President’s Message: Area II Honors Seth Stein
by Jim Nininger, M.D., President, New York State Psychiatric Association

At the last APA Assembly meeting in November, Area II presented the Warren Williams Award to Seth Stein, our Executive Director. The award is given annually by each Area Council to an individual who has made significant contributions to our organization, the practice of psychiatry and the welfare of our patients.

Seth has proven invaluable to us through his legal advice in the area of psychiatric practice, his clear and thorough memos to members on critical issues and managed care, his yearly Medicare updates and fee schedules (NYSSPA is still the only state psychiatric association to provide this invaluable service) and his well-organized preparation of our meetings and services to our members. He has devoted many extra hours working with Barry Perlman, M.D. Chair of our Legislation Committee and Richard Gallo, our legislative consultant in fighting for psychiatrists and their patients, the protection of our scope of practice, managed care regulations and access to care.

Medicare 2000 Update

By Seth P. Stein, Esq.

Early in January 2000, every NYSIPA member received thetwelfth Annual Medical Update, including a detailed memorandum, the 2000 Medicare Fee Schedule and the 2000 Limiting Charge calculations. The fee schedules are now also available on the NYSIPA website: www.nyspsych.org.

2000 Highlights

Three key highlights include:

• While the average increase in all physicians’ fee for 2000 is 5.4%, psychiatric fees will receive a larger increase of 7% in 2000.

• For year 2000, Medicare has implemented a new resource-based methodology for the malpractice expense component of the Medicare Fee System.

• Psychiatrists who first filed an “opt-out” affidavit in 1998 and wish to continue entering into private contracts should renew their “opt-out” status in 2000 by filing a new affidavit with Medicare in accordance with NYSIPA’s guidelines.

NYSSA Legislative Charge

For psychiatrists who are not enrolled as participating physicians in the Medicare program, the New York State Limits-Charge remains at 105% of the Medicare non-participating fee.

New rules apply to all services covered under the Medicare Part B program and may not be waived by the patient. However, limiting charge rules do not apply to Medicare participating physicians. The fee schedules are now also available on the NYSIPA website: www.nyspsych.org.

Private Contracting under the Medicare Program

In the Balanced Budget Act of 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. However, the new private contracts rules have significant limitations and restrictions. First, a physician must opt out for a minimum period of two years. Second, once a physician opts out, the physician must be in compliance with the Medicare program, and may not have private contracts with some Medicare patients, but not others.

There are two required documents for private contracts. First, the physician must file an affidavit with each Medicare carrier (by certified mail, return receipt requested) where the physician submits claims. The affidavit must be filed no later than ten days after the first private contract is entered into by the physician. Once opting out of Medicare, a physician is out of Medicare for all carriers for a two year period from the date the affidavit is signed. After the two year period is over, the physician can elect to return to Medicare or to file another affidavit to continue opt-out status.

Confidentiality Under Siege

By Ann Sullivan, M.D.

The confidentiality of the patient’s clinical record is a cornerstone of the psychiatric practice. New regulations for electronic records are being proposed by the Clinton Administration and the Department of Health and Human Services (HHS). The new regulations violate the basic tenets of confidentiality and place all patients at risk of losing control over who knows and who can utilize their private medical history.

APA National 2000 Election Results

As we go to press, the APA reports the following election results:

President-Elect

Richard K. Harding, M.D. (59.5%)

Vice-President

Marcia Kraft Goin, M.D. (63.1%)

Treasurer

Carol B. Bernstein, M.D. (52.7%)

Trustee-at-Large

Keith W. Yourse, M.D. (50.8%)

MIT Trustee-Elect

Avram H. Mack, M.D. (56.1%)

Area 1 Trustee

Kathleen M. Mogul, M.D. (55.4%)

Area 4 Trustee

Norman A. Clemens, M.D. (67.0%)

Area 7 Trustee

Albert V. Vogel, M.D. (71.6%)

Most proposed amendments passed overwhelmingly with 82.4% or better in favor. Amendment #6, which allows Presidents elected before the year 2000 to continue as members on the Board for life, passed by a narrow margin of 52.2% in favor; 47.8% opposed.

