected from disclosure and are not protected as are much of the QI activities conducted in the institutional setting. Even QI activities in the institutional setting are not protected from disclosure in a malpractice action against an individual who participated in the peer review. We recommend that specific language be inserted to prohibit public access to this data. MSSNY has long advocated for the ability of physicians to perform quality improvement activities in their offices. This is an approach first identified in the IOM's *Crossing the Chasm* report. However, such data is not protected from disclosure to forces who would like to use the data in furtherance of litigation. We request that if the state should want this data, it should prevent access to it – whether it collects it or physicians develop the data through ongoing QI activities of their own.

Moreover, while ABMS or AOA certification is the gold standard, there is a competing certification body which does not require all of its physicians to complete a residency program in the specialty in which the physician is certified. We are concerned, therefore, that with the introduction of 'other equivalent methods' we might recognize physicians who do not meet the rigorous ABMS/AOA standard.

Lastly, we are somewhat surprised that the proposal would empower the physician practice to carry out surveys or complaint investigations and report the data derived from the investigation to the department. We believe that the accrediting agencies are better positioned to and are already accumulating such information on the practices they accredit. We believe that this requirement is redundant of what accreditation agencies are already doing and therefore is unnecessary.

Moreover, we are concerned that this requirement—on either the physician practice or the accreditation body-- to "carry out surveys or complain/investigations upon department request" does not specify the purpose for which such surveys or investigations will be conducted. We believe this creates a basically unlimited right of the Department of Health to investigate a doctor's office for reasons that may go far beyond the type of procedures performed or the quality of care delivered. We believe that at a minimum the language should be modified to enumerate the focus of such survey(s) and/or investigations. Additionally, the proposal requires the reporting of "findings of surveys and complaint/incident investigations and data for all office-based surgical and office-based anesthesia practices". Again, the proposal fails to specify what information should be reported. Should patient and physician identifiable information be reportable? We submit that the information reported should be reported on an aggregate and de-identifiable basis. Also, in addition to surveys and compliant/incident investigations, what other data is to be collected? The language fails to specify. Isn't the OPMC already empowered to conduct investigations regarding complaints? These provisions are redundant of authority already conferred to the department.

5.) Prevent the Proliferation of Retail Clinics

The proposed budget would allow diagnostic and treatment centers owned by for-profit companies to be established to provide health care services within the space of a retail business operation, such as a pharmacy, a store open to the general public, or a shopping mall. They would be referred to as "limited service clinics." The Commissioner is required to promulgate regulations setting forth operational and physical-plant standards, requiring accreditation,: designating or limiting the treatments and services that may be provided; prohibiting the provision of services to patients under two years of age; specific immunizations to patients younger than eighteen years of age and advertising guidelines; disclosure of ownership interests; informed consent; record keeping, referral for treatment and continuity of care, case reporting to the patient's primary care or other health care providers, design, construction, fixtures and equipment. To a large extent the recommendations of the Public Health and Health Planning Council (PHHPC) approved last year would form the substance of these regulations. And while PHHPC did attempt to address many of the concerns MSSNY raised last year when this issue was first advanced, MSSNY continues to have strong concerns regarding this proposal. Chief among these concerns is that this is the first time that the state would allow publicly traded corporations to establish health clinics without need for certificate of need review. As discussed below we respectfully submit that the so called dialysis precedent is not appropriately applied to this retail clinic proposal.

Specifically, the budget language would permit publicly traded corporations to operate diagnostic or treatment centers through which health care services may be provided within a retail business including but not limited to a pharmacy, a store open to the general public or a shopping mall. Currently, while there are some physician offices which have co-located with pharmacies in New York, there is no overlapping ownership thereby protecting the sanctity of the doctor-patient relationship. This proposal would disrupt the independence of medical decision-making and the integrity of the doctor-patient relationship.

'Convenience care clinics' or 'retail clinics' operate in states outside New York in big box stores such as Walgreens or retail pharmacies such as CVS. They are a growing phenomenon across the nation, particularly among upper class young adults who live within a one mile radius of the clinic. These clinics are usually staffed by nurse practitioners or physician assistants and focus on providing episodic treatment for uncomplicated illnesses such as sore throat, skin infections, bladder infections and flu. Physicians feel strongly that retail based clinics pose a threat to the quality of patient care and to the ability of physician practices to sustain financially and should not be allowed to propagate in New York.

Another significant concern is the potential conflict of interest posed by pharmacy chain ownership of retail clinics which provides implicit incentives for the nurse practitioner or physicians' assistant in these settings to write more prescriptions or recommend greater use of over-the-counter products than would otherwise occur. The same self-referral prohibitions and anti-kickback protections which apply to physicians are not applicable to retail clinics, raising the concern for significant additional cost to the health care system. Rather than bend the cost continuum, we will increase costs and negatively impact on quality of care.

