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Testimony Of
The Medical Society of the State of New York
Before The
New York State Assembly Committee On Ways & Means
New York State Senate Finance Committee
On the Governor's Proposed Budget
For State Fiscal Year 2020-2021

Good morning. My name is Moe Auster, Esq., and I am the Senior Vice-President/Chief Legislative Counsel for the Medical Society of the State of New York. On behalf of the over 20,000 physicians, residents and students we represent, let me thank you for providing us with this opportunity to present organized medicine's views on the proposed budget and how it relates to the future of the health care delivery system in New York State.

It must be noted that this proposed budget is being considered simultaneously with a number of market forces which are threatening the ability of physician practices all across New York State to continue to deliver timely and quality patient care. These burdens include ever-increasing health insurer pre-authorization and payment hassles, excessive regulation and enormous medical liability insurance costs that are exacerbated by inadequate payments from health insurers and Medicaid, and huge patient cost-sharing responsibilities. The collective weight of these burdens is a significant reason for the staggering increase in hospital employment for physicians.

New York State remains a world class destination for patient care but its reputation is threatened by a regulatory climate that has caused it to repeatedly be ranked in national surveys as the worst state in the nation in which to be a physician. To preserve patient access to timely and quality care, it is imperative that steps be taken to reverse the many troubling trends that have led to this dubious distinction.

Physicians are increasingly overburdened with unnecessary administrative roadblocks, imposed by insurance companies, that impede the ability of their patients to receive needed care. Far too much time is spent filling out paperwork or on the phone attempting to secure pre-authorization approval. Cumbersome Electronic Health Record (EHR) systems often conflict with, rather than improve, care delivery. Physicians must fight with market-dominant insurers to be paid fairly for the provision of needed patient care while Medicaid payments continue to be among the lowest in the country. Well-meaning but misguided mandates are imposed that often do not have any connection to the delivery of quality care. All the while, medical liability premiums continue to exceed all other states due to a permissive liability system that at times seems to have been developed by trial lawyers themselves.

All these factors have led to increasing numbers of physicians reporting "burnout". Simply put, overburdening physicians with unnecessary bureaucratic hurdles and over-regulation results in reduced physician productivity and diminished patient access. It damages the patient-physician relationship and causes moral injury when physicians believe that they cannot act in their patient's best interests. While MSSNY is working with national organizations on efforts to help physicians confront this rising problem of "burnout" it is imperative the Legislature and Governor not pursue steps that accelerate this growing problem.

MSSNY supports protecting physicians' flexibility to choose which practice setting is best suited to them, be it solo practice, small group, large group, or health system-employed. However, many physicians find they have no choice but to become system employees as their last option for staying in practice. While some physicians prefer delivering patient care in these settings, others report concerns with the loss of clinical control of care delivery and excessive demands to meet patient service quotas.

Not surprisingly, there are many regions across New York experiencing great difficulty in attracting and retaining physicians while our population continues to grow older and more resource-dependent. A recent HANYS study showed that, across upstate New York, 86% of hospital emergency departments indicated there were times when a patient had to be transferred, because a needed specialist was not available.

Physicians undertook years of training and incurred enormous debt because of a desire to heal patients. However, legislative, regulatory and industry-imposed trends are making it exceedingly difficult to stay and work in New York. It is MSSNY's goal to work with the legislature to ensure that our communities' health care needs are met by ensuring a stable supply of physicians.

It is through the context of this lens that we view the proposed State budget. 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) Oppose Cuts to Medicaid Payments

There have been numerous instances over the last several years where the State has tried to balance the Budget by unfairly cutting Medicaid payments to physicians seeking to deliver quality care to their patients. In past years, physicians have had to absorb significant cuts for care provided to their senior and disabled patients covered by both Medicare and Medicaid, making it much harder for these physicians to deliver community-based care.

