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Testimony Of
The Medical Society of the State of New York
Before The
New York State Assembly Committee on Ways & Means
New York State Senate Finance Committee
On the Governor's Proposed Budget
For State Fiscal Year 2022-2023

Good afternoon. My name is Dr. Joseph Sellers. I am an internist and pediatrician in Cobleskill, the Physician Executive for Bassett Medical Group, and the president of the Medical Society of the State of New York. On behalf of the over 20,000 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.

Introduction: The COVID Pandemic's Toll

The enormous suffering endured by New Yorkers and the rest of the country during 2020 related to the Covid pandemic unfortunately did not come to the quick end in 2021 that many had hoped. To end the Covid-19 pandemic, it is imperative that our policymakers continue to work closely with health care professionals to develop the appropriate community infrastructure to ensure that all New Yorkers become vaccinated, while at same time educating the public on steps to minimize the continuing transmission of the virus.

The worst of the pandemic may be behind us, but it has left an indelible mark on many, including our healthcare workforce. Physicians and other health care workers had already reported significant symptoms of burnout before the pandemic began, but the pandemic made this far worse. *A 2021 Medscape report noted that 51% of critical care physicians, as well as 51% of all female physicians, reported feeling burnout. Most physicians (58%) agree that the source of this burnout is too many bureaucratic tasks.* Similarly, an AMA survey of 42 health care organizations across the U.S. which assessed over 20,000 physicians and other workers found that 61% of those surveyed felt high fear of exposing themselves or their families to COVID-19 while 38% self-reported experiencing anxiety or depression. Another 43% suffered from work overload and 49% had burnout. Nearly half of female survey respondents experienced burnout, while 41.5% of the male respondents experienced burnout during the pandemic. Furthermore, a just released **study** concluded that 1 in 5 physicians intend to leave their practice in the next two years because of employee burnout, increased workload, fear of infection, and stress associated with COVID-19. The findings indicate increased pressure on an already strained healthcare workforce.

With the demands on our health care system growing with an aging population and increasing co-morbidities, we must take steps to ensure that we have a physician workforce ready to meet the health care demands of our population. That includes taking steps to reduce the excessive administrative, non-patient care delivery demands that are far too prevalent, as well as refraining from enacted well-intended, but often misguided, legislation that adds additional unnecessary administrative burdens and requirements to those delivering patient care.

Most importantly, we need our policymakers to enact measures to reduce the excessive administrative hassles imposed by health insurers, such as those related to pre-authorization for needed patient care, as well as excessive documentation demands related to the payment of care.

Change is long overdue. New York is regularly ranked at or near dead last in the country in the list of the best states in which to practice medicine because of a lack of competitive compensation, excessive regulatory requirements and excessive liability risk and costs. New York has already lost countless physicians to other states with practice environments more welcoming to physicians than New York.

The Executive Budget: Much Positive with Some Notable Concerns

We are pleased that the Executive Budget recommends several far-reaching initiatives to help support both our health care system and our health care workers who are weary from multiple years of responding to the COVID crisis we have collectively faced. Importantly, the Budget invests in the future of patient medical care delivery by providing significant increases to the Doctors Across New York loan repayment program and invests in care accessibility by ensuring fair payment for patient care delivered via telehealth. The Budget also makes significant investments to ensure more patients have comprehensive health insurance coverage to obtain the quality medical care they need.

However, the Executive Budget also contains some problematic provisions that will adversely impact the ability of physicians to continue to provide needed care their patients. With so many challenges remaining to navigate the pandemic, we urge the Legislature to reject these concerning measures as they finalize a Budget for the 2022-23 Fiscal Year.

1. SUPPORT TELEHEALTH PAYMENT PARITY

MSSNY joins others in the medical community to support the Governor's Executive Budget proposal to amend the Public Health and Insurance Laws to provide for payment parity between the delivery of health care services via telehealth and services delivered in a traditional in-person environment.

The need for social distancing during the pandemic forced patients and physicians needed to embrace new ways to ensure patients were receiving necessary care. While some physicians had already integrated Telemedicine into their practices, prior to the onset of the pandemic, the COVID19 crisis strongly encouraged thousands of physicians across the state to quickly increase their capacity to provide care to their patients remotely. However, from the start, payments to physicians from insurers for care provided virtually, or by phone, were woefully inadequate to what they were receiving for in-office visits, creating barriers for patients to receive the best care.

