THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

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President's Message: Transparency of Clinical Research

By Barry Perlman, M.D.

Barry Perlman, M.D.

Occasionally there are critical events which crystallize an issue and set off a cascade of events which propels change. Such was the case when Eliot Spitzer, the NYS Attorney General sued GlaxoSmith-Kline under consumer fraud statutes for concealing clinical data relevant to the prescribing of Paxil, an antidepressant, for children. NYSPA was proud to be asked to be part of the process by which the AG conveyed information about the suit to the press. No professional society other than NYSPA participated and our press statement was linked to Spitzer's press release on the AG's Web site. (Please see "NYSPA Responds to NYS Lawsuit Against GlaxoSmithKline" in the Summer 2004 issue of NYSPA's The Bulletin.) While NYSPA did not endorse the merit of the suit, we firmly endorsed the need for transparency of clinical research findings as a necessary condition for the ethical and efficacious practice of psychiatry and all medicine.

Within days of the announcement of Spitzer's action, newspaper articles announced an astounding series of "aftershocks." The A.M.A. adopted a resolution, with the strong support of the psychiatric delegates to the House of Delegates, calling for the creation of a database of all clinical drug trials undertaken in this country. The editors of several prestigious medical journals, members of the International Committee of Medical Journal Editors, announced that they were considering a requirement that pharmaceutical companies register clinical drug trials at their inception as a precondition to their publication in the journals. Leading Democratic Senators were said to be considering legislation which would require the creation of a national database in which trials would be registered and the results of which would be publicly available. Remarkably, a major pharmaceutical company, Merck, announced support for the creation of a federally supported drug trial database.

The need for effective responses is as important to us as it is to those we treat. The bedrock foundation of our relation with our patients is trust. As psychiatrists and physicians we must be able to be able to rely on the clinical data available to us when we read the professional literature

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Medicare Agrees to Reverse Reimbursement Disallowance Made in Violation of HIPAA Rules

By Rachel A. Fernbach, Esq., NYSPA Staff Attorney

Because of the vigilance and persistence of one New York psychiatrist, Medicare auditors across the country will now comply with federal HIPAA privacy protections for psychotherapy notes. Ann-Marie Paley, M.D., a NYSPA member practicing in Queens County, had been randomly selected to participate in the Medicare Comprehensive Error Rate Testing program (CERT). The CERT program is a nationwide effort by the Medicare program to detect billing errors by reviewing patient records to determine whether the records support the claim paid by Medicare. Medicare has contracted with various private medical review companies to conduct these random audits of all medical services provided under the Medicare program throughout the country.

Dr. Paley was asked to provide patient records for one patient on two different dates of service. In response, she provided certain portions of the medical records to the CERT contractor, but refused to provide portions of the records containing separately maintained psychotherapy note material. Dr. Paley correctly asserted that, under HIPAA, psychotherapy notes may be disclosed only pursuant to a written patient authorization and Medicare did not provide any such patient authorization.

When Dr. Paley refused to submit the psychotherapy note portion of the records to Medicare for review in connection with the CERT audit, the claims were disallowed and the Medicare carrier recouped the payments. After Dr. Paley contacted Seth Stein at the NYSPA office, Mr. Stein sent a letter to the GHI Medical Director explaining that the demand for repayment in Dr. Paley's case was improper and in violation of the federal HIPAA Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule").

Mr. Stein explained that the Privacy Rule applies to all health plans, health care clearinghouses and health care providers who transmit personal health information electronically. Medicare Part B is a health plan that is subject to HIPAA and the Privacy Rule because it is specifically listed in the Privacy Rule's definition of the term "health plan."

In general, under the Privacy Rule, person-

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Albany Report

By Richard J. Gallo and Karin L. Moran, MSW

Medicare/Medicaid Crossover

Late in the evening on Wednesday, August 11, the New York State Legislature hammered out the final details of the $101 billion State budget for Fiscal Year 2004-05. This was the latest budget enacted in state history. The completed fiscal plan added $1.2 billion to Governor Pataki's proposed budget and is likely to undergo a number of vetoes as it was, in large part, negotiated without his input. Of particular interest to psychiatrists is the inclusion of a $2.5 million member item initiated by Senate Majority Leader Joseph Bruno, in an effort to partially restore last year's Crossover cut. Despite the fact that none of the budget drafts included any such restorative funding, NYSPA, along with the Medical Society for the State of New York (MSSNY), were able to secure this funding during the final hours of negotiations.

