President's Message: The Next Wave in Managed Care - Fee Reductions

At the end of 1998, NYSPA members were confronted by a "dual wave" of fee reductions imposed by the Big Three behavioral managed care companies operating in New York State: Magellan, ValueOptions, and United Behavioral Health. These three companies each control access to treatment of mental illness for millions of New Yorkers sent out notices last December to their provider networks reducing their fee schedules between 13% to 40%, all effective as of January 1, 1999. In response to these unprecedented and simultaneous fee reductions and the consequent outrage from the membership, NYSPA took immediate and decisive action to protect the interests of our members and their patients.

On November 11, 1998, the NYSPA Executive Committee held a special meeting by conference call and authorized the following plan of action:

1. Communicate our concerns to the federal government agencies and the providers of care about fee reductions.
2. Get information to our members and their patients about their legal rights under the contracts if they objected and, finally, how members could preemptively terminate their contracts.
3. Seek to terminate psychiatrists from the provider panels and the clinical staff.
4. Contact appropriate state and federal legislative leaders to request immediate hearings on the issue of managed care and the consequent outrage of the treatment of mental illness.

On January 5, 1999, Seth Stein, NYSPA Executive Director and General Counsel, sent letters to Magellan, ValueOptions, and United Behavioral Health requesting that they rescind the fee reductions. The letters focused on the impact of the fee reductions on patient access. NYSPA restated its written assurance that the fee reductions would not be imposed on any psychiatrist who, in a reasonably timely way, objected to the fee reductions and that any actions taken to terminate psychiatrists from provider panels comply with requirements of state law. The letters also challenged the reductions as encouraging bifurcated treatment where the psychiatrists only provide medication and therapy are affected by a non-psychiatrist. NYSPA urged that the fee schedule be adjusted to encourage integrated treatment by a psychiatrist providing both medication and psychotherapy as the most cost effective and clinically effective form of treatment.

Finally, NYSPA is currently preparing letters to state and federal officials seeking an investigation into the question of whether the simultaneous fee reductions resulted from improper collusive activities in restraint of trade.

On December 4, 1998, NYSPA mailed out an Action Alert to every NYSPA member. This memorandum contained detailed information regarding the fee reductions and reviewed the specific provisions of each contract regarding members' options and rights under the their contracts. We explained what health programs were affected; how members could object to fee schedules; how terminations of the contracted rights of the managed care company to terminate their contracts if they objected and, finally, how members could preemptively terminate their contracts.

Utilization Review by Managed Care Organizations: What You Need To Know About the New Law

The information presented below was provided by Valencia Lloyd of the New York State Department of Health, Office of Managed Care, Bureau of Certification and Surveillance. It contains important points about Utilization Review by Managed Care Organizations, including mandated time-frames and appeal procedures - Ed.

Chapter 705 of the Laws of 1996 resulted in the enactment of Article 49 to the New York State Public Health Law which established detailed standards for the performance of utilization review (UR) activities by both managed care organizations (MCOs) and independent utilization review agents.

Registration Required For Both Co-Compliance Required For All

Article 49 requires all entities (except certified MCO's) conducting UR to be registered with the New York State Department of Health (DOH) or the New York State Insurance Department (3D). Those registering with DOH must renew their registration every two years. Although MCOs are exempt from registration as a utilization review agent, they too must demonstrate compliance with Article 49 by obtaining DOH approval of their UR procedures. Required UR procedures are the same for both registered UR agents and certified MCOs.

Initial Medical Necessity Determinations

For services that require pre-authorization approval, the UR agent or MCO must make its determination within (3) three business days of receipt of the request for service. The determination must be made in writing and by telephone to the enrollee and their provider.

Subsequent Determinations

In the situation where approval is needed for continuing or extending an ongoing treatment, or to add services for an enrollee already under treatment, that determination must be transmitted by telephone and in writing to the enrollee within (1) one business day after receipt of all necessary information.

Requests for Reconsideration

If the UR agent or MCO makes an adverse determination regarding pre-authorization or continuing or extending services, as noted above, without having discussed that determination before-hand with the member's prescribing provider, that provider can request a reconsideration of the determination. The reconsideration must be given to the provider within one (1) business day of the provider's request. The reconsideration is conducted by the enrollee's provider and the clinical peer reviewer making the adverse determination, or a clinical peer reviewer designated by the UR agent or MCO if the original one is unavailable.

Retrospective Determinations

Lastly, a UR agent or MCO can make a retrospective UR determination involving health care services which had previously been delivered and must provide that determination within 30 days of receipt of the necessary information to make a determination.

Emergency Services

It is important to note that emergency services are never subject to prior authorization nor shall reimbursement for emergency services be denied on retrospective review as long as such services were medically necessary to treat an emergency condition. The statute provides for a prudent layperson definition of an emergency condition in the determination of necessity.