Bolstering the urgency for payment parity, a May 2020 MSSNY survey showed that 83% of the physician respondents had incorporated telemedicine into their practice, with nearly half the respondents noting that they were treating at least 25% of their patients remotely. Moreover, a spring 2020 Fair Health study showed that, for the northeastern part of the country, use of Telehealth went from 0.08% of claim submissions in May 2019, to 12.5% in May 2020. Showing that this was not just a temporary bump, telehealth claim lines also increased 2,938% nationally from November 2019 to November 2020, rising from 0.20 percent of medical claim lines in November 2019 to 6.01% in November 2020, according to data announced by FAIR Health. And most recent FAIR Health data from October 2021 shows that telehealth services continue to represent nearly 5% of claim submissions for the northeastern part of the country.

MSSNY commends early efforts by the New York Department of Financial Services (DFS) and Department of Health (DOH), which adopted critically important policies to better enable patients to obtain health care services via telemedicine. This included permitting coverage for audio-only health care services and allowing delivery of telemedicine through smartphone video technologies. Medicare also followed this path, waiving the federal statute that limits Medicare coverage for telehealth to rural areas and significantly increasing payments for video and audio-only telehealth services.

However, physician payment for audio and video services has often not kept pace with rates paid for in-office visits and the gap is often wide. For example,

- a survey by the New York Medical Group Management Association (NY MGMA), revealed that only 23% of all health plans pay the same for telehealth as they do for in-office visits.

- surveys conducted by MSSNY partner organizations found that while telehealth visits conducted by video were reimbursed at higher rates than audio-only, physicians were compensated as little as 30% the rate of in-person appointments, depending on the health plan.

- Audio-only visits were the least compensated, with most payers reimbursing 80% less than for in-office visits.

These low payments threaten the gains made in expanded telehealth access. Paying physicians at substantially lower rates for telehealth services also disproportionately impacts patient access in traditionally underserved communities--including low-income families and those with transportation or childcare challenges-- who often benefit most from the flexibility of telehealth. As a result of vaccine hesitancy and emerging variants, physicians and public health officials expect COVID-19 to remain a public health threat for the foreseeable future, making it imperative that policies that have promoted telehealth services become permanent. Moreover, with many patients from marginalized groups not having adequate access to necessary technology, it is important for the State to address inequities in access to telehealth services including continued coverage for audio-only telehealth.

2. SUPPORT INCREASE IN FUNDING FOR THE DOCTORS ACROSS NEW YORK (DANY) PROGRAM

The Doctors Across New York (DANY) program was established in 2008 to assist with the recruitment and retention of physicians in underserved areas. To incentivize physicians to work in parts of the state which lack an adequate number of physician specialists to meet community need, DANY provides loan repayment and practice support. However, in recent years, the number of placements has not kept pace with the growing physician shortage. To help close this gap, MSSNY strongly supports the Governor's proposed increase from $9M to $15M in state funding for the DANY Program to provide loan forgiveness up to $120,000 for individual physicians who work in underserved areas for three years.

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3. SUPPORT HEALTH INSURANCE REFORM

Coverage Expansion. The Executive Budget contains several important initiatives to help patients obtain and maintain no cost or low-cost health insurance coverage. These include expanding the income eligibility limits for the Essential Plan, expanding the time frame for post-partum coverage, and eliminating premiums for CHIP eligibility for children in families that are below 223% FPL. MSSNY is also supportive of the modest increases in Medicaid payment, restoring a previously imposed 1.5% cut and providing a 1% increase in payments.

Reducing Health Insurer Obstacles. MSSNY further supports the Executive Budget's targeted reforms to address unnecessary and excessive health insurer administrative hassles for physicians and consumers.

In the Budget. The Executive Budget includes recommendations identified in the report of the DFS-DOH Administrative Simplification workgroup that met throughout 2021 which would:

- ***Limit Credentialling Delay***. The Executive Budget includes provisions to address delay in credentialing physicians to participate in networks, ensure that all health insurers are required to follow the statutory 60-day timeframe for reviewing applications for network participation that are currently applicable to only some insurance plans. MSSNY has received numerous complaints from physician practices about difficulty in obtaining updates from health insurers to explain why an application to add a physician to an insurer network has been delayed.

