

**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 2018-2019**

Good morning. My name is Moe Auster, Esq., and I am the Senior Vice-President/Chief Legislative Counsel for the Medical Society of the State of New York. On behalf of 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 ability of physician practices all across New York State to continue to deliver timely and quality patient care. Due to an untenable economic squeeze between rising practice costs and reductions in payments, more and more physicians have faced little choice but to close their practices and join large health systems to be able to continue to deliver patient care, sometimes at the expense of long-term patient relationships and the many jobs they provide. According to a recent Avelere study, the number of physicians who have become hospital employees in New York nearly doubled from 2012-2015.

New York recently received the dubious distinction from Wallet Hub as the most anti-doctor state in the country, due to its low payments for care (compared to other states) combined with exorbitant costs. One of the reasons for this designation is the extraordinarily expensive cost for medical liability insurance in New York State.

At the same time, health insurers continue to shrink their networks and cut payments for care delivered, reducing the ability of physicians to pay these exorbitant premiums. Moreover, Medicaid, Medicare and other payors are demanding participation in various value-based payment programs which require extensive infrastructure investment such as upgraded EHR systems. Failure to meet these criteria could result in significant payment cuts.

Not surprisingly, a recent *Annals of Internal Medicine* study reported that, for every hour a physician spends delivering care, two more hours are spent on paperwork. And a recent study by Milliman noted that health insurers' use of burdensome prior authorization and step therapy requirements for several categories of prescription medications basically doubled between 2010 and 2015.

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 new cost sharing requirements including unaffordable deductibles. Nearly 21% of responding physicians indicated that ¼ - ½ of their patients now face deductibles of \$2,500-\$5,000.

It is imperative that policymakers understand that, in addition to essential care they provide, physicians are under-recognized engine for the state of New York's economy. A recent AMA study

concluded that physicians produce directly or indirectly nearly 700,000 jobs in New York, as well as \$7.3 in total tax returns. This of course becomes jeopardized if we make it too difficult for physicians to remain in practice.

It is through the context of this lens that we view the proposed State 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) 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. Moreover, we are pleased that unlike past years there have been no proposed new conditions placed on the ability of physicians to receive this coverage. We urge that the Legislature include this funding for the Excess program in the final budget adopted for 2018-2019.

By way of background, 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. This already large problem has recently been made even worse as a result of the recent enactment of changes to New York's Statute of Limitations law. These changes are predicted to prompt a significant increase in medical liability insurance costs, even with the agreed-to amendments to reduce some of the ambiguities of the bill, as well as its retroactive impact.

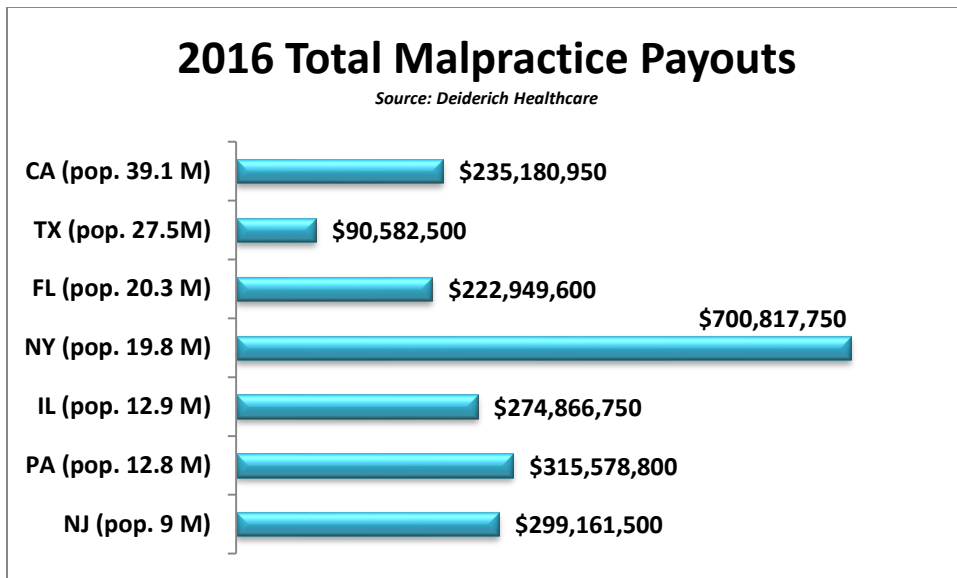
The severity of the liability exposure levels of physicians makes it clear that the protection at this level is essential, especially today. Given the realities of today's declining physician income levels and the downward pressures associated with managed care and government payors, the costs associated 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 in this State.

