# THE BULLETIN

## NEW YORK STATE PSYCHIATRIC ASSOCIATION

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# President's Message: Area II Honors Seth Stein

by Jim Nininger, M.D., President, New York State Psychiatric Association

Jim Nininger, M.D.

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 (NYSPA 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 for parity, protection of our scope of practice, managed care regulations and access to care.

Seth began with NYSPA in 1978 as Special Counsel for the NYSPA Medicaid Committee. Under the leadership of Seymour Gers, M.D., and past President Edward Gordon, M.D., he brought several lawsuits on behalf of our members successfully challenging the Medicaid prior approval system and in 1980, brought suit to correct Medicaid cross–over coverage for psychiatric care and recovered over $250,000 for psychiatrists in retroactive payments.

In 1982, Seth became General Counsel and in 1988, Executive Director. With the increasing involvement of psychiatrists in legislative initiatives, the other Areas and state societies in the APA have come to see the value of our having a full–time executive director with legal expertise in the field of mental illness. Seth has championed the rights of persons with serious mental illness to access to treatment and community based services. Michael Winerip, in his award-winning book, 9 Highland Road, documenting the difficult process of establishing a group home for persons with mental disabilities, describes Seth's efforts on behalf of the agency developing the project to overcome intense community and political opposition to establishment of the group home. Mr. Winerip, a former Warren Williams Award winner himself, has spoken of Seth's dedication to the rights of persons with disabilities and his legal advocacy on their behalf.

*(l to r) Ed Gordon, M.D. (NYSPA Past President) and Barry Perlman, M.D. (NYSPA Legislative Chair) look on as Jim Nininger, M.D. (NYSPA President), presents Warren Williams Award to Seth Stein.*

As the founding and managing partner of the law firm, Stein & Schonfeld, Seth has specialized for the past 15 years in the representation of programs and agencies providing residential, educational and day services to children and adults with mental disabilities, mental retardation and developmental disabilities. His firm has successfully championed the rights of persons with disabilities to housing under the federal Fair Housing Law and his firm has won several landmark fair housing cases.

Recently, because of his experience and knowledge in the operation of a state psychiatric organization, Seth was appointed to the APA District Branch/State Societies Advisory Committee and we are pleased to be represented by him there.

To Seth Stein, on behalf of all our members, a heartfelt thanks and congratulations. ■

# Medicare 2000 Update

By Seth P. Stein, Esq.

Early in January 2000, every NYSPA member received the twelfth annual Medicare 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 NYSPA 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 carriers.

### NYS Limiting Charge

For psychiatrists who are not enrolled as participating physicians in the Medicare program, the New York State Limiting Charge remains at 105% of the Medicare non–participating fee. Non–participating physicians cannot charge patients more than the NYS limiting charge. The limiting charge 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. Please note that Medicare carriers in New York have distributed 2000 fee and limiting charge information based upon the federal limit for 2000 (115%). The NYSPA fee charts contain both federal and NYS limiting charge calculations.

### 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 opts out for all covered services that the physician provides. A physician who opts out must enter into private contracts with all Medicare beneficiaries. A physician 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.

[See **Medicare 2K** on page 2]

**INSIDE THIS ISSUE:**



# Confidentiality Under Siege

By Ann Sullivan, M.D.

The confidentiality of the patient's clinical record is a cornerstone of 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.

[See **Confidentiality** on page 7]

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# 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. Young, 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. Proposed Amendment #6, which allows Presidents elected before the year 2000 to continue as members on the Board for life, passed by a narrow margin: 52.2% in favor; 47.8% opposed. ■

# THE BULLETIN
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Seth Stein, Esq., *Executive Director*

**Information for Contributors**
The Bulletin welcomes articles and letters that NYSPA members will find timely, relevant, and compelling. Articles should be between 750 and 1500 words (three to five double–spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to the editor. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

**Information for Advertisers**
The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 5,500 copies per issue. The Bulletin is received by all 5,000 members of the American Psychiatric Association who belong to a district branch in New York State. The Bulletin is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. The Bulletin is published quarterly. Both classified advertisements and display advertisements are available. Please contact the editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

The opinions expressed in the articles or letters are the sole responsibility of the individual authors, and may not necessarily represent the views of NYSPA, its members, or its officers.

