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 2021-2022

Good afternoon. My name is Dr. Bonnie Litvack. I am the Director of Women's Imaging at Northern Westchester Hospital 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.

The Covid-19 pandemic crisis which we are still continuing to confront has tested New Yorkers and New York's healthcare system like never before. Physicians and other health care workers, particularly early in the crisis, witnessed a scale of patient suffering they thought only existed in history books. To manage the often-unending flow of patients, physicians were often asked to perform services not within their usual training. Moreover, physicians and other health care workers put their life and health - as well as their families' - at risk.

"Burnout" due to excessive administrative burdens was a growing problem for physicians before Covid that was exacerbated by the pandemic. A recent study from the American Medical Association of over 10,000 physicians found that 52% reported at least some symptoms of burnout, and 16% of all respondents reported having persistent symptoms of burnout that won't go away.

In addition to the mental health challenges of dealing with the personal and professional challenges of the pandemic, countless physicians also continue to face significant financial challenges arising from it. As a result of the huge drop in patient visits that arose from the need for social distancing, a Fair Health study concluded – similar to a MSSNY survey – that patient visits dropped by as much as 80% this past spring. Many physicians received some stimulus payments from the federal government, but these only offset a fraction of what was lost. Indeed, 85% of respondents to a MSSNY survey reported that stimulus funds offset less than half of their losses. 40% of physician respondents had to lay off at least 10% of their staff.

Even now, due to limitations on elective procedures, reduced trips out of the home, and limited supplies of PPE, patient visits remain far below usual numbers.

Moreover access to suitable and affordable PPE was and remains a problem for community-based physician practices. A recent MSSNY survey found that 72% of the

physician respondents said that there was still difficulty in securing PPE. Even where it is available, there have been huge jumps in cost, with nearly 40% of the respondents indicating that their PPE costs have gone up by more than 50%. Meanwhile, in states such as California, their state governments have aggressively worked to provide community-based physician practices with PPE to ensure that these shortages do not adversely impact patient care. MSSNY's survey also showed that nearly one third of the responding physicians indicated that delays in obtaining PPE and huge price jumps forced these physicians to reduce their patient treatment capacity by at least 25%.

Despite all these enormous challenges facing New York's dedicated physicians, this year's Executive Budget contains numerous problematic provisions that will adversely impact the ability of physicians to continue to provide needed care their patients. While there are modestly positive measures contained in the Budget, such as PBM reform and enhanced availability of PPE, the concerning provisions far outweigh the positive ones. 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 2021-22 Fiscal Year.

1) OPPOSITION TO IMPOSING COSTS OF EXCESS PROGRAM ON COVERED PHYSICIANS

We are strongly opposed to a proposal contained in Part K of the Health/Mental Hygiene Article 7 bill that would require the 16,000 physicians currently enrolled in the Excess Medical Malpractice Insurance program to bear 50% of the cost of these policies. This proposal was advanced during last year's Budget negotiations, but was rejected by the State Legislature in adopting the final Budget for FY 2020-21

This incredibly short-sighted proposal would thrust over $50 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 would hit these practices at a time when many of these practices are already facing huge losses 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. Moreover, physician capacity to treat patients was and continues to be significantly reduced due to reduced quantities of personal protective equipment (PPE) for themselves and their staffs.

As noted in the below chart, it would impose thousands to tens of thousands of new costs on physicians at the worst possible time.

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	$5,653	$6,561	$6,118	$4,500
Cardiac Surgery	$4,482	$5,202	$4,862	$3,567
OB-GYN	$20,881	$24,235	$22,648	$16,617

Neurosurgery	$35,222	$40,879	$38,202	$28,030

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 as a result of the liability insurance crisis of the mid-1980's to address concerns among physicians that their liability exposure far exceeded available coverage limitations. They legitimately feared that everything they had worked for all of their professional lives could be lost as a result of one wildly aberrant jury verdict.

This fear continues 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 do 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, this proposal has also been regularly rejected by the State Legislature and we have no reason to believe it will meet any greater favorability 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. As noted above, 85% of respondents to a MSSNY survey 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. As a result, physicians averaged a 32% drop in revenue since February 2019, with about one in five doctors seeing revenue drop by 50% or more and nearly 1/3 seeing a 25%-49% decrease.

