



President's Message: Health Care in the 21st Century

By Barry Perlman, M.D.

While the "Commission on Health Care Facilities in the 21st Century" held its third meeting on November 17, 2005 it has yet to gain the level of visibility and concern it deserves in the mental health community. Created as part of the New York State budget legislation for 2005, the Commission has been likened to the federal government's military "base closings" commission. Ultimately, it was put forward as a vehicle for the reorganization and rationalization of the state's health care infrastructure of hospitals and nursing homes. The legislation does not require the Commission to make recommendations regarding the reconfiguration of the state's public mental health system, the NYS system through which most persons with serious and persistent mental illness (spmi) receive care. Nevertheless, the recommendations of the Commission have the potential to exert a vast impact on the mental health system of our state. While I shall provide supporting data for my argument later on, I would like readers to understand that while mental health services comprise a relatively small part of the entire spectrum of services provided by the



Barry Perlman, M.D.

state's Article 28 hospitals and nursing homes, those same institutions play an enormous role in the provision of all mental health services in New York. Therefore it is critical that interested professionals and advocates keep a close watch on the deliberations of the Commission. They must insist that those appointed as Commissioners ask the right

questions and obtain the data pertinent to the role played by institutions licensed under Article 28 of the Public Health Law in the provision of mental health services which they have been charged with reviewing.

Psychiatrists and other advocates interested in New York's public mental healthcare delivery system need to understand the process set in motion by the legislation. The law envisions that through a process involving the Commission, Regional Commissions and related Regional Advisory Committees recommendations on the reconfiguration and "right sizing" of health care facilities will be made to the Governor almost immediately following

[See Message on page 2]

Civil Commitment for Sexually Violent Predators: A Rising Debate in New York State

By Karin L. Moran, M.S.W.

In 1989, when Earl Shriner raped, strangled and sexually mutilated a seven-year-old Tacoma boy, Washingtonians were horrified; when Shriner's extensive criminal past and self admitted desire to re-offend were divulged, they were outraged. The subsequent story that unfolded, about the mentally retarded man with a twenty-four year criminal history that included murder and sexually violent assaults, told like a Hollywood horror movie.

Just two years prior to his headline grabbing assault, Shriner was about to be released from a Washington State prison where he had completed a ten-year sentence for the kidnapping and violent rape of two teenage girls. Preceding his discharge, prison officials learned that he had given detailed accounts to cell mates of his plans to kidnap and torture children upon release. Attempts to detain Shriner failed and the state of Washington had no choice but to release him. But when the seven-year-old Tacoma boy was found clinging to life in the deep woods of Washington State, public outcry hit a crescendo and the name Earl Shriner would be forever associated with the first of its kind statute (allowing a state to indefinitely confine sexually violent predators) known today as the Community Protection Act.

The intent of the Act was to allow the state of

Washington to retain custody of sexually violent offenders who did not meet the specified criteria for a mental disease or defect in existing involuntary commitment law. Unlike any other sexual predator statutes at the time, Washington's new statute allowed for this retention to take place after the offender had served his criminal sentence, not in lieu of it. Predictably, this caused a great deal of controversy and debate. Many critics pointed to the unconstitutionality of such a provision, while others argued that the costs associated with civilly confining such individuals would be exorbitant and prohibitive; further draining from resources that might otherwise be available to the mental hygiene system.

In spite of the controversy, a number of states were quick to follow suit, all of which faced legal challenges; but when the U.S. Supreme Court upheld Kansas' sexually violent predator (SVP) law in 1997, six more states enacted their own version. To date, sixteen states have adopted similar legislation and New York State legislators, primarily Assembly Democrats, are under increasing pressure to fall in line.

For the last seven years, the New York State Senate has passed a SVP bill that calls for a broader definition of mental abnormality to

[See Civil Commitment on page 4]

CMS Rolls Out New Medicare Prescription Drug Program

By Seth P. Stein, Esq. and Rachel A. Fernbach, Esq.

The new Medicare prescription drug program, called Medicare Part D, went into effect on January 1, 2006. Representing an historic change in the Medicare program, Part D will now cover the cost of certain prescription medications for persons enrolled in Medicare. For individuals also receiving state Medicaid benefits, Medicare Part D will replace Medicaid drug coverage in all states.

In order to assist members in understanding Medicare Part D and how it will affect their patients, NYSPA has created the "Guide to the Medicare Prescription Drug Program for New York State Psychiatrists." The Guide is currently posted on the NYSPA website (www.nyspsych.org) and may be accessed by clicking on the "Medicare Part D" link on the home page. The Guide is presented in the form of an outline, with "hot links" to specific topics of information so that psychiatrists can go directly to topics that interest them or are relevant to a particular patient. In the alternative, readers can also download and print out a copy of the entire Guide by using the link provided. In addition to written material on the drug benefit and special considerations for the mental health community, the Guide provides actual listings of New York State drug plans, including drug offerings, costs and formulary restrictions. NYSPA is pleased to offer the Guide as a public resource available to psychiatrists, patients, family members and other individuals in the mental health field.

The following is an overview of some of the basic elements of the Part D program. Medicare has not yet finalized all aspects of Part D and the information in this article reflects the best information available at this time. As new information is available, it will be posted on the NYSPA website.

For most individuals who have Medicare coverage, Part D is an optional benefit program that Medicare beneficiaries can choose to enroll in (by paying an additional premium) or can reject (subject to potential financial penalties if they delay enrollment after they are eligible).

If your patients have encountered any problems with Medicare Part D, please let the NYSPA Central Office know as soon as possible. Let us know the name of the plan, the pharmacy, the medication and the specific difficulty encountered. We are able to get in touch with CMS staff who are assigned to address these types of complaints. You can contact the NYSPA Central Office by telephone at 516-542-0077 or by email at centraloffice@nyspsych.org.

Unlike the Medicaid program, the Medicare Part D program will not simply pay pharmacies for prescriptions presented by individuals enrolled in the program. Instead, the actual operation of the plan will be handled by private prescription drug plans that have agreed to participate in the program. In each region of the country (New York State is its own region), there will be many drug plans competing for enrollment of Medicare beneficiaries. Under the new law, these private drug plans are permitted to have limited formularies (a list of the drugs covered under the plan) and may impose prior authorization requirements and higher copays for higher cost medications. Drug plans also can offer higher premium plans with better benefits and lower out-of-pocket costs.

Although the program is optional for most Medicare beneficiaries, one group of beneficiaries is required to participate. This group, for whom participation is mandatory, is the "dual eligibles," those individuals who receive both Medicare and Medicaid health care coverage. Typically, a person becomes a dual eligible because they are disabled and receive SSI or SSDI benefits and are also enrolled in their state Medicaid program.

Basic Benefit

Under Part D (and similar to most other health insurance coverage), beneficiaries must participate in cost-sharing by paying a monthly premium, an annual deductible and co-pay-

[See Medicare on page 5]

Albany Report

By Richard J. Gallo and Karin L. Moran, M.S.W.

With the start of the 2006 Legislative Session (three weeks away, as we write this report), NYSPA is focused on several issues including:

- the upcoming State Budget request with its inevitable proposals for health care funding cuts;
- insurance parity for mental illness and chemical dependency (Timothy's Law);
- civil commitment of "sexually violent predators" (SVP);
- the deliberations and recommendations of the Commission on Health Care Facilities in the 21st Century; and
- the restoration of Medicaid co-payment for psychiatric services rendered to dually eligible for Medicare and Medicaid, commonly referred to as "Crossover"

TIMOTHY'S LAW

Goal

Amend the Insurance Law to require health insurers and health maintenance organizations (HMO's) in New York State to provide coverage for mental illness and chemical dependency equal to that which is provided for other medical conditions by such insurers and HMO's.