Notices of Adverse Determination

All notices of adverse determination must inform the enrollee of the reasons for the decision including clinical rationale, and instructions on how to initiate an appeal. In addition, all initial and appeal adverse determinations can only be made by a clinical peer reviewer. The statute defines a clinical peer reviewer as a licensed physician who is in the same or a similarly specialized health care provider who is managing the treatment under review. In the case of non-physician reviewers, it is a licensed health care professional who is in the same profession and/or similar specialty as the healthcare provider who manages the treatment under review.

Appeal Time-Limits

An enrollee has at least forty-five (45) days after notification of an adverse decision to file an appeal and the MCO then has sixty (60) days to make a determination regarding the appeal. MCOs and/or UR agents must provide for expedited appeals for care of continued, extended or additional health care services, or in cases where the enrollee's health care plan contains important points about Utilization Review by Managed Care Organizations, including mandated time-frames and appeal procedures - Ed.

Results are in!

As we go to press, the 1999 APA national election results were announced. Elected were the following candidates:

President-Elect - Dan Borenstein, M.D.
Vice-President - Paul Appelbaum, M.D.
MIT Trustee-Elect - Sandra DeJong, M.D.
Trustee-at-Large - Ann Maloney, M.D.
MIT Trustee-Elect - Sandra DeJong, M.D.
MIT Trustee-Elect - Herb Peyser, M.D.
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Results are in!
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LETTER FROM THE EDITOR...
Our First Anniversary

Our psychiatric membership has grown—this past year has seen a lot of activity, leading to even greater representation on the Assembly of District Branches. As events developed, it became clear that this reduction was minuscule compared to APA expenses in general, and in fact we have reduced local input into central activities, leading to even greater dissatisfaction on the part of the grassroots membership. The APA Board of Trustees, in their meeting in December 1998, made no real effort to downsize or reduce their costs; they did not set the example. The Assembly will meet again in May. This promises to be a lively topic of debate.

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New York City politics brought Methadone Maintenance Treatment Programs to the headlines. Mayor Giuliani wanted to eliminate this treatment option. He believes that it perpetuates addiction, substituting one substance for another. Despite the scientific evidence demonstrating real clinical and social benefits, the Mayor took a look forward to another year of bringing you an informative and timely newsletter. This past year has seen a lot of controversy regarding the future of our organization. While efforts to streamline costs are important, especially since reductions in cost can be translated to reductions in dues, there is no general agreement as to who will tighten their belts first. NYSPA was magnanimous in proposing a reorganization plan that would have saved APA some money but would have reduced New York State representation on the Assembly of District Branches. As events developed, it became clear that this reduction was minuscule compared to APA expenses in general, and in fact we have reduced local input into central activities, leading to even greater dissatisfaction on the part of the grassroots membership. The APA Board of Trustees, in their meeting in December 1998, made no real effort to downsize or reduce their costs; they did not set the example. The Assembly will meet again in May. This promises to be a lively topic of debate.

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Reorganization and Other Matters
by Herb Peyer, M.D.

At the December Board meeting one could see the difficulties in the APA Strategic Plan from proposal to actuality. The Plan's goals are absolutely necessary. We are trying to restructure APA and make it more efficient and less costly. And lowering the dues will help in retaining and recruiting members and make APA stronger and more able to carry out its mission. The extreme decrease in DB and state organization autonomy as well as number and participation and representation that was set out for us in the original version of the Strategic Plan. The impact on us of the severe cost cutting and centralization of control was to be foreboding the end of such burdens distributed throughout the APA, one not desirable on any score, DB, organization, Area Council or other structures. Our joint Area VI (California) and Area II (NYS) positions specifically called for cuts to be equitably distributed throughout the APA. We shall have to see what the Assembly does and how the Board deals with the Components in March before moving further with our own reorganization plans and accepting any cuts.

Reshuffling for Efficiency
The Board began rearranging the Committees and Councils in the Components in accordance with the Strategic Plan's priorities to improve efficiency, canceling some, splitting others, and limiting membership slots (but also limiting the number of positions available in the interests of allowing wider member participation while trying to decrease costs). There will be a concentration of allied organizations in Councils and Committees as we move toward integrating them with APA. The hard decisions regarding the Components were held over to March. We have to be careful about membership morale. The beginning of a slow drop in membership reflects a general trend in all professional organizations. However, ours is not bad. The NYS Medical Society has lost almost 2,000 members in the past two years, so our decrease does not look bad at all. And yet there is talk among members and leaders of APA about delinquency of the DBs from APA, a very dangerous road to go down (AMA did it and both the local and the central societies are not doing well). This mirrors it from Texas, here in our Area Council and some DBs elsewhere, and particularly in the Washington State Psychiatric Association.