If last year was a terrible time to adopt this proposal, this year would be even worse. In fact, these new costs 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.

2) OPPOSE UNFAIR DISRUPTION OF PHYSICIAN DUE PROCESS IN DISCIPLINARY PROCEEDINGS

We are also strongly opposed to the Budget proposal that would essentially strip physicians of important due process rights when a complaint has been filed with the Office of Professional Medical Conduct. We agree with the importance of acting quickly when it is imperative, but these proposals would completely undermine important and longstanding due process protections. Given that most complaints are dismissed without any sanction or action, this series of proposed changes to bypass these rights would create a substantial possibility of unfairly destroying an innocent physician's career.

While New York's physicians share the goal of assuring the State has ample power to protect the public when the conduct of a particular health care provider places patients at risk, the Commissioner already has ample power to take summary action prior to the conclusion of a disciplinary hearing in the absence of a finding of misconduct. Therefore, we respectfully urge that these provisions be rejected from the Budget.

To begin with, let us state at the outset our agreement with the goal of this proposal to ensure that New York's disciplinary process moves swiftly when necessary to remove those from practice that present a serious threat to the public. Indeed, one aberrant health care professional reflects poorly on the entire profession.

To that end, we have for many years worked proactively with the Administration and Legislature on laws to enhance the ability of the Office of Professional Medical Conduct (OPMC) to "summarily suspend" physicians in instances where it would be imprudent to wait for a final action. We also understand the need for further targeted improvements to this system as issues arise where it has been reasonably demonstrated that the existing processes prevent OPMC from achieving its mission to protect the public.

However, these laws have long recognized the need for an appropriate balance. There are enormous adverse professional implications when disciplinary action is taken against a physician, or even when there has been an accusation, including loss of reputation and the risk of being dropped by Medicaid and other insurers. With Google, Yahoo and other search functions, an unproven allegation released to the public could linger forever in cyberspace, and permanently and unfairly scar a reputation. Worse, we worry about the crippling impact that making accusations public would have on the trusted relationship physicians have with their patients, creating mistrust and fear.

It is important to remember that an accusation does not prove wrongdoing. Of note, most complaints to OPMC of alleged misconduct do not become actual findings of misconduct. Indeed, most complaints to OPMC do not even get so far as advancing to a formal Investigation Committee review. According to the 2018 OPMC Annual report, while over 9,000 complaints were received by OPMC, and 8,782 complaints closed, only 210 cases resulted in the filing of actual charges. **This is 2% of filed complaints that ended in actual charges.** As noted below, these numbers are similar to previous years. Given the significant disparity between the number of complaints and the number of cases where there is ultimately some finding of misconduct, it is imperative we limit the bypassing of these important due process protections to circumstances when it is clear that the delay of going through these procedures threatens the safety of the public. A subjective assessment that a physician may be a "risk", as this legislation would propose, should not be enough to merit bypassing these long-standing due process protections.

PHYSICIAN DISCIPLINARY COMPLAINTS AND DISPOSITION

YEAR	COMPLAINTS TO OPMC	CLOSED COMPLAINTS	CASES REFERRED FOR CHARGES
2018	9,014	8,782	210
2017	9,722	10,161	238
2016	10,241	10,095	310
2015	8,787	8,896	326
2014	7,957	8,283	223

Furthermore, Public Health Law Section 230 (12)(a) already grants power to the Department of Health to summarily suspend a physician from medical practice without an otherwise required hearing and pre-hearing where there is a "determination that a licensee is causing, engaging in or maintaining a condition or activity which in the commissioner's opinion constitutes an imminent danger to the health of the people. This power was then expanded through a 2018 law that gives the Commissioner the power to summarily suspend a physician's license if they have been accused (not convicted) of a felony charge and, in the commissioner's opinion, the physician's "alleged conduct constitutes an imminent danger to the health of the people".

Regarding making charges public, PHL Section 10 (a) (iv) already provides for the ability of the Commissioner of Health to make charges against a physician public once it is determined that there is enough evidence to warrant a formal hearing. Since there are still a relatively small number of cases each year that get so far as having formal charges brought, it is completely unfair to enable the release of enormously prejudicial information with little if any review process to determine that even formal charges are warranted. Again, the inappropriate disclosing that a physician has had a complaint filed against them could destroy that physician's career, even if no action is ultimately taken against that physician.