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Medicare 2K
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Once a physician files the affidavit, the physician must enter into a private contract with each and every Medicare beneficiary. If a patient refuses to enter into a private contract, the physician who has opted out of Medicare will be unable either to charge the patient for services privately or to bill Medicare. Once a patient signs a private contract with a physician, the patient will receive no reimbursement at all from Medicare for medical care received from that physician and will receive no reimbursement at all from Medicare for Medicare managed-care plan, Medigap or other Medicare supplemental insurance carrier for the opt-out physician. Medicare approved patients opted out in 1998, must renew their opt-out status for an additional two-year period in 2000. Psychiatrists should use the “opt-out” and private contract prepared by the APA. The APA sample documents for private contracting may be downloaded from the APA website (www.psych.org). Psychiatrists in New York considering opting out who have questions regarding how to proceed should contact the NYSPA office directly.

Medicare Facility vs. Non-Facility Fees
In 1999, HCFA implemented the Congressional mandate to develop a resource-based practice expense value for each code. The most dramatic change from this new approach is that there are two practice expense values—both of which are called Facility and Non-Facility for each CPT code based upon the site of service. For most CPT codes (including almost every psychiatric code), HCFA has assigned two distinct fee values for each code—a "Facility" fee and a "Non-Facility" fee depending on the site of service. Of course, some codes by their very definition are only performed in certain settings and therefore, have only one level of practice expense.

In the majority of cases, the higher practice expense fee (and therefore the higher final Medicare fee) is assigned to the Non-Fee facility for services provided in the physician’s office or the patient’s home. When the service is provided in a hospital, a skilled nursing facility or hospital outpatient department, the"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 costs for nonphysician labor, supplies and equipment are typically furnished by the hospital or facility and not by the physician.

Resource-Based Malpractice Expense
In addition to the implementation of the facility practice expense methodology for malpractice RVU component of the Medicare fee schedule. The creation of this new malpractice expense methodology is medical malpractice premium data for each specialty. While the details of the methodology are beyond the scope of this article, the impact of the changes were only slight—a matter of resource-based practice expense value for each code. The most dramatic change from this new approach is that there are two practice expense values—both of which are called Facility and Non-Facility for each CPT code based upon the site of service. For most CPT codes (including almost every psychiatric code), HCFA has assigned two distinct fee values for each code—a "Facility" fee and a "Non-Facility" fee depending on the site of service. Of course, some codes by their very definition are only performed in certain settings and therefore, have only one level of practice expense.

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Corporate Reorganization
by Herb Peyser, M.D.

Unfortunately I had to get the report of the December Board meeting in by February 1st, before the election results were in and we knew whether the 501[c]6 would be approved. The timing of the BULLETIN publication is reality however, and we have to live with reality—I guess. I’ll assume enough members voted, approved the amendment, and the IRS will agree. If so, APA can go ahead with reallocating its resources and charter a 501[c]6 corporation under Washington, DC law, in addition to our 501[c]3. Then we’ll be able to do much more advocacy, cut dues, and share non-dues revenue (perhaps $700,000) with the DBs and state societies (SSs) for their state board advocacy and their membership, ethics and administrative infrastructure. It didn’t pass, it’s back to the old drawing board and trying again. It really is essential.

Making Amends
In connection with the vote some people had brought up the question of a Section 12 2 somewhere allowing a Board supersession (as well as the members) to be able to amend the by-laws. I don’t know why they brought this up at the time, for it did not apply to the old 501[c][3] that was being voted on but only to the new 501[c][6] which will not be created for another year. The reasons for that proposed Section in the new 501[c][6] are related to the IRS and the need to allow for urgent, executive action, but only if necessary. But all this can be reviewed and discussed when the time comes to approve the 501[c][6] by-laws. It had nothing to do with the 501[c][3] we were voting on and was not a matter of leadership imposing controls from the top. After all, the Trustees and the national officers are elected by the members and they are accountable to them, and the best protection is member interest and participation when the time comes.

Election Reform
Similarly, the proposal for election reform that an Ad Hoc Committee presented to the Board — that too was not an attempt to impose undemocratic control. It was to return the election process to the dignity, courtesy and professional process it used to be up to five or ten years ago, and to bring it up to date for all other medical and specialty societies conduct their elections. It was an attempt to get rid of the monthly expensive, intrusive, acrimonious, guidelines-breaking, ad hominem electoral abuses we have seen and been unable to do anything about (we have even been threatened with lawsuits over our efforts toward compliance with the guidelines). For one example, people have found they have to spend more than $50,000 to become President, and this amount is growing.