It is important to note that the Excess program is not a solution to the underlying liability problem in New York State. That problem is caused by a dysfunctional medical liability adjudication 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 have an astounding \$338,252 premium for just one year of insurance coverage and an OB/GYN practicing in the Bronx or Staten Island has a premium of \$186,630. By comparison, an Ob-GYN practicing in Los Angeles, CA pays less than \$50,000, about 25% of New York’s staggering premiums.

This is not surprising, given that a recent report by Diederich Healthcare showed that once again New York State had by far and away the highest number cumulative medical liability payouts (over \$700 million), more than two times greater than the state with the next highest amounts, Pennsylvania (\$315 million), and far exceeding states such as California (\$235 million) and Florida (\$223 million).



To be clear, this is not just a product of New York’s population size. New York again had the dubious distinction of having the 2d highest per capita medical liability payouts in the country – behind New Hampshire, where one aberrant case can significantly affect the ratio.

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. These defensive medicine costs are likely to go up further with the enactment of this new law, as many physicians will believe they have no choice but to recommend patients for additional diagnostic tests or refer to specialists, beyond what they believe is clinically indicated, to better assure the record is “complete” in case they are to be sued many years later.

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 to ensure that physicians can remain in practice in New York State.

2) Oppose the Inclusion of Language Authorizing Retail Clinics

We are very much opposed to proposal in the Executive Budget that would authorize the delivery of health services in a retail setting such as a pharmacy, grocery store, or shopping malls. Sponsors could include a for-profit business corporation such as big-box store or drug store chain. The

language would enable these retail clinics to deliver many health care services including treatment of minor episodic illnesses, episodic preventive and wellness services such as immunizations, administration of opioid antagonists, lab tests, and screening and referral for behavioral health conditions.

This proposal, which has been advanced and rejected in previous Budget proposals, has some improvements by having a loose requirement of “collaboration” with various health care providers. However, it would still fundamentally depart from New York’s long history of rejecting the corporate practice of medical care delivery, and the inherent conflicts of interest that come with it.

This Budget proposal has to be understood in the context of the recent announcement of drug store giant CVS, owner of PBM giant Caremark, to acquire health insurer giant Aetna. If approved, CVS’ overwhelming presence in the retail pharmacy industry and prescription drug coverage administration would be coupled with dominance in the health insurance market. As a result, enactment of this proposal would undoubtedly result in an explosion of retail “Minute Clinics” in pharmacies across New York State, which in turn could cause other “cross-sector” acquisitions or mergers to compete. These developments will jeopardize the viability of the far-less capitalized community primary care “medical homes” who serve patients throughout the State, jeopardizing the continuity of care that these patients receive through these practices. It also could lead to the closure of even more locally-owned community pharmacies preferred by many patients. Moreover, it is easy to foresee that numerous community primary care practices could be dropped from the network of the merged entity in favor of these retail clinics.

It is hard to overstate the pivotal role that community primary care and pediatric practices play in managing patient health, through managing chronic conditions such as asthma, diabetes and hypertension, to slow the progression of these diseases and to prevent avoidable hospitalizations. They also help to coordinate the patient’s care through referrals to needed specialty care physicians, administering immunizations, and reminders to take medications and for follow up care. They are the patient’s medical home.

Yet the retail clinic proposal would jeopardize these medical homes for many patients. Far from complementing the delivery of care, as they claim, physicians are very concerned that this proposal will produce an explosion of these big-box store owned clinics that will drive patients away from traditional primary care practices. Coincidentally, of course, many of these locations will be where patients can have their prescription medications filled.

While such care sites have existed in retail stores in New York, there was always an important distinction that assured that the physician, nurse practitioner, or physician assistant providing care at this retail site not be directly employed by the corporation. The practitioner pays rent for the space, thereby maintaining it as an “arms length” transaction. This arrangement helps to protect the independent decision-making of the health care professional against corporate interference. Of further concern, because the Budget provision states that “retail health services shall not be provided except in accordance with this article,” it would appear that this language would prohibit these existing rental space arrangements in favor of corporate owned care delivery.

