

ENHANCING QUALITY OF CARE

A. Attracting and Retaining Physicians In New York State

The Center for Health Workforce Studies reported recently that the in-state retention of new physicians has gradually declined from a high of 54% in 1999 to a low of 44% in 2011. “Proximity to family” is the main reason cited by new physicians who plan to practice outside of New York. When physicians were asked to report all reasons for leaving New York, 60% indicated better salary offered outside New York, followed by more desirable locations outside New York (56%) and cost of living in New York (50%). This is particularly troubling as demand for physician services continues to outpace physician supply, particularly in ophthalmology, urology, psychiatry, pathology, general internal medicine, general/family medicine, and otolaryngology. There are areas of the state and populations that are already underserved by the current physician supply. The implications of the forecasts for these areas and populations are dire. New York must do more to attract and retain physicians.

- i. Reducing the overhead burden shouldered by physician practices through meaningful civil justice reform (*Please see Section 1A and B of the Program*).**
- ii. Assuring fairness in contracting by leveling the playing field for physicians in their negotiations with health insurers (*Please see Section 1C and D of Program*).**
- iii. Continue an adequately funded Excess Medical Liability program to assure that physicians will have the coverage needed to protect them from personal financial exposure to escalating medical liability awards.**

The Excess Program provides an additional layer of coverage to physicians with hospital privileges who maintain primary coverage at the \$1.3 million/\$3.9 million level. The Excess Medical Liability Insurance Program was created in 1985 as a result of the liability insurance crisis of the mid-1980's to ease concerns among physicians that their liability exposure far exceeded available coverage limitations. This fear continues even today. The size of verdicts in New York State has increased exponentially. From 1999-2005, 59% of all verdicts exceeded \$1 million, thereby making the continuation of the Excess liability coverage even more essential today than when first authorized. Consequently, approximately 25,000 physicians currently have excess coverage. The cost of the program since its inception in 1985 has been met by utilizing public and quasi-public monies. Beginning January 1, 2002, monies from the Health Care Reform Act's (HCRA's) tobacco control and initiatives pool were allocated to fund the cost of this program. The Excess program was extended until June 30, 2014. Importantly, the State Budget adopted for fiscal year 2012-13 included an appropriation of \$127.4M for the Excess program. This appropriation expires on March 31, 2013.

The 2012-13 budget did restrict who would be eligible for the Excess program for the 2012-2013 policy year to physicians who had previously received such coverage for the 2009-10, 2010-11, and 2011-12 policy years. The budget also called for a report by the DFS and DOH by November 1, 2012 which will analyze the solvency of the Excess pool and make recommendation to assure that future appropriations for this program will not exceed the current allocation of \$127.4M.

It is important to note that from the physician's perspective, we are at a point that looks frighteningly familiar to the landscape confronting medicine during the mid-eighties. While frequency remains flat, severity continues to rise. As a result physician premiums have risen precipitously over the last decade. Moreover, the risk that physicians' face personal financial exposure to verdicts and awards which exceed primary coverage limits is just as

real in today's environment as it was back then and, in point of fact, has dramatically increased due to the relentless increase in the severity of awards. From 1999-2005, 59% of all verdicts exceeded \$1 million. However, given the realities of today's aggressive constraints on physician incomes and the downward pressures associated with managed care and government payors, the costs associated with the Excess coverage are simply not assumable by most physicians in today's environment.

In addition, the average age of physicians in practice in NYS is 54 with over 55 percent of physicians in active practice in NYS age 50 and older. New York needs to assure that it remains competitive with other states in attracting young physicians into active practice in New York. This will be quite a challenge if physicians new to practice are ineligible for Excess protection. It is important to highlight that a sizeable number of physicians who practice in communities across New York State are small businesses which are vitally important to the State both in terms of their economic impact and the contribution to the public good. In 2008, each private practice physician supported on average: 7.79 employed persons; corporate sales of \$1.054 million; New York sales tax revenue of \$106,000; and New York local tax revenue of \$111,000. In the aggregate, private practice physicians contributed state tax revenue of \$4.5B and local tax revenue of \$4.6B. We must take all steps necessary to assure that physicians can remain in practice in New York State.