While we understand the need to address significant Budget deficits, physicians across New York are confounded by the recently announced 1% cut to their payments for care delivered to their patients insured by Medicaid. This is particularly difficult to accept given that they were not the beneficiaries of increases to Medicaid payments granted last year to other parts of the health care system. In fact, Medicaid physician payment remains a very small part of New York's overall Medicaid Budget. No wonder, given that New York has one of the lowest Medicaid to Medicare physician payment ratios in the country. We remain further concerned with possible even further unfair cuts in order to meet the MRT 2 goal of achieving a staggering $2.5 billion in Budget savings, and the threat of steep across the Board cuts if such savings are not found.

As we try to address system health costs, and assure patients get the right care at the right time in the right setting, we should be taking steps to expand the availability of community primary and specialty care physicians in Medicaid Managed Care and traditional Medicaid. Further reductions in inadequate compensation will not accomplish that objective.

Reimbursement for care of the most vulnerable populations in New York is already among the lowest in the nation. According to the Kaiser Family Foundation, in 2016 New York ranked 46th in the nation for reimbursement across all services and 47th for primary care. This has been made worse by previous cuts to payments for care to dual eligible patients. Time and time again, New York is rated as one of the worst states in the nation to practice medicine due to a variety of concerns. Chief amongst them are liability issues and low reimbursement.

These huge cuts could force physicians to stop seeing these patients altogether, which in turn could force these patients to receive care in more expensive care settings, thereby completely undermining the supposed cost-savings goal of this cut. Moreover, with so many medical practices operating on paper thin margins to pay rent, pay staff, pay liability insurance and other costs, any cuts to care payments will force more practices to close. As these clinics and physician practices close, patients will have to go to hospitals to receive care that they could be receiving in the community setting.

Please preserve necessary access to care for patients in your community. I urge you to work to reinstate previously imposed cuts, and work to prevent further harmful cuts as the Legislature works to finalize the 2020-21 State Budget.

2) Continuation of an Adequately Funded Excess Medical Liability Program

We are pleased that the Executive Budget continues to fund the Excess Medical Liability Insurance Program. However, it has been reduced to from its historical funding level of $127.4M to $105.1M. While we are aware that there has been a drop in enrollment in the program over the last few years, likely due to the significant increase in the hospital employment of physicians, we urge the Legislature to carefully review whether that funding is adequate to ensure full funding for the program for those who have historically been covered. Moreover, we are very concerned that the Article 7 bill does not include the extensive historical language extending the program and believe the language must be amended to include this historical language that has been included in every other previous extension of the program.

Unless the State is seriously intending to advance liability reform to contain our enormous costs, we cannot threaten to take away this program.

By way of background, the Excess Medical Liability Insurance Program provides an additional layer of $1M of coverage to physicians with hospital privileges who maintain primary coverage at the $1.3 million/$3.9 million level. Since its inception in 1985, the cost of the program has been met by utilizing public and quasi-public monies.

The Excess Medical Liability Insurance Program was created in 1985 as a result of the liability insurance crisis of the mid-1980's to address concerns among physicians that their liability exposure far exceeded available coverage limitations. They legitimately feared that everything they had worked for all of their professional lives could be lost as a result of one wildly aberrant jury verdict. This fear continues since absolutely nothing has been done to ameliorate it. The size of verdicts in New York State has increased exponentially and the severity of awards continues to grow steadily each year. This already long-standing problem was recently made even worse as a result of the enactment of changes to expand New York's Statute of Limitations for medical malpractice actions. Actuaries have predicted that these changes could ultimately require a significant increase in medical liability insurance costs on top of already outrageously high premiums.

The severity of the liability exposure levels of physicians makes it clear that the protection at this level continues to be essential. Indeed, as mentioned earlier, 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. We have heard from carriers and defense bar that, more than ever before, a physician's assets are at stake.

It is important to note that the Excess program is not a solution to the underlying liability problem in New York State. That problem is caused by a dysfunctional medical liability adjudication system and the real solution is reform of that system. Physicians in New York face far greater liability insurance costs and exposure than their colleagues in other states. A recent report from Leverage Rx showed that in 2018, New York once again had the highest cumulative medical liability payouts of any state in the country, 85% more than the state with the 2nd highest amount (Pennsylvania). It also had the highest per capita liability payment, 22% more than the 2nd highest state (Pennsylvania). These disturbing statistics demonstrate a major reason why New York once again received the dubious distinction as being the worst state in the country to be a doctor.

