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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 2025-2026

I am Dr. Paul Pipia, Chair of the Department of Physical Medicine and Rehabilitation at Nassau University Medical Center. I am also the Immediate Past-President of the Medical Society of the State of New York, which advocates for more than 20,000 physicians practicing in regions across New York. We thank you for the opportunity to present testimony today.

The Medical Society supports several positive items in the Executive Budget proposal that would help to expand patient access to care, including: increasing woefully inadequate Medicaid payment, continued funding for MSSNY's Committee for Physician Health substance abuse counseling program; addressing the problematic financial consent requirement enacted in last year's State Budget that requires a patient to consent for payment AFTER services are delivered; continued investments in the Doctors Across New York medical student loan repayment program, and permitting immunization by medical assistants under physician supervision.

Having said that, we are also extremely concerned with several other proposals that would be counterproductive to maintaining patient access to community-based physician care, including: imposing $40 million in new costs on already overburdened physicians for the costs of the Excess Medical Liability Program; eliminating important appeal rights of physicians to challenge unfair underpayment by greedy Medicaid managed care plan, undermining physician-led care teams that assure quality and reduce costs, and eliminating important peer review for Workers Compensation physician participation historically provided by county medical societies.

Overview

The Medical Society of the State of New York represents tens of thousands of physicians, residents and medical students across New York State, delivering care to patients in solo practice, in small and large group settings, or as employed by large health systems. Our diverse membership is committed to ensuring that all New Yorkers have access to quality and affordable physician-led healthcare.

Our efforts to ensure patients receive needed care is challenged by an ever-increasing encroachment of non-physicians into care delivery, including by health insurers, corporate

pharmacy giants, private equity, and even in some cases by market-dominant health systems. Their well-intended but often misguided efforts to improve care and reduce costs frequently come at the expense of limiting treatment options for patients, including by limiting the ability of physicians to advocate for their patients, or by seeking to replace them altogether with various non-physician providers.

These factors are accelerating the disturbing rise in physician burnout, demoralization and moral injury. As the healthcare landscape continues to rapidly evolve, it is imperative that policymakers recognize and address New York's notoriously poor practice environment and find solutions that will help improve professional wellbeing and expand patient access to physician-led care.

Statistics continue to show that the overall state of wellbeing for physicians remains disturbingly low. For the fourth year in a row, 60% of physicians report often having feelings of burnout, compared to 40% in 2018. Moreover, more than half of physicians and medical students know of a physician or colleague who has considered, attempted, or died by suicide.

Nearly 70% of physicians and medical students, and over 60% of medical residents, agree that consolidation in health care is negatively impacting patient access. However, the "Catch-22" is that many physicians believe they have no choice but to practice in large systems as independent practice has become impossible for many due to the enormous and costly infrastructure needed for delivering patient care. This compromises the ability of a physician to be the best advocate for their patients.

One of the driving factors to physician burnout is the overwhelming required use of electronic medical record (EHR) system. For example, between 2022 and 2023, physicians reported an increase of nearly 30 minutes per day in their use EHRs, representing an 8% year-over-year increase. Over half of all physicians indicated that the time they dedicate to EHRs while at home not in their clinical setting is "high" or "excessive.

This is not sustainable, and solutions must be implemented to reverse these problems. For example, 90% of physicians agree that preserving physician autonomy is most helpful as a safeguard against consolidation in healthcare. 79% of physicians and 87% of residents also reported reduction of administrative burdens to be helpful to addressing factors of burnout.

In that regard, policymakers must work to change New York's notoriously poor practice environment. New York is regularly ranked near the bottom on the list of the best states in which to practice medicine. In part, this has been attributed to a lack of competitive compensation, excessive regulatory requirements, and exorbitant liability costs. This is exacerbated by the pervasive cuts in the Medicare fee schedule, which often forms the basis for commercial health insurance reimbursement. New York has already lost countless physicians to early retirement or to other states with practice environments more welcoming to physicians. Furthermore, according to studies, New York retains less than half of the physicians it pays to train.

These trends must change. Making matters worse are the significant cumulative real dollar cuts to Medicare payment (not simply reductions in cost-of living increases) in each of the last 5 years, including a 2.8% cut that went into effect on January 1. Replacing physicians with less skilled non-physicians is not the panacea. We cannot ensure meaningful access to care for patients unless we work to ensure that we have an available supply of primary and specialty care-trained physicians to meet patient needs.

1) **Support Maintaining Funding for the Committee for Physicians' Health (CPH)**

As we highlight the growing incidence of burnout among physicians, we are appreciative of the funding in the Aid to Localities Budget of MSSNY's Committee for Physicians Health (CPH) Program at its historical level of $990,000 (identified on p. 687 as "medical society contract pursuant to Chapter 582 of the Laws of 1984"). This program is essential for assisting physicians in confronting addiction, burnout and mental illness, and most importantly, helping them return safely to delivering patient care when they are healthy.