Background

Throughout the 2005 session, efforts to pass Timothy's Law (insurance parity for mental illness and chemical dependency treatment) were, again, Herculean. NYSPA representatives worked closely with advocates to orchestrate a multi-faceted campaign that included: grassroots mobilization, media focused events, and constant communication with key members of the Legislature which primarily focused on new bill language.

The new bill sought to provide comprehensive insurance coverage for the treatment of mental illness and chemical dependency by:

- defining mental illness and chemical

dependency as DSM - IV (TR) diagnoses with some exceptions;

- codifying in statute (mandating) the upper end of existing benefits for MH and CD to be included in all group health plans in NYS;
- mandating full parity for employer groups of fifty or more;
- providing access to full parity to employees of small employers (under 50);
- creating a catastrophic pool for employees of small employers who do not have full parity; and,
- requiring adequate networks, reporting requirements, public education and a comprehensive study on the impact of parity in New York State.

In the end, much to our chagrin, the two houses did not reach an agreement on the issue; however, the unprecedented attention given to the issue by Senate leadership during the waning days of session certainly seems to indicate a willingness to provide New Yorkers with greater access to mental health services.

Status

Currently, NYSPA is working with the Timothy's Law Campaign (TLC) to develop its 2006 strategy with an eye towards building a stronger grassroots base, recruiting new coalition partners and continuing our communication with legislative members and outside stakeholders.

SEXUALLY VIOLENT PREDATOR LEGISLATION

Goal

To assure that public policy respecting the civil or criminal disposition of sexually violent offenders does not inappropriately utilize the public mental health system nor seek to redefine the principles of psychiatry.

Background

The issue of expanding New York's civil

[See Report on page 3]

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FROM THE EDITOR'S DESK... By Jeffrey Borenstein, M.D.

This edition of The Bulletin highlights a number of ongoing as well as some new legislative and public policy issues. The President's message focuses on the NYS Commission on Healthcare in the 21st Century, and how the commission would impact the state's mental health system. Given the lack of excess capacity in the mental health system, changes in the Article 28 hospitals' capacity



Jeffrey Borenstein, M.D.

require an evaluation of the consequences on the entire mental health system. We also report on another new initiative which has received much attention in the press: the controversy about civil commitment for sexually violent predators and the concern about the potential effect of this initiative on psychiatric care.

The new Medicare prescription drug plan has also received much

media attention. We provide information about the program, in particular how this program will impact the benefits of a significant population: people with dual eligibility for medicare and medicaid. We also provide information about Preferred Drug Programs and the recommendation of NYSPA's task force on this important topic. The Albany report focuses on the upcoming Legislative Session including the budget and parity. We also have the Area II Trustee Report as well as an overview of the Fall Area II Council Meeting. ■

President's Message continued from page 1

the 2006 election. The Governor will send the Commission's recommendations to the legislature shortly thereafter. The legislature will then have to vote to reject the recommendations as received, without further amendment, before year's end. A failure to vote to reject will be tantamount to adopting the Commission's recommendations. If adopted, a process of reconfiguration will begin to be implemented. If defeated, the Commission's report, I believe, will continue to influence the course of change for the health care industry in NYS by virtue of the effort expended and the data and analysis embodied in it. While not at the core of the legislative charge to the Commission, the needs of the mental health system must be given full weight in the Commission's deliberations because their recommendations can not but significantly affect the state's system for the delivery of mental health services.

The "Factors Book" distributed to Commission members at their first meeting describes the statistics used which include a categorization of "Major Service Categories". Among the services referenced is "Psychiatric inclusive of: Psychiatric, Drug Detoxification and Rehabilitation, Alcohol Detoxification and Rehabilitation". To those concerned with the mental health system it is clear that related data subsumed in the above over inclusive category will need to be disaggregated and viewed in more detail.

The following information will make clear why a perspective with greater nuance is required. In 2003 the total of expenditures by Article 28 hospitals in NYS was \$38 billion. Of that amount, \$2.5 billion (7%) was expended on mental health and substance abuse services. Mental health expenditures were: inpatient \$1.4 billion (55%), outpatient \$660 million (26%). Substance abuse expenditures were: inpatient \$250 million (10%), outpatient \$242 million (9%). (These data were derived from 2003 institutional cost reports.) These data make clear that mental health and substance abuse services comprise a relatively small part of the total expenditures of general community and teaching hospitals in NYS.

The question which then follows is, "What proportion of all expenditures for mental health care by licensed facilities and pro-

TABLE 1	Total	Art 28	Art 31	OMH
State Totals	\$ 4.694 billion	37%	31%	31%
Inpatient	\$ 2.541 billion	48%	10%	43%
Outpatient	\$ 1.065 billion	40%	44%	16%
Housing	\$ 429 million	3%	79%	18%
CSP	\$ 387 million	8%	74%	18%
Case Management	\$ 155 million	11%	68%	21%
Emergency	\$ 116 million	53%	27%	20%
Percent Adult services for SPMI adults		78%	80%	88%
Percent kids services for SED kids		76%	79%	97%

grams is accounted for by expenditures by Article 28 hospitals and to what extent do those hospitals serve SPMI adults and SED kids?" To answer these questions we may look to data provided by the 2003 Patient Characteristics Survey as summarized in Table 1.

A final data set worth noting for purposes of this piece's argument relates to inpatient psychiatric capacity and utilization. Currently there are approximately 5800 inpatient psychiatric beds in general hospitals and between 800 and 900 in psychiatric hospitals licensed by OMH. These numbers do not include the number of

TABLE 2	Year	Discharges	Days	ALOS
	1998	106,174	1,613,209	15.19
	1999	108,451	1,647,129	15.19
	2000	109,160	1,634,039	14.97
	2001	109,815	1,666,072	15.17
	2002	111,430	1,669,367	14.98
	2003	108,221	1,609,795	14.88

beds available in the state psychiatric centers. The NYS SPARCS data set, based on information from only the inpatient psychiatric units in Article 28 general hospitals, reveals the following about psychiatric discharges.

The data in Table 1 elucidate the role played in the public mental health system by Article 28 hospitals. As the largest component of the system, they represent 37% of all costs including 48% of inpatient and 40% of outpatient costs and they served a population with almost as many seriously and persistently ill adults and seriously emotionally disturbed children. The data in Table 2 demonstrates the relatively narrow range of discharges, days in hospital, and average length of stay (ALOS) from inpatient psychiatric units in general hospitals over the 6 most recent

years for which data is available. Since 2003 a number of hospitals with inpatient psychiatric units have closed and other hospitals have closed their inpatient psychiatric units. As a result, the pressure on the inpatient system has grown.