The talk is not serious but reflects a mood. There is a lack of awareness on the part of the members as to what APA actually does for them, and here what NYSPA does. APA has gone to a consulting firm for help in better getting the word out to the members, as to its accomplishments, to communicate better with them, and also to help with its work with the DBs to partner with them and to aid communication between the DBs themselves. There have been complaints that those in the center are not adequate, responsive, not truly communicative. All this must be changed for this puts off members, and fewer members means decreased strength for advocacy.

Oldham's Proposal
Meanwhile APA has to go about its other business. The first draft of John Oldham's Task Force's Quality Indicators was reviewed and is in process.

Legislative Brunch in Westchester County
The Psychiatric Society of Westchester (WSB) hosted its annual Legislative Brunch at the Crown Plaza Hotel in New York City on Sunday December 13, 1998. It was well attended by over 70 people including Congressman Gillman and Kelley and a representative from Congresswoman Lowey. In addition there were several elected representatives present. A delegation from the Alliance For The Mentally Ill was there joining Westchester psychiatrists, and also the Executive Council from the New York State Psychiatric Association. Both congresspersons made a special point of noting that, despite the preocupation of Congress with the impeachment activities, healthcare issues are of great concern in Washington. State and county legislators were very positive about the possibilities of making progress with parity legislation. They also were very interested in the formal remarks made by Dr. William Oldham, WSB President, and Dr. Stabinsky, WSB Resident Rep. and Dr. Perman, Area II Rep as well as the informal discussion that took place at the tables during the law brunch set up by Westchester DB - Michael Blumenfeld, M.D., WSB Westchester PA Rep. and Area II PA Rep. - Ronald Silver.

Public Forum in Rockland County
Despite the competition from the World Series, a capacity crowd turned out at the Public Forum on October 21, 1998 sponsored by the Mental Health Coalition of Rockland, of which the West Hudson Psychiatric Society (DB) is the lead agency. Speakers included Dr. Suzanne Vogel-Scibilia, a prominent psychiatrist from Pennsylvania who told of her personal struggle with bipolar disorder. Bouquets to Diane Polhemus, local consumer advocate and bridge at Rockland Psychiatric Center, who courageously shared her and pain and percussion to the road to recovery. Thanks to Mel Zaklin, clinical social worker and psychotherapist, who eloquently revealed the despair and suffering of the families whose loved ones have mental illness. We salute you all in our lives and leaving us with so much hope. Thanks, also, to Commissioner of Mental Health Mary Ann Walsh-Tozer for her introductory comments and to County Executive C. Scott Vanderhoef who presented a declaration in honor of Mental Health Awareness Week.

A component is being developed to manage CME (the criteria of the accrediting agency, the ACGME, have become tighter). In addition to its instructional value, CME is one of APA's most significant sources of non-dues income, most noticeably at the Annual Meeting and the Institute for Psychiatric Services. There is concern over not having too much commercial support that might unduly influence the educational programs. Plans are being laid to work jointly with the DBs in regard to CME, and APA is looking into the use of the self assessment test, the World Wide Web, and CME for helping its members gain certification and recertification (among the specialties, we are the fastest in the nation in getting Board certified members). Education is an important area for APA to be of use to its members, an APA priority just behind advocacy and membership. APA continues to work with the other specialties in a problematic relationship with ACP. It did promise its AMAP (Accreditation Program), dealing with credentialing, clinical performance, the environment of care, and possible revalidation for 100% Board certification by, say, 2005. Other matters included the approval of the Assembly's response to hypothetical attempts to change sexual orientation, support for further work on tele-psychiatry (particularly helpful in rural and areas), approval of the Delirium Practice Guidelines, support for free exchange of information between doctors and patients without doctors being subject to criminal or professional sanctions (this arose out of the US government's threats to doctors discussing medical marijuana use with their patients in California, although the Board has taken a position on medical marijuana use per se). Also it supported the necessary role of the Commission on Psychiatry and Psychoanalysis in reviewing Practice Guidelines before they are finally approved.