Absent meaningful reform of the dysfunctional tort system, the continuation of a properly funded Excess program is critically necessary to prevent the liability disaster that was so narrowly averted in the mid-eighties. MSSNY will work to continue an adequately funded Excess program which continues coverage for all attending physicians who maintain primary coverage at the \$1.3 million/\$3.9 million level. MSSNY will explore other funding opportunities including the application of any Medicaid waiver funding approved by the federal government.

iv. Prevent the imposition of costly and burdensome CON requirements on physician offices and equipment purchases.

Proposals have been advanced to use the certificate of need (CON) process to extend burdensome regulation of certain physician urgent care, office based practice settings and the purchase of office equipment. MSSNY opposes the creation or extension of additional regulatory burdens on private physician practices and recommend consideration of other ways to enable market forces to operate to assure the delivery of cost efficient, high quality care throughout the healthcare system.

New York's Certificate of Need (CON) program was originally established at a time when hospitals were reimbursed based on the costs of their services. This reimbursement was structured prospectively and cost-based reimbursement encouraged hospitals to expand and develop excess service capacity. The CON process was established in order to control this expansion. Under CON regulation, the intended result was that new or improved facilities or equipment would be approved based only on a genuine need in a community.

There are many entities in this state and nationally, including the US Federal Trade Commission and Department of Justice, that have recognized the CON approval processes impede the delivery of high-quality care, and as such have supported the repeal of such laws. The FTC/DOJ testified:

“The Agencies’ experience and expertise has taught us that CON laws impede the efficient performance of health care markets. By their very nature, CON laws create

barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation and weaken the markets' ability to contain health care costs".ⁱ

The FTC and DOJ believe that CON programs can pose serious competitive concerns that generally outweigh CON programs' purported economic benefit. Where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering regulatory barriers to entry, which by their nature are an impediment to health care competition. ⁱⁱBy protecting what are often high-cost providers, CON programs deny patients different, and possibly more affordable, higher quality treatment options or settings. The proponents of CON overstate the purported savings generated by CON programs by failing to offset alleged savings with the a number of significant costs incurred by both CON applicants and the Department during the course of the CON process. Fourteen other states have already repealed CON statutes, and most of the remaining CON states have greatly modified aspects of the programs to encourage more competition and innovation in delivery. Significant thought and consideration must be given to any future planning processes to ensure that private practice providers are not rendered at risk and financially vulnerable due to the significant market influences that current providers may bring to bear.

A process which examines CON Redesign must consider the impact – both positive and negative- of a repeal of the CON process. Many changes occurring in the health care delivery system may make CON irrelevant in the future. Moreover, consideration should be given toward eliminating the application of CON for certain primary care facilities particularly given the need for increased primary care capacity and the movement away from fee-for-service reimbursement.

Clearly, the innovative approaches incentivized by the state and federal government in recent years have encouraged the formation of large, multi-specialty group practices, independent practice associations and physician hospital organizations, and have fostered integrated care delivery and payment and models such as the patient centered medical home or accountable care organization. Such models have enhanced care coordination and payment incentives to improve quality of care while reducing overall health system costs.ⁱⁱⁱ CON should not be used by high-cost providers to discourage the formation of these integrated, physician-driven health delivery systems. Rather, New York public policy should support the further development of these and other innovative models.

For all of these reasons, the CON process should be considered for repeal or significantly modified so as to promote innovative and cost efficient practice models in New York State. MSSNY would oppose any effort to expand CON to impose additional requirements on physician offices or equipment purchases.

v. Put additional resources toward the Doctors Across New York program and modify eligibility to assure a more equitable balance of awards between institutionally based and private practice physicians.

The Doctors Across New York program was enacted in 2008 to respond to the growing shortage of physicians in underserved rural and urban areas of the state. This important program provides necessary financial support by way of physician loan repayment and physician practice support to encourage primary care and specialty physicians to practice in the underserved communities in New York State. The physician loan repayment initiative has funded awards annually with a maximum of \$150,000 in loan repayment over five

years for physicians who practice in rural and inner-city underserved communities. The physician practice support program has provided up to \$100,000 in physician practice support over two years. In Cycles 1-3 of funding, there have been 153 Physician Practice Support Awards and 79 Physician Loan Repayment Awards given. In the 2012-13 NYS Budget, changes were made in the application process to eliminate competitive bidding for awards and to simplify the application process. In March 2014, 75 new Doctors Across New York slots were created by additional funding in the budget, most of which were allotted to physicians already approved or already in the program. In a report published by the NYSDOH to the NYS Legislature in February of 2010, it is noted that, of the awards made, only 21 of the physician loan repayment awards and just 27 of the practice support awards were approved for individual physicians or private practices. The balance of the awards went to hospitals and clinics. Unfortunately, no new monies have since been allocated for new physician loan and practice support awards. MSSNY will work for the inclusion of additional funding for new physician loan and practice support awards and for a more equitable balance of awards between institutionally based and private practice physicians.

vi. Create income tax credits for physicians who practice in specialty shortage areas.