In addition to these exorbitant claims payouts, there are substantial costs related to defending against non-meritorious cases. In fact, according to one major malpractice insurer, 74% of malpractice claims that it defended, against over the last 10 years, resulted in no actual payment to the plaintiff. Yet, that insurer had to spend nearly $900 million on defending those non-meritorious claims.

The problems of the medical liability adjudication system do not just impact physicians – they impact the cost of all health care. Several studies have shown that billions of dollars are unnecessarily spent each year due to the practice of defensive medicine, such as unnecessary MRIs, CT scans and specialty referrals. These defensive medicine costs are likely to go up further with the enactment of this new law, as many physicians will believe they have no choice but to recommend patients for additional diagnostic tests or refer to specialists, beyond what they believe is clinically indicated, to better assure the record is "complete" in case they are to be sued many years later. While estimates vary about the cost impact to the health care system, an MIT study reported in a July 2018 *New York Times* article found the possibility of a lawsuit increased the intensity of health care that patients received in the hospital by about 5%.

State	Total Liability Payouts 2018
New Jersey	$226,712,000
California	$269,240,200
Florida	$346,857,350
Pennsylvania	$369,034,250
New York	*$685,317,000*

(Source: Leverage Rx)

State	Per Capita Payment 2018
California	$6.81
Maryland	$12.02
Massachusetts	$25.20
New Jersey	$25.45
Connecticut	$28.24
Pennsylvania	$28.81
New York	*$35.07*

(Source: Leverage Rx)

Enough is enough! Reform is needed to bring down these exorbitant costs, not additional measures to increase them. Moreover, it is clear the State could realize significant savings to its Budget if it did not have to cover the excessive costs of an out of control liability system.

New York must follow the lead of the many, many other states that have passed legislation to bring down the gargantuan cost of medical liability insurance. We stand ready to discuss any number of proposals that will meaningfully reduce medical liability premium costs for our physicians. Until that discussion occurs, however, we must take all steps necessary to protect and continue the Excess program to ensure that physicians can remain in practice in New York State.

3) Supporting Efforts to Limit Flavored Tobacco and Vaping Use

The Medical Society strongly supports the governor's 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 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 coupons and manufacturer discounts and displays in shops; and increases penalties for illegally selling tobacco products to minors.

MSSNY had strongly supported the actions of the Cuomo Administration in seeking to prohibit the sale of flavored tobacco products, looks forward to the Legislature enacting these restrictions into law. We particularly thanks Senators Hoylman and Assemblymembers Rosenthal and Bichotte for advancing legislation to prevent the sale of these harmful products.

The FDA has identified over 15,000 unique flavors for e-cigarettes and other tobacco products. While flavors like cotton candy, gummy bear, unicorn poop and blueberry seem particularly insidious, mint and menthol flavorings are just as damaging due to their soothing/cooling effect, which makes these products easier to start and harder to quit. We now know that these products have been heavily marketed to kids and it's working. 81% of youth who used a tobacco product chose a flavored product.

MSSNY will continue to encourage the Governor and Legislature to also enact similar policy for flavored tobacco products. The federal government banned flavored cigarettes in 2009 – with the exception of menthol cigarettes. In that time, countless New Yorkers, many of them younger than age 18, have initiated tobacco use and addiction with menthol cigarettes. We urge the New York State enact a similar prohibition for all tobacco products.

4) Oppose Unfair Disruption of Physician Due Process in Disciplinary Proceedings

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

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

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

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

reasonably demonstrated that the existing processes prevent OPMC from achieving its mission to protect the public.