In summary, it is our estimation that this proposal goes far beyond where it needs to go to protect the public from aberrant health care practitioners. We welcome discussions to improve our disciplinary system to address gaps to help protect the public. However, these proposed changes are startling. It will take away long-standing due process

protections and holds the risk to unfairly destroy professional reputations and the trusted patient-physician relationship so essential for providing high quality care. Therefore, we urge that this proposal be rejected.

3) OPPOSE CUTS TO FUNDING FOR THE COMMITTEE FOR PHYSICIANS' HEALTH (CPH)

We are extremely concerned with the consequences of the proposed cut in the Executive Budget of 20% or $200,000 to MSSNY's Committee for Physicians Health (CPH) Program. CPH is established by state statute (Public Health Law Section 230 – re-authorized by the Legislature every 5 years) to enable MSSNY to maintain a program to confront and refer to treatment physicians suffering from alcoholism, chemical dependency or mental illness. MSSNY contracts with the OPMC to provide the services required by law. The program is funded not from a tax but by a $30 surcharge on the physician's license and biennial registration fee, which is specifically dedicated under Education Law Section 652 (9) for this purpose.

Since the inception of this MSSNY program, CPH has assisted over 7,000 physicians, routinely monitors the recovery of 450 physicians, and annually reaches out to 175 physicians thought to be suffering from alcoholism, drug abuse or mental illness. We believe that the work of the CPH program is valuable to all physicians and indeed to the state generally. We urge that the Legislature adopt the language to make this program permanent. We also ask that the appropriation of $990,000 be fully restored

Many of these conditions treated through the CPH program have been exacerbated by the pandemic, making 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. If these cuts were to go through, it would substantially limit the work CPH can provide for physicians – and indirectly the public at large – at a time when the program is needed more than ever.

We urge you as strongly as possible to restore the full funding for this absolutely essential program.

4) STONG OPPOSITION TO CHANGES TO PHARMACY SCOPE OF PRACTICE

We are strongly opposed to several proposals contained in the Governor's proposed State Budget (Part P of the Health/Mental Hygiene Article 7 bill) that may jeopardize patient care by greatly expanding the scope of services provided by pharmacists. 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 2021-22.**

Specifically, these Budget proposals would 1) permit pharmacists to order various lab tests without oversight and without any requirement to coordinate with the patient's physician for follow-up care; 2) exponentially expand the existing physician-pharmacist Collaborative Drug Therapy Program to enable pharmacists to adjust and prescribe the medications provided to entire classes of patients rather than individual patients and 3) eliminate the State Legislature discretion to decide which additional immunizations can be provided by pharmacists by permitting pharmacists the power to administer any vaccination approved by the federal Advisory Commission on Immunization Practices (ACIP), including those that may be added in the future.

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.

The proposal to change the collaborative drug therapy program would endanger patient care by removing the existing statutory requirement that the patient drug management protocols be specific to each patient, and instead enable practitioners to enter into arrangements with pharmacists to manage medications for large numbers of patients on a non-individualized patient basis. It also appears to even remove the requirement for patients to have to consent to have their medications be adjusted by pharmacists under these collaborative models after an initial prescription by a physician. Even more alarming is proposed language that would change state law to define the adjustment of a prescription written by a physician as a "prescription" by the pharmacist – an enormous precedential change. We also object to the inclusion of nurse practitioners as a professional who can enter into such an arrangement without any specification as to the types of conditions that could be subject to such a protocol.

While we support the current existing program that has been in effect for several years that recognizes the uniqueness of each patient in establishing the collaborative drug management protocol, the Budget proposal would give pharmacists enormous new powers to adjust a physician's prescription. Recognizing that the existing program between physician and pharmacists has been successful, MSSNY has suggested that it could be expanded in a more narrowly tailored manner to enable physicians and pharmacists to enter into these protocols for managing the care of patients outside of a hospital or other Article 28 setting, provided there remain tight guardrails on the program, the patient maintains the ability to consent, and it is limited to a defined number of medical conditions. However, we are very concerned that the current proposal jeopardizes patient care in expanding this program in such an enormous manner.