Because of geographic isolation, lack of income potential, or any number of other reasons, some areas of the State have long been hindered by a shortage of health care providers. Both the State and the Federal government have made attempts to make health care more accessible in underserved areas, including the *Doctors Across New York* program, by repaying the medical education loans of physicians who agree to work for a period of time in a shortage area. Despite these efforts, it can take several years for some communities to find a physician who is willing to locate in the area. The offering of income tax credits to physicians who are willing to locate in underserved areas would be useful in enticing physicians to practice in these communities.

vii. Continue Medicaid reimbursement of primary care rates at Medicare levels beyond 2015.

Effective for dates of service on and after January 1, 2013 through December 31, 2014, states are required by law to reimburse qualified providers at the rate that would be paid for the service (if the service were covered) under Medicare. States receive approximately \$12B from the federal government to enhance the rate of payment to the primary care physicians. However, this funding is slated to expire as of December 31, 2014. MSSNY will work with all affected specialties to assure that there remains a parity of payment by Medicaid for primary care services at the rate that would be paid for the service (if the service were covered) under Medicare.

The statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. Under the regulation, "general internal medicine" encompasses internal medicine and all subspecialties recognized by the ABMS, ABPS and AOA.

In order to be eligible for higher payment:

- 1) Physicians must first self-attest to a covered specialty or subspecialty designation; and
- 2) As part of that attestation they must specify that they either are Board certified in an

eligible specialty or subspecialty and/or that 60 percent of their Medicaid claims for the prior year were for the E&M codes specified in the regulation.

Subspecialists that qualify for higher payment are those recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS) or American Osteopathic Association (AOA). For purposes of the rule, “General Internal Medicine” encompasses “Internal Medicine” and all recognized subspecialties. The websites of these organizations currently list the following subspecialty certifications within each specialty designation:

ABMS

Family Medicine – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine

Internal Medicine – Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Geriatric Medicine; Hematology; Hospice and Palliative Medicine; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Sleep Medicine; Sports Medicine; Transplant Hepatology.

Pediatrics – Adolescent Medicine; Child Abuse Pediatrics; Developmental-Behavioral Pediatrics; Hospice and Palliative Medicine; Medical Toxicology; Neonatal-Perinatal Medicine; Neurodevelopmental Disabilities, Pediatric Cardiology; Pediatric Critical Care Medicine; Pediatric Emergency Medicine; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology, Pediatric Transplant Hepatology; Sleep Medicine; Sports Medicine.

AOA

Family Physicians – No subspecialties

Internal Medicine – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Disease; Pulmonary Diseases; Nephrology; Oncology; Rheumatology.

Pediatrics – Adolescent and Young Adult Medicine, Neonatology, Pediatric Allergy/immunology, Pediatric Endocrinology, Pediatric Pulmonology.

ABPS

The ABPS does not certify subspecialists. Therefore, eligible certifications are: American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine. There is no Board certification specific to Pediatrics.

viii. Defeat any proposal to directly or indirectly tax medical services, medical devices or products or sites of service.

Certain forces within the healthcare system have suggested that the Legislature consider the use of the tax code to increase revenue to assist in the re-structuring of the health care delivery system and to increase monies to fund certain programs. Specifically, it has been

suggested that the state tax cosmetic medical procedures, medical devices or products and procedures which occur in non-institutional settings such as ambulatory surgical centers. These proposals are unacceptable to medicine and would have serious adverse consequences. Such taxes set a dangerous precedent for health care professionals who will have the burden of collecting and remitting the taxes back to the state. If the tax were to be applied to a cosmetic medical procedure, device or product, state tax auditors would be in the position of second guessing a physician's determination that a procedure, device or product was medically necessary and not cosmetic. This is not fair to the patients in New York.