But nothing is being done yet. The Board, while favoring reform, is itself divided as to how, and nothing will be done without consultation with the Assembly and a referendum by the membership. We’ll keep watch for tendencies toward top-down imposing by the central leadership, as we have in the past. Incidentally again, the best protection is member interest and participation.

Cutting to the Quick
The Board voted the budget, imposing cuts on the central staff and on itself and moveous cuts on the Components (Councils, Committees, etc.), Assembly, and Area Councils. There were cuts all around to enable revenue sharing and dues relief targeted toward members moving from training to early career, ECP status — without interfering with the advocacy, educational and other functions the members want. As of writing, the Assembly and Area Councils are trying to work out how they will do their part. But if APA cuts its dues, the DBs/SSs must not increase theirs, and should consider staggering their ECP dues too (some already do). Indeed, APA might make its revenue sharing with the DBs/SSs dependent on dues relief, actions for the members basically look at the bottom line and it would not be good if the DBs/SSs pushed the dues back up when APA was trying to lower them.

On the Home Front
This also applies to NYSBA (the central state organization of the 13 NYS DBs) where the governance and Area Council will be taking cuts. But staff activities and costs must be reviewed too just as they were in central APA, and NYSBA and DB dues increases must be resisted, maybe even lowered the way APA is doing. The APA revenue sharing to our Area will have to be divided between the DBs (membership, ethics and administration) and central NYSBA (advocacy, membership, education and administration).

And just as we watch out for policies being imposed top-down from central APA without consulta- tion with the Areas, DBs/SSs and members, so too must we watch ourselves and not let our own state organization slip into a top-down mode without adequate consultation with the DBs and members. Member and DB interest and participation is the best protection here too.

Nevertheless our state organization does an excellent job with distributing Medicare, Medicaid and managed care information and with advocacy in Albany (parity, patients rights, scope of practice and practice legislation). I think NYSBA is better in this than any other state organization.

In Other News...

The Board also:

• Increased non–member registration and industry supported symposium fees at the Annual Meeting.
• Reviewed and supported several suits against HMOs and governmental managed care and litigation interference with professional practices.
• Continued consolidating APA and American Psychiatric Press activities with the goal of achieving a single publishing entity (for cost savings).
• Concerns over areas where management could possibly interfere with journal and book independence (as seen in recent AAA and Mass Medical Society actions) were discussed and initiatives taken to insure editorial independence in the presence of infrastructure improvement.

• Continued working on the development of the medical website, medcom, in conjunction with AMA and other specialty societies.
• Reviewed the folding of the International Office into the Membership Office in light of concerns and objections from abroad. The international part of the Membership Office and the Council on International Psychiatry will probably be significantly beefed up.
• Approved the appointment of Dr. Darryl Regier from NIMH as Director of the APA Research Institute and Office of Research. He is a very distinguished col- league, well known for the Epide- miological Catchment Area Survey and other health services oriented research.
• Moved forward the ongoing work of the Committee on APA/Business Relationships in the direction of getting businesses to be aware of the value of psychiatric care for its employees and support parity.
• Voted to explore making health, death, disability and life insurance and retirement benefits available to DB Faces under the same terms as central APA employ- ees, at local or employe expense.
• I have been working to bring the function- ing of the the central APA staff, what with the turnover, the loss of experi- enced people, and new ones coming in unfamiliar with APA people and APA ways. Please let me know of any problems you might have (chspeysermd@aol.com) so I can help with them. And I urge you to invite me to visit your DBs to discuss APA issues directly with you. In addition, as the elected male by the NYSBA Executive Committee I can discuss NYSBA leadership activities with you as well.

The Horizons of Parity

By Wilfrid Noel Raby, M.D.

Dr. Raby is a psychiatrist at the Washington Heights Community Service affiliated with the New York State Psychiatric Institute, and is Assistant Clinical Professor of Psychiatry at Columbia University. Dr. Raby co-founded the Picnic for Parity in 1995 in an effort to create a public event denouncing the disparity in payment and access for the treatment of mental illness; and to challenge publicly the stigmatization of mental illness. He currently serves as Vice-President and Treasurer of the National Picnic for Parity, Inc. -Ed.

Previously the issue of Parity is one whose time has come. The geographic barriers are expanding: there are now more states with mental health parity laws than without: 28 at last count, with New Jersey and California being the latest adherents to the notion that the suffering of mental illness should not be made more insufferable by the inadequacies of our laws. The political horizon is also enlarging. The latest “State of the Union” address by President Clinton endorsed the notion of mental health parity. No President had made such an unequivocal statement on mental health since John Kennedy publicly called for community mental health centers in 1963.