The program has been extended by the Legislature in 5-year increments, including an extension of the program until 2028 approved by the State Legislature in the final 2023-24 State Budget. We are also very appreciative of the efforts of the State Assembly and State Senate to ensure funding this program for the current fiscal year when it was initially proposed to be eliminated in last year's Executive Budget proposal.

As a reminder, CPH is established by state statute (Public Health Law Section 230(11)(g)), and contracts with New York's Office of Professional Medical Conduct to provide the services required by law. It is important to note that the program is NOT funded from General Appropriations but by a $30 surcharge paid by physicians themselves in their license and biennial registration fee, which is specifically dedicated under Education Law Section 6527 (9) for this purpose.

Since the inception of this program over 40 years ago, CPH has assisted nearly 7,500 physicians, routinely monitors the recovery of 400 physicians, and annually reaches out to 125 physicians thought to be suffering from alcoholism, drug abuse or mental illness. Many believe that the work of the CPH program is not only valuable to physicians, but to all New Yorkers as well.

Many of these conditions treated through the CPH program were exacerbated by the pandemic, making the services provided by CPH more essential than ever. CPH provides important confidential peer-to-peer services to physicians in need of support for their health and well-being. Studies that review the long-term model effect of physician health programs show that physician recovery rates are markedly higher than the general population—even when extended into five years or more.

Again, we appreciate the funding for the CPH program in the ATL Budget bill and urge that its funding be included in the final enacted Budget.

2) **Support Long Overdue Medicaid Payment Increases**

We are supportive of the proposal announced in the Governor's Budget summary to increase funding for what continues to be grossly inadequate Medicaid physician reimbursement. For years, our State's Medicaid program has peripheralized community-based physician care by maintaining one of the lowest Medicaid reimbursement structures in the country for community-based healthcare services Medicaid-to-Medicare Fee Index | KFF, which in turn led to a significant increase in health care services that had to be provided in emergent care settings as opportunities to manage chronic conditions were lost. The reality is that physicians cannot maintain a viable practice, including paying staff, investing in needed medical equipment and paying other significant overhead costs, treating a significant number of Medicaid patients.

In this regard, we applaud the Hochul Administration for seeking to reverse this trend by providing target increases for office-based Medicaid visits in the previous Budget cycles, from 60% of the Medicare fee schedule to 80% of the Medicare fee schedule. This is still far short of what practices need to receive in order to pay their rising overhead expenses and pay their staff, particularly as Medicare has continued to be cut, in real dollars not just inflation, by CMS and Congress over the last several years. However, in conjunction with these targeted increases, this latest proposal to bring up these currently abysmal rates is a positive step towards helping to ensure patients have access to needed community-based physician care, and to help manage chronic conditions before they manifest themselves in a way that will require acute care in settings such as hospital emergency departments.

We also urge that Medicaid Managed Care (MMC) plans be required to reimburse its network physicians at least at the level that is required under the Medicaid fee for service (FFS) fee schedule. When in the past MSSNY has urged DOH to require that Medicaid FFS payments increases contained in prior State Budgets to be applicable to MMC plans, the DOH has advised that step was not necessary because MMC plans' payments are already at or above the level of Medicaid FFS. However, we are aware of at least one MMC plan that recently sent out a notice to some of its network physicians that it was planning to drastically cut its payments to below the Medicaid fee schedule. These cuts are completely untenable and if implemented across a broad spectrum would force many small community-based primary care practices to close.

In addition to reimbursement increases, we are also urging the Hochul Administration to work towards addressing the pervasive delays brought our attention in approving physicians and other care providers to be approved to participate in Medicaid, as this process often takes months to complete, delaying the ability of patients to be treated by these physicians awaiting approval, and/or making it impossible to be paid fairly for provided care needed by patients.

3) <u>Support Efforts to Address Problematic Financial Consent Requirements</u>

We appreciate that the proposed Budget contains a measure in Part L of the Health Budget bill that seeks to address the extremely challenging requirement contained in last year's State Budget that requires physicians and other care providers to obtain a separate "consent for payment" from patients AFTER needed health care services are delivered. We applaud the NYS Department of Health for putting this law "on hold" in an October 18 "Dear Administrator" Letter, following a significant amount of advocacy to DOH by MSSNY and several specialty societies together with countless physicians across the State raising concerns about the problems of implementing such a law. We also thank the many legislators who voiced their concerns about this new law.