In conclusion, these data demonstrate that Article 28 licensed hospitals, key among the facilities slated for review by the "Commission", play a very prominent role in the state's public mental health system. Indeed, the current system rests on the contributions of all three provider sectors, the Article 28s and 31s and the OMH facilities. As practitioners and advocates know there is virtually no excess capacity in the overall system. Community based inpatient units as well as those in the state psychiatric centers are full and hard pressed, outpatient clinics must maintain waiting lists, psychiatric emergency services are often overflowing and stressed, supported housing remains scarce despite welcome, recently announced additions to the pipeline, and case management, CSP, and ACT services are unable to handle all of those in need. Children's services at all levels remain scarce and difficult to access. It is clear that mandating change of the Article 28 hospitals' capacity to provide any category of mental health service without a complete overview of the change's consequence on the entire system would have a potentially devastating impact on the state's public mental health system. Primum non nocere, "First, do no harm", is a dictum familiar to physicians. It should apply as much to those seeking to change health care systems as to those treating individual patients. It is for this reason that the work of the "Commission" deserves the laser like focus of interested mental health professionals and advocates. ■

Notice of Good Faith Estimate of Non-Deductibility of NYSPA 2006 Dues

The Omnibus Budget Reconciliation Act of 1993 included certain provisions denying tax deductibility for the portion of dues paid to 501(c)(6) professional organizations that is spent on influencing state or federal legislation. The law requires NYSPA to provide its members with a good-faith estimate of the portion of their dues which is attributable to lobbying and therefore, is non-deductible for federal income tax purposes.

For 2006 dues, NYSPA has estimated that

33 1/3% of NYSPA/Area II dues are attributable to lobbying and cannot be deducted. The schedule below sets forth the calculation of the deductible and non-deductible portion assuming payment in full. If only a partial payment was made, then 33 1/3% of the amount paid is non-

deductible.

Please note that this notification only applies to NYSPA/Area II dues. It does not apply to APA dues or to district branch dues. If you have any questions, please do not hesitate to contact the NYSPA Central Office. ■

Membership Category	2006 Dues	Deductible	Non-deductible
General Member/Fellow	135.00	90.00	45.00
Member in Training	15.00	10.00	5.00
Life Member/Life Fellow (1-5)	90.00	60.00	30.00
Life Member/Life Fellow (6-10)	45.00	30.00	15.00



Ann Sullivan, M.D.

Happy New Year!! 2005 was a good year for the APA with increased membership, fiscal stability, the launch of a national public affairs campaign, and exciting new initiatives in college mental health, the Hispanic Health Initiative web page, and the successful passage of legislation to increase buprenorphine prescribing capacity. But we also face serious challenges in 2006 in preventing medicaid cuts to our patients much needed services, continuing the battle against psychologist prescribing, helping our patients understand Medicare Part D and helping to shape the new pay for performance environment!

The Board meeting in December addressed many of these key issues, so here are the highlights!

Hurricane Katrina

In response to the devastation of Hurricane Katrina, the Board voted to authorize the establishment of the Disaster recovery Fund for Psychiatrists and Residents using \$50,000 from a SAMHSA contract with initial disbursements of \$15,000 each to Tulane and LSU to support their recovery efforts. The Disaster Committee of the APA working with APA staff did an outstanding

job of coordinating services for the affected areas. APA has provided support both financial and technical to our affected DB's and is in the process of assessing long term needs. Our psychiatrists and DB staff in the affected states and their neighboring states have been heroic in providing crisis services and ongoing care to our patients and their families. Throughout the country APA members were there to help!

Budget and Finance

The APA remains in the black, with a projected surplus of 2.7 million dollars for 2005. As I have said many times, the reserves need to be replenished and staff benefits costs continue to increase, so don't spend all the money yet! We will be able to keep our programs going and continue to fund key initiatives such as grants to DB's \$300,000, the national public affairs campaign \$350,000, the college mental health initiative, and our numerous advocacy and educational activities. The annual meeting in Atlanta showed a profit of 6 million dollars, but this was considerably less than the 10 million dollars in New York. This year's meeting is in Toronto, and a modest profit is expected, but not guaranteed.

In order to grow our investments, the Board passed several measures to allow for more effective and flexible investment strategies. Our investment strategies have yielded positive results in the current market, over 2 million dollars. However the Board once again defeated investing in pooled investment options where it could not be determined if the options included pharmaceutical, managed care or tobacco stocks. Even if such investments are more "profitable" they are seriously at odds with key values of our members.

The budget again includes \$300,000 in sup-

port dollars to the District Branches. This year these dollars were allocated in a competitive grant process to the DB's for projects related to membership recruitment and retention, professional and patient education and public affairs. Brooklyn, Bronx and Queens received grants this year! The process will be reviewed and suggestions are welcome as to whether we should continue with grants, return to a formula distribution to all DB's or utilize another allocation methodology.

Position Statements

In response to the exposure of the use of torture in the interrogation of detainees, it is imperative that the APA make a forceful statement of its position on torture and interrogation. The Board reaffirmed its position passed in October on this issue, and felt that the Assembly's new recommended language was not as definitive. In October, the APA stated that psychiatrists should not participate in or assist in torture, and should not participate in interrogation of detainees or in any way provide information or advice to enforcement authorities regarding likely consequences of specific techniques of interrogation applied to individual detainees. The Assembly voted to include the word "coercive" interrogation. The Board felt that all participation in interrogation should be banned, because how we define coercive becomes too murky and leaves too much room for abuse. Recognizing the importance of Assembly input and approval of this position, the Board appointed a joint ad hoc work group to provide recommendations to the May Assembly. Until then, temporarily, the Board position stands and can be read in its entirety on the APA website. The APA needs to be clear and definitive in its stand

on this critical issue!

The Board also passed additional position statements on: Mentally Ill Prisoners on Death Row; College and University Mental Health; Adjudication of Youth as Adults in the Mental Health system; and Death Sentences for Persons with Dementia or Traumatic Brain Injury. These detailed and informative position statements are developed by the APA members who volunteer their time and expertise to the councils and committees of our governance structure. Such work is critical to keeping the voice of Psychiatry in the forefront of issues critical to our patients and profession!

Practice Guidelines

The APA Practice Guidelines have become a recognized standard for the prevention and treatment of psychiatric disorders. Each guideline represents enormous work by staff and members to provide state of the art, up to date treatment recommendations. Three practice guidelines were approved: Psychiatric Evaluation of Adults, 2nd edition; Treatment of patients with Eating Disorders, 3rd edition; and Treatment of Patients with Substance Use Disorders, 2nd edition.

Membership

APA membership continues to slowly grow in the positive direction! The efforts of all members to recruit colleagues seems to be paying off!! Several initiatives have been started or expanded to improve membership processes. The centralized membership processing pilot program has been going extremely well and will be expanded to all DB's April 2006. All will report back in 6 months with any issues. The Board also approved the Membership Committees' rec-

[See REPORT on page 6]

Albany Report continued from page 1

commitment statute to include sexually violent predators (SVP) has recently emerged as a hot button issue and promises to take center stage early in the 2006 Legislative Session. For years, the Senate and Assembly have locked horns in the debate to add New York to a long list of states that allows for the civil commitment of sexually violent predators following the completion of criminal sentences.

Governor Pataki has consistently called upon the State Legislature to adopt SVP legislation. The Senate has passed the Governor's program bill each year for the last seven years and although the bill has gained bi-partisan support in the Senate it has not passed the Assembly.

Absent the enactment of legislation addressing this issue, Governor Pataki recently ordered his administration to "push the envelope" in applying the state's existing civil commitment statute to sex offenders who are completing their prison terms. As a direct result of that order, the office of mental health reports that 21 out of 78 sexually violent predators being released were deemed appropriate for civil commitment and thus have been committed to the Manhattan Psychiatric Center. A number of them have since been transferred to the related Kirby Forensic Psychiatric Center.