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## Medicare 2K

Continued from page 1

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 from any Medicare managed care plan, Medigap or other Medicare supplemental insurance carrier for the opt–out physician.

Physicians who 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 "resource–based" practice expense value for each code. The most dramatic change from this new approach is that there are two different practice expense values (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 fees 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 value (and therefore the higher final Medicare fee) is assigned to the Non–Facility fee 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, 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 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 resource-based practice expense, starting in 2000 HCFA has implemented the direction in the Balanced Budget Act of 1997 to adopt a resource–based malpractice expense methodology for the malpractice RVU component of the Medicare fee schedule. The foundation of the 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 on psychiatric fees were only slight — a reduction of 0.2%.

### Medicare Audits

Beginning last summer, NYSPA received numerous inquiries from our members regarding an onslaught of Medicare pre-payment audits by Empire Blue Cross Blue Shield. Psychiatrists who submitted claims to Medicare found their claims pended and received a request for a copy of the treatment record for each service being audited. After submitting copies of the treatment records, many of these claims were initially denied or downcoded based on alleged inadequate documentation or failure to demonstrate medical necessity. Psychiatrists with predominantly inpatient practices encountered 100% prepayment review and pending of claims. Psychiatrists who rely on Medicare reimbursement for their livelihood encountered a total cessation of Medicare reimbursement for several months while their claims were reviewed.

Edward Gordon, M.D., Mark Russakoff, M.D., and Seth Stein met with Empire Blue Cross Blue Shield representatives to discuss the audit process. Empire BCBS staff stated that this massive audit campaign is part of a nationwide effort by the Health Care Financing Administration to reduce Medicare expenditures and root out fraud. The carrier conducted a computer analysis of several psychiatric codes and compared rates of utilization in New York to the national average for codes 90801, 90807, 90862, 90846 and 90847 that were identified as having significantly higher utilization rates in New York than in the rest of the country. The stated goal of the audit process is to develop new carrier medical policies to control purported over–utilization of the codes under review.

NYSPA pointed out that the higher utilization figures in New York for certain codes reflect local billing patterns and practices that are entirely appropriate. Dr. Gordon also pointed out that there was little consistency in the standards used to conduct these audits. Based on documentation already submitted to NYSPA by psychiatrists whose claims have been reviewed and denied or downcoded, the carrier's reviewers are not applying a consistent standard of review. NYSPA representatives argued that prepayment review and the pending of claims should be reserved only where there is evidence of billing irregularities on the part of a specific physician. When a carrier is seeking to analyze billing data on a carrier-wide basis, postpayment reviews should be sufficient.

After NYSPA's intervention, Empire staff notified NYSPA that Empire had modified the audit parameters to reduce the frequency of claims that are subjected to prepayment review. Psychiatrists who have be subjected to prepayment review report that most claims have been approved and paid after reconsideration or on appeal.

Finally, at the recent meeting of the Medicare Carriers Advisory Committee consisting of representatives from all NYS medical specialty organizations, a NYSPA sponsored resolution was passed opposing use of prepayment reviews and extended pending of claims for carrier–wide audits based solely on non–physician specific data and requesting a meeting with HCFA, NYSPA and the carrier to discuss the proper use of statistical data and prepayment audits. The HCFA NY Regional Office has asked Empire BCBS to respond to these issues and then has agreed to schedule a meeting with NYSPA representatives to discuss this matter. ■

## New Empire BCBS/Magellan Medicare HMO

Psychiatrists in New York recently received a mailing from Merit Behavioral Health Care, an affiliate of Magellan Behavioral Health, offering psychiatrists the opportunity to enroll as participating providers in the Empire Blue Cross Blue Shield Senior Care plan — a Medicare HMO operating in the downstate region. Under the arrangement, psychiatric care provided Medicare beneficiaries enrolled in the Senior Care HMO would be managed by Magellan and paid for under the Magellan fee schedule.