We are also very concerned with the proposal to eliminate the discretion of the State Legislature to add additional vaccinations to the list of those that can be administered by a pharmacist, and rely instead upon a federal workgroup to make such determinations. This would have the effect of immediately increasing from 8 to 17 the number of vaccinations pharmacists can administer, a number which could increase even further based upon future vaccinations approved by this federal workgroup. Again, this proposal removes the discretion of the Legislature to add additional immunizations as circumstances and patient safety considerations warrant. Moreover, we are very concerned that this proposal would cause further fragmentation of care delivery and is not conducive with the concept of creating a patient "medical home". As more and more patient care is relegated to pharmacists and other non-physician providers, the concept of a patient medical home is eroding and will ultimately be destroyed.

All of 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 community based primary care and specialty care physicians' ongoing ability to manage their patients' care needs.

For all of the reasons stated above, we urge that these proposals be rejected from the final Budget adopted for FY 2021-22.

5) CONCERNS WITH TELEHEALTH PROPOSAL

The impact of the COVID19 crisis was devastating for countless New Yorkers, and physicians were no exception. Patients and physicians needed to embrace new ways to ensure needed care was being delivered. 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. While we believe strongly in continuing to enable the expansion of telehealth services, we are very concerned by the proposal that purports to expand Telehealth coverage in the FY 2022 Executive Budget. We urge that this proposal be substantially revised or removed from the Budget altogether.

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 the span of a month.[1] Showing that this was not just a temporary bump, telehealth claim lines also increased 2,938 percent nationally from November 2019 to November 2020, rising from 0.20 percent of medical claim lines in November 2019 to 6.01 percent in November 2020, according to new data announced this week from FAIR Health

[1] https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/may-2020-northeast-telehealth.pdf

It is important to note early efforts by the New York State 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, including waiving cost-sharing requirements for services delivered via telemedicine, expressly permitting coverage for health care services via audio-only, and allowing delivery of telemedicine services through basic smartphone video technologies. Medicare also followed this path, waiving the federal statute that limits Medicare coverage for Telehealth to rural areas and significantly increased the payments for video and audio-only Telehealth services.

Among our primary concerns in the Executive's FY 2022 proposal on Telehealth expansion is the omission of ensuring payment parity for delivering telehealth services, which would ensure payment for video, and audio-only Telehealth visits, that is on par with payments for in-office appointments. We are particularly concerned that the plan could actually cause in-network New York physicians to be excluded from health plans' network of physicians that provide Telehealth services. That is because the Executive Budget proposal proposes to link insurance coverage and payment to insurers having an adequate telehealth network, essentially giving insurers the power to limit who it will pay for Telehealth services once it asserts it has an adequate network. This concern is exacerbated by the fact that the Executive Budget would also enable the delivery of Telehealth services across state lines by out of state physicians. Therefore, it is not hard to imagine a scenario where a health plan asserts it has an adequate network through a contract with a national Telehealth service company and excluding its community providers from providing Telehealth services.

MSSNY has been arguing that rates at which physicians are paid by insurers have not kept pace with those paid for in-office visits and the gap is wide, and given the withering financial situation for physician practices across the state, equal compensation for care delivered virtually, is vital. To better understand the impact of inadequate payment on physician practices, surveys conducted by key MSSNY partners, of their memberships, revealed the following:

- Participants of a survey by one of our partner organizations, the New York Medical Group Management Association (NY MGMA), revealed that only 23% of all health plans pay equal to what they received for in-office visits.

- 25% said that most plans pay significantly less for in-office visits. More specifically, 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.

For all practical purposes, paying physician practices at a substantially lower rate than traditional office visits will limit uptake in practices and put Telehealth services out of reach for countless patients. Undoubtedly, this will negatively impact communities that often benefit most from the flexibility of Telehealth including low income patients, and those with transportation or child care challenges.

The Executive budget also does not ensure robust coverage for "audio-only" Telehealth services. Across specialties, providers report that during the pandemic, audio only communication was often the difference between care and no care. Physicians need to be able to meet patients where they are, including those without computers or reliable internet access. Limiting audio only services will further exacerbate health care disparities based on race, ethnicity, age and socioeconomic status. We strongly recommend that audio only services be reimbursed across all payers and reimbursed on par with other Telehealth services.