- ***Reduce Excessive Medical Record Requests***. The Executive Budget will help reduce excessive medical record requests when reviewing claims, ensure that HMOs are no longer exempted from current laws applicable to other health insurance plans that prevent against excessive medical record requests. MSSNY has received numerous complaints from physicians in various parts of the State regarding certain health insurers requesting extraordinary amounts of background patient medical information when a claim has been submitted for payment. In

some cases, these health insurers then fail to acknowledge receiving the records, thereby unfairly delaying payment for these claims and tying up physician office staff with hours upon hours of unnecessary back and forth phone calls and e-mail submissions to resolve these disputes. MSSNY has brought these issues to the DFS for further investigation.

Missing from the Budget. Unfortunately, the Executive Budget does not include several other insurance reforms helpful to physicians and consumers that MSSNY hopes the Legislature will enact, including:

- ***Preauthorization***. The Executive Budget does not include important reforms in pre-authorization requirements by health insurers. One of the chief sources of physician complaints has been excessive hassles in obtaining preauthorization for needed patient care.
    - *Conduct Annual Review.* Importantly, the DFS-DOH report also recommended that, at least annually, health plans should review services that are generally approved through preauthorization to identify where preauthorization requirements may be removed.
    - *Limit Repeat Requirements.* In addition, DFS-DOH recommended that health plans should also review circumstances where repeat preauthorization requirements for the same patient/same treatment can be eliminated.
    - *Other Hassles Reduced*. This is contained within separate legislation MSSNY has strongly supported (A.7129/S.6435) that would take several steps to reduce prior authorization hassles, including provisions that would reduce the time frame for receiving prior authorization as well as eliminating requirements to obtain repeat prior authorizations once initially approved. MSSNY is also supportive of legislation (soon to be introduced by Senator Breslin) similar to that recently enacted in Texas that would create a "gold card" exemption for physicians having to complete prior authorization requirements for a specific patient care service when that physician has received prior authorization for a particular service 90% of the time from that health insurer.

- **Medical Necessity Guidelines.** MSSNY supports another provision in the DFS-DOH report calling for health insurers to ensure that their utilization review (medical necessity) guidelines are evidence-based, and peer reviewed, as is currently required for step therapy/fail first protocols.

- **Network Adequacy**. Finally, MSSNY urges DFS and DOH to update outdated network adequacy standards to ensure the availability of comprehensive physician networks that are sufficiently comprehensive the meet the health care needs of consumers, especially in diverse and underserved communities across New York State. In addition, DFS and DOH should improve the transparency of various insurer provider networks, so consumers can effectively comparison shop and understand when their health plan contains a narrow network. Further, DFS and DOH should step up enforcement of network adequacy to root out inaccurate or misleading information about participating providers.

4. OPPOSE IMPOSING NEW COSTS ON PHYSICIANS FOR EXCESS MALPRACTICE COVERAGE

MSSNY strongly opposes a proposal contained in Part Z of the Health/Mental Hygiene Article 7 bill that would profoundly restructure the Excess Medical Malpractice Insurance Program by requiring the nearly 17,000 physicians currently enrolled in the program to front the cost of these policies, and then be reimbursed in 2 yearly installments. There are similarities to policies advanced in recent Executive Budgets but thankfully rejected by the State Legislature.

This short-sighted proposal would essentially thrust over $100 million of new costs on the backs of our community-based physicians who served on the front lines of responding to the pandemic. This new cost imposition – even reimbursed - would hit these practices at a time when many of these practices are still seeking to recover from huge losses they faced as a result of a substantial reduction in the number of patients receiving care during the pandemic. Many procedures were delayed due to elective surgery restrictions, as well as patients appropriately limiting their trips out of their homes.

As noted in the below chart, this policy if adopted would impose tens or even hundreds of thousands of dollars in new costs on many physician groups at the worst possible time.

NEW COSTS ON PHYSICIANS FOR EXCESS MALPRACTICE COVERAGE BASED ON BUDGET PROPOSAL

SPECIALTY	Long Island	Bronx, Staten Island	Brooklyn, Queens	Westchester, Orange, Manhattan
ER	$9.851	$11,443	$10,684	$7,839
Cardiac Surgery	$7,166	$8,317	$7,772	$5,703
OB-GYN	$33,382	$38,743	$36,206	$26,656
Neurosurgery	$56,308	$65,352	$61,072	$44,810

Imposing these new costs is grossly unfair and an insult to all they did to serve the public during this crisis, putting their health and their families' health at risk. Many became sick and some even passed away.