The horizons of psychiatry have expanded under the challenge of changing practices of the medical insurance industry. The issue of parity of the newest recognition has forged alliances between psychiatrists and consumers in ways hardly predictable a few years ago. All these changes of horizon are one con- clusion that parity will be the norm across this land, if not tomorrow, certainly some day.

The details about parity can be quite obtuse, but they can be con- densed to the conclusion reached by

understanding that allows the disparity against mental illness to persist. Disparity is fueled by the public’s (and perhaps our) willingness to view mental illnesses differently from all others; or, yet, our silence that colludes with those who view mental illness differently from illness. Our willingness or our silence is a public stance, a discourse of opinion and attitude. This is why the disparity against mental illness must be chal- lenged in the public place. Our fellow citizens must hear our voice about parity; and when they do, most welcome it. Many groups have arisen to the challenge. The New York State Psychiatric Association (NYSBA) has formed the MEND coalition (Mental Health Equality, Not Discrimination) to lobby our legislators. The Picnic for Parity is another voice, bringing forth a broad coalition of consumers, families with members with mental illness, advocates, psychiatrists and other providers, to request in the public arena the rights of the treatment to the mentally ill.

Each movement lends a shoulder to the effort that must be deployed, in this instance to achieve parity. No political change is ever brought forth without a complicity of diverse efforts. In England at the beginning of the nineteenth century, there emerged a
A Proposal For A Workable National Health Care Plan

By John Rosenberger, MD

John Rosenberger, M.D.

A common metaphor used to epitomize the means for controlling health care costs is the term 'reins vs. fences. ' 'Reins' refers to the indemnity insurance model wherein an insurance company, under contract to a health care consumer will pay to licensed providers a particular fee for a particular service, which fees and services are exclusively defined in the contract. These definitions are the 'reins' of this system, providing the insurance company the means for controlling its costs by pulling, as it were, on these 'reins'.

Under the 'fences' model an insurance company enters into two contracts, one with a group of health service consumers (usually their employer) to which it will provide a set package of defined health care services, without limit in quantity, for a set amount of money, and the other with a health service provider to which the insurance company will pay a set amount of money for providing to the consumer group the set of services it contracted to provide, again without limit in number. The 'fence' here refers to the set amount of money, no more, no less, that the health insurance company gets from the first group, the consumers, and pays to the second group, the providers. While one approach or the other, 'reins' or 'fences', is definitely needed to control health care costs, neither works very well. The 'reins' approach, to work well, requires a philosopher-king who, one, is an accepted oracle, and who, two, can in fact predict exactly when and how much to pull on the reins. In practice, having no such person, 'reins' insurance companies must negotiate with the pertinent state regulatory agency to re-define the reins that control health care (i.e., the changing of fee they will allow for any particular service), so that, no matter what the demand and what the rate of inflation, they will continue to make their 'allowed' profit. This leads to more and more of the health care dollar being spent on bureaucratic regulation, as decisions about fees and services become more and more talmudic. The Medicaid and Medicare programs are examples of such an ineffective process. 'Fences', on the other hand, after the 'creaming' of the well-patient/every patient group comes to an end, leads inevitably to de facto rationing (i.e., making the fenced-in area of allowed services smaller and smaller, since HCFA can't limit quantity). We have seen this happen now with HMO's, and, in the public sector, with the British Health Service system, a government HMO. To repeat, one of these systems is needed but neither works well. What to do?

The Proposal

My approach to this problem is the 'reins' approach. My plan, however, seeks to control costs and maintain quality by putting the reins of health care directly into the hands of those most interested in quality and best care, namely the patient (i.e., the king) and the most interested in quality and best care, namely the patient (i.e., the king) and the practitioner as the health professional most interested in quality and best care directly into the hands of those who are already making his living practicing medicine, and aren't.

1. Medical Savings Account. Every family/individual would have to create a Medical Savings Account (MSA), defined by law, which would establish a tax-free fund for the family out of which the family would have to buy hospital insurance (in the marketplace) and with which the family would 'buy' other health services, as long as such services were bought from a licensed health care practitioner. Such MSA's would be subject to audit by the IRS. With respect to 'other health services' families could, if they wanted, pay health service providers directly for a provided service, or they could buy insurance to cover a range of health services, or they could join an HMO. They could buy any health service they wanted from a licensed health care practitioner) with monies from their MSA, but when their MSA became depleted in any one year they would have to buy such services with taxable funds.

