MSSNY Responds to Governor’s Statement on Physician Discipline Proposal

“New York’s Physicians have a great interest in working with the State Health Department to ensure that New York’s disciplinary process moves swiftly when necessary to remove those from practice that present a threat to the public. To that end, we have worked proactively with the Administration and Legislature on laws to enhance the ability of OPMC to “summarily suspend” physicians in certain instances where it would be imprudent to wait for a final action. And it is imperative that we work for improvements to this system as issues arise that interfere with its mission to protect the public.

At the same time, an appropriate balance is needed. Recognizing that there are enormous professional implications when disciplinary action is taken against a physician, or even when there has been an accusation, we must also ensure that fair due process is provided when a physician is accused of professional misconduct. Indeed, most complaints of alleged misconduct do not become actual findings of misconduct. Yet with Google and Yahoo search functions, an unproven allegation could linger forever in cyberspace, and permanently and unfairly scar a reputation.

We look forward to reviewing the text of this proposal as it becomes available and working with the Legislature and Governor to ensure we maintain the critical balance of protecting the Public while also protecting against the consequences of unfounded allegations.”

Click here to urge your legislator to reject this proposal.

Governor Announces Proposed Budget

Governor Cuomo released his proposed $178 billion Executive Budget for the 2020-21 fiscal year, including measures to close a $6.1 billion budget deficit, through creating a new Medicaid Redesign Team (MRT) to recommend $2.5 billion in Medicaid savings, assuming an additional $2 billion in new tax revenue, and $1.8 billion in reduced payments to localities. Among the most notable items for physicians upon initial review are:

**ITEMS OF SIGNIFICANT CONCERN INCLUDE:**

As previously announced, expanding the ability of the Commissioner of Health to notify the public that a physician is under investigation and to make it easier for the Commissioner to summarily suspend a physician license during a disciplinary investigation. Send a letter to your legislators urging they oppose this grossly unfair proposal.

- Expanding the information on the physician profile to include office hours, whether accepting new patients and insurance participation information.
- Legalizing, regulating and taxing the production, distribution, transportation and sale of cannabis.
- Expand the list of adult immunizations that can be provided by pharmacists.
- Expand the existing physician-pharmacist collaborative drug therapy program to include nurse practitioners and physician assistants.

**POSITIVE ITEMS UNDER THE PROPOSED BUDGET:**

- Require the regulation of Pharmaceutical Benefit Managers (PBM)s with the Department of Financial Services (DFS) and to disclose financial incentives they receive.
- A comprehensive anti-smoking package including: prohibiting the sale or distribution of e-cigarettes or vapor products that have a characterizing flavor; prohibiting the sale of tobacco products in all

(Continued on page 19)
A recent report found providers on average spend almost $11 per transaction to conduct a prior authorization manually versus $1.88 for an electronic transaction.

The cost of prior authorization requirements on physician practices has continued to increase – up 60% in 2019 to manually generate a request to insurers.

The just released CAQH 2019 Index, which concluded that the healthcare industry can save $13.3 billion on administrative waste through automation of eight transactions including prior authorizations, said the medical industry could see potential annual savings of $454 million by transitioning to electronic prior authorizations.

The CAQH report said prior authorization is the most costly, time-consuming administrative transaction for providers. On average, providers spent almost $11 per transaction to conduct a prior authorization manually and nearly $4 using a web portal. The cost of an electronic transaction is $1.88.

The process is time-consuming for practices. On average, a manual prior authorization required 21 minutes of provider staff time, while electronic prior authorization transactions can be completed in four minutes.

Prior authorizations were just one of the changes the CAHQ report highlighted. The U.S. healthcare industry spends $40.6 billion annually on just eight healthcare administrative transactions related to verifying patient insurance coverage and cost-sharing, obtaining authorization for care, submitting claims and supplemental information and sending and receiving payments, according to CAQH researchers.

CAQH found that by adopting fully electronic processes for just these eight transactions the industry can reduce waste by $13.3 billion annually—33% of administrative spending. Those eight transactions are:

1. Eligibility and benefit verification
2. Prior authorization
3. Claim submission
4. Attachments
5. Coordination of benefits
6. Claim status inquiry
7. Claim payment
8. Remittance advice

Of the $13.3 billion in potential savings through automation, $9.9 billion can be saved by medical plans and providers, while $3.4 billion can be saved by the dental industry, according to the report. In both industries, the greatest savings exist for providers as compared to plans.

(Fierce Health, Jan. 2020)
Your Future is Now

Physician Advocacy Day

Wednesday, March 4, 2020 • Albany, New York

Join your colleagues to discuss priority issues with your legislators

- Preventing Counterproductive Medicaid Cuts
- Preserving Due Process for Physicians
- Reducing Prior Authorization Hassles
- Rejecting Burdensome Mandates

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MORE INFO
PRESIDENT’S COLUMN

The George Bailey Profession

As the Holidays slowly fade into history, a few things still stand out, especially the movies. For sure there’s Dickens’ timeless A Christmas Carol in many versions, including the Bill Murray Scrooged. And of course, Jean Shepherd’s “You’ll shoot your eye out” A Christmas Story. But the film which should have a special meaning for physicians is Frank Capra’s It’s A Wonderful Life. It tells the story of a despondent George Bailey who in the depths of despair contemplates suicide. He is spared by the intervention of Clarence, an angel-trainee, who shows George how much his life impacts the lives of all those around him and how much worse the world would be for his passing. George regroups and, in the end, Clarence gets his wings. Folks, Medicine is the George Bailey profession. We’ve had two studies demonstrating the economic impact that physicians have on their local, state and national economies. The first, done in 2009, showed that NY’s physicians contribute billions in local, state and national tax revenue, employ hundreds of thousands, and also contribute to the public good by promoting better health for all New Yorkers.

In 2018, the AMA produced another economic impact study which again demonstrated physicians’ impact far outside the confines of the exam room. NY’s physicians’ economic activity alone generated over $140 billion. Over 600,000 jobs were either directly or indirectly supported by physicians’ activity. Now consider the graph below. Feeling unappreciated? We’ve every right. And now, NY proposes to cut to already inadequate Medicaid payments by 1%. In Shawshank Redemption, Red gets to the point – “Get busy living or get busy dying.” There’s no Clarence in our future. It’s in our hands. Let me know how you feel on March 4th. Who’s with me?

Support MSSNYPAC
Call 518-465-8085 and ask for Jen Wilks

Inadequate increases in the Medicare Physician Fee Schedule has resulted in more that 20 percent reduction in real (inflation adjusted) Compensation since 2007.
CMS, 2017: Orthoindex Analysis 2017
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**“Dear New York Medical Marijuana Attorney: What Happens After A Qualified Patient Is Issued A Certification Permitting The Purchase Of Medical Marijuana”**

*By Andrew Zwerling, JD Partner, Garfunkel Wild*

In 2014, New York enacted the Compassionate Care Act, which ultimately led to the implementation of New York’s Medical Marijuana Program (the “Program”). The Program allows patients who suffer from specific serious conditions and who also have a condition clinically associated with, or a complication of, the serious condition, to be certified by a qualified practitioner to receive medical marijuana products for medical use.

This then raises the issue: what happens after the patient is issued his or her certification from a qualified practitioner.

**THE REGISTRATION REQUIREMENT**

Once a patient possesses a certification from a registered practitioner, the patient must register with the Medical Marijuana program through the New York State Department of Health’s (“DOH”) online Patient Registration System. The certified patient must be a resident of New York State, or be receiving care and treatment in New York State; and possess a certification issued by a registered practitioner. As specified by statute and regulation, patients will be required to provide proof of their identity and residency during the application process.