Budget Summary on Way
The budget summary will be published in Psychiatric News and will be sent out in more detail to the Assembly Executive Committees, in the interests of increased accountability and openness of the APA. The number of international members is inching up towards 12,000 (rather than 18-month) dues drop process has resulted in 1,700 members still on the drop list, but every effort is being made to work with them and keep them in APA. The result of shortening the delinquent dues drop process, however, has been to increase APA's available funds at the moment. Five DB Presidents-Elect addressed the assembly, bringing some of the member and DB concerns noted above but also concerns with the cost and litigious quality of the edge of the state, in an era of over ever mounting pressure from PAs, RNs and, particularly, psychologists for increased prescribing privileges. It was noted that the DOD's interest in that the reorganization develops, if there are any problems, problems with the leadership or staff at the center or with NYSPA, call me I'll help.
As we prepare this article, the newly elected State Legislature has been in session for a month. The Legislature, along with everyone else with business at the Capitol, is trying to decipher the Governor's Executive Budget Request which, unlike prior years' discrete multi-bill packages, is lumped into a single voluminous document this year. The overall legislative concerns for NYSIPA in 1999 fall into roughly the same categories as last year's issues:

- The Executive Budget
- Parity
- Scope of Practice
- HMO Liability and other Managed Health Care Reforms
- Compulsory Psychiatric Hospita lization of Post-Incarcerated Sexually Violent Predators

However, the similarities end there. The Executive Budget is not so generous or benign toward health and mental health care as it might expect from the second year of budget surpluses that exceed $2 billion.

Parity for mental health coverage, despite significant progress last year in both Houses of the Legislature has major obstacles to overcome to win passage in the Senate. The issue of who may diagnose and treat mental illness is up for grabs again soon with the reintroduction of legislation to define and expand the scope of practice of several categories of “Mental Health Practitioners.”

HMO liability legislation has already passed the Assembly but the Senate has yet to act; or rather, its Senate Rules Committee.

The Governor and the newly elected Assembly currently have announced their combined, bipartisan support for legislation to compel psychiatric hospitalization of sexually violent offenders upon their release from prison.

The overall budget for mental health services presented by the Governor is less troublesome in many respects than past years' budgets. For example, hospital based psychiatry is not much cut or in line with prior budgets for such things as targeted Medicaid caps on inpatient days. However, the budget is by no means benign with respect to psychiatry.

Of paramount concern to NYSIPA is the Governor's proposal to eliminate Medicaid payments for Medicare deductibles and coinsurance. This is the Governor's proposal to eliminate Medicaid payments for Medicare deductibles and coinsurance. This proposal is currently funded by the State, in conjunction with OMH affiliation agreements with teaching hospitals. Twenty-five psychiatrists who practiced in programs currently supported by the State's General Fund will have to be financed by outside grants and indirect cost recovery funds, or be eliminated.

The budget also proposes Medicaid aid to hospitals totaling $321 million of which no doubt will fall upon hospital psychiatric departments.

Parity for Mental Illness Coverage

As noted above, one of the more encouraging legislative developments for psychiatry and the mental health community last year was the progress made on insurance parity legislation. The Assembly unanimously passed a broad parity bill introduced by Assemblyman James Brennan (D-Brooklyn) early in the last session year. In the Senate, parity legislation introduced by Senators Thomas F. Gano (R-Binghamton) was reported favorably from the Senate Insurance Committee (Leg 1) to the Senate Rules Committee. Unfortunately, the Senate Rules Committee did not report the bill to the full house for a vote.

The progress being made on parity is due in large part to the dedication of NYSIPA and ADP and parity-based efforts of the Mental Health Equality Not Discrimination (MEND) Campaign and the organizations it represents. The MEND campaign (of which NYSIPA is a co-founder) is a coalition of more than 100 organizations urging enactment of insurance parity legislation. MEND members are busy again this year promoting insurance parity with legislators, the press, and business organizations.

Your legislator, especially your State Senators, needs to hear from you about the problems faced by people whose health benefits plan discriminates against mental illness.

Scope of Practice

In the closing days of the 1998 Session of the Legislature a major initiative was advanced and defeated that would have licensed a broad range of mental health practitioners including “mental health counselors,” “creative arts therapists,” “marriage and family therapists” and “psychologists.” The legislation also proposed to expand the scope of practice of currently licensed psychologists and social workers. The bill would have conferred upon all of the enumerated practitioners a scope of practice authorization to engage in activities presently reserved to the practice of medicine.

Although there are bills that have been introduced on the subject already this year, the operative legislation expected from the respective Chairmen of the Senate and Assembly Higher Education Committees is similar research and as we go to press. The Medical Society of the State of New York and the New York State Psychiatric Association must continue to push their opposition to legislation granting to non-physician mental health practitioners practice activities for which a medical license has heretofore been required.

Managed Health Care Reforms

The hard fought and incremental process of re-balancing health care delivery in favor of the medical needs of consumers and the clinical judgments of their physicians is continuing in full force during the current legislative session.

Last year, the Governor signed into law a bill that assures patients and providers the right to an independent and external review of denial of coverage by health insurance companies and HMOs. Unfortunately, this important patient protection measure has limited applicability where mental illness is involved. Because of the exclusions and limitations on coverage for mental illness, the matter of appeal and review of an adverse determination is of questionable value if one has already exhausted their coverage.