2. Additional Funds. A family financially unable to establish a full MSA, as defined by law via a means test, must, to the extent the family is able, buy hospital insurance, with the federal government supplying additional funds needed to purchase a mandated level of such insurance. Regarding the obtaining of health care services by this family, the family must seek for such services whatever additional funds, if any, it could segregate in its MSA, after which this family would become eligible to receive services from private health care practitioners (i.e., individuals or any proprietary medical institution) who would deduct their usual fee for that service from their taxable income. There is no financial limit to the amount of such services and as many as the family could receive, and the designation of the need for such services is decided by the treating practitioner, according to the accepted standard of care in his/her area of practice. (This proposed program would not replace Medicare, which would continue, for many reasons, not least political reality.)

3. Provider Participation. Private licensed health care professionals in any form of practice that generates income from patients for whom they provide care would participate in this program. This would include any medical facilities that derive income from patients to whom they provide care, on which income they pay taxes. (There is the question of whether or not all such practitioners should be required to participate in this program. I wrestle with this question and cannot comment on it further here.) There would be no review of medical decisions by these practitioners, just as there is no review of care they provide to patients who pay directly for their care. Investigations of cheating by practitioners would be done by the IRS. Note that any cash any practitioner could provide to impune patients under this program would be an amount equal to that he provided to his/her paying patients. Given prevailing tax rates this means he/she would be 'working off' for the government under this program, at most, half-time at ~60% his/her usual fee (assuming his/her federal tax bracket is in the 40% range). It shouldn't be difficult to identify those physicians who say they are working half-time for the government and aren't.

4. Current Medicare Providers. What of those many physicians who do treat presently, with respect and serious competence, a majority of Medicaid patients and who therefor would not stand to benefit from this program? Once identified, they could enter a special program that would pay them for their services, perhaps along the lines of a capitation/HMO system.

5. Monitoring. To monitor this program impugnacious physicians would, of course, have to be identified. The IRS would, as this, indicated by a means test, and such individuals would then get a card identifying them as eligible for government HMO practitioner. This practitioner would provide the necessary service (with no prior approval) to the patient who presented receipt of the service, would sign a bill, with his confidential ID, for the service provided. The practitioner then, at 'tax time' would submit this bill of 'donated' services to the IRS as documentation, the cost of which he/she would deduct from his taxable income — just like a charitable contribution! Using such an IDR system should address the problem of confidentiality, and, too, it would provide, as suggested, a means for gathering the data needed to keep corruption to a minimum among health care practitioners.

6. Catastrophic Illness. There remains (at least!) the issue of how families would handle the medical problems the cost of which, from taxable income, would reasonably be beyond the means of most families (e.g., a chronic illness, an illness requiring extraordinarily expensive intervention, etc.). This would be dealt with in the following manner: Each family at the end of the year would have to donate a percentage of those funds remaining in the MSA to a Medical Superfund (since such funds already are tax free, the remainder of the funds in the MSA at the end of any one year would be 'turned over' to the next, ad infinitum), run by some board, which would buy 'catastrophic illness insurance' which insurance would be available for such expenses on application by the family's physician. Since this would involve large sums of money, appropriate review and auditing procedures would be needed to regulate such expenditures.

That's the proposal. I would appreciate comments and support for putting forth this program in the marketplace of ideas about establishing a workable and quality program of health services for all citizens.
each year it is important to remember that NYSPA continues its long tradition of State Budget analysis and comment. The budget, more than any other health related matter before the Legislature, holds the potential for either improving or worsening the quality of care for the vast majority of seriously mentally ill New Yorkers. Interestingly, this year, the sound and fury that usually accompanies the Executive’s fiscal plans for health and mental health services has been quieted considerably by two important developments: the first being the enactment of Chapter 1 of the Laws of 2000 — the New York Health Care Reform Act of 2000 (HCRA 2000) — which substantially affirms the direction of New York’s public health policy and the financing mechanisms that support it. This effectively takes health care issues out of the budget negotiations. The second, the Governor’s pre-budget announcement to add $12.5 Million in new funding to support State and community-based mental health initiatives the Administration plans to undertake.