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

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

PHYSICIAN DISCIPLINARY COMPLAINTS AND DISPOSITION

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

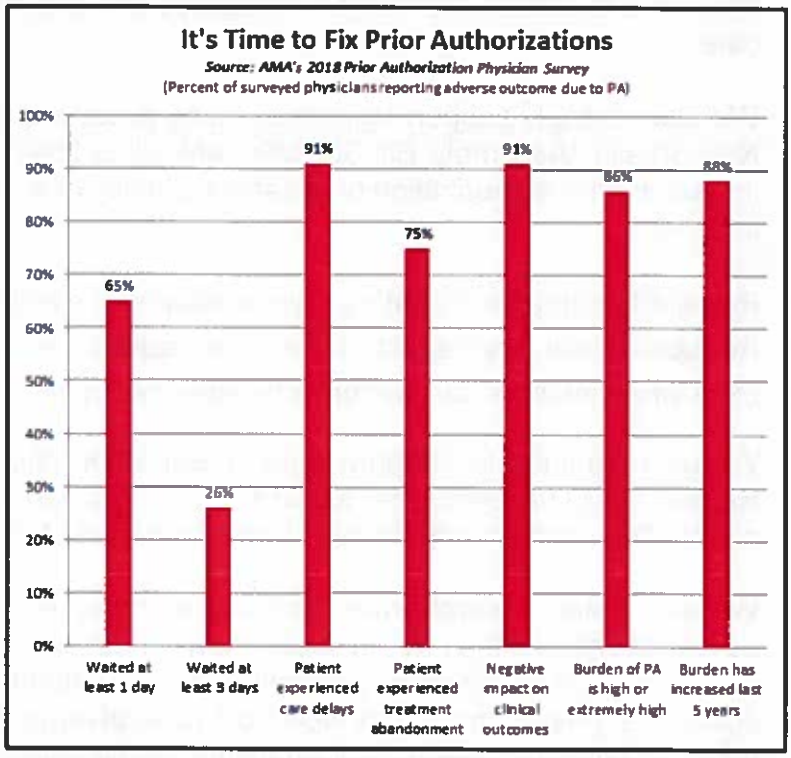
Furthermore, Public Health Law Section 230 (12)(a) already grants power to the Department of Health to summarily suspend a physician from medical practice without an otherwise required hearing and pre-hearing where there is a "determination that a licensee is causing, engaging in or maintaining a condition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

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

In sum, it is our estimation that this proposal goes far beyond where it needs to go to protect the public from aberrant health care practitioners. We welcome discussions to improve our disciplinary system to address gaps to help protect the public. However, these proposed changes are startling. It will take away long-standing due process protections and holds the risk to unfairly destroy professional reputations and the trusted patient-physician relationship so essential for providing high quality care. Therefore, we urge that this proposal be rejected.

5) Putting Patients Over Paperwork through Oversight of Insurer Tactics

We welcome proposals in the Executive Budget to address the myriad of insurer-imposed hassles faced by physicians and other health care providers. While we are disappointed that the bulk of the proposals appear to be directed to hospital care rather than physician-led care, the Budget proposal does include some positive proposals effecting all physicians to expedite claims payment, reduce credentialing delays, require greater transparency of claim denials and create a mechanism to reduce the excessive hassles faced by physicians and their staff in assuring their patients can get the care and medications they need.



Prior authorizations are a huge hurdle to patient access to care and medications, prescribed by their physicians, and a bureaucratic nightmare for physicians. Administrative roadblocks don't just take time away from delivering care, they often adversely impact patients, as well. For example, a recent *Annals of Internal Medicine* study found that for every hour spent with a patient, physicians spent two hours on administrative tasks, while a recent study conducted by MSSNY last fall, revealed that:

- 43% of responding physicians, and their staff, spent more than 10 hours per week managing insurer prior authorization requests, alone.
- 22% of responding physicians indicated that they, and their staff, spent greater than 20 hours per week on these tasks.
- 92% of physicians indicated that prior authorization requirements at least sometimes adversely impacted their patients' health, and 48% indicated that they frequently did.
- One particularly frustrating time-waster is having to repeat prior authorization requests that were previously approved.
    - 94% of responding physicians and their staff indicated that they had at least sometimes had to repeat a prior authorization request for care or medication that had already previously been approved.
    - 48% indicated that they were often required to repeat previously obtained prior authorization requests.