If an applicant applying for registration is not a resident of New York State but is receiving care and treatment in this state, he or she may qualify for registration as a certified patient if the person otherwise meets the requirements necessary to be a certified patient under Article 33 of the Public Health Law, and is temporarily residing in New York State for the purpose of receiving care and treatment from a practitioner registered with the department. Notably, being registered under the Program does not grant the non-New York State resident/applicant authorization to transport approved medical marijuana products outside of New York State.

**DESIGNATED CAREGIVERS AND DESIGNATED FACILITIES**

A certified patient may designate up to two proposed designated caregivers, either a natural person or a facility. (The term “facility” includes, but is not limited to, a general hospital or a residential health care facility operating pursuant to Article 28 of the Public Health Law or any individual division, department, component, floor or other unit of such facilities.) No person may be a designated caregiver for more than five certified patients at one time. A certified patient’s designation of a designated caregiver shall not be valid unless and until the proposed designated caregiver successfully applies for and receives a designated caregiver registry identification card.

(Continued on page 8)

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**Off to the Races with $178 Billion Proposed Budget!**

And just like that, we are off to the races, with the Legislature back in Albany and the Governor presenting his proposed $178 Billion Budget.

The enormous (even for New York) $6 billion Budget deficit facing New York State forces several difficult policy decisions as the Legislature and Governor try to finalize a State Budget by April 1.

Physicians, hospitals and many other health care provider groups have already received a New Year’s “present” of a 1% cut to their Medicaid payments, and we are all fearing future cuts as the Governor and the Legislature seek to close the deficit.

The Governor is also seeking to save money in his Budget by expanding the immunizations that can be provided by pharmacists and enabling nurse practitioners to collaborate with pharmacists to manage a patient’s drug therapy.

Reductions have been proposed to the Excess Medical Malpractice Program.

And then there are the disconcerting proposals relating to reforming the physician discipline process.

**POSITIVE ASPECTS**

To be fair, the proposed Budget is not without its positive aspects too. Regulation of PBMs, prohibiting the sale of flavored tobacco and e-cigarette products, some modest tort reforms, reduction of taxes for small businesses, and efforts to reduce physician burdens with insurance companies are all worthy initiatives that have also been included.

Much also remains to be seen, as the Governor has called for the creation of a “MRT2”, a re-gathering of the original Medicaid Redesign Team that was formed after he was first elected in 2010. The group will be tasked with finding $2.5 billion in Budget savings.

Many of the items that MSSNY has successfully fought against in previous Budgets could end up under discussion by this group.

As the Legislature seeks to finalize a Budget by April 1, this is where we need you.

It is clear we face many challenges this year. Therefore, we need you to be in regular conversation with your legislators both in the district and in Albany.

We need you in Albany for our Physician Advocacy Day on March 4.

It is an opportunity for you to hear from our legislative leaders, as well as for you to ask them questions about their priorities for preserving access to care in our communities. Most importantly, you can visit with all your local legislators.

Legislators need to see physicians in white coats all over the Capitol as a reminder that they need to take the right choices to help protect our patients.

Please make it a priority to be in Albany on March 4. You can register here.

We also need you to help support our political efforts. With the State’s primary date being bumped up from September to June, we have and will continue to be overwhelmed with requests to support campaigns. Participation in these events are a great opportunity to get to know your local legislators.

We certainly know our policy opponents will be in attendance.

Our lobbyists in Albany maintain many strong relationships with key elected officials and their staffs, as do many physicians in their respective communities. A strong PAC helps tie all these together, helping the medical community have a stronger voice in the halls of the Capitol as difficult legislative and Budget decisions are being made.

Please make it a priority to support MSSNYPAC. With so many new faces and leaders in the New York State Legislature, we must continue to develop and enhance the physician community’s relationships with these new leaders.

To contribute or supplement your contribution, click here.

With so many challenges facing the medical profession in 2020, it is imperative for physicians to stay active in the policy making and political process.

Don’t sit on the sidelines. Join our efforts today!
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**Dear New York Medical Marijuana Attorney**

(Continued from page 6)

Once registered with DOH as a designated caregiver, a facility may assist the patient with the possession, acquisition, delivery, transfer, transportation and/or administration of approved medical marijuana products. There are strict requirements with regard to the storage of approved medical marijuana products in order to diminish the risk of diversion, as well as regarding the disposal of such products. Such products must be disposed of in a manner that renders the product non-recoverable beyond reclamation.

**PROCEDURES AND PROTOCOLS AFTER THE ISSUANCE OF A REGISTRY ID CARD**

Certified patients or their designated caregivers who are registered with the Medical Marijuana Program can purchase medical marijuana products from a registered organization’s dispensing facility in New York State (whose locations can be found on the DOH website) by bringing their registry ID cards and their certifications to the dispensing facility. Designated caregivers obtaining medical marijuana on behalf of their patients must bring their caregiver registry identification cards and their patients’ certifications to the dispensing facility.

Certified patients and designated caregivers must always carry their registry ID card whenever they possess approved medical marijuana products, and medical marijuana products may not be transported outside of New York State. New York State does not accept certifications or registry ID cards from other states.

**PROTOCOLS RELATING TO THE DISPENSING AND USE OF MEDICAL MARIJUANA**

The marijuana that may be possessed by a certified patient shall not exceed a thirty-day supply of the dosage as determined by the qualified practitioner, except that during the last seven days of any thirty-day period, the certified patient may also possess up to such amount for the next thirty-day period. The medical marijuana must be kept in the original package in which it was dispensed, except for the portion removed for immediate consumption for certified medical use by the certified patient.

Each registered organization may initially produce up to five brands of medical marijuana product, with each brand having a specific concentration of total Tetrahydrocannabinol (THC) and total Cannabidiol (CBD), with the price set by DOH. Approved medical marijuana products are limited to the following forms of administration: 1) metered liquid or oil preparations; 2) solid and semi-solid preparations (e.g. capsules, chewable and effervescent tablets, lozenges); 3) metered ground plant preparations; and 4) topical forms and transdermal patches. Medical marijuana may not be incorporated into food products by a registered organization, unless approved by DOH. Importantly, smoking is not an approved route of administration.

**WHERE MEDICAL MARIJUANA MAY BE USED BY THE CERTIFIED PATIENT**

Possession of medical marijuana shall not be lawful if it is smoked, consumed, vaporized, or grown in a public place, regardless of the form of medical marijuana stated in the patient’s certification. Approved medical marijuana products are prohibited from being vaporized in a public place. Likewise, vaporization of approved medical marijuana products shall not be permitted and no person shall vaporize an approved medical marijuana product within 100 feet of the entrances, exits or outdoor areas of any public or private elementary or secondary schools (unless the vaporization transpires in a residence, or within real property boundary lines of such residential real property).

Also, consumption of approved medical marijuana product shall not be permitted in any motor vehicle, either public or private, that is located upon public highways, private roads open to motor vehicle traffic, parking area of a shopping center or any parking lot, as defined in section 129 of the Vehicle and Traffic Law.

Finally, if a certified patient or designated caregiver willfully violates any provisions of the Program, his or her registry identification card may be suspended or revoked.
Male Physicians Earned 17% More Than Females After Completing Residencies

Male physicians earned about 17% more than their female peers upon completing medical residencies in New York, and the difference in pay persisted even when adjusting for differences in specialty and work-life balance preferences, according to a study published January 21 in *Health Affairs*.

The analysis of physicians completing residencies here between 1999 and 2017 showed that men starting their career in medicine earned an average of $235,044, compared with $198,426 for women.

The study builds upon existing research into the differences in salaries between men and women in medicine and sought to expand upon it by incorporating questions about individuals’ desired work-life balance. The study’s authors hypothesized that physicians who wanted more control over their schedule and more predictable hours might draw lower salaries.

