



The Medical Society
of the State of New York

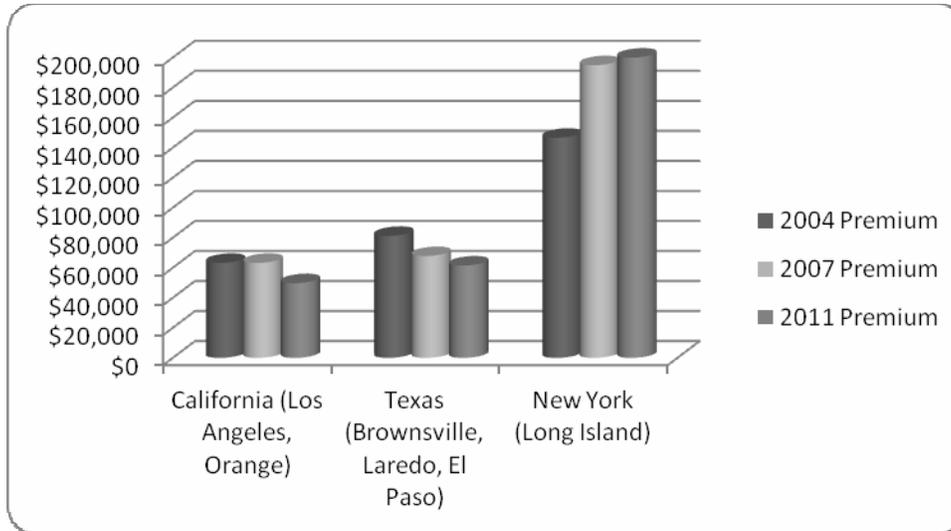
**Testimony Of
The Medical Society of the State of New York
Before The
New York State Assembly Committee
On Ways & Means and Senate Finance Committee
On the Governor's Proposed Public Health Budget
For State Fiscal Year 2013-2014**

Good morning. My name is Elizabeth Dears, Esq. I am the Senior Vice-President/Chief Legislative Counsel for the Medical Society of the State of New York. On behalf of Robert Hughes, MD, President of the Medical Society of the State of New York and the almost 25,000 physicians, residents and students we represent, let me thank you for providing us with this opportunity to present organized medicine's views on the proposed budget and how it relates to the future of the health care delivery system in New York State. From the outset, we must state our concerns about the economic and patient-care consequences regarding several of the proposals advanced in the proposed budget as well as those not included in the document. Independent private practice physician practices are ranked second in the number of total business establishments in New York, employing well over 700,000 people statewide. And yet, their businesses are threatened by rising overhead expenses and shrinking revenue. The proposed budget fails to take action to address one of our largest non-salary expenses, the cost of medical liability premium and actually operates to threaten the extent of coverage many physicians currently maintain. Additionally, as it relates to quality of care, the budget includes proposals which will operate to negate system-wide changes now being implemented to enhance integrated care coordination among primary care physicians and their specialist colleagues. We urge you to listen to the concerns of New York's physicians – who are the ones predominately providing the care in our medical infrastructure - and to take action to assure that we create and preserve an economically sensible health care delivery system.

1.) Addressing Medical Liability Reform in the Context of the State Budget for Fiscal Year 2013-2014 Will Reduce Medicaid Expenditures for Liability Exposure and Defensive Medicine Costs

We are very disappointed that the proposed budget for FY 2012-13 did not include any relief for the perpetual medical liability premium costs shouldered by physicians practicing in the State of New York. Physicians can no longer afford the costs that arise from a deeply flawed and unsustainably expensive civil justice system. Moreover, the extremely difficult practice environment physicians face in New York State makes moving to other states an increasingly attractive option, particularly as more and more states enact legislation to reform their medical liability laws. To bring down the costs of health care in New York as well as to preserve access to New York's world-class but financially strained health care system, the State Legislature must enact meaningful medical liability reform.