- 88% of responding physicians believed that these repeat prior authorizations were not necessary.

In 2016, the legislature passed, and the Governor signed into law, a bill that established defined criteria to enable a physician to override a health insurer's step therapy medication rules when warranted by the patient's individual circumstances. However, the survey reported that half the respondents to the MSSNY survey said that the health plan's process to attempt overrides was, at the very least, "challenging", while 28% found the override process to be "extremely difficult", with more than 30% unable to ever override a health insurer's decision to impose step therapy protocol on patients.

It's also critical to note that excessive time spent trying to secure prior authorizations is a well-documented, significant contributing factor to the increasing problem of physician "burnout". We must find ways to reduce the excessive hassles that prevent physicians from delivering the highest quality care.

We also strongly support legislation being advanced by Assemblyman Richard Gottfried and Senator Neil Breslin (Assembly Bill 3038/Senate bill S.2847) that addresses MSSNY's concerns about the impact of prior authorization on a patient's ability to access the care they need. These proposed reforms include:

- Require health plan utilization review criteria be evidence-based and peer reviewed.
- Reduce insurer timeframe to review prior authorization requests.
- Limit when insurers can withdraw or repeat a previously approved prior authorization.

We also continue to strongly support legislation sponsored by Assemblyman Gottfried and Senator Rivera (A.2393/S.3462) that would enable physician and other care providers the ability to collectively negotiation contract participation terms with market dominant health insurers.

We also thank Assemblyman Gottfried and Senator Rivera for their continuing efforts to attempt to address concerns the physician community has raised with their single payor proposal, which of course has as its goal administrative simplification for patients and physicians. As we have stated on multiple occasions, physicians across New York have divergent perspectives on the impact of a potential single-payer health care system for our patients. Some believe it would help reduce some of the many insurer-imposed administrative hassles physicians have experienced in the current for-profit insurer-controlled system, or at least create some uniformity in the hassles. Others recognize that goal, but also raise concerns that it could create new barriers to patient care delivery by adding an enormous new state government bureaucracy that would oversee care delivery that is subject to Budget limitations similar to our Medicaid program.

MSSNY looks forward to working with both the Legislature, and Governor to find solutions, and enact reforms, that truly put patients over paperwork and ensures that they get the care and treatments they need in a timely fashion.

6) Support of PBM Regulation

We support the proposal in the Governor's Budget to require Pharmaceutical Benefit Managers (PBMs) operating in New York State to be licensed by 2021 and to disclose any financial incentive for promoting a specific drug or other financial arrangements affecting health insurers. It also would give DFS the power to suspend or refuse to renew a PBM license if it determines that the PBM had violated insurance law or provided misleading information in its application or reports, or other reasons. We also supported

the comprehensive legislation advanced by Assemblyman Gottfried and Senator Breslin that passed the Legislature last year but was vetoed by the Governor. We are hopeful that, given the support of many key leaders for achieving PBM regulation, that all the parties can work together to help achieve enactment of a law.

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

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

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

We urge you to stand up against this accumulation of power in our health care system that jeopardizes the ability of patients to continue to receive necessary care from their physicians. Certainly oversight and transparency are important first steps in helping to assure that PBMs make formulary decisions on behalf of health plans that will not inappropriately interfere with patient care delivery. Therefore, we urge you to support PBM licensure as you finalize the Budget for Fiscal Year 2020-21.

7) Oppose Legalization of Recreational Marijuana

The Medical Society of the State of New York continues to oppose the legalization of recreational or "adult use" marijuana. MSSNY has been working with other organizations in urging the State Legislature and the Governor to take a "go slow" approach. In addition to MSSNY, we know strong concerns have been raised by the Association of County Health Commissioners, the New York State PTA, and Smart Approaches to Marijuana (SAM), plus various law enforcement associations.

Last year, we supported legislation to remove the threat of criminal sanction for possession of small amounts of marijuana, as well as the expungement of prior criminal history for such possession. We believe there should more time given to assess if it achieved its purpose.