The additional funds will be available to physicians treating dually eligible patients during the first quarter of 2005. Information regarding access to these funds will be forthcoming as the final details are solidified. NYSPA is extremely grateful to Senator Bruno for his dedication and support on this vitally important issue.

Preferred Drug Program and Forge-proof Prescription Initiative

The Legislature rejected the Governor's proposed budget initiative to create a preferred drug list for the Medicaid program. While physicians generally were concerned with a proposal that would have required them to take extraordinary steps to assure that their Medicaid patients receive the most appropriate medications if such medications were not on the preferred drug list, the Governor's proposal, as well as separate but different versions in both houses, had varying degrees of exemptions for psychotropic medications.

On a related issue, the Legislature preserved the Governor's budget proposal to implement the use of forge-proof prescription forms for the writing of all prescriptions. The initiative, which is expected to be in place by April, 2006 will impose no new costs on physicians and will eliminate the current requirement that physicians purchase and use triplicate forms for prescribing controlled substances.

Timothy's Law

Mere words cannot convey the dedication and effort expended by so many in pursuit of a "two-house" agreement on health insurance parity for mental illness and chemical dependency (Timothy's Law). Our mission to achieve this end took numerous twists and turns throughout the 2004 legislative session. The year began with identical bills in both houses, which would have mandated comprehensive coverage for mental illness and chemical dependency (S.5329/A.8301 by Senator Libous, R-Binghamton and Paul Tonko, D-Amsterdam).

While the Assembly overwhelmingly passed A.8301, the Senate had grave concerns that the coverage provided in the language of the bill was too comprehensive and costly, despite actuarial projections to the contrary. Rather then abandon the issue as a result of those concerns, Senate Majority Leader Joe Bruno (R-Brunswick) and Senator Thomas Libous introduced S.7296, a significantly abridged version of the earlier bill. This bill: excluded employers with less then 50 employees; defined a narrow list of "biologically based" mental illnesses to be covered; conditioned coverage for children on a crisis threshold criterion; sunset within two years; and failed to include chemical dependency coverage. While

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Jed Foundation

By Liz Lipton, M.A.

After dealing with a tragedy, most people try to piece their life back together and move on. However, there are a small number of people who take a different tack: They courageously do whatever it takes to prevent others from having to face a similar tragedy.

Phillip and Donna Satow of Manhattan fall into the latter group. After their son, Jed, completed suicide at college, they founded the Jed Foundation <www.jedfoundation.org>, a nonprofit organization dedicated to reducing the suicide rate of college students and improving the mental health support provided by colleges and universities. Suicide is the second leading cause of death among college age students. And the Jed Foundation predicts that in 2004, alone, more than 1,000 college students will complete suicide.

In the four years since they began the Jed Foundation—the nation's first nonprofit group whose aim is to reduce suicide among college students-- the Satows have spearheaded a number of impressive initiatives including the following: <www.Ulifeline.org>, a comprehensive mental health Web site for college students that features a mental health screening program; a pilot suicide prevention program; and a checklist of mental health services that colleges should offer.

They also are in the process of gathering data on suicides and attempted suicides for their National College Registry Program, creating a model medical leave policy statement ensuring that college students who take a leave of absence for mental health reasons have the option of returning to their college, educating various college professionals such as clergy and athletic department staff about mental health issues, creating a freshman questionnaire that will help colleges identify students who have psychiatric disorders, and forming a group of influential college presidents who will bring attention and resources to this issue. The Satows work closely with the Jed Foundation's Board of Directors, Medical Advisory Board, and several prominent physicians who work as consultants.

Mr. Satow is giving the welcoming address at the Annual Jed Foundation Event at the Rainbow Room on June 7, 2004.

Mrs. Satow said, "Suicide is the second leading cause of death among college students, and more teenagers and young adults die from suicide than from all medical illnesses combined, yet it is very preventable. Before attempting suicide, four out of five young adults say and do things that indicate they are contemplating suicide. Unfortunately, the majority of students who completed suicide did not go for help at the [college's] counseling center. Today no young person needs to die by suicide because there are so many treatments that could be offered."