The Texas Medical Liability Trust, the largest medical liability insurer in Texas, recently reduced premiums to physicians for the tenth straight year since the enactment of comprehensive medical liability reform legislation in Texas 2003. 90% of Texas physicians have seen a minimum 30% reduction in their premiums since 2003 according to the Texas Alliance for Patient Access. In Los Angeles, California, in a state where strong medical liability reforms were enacted in the mid-1970s, OB-GYNs pay less than 1/3 the premiums that New York physicians pay. As noted below, in both these states, medical liability premiums have gone down significantly since 2003 while the opposite has occurred in New York.



Source: Medical Liability Monitor, 2011

Liability premiums for New York physicians went up 55-80% from 2003 to 2008, and went up an average additional 5% in 2010 and an additional 3% in 2012 (for some physicians it was significantly higher). Many New York physicians now pay premiums that far exceed \$100,000 and some even exceed \$200,000. For example, for just a single year of coverage, the cost of medical liability coverage for the 2012-13 policy year was:

- \$306,393 for a neurosurgeon in Nassau and Suffolk counties;
- \$171,275 for an OB-GYN in Bronx and Richmond counties;
- \$116,989 for a general surgeon in Kings and Queens counties; and
- \$109,019 for a vascular surgeon or cardiac surgeon in Bronx and Richmond counties

With continuing downward pressure from health insurance companies and government payors to reduce payments for patient care, the costs currently paid by New York physicians for their medical liability premiums are not sustainable. Something has to give. It is imperative that we reduce the direct and indirect costs of medical liability as a way to bring down the costs of New York's extraordinarily expensive Medicaid program. It is important to remember, furthermore, that New York's out of control liability system has created a "defensive medicine" culture which significantly increases health system costs well beyond the impact of direct premium costs. Other states are passing measures to assure patients can continue to access necessary physician care. For example, in 2011, three more states, North Carolina, Oklahoma and Tennessee, enacted laws to provide meaningful limits on non-economic awards in medical liability actions bringing to over 30 the number of states which have enacted such limitations. The time for change is now!

While the Governor's proposed budget for FY 2011-12 included meaningful tort reform including a cap on pain and suffering along with a medical indemnity fund (MIF), the final budget included only the MIF. It has been reported to us that the MIF has had a positive impact on hospital medical liability premiums, reducing what hospitals pay for medical liability coverage by as much as 20%. The MIF, however, had absolutely no impact on physician liability rates.

Physicians cannot continue to bear the brunt of this liability cost. While we know from the experience of other states, that a cap on pain and suffering if enacted here would result in a meaningful reduction in physician premium costs, we are open to examining a number of different approaches provided that the ultimate objective of reducing New York physicians' extraordinarily medical liability cost burden is addressed. Some alternative approaches include: (1) require disclosure of the identity and deposition of an expert witness prior to trial; (2) require that a physician consulted for a Certificate of Merit be identified, be of the same specialty as the physician against whom the suit is filed and be required to file a certification statement; (3) protect physicians who express sympathy to a patient for an unanticipated outcome from having such statement used against the physician in any subsequent litigation that may arise; and (4) extend existing confidentiality protections to all statements and information volunteered at peer-review quality assurance committees. Enactment of these reforms will result in a modest impact on physician liability premium costs. Importantly, however, these reforms will demonstrate to physicians across this State that State leaders understand the cost burden they shoulder and are willing to take incremental steps to lessen their liability cost while assuring procedural fairness within the civil litigation system and enhanced quality of care through the peer review process.

2.) Continue an Adequately Funded Excess Medical Liability Program for Physicians Traditionally Covered and Physicians New to Practice

Exacerbating the problems faced by physicians due to the failure to address the physician liability burden is proposed changes to the Excess Liability Insurance Program that will cause many physicians – including physicians who treat the most high-risk patients – to be unable to secure coverage under the program.