As you may be aware, the Excess Medical Malpractice 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 program was created because 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 their professional lives could be lost as a result of one wildly aberrant jury verdict.

This fear continues today since New York State has failed to enact meaningful liability reform to ameliorate this risk. The size of medical liability awards in New York State has continued to rise significantly and physician liability premiums remain far out of proportion compared to the rest of the country. For example, a recent report from Diederich Healthcare showed that in 2019, New York once again had the highest cumulative medical liability payouts of any state in the country, 68% more than the state with the second highest amount (Pennsylvania). It also had the highest per capita liability payment, 10% more than the 2nd highest state (Massachusetts). These disturbing statistics demonstrate a major reason why New York once again received the dubious distinction as being one of the worst states in the country to be a doctor.

We note that the Executive Budget also proposes to limit interest on court judgments to a market-based rate instead of the ridiculously high statutory rate of 9% (one more element of New York's tort laws which makes our State such a huge outlier), which could have a moderating impact on premiums and potentially offset some of these huge new costs that would have to be borne by physicians. However, similar proposals have also been regularly rejected by the State Legislature and we have no reason to believe it will be different this year.

With all the pressure our healthcare system is under now, the Excess program is more important than ever. While many physicians did receive some stimulus support from the federal government to help offset the historic drop in patient visits, most report that these funds only helped to cover a fraction of their lost costs. A MSSNY survey had reported that 85% of respondents reported that stimulus funds offset less than half of their losses, and that 40% of physician respondents had to lay off at least 10% of their staff because of these losses. Furthermore, an AMA survey reported that during the pandemic the average number of in-person visits to physician offices fell from 97 per week to 57.

This profound change would likely force many physicians to forego obtaining the coverage altogether. We believe this would be contradictory to the goal of the Excess program to help protect patients and the public at large.

Again, we urge you to reject this short-sighted proposal and to maintain the existing mechanism for covering the Excess Medical Malpractice Insurance Program.

5. OPPOSE ADDING INSURER PAYMENTS TO NEW YORK'S INDEPENDENT DISPUTE RESOLUTION SYSTEM

MSSNY supports many of the provisions in the Executive Budget that are necessary to conform New York protections to the federal No Surprises Act. However, one important provision in the Executive Budget is unnecessary to conform to federal law and may tip the delicate balance in the State independent dispute resolutions (IDR) process unfairly in favor of insurers, risking access to care for consumers.

MSSNY has supported state and federal legislative efforts to remove patients from the middle of disputes between out of network physicians/hospitals and health insurers, including strong support of New York's surprise medical bill law enacted in 2014. Indeed, MSSNY supports Executive Budget provisions to conform New York's landmark "Surprise" medical bill law with new federal law protections, incorporating many changes

New York is required to adopt that have been identified through DFS Circular letters 10, 11, 12 and 13 of 2021.

For example, MSSNY supports the Executive Budget language to eliminate what has now become an obsolete requirement for a physician to obtain an Assignment of Benefits from a patient receiving unplanned out of network care as a precondition to submit a dispute to an Independent Dispute Resolution (IDR). This requirement is no longer necessary because the patient receiving unplanned out of network care can no longer receive a bill from that physician for anything other than the applicable cost-sharing amount as required by the patient's insurance policy.

However, MSSNY is concerned with other Executive Budget provisions that are not necessitated by the No Surprises Act. One of these proposed changes would expressly permit an IDR entity's consideration of insurer median payments even though this change to New York's law is not required by the federal law. Current New York law already enables the IDR entity to consider this information. But expressly including insurer median payments as defined statutory criteria for IDR consideration could significantly increase the weight it will be given by the IDR entity, raising the possibility that a physician may lose the IDR. This change may, in turn, discourage some physicians from providing essential on-call emergency department care. The risk to consumer access to care is not worth this unnecessary change in New York's groundbreaking Surprise Billing Protection Act. Another concern in the Executive Budget is a proposal that would lengthen the time period for the IDR entity's consideration from 30 days to 30 business days, which will essentially add 10 days to the time frame and unnecessarily delay fair payment for care delivery.