**WORK LIFE BALANCE**

Women were more likely to respond that they cared about work-life balance, but the difference didn’t influence their salary. “Much to my surprise, these new variables in no way explained the persistent gap in starting salaries for male and female physicians,” said Anthony Lo Sasso, a co-author of the study and a professor of economics at DePaul University in Chicago. “That came as quite a shock to me. I thought it would explain the gap, and it did nothing.”

**BASED ON NEW YORK DATA**

The paper analyzed survey responses from 16,047 people – 9,042 men and 7,005 women. The data come from the annual New York Survey of Residents Completing Training, which is conducted each year by the University at Albany’s Center for Health Workforce Studies. The researchers noted that New York trains more resident physicians than any other state.

The study found about 60% of the difference in pay between men and women could be explained by what specialty they chose to pursue, with men more likely to practice in lucrative surgical specialties and women more often choosing primary care. But even when adjusting for specialty and demographic differences, the analysis showed about a $20,000 gap between men and women.

That gap hasn’t narrowed in recent years. It was about $7,700 in 1999 and grew to nearly three times that amount, $20,200, by 2017, including adjustments for inflation.
NY 4th in Nation for People Over Age 60

New York is home to 4.3 million older adults, ranking fourth in the nation in the number of individuals age 60 and older, the state Office for the Aging found. By 2030 that population is expected to grow to more than 5.3 million, or 25% of the state’s population.

The state Department of Health noted in a 2017 report that the growing number of individuals with Alzheimer’s disease and dementia “has created an urgent need for additional trained professional caregivers” in New York.

The department’s most recent data estimated that 390,000 people in the state have Alzheimer’s – the most common form of dementia – with the number expected to increase to 460,000 by 2025.

Millennials Most Likely to Skip Flu Shot, Survey Finds

Anti-vaccine sentiment may be fueling many millennials’ decision to skip the flu shot, according to a survey from the American Academy of Family Physicians.

Wakefield Research conducted the online survey on behalf of AAFP, polling 1,500 Americans ages 25-73 between Nov. 27 and Dec. 9, 2019.

Five survey findings:
1. About half of Americans (51 percent) did not get a flu shot this season.
2. Millennials were most likely to skip the flu shot. Fifty-five percent had not gotten vaccinated when surveyed, and 33 percent said they were not planning to get the flu shot this season.
3. About 61 percent of millennials who knew about the anti-vaccine movement said they agreed with some of its beliefs. Just 52 percent of adults and 42 percent of baby boomers said the same.
4. African American respondents were least familiar with the anti-vaccine movement of all respondent groups. However, among individuals who were familiar with the movement, African Americans were most likely to say they agree with anti-vaccine sentiment.
5. Men were more likely to underestimate the flu’s dangers than women. Twenty-three percent of men reported skipping vaccination because they don’t think the flu is serious, compared to 5 percent of women.

To view more survey findings, click here.

Doctors’ White Coats

(Continued from page 8)

that the impact of doing that on health care-associated infection outcomes remains unknown.”

Bearman added that when developing the guidelines, SHEA “aimed for something that was practical.”

Olvera-Lopez said a lack of attention to the cleanliness of white coats “happens throughout the nation, and even in other countries. And not just doctors, but respiratory therapists, social workers, anyone who wears a long-sleeved white coat.” And while research on the issue is lacking, the fact that the issue is so widespread shows “there’s a real need for education about this within the hospital,” he said.

Olvera-Lopez noted, “It was shocking to see the reaction from colleagues when I presented these results.
An appeals court has declared that it is not fraud when a physician’s reasonable medical judgment does not match that of a doctor testifying for government prosecutors. That ruling agrees with the position argued in an amicus brief filed by the AMA and others.

**STANDING FOR PHYSICIANS**

In this instance, the government accused a hospice company of violating the False Claims Act, claiming too many patients outlived the physician-certified, terminal prognosis of six months that made their care eligible for the Medicare hospice benefit. To prove its case, the government brought in a single physician expert witness who, based on a review of medical records, disagreed with the conclusions of the certifying physicians.

The AMA and four hospice professional organizations disputed the notion that one professional opinion pitted against another could be proof of fraud.

“For a given patient, there could be a range of reasonable prognoses,” says their friend-of-the-court brief. “Though physicians might reach differing conclusions about how long the patient will live, none of those conclusions would necessarily be false.”

The decision upheld part of the trial court’s ruling in United States of America v. AseraCare Inc. et al., which summarily dismissed False Claim Act charges post-verdict following a complicated, bifurcated trial. The appeals court sent the case back to that trial court, the United States District Court for the Northern District of Alabama, to allow the government to present additional evidence.

**DEFINING “REASONABLE”**

“The nature of prognoses, the nature of death, and the limitations of medical records in capturing all of the considerations that accompany a prognosis of impending death,” describe the broad wide ranges of what can be reasonable in forecasting which the brief examines in detail.

A reasonable conclusion can’t be false. The brief uses the example of a thermometer – there is no disputing when it reads 98.6 degrees. The brief contrasts that with another example – treatment based on cholesterol levels, which can easily vary. “One physician might prescribe more exercise along with medication; another physician might prescribe only more exercise. Neither physician’s prescription is wrong if the facts support both courses of action.”

There is a wide range for reasonable conclusions on individual life expectancy. “Numerous factors can influence when a person will die, including not just the terminal illness itself, but other health conditions,” notes the brief. “There is no simple formula for determining how much weight to give each factor.” It gives a detailed history of the government revising the standards, making them less rigid over the years—initially many physicians resisted certifying patients for hospice over certainty concerns.

End of life is inherently difficult to

*(Continued on page 19)*
No other event brings together New York State’s top players in the medical profession!

The Medical Society of the State of New York’s Annual House of Delegates Meeting & Vendor Expo is the society’s only annual event for hundreds of physician leaders - including medical students, residents and young physicians. These physician leaders - from Montauk to Buffalo - come together to deliberate legislative policy, to attend educational seminars, to network with colleagues, and to visit the Vendor Expo.

The Expo features carefully vetted vendors that showcase their companies and services, which enhance physicians’ lives as well as their practices.

MSSNY House of Delegate attendees are decision makers. They represent the full spectrum of New York State medical professionals, including all specialties and sub-specialties. These attendees represent the specific interests of group medical staffs, small practices, IPAs and single practitioners. County medical societies and specialty societies also participate in the deliberations and send members of their executive staffs to seek out and recommend new and improved benefits for their members.

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Contact Roseann Raia 516-488-6100 ext. 302 • rraia@mssny.org
ALBANY UPDATE

PARTIAL FILL PRESCRIBING ON SENATE CALENDAR

A measure that would enable the dispensing of a partially filled controlled substances prescription, is now on the Senate calendar for a vote. The measure, S. 7115/A.9034, sponsored by Senator Gustav Rivera and Assemblymember John McDonald, would allow a prescriber to issue a partially filled prescription for a Controlled Substance II, III, IV, V to a patient.

The prescription would be recorded in the same manner as a refill and the remaining quantity of the prescription may be dispensed separately. In 2016, Congress passed legislation that would enable partial fill prescription under the Comprehensive Addiction and Recover Act (CARA). This state measure would allow New York State to conform to what is allowable under federal law.

A similar measure had passed during the 2019 legislative session, but was vetoed by Governor Andrew Cuomo. This new bill addresses concerns expressed by the administration. The Medical Society supports this measure and believes that it will help to reduce the amount of unused pain medication that can accumulate in home medicine cabinets and will allow prescribers to help patients balance the need to relieve pain with an adequate supply of medication.

NYS DOH ISSUES GUIDANCE ON 2019 NOVEL CORONAVIRUS (2019-nCOV)

The New York State Department of Health issued guidance on the 2019 novel coronavirus (2019-nCoV) and this includes healthcare providers and facilities collecting a travel history for patients presenting with febrile illness and remain aware of current outbreaks overseas. Patients who meet either of the following criteria should be evaluated as a person under investigation (PUI) in association with the 2019-nCoV outbreak.