The proposed budget would continue the Excess Medical Liability Insurance Program but would reduce its appropriation for this already underfunded program by \$12.7 million and dramatically restrict eligibility for the Excess coverage. Specifically, the budget proposes to limit eligibility for Excess coverage to a physician or dentist who (i) has professional privileges in the general hospital that is certifying the physician's or dentist's eligibility; (ii) from time to time provides emergency medical or dental services, including emergency medical screening examinations, treatment for emergency medical conditions, including labor and delivery, or treatment for emergency dental conditions to persons in need of such treatment at the general hospital that is certifying their eligibility; (iii) accept Medicaid; and (iv) (1) has in force coverage under an individual policy or group policy written in accordance with the provisions of the insurance law from an insurer licensed in this state to write personal injury liability insurance, of primary malpractice insurance coverage in amounts of no less than \$1.3M/\$3.9M or, (2) is endorsed as an additional insured under a voluntary attending physician ("channeling") program previously permitted by the superintendent of insurance and covering the same time period as the equivalent excess coverage. The language also requires coverage of the highest risk physicians by category and region on a first-come basis. This proposal is envisioned "to enable community hospitals to attract doctors in high-need, high-risk specialties to address health care access concerns". Frankly, we are concerned that it will actually make it harder to

assure the availability of physicians to provide high risk care. It will operate to cause physicians who currently provide on-call specialty services in the emergency room to refuse to do so. New York's Medicaid program has for decades paid physicians a pittance for their service to the Medicaid beneficiary. We recognize that the program is changing, but its payment levels remain far too low for physicians to participate in any substantial way. Many physicians, some of whom include neurosurgeons, surgeons, orthopedic surgeons and plastic surgeons, provide on-call services, in safety net hospitals but simply do not bill Medicaid for reimbursement. If they must participate in Medicaid, many have indicated they will drop on-call service to these institutions. Surely, that cannot be the goal of this proposal. Moreover, physicians who live near contiguous states, may be encouraged to seek positions in those other states. For other physicians, it could impose a huge new cost burden to purchase the coverage privately or risk losing their assets every time they see a patient. Again this proposal threatens the availability of needed care and threatens the jobs these physicians provide in the communities in which their practices are located.

It is important to understand the historical underpinnings of this program. 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.

The program has always been viewed as a "substitute" for comprehensive medical liability reform. The severity of the liability exposure levels of physicians makes it clear that the excess protection is essential, especially to physicians who have had such coverage until now. 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. The ability of a physician to maintain even the primary medical liability coverage is increasingly compromised as a result of escalating costs and decreasing reimbursement. Absent meaningful reform of the dysfunctional tort system, the continuation of a properly funded Excess program which provides coverage to all physicians who have traditionally received such coverage as well as physicians new to practice is critically necessary to prevent the liability disaster that was so narrowly averted in the mid-eighties.

3.) Eliminate Inappropriate Scope of Practice Expansion for Non-Physician Providers

We are also very concerned by the opportunistic advocacy attempts by certain non-physician providers to use the budget crisis now facing the state to advance their effort to expand their scope of practice. Their attempt to camouflage this effort under the guise of cost-efficiency is misplaced. Such proposals can only be appropriately considered through the spectrum of quality of care. Although nurses, nurse practitioners, physician assistants, pharmacists and other non-physician providers are competent within their own fields, they should not be allowed to work in areas beyond their competence and training and/or without an appropriate relationship with a physician. Specifically, with regard to nurse practitioners, the proponents of

independent practice for NPs argue that such a policy change would result in reduced health spending, presumably because NPs earn less than physicians. The Cochrane review suggests that this differential may be offset by increased utilization of services and referrals by NPs. This assertion was confirmed in a study by the American College of Physicians that compared utilization rates among physicians, residents, and nurse practitioners in the *Journal Effective Clinical Practice*. “Researchers showed that utilization of medical services was higher for patients assigned to nurse practitioners than for patients assigned to medical residents in 14 of 17 utilization measures, and higher in 10 of 17 measures when compared with patients assigned to attending physicians. The patient group assigned to nurse practitioners in the study experienced 13 more hospitalizations annually for each 100 patients and 108 more specialty visits per year per 100 patients than the patient cohort receiving care from physicians”. *The Question of Independent Diagnosis and Prescriptive Authority for Advanced Practice Registered Nurses in Texas: Is the Reward Worth the Risk?*, (Ramos, 2011).