Status

On November 15, 2005 Justice Jacqueline W. Silberman of the State Supreme Court in Manhattan, ruled that twelve plaintiffs challenging their commitment were "denied their right to an independent hearing" and called for an examination by two court-appointed physicians to determine whether they suffered from mental illness to the degree that they needed to be involuntarily confined to an institution.

The Governor immediately appealed Justice Silberman's ruling which led to a temporary stay on the judge's order, hence the plaintiffs remain in custody as the state appeals the court decision.

Meanwhile, under the leadership of

Speaker Sheldon Silver, the Assembly has recently drafted its own SVP legislation known as the *Child Safety and Sexual Predator Punishment and Confinement Strategy* which calls for mandatory life maximum sentences for the most serious sex crimes, civil commitment for "the most dangerous predators," enhanced parole supervision, and a number of additional measures designed to assist victims.

While each of the proposals differ to some degree, both the Senate and Assembly bills seek to utilize the mental health system as an indefinite retention center for individuals that may not in fact suffer from a mental illness. With that in mind, NYSPA is concerned with any proposal that seeks to redefine the principles of psychiatry, and as such will be closely examining all legislative proposals associated with this controversial issue. Presently, three NYSPA committees (Legislation, Public Psychiatry, and Psychiatry and the Law) are working together to develop the Association's position which will then be discussed with key legislative members.

COMMISSION ON HEALTH CARE FACILITIES IN THE 21ST CENTURY

Goal

Monitor and comment upon the deliberations of the Commission on Health Care Facilities in the 21st Century to assure that the Commission's recommendations are mindful of the enormous role of general hospital in the delivery of community mental health services.

Background

The newly established Commission on Health Care Facilities in the 21st Century recently held its third meeting in early November. The Commission, according to a recent press release by the Governor's office is charged with "examining the needs and capacities of the health care system and making recommendations to right-size hospitals and nursing homes." More candid descriptions liken it to the federal government's military base closings commission. While NYSPA is not diametrically opposed to examining the states existing

hospital and nursing home infrastructure, we are very concerned by the lack of community mental health expertise on the Commission or its regional advisory panels, especially since a large percentage of the community mental health services are delivered under the auspices of general hospitals.

Absent the expertise and input of mental health professionals on the Commission, it is vitally important that practitioners and advocates alike closely monitor all deliberations and recommendations of the Commission. Conceivably, the psychiatric unit of a general hospital could be operating beyond capacity while the hospital at large is operating considerably below capacity and thus a candidate for consolidation or closure. In such a scenario NYSPA is gravely concerned about the inpatient and outpatient needs of those individuals being treated by the threatened psychiatric unit.

Status

In an attempt to proactively engage the Commission regarding NYSPA's concerns, NYSPA is in the process of developing a formal position statement on the issue which will then be circulated to concerned stakeholders for co-signatures and distributed to all members of the Commission. We would urge legislators to familiarize themselves with these concerns and use their good offices to assist in assuring that the needs of the mentally ill and their communities are properly considered in the Commissions deliberations.

CROSSOVER FUNDING

Goal

Fully restore Medicaid coinsurance payments to 2003 levels for persons who are dually eligible for both Medicare and Medicaid. Increase the states share of Medicaid to effect comparable reimbursement for psychiatric services.

Background

Efforts by NYSPA, the Medical Society of the State of New York and others over the past 24 months have resulted in minor

adjustments to the original proposal to completely eliminate Medicaid crossover funding. As part of the 2004-05 Budget, a small restoration (\$2.5 million) of Medicare/Medicaid "Crossover" funding was accomplished through a member item initiated by Senate Majority Leader, Joseph Bruno (R-Brunswick) in the 2005-06 Budget.

Status

In early June, the state submitted a "state plan amendment" to the Center for Medicare and Medicaid Services (CMS) to assure that the \$2.5 million allocated by the state legislature would be matched by the federal government. The amendment was recently approved resulting in a \$4.7 million allocation to provide supplemental reimbursement to physicians that received Medicare/Medicaid crossover payments between April 1, 2005 and June 30, 2005. According to the New York State Department of Health, physician payments are slated for early December 2005 and will be determined as follows:

- Pursuant to the legislation, DOH will determine the ratio of each physician's crossover payments to the total of all crossover payments made to physicians, during the April 1, 2005 through June 30, 2005 period. This ratio will be expressed as a percentage.
- For each physician, the Department will then multiply the percentage by \$4,700,000.
- The result of such a calculation represents the "2005 Coinsurance Enhancement"

DOH has determined that approximately 17,000 physicians will receive a coinsurance enhancement payment with amounts ranging from as little as \$1 to over \$20,000. Payments will be made in separate checks mailed to qualifying physicians. There will be no supporting documentation provided. Questions can be directed to Computer Sciences Corporation Provider Relations at (800) 522-5518 or (518) 257-4104. ■

The explosive rise in pharmaceutical costs over the last several years has given rise to much debate and concern throughout the years; but, when coupled with the escalating costs of Medicaid, the anxiety quotient is raised exponentially. Pharmaceuticals have emerged as the fastest growing component of the Medicaid system, and as such, there has been much conjecture on how to contain costs while still providing access. Not surprisingly, many states, including New York, have looked for relief by developing Preferred Drug Programs (PDP). Such programs are established by private insurers and government health programs (typically, Medicaid) to permit a state to secure significant reductions in expenditures for medications by limiting medication coverage to one or two medications in a therapeutic class. States use their buying power, enhanced bargaining position and the offer of PDP exclusivity to extract substantial financial concessions from drug manufacturers. In turn, a PDP will typically employ various procedures to compel or, at least encourage, physicians to limit their prescribing to those drugs on the PDP.

After years of debate, New York passed its own PDP in the spring of 2005, albeit with a number of exclusions. One notable exemption was for atypical anti-psychotics and anti-depressant medications, a measure initially supported by NYSPA. However, upon greater reflection and armed with the knowledge that the cost of atypical medications had gone from 1/4 - 1/2 billion dollars in just four years time, NYSPA President, Barry Perlman M.D. resolved to re-examine the issue of whether it was indeed necessary to exclude such medications.

Dr. Perlman set about creating an Ad-hoc Committee of NYSPA member psychiatrists who had no ties to the pharmaceutical industry. Perlman himself served only as an Ex-Officio member to the Committee. Jack Gorman, M.D., former Professor of Psychiatry and Neuroscience at Mount Sinai School of Medicine, current President and Psychiatrist-in-Chief of McLean Hospital and Chair of the Scientific Advisory Council to NAMI, agreed to serve as Chair. Members included: Carl Cohen, M.D., Professor of Psychiatry at SUNY Downstate Medical Center, Mantosh Dewan, M.D., Professor and Chair of Psychiatry and Behavioral Sciences at SUNY Syracuse, Laura Fochtman, M.D., Professor of Psychiatry at Stony Brook; and, Fleming Graae, M.D., Chief of Child and Adolescent Psychiatry at Westchester Medical Center, who was added

at the request of NYSPA's Committee on Children and Adolescents. In addition, Seth P. Stein, Esq., NYSPA Executive Director, served as staff to the Committee and greatly assisted in the writing of the final report.