Fever AND symptoms of lower respiratory illness (e.g., cough, shortness of breath) and in the last 14 days before symptom onset had:

A history of travel from Wuhan City, China OR close contact with a person who is under investigation for 2019-nCoV while that person was ill. Fever OR symptoms of lower respiratory illness (e.g., cough,短ness of breath) and in the last 14 days before symptom onset had:

Had close contact with an ill laboratory-confirme d2019-nCoV patient. A copy of the NYS DOH guidance is here.

MSSNY is planning to conduct a webinar on 2019 Novel Coronavirus (2019-nCoV) in March. More information will be available shortly.

REGISTRATION NOW OPEN FOR STEPS TO PHYSICIAN WELLNESS AND RESILIENCY

MSSNY is proud to announce our first webinar entitled Steps to Physician Wellness and Resiliency on February 25 from 7:30-8:30am. Jeffrey Seltzer, MD will serve as faculty for this webinar.

Educational Objectives are:

- Review the warning signs that stress, depression, anxiety or substance use may impact work or personal life
- Identify strategies to increase personal empowerment toward making positive change, including self-assessment tools
- Recognize self-monitoring strategies for stress related problems and know when to seek professional assistance

Register by clicking here.

Additional information or assistance with registration may be obtained by contacting Melissa Hoffman at mhoffman@mssny.org.

The Medical Society of the State of New York is accredited by the Accreditation Council for Continuing Medical Education (ACCMEd) to provide continuing medical education for physicians.

The Medical Society of the State of New York designates this live activity for a maximum of 2.0 AMA/PRA Category 1 credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

(HOFFMAN)

LEGISLATION TO EXPAND MANDATE FOR PAIN MANAGEMENT FOR ALL DEA PRESCRIBERS ON SENATE CALENDAR

A measure that would expand the coursework under the current pain management requirement has moved to the Senate calendar. S.7102, sponsored by Senator Brian Benjamin, would expand the topics within the three hour course to include techniques that would reduce the likelihood of overdose and spread of blood-borne diseases by those who use drugs; medications used for the treatment of addiction and information about becoming a buprenorphine prescriber.

The Medical Society of the State of New York is opposed to this measure. MSSNY staff has been discussing the implications of this measure with Senators and Senate staff and its effect on prescribers who may have already taken course work to meet the requirement. Physicians and other health care providers who have a DEA license were required to take a three hour course on pain management, palliative care, addiction that included the state and federal requirement for prescribing controlled substances, appropriate prescribing, managing acute pain, palliative medicine, prevention, screening and signs of addiction, responses to abuse and addiction and end of life care.

This requirement passed the Legislature in 2016 and physicians were required to have taken this program by July 1, 2017. The law also requires that DEA prescribers take the course every three years—2020 is the start of a new cycle and physicians are again required to take this course.

MSSNY OPPOSES LEGISLATION TO ALLOW ESTHETICIANS & OTHERS TO PERFORM LASER HAIR REMOVAL

A bill (S.2834/A.821) that would allow estheticians, and others, to perform laser hair removal with only minimal physician oversight, was reported out of the Senate Committee on Consumer Protection at its first meeting of 2020, on Tuesday, January 14. MSSNY has long opposed this legislation as it would essentially legitimize a currently unregulated practice to perform a procedure that should only be done by an appropriately trained and educated individual, under physician supervision.

MSSNY indicated in its’ memo of opposition that it appreciates the intent of the legislation to increase safety and oversight and is working with the sponsors to make changes to the bill that establishes critical physician oversight and ensures patients’ safety.
Key Findings

Merritt Hawkins’ 2019 Survey of Final-Year Medical Residents reflects the concerns and expectations of physicians who are about to complete their final year of training and enter the employment market.

**KEY FINDINGS OF THE SURVEY INCLUDE**

- **Residents approached by recruiters 51 or more times**
  - Medical residents completing their training are inundated with recruiting offers. Two thirds (66%) received 51 or more recruiting offers during their training, while 45% received more than 100.
  - The majority of final-year residents (63%) said they received too much contact from recruiters during their training, while only 7% said they received too little.
  - Residents cited “geographic location” as their number one priority when considering a practice opportunity, followed by “a good financial package” and the availability of “personal time.”

- **Resident who graduated from international medical schools carry significantly less educational debt than U.S. medical school graduate residents. Almost half of U.S. graduates (48%) said they carry $200,000 or more of educational debt compared to 24.5% of IMGs. Over 57% of IMGs said they carry no educational debt compared to only 22% of U.S. graduates.**

- **Residents who prefer to be employed at a hospital, medical group or other facility**
  - The great majority of residents (91%) would prefer to be an employee of a hospital, medical group or other facility than to be in independent private practice.
  - Over one-third of residents (38%) said they are unprepared to handle the business side of medicine. Only 8% of residents said they are very prepared to handle the business side of medicine.
  - Over half of residents (53%) said they received no formal instruction during their medical training regarding medical business issues such as contracts, compensation arrangements, and reimbursement methods.

- **Residents who prefer to practice in a town of 25,000 people or less**
  - Only 1% of residents who are U.S. medical school graduates would prefer to practice in a town of 25,000 people or less. The number is somewhat higher (4%) for international medical school graduates.
  - More residents (43%) indicated they would prefer to be employed by a hospital than any other practice option. Only 2% percent indicated they would prefer a solo setting as their first practice.

- **Residents who would not choose medicine as a career again**
  - Though swamped with recruiting offers, 19% of residents said they would not choose medicine as a career if they could have a do-over. However, only 13% of residents who are international medical school graduates (IMGs) would not choose medicine as a career again, compared to 21% of U.S. medical graduates.

- **Final-year medical residents 2019 survey**
  - 66% residents approached by recruiters 51 or more times.
  - 69% primary care residents received 51 or more recruiting offers during their training.
  - 91% residents who prefer to be employed at a hospital, medical group or other facility.
  - 48% U.S. graduates compared to IMGs with >$200,000 educational debt.
  - 24.5% of U.S. graduates carry $200,000 or more of educational debt compared to 24.5% of IMGs. Over 57% of IMGs said they carry no educational debt compared to only 22% of U.S. graduates.
  - The majority of residents (79%) expect to make $176,000 or more in their first practice.
  - The majority of residents (74%) begin a serious job search either within one year of completing their training or more than one year before completing their training. 26% percent wait until six months before completing their training to start a serious job search.
The New York Consumer Guide to Health Insurers ranks insurers by complaints, internal and external appeals, grievances, and dispute resolution, as well as by quality of care in various categories such as child and adolescent health, women’s health, adult health and behavioral health. It also includes information on health insurers’ accreditation, and resources such as contact information for insurers, how to make a complaint and how to apply for health insurance offered on New York’s health insurance marketplace.

The guide lists the following information:

**Rank:** Each health insurance company’s rank is based on the number of prompt pay complaints upheld, relative to the company’s premiums. A lower number results in a higher ranking. A higher ranking means that the health insurance company had fewer complaints relative to its size.

**Total Complaints:** This represents the total number of complaints closed by DFS in 2018. Complaints typically involve issues about prompt payment, reimbursement, coverage, network adequacy, benefits, rates and premiums.

**Total Prompt Pay Complaints:** This is the total number of prompt pay complaints closed by DFS in 2018. Large health insurance companies may receive more complaints because they have more members and pay more claims than smaller health insurance companies.