The Governor’s budget would eliminate the requirement for a written practice agreement or written practice protocols for nurse practitioners who provide only primary-care services as determined by the commissioner of health, but only if they demonstrate to the Department of Health that it is not reasonable to require such agreement or practice protocols. This language is preferable to legislation to eliminate the written practice agreement altogether. This language must be tightened to more clearly define the limited circumstances where a collaborative relationship requirement can be waived. We can fathom no instance where the quality of patient care can reasonably require the elimination of the written practice agreement and protocols.

The purpose of defining scope of practice in statute is to ensure that practitioners are only practicing within the parameters of their education and training and, if required, in a defined relationship with a physician. This provides protection and safety for patients in their care. These proposals would seriously endanger the patients for whom they care. Moreover, expansion of scope of practice for non-physician providers without an adequate educational base will inevitably increase health care costs – not decrease them. Nor will such proposals address our physician workforce shortage. Non-physician practitioners wish to practice in the very same regions of the state in which physicians now practice. Studies show clearly that they do not choose to practice in rural or urban underserved communities.

4.) Prevent the Proliferation of Retail Clinics

The proposed budget would allow diagnostic and treatment centers owned by for-profit companies to be established to provide health care services within the space of a retail business operation, such as a pharmacy, a store open to the general public, or a shopping mall. They would be referred to as “limited service clinics.” The Commissioner is required to promulgate regulations setting forth operational and physical-plant standards including: designation of the diagnoses and services that may be provided; a prohibition on providing care to children under two years of age; advertising guidelines; disclosure of ownership interests; informed consent; record keeping. The commissioner may consult with a work group composed of representatives from professional societies and others on how to strengthen and promote primary care, how to integrate services of limited-service clinics and health care providers, and how to appropriately transmit patient information.

Specifically, the budget language would permit publicly traded corporations to operate diagnostic or treatment centers through which health care services may be provided within a retail business including but not limited to a pharmacy, a store open to the general public or a

shopping mall. Currently, while there are some physician offices which have co-located with pharmacies in New York, there is no overlapping ownership thereby protecting the sanctity of the doctor-patient relationship. This proposal would disrupt the independence of medical decision-making and the integrity of the doctor-patient relationship.

‘Convenience care clinics’ or ‘retail clinics’ operate in states outside New York in big box stores such as Walgreens or retail pharmacies such as CVS. They are a growing phenomenon across the nation, particularly among upper class young adults who live within a one mile radius of the clinic. These clinics are usually staffed by nurse practitioners or physician assistants and focus on providing episodic treatment for uncomplicated illnesses such as sore throat, skin infections, bladder infections and flu. Physicians feel strongly that retail based clinics pose a threat to the quality of patient care and to the ability of physician practices to sustain financially and should not be allowed to propagate in New York.

Unlike primary care physician practices, retail clinics provide just one primary care function: first contact care. We are concerned that retail clinics will harm continuity of care. Data from one study demonstrate that patients who visited retail clinics subsequently had less first-contact care and less continuity of care with primary care physicians. *Retail Clinic Visits and Receipt of Primary Care*, (Reid, 2012). Another study found it noteworthy that “a large fraction of patients at retail clinics continued to report that they did not have a primary care physician”. *Visits To Retail Clinics Grew Fourfold From 2007 To 2009 Although Their Share Of Overall Outpatient Visits Remains Low*, (Mehrotra & Lave, 2012). While the budget language authorizes the Commissioner of Health to consult a work group of physicians and others concerning ways to enhance continuity of care and referrals to primary care physicians, this authority is permissive only. Moreover, retail clinics should not serve as replacement for a primary care physician.

While convenient to their clientele, retail clinics are not the most appropriate venue through which to provide care for the chronically ill, elderly and pediatric population. Individuals with chronic conditions taking multiple medications which could have harmful interactions with medications prescribed for acute conditions require the type of care coordination found in a private physician practice, not at a retail clinic. Similarly, the health needs of the elderly are complex and because retail clinics focus on episodic care, retail clinics are not an appropriate site of care for the elderly. Moreover, children are not adults and shouldn’t be treated episodically. Treatment for a ‘minor condition’ enables the pediatrician to catch up on immunizations, identify undetected illness, discuss any problems with obesity or mental health and enhance their bond with the child and family.