To summarize, this proposal would result in a massive accumulation of power in the drug dispensing, drug coverage management, health insurance and medical care delivery areas. We urge you to stand up against this accumulation of power in our health care system that jeopardizes the ability of patients to continue to receive necessary care from their physicians. We urge you to reject this proposal as you finalize the Budget for Fiscal Year 2018-19.

3) Oppose the Independent Practice of CRNAs

We urge you to reject this proposal in the 2018-19 Executive Budget that would create the title of "certified registered nurse anesthetist" in New York State. Specifically, we are very concerned that this proposal would jeopardize the health of New York patients by permitting Nurse-Anesthetists to administer anesthesia without adhering to the existing requirement that a physician-anesthesiologist be physically present and immediately available to supervise the nurse anesthetist.

This proposal would render null and void the longstanding standards of anesthesia care (the physician led anesthesia care team) established nearly 30 years ago by the New York State Department of Health for the delivery of anesthesia. It would eliminate the requirement that, in all medical treatments requiring anesthesia, neither the physician-anesthesiologist nor the operative surgeon must supervise and accept the responsibility for the nurse anesthetist. Under this proposal, physician supervision of the nurse anesthetist would be discretionary and introduces an untested and ambiguous standard to make a determination whether a case is sufficiently "complex" to require physician supervision. If physician supervision is not imposed, nurse anesthetists would be permitted to administer anesthesia independently under a collaborative relationship.

We cannot stress enough that the operating room is a unique healthcare environment. If a patient undergoing anesthesia develops life-threatening complications, immediate medical intervention is required which will not be accomplished by a collaborating physician who is not required to be immediately available or present, as proposed. Anesthesiologists have graduated from four years of medical school, completed 3-8 years in residency and fellowship training, and will have spent between 12,000-16,000 hours treating patients before practicing as specialists in their field.

Independent studies have concluded that the odds of an adverse outcome are 80% higher when anesthesia is provided only by a nurse anesthetist as opposed to a physician anesthesiologist. Adverse outcomes lead to higher costs for patients in both monetary and physical terms when patients require longer stays in hospitals. Therefore, any suggested cost savings from this proposal is illusory.

It is also important to clarify two misstatements regarding this proposal. First and foremost, we strongly disagree with the statement that this expansion would allow nurse anesthetists (NAs) to practice to the full extent of their training, in a fashion that is consistent with other states. NAs in New York already work to the full extent of their training. What's more, there are only four states that allow nurse anesthetists to practice independently and none have the population size of New York. They are Montana, Oregon, Rhode Island and Utah. There are 46 states that require some level of physician oversight of nurse anesthetists, with most, like New York, requiring direct supervision.

It is especially significant to point out that in 2017 the Veterans Health Administration reviewed a similar expansion of scope for nurse anesthetists, ultimately concluding that there was no justification to allow NAs to practice independently.

Moreover, we are very concerned with the assertion that this proposal would save \$10 million in healthcare costs. In fact, there is no cost savings associated with this change to the current standard of care. Under Medicare and Medicaid, reimbursement for anesthesia services is exactly the same whether it is administered by a physician anesthesiologist or by a nurse anesthetist who is medically directed by a physician anesthesiologist or supervised by a surgeon.

We urge you to reject this proposal as you finalize the 2018-19 State Budget

4) Funding for the Committee for Physicians' Health (CPH)

Public Health Law Section 230 authorizes the state medical and osteopathic societies to create a Committee of Physicians to confront and refer to treatment physicians suffering from alcoholism, chemical dependency or mental illness. MSSNY contracts with the Department of Health' Office of Professional Medical Conduct (OPMC) to provide the services required by law. The program is funded not from a tax but by a \$30 surcharge on the physician's license and biennial registration fee, which is specifically dedicated by statute for this purpose.

To begin with, we are also pleased that the budget will continue the \$990,000 appropriation for program operation. However, as the program has been subject to sunset every three or five years since its inception, we need the Legislature to pass legislation to extend the program beyond its current sunset date of March 31, 2018. We note that, in 2013, there was language included in the Executive Budget program to make permanent the CPH program and the Legislature ultimately agreed to extend it for another 5 years.