Once created, the charge of the Taskforce was to examine the feasibility of including psychiatric medications in the New York State Medicaid PDP and identify procedural safeguards to protect patients' access to medically necessary medication if it is determined that such drugs should be included. Members of the Taskforce came to the conclusion, and reported to the Council, that if done properly, including anti-psychotic and anti-depressant medications on the PDP was in fact both possible and practical. Following is a copy of the Taskforce's Report as it was presented to, and later accepted by, the Council.

REPORT OF THE TASKFORCE ON PREFERRED DRUG PROGRAMS

Most commentators and mental health advocacy groups have advocated for exclusion of psychiatric medications - especially atypical antipsychotics from PDP restrictions, many PDP's have in fact included provisions excluding certain psychiatric medications - atypical antipsychotics and antidepressants - from PDP. Other PDP's have excluded certain psychiatric diagnoses - schizophrenia and major depressive disorder - from PDP restrictions. Often, these exclusions were necessitated because the PDP included "fail first" or "step therapy" requirements - requirements that patients fail on a PDP medication before being able to secure a non-PDP medication. "Fail first" is clinically inappropriate for psychiatric medications because clinical data indicate that psychiatric medications are not interchangeable, i.e., each psychiatric medication, even medications within the same therapeutic class, are unique and cannot be therapeutically substituted for one another. Second, there are few data demonstrating the superior efficacy of any particular psychiatric medication in certain classes of medications, e.g., atypical antipsychotics. Finally, a "fail first" approach significantly increases the chances of relapse and re-hospitalization of patients with chronic mental illnesses - thereby resulting in increased costs for such patients that far exceed any savings from the PDP.

FIRST TRY

The Task Force recommends an approach which it calls First Try. PDP formulary restrictions should only apply to patients who are being prescribed a psychiatric medication in a

given therapeutic class for the first time. First Try would also exempt patients from PDP restrictions in the following situations:

- Patients who are already successfully utilizing a medication in a therapeutic class will be permitted to continue on their medication regardless of whether it is on the PDP formulary.
- Patients who are not currently taking a medication if they have a prior history of a positive response to psychiatric medication not on the PDP formulary
- Patients who have a history of a negative response (poor efficacy, unacceptable side effects or adverse reactions) to a medication on the PDP formulary.
- Patients who are taking a non-psychiatric medication with which a PDP medication has an adverse drug interaction with the non-psychiatric medication the patient is already taking. In such cases, the patient's psychiatrist should be able to select a non-PDP formulary medication.
- Patients who have a First Try on PDP medication(s) and who do not respond would then be free from PDP restrictions. In essence, First Try would require limited trials on a PDP formulary medication(s).
- No restrictions should be imposed based upon off-label uses or patient diagnosis. A psychiatrist should be able to prescribe any medication on the PDP formulary (both psychiatric and non-psychiatric medications) for any mental illness or conditions as long as such treatment is consistent with generally accepted psychiatric practice.
- No restrictions should be imposed on the prescription of multiple medications consistent with generally accepted psychiatric practice.
- The PDP must include a provision for bypassing the PDP formulary in a medical emergency if necessary to secure medication on a short-term basis.

EASY PASS

Essential to the First Try approach is a simple system for psychiatrists to bypass the PDP under the eight First Try exclusions listed above. The PDP must not include a prior authorization system that impedes access to clinically appropriate medication. APA calls this approach an Easy Pass. There should not be any elaborate or complicated procedures to bypass the First Try requirements when permitted. One approach would be to permit psychiatrists to check off the basis for bypass-

ing the PDP formulary on the prescription form that is submitted to the pharmacy.

Finally, a PDP must always include a mechanism to permit a psychiatrist to secure prior authorization in those cases not otherwise covered by the First Try exceptions. While the Task Force believes that the exceptions listed above should address most clinical situations, there must be a mechanism to permit a treating psychiatrist to prescribe any medication consistent with generally accepted psychiatric practice as deemed necessary and without regard to the PDP formulary based upon the patient's individual clinical circumstances.

NIMH is currently funding a 5 year, \$47 million study entitled Clinical Antipsychotic Trial of Intervention Effectiveness (CATIE) to evaluate the head-to-head effectiveness of atypical antipsychotic medications based upon efficacy, side effects and outcome differences. Results from the CATIE study will likely not be available until 2006.

THERAPEUTIC CLASSES

Critical to the clinical appropriateness of a PDP for psychiatric medication is the identification of the appropriate therapeutic classes and subclasses of psychiatric medications. In each therapeutic class and subclass, the Task Force recommends that a PDP include at least two medications. In addition, the Task Force recommends that certain specific medications be included in addition to the two designated medications. In these cases, the Task Force has concluded that because of the unique properties of a specific medication, inclusion in the PDP is clinically mandated. Of course, these classifications, the drugs placed on the formulary, and the mandatory drugs must all be subject to regular review, reconsideration and revision if necessary based upon clinical data and findings regarding efficacy, side effects, adverse reactions and possible drug interactions (e.g. CATIE study) and the availability and uses of new medications. Based upon current generally accepted psychiatric practice, the Task Force recommends the following classes, subclasses and clinically mandated medications:

Antipsychotics

- 1st Generation (Typical)
- 2nd Generation (Atypical)
- Clozapine (mandatory inclusion)

Antidepressants

- MAO Inhibitors
- Tricyclics
- SSRIs
- Effexor (venlafaxine) or Cymbalta

[See Programs on page 5]

Civil Commitment continued from page 1

include violent sexual offenders. If enacted, such a statute would allow the state to involuntarily commit offenders to a psychiatric hospital. Assembly Democrats, however, have not supported the measure, citing the need to look at alternatives, such as utilizing existing involuntary commitment laws, imposing longer sentences and reducing the rate of plea bargaining. Predictably, such arguments have resulted in a classic two-house standoff; and, just as the 2005 Legislative Session was coming to a close, the issue was thrust into high gear once again with news of a fatal stabbing in Westchester County perpetrated by a level three sex offender who had been paroled in 2003 after serving a sentence of twenty years for the violent rapes of three Bronx women.

As calls for an SVP law were renewed and pressure was once again applied to the Assembly, Assembly members Peter Rivera (D-Bronx), Chairman of the Mental Health Committee, Jeffrion Aubrey (D-Queens), Chair of the Committee on Corrections, and Joseph Lentol (D-Kings), Chair of the Committee on Codes responded by holding a number of hearings on the subject throughout the state.

The Governor, however, characterized the hearings as a "stall tactic" and countered with a stunning move when he directed the New York State Office of Mental Health and Department of Corrections to "push the envelope" and apply the states existing involuntary commitment of the mentally ill

statute to sexual predators that have completed their sentences.

Since the Governor's order, the Office of Mental Health reports that twenty-one out of seventy-eight sexually violent predators scheduled for release were deemed appropriate for civil commitment and thus have been held at the Manhattan Psychiatric Center. A number of them have since been transferred to the related Kirby Forensic Psychiatric Center. This has, of course, set the stage for a legal battle.

On November 15, 2005, Justice Jacqueline W. Silberman of the State Supreme Court in Manhattan, ruled that twelve plaintiffs, challenging their commitment, were "denied their right to an independent hearing" and called for their release. The Governor immediately appealed Justice Silberman's ruling which led to a temporary stay on the judge's order, leaving the plaintiffs in custody as the state appeals the court decision.