As noted at the beginning of this article the State Assembly has already passed the HMO liability bill. A full court press by the broad-based Campaign for Quality and Choice, of which NYSIPA is a member, is now under way to secure Senate passage of the bill.

We are Not Alone: Focus on MSSNY

Crucial but unheralded component of NYSIPA's government relations program is the building and maintaining of alliances. NYSIPA comes together with many groups to promote a host of common legislative interests. Such alliances often help enable favorable legislative outcomes for MSSNY. An example of this cooperation and informal process. However, MSSNY will no longer recommend or nominate physicians for government posts unless they are MSSNY members. The Governor's Office, as well as several state agencies — including the Attorney General's Office, the Department of Health, the Insurance Department, the Education Department and the Workers' Compensation Board — seek the advice and counsel of MSSNY when recruiting physicians for important voluntary and paid posts. MSSNY in turn has called upon the specialty societies for recommendations and allies that directly affect the practice of Psychiatry and routinely solicits our viewpoint on other public policy business affecting the practice of Medicine. Communications between our respective government relations offices are open and frequent.

MSSNY's swift deployment of resources at the end of this 1998's legislative session proved invaluable to our securing the abrupt defeat of the most egregious mental health therapist licensing bill ever. In addition, MSSNY's commitment to NYSIPA's initiative on Parity for mental illness in health care benefit plans was a driving force in 1998's development and subsequent victories of the broad-based Mental Health Equality Not Discrimination (MEND) campaign.

In view of MSSNY's substantial record of support for organized psychiatry's legislative agenda in New York State it is disheartening to learn that only 12% of the psychiatrists in the State are members of MSSNY, while an average of 41.5% of other specialists in the State are MSSNY members. As psychiatrists in New York State increasingly recognize the need for legislative and regulatory changes in order to protect their patients and their profession they must give more consideration to joining MSSNY along with NYSIPA.

Recent changes in MSSNY's policy regarding recommending physicians for government panels and advisory groups further attests to the importance of MSSNY membership. The Governor's Office, as well as several state agencies — including the Attorney General's Office, the Department of Health, the Insurance Department, the Education Department and the Workers' Compensation Board — seek the advice and counsel of MSSNY when recruiting physicians for important voluntary and paid posts. MSSNY in turn has called upon the specialty societies for recommendations and guidance in such matters. Dozens of psychiatrists now serving on important state panels were considered for such panels through this cooperative and informal process. However, MSSNY will no longer recommend or nominate physicians for government positions unless they are members of Medical Society. Some examples of where psychiatrists have been appointed with MSSNY's support are: the Medical Misconduct Board, the State Board for Medicine, the Patient Access to Records Review Panel, the State Board for Medicine, the State Board for Medicine, the Patient Access to Records Review Panel, the Public Health Council, and the State Hospital Review and Planning Council.

We hope in the next year many more psychiatrists in New York State will become members of MSSNY.
Outpatient Civil Commitment in New York

by Howard Owens, M.D.

Dr. Owens is on the Editorial Board of the Bulletin and is active in the area of Psychiatry and the Law. He is Assistant Medical Director of the Forensic Psychiatry Clinic, located at the Criminal Court in Manhattan and is Clinical Associate Professor of Psychiatry at the NYU School of Medicine. He also has a private practice in general psychiatry—Ed.

Psychiatrists in the State of New York may not be aware that for the past three years the state has been conducting a pilot project to evaluate the usefulness of outpatient civil commitment. This project has been operating out of Bellevue Hospital in New York City and is not yet available for general clinical use across the state. Depending on how the state legislature views the results of this project, it is possible that psychiatrists in New York may in the future have the option of outpatient civil commitment for the treatment of certain non-compliant patients.

In 1994 the state legislature authorized the establishment of a three-year program at Bellevue, which was to begin in July of 1995. The legislation establishing the program required that an outside evaluator be hired to study its effectiveness, and the City of New York contracted with Policy Research Associates, Inc. of Delmar, NY, to conduct this study. The final report from Policy Research Associates was published in early December 1998.

The pilot program was instituted at Bellevue under the leadership of Howard Telson, M.D. It provided for a prospective evaluation, with a control group, of the effectiveness of a court order on the treatment outcome of non-compliant out-patients. The patients in the study were drawn from the in-patient services of Bellevue Hospital and were required to meet the following criteria: (1) over age 17; (2) “suffering from a mental illness”; (3) incapable of surviving safely in the community without supervision; (4) lack of compliance with treatment that led to involuntary hospitalization at least twice in the past eighteen months; (5) unlikely to participate voluntarily in treatment because of mental illness; (6) in need of involuntary treatment in order to prevent relapse or deterioration which would likely lead to serious harm to self or others; and (7) likely to benefit from involuntary outpatient treatment. These criteria clearly defined a limited group of patients who would be eligible for the program. It is also important to recognize that the program was not designed to deal with patients who were identified as having a high risk for violence.