Since the inception of this MSSNY program, CPH has assisted 4445 physicians, routinely monitors the recovery of 450 physicians, and annually reaches out to 175 physicians thought to be suffering from alcoholism, drug abuse or mental illness. We believe that the work of the CPH program is valuable to all physicians and indeed to the state generally. We urge that the Legislature adopt the language to make this program permanent. We also ask that the appropriation of \$990,000 be continued.

Moreover, we urge the adoption of the S.2245/A.2703, Hannon-Gottfried legislation that would clarify that the statutory liability protections offered for physician participants in the CPH program extend to the organization who sponsors the program as well as to the employees of the sponsoring program acting without malice and within the scope of its functions for the committee.

To encourage physicians with appropriate expertise to actively participate in efforts to rehabilitate physicians suffering from these conditions, this statute expressly provides them liability protections for serving on these committees for actions taken within the scope of their functions for the committee. However, a recent lower court decision interpreted these liability protections as not applying to the entity creating this physician committee even though the statute expressly provides liability protection for the physician members serving on this committee. Such a conclusion could not have possibly been contemplated when the law was first enacted. Thankfully, the decision was ultimately reversed on appeal and the case dismissed. However, because the appellate court did not address the issue of the statutory liability protections, there remain serious concerns that, without clarifying the scope of the liability protections offered in this legislation, the program run by MSSNY and other similar programs in New York State will be unable to continue to function.

Enactment of this legislation will enable physicians in need of treatment and counseling who have not harmed patients to continue to be able to obtain referrals for this needed treatment.

5) Cuts to Medicaid Payments

There have been numerous instances over the last several years where the State has tried to balance the Budget by unfairly cutting Medicaid payments to physicians seeking to deliver quality

care to their patients. In past years, physicians have had to absorb significant cuts for care provided their senior and disabled patients covered by both Medicare and Medicaid, making it much harder for these physicians to deliver community-based care.

This year's Budget contains a very troubling 2-part proposal that would a) slash funding for physicians participating in the State's Patient Centered Medical Home (PCMH) project from \$7 PMPM-\$2 PMPM for the months of May and June and b) restore the cut on July 1, but only if physicians enter into a Value-Based contract with a Medicaid Managed Care plan, instead of the existing PCMH standards. The arbitrary and counterproductive cut would jeopardize the development of PCMH physicians have worked to establish in partnership with the State to enhance the care to patients, and to help reduce avoidable health care costs. According to DOH, there are now over 8,000 various health care practitioners participating in this program. While seeking alignment to reduce conflicting treatment and coordination activities is a laudable goal, the proposed PMPM distinction is a slap in the face to tremendous efforts that physicians have undertaken to adopt the PCMH model in an effort to improve patient care. It is also unknown at this time if these practices have even been approached by Medicaid Managed Care plans requesting that they enter into VBP contracts, yet there requirements would foisted upon these practices with the proverbial gun to their head. It is grossly unfair and counterproductive to the development of medical homes.

The Patient-Centered Medical Home (PCMH) is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. The objective is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. What is incredibly ironic is that the State has spent billions of dollars on DSRIP with the goal of reducing avoidable hospitalization, while they now propose to drive away many whose activities are essential to achieving the goals of DSRIP.

We are also concerned that the proposed State Budget fails to include funding to restore funding for "crossover" payments, cut in previous years, for care provided by physicians to patients who are dually eligible for Medicaid and Medicare. For many years, New York State paid most or at least some of the cost-sharing payments for Medicare enrolled patients who are also eligible for Medicaid. However, these payments were completely eliminated in the 2015-16 State Budget. These cuts have had a disproportionately negative impact on health care practices that treat the poorest and sickest of patients. For example, community cancer clinics potentially will lose tens of thousands of dollars as a result of these cuts, exacerbating other economic trends that are forcing many of these practices to close or be acquired by hospitals. As these clinics and physician practices close, patients will have to go to hospitals to receive care that they could be receiving in the community setting.

6) Oppose Increasing Prior Authorization Burdens Through 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 ensure that their patients covered by Medicaid 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 burdens 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. As noted above, another study from the *Annals of Internal Medicine* reported that, for every hour a physician spends delivering care, two is spent on paperwork. 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 ensure Medicaid managed care plans follow the law and to address these unnecessary hassles.