It must be understood the myriad of logistical challenges associated with requesting a patient exiting a medical office or hospital to stop to sign a document after they have received needed health care treatment. That is one reason why, historically, consents and other paperwork have been requested of the patient as they enter the medical office, or before they even arrive at the medical office. Furthermore, once the patient leaves the medical care setting, it is often very difficult to secure the completion of the needed paperwork by the patient.

Moreover, this new requirement appears to be in conflict with existing state and federal laws requiring disclosure of professional fees PRIOR TO patient services being delivered. Health care professionals are already required under the Public Health Law and the federal No Surprises Act to provide information to patients regarding charges for service prior to

the provision of non-emergency services, and it is unclear how these requirements can both be followed. We note that the "Provider Rights and Responsibilities" section of the NYS Department of Financial Services website Health Care Provider Rights and Responsibilities | Department of Financial Services (ny.gov) contains the following information

> ***Cost of Services.*** *That the amount or estimated amount that the health care professional will bill the patient for health care services is available upon request if the health care professional does not participate with a patient's or prospective patient's health plan. Health care professionals are required to provide this information to patients prior to the provision of non-emergency services. Upon receipt of a request from a patient or prospective patient, the healthcare professional is required to disclose to the patient or prospective patient in writing the amount or estimated amount that will be billed for health care services provided or anticipated to be provided absent unforeseen medical circumstances. With respect to a health center, this may be provided in the form of a schedule of fees provided under 42 USC §254b(k)(3)(G)(i).*

Adding to this challenge of this new law is that it is unclear from the statute which cohort of patients for whom these requirements are applicable. As challenging as it will be to implement this requirement for self-pay patients, it will be even more challenging when patients are insured, as most payors such as Medicare, NYSHIP and commercial health insurance require the physician to bill the patient for cost-sharing responsibilities that are not paid by the patient's health insurance plan. If the patient fails to sign the payment consent, would that mean that the health care professional cannot bill the patient for the applicable co-pay or deductible? That would be grossly unfair, and potentially place the physician at risk for fraud accusations.

The collective weight of each of these challenges associated with implementation of this law substantially increases the risk of non-payment for necessary care that is not fully covered by the patient's health insurance. Unlike Article 28 facilities, there is no Bad Debt and Charity Care pool for private physician offices for uncollected payments for necessary medical care. In this regard, we appreciate the Governor's effort to make targeted revisions to this law to enable the consent for payment to be provided prior to, not after, the delivery of health care services. If such changes are not made, it could have a serious adverse impact on the ability of community-based physicians to maintain their staff or even to remain in practice to continue to deliver the care expected and deserved by our patients.

4) **Oppose Imposition of Costs of Excess Medical Liability Program on Covered Physicians**

We are strongly opposed to a proposal within Part G of the Health/Mental Hygiene Article 7 bill that would require the nearly 16,000 physicians currently enrolled in the Excess Medical Malpractice Insurance program to bear 50% of the cost of these policies. This proposal has been advanced in multiple previous Executive Budgets but thankfully has been rejected by the State Legislature because of its adverse impact not only on physicians, but for the patients who are the ultimate beneficiaries of this program. We urge the Legislature to again reject this proposal and protect needed patient access to primary and specialty-based physician care.

This incredibly short-sighted proposal would thrust nearly $40 million of new costs on the backs of our community-based physicians who served on the front lines of responding to the pandemic. Many of these physicians are struggling to stay in practice to deliver needed care, at a time when physicians already face staggeringly high liability premiums that have gone up by nearly 12% in the last 3 years and face continuing cuts in reimbursement from Medicare and other payors.

The unconscionable cost imposition will most acutely impact those specialty physicians where we are already seeing physician shortages, including reproductive healthcare services, emergency care and surgical services.

Many of these physicians will have no choice but to move to other states with more favorable practice environments. Many others may forego the coverage in order to avoid the thousands to tens of thousands of dollars of new costs, *per physician,* this Budget proposal would impose.