Patients who met eligibility criteria and consented to participate were randomly assigned to an experimental or control group. The experimental group was taken to court for a hearing to determine if they were suitable for outpatient commitment. The control group was discharged without a court order but with the same package of enhanced treatment services that was made available to the committed group.

Dr. Telson’s Outpatient Commitment Coordinating Team consisted of himself as psychiatrist-director, two full-time social workers, a secretary and a part-time attorney. An additional part-time psychiatrist was added to the team in mid-1998. The Coordinating Team performed a variety of functions: initial assessment for inclusion in the program; formulation of a comprehensive discharge plan; presentation of cases to the court for commitment; and, most important, the recruitment of clinical services in the community to provide the actual treatment to the patients, including in many cases residential treatment. In order to “sell” the program to community providers, Dr. Telson’s group had to make clear to them that Bellevue Hospital would provide on-going back-up support in managing the referred patients. All the patients in the study (again, including those who were not under court order) received case management services.

While the scarcity of certain community services was a problem, the Coordinating Team was generally successful in placing patients in the appropriate treatment. Sixty percent of patients were discharged to highly structured types of treatment, such as residential MICA programs or day treatment programs. The results of the Policy Research Associates study were quite positive and yet ironic, since there was no statistically significant difference between the experimental and control groups when measured by acute or state rehospitalization, or in terms of the total days spent hospitalized during follow-up. Both groups benefited equally from the enhanced aftercare services provided, regardless of whether a commitment order was in place. For both groups there was a statistically significant reduction in rehospitalization over an eleven-month follow-up, compared to the year preceding the index admission. For the experimental group the proportion re-hospitalized went from 87.1% to 51.4%, and for the control group from 80% to 41.6%. There was also no difference in arrest rates (12% for experimental and 16% for controls). The report concluded that the Coordinating Team made a substantial, positive difference in the post-discharge experience of both groups, by providing crucial functions in mobilizing treatment resources, and coordination of services.

[See Civil Commitment on page 7]
Opening Remarks. Paul Lynch

Sexual Issues. New York City Comp-

oting out to the public, as we struggle

tion. “With this panel we are reach-

noted author; and Ralph Roughton,

with our own history.”

“Any work

against homophobia has been enormously

important, and given the

effort by the right wing to

bolster their bigotry, your willing-

ness to speak out in this way is

enormously important to the

country, and of great benefit to the

victims of this prejudice.”

The Public Forum highlighted

broader, major changes within the

Association. The Association has moved

from a stance of anonymity to the

public to an active involvement with

significant political and cultural

issues of our time. This shift is most

prominently evidenced by the

Association’s current president,

Robert Pyles. Pyles is one of the

founders of the Coalition for

Patient’s Rights (CPR), an activist

lobbying organization with special

interest in issues of patient-therapist

confidentiality.

These changes in the Association,

now frequently called “the New

American,” were stressed by Past-

president Marvin Margolis in his

Plenary Address. “In response to the

crisis in psychoanalysis, our Associa-
tion has reinvented itself as a more

welcoming democratic organiza-
tion,” he commented. “We have also

begun to work more closely with

other psychoanalytic groups. Local

psychoanalytic alliances have

become increasingly effective.”

Margolis, who emphasized democ-

racy, openness and inclusion,

summarized the multitude of areas

in which the American has made

extensive changes in these areas.

Prominent New York psychoana-

lyst, Shelly Orgel, presented the

Plenary Address, “Letting Go: Some

Thoughts about Termination.” Orgel

considered termination as a wide-

angle of the analytic situation con-
taining the elements of the analytic

process. He explored and widened

Freud’s views, in particular,
termination’s relationship to mourn-
ing and the permanence of the

analytic transference. Finally, he

presented meaningful vignettes from

his own experience.

The trend to devalue analysis in
general psychiatry was addressed in the
Presidential Symposium “Psy-

choanalysis and American Medical

Education for the Millennium: Recruit-

ment, Teaching and Practice

Building Opportunities in Medical

Schools.” The panel was introduced by

Professor of Christian Morals, Harvard Uni-

versity; Nancy Chodorow, analyst

and noted author; and Ralph Roughton,

analyst and former chair of the

American’s Committee on Homo-

sexual Issues. New York City Comp-
troller Alan G. Hevesi made the

opening remarks. Paul Lynch

chaired the panel. Barney Frank,

congressman from Massachusetts, who

was scheduled to attend but was unable
to leave Washington because of the

Clinton impeachment

debate, wrote “Your work

against homophobia has been enormously

important, and given the

effort by the right wing to

bolster their bigotry, your willing-

ness to speak out in this way is

enormously important to the

country, and of great benefit to the

victims of this prejudice.”