Another concern is the potential conflict of interest posed by pharmacy chain ownership of retail clinics which provides implicit incentives for the nurse practitioner or physicians’ assistant in these settings to write more prescriptions or recommend greater use of over-the-counter products than would otherwise occur. The same self-referral prohibitions and anti-kickback protections which apply to physicians are not applicable to retail clinics, raising the concern for significant additional cost to the health care system.

The retail clinic model of care delivery could lead to increased fragmentation of care and to the erosion of patient relationships with primary care physicians. This fragmentation could lead to missed diagnoses and missed opportunities for preventive services.

High quality of care requires ongoing care coordination among providers, necessitating a transfer of information to primary care providers after a patient has been seen at a retail clinic.

Providing a patient with a printed record of the visit is not adequate to assure that the information reaches the primary care provider. And while EHRs are used in retail clinics, interoperability remains illusive.

It is significant that in 2008 more than twenty physician groups or hospital chains operated retail clinics, including Mayo Clinic and Geisinger Health Systems. Each retail clinic is linked to a primary care practice(s). In this integrated model, the retail clinic is the extension of the Patient Centered Medical Home. This type of model would enable the PCMH to offer extended hours and convenience for the patients served by the PCMH. This model is far preferable to the Minute Clinic model advanced as part of the aforementioned legislation which merely provides episodic care for services more commonly provided in urgent care or ER but at a lower price-point. Rather than only considering the cost of care, our developing system of care must at its core retain the care coordination and integrative structures of PCMH.

In New York State, section 2801-a(4)(e) provides as follows: “No hospital shall be approved for establishment which would be operated by a corporation any of the stock of which is owned by another corporation or a limited liability company if any of its corporate members’ stock is owned by another corporation.” The definition of a hospital in New York State would include a diagnostic and treatment center such as the limited service clinic proposed by this initiative. The only for-profit corporations/limited liability companies that are currently permitted to operate hospitals are corporations/companies owned by individuals. A very limited exception was enacted in 2007 to enable publicly traded companies to participate in the operation of dialysis facilities. This was advanced, however, only after significant study over several years by the NYS Department of Health and the State Hospital Review and Planning Council and Public Health Council. This recommendation was expressly limited to dialysis facilities based on the unique characteristics of the service including:

- Chronic renal dialysis is a discrete, definable outpatient service, which varies little in how and when it is prescribed and administered;
- Virtually all those who receive chronic dialysis suffer from a common diagnosis (end stage renal disease);
- Chronic renal dialysis is the only service supported by a federally-guaranteed insurance program of coverage based on dialysis; and
- The continued decline in real terms of Federal payment for dialysis required an alternative to the State’s prohibition on publicly traded corporations in this area if access to care is to be ensured over the longer term.

We submit that none of the indicia, which existed to support the limited exception to prohibitions against ownership of hospitals as that term has been defined or would be defined under this proposal, exist to support similar treatment for retail clinics operated by publicly traded corporations.

The retail clinic model of care delivery diverges from the integrated and coordinated care delivery model health policy makers believe will rein in the cost of health care while improving overall health outcomes. Importantly, the integrated and coordinated care delivery model emphasizes comprehensive care which is coordinated across all providers and for all patients, even those with more complex and chronic illnesses. Rather than bend the cost continuum, we will increase costs and negatively impact on quality of care.

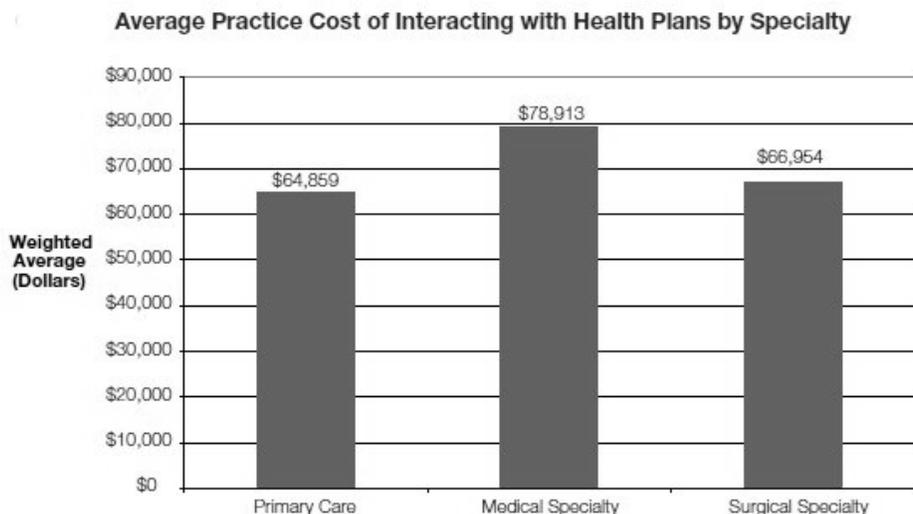
We must also be mindful that this proposal may threaten the financial viability of primary care physician practices in the community. This will cause physician practices in certain areas to