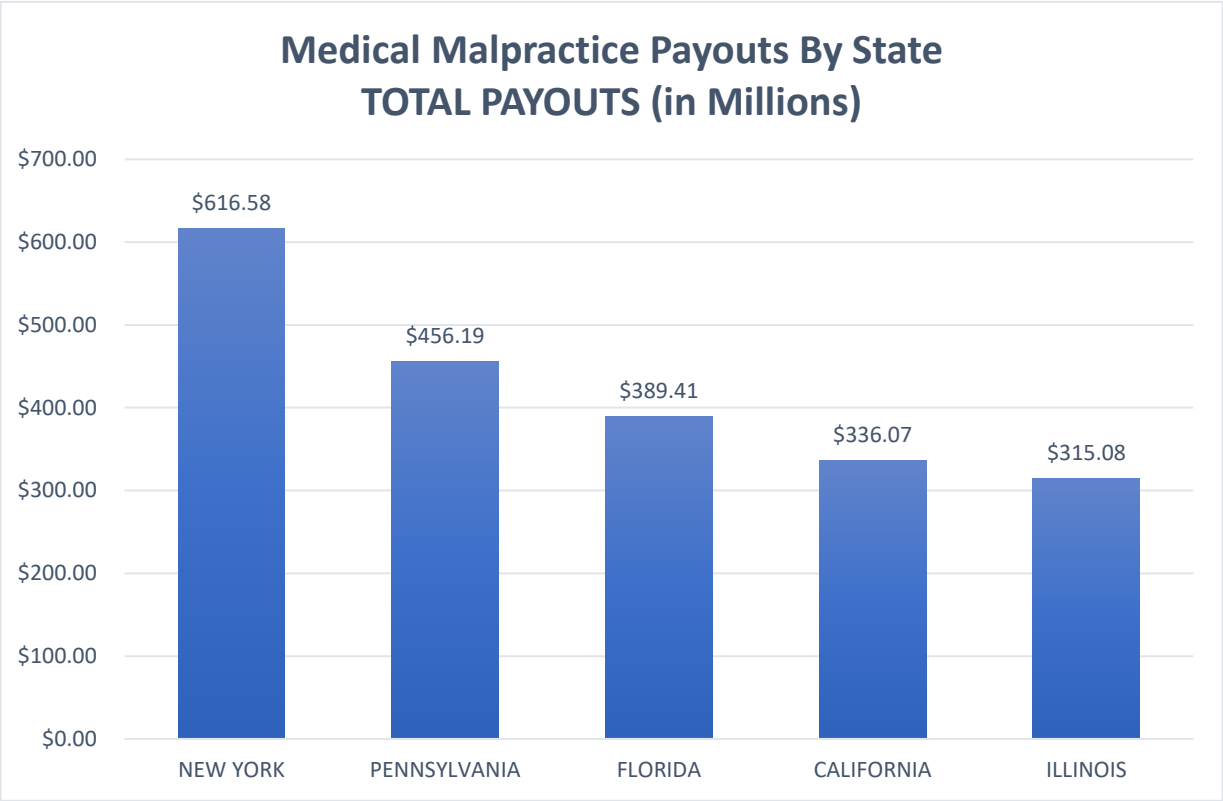
ESTIMATED NEW COSTS TO BE IMPOSED ON PHYSICIANS FOR EXCESS COVERAGE BASED UPON GOVERNOR'S 50% COST BUDGET PROPOSAL

SPECIALTY	Long Island	Bronx, Staten Island	Brooklyn, Queens	Westchester, Orange, Manhattan
ER	$5,554	$6,446	$6,024	$4,199
Cardiac Surgery	$3,848	$4,466	$4,173	$2,909
OB-GYN	$17,071	$19,813	$18,516	$12,916
Neurosurgery	$28,796	$33,423	$31,233	$21,771

Based on 2023-24 MLMIC Excess Policy rates

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 on for all their professional lives could be lost because 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. While many other states have passed laws to contain medical liability payouts and provide greater fairness in medical liability litigation, New York has not, which is why our medical liability insurance and payout costs far exceed every other state in the country. In fact, in 2023 New York exceeded the 2d highest state Pennsylvania by 35%, the third highest state Florida by 58%, and 4th highest state California by 83%! For these reasons, New York is regularly ranked worst among states in the country for physicians to practice medicine.



Absent comprehensive liability reform to bring down New York's grossly disproportionate medical liability costs, maintaining an adequately funded Excess Medical Malpractice Insurance Program is essential to maintaining some availability of skilled physician care in New York. We urge you to reject this proposal, and work for the enactment of measures that will help to reduce these overwhelming costs that are interfering with patient access to needed care.

5) **Oppose Eliminating Right of Physicians to Appeal Medicaid Managed Care Underpayments**

We **strongly oppose** a proposal within Part E of the Executive Budget Health & Mental Hygiene bill that would eliminate the right of physicians to bring a claim dispute to the Independent Dispute Resolution (IDR) process for various public health insurance plans. We thank the Senate and Assembly for rejecting a similar proposal in last year's Executive Budget and urge you to do so again.

We are very concerned with the serious adverse impact that this change will have on patients' access to skilled specialty physician care, including access to needed and often immediate surgical care in hospitals across the State. In implementing New York's successful surprise billing law, policymakers have regularly sought to ensure access to a fair dispute resolution process to resolve payment disputes that does not favor either physicians or health insurers. Without the ability to access this appeal process, physicians will be forced to accept absurdly low Medicaid payment rates that do not even come close to covering physicians' rapidly rising overhead costs. As noted above, New York notoriously has among the lowest Medicaid physician payment rates in the country Medicaid-to-Medicare Fee Index | KFF.