The 92 discussion groups contin-
ed the day’s broad discussion.

“Successful New York Meeting Spotlights APsaA Changes”

by W. Illiam D. Jeffrey, M.D.

Dr. Jeffrey is a Clinical Associate Professor at the New York University Medical Center

Psychoanalytic Institute. He is Director of the Adult Outpatient Service of the Department of

Psychiatry at Manhattan Medical Center. Dr. Jeffrey edits The American Psychoanalyst, the

newsletter of the American Psychoanalytic Association, and has a private practice in Brooklyn.

Ed.

The Menninger Prize went to J. P. Verne. The

American will meet again

in May 12 to 16 in Washington, DC. The American will meet again


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New York City Comptroller, Alan Hevesi, addresses the American Psychoanalytic Association at the Public Forum, “Homophobia: Analysis of a ‘Permissible’ Prejudice.” Participants are left to right: Paul Lynch, Peter Gomes, Nancy Chodorow, Ralph Roughton, and Leon Hoffman. Photo credit: Mervin Stewart.
Civil Commitment

Continued from page 5

About their legal authority to perform. Eventually, and only toward the end of the study period, an agreement was reached with the New York City Sheriff's Department to transport patients to Bellevue for immediate observation or hospital treatment. This problem may also account for the lack of discernible effect of the court order on clinical outcome.

On December 16, 1998 a public hearing was held regarding the effectiveness of outpatient civil commitment. At this point, the future of the concept is in the hands of the New York legislature. Richard Rosner, M.D., Chair of NYSIPA's Committee on Psychiatry of Civil Law has recommended that the Pilot Program at Bellevue and the Research Study of the program should be continued for an additional three years. At the present time there is insufficient data to determine if there is a group of patients for whom court-mandated treatment does improve compliance. An additional period of evaluation would permit the collection of more outcome data in an attempt to answer outstanding questions about the effectiveness of outpatient commitment.

One conclusion from the Pilot Program does stand clear, however, a conclusion which the average practicing psychiatrist might voice ruefully with a feeling of déjà vu. The Study demonstrates that an enhanced and aggressive program of community treatment does benefit de-institutionalized patients. The wisdom of Dr. Rosner's recommendation for further study of outpatient commitment really rests on two legs. First is the insufficiency of data to conclude the question as to whether the court order for commitment, in itself, is actually of any clinical benefit. The second point is that, even if the benefit is clearly demonstrated after further study, there would be significant problems in the implementation of an outpatient commitment law statewide. The clinical success of the Bellevue Pilot Program clearly resulted from the well-organized and consistent efforts of Dr. Howard Telson and his Coordinating Team. Any legislation designed to establish an outpatient commitment state-wide would have to provide for funding and for the necessary groundwork for the training and establishment of such teams across the state. Funds for the training of judicial and police agencies across the state would also be needed, so that the actual enforcement of commitment orders would be possible. Without such funding, leadership, organization, and training, an enhanced and aggressive commitment law would likely represent an empty promise.

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The Children's Village Crisis Residence A New Way

Benefiting from Others' Suffering

By Anand Pandya, M.D.

Dr. Pandya was one of the four senior residents in psychiatry from the New York State Psychiatric Institute (NYSPI) who participated in the disaster response team for the 1998 Swissair crash. The residents assisted families and relief workers at both New York's JFK Airport and at the crash site in Now Scotia. Moved by this powerful experience, these four residents have formed a work group to address the mental health issues of the New York City Police Department any mental health resident. Dr. Pandya is currently a chief resident at NYSPI and also serves as chief of the NYSPI's Disaster Medicine Program.

After an unexpected trip to Halifax, Canada on Labor Day weekend, my dominant, disturbing mood was: "How am I going to use this experience?"

A few days earlier, a Swissair flight from New York City to Geneva crashed into the waters near Halifax, Canada and all aboard the flight died. The day after the crash, I was offered the opportunity to volunteer with the mental health residents coordinated by The American Red Cross and the New York City Department of Mental Health. I expected to spend a day at JFK Airport offering whatever kind of help I could to grieving family members, but midway through the day, I was offered the opportunity to fly to Canada with a group of family members.

I enthusiastically jumped on this opportunity and with this enthusiasm, my unceasing worries began. I thought that I would expect to see more normal and abnormal grieving in the next few hours than I had learned in three years of psychiatry residency. I could comfortably be excited about that. But I needed to examine other possible reasons for the excitement. The airport was a media circus, with a thick air of broadcast antennas rising from the television station vans in the parking lot. I knew that my experience would interest my colleagues, my friends, my family, and almost anyone else I could not have had a more engaged in my personal space in any way as helpful as humanly possible. I was deeply moved by the grief I witnessed. But at times during that day, I felt that I had nothing to offer these families.