The Satows have devised a unique mechanism that encourages at risk students and others to go for help at their college's counseling center: After a student logs on to <wwwUlifeline.org>, a homepage appears that features a link directly to his or her college's health center or mental health center.

Currently, Ulifeline serves over two million students on 370 campuses including Harvard, University of Vermont, Tufts University, and MIT. In New York State, the colleges include NYU, Columbia, Fordham, City College (CUNY), Colgate University, Vassar, Columbia University, Cornell, New School University, and Bard. Ulifeline receives an average of 200,000 hits per month.

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


Jeffrey Borenstein, M.D.

This edition of the Bulletin highlights the efforts NYSPA is making on behalf of our patients and our profession as well as other initiatives to improve the quality of psychiatric care. The President's Message focuses on the issue of transparency in clinical trials and NYSPA's involvement with the NYS Attorney General's press release on this topic. The Albany Report summarizes results of the final budget and the status of other legislative initiatives. We also have reports from the Area II Trustee and the Speaker of the Assembly of APA.

We report on the successful efforts of an individual psychiatrist, with assistance from NYSPA, to protect the privacy of patient records in accordance with HIPAA regulations during a Medicare audit. We also report on a number of potential problem areas and issues with provider contracts sent by Magellan and NYSPA's efforts to resolve these issues. We have an article about the Jed Foundation and their work to increase awareness and treatment of psychiatric conditions and reduce suicides in colleges. We also have an article about the New York City Mental Health Coalition and their focus on mental health screening and education..

In addition, we have an article about the Medicaid Psychiatric Hospital Fairness Act and a report about the Medication Grant Program which is available in a number of counties in NYS for people who are waiting for Medicaid to become active. Finally, we have a list of 2004 contributors to the NYSPA PAC; the PAC is key to the continued success of NYSPA's advocacy for our patients and profession. ■

President's Message continued from page 1

published in peer reviewed journals or hear new data presented at psychiatric meetings. Without that confidence we cannot assure those for whom we prescribe of the soundness of our judgments. For these reasons it has been discomforting to learn that important clinical evidence may have been withheld when the outcomes of pharmaceutical company research weigh against the drug sales. Likewise, we are dismayed when pharmaceutical companies misrepresent claims about the safety of medications in promotional material. Unfortunately, when patients and their families learn that they have been deceived and even possibly endangered by taking medications purchased at considerable expense whose benefits may be marginal or non existent it breeds cynicism and distrust of not only the drug company but also the prescribing physician. It is clear that physicians, dependent as we are on a relation of trust with our patients, cannot tolerate deception to rend the whole cloth of the healthcare system.

As an editorial in the New England Journal of Medicine began, "For many years, the registration in a public data bank of all clinical trials – from start to completion and reporting of results – has seemed a quixotic quest of some academic researchers, medical-journal editors, and librarians." (2004; 345: 315-317) The possibility of a constructive resolution to a long recognized and simmering problem no longer seems "quixotic" in the wake of the AG's action. It is incumbent on all of us, whose primary concern is our ability to care for our patients to the best of our ability, to act in concert to assure that the current momentum is not dissipated. If this issue is allowed to disappear from our "radar screens" it would be at our peril and that of our patients and the bond which unites us. We must insist that APA and AMA continue to work vigorously towards the creation of a transparent clinical drug trial registry by letting members of the Congress know how important this matter is to our ability to provide quality health care to them, their families and their constituents. ■

Albany Report Continued from page 1

some of the members of the Timothy's Law Campaign (TLC) endorsed the introduction as a means to jump-start the negotiations, the bill itself, was not supported by TLC.

As the end of the 2004 session loomed, there seemed to be a forthcoming compromise. During the remaining days of the session, NYSPA continued its constant communication with key members of the Senate and the Assembly in an effort to bridge the gap between the two bills. In an attempt to address one of the Senate's central concerns, the Assembly modified its position introducing a new bill (A.11694), which maintained broad coverage for both mental illness and chemical dependency, but also included a tax credit for small businesses to help defray any cost of the new coverage. Unfortunately, during the final hours of the last night of the 2004 regular session, it was announced that all discussions (not exclusive to parity) between the Senate and the Assembly had collapsed. The end result of this breakdown was the passage of two "one house" parity bills.