close or to be sold to large hospital systems, displacing their patients, their employees and further destabilizing the health care delivery system in that community. We strongly urge that the Legislature reject this proposal.

5.) Preserving Prescriber Prevails Under the Medicaid Prescription Drug Program

As you know, the Medical Society has long advocated for protection of the physician’s clinical decision making authority and the patient’s unfettered right to access the medication or treatment prescribed by their physician. This is why we strongly supported the Legislature’s efforts in the past to establish and continue the “provider prevails” language as it pertained to the preferred drug program (PDP) and clinical drug program (CDRP) and why we oppose proposals contained in the budget to eliminate prescriber prevails for anti-psychotic medications as well as in the Medicaid fee-for-service program. Central to our consideration of these programs was our position that the PDP & CDRP procedures and rules should not interfere with the ability of a physician to assure that his or her patient had the most appropriate medication. We ask for you to remove these proposed changes in the proposed budget and for your support for applying a “provider prevails” policy to prior authorization administered by Medicaid managed care plans for prescribed medical services and pharmaceuticals.

Physicians are subject to an absurd number of requirements imposed by managed care plans and health insurers which force them to take more and more time away from their patients but which in many cases provide no commensurate benefit to the problem. This is extremely costly to the provider and very often diminishes rather than enhances care, quality and access.



Source: *Changes in Healthcare Financing & Organization*, March 2010

As government seeks to shift risk downward to the health plans, we are concerned that already burdensome prior authorization processes will become more and more intrusive upon the physician. Already, physicians feel that the medication approval processes in New York cost them unnecessary time and money as they seek to assure that their patients have access to the medications they prescribe. As we move more and more of the Medicaid population into Medicaid managed care, this problem will worsen unless you take action to establish appropriate protections for physicians and their patients. Increasing ancillary practice burdens on physicians will not and cannot save money in the long term. Additional time consuming requirements take large amounts of time and time is an expensive commodity. These

problems will become even more acute as hundreds of thousands of New Yorkers will become newly insured in 2014, which will exacerbate the already extraordinary administrative burdens imposed on doctor's office. We must reduce this burden or patients will be unable to obtain the care they expect to receive by being insured.

As an example of these administrative burdens, I would like to draw your attention to the results of a survey of over 650 physicians conducted by MSSNY just over a year ago which clearly demonstrate the significant concerns of physicians regarding prior authorization for medications. Many of these physicians treat a large number of Medicaid patients in their practice. 96% percent of responding physicians believe that the current PA processes for medications present a burden to physicians and their office staff. 65% of these indicated that they or their staff spent more than fifteen minutes to receive PA from a Medicaid managed care plan for a prescription needed for their patients. 87% of respondents indicated that the Medicaid managed care plan either occasionally denied or frequently denied their request for PA for a prescription for a patient. 47% of physicians appealed the plan's denial of their PA request. Importantly, 72% of physicians who responded to the survey stated that at no time during the PA or appeal process were they afforded an opportunity to speak with a physician or pharmacist concerning the appropriateness of their prescription for their patient. Overall, 74% of respondents believe that the PA process is more difficult than what existed prior to October 1st and 75% find it to be difficult to access information regarding the Medicaid managed care plan formularies or step therapy rules. An overwhelming 94% of respondents believe that the lack of a single state-wide formulary for all Medicaid patients increases the burden on them and their office staff. Some of the most frequently cited Medicaid managed care plans include Fidelis, Blue Cross/Blue Shield, HealthFirst, HIP And MVP.