This, in turn, will likely discourage many physician specialists from providing essential on-call emergency department care, at a time when many such departments are already frequently understaffed and have insufficient on-call coverage. Even worse, this change

will encourage these Medicaid Managed Care plans to significantly cut payments for all of their network-participating physicians, endangering access to care for their enrollees and further threatening the viability of many community-based physician practices. There have been other circumstances where the loss of access to appeal claims through the IDR process leads to health insurers cutting payments precipitously and narrowing their networks. The end result is that many of these physician practices will be forced to seek private equity backing simply to stay afloat, or will be forced to shutter their practices altogether and move to other states.

The relatively small State Budget savings of this proposal is significantly outweighed by the significant risk that this change would have on patient access to urgently needed skilled physician care. We urge that this proposal be rejected as part of adopting a final State Budget for the 2025-26 Fiscal Year.

6) **Oppose Eliminating Role of County Medical Societies to Review Workers Compensation Participation**

We urge you to oppose a proposal contained within Part BB of the Executive Budget Public Protection and General Government bill that would eliminate the historical review role that county medical societies have played in recommending physicians to participate in New York's Workers' Compensation program.

We appreciate the goal of this proposal to ease the burdens associated with participation in the Workers' Compensation program. However, this proposal does not address the fundamental challenges that have resulted in limited physician participation in this program. The issue is not the application process but instead the often-challenging process for obtaining approvals for patient care, excessive patient record submission and other administrative requirements, as well as the significant challenges in navigating the burdensome process to be fairly paid after services have been delivered to injured workers. There are numerous claim appeals, hearings, depositions and paperwork. It can take months or even years to receive payment for care that was appropriately delivered to injured workers.

Even more frustrating is that a Board decision setting forth a carrier's responsibility for making payment does not necessarily even mean that payment will actually be made to the physician providing care. Certain payors, particularly municipal entity payors, regularly fail to make payments that have been adjudicated to be due to physicians, as a result of the lack of a meaningful enforcement mechanism and appropriate penalty against these payors.

The fact of the matter is that this Executive Budget proposal does not address these concerns, which impose barriers to timely care, in a meaningful manner.

It is also important to note that county medical societies provide an important review function in ensuring qualified physicians are participating in this essential program, which includes ensuring that the applications submitted by physicians to the Workers' Compensation Board are complete. The No-Fault program, which does not have a process for the approval of participating providers, has witnessed significant allegations of fraud and abuse in the program. One such reason may be the lack of a proper vetting process for participation in that program that currently exists for Workers' Compensation but under this proposal would be eliminated. Moreover, most forms of insurance coverage, whether it be Medicare, Medicaid or commercial health insurance require a vetting process for provider participation to help ensure that patients accessing care under that program are being treated by quality providers.

Of perhaps greatest concern, permitting every physician to participate in the Workers' Compensation program by virtue of their license could impede the processing of claims by injured workers because many of these physicians may not have the deep knowledge of the Workers' Compensation treatment guideline and claim process that participating physicians must have. Having physicians poorly vetted or less knowledgeable of workers' compensation process provide care could potentially jeopardize an injured worker's legitimate claim under workers' compensation laws.

It is essential that we find solutions to the systematic challenges that deter physician participation in the Workers' Compensation program. We do support another Executive Budget measure to require an injured worker's health insurance plan to cover the costs of the patient's care if the WC carrier controverts the claim. However, eliminating the important review role played by county medical societies in the vetting process for participation does not address these challenges, and may have the effect of endangering care for injured workers.

Therefore, we respectfully request that this provision be opposed and be removed from the State Budget.

7) <u>Oppose Eliminating Important Oversight Provided by Physicians Over the Care Provided by Physician Assistants</u>

As we talk about steps to ensure that patients have access to needed care, we believe that top of the list or policymakers should be addressing the challenges to retaining and attracting physicians to practicing in New York, and not with proposals that seek to replace physicians with non-physicians through expansion of these practitioners' scope of practice. In this regard, we have strong concerns with the proposal in Part V the Health Budget bill that would permit many physician assistants to practice without physician supervision or collaboration. Our concerns with these proposals are exacerbated because of our above-stated concerns with those proposals that will have the effect of reducing the availability of physicians to deliver care in New York State.

We thank the Legislature for rejecting this proposal in the previous 2 years State Budget and urge you to do so again.