Health Care Reform Act
HCRA 2000, among other provisions, creates the Family Health Plus Program (FHPP) to provide health care coverage for certain low-income individuals and families. The program is designed to lessen the ranks of the uninsured who can neither afford to buy private health insurance nor qualify for Medicaid because their earnings are just north of Medicaid eligibility thresholds. The FHPP includes coverage for mental illness, albeit probably unequal to the benefits available for other illness. The bill language is silent on the extent of coverage for mental illness stating only that the benefits for mental illness will be determined by the Commissioner of Health in consultation with the Superintendent of Insurance. Follow-up discussions with the Governor’s office suggest the Administration’s intent to also involve the Office of Mental Health in designing the benefit package for mental illness. Two things to keep in mind about what can be expected from this measure:

- First, the FHPP is seen as an expansion of the existing Child Health Insurance Plus (CHIP) Program where the benefit for mental illness is the HMO 30/20 standard.
- Second, an enormous feud had erupted between the Governor and the Senate Majority Leader over the requirement for counties to pick up a significant share of the cost for FHPP, the counties, supported by the Majority Leader, see it as another expensive and unfunded mandate; the Governor says the counties can afford it because they will be the recipients of the lion’s share of the tobacco settlement due the State.

OMH Budget
The Executive Budget for FY 2000-01 features the first-year phase-in of a two-year initiative termed the Enhanced Community Services program (ECS). The Budget also includes funding to fully implement Kendra’s Law. Please note that the state share of Medicaid is supplemented by federal and local contributions. Some details:

- Adult Services: Case management services and ACT teams — $14.8 million in new local aid. When fully implemented in FY 01-02, the ECS program will provide case management services to 10,000 additional children with $22.2 million in local aid and $24.2 million in Medicaid funding — for a total of $52.4 million.
- Children & Youth Services: Case management services — $1.7 million in new local aid. When fully implemented in FY 01-02, the ECS program will provide case management services to 10,000 additional children with $6.9 million in local aid and $6.1 million in Medicaid funding — for a total of $13.0 million. Home and Community-based Waiver program - $3.1 million in state share Medicaid for approximately 130 new slots. Family Support Services - $2.0 million in new local aid for services effective 10/1/00 (annualized value of $2.6 million in new local aid). Family-Based Treatment - $5 million to fund 125 new slots (including $2.5 million in local aid and $2.0 million in state share Medicaid, and other funding).

Children’s Residential Treatment Facilities (RTF) recommended to receive 3% trend factor for both the operating and education components of the program. COLA: Residential programs are recommended to receive 2% COLA effective 4/1/00 — $7.1 million in new local aid over 15 months.

Community Mental Health Reinvestment: $51 million in new Reinvestment funding reflecting an adjustment for actual prior year psychiatric center bed closures (annualized value of $31.43 million). ECS initiative includes a one-year moratorium on psychiatric center bed closures.

- Community-Based Housing: Supported housing – 1,500 new units, one-year moratorium on psychiatric center bed closures (annualized value of $31.43 million). ECS initiative includes a one-year moratorium on psychiatric center bed closures.
- Community-Based Housing: Supported housing – 1,500 new units for adults to be developed and opened in FY 00-01 with $14.65 million in new local aid. When fully implemented in FY 01-02, the ECS program will have developed and opened 2,000 new supported housing units for adults with new local aid annualized at $20 million.
- Employment: Supported employment - 400 new supported employment slots with $880,000 in new local aid.
- Kendra’s Law: $28.9 million in new local aid for care coordination (ICM/SCA/ACT teams), medication grants program, and drug testing. $11 million in Medicaid funding to support Kendra’s Law.
- Local Capital Projects: Capital projects - $13.4 million in new local aid for ongoing maintenance and rehabilitation of residential and non-residential community-based mental health programs.
- Special Needs Plans (SNP): Start-up funding for Mental Health SNPs reappropriated - $30 million.
- State Workforce: Enhanced Community Services Program - $338,000 in new local aid (and related non-personal expenses) to support: 1) five transitional residences to be located on state psychiatric center grounds in New York City; 2) four new mobile mental health teams to serve juvenile offenders in Office of Children and Families facilities, and 3) enhanced OMH oversight of community service programs — $5.9 million in new state operations funding ($5.9 million annually). Forensic: 75 new state positions to provide services to forensic inmates housed in administrative segregation units and to support a new mental health satellite unit at the Seneca Correctional Facility — $3.4 million in new state operations funding.

Eli Lilly Ad
chance to be started on high doses of methadone and be detoxified over a long length of time, precisely what he desires.