In our opinion, a provider prevails policy is an important protection which will assure access to medically necessary care and treatment. Additionally, another needed protection which would become operative upon the making of an adverse determination would be a requirement for the review of a physician in the same or similar specialty as the physician who has prescribed the medication. Currently, Article forty nine of the public health law does not require a physician in the same or similar specialty to be involved in the internal appeal of an adverse determination. We also support legislation (A. 2693) sponsored by Assemblyman Gottfried which would require a clinical peer reviewer to be a physician in the same or similar specialty as the physician who ordered the treatment or service or prescribed the medication. Moreover, we support legislation to require managed care plans to provide physicians with access to a clear and convenient process to override plan step therapy restrictions where (a) the physician believes in his/her professional judgment that the preferred treatment is expected to be ineffective based on the known relevant physical or mental characteristics of the covered person and known characteristics of the drug regimen, and is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or (b) the physician believes in his/her professional judgment the preferred treatment has caused or is likely to cause an adverse reaction or other harm to the covered person. This language is contained in legislation (S.2086 Young) currently pending before the Senate Insurance Committees.

Lastly, we would note that the physicians who responded to our survey by a ratio of 3:1 felt that the PA process for medications is now more difficult. 76% found it difficult to access information regarding the Medicaid managed care plan formularies or step therapy rules. We believe that these responses are interrelated. To the extent that physicians cannot access important information regarding whether a drug is on formulary, the more time is devoted to the process and the impression that it is more difficult is made. Moreover, respondents almost uniformly (94%) believe that the lack of a single state-wide formulary for all Medicaid patients

increases the burden on them and their office staff. Development of a single formulary is complicated, but we would be willing to continue to discuss this possibility with you in the future.

We urge you to reject the changes to the “prescriber prevails” requirements in New York Medicaid, and instead urge you to work to address these choking administrative burdens.

6.) Funding for the Committee for Physicians’ Health (CPH)

Public Health Law Section 230 authorizes the state medical and osteopathic societies to create a Committee of Physicians to confront and refer to treatment physicians suffering from alcoholism, chemical dependency or mental illness. MSSNY contracts with the Department of Health’ Office of Professional Medical Conduct (OPMC) to provide the services required by law. The program is funded not from a tax but by a \$30 surcharge on the physician’s license and biennial registration fee, which is specifically dedicated by statute for this purpose. Historically, the program was subject to sunset every three or five years making it difficult for MSSNY to establish a long-term business plan. We are pleased by the inclusion of language in the proposed budget which will make permanent the CPH program. We are also pleased that the budget will continue the \$990,000 appropriation for program operation.

Since the inception of this MSSNY program, CPH has evaluated 3505 physicians, routinely monitors the recovery of 450 physicians, and annually reached out to an additional 190 physicians thought to be suffering from alcoholism, drug abuse or mental illness. We believe that the work of the CPH program is valuable to all physicians and indeed to the state generally. We urge that the Legislature adopt the language to make this program permanent. We also ask that the appropriation of \$990,000 be continued.

Conclusion

Thank you for allowing me, on behalf of the State Medical Society, to identify our concerns and suggestions for your consideration as you deliberate on the proposed budget for state fiscal year 2013-2014. To summarize, we believe that the state can achieve significant savings through the enactment of medical liability reforms. The continuation and dedication of funding for the Excess medical liability program is important to facilitate the retention and recruitment of needed primary care and specialty physicians in certain rural and underserved urban communities in New York State. We caution against and oppose the inappropriate expansion of scope of practice for nurse practitioners and other non-physician practitioners. Additionally, we believe that it is critically important that the Legislature prevent the proliferation of retail clinics in New York State. We also ask your support for continuing a “provider prevails” policy to prior authorization administered by Medicaid managed care plans for prescribed medical services and pharmaceuticals. Finally, we encourage the adoption of language to make MSSNY’s Committee on Physicians’ Health permanent and the adoption of an appropriation at current levels to sustain the operation of this important program.