MSSNY is gravely concerned with the mixed message to youth that using recreational marijuana is acceptable, even with proposals that limit purchase to those 21 and over, and even with strong advertising restrictions. One need only look to the teenage "vaping" epidemic that has taken hold in

New York State and across the country because of perceptions among many teenagers that a particular substance may not be harmful. We now know that "vaping" of marijuana has caused significant health damages to young and older Americans. The very act of "vaping" of any substance and the devices used could be causing harm to thousands of New Yorkers. We are also particularly concerned by a recent CDC report that indicated that several of the patients who developed vape-related lung illness actually obtained cannabis through legal sources.

We also continue to be concerned about the potential traffic impact of legalizing recreational marijuana, given data from other states after it was legalized

MSSNY continues to urge Gov. Andrew Cuomo and the New York State Legislature to approach the issue of marijuana legalization with serious forethought, and to heed the recommendations from leading medical organizations. We certainly believe that creation of Cannibis Research Center holds promise to provide a true fact-based analysis for the health benefits and risks of its use. Indeed, we have been urging Congress to re-schedule marijuana so that expert review can be performed. We ask that you perform a thorough analysis of scrutinized data from other states that have legalized recreational marijuana use.

Specifically, we recommend that proposals to legalize recreational marijuana use be removed from the State Budget. We are also concerned about the removal of the marijuana for medical purposes would be removed from the Department of Health and placed in a newly created Office of Cannabis.

In 2017, the American Medical Association (AMA) approved a policy position based upon recommendations from its Council on Science and Public Health that concluded that cannabis is a dangerous drug and a serious public health concern, and that the sale of cannabis for recreational use should not be legalized. Its position was based upon the analysis of multiple studies that found that, even as cannabis had some therapeutic benefits, there was substantial evidence of a statistical linkage between cannabis smoking and health issues. The AMA-issued paper looked at data from jurisdictions that legalized cannabis that demonstrated adverse impacts, such as unintentional pediatric exposures resulting in increased calls to poison control centers and emergency department visits. That data also showed that there was an increase in traffic deaths due to cannabis-related impaired driving. It is noteworthy that another leading medical organization, the American Society of Addiction Medicine (ASAM), does not support the legalization of marijuana. ASAM recommends that states that have not acted to legalize marijuana should not proceed until more definitive data from the states that have legalized marijuana can be studied.

We appreciate that the Governor's Budget proposal seeks to place some meaningful restrictions around the sale and advertising of marijuana to prevent diversion to youth. However, we remain concerned, as noted above, that legalization will still result in marijuana being abused by kids and threaten public safety through an increase in drugged driving. For these reasons, we urge that the Legislature not rush to enact legislation to legalize the recreational use of marijuana. Instead of being included in the State Budget, there should be careful analysis of its potential impacts – both positive and negative – with a particular emphasis on availability to children and impact on driver safety.

8) Oppose Expansion of Collaborative Drug Therapy Program

We have strong concerns with a provision in the Executive Budget that would expand the existing physician-pharmacist collaborative drug program to include physician assistants or nurse practitioners. In effect this would enable these non-physician practitioners to defer to pharmacists the ability to adjust or change the medications of patients with specific diseases states according a written protocol. There

is also problematic language that would remove the existing requirement for these protocols to be specific to each patient, and instead enable practitioners to enter arrangements with pharmacists to manage medications on a non-patient specific basis. Even more alarming is proposed language that would define the adjustment of a prescription written by a physician as a "prescription" by the pharmacist, which would be an enormous new change in scope for pharmacists.

The current collaborative drug therapy law was originally established with a "sunset date" in 2015 and was extended by the State Legislature in 2018 to continue until 2020. However, this proposal goes far beyond this demonstration program.

MSSNY has supported the development and gradual expansion of this program. Many physicians believe that these programs, if structured properly, can be helpful to managing the treatment of a patient. However, this Budget proposal is an enormous expansion of the program, endangering patient care by expanding who can enter into these protocols, and eliminating the requirement for these protocols to be on a patient by patient basis, and significantly narrowing the control the prescribing health care practitioner has over the adjustments of medication by the pharmacist.