Once hospitalized, he succeeds in tricking credulous physicians by his "pathognomonic" complaints. Eventually, they learn by experience and becomes suspicious. At that point, his pains and aches mysteriously disappear during daytime; henceforth, they will only occur during the later hours of the week-end, precisely when his regular—and by now wiser—ward physician happens to be off duty.

One morning, our man wants a taste of honey, in this case phenobarbital and/or a benzodiazepine. Nonchalantly he mentions to the nursing staff that, alas, he is an epileptic but fortunately his seizures have lost their "sleeper." As the order is indeed honored, a procession of "insomniacs" galvanizes to his bedside. After he has been granted satisfaction, he vociferates the pleasure of the tonic with an exultation which, in his estimation, 'would make you weep with joy!'

"This guy did really a fantastic job! A real artist! Next time I lecture medical students about convulsions, I’d love to have him repeat his performance and mimic the disorder." At that point, the by now inert body regains its motility, a smile appears over the moth-burned face and a crystal-clear voice answers: "Anytime, doc!"

Later on, the specialist emphasizes how difficult the diagnosis of a seizure disorder can be. Thus, an EEG can remain negative. An individual can easily yet himself or bite his tongue and all signs of that is required to obtain the "magic pill". "In fact," the doctor confesses, "I am concerned that this great impersonator may feign the precordial pains of an infarction, the day he finds out that he can then be re-warded with a shot of morphine!"

Another time, another ward, another staff. Freddy wishes to experience the pleasurable effects of a hypnotic prescribed to him on a PRN basis. "Yes, problem? He falls asleep as soon as the light are turned out.

The solution? He instructs a prostatic patient who makes frequent nocturnal trips to the toilet, to wake him up after midnight. Then, hardly able to keep his eyes open, he stumbles to the nursing station. Therein, he states in a soft voice that he has patientily—but in vain—tried to fall asleep for hours and could he now please, be handed the much needed medication? Minutes after he has been granted satisfaction, a procession of "insomniacs" galvanized by his success surrounds the nurse on duty claming for their "sleeper."

Does he want high doses of Librium? First, he claims to have previously experienced episodes of delirium tremens. Afterward, he complains of nausea, weakness and hallucinations, and shows irritability, all signs of alcohol withdrawal. Likewise, he is a master at conveying the impression of being highly anxious, with the goal of receiving fast acting Auvan, from a busy staff.

In Bellini's Carmen, the prima donna, his movie, the hero is shown a crowned fair arm wrestling a herculean woman. When he realizes he cannot win by sheer strength, he decides to charm her. Lo and behold, she lets him, by now wiser, ward physician happens to be off duty.

One day, the neurologist happens to find a "sleeper." By a strange coincidence, he finds out that he can then be re-warded with a shot of morphine! Thus, in a detox unit on the 25th day of December, while the piped music murmurs Silent Night, Holy Night: aware that he can no longer fool his psychiatrist, he capitalizes on her large dark eyes on the vein of the arm.

Eventually, the staff becomes so suspicious of this addict that when he asks for vitamins, the intern prescribes applications of an antifungal ointment, they wonder whether he has become hooked on these substances?

LENVOI. As at medical school it was customary that a student in his senior year write a thesis before graduation. It was also customary that in the process he credits the teachers who have guided him throughout his studies. Oscar, always a bit rebellious, decided instead to write his thesis to his girlfriends, "for all the wonderful things in life they have taught me," and omitted to mention his eminent professors. One of them, peevd when reading the young man's draft, mentioned to him: "If you have not thanked the Faculty, it only means that you have not learned much from them. Therefore, you are not ready yet to become a MD!" Enlightened, the doctoral candidate, in the next version of his preamble, dutifully listed the names of his donors, sadly leaving out those of his girlfriends!

In the same vein, the young resident should be grateful to Freddy and his like, his de facto informal teachers. Thanks to them, he learns many useful tricks of his trade. He is obliged to carefully study the few pages in medical manuals devoted to "malingering." He is impressed with the imperative necessity to differentiate the signs of a genuine seizure or the pains of a gallbladder stone, from a dodge one. And to ascertain whether his client suffers from a genuine generalized anxiety or panic attack, or is only trying to obtain unneeded but addictive substances.

During his studies he has been trained to trust his patients and believe that they want to be treated. Now he may wonder about some of them: "Do they really wish to improve? Are they trying to take advantage of my credulity and good faith? Can they "read" me? Have they discovered my Achilles' heel and now manipulate me?"