6. OPPOSE ELIMINATING NURSE PRACTITIONER-PHYSICIAN PRACTICE COLLABORATION

Our patients benefit from the combined care of a team, led by a physician whose education and training enables them to oversee the care to ensure optimal medical treatment for the patient. Ensuring treating professionals are acting within their scope of practice is a matter of patient safety. Therefore, MSSNY strongly opposes the Executive Budget proposal (Part C of the Health Article 7 Budget bill) to eliminate the requirement for a nurse practitioner to have written evidence of collaborative agreements with physicians practicing in same specialty as the nurse practitioner.

To promote optimal care, MSSNY believes that there needs to be far stronger required documentation of protocols, to be followed by independently practicing NPs, with physicians to coordinate the care of patients. In this regard, we appreciate that the proposal protects these important patient protections for NPs practicing in a non-primary care area, as well as for all NPs with less than 3,600 hours experience.

While NPs are essential members of the health care team, with no residency requirement and only 500-720 hours of clinical training, their education is far less rigorous than the training of physicians. By sharp contrast, physicians complete 4 years of medical school plus 3-7 years of residency, including 10,000-16,000 hours of clinical training.

But it is more than just the vast difference in hours of education and training – it is also the difference in rigor and standardization between medical school/residency and nurse practitioner programs. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological and behavioral aspects of human conditions. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients. During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess a physician's readiness for licensure. At this point, medical students "match" into a 3-7 residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. NP programs do not have similar time-tested standardizations. In summary, NP education and training to deliver patient care is not interchangeable with physician education and training.

MSSNY is also concerned that this legislation could result in increased health care costs due to overprescribing and overutilization of diagnostic imaging and other services by NPs. One study showed that, in states that allow independent prescribing, NPs were 20 times more likely to overprescribe opioids than those in prescription-restricted states. Multiple studies have also shown that NPs order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the *Journal of the American College of Radiology*, which analyzed skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially – more than 400% by non-physicians, primarily nurse practitioners and physician assistants during this time frame. A separate study published in *JAMA Internal Medicine* found NPs ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist. The authors opined this increased utilization may have important ramifications on costs, safety and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding nurse practitioner scope of practice alone.

Eliminating existing statutory collaboration requirements would undermine, not improve, quality patient care. In a recent MSSNY survey, nearly 2/3 of the physician respondents indicated that advanced care practitioners working independently during the pandemic under the Governor's Executive Orders (waiving physician collaboration and/or supervision requirements) had committed an error while treating a patient; over 80% indicated that the error could have been prevented had there been physician oversight. There were countless comments and provided by physicians participating in this survey that praised the care provided by these advance care practitioners, while at the same time expressing significant concerns and presenting examples about their limited knowledge in recognizing potentially complex patient cases, often noting that NPs "don't know what they don't know". Moreover, in a 2021 survey of random New York voters conducted by the American Medical Association, 75% of respondents indicated that it was very important for physicians to be involved in diagnosis and treatment decisions.

Patients benefit most by having a team-based approach to health care delivery,

not creating silos. We urge you to maintain the existing statutory patient safety protections that ensures continued collaboration between physicians and nurse practitioners. We urge you to oppose this State Budget proposal.

7. OPPOSE POTENTIALLY HARMFUL CHANGES TO PHARMACY SCOPE OF PRACTICE

MSSNY strongly opposes several proposals contained in the Governor's proposed State Budget (Part C of the Health/Mental Hygiene Article 7 bill) that may jeopardize the availability of physician-led team care by greatly expanding the scope of services provided by pharmacists without coordination with the patient's physician. We are very concerned that these proposals would greatly enhance the power of corporate giants such as CVS and Walmart to control various aspects of patient care delivery not in coordination with but to exclusion of community-based primary care and specialty care physicians who typically manage a patient's care. Therefore, we urge that these provisions be rejected from the State Budget for Fiscal Year 2022-23.

Specifically, this proposal would permit pharmacists to order various waived lab tests without oversight and without any requirement to coordinate with the patient's physician for follow-up care. According to the FDA website, there are nearly 140 of these waived lab tests, including tests used to diagnose HIV, diabetes, STDs, and other serious conditions where immediate and ongoing medical care is warranted.