Meanwhile, under the leadership of Speaker Sheldon Silver, the Assembly has recently drafted its own SVP legislation, known as the *Child Safety and Sexual Predator Punishment and Confinement Strategy*, which calls for: mandatory life maximum sentences for the most serious sex crimes, civil commitment for "the most dangerous predators" and a number of additional measures designed to assist victims.

Concurrently, stakeholders in the delivery of mental health services, civil libertarians, and the public at large have all been weighing in.

Many mental health advocates around the state have focused their debate on the high costs associated with an impending SVP statute, arguing that the mental health system cannot afford to have its already strained budget tapped into for yet another unfunded mandate. Estimates for housing an offender in a New York State psychiatric hospital have ranged from between \$70,000 to over \$100,000 per person, per year. The cost of housing an individual in the correctional institution is estimated at around \$30,000 per person, per year.

Recently, the Washington State Institute for Public Policy attempted to compare costs associated with state's sexually violent predator civil commitment laws; however, they found the task to be difficult at best, citing that variations in service delivery models and state's budgeting techniques proved to be problematic when trying to determine actual costs. The resulting report shows costs ranging from as low as \$12,680 (South Carolina) to as high as \$109,000 (Minnesota) per year, per detainee.

But concern over SVP legislation runs deeper than funding mechanisms for mental health practitioners. The American Psychiatric Association (APA) staunchly opposes sexual predator commitment laws of this nature, deeming it "necessary to preserve the moral authority of the profession and ensure continuing societal confidence in the medical model of civil commitment."

Paul Appelbaum, M.D., Chair of the APA

Task Force on Sexually Dangerous Offenders, noted concern that "Psychiatry being used to preventatively detain a class of people for whom confinement rather than treatment is the real goal...has struck many as a misuse of psychiatry." As spokesman for the Task Force, Appelbaum went on to recommend "that societal concern about the protection from dangerous sex offenders be met through customary sentencing alternatives within the criminal justice system."

Echoing Appelbaum's sentiments in a recent article published in the New York Times, was Harvey Rosenthal, Executive Director of the New York Association of Psychiatric Rehabilitation Services, stating that "Everyone is concerned about the risks posed to the public by sex offenders, but this is a misuse of the mental health system. This is more of a criminal justice matter, and I don't believe that the mental health system is the appropriate place for it."

Presently, three NYSPA Committees (Legislation, Public Psychiatry, and Psychiatry and the Law) are working together to evaluate the many proposals put forth to deal with this highly controversial issue. "NYSPA's overriding concern, with respect to these proposals, is to assure that public policy respecting the civil disposition of sexually violent offenders does not inappropriately utilize the public mental health system, nor seek to redefine the principles of psychiatry" said NYSPA President, Barry Perlman, M.D. ■

NYSPA's Fall Area II Council Meeting was recently held at the LaGuardia Marriott in East Elmhurst, NY on October 22, 2005. With a full agenda ahead, NYSPA President, Barry Perlman, M.D., began the semi-annual event by presenting NYSPA's Distinguished Service Awards to "three men who have contributed so much to organized psychiatry, NYSPA, and to me personally, they hardly need an introduction; but nonetheless, it is my pleasure to present to you this year's recipients: Dr. Harvey Bluestone, Dr. Edward Gordon, and Dr. Edward Hanin."

In their respective acceptance speeches, each of the recipients graciously offered their gratitude to NYSPA for acknowledging their work and dedication to the profession of psychiatry and its esteemed organization.

Genesee Valley Council Representative, Aaron Satloff, M.D., also presented a Distinguished Service Award to Robert Thompson, CEO of the Monroe Plan for Medicaid Care. In presenting the award, Dr. Satloff discussed Mr. Thompson's success in providing psychiatric patients in the southern tier with treatment that is at parity with those suffering from physical illnesses; referring to Thompson as a "True innovator in the field of health care administration and a man eminently suited to receive NYSPA's Distinguished Service

Award." In his acceptance speech, Thompson responded to Dr. Satloff's remarks by saying "It is psychiatrists who deserve accolades for all that they do to serve the mentally ill."

Recognition was also given to new members of the Council, as Dr. Perlman called for the introduction of newly elected District Branch Leaders. Those who were present were: Kenneth Ashley, M.D., President Elect of the NY County District Branch, Sarah Atkinson, M.D., President Elect of the Genesee District Branch, Arlene Chapman, M.D., Executive Director of the New York County District Branch, Diane DeKeyser, M.D., Westchester Representative to the Committee on MIT's, Edward Herman, M.D., President of the Westchester District Branch, Munibar Khan, M.D., Queens Representative to the Committee on MIT's, and Gene Lui, M.D. Westchester Deputy Representative to the Committee on MIT's.

Also recognized by Dr. Perlman, was Jeffrey Borenstein, M.D., Editor-in-Chief of the Bulletin and CEO of Holliswood Hospital in Queens, for his recent appointment as the Editor of Psychiatric Quarterly and his work as Chair of the Section on Psychiatry for the New York Academy of Medicine. In addition, Dr. Perlman noted that Dr. Borenstein is about to begin hosting a thirteen-part tele-

vised series entitled Healthy Minds which is slated to air on New York's Public Broadcasting System beginning November 2, 2005.

In other news, several reports were given to the Council. NYSPA Treasurer, Seeth Vivek M.D., gave a brief synopsis of NYSPA's current financial statements, Budget Committee Chair, Glenn Martin, M.D., reported on NYSPA's proposed 2006 Budget and PAC Chair, Edward Gordon, M.D., reported on NYSPA's PAC activity over the last six month period. Especially noteworthy, however, is the unfortunate fact that PAC contributions are down again this year. In a follow-up to Dr. Gordon's report, Dr. Perlman stressed the importance of PAC donations and urged Council members who had not already done so, to contribute as soon as possible.

Additional reports were given by Richard Gallo, NYSPA's Legislative Consultant, C. Deborah Cross, M.D., Vice President of NYSPA and Chair of the Committee on Public Affairs, Barry Perlman, M.D. President of NYSPA and Ex-officio Member of the Task Force on Preferred Drug Programs, and Seth Stein, Esq., Executive Director of NYSPA.

Committee on Legislation

During his report, Mr. Gallo discussed mounting pressure being applied to the New York State Legislature to pass civil commit-

ment legislation for sexually violent predators, especially given the Governor's recent controversial actions related to the subject (See page # for a full report). In response, NYSPA's Committees on Legislation and Psychiatry and the Law will establish a joint sub-committee to develop the organization's formal position and legislative strategy with respect to the issue.

Also discussed, was the Governor's newly appointed Commission on Health Care Facilities in the 21st Century; which, according to a recent press release by the Governor's office, will "examine the needs and capacities of the health care system and make recommendations to right-size hospitals and nursing homes." While NYSPA is not diametrically opposed to such a notion, Mr. Gallo noted that "A large percentage of the mental health care delivered in the community is under the auspices of general hospitals and there appears to be little or no community mental health services expertise on the Commission or on its regional advisory panels. Conceivably, the psychiatric unit of a general hospital could be operating beyond capacity while the hospital at large is operating considerably below capacity and thus a candidate for consolidation or closure. In such a scenario, NYSPA is concerned about the inpatient and outpatient needs of those

[See Area II on page 6]

Medicare continued from page 1

ments for each prescription. What is different about Medicare Part D is the requirement that beneficiaries pay 100% of their drug costs between \$2,250 and \$5,100, the so-called "doughnut hole." In addition, the premium and deductible amounts may change from year to year because they are based on a fixed percentage of costs for the total Part D program. It is anticipated that in future years, the premium, deductible and the "doughnut hole" may increase.