We applaud the essential role provided by advanced care practitioners in filling in gaps to meet our care delivery demands, but patients are served best by having a physician providing oversight over delivery. In fact, surveys on patient sentiment report that 95% of patients believe it is important that a physician be involved with their diagnosis and treatment decisions, and that 91% say that a physician's education and training are vital for optimal care.

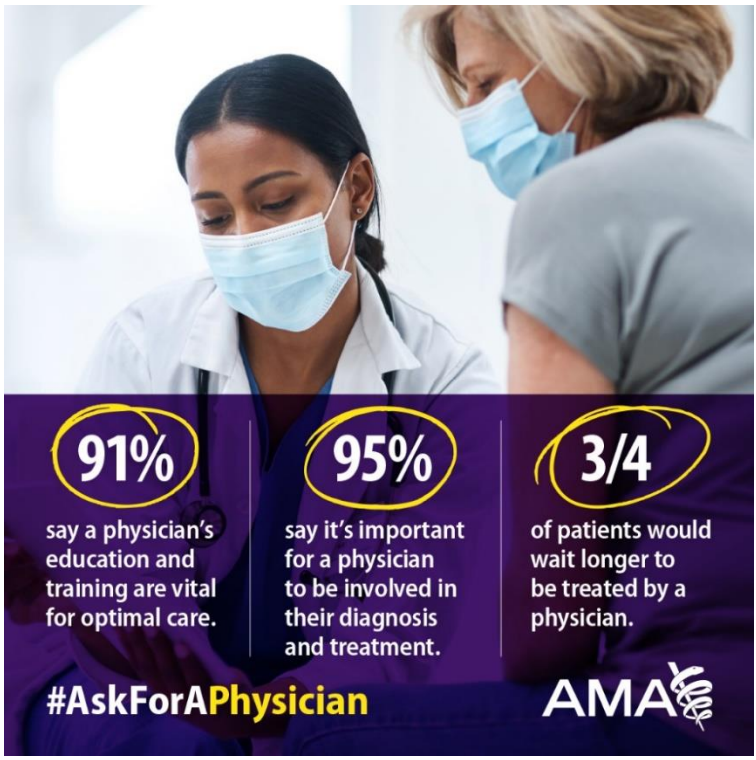
The solution to the physician shortage challenges we face is to make New York a more welcoming environment for physicians to deliver care, not expanding services provided by non-physician providers. In addition to state measures, there are number of federal proposals that would expand physician availability in New York, including legislation to increase our residency slots and legislation to permit New York to avail itself of Conrad-30 waivers used by other states.

Training. It is impossible to overstate the importance of a physician's comprehensive education and training to ensure quality patient care**.** Most physicians must complete 4 years of medical school plus 3-7 years of residency and fellowships, including 10,000-

16,000 hours of clinical training before they are permitted to treat patients independently. During this training physicians receive approximately 5,000 hours of clinical experience in medical school, 4,000 hours of clinical experience in internship, and 6,000 to 18,000 clinical hours during specialty training. Various milestones must be met as part of this training to help these young physicians learn to differentiate among the many possible diagnoses for any possible patient condition. This training is unlike any other healthcare provider, including PAs and NPs. This extensive training makes physicians best suited to deliver and coordinate needed primary and specialized patient care, which cannot be replaced by a non-physician.

***The Cost-Effectiveness of Physician-Led Team Care*.** A recent AMA study finds that when non-physicians are permitted to practice independently, the difference in training results in increased health care costs and patient safety risks. An examination of 10 years of cost data on 33,000 patients by the South Mississippi system's Accountable Care Organization of physicians and independently practicing PAs and NPs found that NPs and PAs ordered more tests and referred more patients to specialists and hospital emergency departments than physicians. Moreover, the data also showed that physicians performed better on nearly all quality measures.

Moreover, another study reported that NPs delivering emergency care without physician supervision or collaboration in the Veterans Health Administration (VHA) increase lengths of stay by 11% and raise 30-day preventable hospitalizations by 20% compared with emergency physicians. Yet another study in the *Journal of the American College of Radiology* analyzing skeletal x-ray utilization for Medicare beneficiaries over 12 years found ordering increased substantially – more than 400% by non-physicians, primarily NPs and PAs during this period.



We further note that last year the State Legislature and Governor enacted legislation to expand regulatory flexibility by increasing the number of PAs a physician may supervise and increasing the types of services PAs can provide and coordinate, including permitting them to initiate 12 different types of standing orders with nurses that currently may only be initiated by nurse practitioners, and making orders for durable medical equipment. The PA society's own communications lauded the new law as a modernization of PA practice in New York State and how it will enhance patient access to care in underserved communities.

This newly enacted law, which does not even go into effect until mid-February, should be evaluated for its effectiveness and impact on patient access and patient safety before enacting more expansive measures for independent PA practice such as those proposed in the State Budget.