**Upheld Prompt Pay Complaints:** Number of closed prompt pay complaints where DFS determined that the health insurance company was not processing claims in a timely manner. Prompt pay complaints—HMOs 2018

<table>
<thead>
<tr>
<th>HMO</th>
<th>Rank</th>
<th>Total Complaints to DFS</th>
<th>Upheld Complaints by DFS</th>
<th>Premiums (Millions $)</th>
<th>Complaint Ratio</th>
<th>Total Complaints to DOH</th>
<th>Upheld Complaints by DOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital District Physicians Health Plan</td>
<td>2</td>
<td>9</td>
<td>1</td>
<td>541.47</td>
<td>0.0018</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Community Blue (HealthNow)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>183.02</td>
<td>0.0000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Empire HealthChoice HMO, Inc.</td>
<td>8</td>
<td>338</td>
<td>193</td>
<td>124.76</td>
<td>1.5470</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Excellus Health Plan</td>
<td>4</td>
<td>14</td>
<td>6</td>
<td>397.21</td>
<td>0.0151</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>HIP Health Maintenance Organization</td>
<td>7</td>
<td>688</td>
<td>400</td>
<td>2,501.09</td>
<td>0.1599</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Independent Health Association, Inc.</td>
<td>3</td>
<td>18</td>
<td>2</td>
<td>228.96</td>
<td>0.0087</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MVP Health Plan, Inc.</td>
<td>5</td>
<td>38</td>
<td>17</td>
<td>584.97</td>
<td>0.0291</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>UnitedHealthcare of New York, Inc.</td>
<td>6</td>
<td>79</td>
<td>35</td>
<td>792.96</td>
<td>0.0441</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,184</strong></td>
<td><strong>654</strong></td>
<td><strong>5,354.44</strong></td>
<td><strong>0.1221</strong></td>
<td><strong>7</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

1HMOs with a lower complaint ratio receive a higher ranking.

**Complaints—EPO/PPO Health Plans 2018**

<table>
<thead>
<tr>
<th>EPO/PPO Health Plan</th>
<th>Rank</th>
<th>Total Complaints to DFS</th>
<th>Upheld Complaints by DFS</th>
<th>Premiums (Millions $)</th>
<th>Complaint Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company</td>
<td>12</td>
<td>1,300</td>
<td>455</td>
<td>1,975.90</td>
<td>0.2303</td>
</tr>
<tr>
<td>CDPHP Universal Benefits, Inc.</td>
<td>3</td>
<td>9</td>
<td>4</td>
<td>508.50</td>
<td>0.0079</td>
</tr>
<tr>
<td>CIGNA Health and Life Insurance Company</td>
<td>9</td>
<td>180</td>
<td>102</td>
<td>1,157.74</td>
<td>0.0881</td>
</tr>
<tr>
<td>Empire HealthChoice Assurance, Inc.</td>
<td>10</td>
<td>423</td>
<td>227</td>
<td>2,549.34</td>
<td>0.0890</td>
</tr>
<tr>
<td>Excellus Health Plan, Inc.</td>
<td>5</td>
<td>88</td>
<td>27</td>
<td>2,866.75</td>
<td>0.0994</td>
</tr>
<tr>
<td>Group Health Incorporated</td>
<td>13</td>
<td>1,515</td>
<td>1,111</td>
<td>806.75</td>
<td>1.3771</td>
</tr>
<tr>
<td>HealthNow New York Inc.</td>
<td>4</td>
<td>42</td>
<td>14</td>
<td>1,502.44</td>
<td>0.0993</td>
</tr>
<tr>
<td>Independent Health Benefits Corporation</td>
<td>1</td>
<td>11</td>
<td>1</td>
<td>565.62</td>
<td>0.0018</td>
</tr>
<tr>
<td>MVP Health Services Corporation</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>734.03</td>
<td>0.0041</td>
</tr>
<tr>
<td>Nippon Life Insurance Company of America</td>
<td>6</td>
<td>11</td>
<td>3</td>
<td>62.67</td>
<td>0.0479</td>
</tr>
<tr>
<td>Oscar Insurance Corporation</td>
<td>11</td>
<td>132</td>
<td>39</td>
<td>298.80</td>
<td>1.3050</td>
</tr>
<tr>
<td>Oxford Health Insurance, Inc.</td>
<td>17</td>
<td>1,054</td>
<td>319</td>
<td>6,590.88</td>
<td>0.0484</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York</td>
<td>8</td>
<td>289</td>
<td>106</td>
<td>1,966.61</td>
<td>0.0539</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,064</strong></td>
<td><strong>2,411</strong></td>
<td><strong>21,586.03</strong></td>
<td><strong>0.1117</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

1EPO/PPO health plans with a lower complaint ratio receive a higher ranking.

2Complaints, complaint ratios and premiums include data from the health insurance company’s EPO, PPO and commercial business.
**Internal Appeals—HMOs 2018**  
Data Source: DFS

<table>
<thead>
<tr>
<th>HMO</th>
<th>Filed Appeals</th>
<th>Closed Appeals¹</th>
<th>Reversals on Appeals</th>
<th>Reversal Rate (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital District Physicians Health Plan</td>
<td>224</td>
<td>223</td>
<td>78</td>
<td>34.98%</td>
</tr>
<tr>
<td>Community Blue (HealthNow)</td>
<td>145</td>
<td>141</td>
<td>34</td>
<td>24.11%</td>
</tr>
<tr>
<td>Empire HealthChoice HMO, Inc.</td>
<td>442</td>
<td>649</td>
<td>255</td>
<td>39.29%</td>
</tr>
<tr>
<td>Excellus Health Plan</td>
<td>58</td>
<td>60</td>
<td>23</td>
<td>38.33%</td>
</tr>
<tr>
<td>HIP Health Maintenance Organization</td>
<td>2,454</td>
<td>2,436</td>
<td>1,178</td>
<td>48.36%</td>
</tr>
<tr>
<td>Independent Health Association, Inc.</td>
<td>187</td>
<td>185</td>
<td>84</td>
<td>45.41%</td>
</tr>
<tr>
<td>MVP Health Plan, Inc.</td>
<td>217</td>
<td>221</td>
<td>125</td>
<td>56.56%</td>
</tr>
<tr>
<td>UnitedHealthcare of New York, Inc.</td>
<td>280</td>
<td>283</td>
<td>183</td>
<td>64.66%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,007</strong></td>
<td><strong>4,198</strong></td>
<td><strong>1,960</strong></td>
<td><strong>46.69%</strong></td>
</tr>
</tbody>
</table>

¹Closed internal appeals can exceed filed internal appeals in 2018 because closed internal appeals also include internal appeals filed prior to 2018.

**Internal Appeals—EPO/PPO Health Plans 2018**  
Data Source: DFS

<table>
<thead>
<tr>
<th>EPO/PPO Health Plan</th>
<th>Filed Appeals</th>
<th>Closed Appeals¹</th>
<th>Reversals on Appeals</th>
<th>Reversal Rate (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company²</td>
<td>1,441</td>
<td>1,441</td>
<td>576</td>
<td>39.97%</td>
</tr>
<tr>
<td>CDPHP Universal Benefits, Inc.</td>
<td>127</td>
<td>130</td>
<td>44</td>
<td>33.85%</td>
</tr>
<tr>
<td>CIGNA Health and Life Insurance Company²</td>
<td>3,476</td>
<td>3,439</td>
<td>1,346</td>
<td>39.14%</td>
</tr>
<tr>
<td>Empire HealthChoice Assurance, Inc.²</td>
<td>7,889</td>
<td>8,334</td>
<td>3,131</td>
<td>37.57%</td>
</tr>
<tr>
<td>Excellus Health Plan, Inc.²</td>
<td>5,487</td>
<td>5,429</td>
<td>1,691</td>
<td>31.15%</td>
</tr>
<tr>
<td>Group Health Incorporated²</td>
<td>1,841</td>
<td>1,830</td>
<td>1,081</td>
<td>59.07%</td>
</tr>
<tr>
<td>HealthNow New York Inc.²</td>
<td>1,342</td>
<td>1,314</td>
<td>261</td>
<td>19.86%</td>
</tr>
<tr>
<td>Independent Health Benefits Corporation</td>
<td>546</td>
<td>537</td>
<td>315</td>
<td>58.66%</td>
</tr>
<tr>
<td>MVP Health Services Corporation²</td>
<td>325</td>
<td>325</td>
<td>162</td>
<td>49.85%</td>
</tr>
<tr>
<td>Nippon Life Insurance Company of America²</td>
<td>153</td>
<td>142</td>
<td>50</td>
<td>35.21%</td>
</tr>
<tr>
<td>Oscar Insurance Corporation</td>
<td>447</td>
<td>436</td>
<td>167</td>
<td>38.30%</td>
</tr>
<tr>
<td>Oxford Health Insurance, Inc.²</td>
<td>10,318</td>
<td>10,324</td>
<td>5,807</td>
<td>56.25%</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York²</td>
<td>3,848</td>
<td>3,848</td>
<td>1,280</td>
<td>33.26%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37,240</strong></td>
<td><strong>37,529</strong></td>
<td><strong>15,911</strong></td>
<td><strong>42.40%</strong></td>
</tr>
</tbody>
</table>