On the flight to Halifax, I wondered whether I was there literally just for the ride. While talking to other volunteers, I was reassured that it was normal to feel peripheral. This type of grief work requires a "light touch." That evening, I hovered at a distance from a woman who fell to the ground crying. I thought that it was the best thing I could do. I felt that my commitment was more to the individual than to the group. I had come to the hospital to help and my desire not to intrude felt that I was not helping and not helping. Eventually, more experienced clinicians reassured me in that my ambivalence; I had stumbled on a fine execution of the "light touch." My data collection was not space consuming and the grief.

But my doubts that day were dwarfed by my feelings after returning home. I wondered how I was going to use this experience. My thoughts ranged from developing an AIDS workshop to calling my mother. When I did finally call my mother, she was so proud that she arranged for an article about my experience in an Indian-American newspaper. I joined with three other residents who volunteered to form a group to make it easier for residents to participate in future disaster response. Any residents interested in this can get more information by calling me at (212) 23-4-619.

Yes, I learned about the "light touch" needed to deal with grief. But I also learned about the "light touch" needed to deal with what that grief raises in myself.
The 1999 Medicare Highlights
by Seth P. Stein, Esq.

Last December, NYSPA sent out the eleventh annual Medicare update. Every NYSPA member received a 1999 Medicare memorandum and fee schedules for the localities where they practice. NYSPA is the only APA component that sends a Medicare update and locality fee schedules every year to every member.

Highlights for 1999 are:

- This year will be the first year of implementation of a new methodology for assigning a "resource-based" practice expense value to each code. Under the new direction, HCFA was called upon to assess the cost in staff, equipment, supplies and expenses required in providing each CPT code in various settings. There are to be two separate Medicare fees based upon the site of the service. There is one fee for "Facility" sites of service (primarily inpatient) and a separate fee for "Non-Facility" sites of service (primarily office and outpatient). In the majority of cases, the higher practice expense value (and therefore the higher final Medicare fee) is assigned to the Non-Facility fee. When the service is provided in a hospital, a skilled nursing facility or hospital outpatient department, then a lower Facility practice expense (and therefore a lower final Medicare fee) is assigned to these services. HCFA justified imposing a lower practice expense for Facility services because in a Facility setting non-physician labor, supplies and equipment are typically furnished by the hospital or facility and not by the physician.

- Because of efforts by the APA to enhance the relative values assigned to the psychiatric codes, psychiatric fees will receive an average 4% increase in 1999. However, fees for some codes (e.g., 90805) are slightly less than last year because increases in relative values were offset by greater decreases in the Medicare conversion factor. Over the next four years, the new resource based practice expense methodology will be fully phased in and many psychiatric codes will have enhanced relative values.

- HCFA has adopted new regulations regarding private contracting and opting out of the Medicare program. In 1997, Congress amended the Medicare law to permit private contracting effective as of January 1, 1998. If a physician opts out of Medicare and enters into private contracts with patients, the physician is no longer subject to the Medicare limiting charge rules and may set a fee with the patient. While the new HCFA regulations do not change significantly private contracting procedures, HCFA has stated that it will issue its own sample documents for use by physicians who wish to opt out of Medicare. Unfortunately, HCFA staff do not expect the HCFA documents to be available until this summer or even later in the year. APA has retained legal counsel to update its private contracting documents and will post them on the APA web site (www.psych.org) as soon as they are available.

- Under new HCFA rules, Medicare services must be billed to the carrier and using the fee schedule for the locality where the service is actually provided without regard to the location of the physician’s office. In the past, physicians could use the fee schedule for the locality where their office was located. Now, physicians who provide services at multiple locations must use the fee schedule for the locality where the patient actually receives the service.

- Medicare has not finalized guidelines for the documentation of CPT services (CPT codes 99xxx). The APA is working actively with the AMA to insure adoption of fair and workable documentation guidelines. There will be specific requirements for psychiatric services. The amount of documentation required will depend upon the level of E&M service provided. The greater the intensity of the service, the greater the level of documentation will be required. As soon as the documentation guidelines are finalized, they will be available on APA, NYSPA and Medicare websites.

NYSPA Calendar of Events

NYSPA Committees
Saturday, March 20, 1999 • 8:00 a.m. to 12 noon
Area II Council Meeting – Spring 1999
Saturday, March 20, 1999 • 12 Noon to 5:00 p.m.
Saturday, March 21, 1999 • 8:00 a.m. to 12 noon
NYSPA ECP Job Fair
Saturday, March 20, 1999 • 12 Noon to 3:00 p.m.

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