Moreover, it is imperative that the public have detailed information regarding the various health care providers from whom they are or are considering receiving treatment. To that end, MSSNY supports "Truth in Advertising" legislation that would ensure that all health

care providers be required to conspicuously identify their type of state license when treating patients in all health care settings, as well as in their advertisements to the public. It would also ensure that various non-physician health care professionals that identify themselves as being a doctor also identify to patients that they are not "physicians".

However, we strongly oppose legislation that would create health care silos and remove the important oversight provided by a trained physician in delivering patient care, including through removing important supervision of care provided by physician assistants and other care providers. Therefore, we urge that this proposal be removed from the State Budget.

8) **Oppose Repeal of "Prescriber Prevails", Preventing Imposition of New Prior Authorization Hassles**

We urge you to reject the proposal in Part I of the Health Budget bill to repeal the authority of physicians and other 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 thank you the Legislature for your efforts in previous years to reject this proposal and urge that you do so again.

Repealing this critical patient protection would jeopardize patient care as well as undercut initiatives the State has undertaken to reduce unnecessary and avoidable hospitalizations. 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. We thank the Senate and Assembly for standing up for patients and rejecting this proposed change in previous budget years and urge you to do so again.

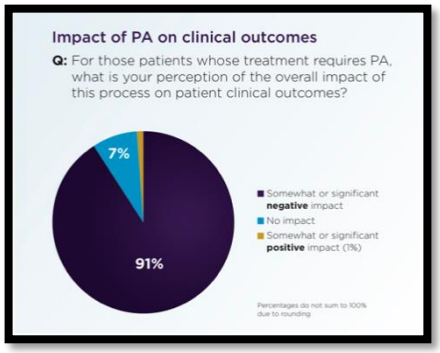
The proposed repeal of the longstanding prescriber prevails provision is particularly troublesome as the pharmacy benefit for those enrolled in mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARPs), and HIV-Special Needs (SNPs) recently returned to fee-for-service as part of the NYRx program.

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. Given the well documented dynamic that these time-consuming administrative hassles are contributing significantly to the problem of clinician "burnout," this proposal would only exacerbate this problem at the worst possible time. 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.

Furthermore, this proposal is completely at odds with the need to counteract pervasive payor-imposed, excessive administrative barriers interfering with patient care delivery. According to a recent American Medical Association (AMA) survey, 93% of physicians surveyed, reported care delays because of payor imposed prior authorization (PA) requirements, while 82% said that PA can lead to patients abandoning their treatments. Moreover, 91% reported that excessive PA burdens have had a negative impact on clinical outcomes, while 88% reported the burden as high, or extremely high.

Aggravating this problem is that health insurers often use insufficiently trained health care providers to review PA requests and other claim submissions. A recent MSSNY survey showed that 86% of responding physicians indicated that they had a PA or claim

submission denied by a health plan reviewer that was not a physician trained in the same or similar specialty as the physician providing the recommended patient care.



Of greatest importance, we believe any projected savings based on the repeal of "prescriber prevails" would be dwarfed by the health care complications likely to arise as a result of individuals not being able to access the medications they need to remain healthy in the community. For many physical and mental health illnesses and conditions 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 important that once made the decision is respected to preserve continuity of care and enhance treatment adherence.

For all these reasons, it is imperative the prescriber prevails authority be maintained as it is an important safety net for our most vulnerable often battling multiple comorbidities. We urge the Legislature to again reject this proposed change.

9) Oppose Permitting Psychiatric NPs to Certify for Involuntary Commitment

MSSNY shares the serious concerns identified by the New York State Psychiatric Association with Section 3 of Part EE of the Health Budget Bill which would amend the Mental Hygiene Law to authorize psychiatric nurse practitioners, in addition to physicians, to complete the requisite certificate for involuntary commitment.

The professional responsibilities and procedures set forth in Article 9 of the Mental Hygiene Law are currently carefully crafted to balance the interest of the public with the fundamental loss of liberty for the person who would be involuntary confined. By granting equal status to two professions which are not equal in the eyes of the Education Law, it may provide new grounds for a legal challenge to the state civil commitment laws that have been upheld by previous court decisions. The gravity of the proposed change cannot be understated as an individual committed individual can be held for up to 60 days, and for more than 60 days upon court order if the standard for involuntary commitment continues to be met.

The law currently provides for flexibility by authorizing the certificates to be completed by physicians who do not have to be psychiatrists to initiate the process and subsequent confirmation examination by a staff psychiatrist. There has been no data or evidence presented to support the proposed change to New York's involuntary treatment law requirements.