In order to achieve true equity in health care access, New York must require that payment parity is also ensured in Medicaid Fee for Service and Medicaid Managed Care. Without this parity across all systems, Medicaid providers may not have the financial capacity to provide Telehealth services to beneficiaries, creating a hurdle in accessing care that doesn't exist in commercial insurance. A divided system where only some patients can access Telehealth services is extremely problematic to our shared goal of promoting high quality care and equitable access.

Furthermore, even though two of the many vaccines in clinical trials have received final approval from the Food and Drug Administration (FDA) and are currently being administered around the country, public health experts anticipate that COVID-19 will remain a public health threat for the foreseeable future, making continued access to Telehealth services critical.

For all of the reasons stated above, we urge that this Budget proposal be substantially revised or removed from the final Budget.

6) OPPOSE REPEAL OF "PRESCRIBER PREVAILS"

We urge you to reject the recommendation 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 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 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 are able to 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 has to 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 all the 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 in the 2020-21 NYS budget that is effective on April 1, 2021.To assure 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.

7) NURSE PRACTITIONER-PHYSICIAN PRACTICE PROTOCOLS NEED TO BE STRENGTHENED

The Executive Budget proposes a 6-year extension of a sunsetting law that enables nurse practitioners to practice independently without a written collaborative agreement provided they have 3,600 hours of supervised practice by a physician and there is written evidence of collaborative agreements with physicians practicing in same specialty as the physician. 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.

While NPs are essential members of the health care team, with only a few years of education, no residency requirement and only 500-720 hours of clinical training, they are not adequately trained to practice without any physician collaboration. 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 year 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. While there are many reputable nurse practitioner programs, there has been a recent proliferation of online-only nurse practitioner programs, some boasting 100% acceptance rates and programs that offer little to no oversight of students' clinical training.

We are 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.

While NPs play a critical role in providing care to patients, their skillsets are not interchangeable with that of fully trained physicians. Therefore, the statutory standards for physician-NP collaboration should be strengthened to incorporate additional documented criteria for how care will be coordinated with a physician practicing in that specialty to help better recognize and treat potentially complex cases.

8) SUPPORT OF PBM REGULATION

We support the proposal in the Governor's Budget to require Pharmaceutical Benefit Managers (PBMs) operating in New York State to be licensed by DFS. We have also supported the comprehensive legislation advanced by Assemblyman Gottfried and Senator Breslin that passed the Legislature in 2019 but was vetoed by the Governor. We

are hopeful that, given the support of many key leaders for achieving PBM regulation, that all the parties can work together to help achieve enactment of a law.

As noted above, physicians face an increasing amount of requests for prior authorizations and repeat prior authorizations, in large part due to increasing hassles associated with ensuring patients can obtain the medications they need. Further oversight of the reasons why some drugs are preferred and others are not, requiring prior auths, is needed.

This is particularly important given the enormous consolidation in the industry. Physicians and other independent care providers are very concerned with the recent acquisitions of Aetna by CVS/Caremark, and of Express Scripts by Cigna. We appreciate the comments that several key New York legislators made in opposition to this merger in both legislative hearings and in communications to the US Department of Justice, such as those by Assemblymembers Cahill and Gottfried, and Senator Skoufis. Physicians are very concerned that these combined entities will greatly empower their subsidiary PBMs to impose even more burdensome prior authorization hassles for physicians and their staff that already unduly interfere with patient care delivery. Already, New York physicians spend an inordinate amount of time on receiving prior authorizations. As noted previously, several studies have highlighted the significant increases in prior authorization burden in recent years.

Adding to our concerns is the fact that PBMs are not regulated by the state of New York despite the enormous involvement these entities have in the development of prescription drug plans including determining which drugs will be “preferred”, and which drugs will be placed on higher cost-sharing tiers. These decisions are often based upon the financial deals made with drug manufacturers and wholesalers and do not always lead to cost savings. This was further highlighted by Caremark’s tactics with the Ohio Medicaid Managed Care program, which caused the State to cancel all of its contracts with PBMs.

We urge you to stand up against this accumulation of power in our health care system that jeopardizes the ability of patients to continue to receive necessary care from their physicians. Certainly oversight and transparency are important first steps in helping to assure that PBMs make formulary decisions on behalf of health plans that will not inappropriately interfere with patient care delivery. Therefore, we urge you to support PBM licensure as you finalize the Budget for Fiscal Year 2021-22.