Psychiatrists who are considering enrolling in the plan as a participating provider should consider the following:

- Psychiatrists who enroll in the Senior Care HMO are agreeing to accept the Magellan fee schedule — on average *30% lower* than the Medicare fee schedule — as payment in full for all Senior Care HMO patients.
- Psychiatrists who enroll in the Senior Care HMO are also agreeing to submit their treatment of Medicare Senior Care HMO patients to Magellan *utilization management* and prior authorization procedures.
- If a patient enrolls in a Medicare HMO and the treating physician is *not* a participating provider in the plan, the physician may charge and collect from the patient the NYS Limiting Charge, but the patient receives no reimbursement of any kind from the Medicare HMO.
- Psychiatrists must enroll in order to participate in the Senior Care HMO. *If you do not wish to enroll in the Senior Care HMO, no action is necessary.*

### On the Web...

*NYSPA's Medicare 2000 memo and fee charts in their entirety are available for downloading at the NYSPA web site. Visit:*

*www.nyspsych.org*

## LETTERS TO THE EDITOR

*Letters to the Editor are welcomed but are limited to 750 words.*

The article by Howard Owens is a fine outline of the clinical, political and economic complexities of "Kendra's Law" With this kind of quality production THE BULLETIN will continue to thrive.

Thanks.

**Stuart L. Keill, M.D.**

# Corporate Reorganization

by Herb Peyser, M.D.

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][3] corporate reorganization amendment had been approved. The timing of THE BULLETIN publication is reality however, and we have to live with reality — I guess.

So I'll assume that 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 level advocacy and their membership, ethics and administrative infrastructure.

If 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 supermajority (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 DC law, 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 control from the top. After all, the Trustees and the national officers are elected by the members at large, represent and 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 the way the DBs/SSs and all other medical and specialty societies conduct their elections. It was an attempt to get rid of the terribly 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 members. We'll watch for tendencies toward top–down imposing by the central leadership, as we have in the past, but 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 more serious 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 such 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 NYSPA (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 NYSPA and DB dues increases must be resisted, maybe even lowered the way APA is doing. The APA revenues flowing to our Area will have to be divided between the DBs (membership, ethics and administration) and central NYSPA (advocacy, managed care and administration).

And just as we watch out for policies being imposed top–down from central APA without consultation 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 other legislation). I think NYSPA is better in this than any other 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 HMO and governmental managed care and litigation interference with professional practice.
- 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 AMA and Mass. Medical Society actions) were discussed and initiatives taken to insure editorial independence in the presence of infrastructure consolidation.
- Continued working on the development of the medical web site, medem.com, 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 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 colleague, well known for the Epidemiological 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 business 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 certain retirement benefits available to DB Execs under the same terms as central APA employees, at local or employee expense.

I have been watching the functioning of the the central APA staff, what with the turnover, the loss of experienced people, and new ones coming in unfamiliar with APA people and APA ways. Please let me know of any problems you might have (<hspeysermd@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 a member of the NYSPA Executive Committee I can discuss NYSPA leadership activities with you as well. ■



# The Horizons of Parity

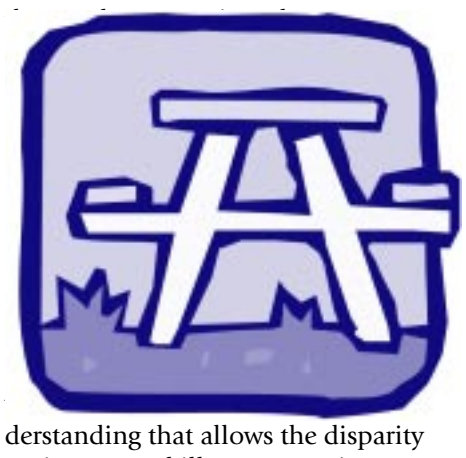
By Wilfrid Noel Raby, M.D.

*Dr. Raby is a psychiatrist with 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.*

Increasingly, the issue of Parity is one whose time has come. The geographic horizon is 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 called for community mental health centers in 1963.

The horizons of psychiatry have exploded under the pressure of changing practices of the medical insurance industry. The issue of access to the newer medications has forged alliances between psychiatrists and consumers in ways hardly predictable a few years ago. All these changing horizons gives one confidence 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 condensed to the conclusion reached by



derstanding 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 challenged 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 (NYSPA) has fostered 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 place a redress of the rights to treatment of 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

[See **Parity** on page 7]

# A Proposal For A Workable National Health Care Plan

By John Rosenberger, MD

*Dr. Rosenberger is a psychiatrist at Manhattan Psychiatric Center. He would like to hear from you regarding these ideas. Please send any comments, responses, ideas to Dr. John Rosenberger, 2211 Broadway, #1G, NY, NY 10024; e-mail: <Dutch3456.aol.com>. -Ed.*

John Rosenberger, M.D.