Additionally, a tax applied to ambulatory surgery centers is particularly inequitable and inappropriate. Ambulatory Surgery Centers (ASCs) provide high-quality healthcare in the most cost efficient settings. According to the Medical Payment Advisory Commission, Medicare payments to ASCs are lower than payments to hospitals for comparable services for 87% of procedures. Moreover, coinsurance costs for procedures furnished in ASC settings are less than coinsurance costs for comparable procedures in the hospital setting. Importantly, patients often prefer the convenience of ASCs.

Taxing physician services unfairly targets small business since a significant number of New York's physicians are either self-employed or part of small physician-owned group practices. An additional tax on the physician business owner poses a significant and disproportionate burden on New York's physicians and the patients who need their services. MSSNY will continue to oppose the imposition of any and all such taxes.

ix. Defeat any proposal to increase the biennial physician registration fee.

MSSNY strongly opposes any increase in the biennial physician registration fee. Currently, the physician registration fee is \$600 which is paid biennially of which \$30 is also paid to support the operation of the Committee for Physicians' Health, which works to identify, refer to treatment and subsequently monitor physicians impaired by chemical dependency or psychiatric illness. MSSNY actively supported the last substantial increase in the biennial registration fee to assure that the work of the Office of Professional Medical Conduct was continued. This support was conditioned upon the promise that all monies collected as a result of the increase would be applied only to OPMC operations. At that time, OPMC, hampered by insufficient resources, had difficulty in addressing pending complaints on a time-sensitive basis. Since then, however, the OPMC operations have improved dramatically. Additional investigators and prosecutorial staff were hired. Complaints have been handled in a timely and proactive manner. New York's standing among other states in the country has also improved. New York continues to have a stronger record than other large states when it comes to disciplining physicians. Moreover, the registration fees paid by physicians in virtually all other states do not even begin to approach the amount which physicians in New York currently pay let alone the amount which would be paid by physicians in New York in the event of another registration fee increase. At a time that physician revenue is going down the imposition of what amounts to a unique New York tax on physicians, presents yet another reason for young physicians to look elsewhere to open or relocate their practices.

B. Enhancing Quality of Care Through Peer Review

Importantly, MSSNY will work to enact legislation which would extend existing confidentiality protections to all statements and information volunteered at peer-review quality assurance committees within hospitals. Protection from disclosure of statements made at peer-review meetings was established in 1985 to enhance the objectivity of the process and to assure that medical peer-

review committees could frankly and objectively analyze the quality of health services rendered in the hospital. An exception contained in that law, however, permits the disclosure of statements made at a peer-review meeting by an individual who subsequently becomes a party to a malpractice action if such action involves the conduct which was the topic of the discussion at the peer-review meeting. The enactment of legislation which would remove this limitation is vitally important to assure improvement in quality of care. Such action will assure physician participation in the critical process of quality review. Moreover, MSSNY will also support legislation to protect against disclosure of such information in peer-review quality-assurance committee meetings outside of the hospital setting, including in office-based surgical practices. Importantly, MSSNY will also advocate to protect from discovery by OPMC statements made or information obtained during the course of a peer-review proceeding.

C. Enhancing Care By e-Prescribing

E-prescribing is one of several solutions advanced to improved patient safety and quality of care through clinical decision support and ready access to patient medication history. Legislation enacted in 2012, requires the creation of a “real time” prescription drug monitoring registry to provide enhanced information to prescribers and pharmacists concerning prescriptions obtained by patients for controlled substances. This law also mandates the electronic submission of all prescriptions by December 31, 2014. Regulations setting forth standards for e-prescriptions will be promulgated by the end of 2012. The law requires that the registry be compatible with e-prescribing technology which for the first time will facilitate the electronic transmission of controlled substances. The federal regulations specifically require software with two-factor identification for e-prescribing of narcotics. These products are slowly being certified and marketed. To date, only approximately 30 of the more than 750 e-prescribing products are certified for EPCS. These include the following:

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| Advanced Data Systems Medics DocAssistant/7 | Allscripts/NEPSI |
| Ankhos Clinical Oncology Software/3.3 | Bizmatics PrognoCIS/3.0 |
| Cerner Power Chart/2012.01.19 | CoPilot eRx Engine/1 |
| Delta Care Rx Hospice Prescribing/1.0 | DrFirst Rcopia/3.0 |
| EMPS ntreatment.com/2 | Epic |
| Glenwood Systems Glace EMR/4.5 | HMS E-scripts/2.0 |
| HealthPostbox Express EMR | HealthPort EMR/9.02 |
| MD Toolbox-Rx/3.1 | Medflow EMR/8.01 |
| Meditab Intelligent Medical Software (IMS)/14 | Net Health Systems i-Heal/2 |
| New Crop Core/13.05.14.05 | NextGen HER/5.8X |
| OmniMD/13.7 | Optimantra Practice management/1.5 |
| Optimantra Dermio/1 | RxNT EHR/7.1 |
| ScriptRx/ 4.3 | StratusRx/2 |
| TECNEX MD-2 EHR/PM/5 | The Echo Grou Clinician’s Desktop/8.13 |
| VersaSuite/8.2 | Zenith Technology Solutions Hygeia/5.0 |

Many of the EHR vendors with the largest market share in New York State have not yet been certified. MSSNY will take action to protect physicians associated with these vendors from actions to penalize the physician when the inaction of the vendor has delayed timely implementation of software updates to comport with DEA EPCS standards.

Not all physicians, however, are interested in purchasing e-prescribing technology. The law does provide certain exceptions to the e-prescribing mandate and allows for the issuance of a renewable one year waiver to physicians who can demonstrate economic hardship, technological limitations that are not reasonably within the control of the physician, or other exceptional circumstance. MSSNY will work to assure that the waiver process is available to physicians for whom purchase and implementation of e-prescribing technology is impractical. MSSNY will also work to assure that the technologies used as part of the prescription drug monitoring registry are compatible with all e-

prescribing systems so that physician consultation with the registry is streamlined. Moreover, MSSNY will work to enable registered nurses working with a physician to be authorized to send an electronic prescription to the pharmacy much like a prescription today is phoned into a pharmacy by a nurse upon the verbal order of a physician.

D. Enhancing Quality & Integration Using Health Information Technology

The Statewide Health Information Network of New York (SHIN-NY) is a network of information transmitted between users. Like the internet, as more users connect, it grows, evolves, and becomes more secure, efficient, and easy to use.

As an increasing number of private practices, nursing homes, clinics, and hospitals begin to digitize their records, they have the option to connect to information hubs (or RHIOs/QEs) in their region of the state. These Regional Health Information Organizations collect health record data from the healthcare providers in their area, and, with patient consent, allow this information to be shared securely with other providers in the region.

The SHIN-NY connects these regional hubs to create a private and secure network spanning the entire State of New York.

Currently, the two main capabilities of the SHIN-NY are Direct Messaging and Patient Record Look-Up. Direct Messaging functions like a highly secure email, giving clinicians the ability to seamlessly exchange authenticated, encrypted clinical data with one another. Patient Record Look-Up is comparable to a highly secure search engine, allowing healthcare providers to retrieve individual patient records from across the network once they receive patient consent.

The promise of interoperability has not yet been obtained. There are a number of reasons for this including the costs associated with integration between EHRs in order to enable the bi-lateral flow of information. The State through NYeC and health care stakeholders is working to reduce the burdens and cost associated with integration. MSSNY will continue to work with the state in the development of plug and play technology which will enable cost efficient interoperability.

E. Elimination of Health Care Disparities

Lack of access to competent medical care is a driving factor in determining health care disparities. This lack of access can result from lack of racial and ethnic diversity in the medical workforce; lack of health insurance coverage; lack of access to physicians and other providers; lack of understanding of religious, cultural and ethnic beliefs and traditions; or a host of other causes. In many areas of New York State, both rural and urban, shortages of both primary care and specialty physicians limits the care available to residents. The state's health care workforce is comprised of less than 10% underrepresented minority physicians, despite the fact that underrepresented minorities account for 35% of New York's population. This disparity between the race and ethnicity of physicians and the population of the state is expected to widen in future years. As our population increasingly diversifies, there is growing emphasis on the need for a culturally competent health workforce which understands the health needs of the population it serves.