Thinking critically becomes essential. No longer will he underestimate the ingenuity of clients with an "addictive personality" who crave drugs he can easily prescribe. He also learns that a "dumb guy" can acquire unexpected skills from a sharp "counselor" willing to tutor him. In brief, per aspera ad astra as the Latin saying goes, the once naive resident will turn into a better doctor…

Teacher

Continued from page 8

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New York State Psychiatric Association • THE BULLETIN

Spring 2000

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You're Invited

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An Unexpected Teacher
By Gabriel Laury, M.D.

Dr. Laury is a psychiatrist at the FDR VA Hospital in Montrose, NY, and a Assistant Professor of Psychiatry at the Mount Sinai School of Medicine. He has served as President of the (former) Suffolk County District Branch. –Ed.

Freddy carries a diagnosis of multisubstance dependence. When asked which drug he uses, he answers cheerfully: “Anything I can get my hands on.” Tall and slender, he makes frequent use of a charming smile which reveals beautiful immanate teeth. His silky black hair is divided into symmetrical halves by a neatly drawn parting. He sports a thin mustache which would look ridiculous on anybody else, but distinguishes on him and Clark Gable. His neat di-parting. He sports a thin mustache which would look ridicu-

tious on anybody else, but distinguishes on him and Clark Gable. W
rmth, friendliness and honesty exude from his large dark eyes. Deep and melodious is his voice. His exude from his large dark eyes. Deep and melodious is his voice. His exude from his large dark eyes. Deep and melodious is his voice. His exude from his large dark eyes. Deep and melodious is his voice. His exude from his large dark eyes. Deep and melodious is his voice.

Those who have treated him are aware that he is an “operator,” a “con

man,” knowing his way around unsuspecting health professionals. In the community at large, he goes from one medical office to the next, attempting to convince practitioners to write prescriptions for the “meds” he is craving. Among other roles, he is a master at faking the pains of a gallbladder or kidney stone, as he presents himself bent over in unbearable agony.

The staff at detoxification facilities occasionally show reluctance to hospitalize a homeless individual. They may wonder whether he is actually willing to be treated or only wishes to stay as long as possible in a cozy setting. Consequently, when seeking admission Freddy announces a “good” but fictitious address, even when sleeping in parked cars. He also mentions using extravagant doses of heroin: “You know, Doc, at least 15 bags worth several hundred dollars a day.” This way, he stands a good chance to explore opportunities in psychiatry within New York State, the U.S. and overseas. Admission is free! Refreshments will be served.

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Redefining Psychotherapy as a Treatment for Only a Few Conditions
By Edward Gordon, M.D., NYSPA Past President

E
time Medicare in New York City has published a draft Psychiatry policy, which will be discussed at the March 22 Medicare Carrier Advisory Committee (MCAC) in New York City. Copies of the policy are available from the NYSPA office, or on the NYSPA website, www.nyspsych.org.

The Committee consists of members of all Medical Specialty Societies, as well as other suppliers of Medicare services. Proposed policies are presented for discussion before being adopted by the carrier medical directors. I have served as NYSPA representative Seth Stein and I will be reviewing the proposed policy before meeting with the carrier to request changes which will hopefully conform the policy to current good psychiatric practice.

Input from members will be essential in drafting our response by describing usual practice characteris-tics in New York. The prior policy was interpreted narrowly by Empire, and resulted in the widespread use of prepayment audit for codes 90862 (medication management) and 90847 (family psychotherapy). The proposed policy, unless changed, will be even more disastrous, redefining psychiatric treatment in Medicare terms, and requiring documentation unrelated to the communication purpose of chart notes. The new policy includes, in part:

• The requirement for written informed consent for treatment.

• “Incident to” services are defined and permitted, with close personal supervision. In a partial hospital program, the physician must be present in the same room as the therapist.

• Psychologist, Social Worker, Physician Assistant and Nurse Practitioner services are defined.

• Documentation requirements are defined, elaborate, and would permit almost all treatment to be disqualified on review.

• Permit and excluded psychiatric procedures are listed, as well as who may bill each procedure, and which diagnoses are permitted, by code.

• Psychotherapy is redefined as “an adjucitive form of treatment for few psychiatric conditions”, excluding the personality disorders. Personality disorders are excluded from psychotherapy and pharmacologic management, but may be treated by psychoanalysis.

• Psychologists may only perform individual or group psychotherapy.

[See Empire on page 7]