A common metaphor used to epitomize the means for controlling health care costs is termed '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 exquisitely 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., by changing the 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/employee 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 the HMO can't limit quantity). We have seen this happening 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 able to provide the most efficient care, namely the patient (i.e., the king) and the 'better' practitioner (i.e., the philosopher). It defines 'better' practitioner as the health professional who is already making his living taking care of patients in the private health care market place. Finally it addresses the main problem of the delivery of health care in our country: the inability of poor people to pay for their own care.

The main features of the plan are:

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 market place) and with which the family would 'buy' other health service, 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 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 expend 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 an eligible 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 now 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 the most care a practitioner could provide to impecunious 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' 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 Medicaid Providers**. What of those many physicians who do treat already, with respect and serious competence, a majority of Medicaid patients and who therefore 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 impecunious patients would, of course, have to be identified. The IRS would do this, as indicated, by a means test, and such individuals would then get a card identifying them as eligible for going to an eligible practitioner. This practitioner would provide the necessary service (with no prior approval!) to the patient who, upon 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 ID# 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 major 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 its 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 comment about, 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. ■

# NYSPA Legislative Report: The Year Ahead

By Barry B. Perlman, M.D., Chair, Legislation Committee, and
Richard J. Gallo, Government Relations Advocate

Each year it is important to remember that NYSPA continues its long tradition of State Budget analysis and commentary. The budget, more than any other health related matter before the Legislature, holds the potential for either improving or worsening the quality of life 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 $125 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 its many 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 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 00-01 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 for 10,000 additional individuals with $28.2 million in local aid and $24.2 in Medicaid funding—for a total of $52.4 million.
- Children & Youth Services: Case management services— $3.7 million in new local aid. When fully implemented in FY 01-02, the ECS program will provide case management services to 2,600 additional children with $6.9 million in local aid and $6.1 million in Medicaid funding - for a total of $13 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 $2.35 million in now local aid, $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 a 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 $11.43 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/SCM/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 positions (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 ($19.6 million annualized). **Forensic** – 75 new state positions to provide services to prison 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. **Kendra's Law** - 39 new state positions to provide for coordination and monitoring of program, improve discharge planning for individuals released from prison, and support administration of the medication grant program — $3.1 million in new state operations funding. One hundred administrative and support positions to be eliminated at Pilgrim and Manhattan psychiatric centers. Psychiatric residences — elimination of 18 positions. Data Center Consolidation — elimination of 14 positions. No further restoration of state shared–staff positions eliminated in FY 99-00. Funding provided for 66 positions previously restored.

Additional details about proposed mental health appropriations by service category and related program narrative will soon be posted on the Legislative Page of NYSPA's Website: <www.nyspsych.org>.

## Parity

NYSPA is pushing vigorously to make 2000 the year New York State finally puts an end to the gross disparity between health benefits for mental illness and those provided for other illness in most health benefit plans. We are pleased to report the Assembly, three weeks into the new Legislative Session (January 24), once again unanimously passed A. 6235 (by Assemblymember Brennan, et al.). A. 6235 is the more inclusive of the two operative parity bills now before the Legislature.

[See **Albany Report** on page 6]

# Teacher

Continued from page 8

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 miraculously disappear during daytime; henceforth, they will only occur during the later hours or on a weekend, 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 are under control, thanks to these specific drugs. He deplores that through an oversight at admission time, these orders have not been renewed. "Easy mistake to make. You know how busy them docs are," he adds understandingly.

By a strange coincidence, he develops severe convulsions that same afternoon. So realistic are the tonic and clonic stages of his grand mal, that they frighten the health professionals who stand by. One of them, instead of helping the patient, looks frantically through the medical record to check the name of the inept physician who has overlooked the anticonvulsants.