The concern is not with pharmacists performing these tests so much as the concern that these tests would be performed without any referral from patient's physician or other care provider, and without requirement to connect a patient to a physician to manage the condition once diagnosed. The proposal to permit pharmacists to independently administer lab tests is completely at odds with the patient centered medical home model that New York State has sought to promote and would lead to siloed patient care rather than integrated care. The present system recognizes that CLIA-waived testing of patients by pharmacists must be under an established protocol and supervision of a physician, or other primary care provider, who can help the patient to interpret the test results, provide needed context and most importantly set forth a care plan for the patient should the results require further medical intervention. This Budget proposal does not provide for coordination with a patient care physician which would completely upend the existing model for coordinated diagnostic testing and lead to disjointed, uncoordinated care.

All these programs together have the great potential to threaten patient safety and would incentivize the development of health care silos at the expense of the patient centered medical home model we have worked so hard to develop in New York. It would also marginalize the care provided by community based primary care and specialty care physicians' serving diverse patient populations.

For all the reasons stated above, we urge that these proposals be rejected from the final Budget adopted for FY 2022-23.

8. OPPOSE REPEAL OF "PRESCRIBER PREVAILS"

MSSNY thanks the Assembly and Senate for your efforts to reject the proposal in previous Executive Budget submissions to repeal the authority of physicians and other

qualified prescribers to make the final determination regarding the medication prescribed to individuals covered under Medicaid Fee-for-Service and Medicaid Managed Care, commonly referred to as "prescriber prevails." We urge you to again reject the proposal in this year's Executive Budget.

Repealing this critical patient protection would jeopardize patient care as well as undercut the initiatives the State has undertaken to reduce unnecessary and avoidable hospitalizations, which have been trending downwards in the last several years. A key component in sustaining and accelerating such a trend is assuring individuals can obtain the medications prescribed by their physician to alleviate the symptomatology of their physical and/or mental health conditions.

As the State began shifting additional populations into Medicaid Managed Care as part of the Medicaid Redesign Process, the "prescriber prevails" provisions were extended to this population for non-formulary atypical antipsychotic medications at first and later to anti-depressant, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic therapeutic classes. As it is, under the current law the prescriber must go to great lengths to "demonstrate" the medication is medically necessary and warranted, a process that has prescribers spending an inordinate amount of time navigating a maze of pharmaceutical management processes to obtain approval to prescribe the medications their patients need. Over the years, the Legislature has rejected the administration's budget proposals to curtail or eliminate the patient protections embodied in the prescriber prevails provisions of the law.

We believe any projected savings based on the repeal of "prescriber prevails" in Medicaid Fee-For-Service and Managed Care would be dwarfed by the health care complications likely to arise as a result of many patients not being able to access the medications, they need to remain healthy in the community. For many physical, mental health and substance use disorders, finding the most efficacious medication for a patient is often not a one-size-fits-all approach, making it even more imperative that once determined the decision is respected in order to preserve continuity of care and enhance treatment adherence.

Furthermore, this proposal is ill-timed given the COVID-19 pandemic and transition of the Medicaid pharmacy benefit from managed care back to fee-for-service pursuant to a provision contained in the 2020-21 NYS budget. To ensure continuity of care, it is imperative the prescriber prevails authority be maintained as it is an important safety net for our most vulnerable often battling multiple comorbidities.

9. EXPAND LIMITATIONS ON NON-COMPETE AGREEMENTS

The Education & Labor Budget bill contains a provision that seeks to restrict the use by employers of restrictive covenants. While we believe this is an important proposal, we are concerned that the proposal does not go far enough. With nearly half of physicians across the country and in New York employed rather than in private practice, many of whom have faced little practical choice but to enter into these arrangements due to excessive administrative hassles that make private practice impossible, many physicians are at the mercy of these large systems with unequal bargaining power. We note, for example, that the Budget language does not even place a mileage limitation on the use of a restrictive covenant. These limitations are particularly challenging because they interfere with continuity of care for patients should

a physician feel compelled to leave an employment arrangement and return to private practice. To this end, MSSNY has adopted a position to support legislation that prohibits any "restrictive covenant" provision in a health system-physician employment contract or in a contract between a Management Services Organization (MSO) and a physician that limits the ability of such physician to deliver care in the same region after the physician leaves employment from such health system or leaves the medical practice that utilizes that MSO.