The law has been carefully crafted over the years to require that these decisions be made by those with the highest level of education and medical training as the process involves complex medical, clinical (medication management and treatment planning), and legal determinations that profoundly impact individuals' lives and liberty. Allowing non-physicians to take on this critical role raises concerns regarding the credibility of the certifications, which may be subject to judicial scrutiny depending on lengths of stay and continued need for treatment. Physicians/Psychiatrists can be cross-examined by Mental Hygiene Legal Services about specific aspects of the comprehensive treatment plan such as the type of medication used, side effects and mitigation of such effects, and other aspects of clinical treatment that psychiatric nurse practitioners would not be qualified to respond based on their education and training.

While some have asserted this change is necessary to address situations where hospitals lack coverage by physicians or psychiatrists to handle admissions, these arguments fail to account that virtual hearings are now permitted and its use could be expanded, which would enable physicians/psychiatrists to participate remotely while remaining at the hospital to provide continued coverage for other inpatient psychiatric admissions.

We urge that this proposal be removed from the State Budget.

10) Support for Medical Assistants to Administer Immunizations

MSSNY supports the proposal to permit immunizations by medical assistants when supervised by physicians. Finding nurses is often a challenge for primary care and pediatric practices, and particularly in the rural and underserved regions of this state, so this proposal would assist these busy practices in meeting the demand.

11) Support Legislative Addition of New Funding for the Veterans' Mental Health Training Initiative (VMHTI) Program

MSSNY, together with the New York State Psychiatric Association (NYSPA), and the New York State Chapter of the National Association of Social Workers (NASW-NYS), are urging you to support funding in the 2025-26 New York State budget for the continuation and expansion of the comprehensive statewide training program, known as the Veterans Mental Health Training Initiative (VMHTI). The program educates both community mental healthcare providers and primary care healthcare physicians and specialists on veterans-specific mental health issues including combat and service-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.

We would like to thank Senators Brouk and Scarcella-Stanton for championing this program for the last several years.

For over a decade, the VMHTI has worked hand in glove with the Joseph P Dwyer Peer to Peer Program, an endeavor that continues as the peer program expands to additional counties. 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: one led by the NASW-NYS, providing an accredited education and training program for community mental health workers, and one led by NYSPA and MSSNY training primary care physicians and health practitioners from across the primary care specialties, including internal medicine, family practice, emergency medicine and OB-GYN. The training programs are also of benefit to psychiatrists whose practices have seen a dramatic influx of combat and service-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 in 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 5,900 primary care physicians and practitioners through the NYSPA & MSSNY programs, and over 15,000 social workers and community mental health providers.

The need for continued support is more critical than ever in light of 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. The New York Health Foundation's Data Snapshot: Veteran Suicide in New York State 2022 Update released in January 2025 finds veterans in New York State die by suicide at a rate nearly twice as high compared to civilians. Alarmingly, the use of firearms in veteran suicides rose from 50% in 2021 to 56% in 2022. The data report states, "Nationally, firearm usage in suicides among veterans increased by 1.3% between 2021 and 2022. By contrast, New York had a significant increased – 12.4% -- in firearm modality among veterans."

The VMHTI has also 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.

Continued support of the VMHTI in the FY 2025-26 state budget remains essential as the US Department of Veterans Affairs launched a new initiative to allow veterans in crisis to obtain care in practices and facilities outside of the VA. While this initiative will increase access to services, it will place an even greater reliance on private practices and community mental health practitioners for services not provided by the VA or when the VA is unable to meet the demand. For the above reasons, NYSPA, MSSNY and NASW-NYS urge the final budget for 2025-26 include the $350,000 appropriation for the VMHTI.

12) Support Additional Funding for 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 areas of need across New York State that lack capacity to meet community needs by providing funding in exchange for loan repayment and practice support. Since then, DANY has become a valued tool in the recruitment and retention of physicians in underserved areas across the state.

In 2022, the legislature approved an increase in funding from $9M to nearly $16M 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. MSSNY strongly supports Governor Hochul's proposed continuation of this important program in her budget for FY2026. Given the need to enhance efforts to retain physicians in New York State, particularly in underserved areas, MSSNY supports increasing the allocation of funding for this program to increase the number of recipients.

Conclusion

Thank you again for the opportunity to express MSSNY's perspective on behalf of the 20,000 physicians we represent. Again, there are numerous Budget provisions that

MSSNY supports that would expand the ability of patients to receive needed care. However, there are numerous concerning items that will reduce patient access to community-based physician care, and remove important oversight and collaboration provided by physicians that better ensures patient safety. Policymakers must prioritize expanding access to skilled primary and specialty care physicians instead of imperfect solutions that seek to replace them.

I would be happy to answer any questions you may have.