A neurologist happens to find himself on the same floor and has observed the scene. Brought an order sheet and expected to immediately prescribe, he tells the stunned staff: "This guy did really a fantastic job! A real artist! Next time I lecture medical students about convulsions, I'd love to ask him to repeat his performance and mimic the disorder." At that point, the by now inert body regains its motility, a smile appears over the moribund's 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 wet himself or bite his tongue -other sure signs- if that is the required price to obtain the "magic pills". "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 rewarded 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. The 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. There, he states in a soft voice that he has patiently -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 clamoring 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 Ativan, from a busy staff.

In Fellini's *Casanova*, the 1976 movie, the hero is shown at a crowded 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 gradually bend her arm and win. When needed, Freddy utilizes a similar approach to obtain what he wants. 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 feelings of compassion to extract an additional dose of methadone. "In the Christmas spirit, have a heart, Doc!" he implores, staring at her with his large dark eyes on the verge of tears.

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

L'ENVOI. At one medical school it was customary that a student in his senior year write a thesis before graduation. It was also customary that in the preamble he credits the teachers who have guided him throughout his studies. Oscar, always a bit rebellious, dedicated instead 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, peeved 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 dons, 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 faked 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…



# Albany Report

Continued from page 5

The other Parity bill, S. 2089 (by Senator Libous, et al.), also prohibits disparity in coverage for mental illness but would only apply to managed health care plans.

Both bills have been in the legislative hopper for over three years. Clearly, the Senate Republican Majority is less enthusiastic about this legislation than Assembly members from either political party. However, there has been progress in the upper House and we can take solace in the fact that twenty-two Senate Republicans have agreed to be sponsors of S. 2089 (up from just four one year ago), and that the bill has twice been reported favorably from the Senate Insurance Committee.

The increase in the number of Republican senators sponsoring S. 2089 is the result of meetings conducted with those senators or their staff by mental health advocates in Albany and constituents "back in the District." Likewise, legislative support for parity was bolstered by the activities of the Mental Health Equality Not Discrimination (MEND) Campaign, which delivered its parity message to legislators in the form of a large pizza with a piece missing to symbolize the noticeably missing piece of health insurance — mental health. The parity issue also received favorable editorials from several regional newspapers last year and was the genesis for the "Picnics for Parity" held in a dozen cities across the State. Of course, the first, last and most effective means of securing the interest of a legislator are letters and phone calls from constituents and many such communications were made in support of parity legislation.

## Mental Health Practitioners

In the Fall 1999 issue of THE BULLETIN, we reported on this matter in some depth. Since then, the status of the legislation remains unchanged except, as a procedural matter, it was returned to its Committee(s) of origin at the end of 1999. NYSPA, together with the State Medical Society, continue our effort to resolve this issue in a manner, which is protective of the public, the common goal of all concerned.

Like last year, NYSPA anticipates long hours will be spent on trying to achieve conceptual agreements and composing bill language. We are hopeful but not yet optimistic about what can be accomplished this year. In the meantime, NYSPA and MSSNY maintain their opposition to the bill (S. 2990—D Senator LaValle / A. 5410—D Assemblyman Ed Sullivan).

Copies of 1999 opposition memoranda and related information regarding the mental health practitioner's bill can be obtained from the NYSPA Website — Legislative page.

**Coming Soon to the Web!**

*Soon you will be able to visit NYSPA's web site for details on:*

- *1999 opposition memorandum and the mental health practitioner's bill*
- *Proposed mental health appropriations*

*www.nyspsych.org*

# Parity

Continued from page 3

fervent movement against slavery, and marches were held in the streets, particularly against the slave trade occurring in eastern Africa, in the area that was to become Tanzania. Wedgewood, a manufacturer of fine china and porcelain, took the issue to heart, and he felt that the bourgeois class — his clientele — did not know enough about slavery. He ventured to change the seal he would appose on the back of his plates and cups to one showing a African slave in chains. This brought the images of slavery into all the well–to–do tea rooms of England, which in turn led to large donations to finance the movement to buy the freedom of slaves from traders. The antislavery cause gathered thus an irreversible momentum that led to the end of the slave trade in Eastern Africa by 1891.

When the *Universal Declaration of Human Rights* stipulates in article one that "All human beings are born free and equal in dignity and in rights," how can this be true when access to care to treat an illness is denied to some and not to others because of the nature of the illness? When the *Declaration of Independence* states as unalienable rights "life, liberty and the pursuit of happiness," how can they be enjoyed when an illness imposes a limit that can now be removed by treatment, if only one could get it.