7) Support The Taxing of E-cigarettes Similar to Tobacco Cigarettes

The Medical Society of the State of New York supports the extension of cigarette taxes to e-cigarettes as proposed by the 2018-19 New York State budget. Electronic cigarettes are electronic devices that deliver nicotine to the user. The heat up liquid nicotine and emit water vapor together with various chemicals, of which there is very little known. People are being placed at risk because of the lack of information regarding the chemical makeup of liquid nicotine or the risk to individuals from inhaling the water vapor either directly or through secondhand exposure.

Testing done by the FDA shows that electronic cigarettes can be dangerous because users inhale carcinogens and toxic chemicals, such as diethylene glycol, an ingredient found in antifreeze. Recent studies have suggested that e-cigarettes may contain more carcinogens than traditional cigarettes, in some instances ten times the carcinogens of traditional cigarettes.

We urge that this provision remain in the State Budget.

8) Concern with Medication Management Programs

We have strong concerns with a provision in the Executive Budget that would permit pharmacists to enter into “comprehensive medication management protocols” with physicians or nurse practitioners to manage, adjust or change the medications of patients with a chronic disease or diseases who have not met clinical goals of therapy, or are at risk for hospitalization. While many physicians believe that these programs, if structured properly, can be helpful to managing the treatment of a patient, the Budget proposal would go much further than the “collaborative drug therapy” programs that are currently permitted within the hospital environment on a demonstration basis.

The current collaborative drug therapy law was originally established with a “sunset date” in 2015, and was extended by the State Legislature to continue until 2018. However, this proposal goes well beyond this demonstration program.

Currently, only physicians are permitted to enter into such protocols with pharmacists employed within a health care institution. Not only would this proposal expand the existing law to permit NPs to enter into these protocols in a hospital or other article 28 entities, it would permit them to enter into these protocols in any care setting. We are concerned that there has been no demonstration within a specific care setting in New York, such as in a hospital, that nurse practitioners have the sufficient

pharmacology background to successfully work with pharmacists on managing patient medications (and potential interactions) on a large scale basis as is contemplated in this proposal. By contrast, physician-pharmacist CDTM protocols were studied extensively following the enactment of New York's law, which led to the Legislature extending the existing program in 2015. As such, it would be premature to now add Nurse Practitioners. Moreover, while many states across the country have established CDTM programs, very few have permitted these protocols between nurse practitioners and pharmacies. Additionally, some of those states still require nurse practitioners to maintain a collaborative agreement with a physician. Finally, we are concerned that there is no specification of specific disease states or medications for which a nurse practitioner would be able to coordinate with a pharmacist.

Again, these programs, if carefully structured, can be helpful to managing the treatment of patients suffering from chronic conditions. However, we are concerned that what is proposed in the State Budget is far too broad and therefore urge that it be removed from the Budget.

9) More Definition Needed for Community Paramedicine

We have concerns with "Community paramedicine" proposal in the Executive Budget to allow emergency medical personnel to provide non-emergency care in residential settings. While the goal of this proposal to expand care options to homebound patients or other at-risk patients is laudable, MSSNY has concerns regarding how the interactions of the EMS workers with homebound patients will be coordinated with the patient's existing care providers, both in terms of selecting which patients will receive care through these collaboratives, as well as the specific care that will be provided. As written, the proposal only requires the collaborative to include in a written plan how they will coordinate with the patient's treating providers, rather than a specific requirements to communicate with actively treating physicians and other care providers. At the very least, this proposal should be modified to require specific communications from the collaborative to the patient's treating providers. Moreover, some consideration should be given to establishing a demonstration program before enacting such a broad change.

Conclusion

Thank you for allowing us, 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 2018-2019. To summarize, 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 tort reform is enacted. We urge that you reject proposals that would jeopardize safe anesthesia for patient through the independent practice of CRNAs. We urge you that you protect patient access to community primary care sites by reject the proliferation of big-box store owned retail clinics. We urge that you extend the CPH program. We also ask that you remove provisions that would repeal existing "prescriber prevails" provisions, as well as eliminating cuts to payment for the care provided to patients covered by Medicaid.