¹Closed internal appeals can exceed filed internal appeals in 2018 because closed internal appeals also include internal appeals filed prior to 2018.

²Internal appeals and reversals rates include data from the health insurance company’s EPO, PPO and commercial business.

**External Appeals—HMOs 2018**  
Data Source: DFS

<table>
<thead>
<tr>
<th>HMO</th>
<th>Total External Appeals</th>
<th>Reversals on External Appeals</th>
<th>Reversed in Part External Appeals</th>
<th>Upheld External Appeals</th>
<th>Reversal Rate (Percentage)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital District Physicians Health Plan</td>
<td>28</td>
<td>19</td>
<td>2</td>
<td>7</td>
<td>75.00%</td>
</tr>
<tr>
<td>Community Blue (HealthNow)</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0.00%</td>
</tr>
<tr>
<td>Empire HealthChoice HMO, Inc.</td>
<td>39</td>
<td>10</td>
<td>2</td>
<td>27</td>
<td>30.77%</td>
</tr>
<tr>
<td>Excellus Health Plan</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>33.33%</td>
</tr>
<tr>
<td>HIP Health Maintenance Organization</td>
<td>137</td>
<td>31</td>
<td>4</td>
<td>102</td>
<td>25.55%</td>
</tr>
<tr>
<td>Independent Health Association, Inc.</td>
<td>10</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>50.00%</td>
</tr>
<tr>
<td>MVP Health Plan, Inc.</td>
<td>11</td>
<td>5</td>
<td>0</td>
<td>6</td>
<td>45.45%</td>
</tr>
<tr>
<td>UnitedHealthcare of New York, Inc.</td>
<td>11</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>54.55%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>242</strong></td>
<td><strong>75</strong></td>
<td><strong>10</strong></td>
<td><strong>157</strong></td>
<td><strong>35.12%</strong></td>
</tr>
</tbody>
</table>

¹Rate includes “reversed-in-part” decisions.
## External Appeals—EPO/PPO Health Plans 2018

Data Source: DFS

<table>
<thead>
<tr>
<th>EPO/PPO Health Plan</th>
<th>Total External Appeals</th>
<th>Reversals on External Appeals</th>
<th>Reversed in Part External Appeals</th>
<th>Upheld External Appeals</th>
<th>Reversal Rate (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company²</td>
<td>130</td>
<td>36</td>
<td>5</td>
<td>89</td>
<td>31.54%</td>
</tr>
<tr>
<td>CDPHP Universal Benefits, Inc.</td>
<td>14</td>
<td>4</td>
<td>0</td>
<td>10</td>
<td>28.57%</td>
</tr>
<tr>
<td>CIGNA Health and Life Insurance Company²</td>
<td>53</td>
<td>19</td>
<td>1</td>
<td>33</td>
<td>37.74%</td>
</tr>
<tr>
<td>Empire HealthChoice Assurance, Inc.²</td>
<td>349</td>
<td>122</td>
<td>5</td>
<td>222</td>
<td>36.39%</td>
</tr>
<tr>
<td>Excellus Health Plan, Inc. ²</td>
<td>179</td>
<td>60</td>
<td>1</td>
<td>118</td>
<td>34.08%</td>
</tr>
<tr>
<td>Group Health Incorporated²</td>
<td>40</td>
<td>18</td>
<td>8</td>
<td>14</td>
<td>65.00%</td>
</tr>
<tr>
<td>HealthNow New York Inc. ²</td>
<td>26</td>
<td>9</td>
<td>0</td>
<td>17</td>
<td>34.82%</td>
</tr>
<tr>
<td>Independent Health Benefits Corporation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>MVP Health Services Corporation</td>
<td>22</td>
<td>7</td>
<td>0</td>
<td>15</td>
<td>31.82%</td>
</tr>
<tr>
<td>Nippon Life Insurance Company of America²</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>50.00%</td>
</tr>
<tr>
<td>Oscar Insurance Corporation</td>
<td>55</td>
<td>20</td>
<td>0</td>
<td>35</td>
<td>36.36%</td>
</tr>
<tr>
<td>Oxford Health Insurance, Inc.²</td>
<td>237</td>
<td>95</td>
<td>7</td>
<td>135</td>
<td>43.04%</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York²</td>
<td>35</td>
<td>21</td>
<td>0</td>
<td>14</td>
<td>60.00%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,144</strong></td>
<td><strong>413</strong></td>
<td><strong>27</strong></td>
<td><strong>704</strong></td>
<td><strong>38.46%</strong></td>
</tr>
</tbody>
</table>

¹Rate includes “reversed-in-part” decisions.
²External appeals and reversal rates include data from the health insurance company’s EPO, PPO and commercial business.

## Grievances—HMOs 2018

Data Source: DFS

<table>
<thead>
<tr>
<th>HMO</th>
<th>Filed Grievances</th>
<th>Closed Grievances¹</th>
<th>Reversed Grievances</th>
<th>Upheld Grievances</th>
<th>Reversal Rate (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital District Physicians Health Plan</td>
<td>216</td>
<td>222</td>
<td>102</td>
<td>120</td>
<td>45.95%</td>
</tr>
<tr>
<td>Community Blue (HealthNow)</td>
<td>66</td>
<td>64</td>
<td>27</td>
<td>37</td>
<td>42.19%</td>
</tr>
<tr>
<td>Empire HealthChoice HMO, Inc.</td>
<td>406</td>
<td>502</td>
<td>192</td>
<td>310</td>
<td>38.25%</td>
</tr>
<tr>
<td>Excellus Health Plan</td>
<td>55</td>
<td>64</td>
<td>22</td>
<td>42</td>
<td>34.38%</td>
</tr>
<tr>
<td>HIP Health Maintenance Organization</td>
<td>1,112</td>
<td>1,041</td>
<td>431</td>
<td>610</td>
<td>41.40%</td>
</tr>
<tr>
<td>Independent Health Association, Inc.</td>
<td>144</td>
<td>144</td>
<td>55</td>
<td>89</td>
<td>38.19%</td>
</tr>
<tr>
<td>MVP Health Plan, Inc.</td>
<td>76</td>
<td>76</td>
<td>19</td>
<td>57</td>
<td>25.00%</td>
</tr>
<tr>
<td>UnitedHealthcare of New York, Inc.</td>
<td>37</td>
<td>51</td>
<td>17</td>
<td>34</td>
<td>33.33%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,112</strong></td>
<td><strong>2,164</strong></td>
<td><strong>865</strong></td>
<td><strong>1,299</strong></td>
<td><strong>39.97%</strong></td>
</tr>
</tbody>
</table>

¹Closed grievances can exceed filed grievances in 2018 because closed grievances also include grievances filed prior to 2018.