The Picnic for Parity is one of many efforts to bring fairness and parity to those suffering from mental illness. In New York State, it will be held on May 26th 2000, in New York City (Bryant Park), Albany, Buffalo, Binghamton, Rockland County, and Long Island. Other sites are expected to join as well. Please come and join us at the various sites to let your voice be heard. Further details can be obtained by contacting the National Picnic for Parity Inc. at 212-989-8460. ■

## You're Invited

***Join your colleagues at the Picnic For Parity***

***May 26, 2000***
***Bryant Park***
***New York City***

***For more details and other locations and dates, contact Picnic for Parity Inc. at (212) 989-8460***

# Empire

Continued from page 8

in hospitals under the supervision of physicians.

- 90862 (Pharmacologic management) appears to be redefined as requiring minimal psychotherapy.
- M0064 is redefined downward from a level 2 to a level 1 service E/M equivalent.
- Patients with dementia may not be provided individual or family psychotherapy.

The policy is derived from a Model policy written by the Carrier Medical Directors Clinical Workgroup. There has been no prior input by APA or any branch of organized psychiatry. The only psychiatrist who serves as a Carrier medical director is Richard Baer, M.D., who may have had a large hand in the writing of the model policy. According to HCFA procedures, this policy will serve as the basis for all new Medicare policy in all states.

APA, through the Council on Healthcare Systems and Financing (Lloyd Sederer, M.D., Chair) is working on a strategy to improve the regulatory process and support the local MCAC psychiatrist members. I was recently appointed Chair of the APA Medicare Advisory Committee, which has a listserv, and is working to coordinate and educate the MCAC members in all states.

Clearly, NYSPA members have a lot of work to do. Please request a copy of the draft standards, or download them. Review them and send your comments, as soon as possible, to Seth Stein at NYSPA. Late comments will also be welcomed as these discussions will likely be prolonged and the comments can be included on the next round of talks. ■

# Confidentiality

Continued from page 1

The privacy protection proposal of the Clinton Administration and HHS is actually the opposite: an opening of previously confidential electronic information to a wide variety of individuals, organizations, government and insurers. Key protections are not provided including no requirement for an individuals personal consent before information is transmitted for broadly defined health payment and "operations" purposes; no significant safeguards for psychotherapy notes; no audit trails showing where information has been sent; decreased protection for use and disclosure in judicial proceedings.

In addition, language in the regulations, while decreasing patient privacy in general, increases physician liability for breaches of confidentiality. Poorly written language, could, for example, leave a physician liable for the absolute confidentiality of any and all faxed information.

While a deadline for comments on the new regulations is February 17, 2000, it is quite likely that the battle to modify these regulations will continue throughout the year. You can access the latest update on privacy issues and recommended actions at the APA website <www.psych.org>, (click on Public Policy Advocacy and also "Action Alerts").


■

ONE-TO-ONE

# An Unexpected Teacher

By Gabriel Laury, M.D.

*Dr. Laury is a psychiatrist at the FDR VA Hospital in Montrose, NY, and is 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 immaculate 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 distinguished on him and Clark Gable. Warmth, friendliness and honesty exude from his large dark eyes. Deep and melodious is his voice. His elongated hands seem to belong to an artist. Dressed with taste, he manages to look classy even when wearing the used clothes handed out in a public facility.

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

[See **Teacher** on page 6]

## JOB FAIR 2000!

NYSPA's Early Career Psychiatrists Committee announces Job Fair 2000, a chance to explore opportunities in psychiatry within New York State, the U.S. and overseas. ***Admission is free!*** Refreshments will be served.

**Saturday, March 25**
**12:00 noon - 3:00 p.m.**

Place: LaGuardia Marriott, East Elmhurst, NY

RSVP: (516) 542-0077 • E-Mail: nyspamd@idt.net



NYSPA ALERT!

# Redefining Psychotherapy as a Treatment for Only a Few Conditions

By Edward Gordon, M.D., NYSPA Past President

Empire 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 characteristics 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.
- Permitted 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 adjunctive 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]

### Download & Read the Proposal!

*NYSPA has made Empire's proposal available on the NYSPA web site. Download the entire draft (available in Microsoft Word format) at:*

*www.nyspsych.org*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