Currently, only physicians are permitted to enter into such protocols with pharmacists employed within a health care institution. We are concerned that there has been no demonstration within a specific care setting in New York, such as in a hospital, that nurse practitioners have the sufficient pharmacology background to successfully work with pharmacists by themselves on managing patient medications (and potential interactions) on a large scale basis as is contemplated in this proposal. By contrast, physician-pharmacist CDTM protocols were studied extensively following the enactment of New York's law, which led to the Legislature extending the existing program in 2015. As such, it would be premature to now add Nurse Practitioners or Physician Assistants. Moreover, while many states across the country have established CDTM programs, few have permitted these protocols between nurse practitioners and pharmacies. Additionally, some of those states still require nurse practitioners to maintain a collaborative agreement with a physician. Finally, we are concerned that there is no specification of specific disease states or medications for which a nurse practitioner or PA would be able to coordinate with a pharmacist.

Again, these programs, if carefully structured, can be helpful to managing the treatment of patients suffering from chronic conditions. However, we are concerned that what is proposed in the State Budget is far too broad and therefore urge that it be removed from the Budget.

9) Oppose Expansion of Pharmacists as Immunizers

MSSNY opposes a provision in the Governor's proposed budget that would broaden the vaccines that pharmacists would be allowed to administer to adults to include any vaccine recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunizations Practices (ACIP) on the adult immunization schedule.

The Medical Society believes that this proposal would cause further fragmentation of care and is not conducive with the concept of creating a patient "medical home". As more and more patient care is relegated to pharmacists and other non-physician providers, the concept of a patient medical home is eroding and will ultimately be destroyed.

This proposal would greatly expand the number of vaccines, from 7 to 16, that a pharmacist would have authority to administer. Many of these immunizations are given as a series with specific time parameters, and calling back a patient within a physician's office, where contact information available,

is at times difficult. Calling back an individual to a pharmacy to get the additional immunizations may be beyond the capability of that pharmacy. Or, the pharmacy may have the capability but may not have the same credibility to the patient as the patient's physician. Perhaps of even greater concern, this proposal prevents a review by the NY Legislature or even the Governor's office as to whether pharmacists should be performing any additional immunizations that may be recommended by ACIP in the future.

Currently, the New York State Education Laws 6527, 6801, and 6909 permit licensed pharmacists, who obtain an additional certification, to administer influenza vaccine to children between the ages of 2 and 18 years of age and to adults 18 years of age and older, and to administer, pneumococcal, meningococcal, tetanus, diphtheria, pertussis and herpes zoster vaccinations to adults 18 years of age and older under either patient specific or non-patient specific orders. These diseases are highly contagious. Moreover, MSSNY requests that the state provide data specifically on whether immunizations rates have improved as a result of pharmacists being able to provide these vaccines.

The education law also currently requires that when a licensed pharmacist administers an immunizing agent, he or she shall: a) report such administration by electronic transmission or facsimile to the patient's attending primary health care practitioner or practitioners, if any, and, to the extent practicable, make himself or herself available to discuss the outcome of such immunization, including any adverse reactions, with the attending primary health care practitioner, and to the statewide immunization registry or the citywide immunization registry, and b) provide information to the patient or, where applicable, the person legally responsible for the patient, on the importance of having a primary health care practitioner. The Medical Society of the State of New York has received reports that some pharmacies may not be complying fully with the law, and strongly recommends that the Governor and the Legislature require reporting of compliance with the current provisions of the law.

10) Oppose Expansion to allow Pharmacist Technicians to Compound Drugs

MSSNY opposes the proposal to allow pharmacist technicians, who may only have a high school diploma from being allow to compound medications. Compounding medications is an important aspect of the dispensing of medicine by the pharmacists who has many years of training to allow him/her to do this—to now designate a technician, who has not underground this training, will put patients throughout New York State at risk.

Conclusion

Thank you for allowing us, 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 2020-21.