As indicated above, we believe that the policy direction taken with this proposal—to obviate the need for certificate of need review—is inappropriate. In New York State, section 2801-a(4)(e) provides as follows: "No hospital shall be approved for establishment which would be operated by a corporation any of the stock of which is owned by another corporation or a limited liability company if any of its corporate members' stock is owned by another corporation." The definition of a hospital in New York State would include a diagnostic and treatment center such as the limited service clinic proposed by this initiative. The only for-profit corporations/limited liability companies that are currently permitted to operate hospitals are corporations/companies owned by individuals. A very limited exception was enacted in 2007 to enable publicly traded companies to participate in the operation of dialysis facilities. This was advanced, however, only after significant study over several years by the NYS Department of Health and the State Hospital Review and Planning Council and Public Health Council. This recommendation was expressly limited to dialysis facilities based on the unique characteristics of the service including:

- Chronic renal dialysis is a discrete, definable outpatient service, which varies little in how and when it is prescribed and administered;
- Virtually all those who receive chronic dialysis suffer from a common diagnosis (end stage renal disease);
- Chronic renal dialysis is the only service supported by a federally-guaranteed insurance program of coverage based on dialysis; and
- The continued decline in real terms of Federal payment for dialysis required an alternative to the State's prohibition on publicly traded corporations in this area if access to care is to be ensured over the longer term.

We submit that none of the indicia, which existed to support the limited exception to prohibitions against ownership of hospitals as that term has been defined or would be defined under this proposal, exist to support similar treatment for retail clinics operated by publicly traded corporations.

We must also be mindful that this proposal may threaten the financial viability of primary care physician practices in the community at a time when we have been working hard to expand primary care and medical home capacity. This will likely cause physician practices in certain areas to close or to be sold to large hospital systems, displacing their patients, their employees and further destabilizing the health care delivery system in that community. We strongly urge that the Legislature reject this proposal.

6.) Oppose rollback of "prescriber prevails" protections

We are concerned with a number of different proposals in the Executive Budget that would eliminate the "prescriber prevails" protection given to prescribers to better assure that their fee for service Medicaid patients can obtain the prescription medications without adding on to the extraordinary "hassle factor" most physicians already face in their interactions with insurance companies and government payors. Physicians are already drowning in paperwork and other administrative burden in seeking to assure their patients can get the care they need. In a recent MSSNY survey, nearly 83% of physicians indicated that the time they spend obtaining authorizations from health insurers for needed patient care had increased in the last three years, and nearly 60% indicating it had increased significantly. Please do not add to this burden by forcing physicians to go through yet another time-consuming hassle. At the same time, we have heard from numerous physicians who have described the hassles Medicaid managed care plan impose on physicians in order to assure their patient receiving needed medications, even within the drug classes where the Legislature has required "prescriber prevails" protections. Therefore, we urge you to take all possible steps to assure Medicaid managed care plans follow the law and to address these unnecessary hassles.

7.) Support Removal of Workers Compensation Arbitration Fees

We support the provisions of the Budget proposal that would remove the fee necessary for a physician to bring a payment dispute with a carrier to arbitration. We are aware that the WCB has engaged in a Business Process Re-engineering (BPR) with among the goals to reduce the hassles that have caused many physicians to stop participating in Workers Compensation. One of these hassles is carriers forcing physicians to initiate arbitration in order to be paid fairly for the care and treatment they provide to injured workers. We are hopeful that there are other actions by the Board to reduce these payment hassles, such as development of a medical portal and other reductions in receiving necessary pre-authorization, but eliminating arbitration fees is a positive first step.

8.) Support Inclusion of E-cigarettes Under Clean Indoor Air Act and Proposals to Reduce the Incidence of HIV

The Medical Society of the State of New York strongly supports the inclusion of e-cigarettes under the Clean Indoor Air Act (CIAA) as proposed by the 2015-16 New York State budget. In 2010, MSSNY had called for these products to be treated the same as tobacco products and also called for inclusion under the CIAA. MSSNY also supports the Governor's proposal to ban marketing of these devices to children.

MSSNY applauds the action taken by the Governor and the New York State Legislature last year to eliminate written informed consent for HIV testing as we strongly believe that making this test a routine component of an office visit is essential to ending the epidemic. MSSNY has been supportive of the efforts of the Task Force to End the Epidemic and supports proposals to include funding to identify undiagnosed persons and to link them with treatment. MSSNY also supports access to necessary medications to assure that HIV negative individuals remain HIV negative in order to prevent the further spread of the disease.

Conclusion

Thank you for allowing me, on behalf of the State Medical Society, to identify our concerns and suggestions for your consideration as you deliberate on the proposed budget for state fiscal year 2015-2016. To summarize, in the interest of our patients we are support a delay in the implementation of the e-prescribing mandate. Moreover, we support the continuation and dedication of funding for the Excess medical liability program which is important to facilitate the retention and recruitment of needed primary care and specialty physicians in New York until such time as meaningful civil liability reform is enacted. We ask that you remove the language which would allow an outstanding tax obligation to render and otherwise eligible physician ineligible for Excess coverage. We urge your opposition to proposals which would threaten the viability of physician owned urgent care practices including any requirement for such practices to be accredited. We urge your opposition to language which would unnecessarily burden OBS practices and potentially expose them to unsubstantiated litigation. Also, we believe that it is critically important that the Legislature prevent the proliferation of retail clinics in New York State. Moreover, we encourage that you do not impose additional prior authorization requirements on generic drugs used for off-label purposes. We also urge your support of the removal of the fee necessary for a physician to bring a payment dispute with a carrier to arbitration. Finally, we support the inclusion of e-cigarettes under the clean indoor air act and proposals to reduce the incidence of HIV.