Enrollment

For the typical Medicare beneficiary, the Part D initial enrollment period for 2006 only begins November 15, 2005 and ends May 15, 2006. This six-month enrollment period applies to those individuals already eligible to participate in Medicare or who will become eligible in November 2005, December 2005 or January 2006. For those who become eligible to participate in Medicare Part D after January 2006, the initial seven-month enrollment period for Medicare Part D is the three months prior to the beneficiary's 65th birthday, the month of the birthday and the three months following the birthday.

Most Medicare beneficiaries may only change their Part D plan during the annual coordinated election period, which is November 15th - December 31st of each calendar year. To switch plans, beneficiaries may simply enroll in the new plan by contacting the desired plan, visiting www.medicare.gov or calling 1-800-MEDICARE. Upon enrollment with the new plan, the beneficiary will be automatically disenrolled from the previous plan.

In addition to the initial and annual enrollment periods, there are also special enrollment periods to address special situations. Persons who move out of their plan service area (i.e., New York State for persons currently residing in New York) may enroll in a new plan in their new plan service area.

Individuals entering, residing in or leaving a nursing home (or, in New York, an intermediate care facility for the mentally retarded) may also change drug plans. Finally, a person may enroll at any time when they no longer have drug coverage under the private health insurance plan that met the requirements for "creditable coverage." Finally, there is a special enrollment rule for persons covered by both Medicare and Medicaid (so-called "dual eligibles"). Dual eligibles, who must enroll in Medicare Part D, can change their plans at any time, as often as once a month.

In order to encourage eligible beneficiaries to participate in Medicare Part D, the government has instituted a financial penalty for those individuals who do not enroll in Medicare Part D as soon as they are eligible. This penalty is equal to 1% of the beneficiary's base monthly premium for each month that they are not enrolled and will continue to be charged as long as the beneficiary stays in the

Medicare prescription drug plan. However, no penalty will be imposed if the individual can prove that they had "creditable coverage," which means other drug coverage that provides drug coverage equal to or better than Medicare Part D.

Dual Eligibles

Prior to enactment of the new Medicare Part D law, dual eligibles received their prescription drugs through their state's Medicaid program. However, when Congress enacted the new Medicare Part D law, it included provisions that ended Medicaid drug coverage for all dual eligibles and mandated that dual eligibles be enrolled in the Medicare Part D program in order to receive their prescription drugs.

In contrast to the basic benefit for the typical Medicare beneficiary, dual eligibles will have no premiums or out-of-pocket deductibles and are not required to participate in any cost-sharing. Generally, dual eligibles will be responsible for co-payments of either \$1 for generics or \$3 for brand-name drugs, but those who live in a nursing home or other long term care facility (in New York, an ICF/MR) will have no co-payment responsibilities at all. Dual eligibles who are receiving SSI (and not living in a nursing home or ICF/MR) will be covered under Medicare Part D and will only have to pay a co-payment of \$1 for generics and \$3 for brand-name drugs. Currently, there is no plan for New York State Medicaid to pick up the cost of these co-payments.

Mandatory Enrollment for Dual Eligibles

Although the Part D program is optional for most Medicare beneficiaries, dual eligibles are required to participate and will be automatically enrolled by the Medicare administration in a Medicare drug plan in their area, effective January 1, 2006. In New York, for example, dual eligibles will be auto-enrolled in one of 15 "benchmark plans" that service the New York State region. A "benchmark" plan is defined as a plan whose monthly premium is at or below the average premium for plans in that region.

However, dual eligibles are not required to stay in their auto-enrollment plan and can enroll in a different plan starting November 15, 2005. Dual eligibles have been granted a continuous special enrollment period which permits them to change their plan once a month, if necessary.

Finally, while it is technically possible for a dual eligible to disenroll from Medicare Part D, such individuals would be left with no drug coverage at all. Even worse, disenrollment from Medicare Part D could result in loss of all Medicaid benefits since New York State requires Medicaid beneficiaries to participate in all government programs that provide health benefits as a condition of continued Medicaid coverage.

Drugs Covered

All Part D plans must include in their formulary at least two drugs in each class of drugs, but plans are not required to include all drugs or all dosages or methods of administration. However, CMS has mandated that for 2006, drug plans must cover all or substantially all of the drugs in the following six classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, antineoplastics, and immunosuppressants. Even in this special group of six classes, drug plans will not have to cover all dosages or formulations and can impose higher co-pays, prior authorization and step therapy requirements for drugs in these six categories.

Certain types of drugs are excluded from the Part D program by law, including barbiturates, benzodiazepines, drugs used to treat anorexia, infertility drugs, and medications used to relieve cough and cold symptoms, among others. The exclusion of barbiturates and benzodiazepines is of particular interest to the mental health community because these excluded drugs may be used to treat certain mental illnesses.

NYS Medicaid Wrap-Around Program for Dual Eligibles

Because New York State traditionally covers benzodiazepines and barbiturates under its Medicaid program, the federal government has mandated that these drugs must continue to be covered through the New York State Medicaid Program for all dual eligibles. Therefore, even though these types of drugs are excluded from the Medicare prescription drug program, New York State will continue to provide reimbursement for benzodiazepines, barbiturates and certain over-the-counter medications covered by Medicaid prior to January 1, 2006.

In addition, New York State Medicaid has announced that it will provide a special "wrap-around" benefit to provide coverage through the Medicaid program when a dual eligible cannot secure coverage for a prescription through a Medicare Part D plan because the plan does not include the drug or has refused to cover the drug because of special coverage rules. Medicaid will cover the drug only when the Medicare plan has made a final determination to deny coverage of a specific drug for a specific patient.

The State of New Jersey has also reported that it plans to offer Medicaid wrap-around coverage, but this coverage is entirely optional and many states will not provide dual eligibles with wrap-around coverage for drugs not covered under Medicare Part D.

Exceptions and Appeals

All Part D plans are required to implement exception procedures for distribution of drugs in tiered formularies. If a drug is not covered, if prior approval is denied, or if "fail first" is required, a plan enrollee can request an excep-

tion from the plan. If the request for an exception is denied, the enrollee can appeal that decision. There are a total of six levels of appeal in the Part D program:

1. Coverage Determination or Exception from the plan
2. Redetermination by the plan
3. Reconsideration by an Independent Review Entity
4. Hearing before an Administrative Law Judge
5. Review by a Medicare Appeals Council
6. Judicial Review in federal district court.

The initial request for a coverage determination or exception may be made by the beneficiary, his or her legally authorized representative or the prescribing physician. In general, drug plans are required to respond to an exception request within 72 hours - this is called a standard request. However, if the request is made by the enrollee's physician and the physician requests expedited review, the plan must respond to the request within 24 hours - this is called an expedited request.

Low Income Subsidy

The Low Income Subsidy is a program developed to offer financial assistance to Medicare beneficiaries who need extra help paying for their prescription drugs. Certain classes of individuals will automatically qualify for the subsidy, including Medicare and Medicaid dual eligibles, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI) and Supplemental Security Income beneficiaries (SSI). All other low-income individuals with Medicare must complete an application in order to qualify for the financial assistance program.