10. SUPPORT CONTINUED EFFORTS TO ADDRESS THE PANDEMIC

On January 20, 2020, the first cases of SARS-CoV-2 (COVID-19) was confirmed in the United States. Coronaviruses are from a large family of viruses that have been around for a long time. Many of them can cause a variety of illnesses, from a mild cough to severe respiratory illnesses. The novel coronavirus that causes COVID-19 is one of several known to infect humans and as has been proven, deadly. SARS-CoV-2 has since mutated into variants, the most notable are the Delta variant which was rampant in the spring-fall in 2021. The Omicron variant was detected in this country on December 20, 2021. Omicron has rapidly increased the proportion of COVID-19 cases. The Omicron variant has spread more easily than the original SARS-CoV-2 virus and we now know that Omicron infection impacted on the individuals who were vaccinated or to unvaccinated individuals without having symptoms.

The good news is that New York State's hospitalization rate has significantly decreased from the height of the Omicron surge (January 7, 2022). However, according to the Centers for Disease Control, New York State's death toll stands at 65,427. On the positive side, 84.5 % of New Yorkers, 18 and older have completed the vaccine series and 95% have complete at least one dose of the vaccine. Vaccines and boosters are readily available to anyone. The Medical Society of the State of New York believes the COVID-19 immunization will lead us out of this pandemic. A January 22, 2022, study from the CDC shows the importance of vaccination and the power of boosters. The study shows that once a booster is given, the risk of getting severely ill from Covid is very small, even if you are older or have health related issues. (https://www.cdc.gov/mmwr/volumes/71/wr/mm7104e2.htm?campaign_id=9&emc=edit_nn_20220131&instance_id=51759&nl=the-morning&regi_id=22495210&segment_id=81212&te=1&user_id=60a7a753a61ad81fea570fd87c7c323e)

MSSNY began preparing educational programming for physicians in December 2019. MSSNY first webinar on COVID-19 occurred on March 18, 2020—four days before New York State closed all nonessential business in its efforts to prevent the spread of SARS-CoV-2 virus. MSSNY has conducted 18 live webinars and has educated over 2500 physicians. These webinars are also posted on-line for physicians and other health care providers to take when it's convenient for them. MSSNY also has posted nine podcasts for patients and physician to listen to obtain information on COVID-19. MSSNY podcasts are listen to on Spotify, Apple Play, and Google Play.

Early in the pandemic, physicians' practices were closed down and those that remained open had difficulty in obtaining and receiving personal protective equipment. The office-based physician had the need for this type of equipment, and it was extremely difficult to find. While there have been efforts for the state to stockpile this equipment, the need to secure enough PPE for office-based physicians in a public health emergency

remains an outstanding issue. I will remind you that it was an office-based physician who detected the first Anthrax case in October 2001. And, in the spring of 2009, a novel influenza A (H1N1) virus emerged—again detected by an office-based pediatrician. The H1N1 virus was detected first in the United States and spread quickly across the United States and the world. That too was a pandemic that had consequences for young people. Fortunately, a vaccine was quickly developed, and the costs, including lives lost from this pandemic, were mitigated.

MSSNY supports the Hochul Administration's requirement that all health care workers be immunized and has strongly advocated for this since last fall. MSSNY's Infectious Disease Committee and Council has reviewed the evidence of requiring vaccination for various populations and supports the healthcare immunization requirement, and a school-based requirement for COVID-19 immunization. To that end, MSSNY strongly supports the tenants of infection control: Be Immunized. Wash hands, keep social distance and wear a mask. The Mayo Clinic researchers published a study this summer that shows the proper use of masks reduces the spread of respiratory droplets. The findings strongly support the protective value and effectiveness of widespread mask use and maintaining physical distance in reducing the spread of COVID 19.

As the pandemic unfolds, we know that resources are initially scarce (i.e., vaccines. Federal and state guidance was provided as to who should receive the vaccine first; and healthcare workers were first in line). The guidance was changed to address the immunocompromised and age categories. Today, as production of the vaccine supply has ramped up, vaccine and booster are readily available. There has been discussion of the shortage in supply of the monoclonal antibodies and the anti-virials (Pfizer's Paxlovid and Merck's Molnupiravar received emergency use authorization (EUA) by the U.S. Food and Drug Administration). Physicians understand risk assessment, triage, and allocation of resources. In many ways, we have been doing triage and resource allocation, and making treatment decisions throughout COVID. Managing the pandemic calls to mine the HIV/AIDS crisis whereby we employed the same treatment strategies applied in the recent past with HIV/ AIDS treatments. During the HIV/AIDs crisis we were also in short supply and strategies to treat the illness, but it evolved with improved access to drugs and new drug development. One of the earliest HIV/AIDs treatments was AZT-we knew all patients should be eligible for treatment, however the supply AZT was limited. Risk assessment was required during a time of short supply with AZT. We are also faced with similar challenges in our fight against COVID-19. Enhanced supplies will come, and new and better treatments come through the pipeline.