The Medical Society of the State of New York's Committee to Eliminate Healthcare Disparities is working to help ensure that all New Yorkers receive the best possible care. This work includes attracting a more diversified physician workforce including augmenting the numbers of minority faculty teaching in medical schools and academic health centers; expanding medical school pipeline programs in rural and urban areas, and adoption of legislation that addresses the root problems. This Committee will seek a partnership between our Committee, Medical Schools, Colleges, High Schools, Middle Schools, and Elementary Schools, which would allow us to expand our current American Medical Association program entitled *Doctors Back to School*, in which groups of physicians go into

middle and high schools in areas with high minority populations and talk to the students about choosing medicine as a career.

An additional important goal is securing private reimbursement for language services for patients with limited English proficiency. The collection and aggregation of health care and demographic data on a regional and institutional level is also essential to facilitate analysis by race and ethnicity as well as by access of the general population to identify areas where improvements can be made to enhance care and eliminate disparities in health care. The Committee has conducted a series of CME programs around New York State to educate physicians in Health Literacy, as well as a series on Cultural Competency. MSSNY's long-standing commitment to finding real solutions to improve access to high-quality medical care for all New Yorkers is reflected in the work of its Committee to Eliminate Health Care Disparities.

F. Assuring Quality through Physician Led Team-Based Care

In recent years, it seems that almost every non-physician health care provider has attempted to either become licensed and have a scope of practice or to expand their existing scope of practice to allow them to perform many of the same if not all of the same functions that physicians can perform. This is being done for financial gain and to attain autonomy, allowing them to be free of physician supervision or collaboration, and able to bill and be reimbursed directly by health plans. Scopes of practice are used for patient protection, as a means of limiting what a practitioner can do based on their education and training, or based on what their supervising or collaborating physician believes they are capable of doing safely. Scopes of practice are of two types – either very general and broad, in which case the practitioner must be supervised by or in a collaborative relationship with a physician; or restrictive, spelling out exactly what the practitioner can or can't do based on their education and training. In most cases, the practitioner's education and training has remained the same – only their desire to increase their scope of practice has changed. For the safety of the patients in their care, the statutory scope of practice must remain at a level consistent with the education and training of the practitioner.

Non-physician practitioners often claim they are cost-effective because they are paid less. If they become autonomous, and not employed practitioners, their medical liability insurance premiums and their business expenses will increase to a level similar to what a physician pays. This will require a higher reimbursement rate for them and negate any cost savings. Although these non-physicians are competent within their own field, they should not be allowed to work in areas beyond their competence and training and/or without an appropriate relationship with a physician. Doing so without an adequate educational base could seriously endanger the patients for whom they care. Moreover, expansion of scope of practice for non-physician providers will inevitably increase health care costs – not decrease them. The Medical Society will continue to oppose such efforts. In the case of unlicensed professions wishing to be licensed, we must look at whether there is a real need for another licensed health care provider with a scope of practice that overlaps that of physicians or other providers already licensed. If it is determined that there is, we must then determine whether the training of the group is adequate, and whether their proposed relationship with other providers is appropriate.

Some specific examples of legislative proposals relating to expansion of scope of practice which we oppose are:

- ✓ Licensing or certifying naturopathic providers as naturopathic physicians or doctors of naturopathy and allowing them to provide primary medical care, including certain invasive office procedures, childbirth and prescriptive privileges;
- ✓ Inappropriate expansion of the scope of practice of psychologists, including a proposal which would allow them to prescribe pharmaceutical agents;

- ✓ Oral and maxillofacial dental surgeons performing cosmetic surgery or other surgery not related to dental health;
- ✓ Inappropriate expansion of the scope of practice of optometrists, including any proposal which would allow optometrists to prescribe certain therapeutic pharmaceutical agents;
- ✓ Nurse anesthetists practicing without physician supervision or selecting or ordering anesthetic drugs for surgical procedures;
- ✓ Pharmacists conducting medical assessments, ordering or interpreting lab tests and devices, prescribing drugs or administering medications;
- ✓ The inappropriate practice of electrodiagnostic medicine by physical therapists;
- ✓ Allowing non-physicians, not currently specifically allowed by law, to administer certain injectable materials including, but not limited to, fluorescein dye, and collagen of Botulinium toxin;
- ✓ Requiring licensure to practice genetic counseling in New York State;
- ✓ Legislation to remove the requirement that a nurse practitioner have a written practice agreement with a physician;
- ✓ Efforts to enable the development of the retail clinic care delivery model in New York State; and
- ✓ Eliminating or lessening the effect of the corporate practice of medicine doctrine.