## Grievances—EPO/PPO Health Plans 2018

Data Source: DFS

<table>
<thead>
<tr>
<th>EPO/PPO Health Plan</th>
<th>Filed Grievances</th>
<th>Closed Grievances¹</th>
<th>Reversed Grievances</th>
<th>Upheld Grievances</th>
<th>Reversal Rate (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company²</td>
<td>136</td>
<td>133</td>
<td>45</td>
<td>88</td>
<td>33.83%</td>
</tr>
<tr>
<td>CDPHP Universal Benefits, Inc.</td>
<td>244</td>
<td>238</td>
<td>141</td>
<td>97</td>
<td>59.24%</td>
</tr>
<tr>
<td>CIGNA Health and Life Insurance Company²</td>
<td>172</td>
<td>185</td>
<td>31</td>
<td>154</td>
<td>16.76%</td>
</tr>
<tr>
<td>Empire HealthChoice Assurance, Inc.²</td>
<td>2,024</td>
<td>2,036</td>
<td>389</td>
<td>1,647</td>
<td>19.11%</td>
</tr>
<tr>
<td>Excellus Health Plan, Inc. ²</td>
<td>1,372</td>
<td>1,378</td>
<td>309</td>
<td>1,069</td>
<td>22.42%</td>
</tr>
<tr>
<td>Group Health Incorporated²</td>
<td>770</td>
<td>746</td>
<td>146</td>
<td>600</td>
<td>19.57%</td>
</tr>
<tr>
<td>HealthNow New York Inc. ²</td>
<td>277</td>
<td>277</td>
<td>52</td>
<td>225</td>
<td>18.77%</td>
</tr>
<tr>
<td>Independent Health Benefits Corporation</td>
<td>471</td>
<td>460</td>
<td>171</td>
<td>289</td>
<td>37.17%</td>
</tr>
<tr>
<td>MVP Health Services Corporation</td>
<td>74</td>
<td>74</td>
<td>20</td>
<td>54</td>
<td>27.03%</td>
</tr>
<tr>
<td>Nippon Life Insurance Company of America²</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Oscar Insurance Corporation</td>
<td>488</td>
<td>468</td>
<td>128</td>
<td>340</td>
<td>27.35%</td>
</tr>
<tr>
<td>Oxford Health Insurance, Inc.²</td>
<td>10,044</td>
<td>10,073</td>
<td>2,349</td>
<td>7,724</td>
<td>23.32%</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York²</td>
<td>7,048</td>
<td>7,051</td>
<td>1,660</td>
<td>5,391</td>
<td>23.54%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23,120</strong></td>
<td><strong>23,119</strong></td>
<td><strong>5,441</strong></td>
<td><strong>17,678</strong></td>
<td><strong>23.53%</strong></td>
</tr>
</tbody>
</table>

¹Closed grievances can exceed filed grievances in 2018 because closed grievances also include grievances filed prior to 2018.
²Grievances and reversal rates include data from the health insurance company’s EPO, PPO and commercial business.
Quality of Providers—HMOs 2017
Data Source: DOH

Understanding the Chart
The symbols in the chart show how each HMO compares to the average for all New York HMOs. HMOs with a “▲” performed better than the New York HMO average.

Note: Symbols show statistically significant differences between each health insurance company’s score and the New York average. “Statistically significant” means scores varied by more than could be accounted for by chance.

When comparing plan rates, note that some plans have the same rate but a different symbol. This is because plan rates are based on the number of members, which can differ among plans, and how much a plan’s rate differs from the New York average.

<table>
<thead>
<tr>
<th>HMO</th>
<th>Satisfaction With Personal Doctor</th>
<th>Satisfaction With Specialist</th>
<th>Satisfaction With Provider Communication</th>
<th>Doctors Who Are Certified by a Medical Board</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>NY HMO Average</td>
<td>85</td>
<td>84</td>
<td>95</td>
<td>77</td>
</tr>
<tr>
<td>Capital District Physicians Health Plan</td>
<td>89 ▲</td>
<td>87</td>
<td>97</td>
<td>▲</td>
</tr>
<tr>
<td>Community Blue (HealthNow)</td>
<td>88</td>
<td>90 ▲</td>
<td>95</td>
<td>▼</td>
</tr>
<tr>
<td>Empire HealthChoice HMO, Inc.</td>
<td>86</td>
<td>80</td>
<td>96</td>
<td>▲</td>
</tr>
<tr>
<td>Excellus (Univera Healthcare) 2</td>
<td>84</td>
<td>87</td>
<td>96</td>
<td>▼</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield 3</td>
<td>84</td>
<td>87</td>
<td>96</td>
<td>▼</td>
</tr>
<tr>
<td>HIP Health Maintenance Organization</td>
<td>78 ▼</td>
<td>77 ▼</td>
<td>89 ▼</td>
<td>▼</td>
</tr>
<tr>
<td>Independent Health Association, Inc.</td>
<td>85</td>
<td>85</td>
<td>95</td>
<td>▼</td>
</tr>
<tr>
<td>MVP Health Plan, Inc.</td>
<td>88</td>
<td>82</td>
<td>95</td>
<td>▼</td>
</tr>
</tbody>
</table>

1Includes data for HealthNow PPO membership. 2Includes data for Univera PPO membership. 3Includes data for Excellus BlueCross BlueShield PPO membership.

Legend
▲ Significantly better than the NY HMO average.
▼ Significantly worse than the NY HMO average.
No symbol indicates that the average is not different from the NY HMO average.

Quality of Providers—PPOs 2017
Data Source: DOH

Understanding the Chart
The symbols in the chart show how each PPO compares to the average for all New York PPOs. PPOs with a “▲” performed better than the New York PPO average.

Note: Symbols show statistically significant differences between each health insurance company’s score and the New York average. “Statistically significant” means scores varied by more than could be accounted for by chance.

When comparing plan rates, note that some plans have the same rate but a different symbol. This is because plan rates are based on the number of members, which can differ among plans, and how much a plan’s rate differs from the New York average.

<table>
<thead>
<tr>
<th>PPO 1</th>
<th>Satisfaction With Personal Doctor</th>
<th>Satisfaction With Specialist</th>
<th>Satisfaction With Provider Communication</th>
<th>Doctors Who Are Certified by a Medical Board</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>NY PPO Average</td>
<td>84</td>
<td>83</td>
<td>95</td>
<td>77</td>
</tr>
<tr>
<td>Aetna Life Insurance Company</td>
<td>85</td>
<td>81</td>
<td>96</td>
<td>77</td>
</tr>
<tr>
<td>CDPHP Universal Benefits, Inc.</td>
<td>86</td>
<td>83</td>
<td>96</td>
<td>81 ▲</td>
</tr>
<tr>
<td>Cigna Health and Life Insurance Company</td>
<td>82</td>
<td>85</td>
<td>92</td>
<td>76</td>
</tr>
<tr>
<td>Empire HealthChoice Assurance, Inc.</td>
<td>86</td>
<td>88</td>
<td>97</td>
<td>83 ▲</td>
</tr>
<tr>
<td>Group Health Incorporated</td>
<td>85</td>
<td>81</td>
<td>93</td>
<td>76</td>
</tr>
<tr>
<td>MVP Health Services Corporation</td>
<td>82</td>
<td>79</td>
<td>97</td>
<td>74</td>
</tr>
<tr>
<td>Oscar Insurance Corporation</td>
<td>78 ▼</td>
<td>77 ▼</td>
<td>95</td>
<td>71 ▼</td>
</tr>
<tr>
<td>Oxford Health Insurance, Inc.</td>
<td>88</td>
<td>87</td>
<td>95</td>
<td>76</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York</td>
<td>89</td>
<td>84</td>
<td>97</td>
<td>77</td>
</tr>
</tbody>
</table>

1Data for Excellus BlueCross BlueShield PPO, HealthNow PPO and Univera PPO are included in the HMO tables.