In September 2021, at the request of the NYS Department of Health, MSSNY began facilitating a monthly call with officials from the NYS Department of Health and NYC Department of Health, to get more physicians enrolled into a COVID-19 provider. This call is held with the various medical specialties, the county medical societies, the local county health commissioners, and the NYS Association of County Health Officials. The monthly call has proven invaluable to MSSNY and the respective societies as it has proven to be an important component in improving communication with the various state and local health officials about issues pertaining to vaccines, guidance, supply, and antiviral use.

11. SUPPORT CONTINUATION OF THE VETERANS' MENTAL HEALTH PROGRAM

The Medical Society of the State of New York (MSSNY), the New York State Psychiatric Association (NYSPA), and the New York State Chapter of the National Association of Social Workers (NASW-NYS) are seeking funding in the 2022-2023 New York State budget for the continuation and expansion of the comprehensive statewide training program, known as the Veterans Mental Health Training Initiative (VMHTI). MSSNY and NYSPA seek an appropriation of $150,000 for each respective medical society, and the NASW-NYS seeks an appropriation of $250,000 to be included in the 2022-23 NYS Budget.

This program educates both community mental healthcare providers and primary care healthcare providers on veterans-specific mental health issues including combat-related post-traumatic stress disorder, traumatic brain injury, suicide in veterans, substance use, military culture, and women veterans' mental health conditions including the impact of military sexual trauma.

The VMHTI has two pathways and one led by MSSNY and NYSPA which trains primary care physicians and health practitioners from across the primary care specialties, including internal medicine, family practice, emergency medicine and OB-GYN. The other track is led by the NASW-NYS, providing an accredited education and training program for community mental health workers. The trainings are also of benefit to psychiatrists whose practices have seen a dramatic influx of combat-related mental health problems. The program educates both community mental healthcare providers and primary care healthcare providers on veterans-specific mental health issues including service-related post-traumatic stress disorder, traumatic brain injury, substance use disorders, suicide, and suicide prevention, as well as enhancing competency on military culture.

The VMHTI is equipping New York's healthcare workforce in the community to meet the challenges of combat veteran specific mental health and related problems, which is critical as the data indicates more than half of all military veterans will seek care from a health care provider in his or her community upon return from combat. Prior funding for the VMHTI has allowed the VMHTI to successfully train over 3,400 primary care and psychiatric practitioners through the MSSNY and NYSPA programs, and over 4,000 social workers and community mental health providers through the NASW-NYS program.

The need for continued support is more critical than ever considering COVID-19 pandemic's impact on veterans and their families, including the exacerbation of mental health and substance use disorder symptomology, isolation, and loneliness as well as economic stress that burdens veterans. Recent reports and data from the Army indicate that suicides during the pandemic have increased by 20% in the military and by as much as 30% among active-duty soldiers. In addition, a recent national survey found most veterans had reported that their mental health worsened since social distancing measures were implemented and more than half reported having had mental health appointments canceled or postponed during the pandemic.

The VMHTI has pursued linkages with veteran peers including the Joseph P. Dwyer Peer to Peer Program (Dwyer Program). The Dwyer Program has a specific charge of

peer support for veterans and their families. Peer support covers many areas including connection to concrete services, peer-based group, and individual support as well as service activities. The Dwyer Program does not provide medical or mental health clinical services. The VMHTI seeks to close the gap between Dwyer Programs and clinical services by working together to create a referral system for veterans seeking medical and mental health care. This expansion of VMHTI will provide wrap around support for veterans by providing a direct connection to trained clinicians. The VMHTI has been an important vehicle for meeting this need and is especially important as all remaining troops from Afghanistan were abruptly withdrawn earlier this summer, including many of soldiers who call New York their home. Accordingly, MSSNY, NYSPA and NASW-NYS seek the Legislature's approval of the funding described above.

Thank you for your attention to all these comments on the proposed State Budget for Fiscal Year 2022-23. I am happy to answer any questions you may have.