MSSNY will seek to amend current law, or seek new legislation that protects the term “physician” for the exclusive use of MDs and DOs, or their foreign equivalents, and imposes penalties for those who mislead the public with unauthorized use of the title. It is vital that patients are made aware of the credentials of the health care provider caring for them. Patients have an absolute right to this information.

MSSNY will support legislation to:

- ✓ Define “surgery” and limit its performance to licensed physicians, dentists and podiatrists, as appropriate;
- ✓ Codify the current practice of nurse anesthesia, including requiring physician supervision of nurse anesthetists;
- ✓ Prohibit the creation of any new category of nurse practitioner anesthesia;
- ✓ Enable otolaryngologists to dispense hearing aids at fair market value;
- ✓ Permit medical assistants, including cast technicians, to perform appropriate duties under the direct supervision of a physician; and
- ✓ Establish Truth in Advertising to assure that the advertisements of all health care professionals adequately inform the public of their own professional credentials.

MSSNY will continue to oppose cost-cutting restrictions imposed by managed care companies that limit or preclude patients from visiting a physician as their first line of care, or “gatekeeper”. Such restrictions are clearly not in the best interest of the patients whose medical care is covered by these managed care companies.

MSSNY will also advocate for proactive enforcement of New York State regulation that gives patients the necessary information to make informed decisions about who is providing their health care. Moreover, MSSNY will seek enactment of legislation to require all health care professionals in all healthcare settings to wear identification tags that state their professional designation in large block letters (PHYSICIAN, NURSE, PHYSICIAN ASSISTANT, etc.). Additionally, MSSNY will advocate for the elimination of the prohibition against the use of testimonials by physicians provided that appropriate disclosure is included to prevent any misleading information or imagery to be used.

G. Assuring Clinical Clerkship Slots for U.S. Medical School Students

Medical students who attend LCME/COCA-accredited New York State medical schools are very concerned that they may not have access to necessary clinical clerkship programs in New York

Hospitals as a result of Caribbean Offshore Medical Schools purchasing increasing numbers of these clerkship slots for their students from hospitals in New York. In the past, procurement of these clinical clerkship rotations by LCME/COCA accredited medical schools for students in their clinical years has depended on agreements made between the medical schools and the hospital, based not on financial transactions, but on providing the highest quality of education to the students, thereby ensuring continuation of the best medical care for the community served and for the United States. For-profit offshore medical schools are not required to meet LCME/COCA accreditation standards. They are continuing to increase in numbers, so that there are more students from these schools each year coming to the U.S. and to New York in particular for their clinical training, as many of them do not have an affiliation with a local teaching hospital in the Caribbean. In order to secure clinical rotation sites for their students, these for-profit offshore schools are contracting with hospitals in New York to pay in excess of \$400 per student per week of clerkship experience. U.S. medical schools cannot match these amounts and it has been estimated that enabling U.S. schools to match the amounts paid by offshore schools would require a tuition increase of \$35,000. The New York City Health and Hospitals Corporation has a ten-year exclusive contract with St. Georges Medical Schools to send 600 new students per year of education into an area that already has difficulty accommodating seven U.S. medical schools, and is a very desirable site by U.S. medical schools nation-wide. LCME/COCA standards are required to be met for American medical students to participate in third-year clerkships, but for-profit offshore medical schools do not have a standardized equivalent system of evaluation for their students before they participate in third-year clerkships in American hospitals. As a result of this, MSSNY will support that preference not be given to students from international and dual-campus medical schools over students from LCME/COCA accredited medical schools for clinical clerkship rotations in hospitals or affiliated clinics. Moreover, MSSNY is following the meetings of the Advisory Committee on Long-Term Clinical Clerkships, created by the New York State Education Department, and hopes to be able to support the future work of this Committee as it looks at the regulations of long-term clerkships and at the standards of the off-shore medical school curriculums, didactic program outcome measures, clinical program outcome measures and faculty constructed exams and evaluations. The Advisory Committee will also review and make changes in site visits to the off shore medical schools to determine whether they will be considered an “approved school”, which would give them the ability to send their students to New York State long-term clinical clerkship programs. Approvals will be time-limited and re-site visits will occur every 3-5 years.

ⁱ Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform (September 2008).

ⁱⁱ *Id.*