For additional information, visit www.medicare.gov, www.mentalhealthpartd.org (a website co-sponsored by the APA that provides Part D information specifically targeted to the mental health community), or call 1-800-MEDICARE (1-800-633-4227). ■

Programs cont. from p. 4

(duloxetine) (at least one must be a mandatory inclusion)
 Remeron (mirtazapine)(mandatory inclusion)
 Bupropion SR or XL (mandatory inclusion)

Bipolar Disorder Medications

Lithium (mandatory inclusion)
 Anticonvulsants

Dementia Medications

Cholinesterase inhibitors
 Namenda (memantine)
 (mandatory inclusion)

ADHD Medications

Stimulants, regular and long acting
 Strattera (mandatory inclusion)
 Beta blockers
 Alpha 2 adrenergic agonists ■

Area II continued from page 5

individuals being treated by the threatened psychiatric unit."

In an attempt to proactively engage the Commission regarding NYSPA's concerns, and under the recommendation of Mr. Gallo, NYSPA will: create a formal position paper on the issue, solicit co-signatures from other concerned stakeholders, and distribute it to all members of the Commission.

Mr. Gallo also recommended that NYSPA examine the feasibility of hosting various symposiums and/or conferences in the future, citing a need for NYSPA to increase its visibility in the public arena.

Committee on Public Affairs

Dr. Cross's report focused on efforts recently undertaken by the APA to reinvigorate the Association's Public Affairs activities, citing her hopes "... of a trickle down effect to the State Associations." Dr. Cross reports that she has already seen evidence of such an effect as "Members have been taking advantage of Media Workshops offered by the APA. The West Hudson, Brooklyn and Queens District Branches have held their own public affairs events such as movie screenings and health fairs, and a number of people have requested additional media training."

Dr. Cross went on to state the importance of un-coupling Government Relations and Public Affairs at the APA level. "In other words...while the field of psychiatry certainly has a lot to say regarding legislation, we need to increase our visibility in other arenas as well. For instance, when Tom Cruise recently attacked the field of psychiatry, we were able to provide the world with an alternative perspective...we need to continue such efforts and it's gratifying to see that the APA is so well prepared to be proactive in this instance. I'm glad that the APA has become so proactive in this area."

Dr. Cross also noted that the APA is planning additional Media Trainings, the details of which will be forthcoming.

Task Force on Preferred Drug Program

In the absence of Dr. Jack Gorman, Chair of

the NYSPA Taskforce on Preferred Drug Program, Dr. Perlman presented the Taskforce's findings and recommendations regarding the feasibility of adding atypical anti-psychotics and anti-depressant medications to the State's recently enacted Preferred Drug Program. The findings of the Taskforce were later accepted by the Council. A full report can be found on page # .

Executive Director's Report

Seth Stein's report covered a number of issues facing the field of psychiatry, such as: pending Medicare Fee reduction, Medicare Part D compliance, and the status of the psychoanalyst lawsuit.

Elaborating on the pending Medicare fee reduction, Mr. Stein explained that "Physician payment, under the Medicare program, is slated to be reduced by 4.3 percent in 2006. However, Congress is attempting to prevent such cuts through a bill known as the Preserving Patient Access to Physicians Act of 2005, which seeks to stop payment cuts in 2006 and 2007 and provide physicians with positive payment updates of 2.7 percent and 2.6 percent, respectively, for those years." Mr. Stein went on to say that NYSPA will continue to monitor the situation and keep members abreast of any new developments.

With respect to Medicare Part D compliance, Mr. Stein discussed the intricacies and complications associated with the new program, citing it to be "The most complicated and confusing Medicare program ever." He went on to discuss the available options for Medicare Part B beneficiaries and dual eligibles noting that such information will be posted on the NYSPA website shortly.

In his update regarding the licensed psychoanalyst's litigation, Mr. Stein reported to the Council that the judge in the case had recently dismissed the suit on the grounds that the petitioners (NYSPA and the New York State Psychoanalytic Confederation) did not have standing to bring this lawsuit. However, NYSPA is moving forward with an appeal which is expected to be heard in December or January. ■

Report continued from page 3

ommendation to expand the monthly payment plan to all members and to provide members the ability to update their membership profile on line. Also, a long standing request for a monthly electronic dues payment system will soon be available through a contract with Solveras Payment Systems. Lastly, the pilot programs that have added local PAC contribution requests to the dues notices are being reviewed by various components to recommend whether this should be expanded to any interested DB.

Also, the APA ethics annotations was updated to include our position that "psychiatrists shall not participate in torture". The larger project of the Task Force to update the body of the ethics annotations is ongoing and has received extensive feedback from members.

This is an important process of reviewing the APA's code of ethics in light of current needs and practice of our profession and our patients. The first draft is online at the APA website and the task force welcomes all feedback.

Finally, the Board approved new language for the APA By-Laws, which will be referred to the By-laws committee and then the Assembly, to further clearly define the dual membership policy of the APA. As regards the issues with TSPP (Texas Society of Psychiatric Physicians), the Board will continue to monitor the APA-TSPP relationship and work to find a mutually acceptable resolution. The goal of the Board is to keep the APA and all of our District Branches strong and effective.

Advocacy

The division of government relations is tirelessly advocating on capitol hill in our interest and the interests of our patients. We are part of a major coalition to prevent damaging medicaid cuts, are actively involved in the planning of the pay for performance project, meet regularly with legislators on parity, confidentiality and medicare equity, and have begun to gain some traction on the legislation to provide financial incentives to

increase the child psychiatry workforce. The struggle to prevent psychologist prescribing continues. The Board of Trustees voted to join the AMA Scope of Practice Partnership at a funding level of \$25,000, a critical partnership for this ongoing struggle. Once again the Board approved grant assistance to DB's in Ohio and New Hampshire to support efforts on scope of practice issues. In response to an Assembly action paper, the Board approved an action plan to assist DB's in fighting for an independent appeals mechanism for managed care denials that includes development of model state legislation and dissemination of available consumer—that's us—guidelines for disputes developed by the Kaiser Foundation.

A component Task Force on Forensic Outpatient Services was established to focus on key issues affecting our colleagues working in these settings, and this vulnerable patient population.

A special Presidential Task Force on College Mental Health is actively developing recommendations for optimal services on campuses and preventive strategies for this critical population.

The Curriculum Resource Guide for Cultural Competence is now available on the APA website.

Finally, it is important for the APA to be present at the table of organizations whose recommendations, guidelines, etc. affect our patients and our profession. The APA has joined the Commission on Accreditation of Rehabilitation Facilities (CARF) to advocate for our patients and our colleagues working in those settings. The APA will also become a member of the Ambulatory Care Quality Alliance.

I hope I haven't been too detail oriented in this report, but I wanted to give you a sense of the hard work being done for our members and our patients throughout the organization! Once again best wishes for a happy, healthy and peaceful New Year!! Please feel free to e-mail me at ann.sullivan@mssm.edu or call 718-334-3536. ■

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As a Program participant, you can call the **Risk Management Consultation Service (RMCS)** to obtain advice and guidance on risk management issues encountered in

psychiatric practice. Staffed by experienced professionals with both legal and clinical backgrounds, the RMCS can help prevent potential professional liability incidents and lawsuits.

If you are not currently insured with The Program, we invite you to learn more about the many psychiatric-specific benefits of participation. **Call today to receive more information and a complimentary copy of "Six Things You Can Do Now to Avoid Being Successfully Sued Later."**

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