Legend
▲ Significantly better than the NY PPO average.
▼ Significantly worse than the NY PPO average.
No symbol indicates that the average is not different from the NY PPO average.

(Continued on page 19)
Governor Announces Proposed Budget

(Continued from page 1)

pharmacies; expanding the definition of “place of employment” to define indoor space and limit second hand smoke exposure; restricting the advertising of vapor products requires manufacturers of vapor products to disclose to the DOH Commissioner and the public, information regarding the ingredients, by-products, or contaminants in vapor products, bans certain carrier oils if they are determined to be harmful; bans coupons and manufacturer discounts and displays in shops; and increases penalties for illegally selling tobacco products to minors.

• Establishing the Behavioral Health Parity Compliance Fund for the collection of penalties imposed on insurance carriers who violate New York’s Behavioral Health Parity laws, which will be used to support the Substance Use Disorder and Mental Health Ombudsman program.

• Significantly reduce the interest rate on medical malpractice and other court judgments, from 9% to a market-based rate.

• Reduce the business income tax rate from 6.5% to 4% for businesses with 100 or fewer employees and with net income below $390,000 that file under Article 9-A.

• $14.2 million in funding to ensure access to a full array of reproductive services for women due to the loss of Title X funding.

• $8 million to improve maternal health outcomes and for the implementation bias training and incentives for an expansion of community health workers related to Maternal Mortality.

• Continuation of funding for the Excess Medical Malpractice Insurance Program.

• Continuation of funding for the Committee for Physicians’ Health.

OTHER ITEMS OF NOTE:

• Convene a new Medicaid Redesign Team (MRT) to come up with $2.5 billion in savings.

• DFS will be authorized to investigate pricing of any prescription drug if the price of such drug has increased by more than 100% within a one-year time period.

• Capping the co-payments required of insured patients at $100 for a one-month supply of insulin.

• Development of “NYHealthCareCompare”, a website that will allow New Yorkers to look up charges for medical services, the quality of services provided and access information about financial assistance programs, as well as what to do about a surprise medical bill.

• Impose a Certificate of Need surcharge on hospitals to oversee construction projects.

• Local governments will be required to stay within 2% property tax increase or be held accountable for excess growth in Medicaid costs.

• Several items of concern from previous budgets, such as cuts to Medicaid payments for treating dual eligible patients, elimination of “prescriber prevails” under Medicaid, and expansion of CRNA scope of practice WERE NOT included (but could be brought up under the new MRT).

Doctors Are Not Fortune Tellers

(Continued from page 11)

predict, notes the brief. “It entails a reasoned analysis of multiple variables. And the changing composition of hospice patients over the years has made that complex task even more difficult.”

RELATED COVERAGE

Terminal cancer may generally be considered dependable predictable, but there is a growing percentage of hospice cases involving dementia, heart disease or lung disease. Face-to-face consultations with patients—not part of the government’s after-the fact-reviews—can be especially important when judging how long that patient will live.

In this particular case, the government failed to prove the prognosis was false. To prove that the medical prognoses in this case were false, the government had to demonstrate that they fell “beyond the range of reasonableness. It had to show, in other words, that no reasonable physician would have certified the patients as terminally ill,” says the brief, which adds that the government failed to meet that burden.

Check Out Your Member Benefits at www.MSSNY.org

2019 New York Consumer Guide to Health Insurers

(Continued from page 18)

Independent Dispute Resolution—2018

Data Source: DFS

<table>
<thead>
<tr>
<th>Category</th>
<th>Emergency Services</th>
<th>Surprise Bills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Not Eligible</td>
<td>187</td>
<td>165</td>
</tr>
<tr>
<td>IDRE Decision Rendered for Eligible Claims:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Plan Payment More Reasonable</td>
<td>174</td>
<td>50</td>
</tr>
<tr>
<td>Provider Charges More Reasonable</td>
<td>196</td>
<td>222</td>
</tr>
<tr>
<td>Split Decision</td>
<td>208</td>
<td>220</td>
</tr>
<tr>
<td>Settlement Reached</td>
<td>83</td>
<td>66</td>
</tr>
<tr>
<td>Total Received</td>
<td>848</td>
<td>723</td>
</tr>
</tbody>
</table>

February 2020 • MSSNY’s News of New York • Page 19
Top 10 Health Hazards for 2020: ECRI Institute

The Emergency Care Research Institute released its Top 10 Health Technology Hazards 2020 report for hospitals, medical practices and homecare providers.

For the 13th annual report, ECRI identified the top health technology concerns that healthcare leaders should address based on review of ECRI’s incident investigations, medical device testing, and public and private incident reporting databases.

Here are the top 10 health technology hazards for next year, as ranked by ECRI:

1. Surgical stapler misuse
2. Point-of-care ultrasound
3. Sterile processing errors in medical and dental offices
4. Central venous catheter risk in at-home hemodialysis
5. Unproven surgical robotic procedures
6. Alarm, alert and notification overload
7. Connected home healthcare security risks
8. Missing implant data and MRIs
9. Medication timing errors in medical and dental offices
10. Loose nuts and bolts in devices

To access the full report, click here.
ANNOUNCEMENT OF ANTICIPATED JOB OPPORTUNITY
OPEN TO THE PUBLIC

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SALARY/GRADE $109,956 - $138,763 / M-4

NEGOTIATING UNIT Management Confidential (06)

LOCATION Division of Family Health

MINIMUM TRANSFER: Current NYS employee with one year
more of contingent-permanent or permanent competitive service in a title at or above Grade 29/M-3 and eligible for transfer under Section 52.6 of the Civil Service Law.

QUALIFICATIONS

PROVISIONAL*: a bachelor's degree AND seven years professional public health experience in a governmental public health agency or public health program* that receives funding from a public health governmental agency. Of the seven years required experience, three years must include supervision of professional staff and the following management responsibilities: program planning and implementation, program evaluation and monitoring, AND development and implementation of policies and procedures. The required professional experience must include either:

1. Designing or implementing a public health outreach, promotion, or disease prevention program; OR
2. Conducting disease surveillance or a disease control program.

For the purposes of this recruitment, a public health program focuses primarily on the prevention of disease through outreach and public health education or health promotion, including population-based plans of care, not just plans of care for individual patients, or the study of the prevalence or causes of disease through population-based studies.

Examples of non-qualifying experience include, but are not limited to:

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- Chemung Elmira and Southport Corr Facilities (Gateway to the Finger Lakes)
- Columbia* Hudson Correctional Facility (antiquing, arts & collectables)
- Dutchess Green Haven Correctional Facility (Hudson River Valley Beauty)
- Franklin* Franklin & Upstate Corr Facilities (North Country, 1 hour to Montreal)
- Greene* Greene Correctional Facility (rural charm yet only 2 hours to NY City)
- Livingston* Groveland Correctional Facility (State Parks, hiking, fishing)
- Oneida Mohawk Correctional Facility (Cooperstown, breweries)
- Orleans Albion Correctional Facility (Greater Niagara Region & Canal Town Culture)
- Sullivan Woodbourne Correctional Facility (mountains, outlets, entertainment)
- Seneca* Five Points Correctional Facility (heart of wine country)
- St. Lawrence Riverview Correctional Facility (hiking, boating and museums)
- Ulster Shawangunk and W-Corr Facility (Catskill Mountains, Casinos)
- Washington Great Meadow Corr Facility (Between Vermont & Green Mountains)
- Westchester Bedford Hills Correctional Facility (Less than 1 Hour to NYC)

Inquire with the Facility Personnel Office regarding benefits and anticipated opportunities: http://www.doccs.ny.gov/facalist.html

Contact: www.doccs.ny.gov or DOCCS Personnel Office at (518) 457-8132 for more information and to apply.

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