Scope of Practice

Although the 2002 social work licensure bill has yet to go into effect, several attempts to broaden the agreed upon language were proposed under the guise of a "clean up" bill. These actions prompted both NYSPA and MSSNY to voice strong opposition to all but the technical changes that were agreed upon by all parties in 2002. We were successful in this endeavor with one exception.

Laying somewhere between a "technical correction" and "substantive change" was the matter of divestiture of existing corporate practices involving ownership by both social workers and non-social workers, in most instances with psychologists. The psychology licensing law does not prohibit multi-professional practices for psychologists, nor did the social work licensing statute prior to the enactment of the new social work licensure law. However, the 2002 changes to the social work licensing statute, as well as the law governing the licensing of the four new mental health professions, prohibit such interdisciplinary practices. Nonetheless, due to the number of such practices already in existence, there was some reluctance by the Legislature to mandate an immediate divesting of these groups on the effective date of the licensure law, September 1, 2004. Also, of concern to NYSPA was an attempt to allow new Limited Liability Corporations to form before the law was enacted.

NYSPA and MSSNY both met with key members of the Senate and Assembly in an effort to resolve this issue. Once proponents conceded that new practices would not be allowed to form, their next effort was to allow practices already in existence a ten-year window before they would be mandated to divest. After many hours of negotiations, NYSPA and MSSNY successfully shaved that number down to five.

Electro-Convulsive Therapy

NYSPA was again successful in holding back legislation targeting the use of ECT. Although the Governor vetoed ECT reporting legislation at the end of 2003, Assemblyman Peter Rivera (D-Bronx), Chair of the Assembly Mental Health Committee, reintroduced the package of four ECT related bills. The Senate for its part introduced only one bill on the subject of ECT (S.6954), that being a revised ECT reporting bill. The Assembly followed suit with the introduction of a companion bill (A.10170). This bill passed the Assembly in late June, but was never brought to the floor for a vote in the Senate. ■

APA Job Bank on NYSPA Website

The APA Job Bank is an interactive employment site which can be accessed directly from the home page of the NYSPA website. Psychiatrists looking for available positions will have the opportunity to search the site by discipline or geographic location or to post their CV's to the site. Employers interested in posting employment opportunities can do so through the NYSPA Central Office. NYSPA will receive royalties for all job posting contracts, provided that they are arranged through our site, so please encourage your colleagues to contact NYSPA if they are interested in posting a position.

To post a job opening on the APA Job Bank, or for additional information, contact the NYSPA Central Office by phone (516-542-0077) or by email (centraloffice@nyspsych.org).

New Office Space Classifieds Section on NYSPA Website

NYSPA has added a Classifieds section to their website which will enable professionals to search for available office space for sale or rent. To view or post an ad in the Classifieds section, both members and non-members can access the site by clicking the Classifieds link on the left side of the NYSPA home page and accepting the disclaimer. Ads must be paid, in advance, by credit card or check.

For additional information, please contact the NYSPA Central Office by phone (516-542-0077) or by email (centraloffice@nyspsych.org).

Magellan Sends Out New Provider Contracts By Rachel A. Fernbach, Esq., NYSPA Staff Attorney

NYSPA members enrolled in the Magellan network recently received a large packet from Magellan described as the "new Group Provider Participation Agreements." The packet included four contracts for the Magellan indemnity and HMO plans together with five addenda, two amendments, an EAP attestation and six reimbursement schedules.

NYSPA Central Office has received numerous telephone calls inquiring about this welter of agreements, addenda, amendments and schedules and asking about various provisions in the agreements. In response, Seth Stein, NYSPA Executive Director, prepared a memorandum identifying potential problem areas and issues in the contracts. A copy of the memo has been posted on the Members-Only Section of the NYSPA website (www.nyspsych.org). A letter was also sent to Magellan identifying ten areas of concern in the Magellan contracts.

The following key issues and problems were identified:

- Indemnification Requirements - All provider contracts include a provision that requires the provider to "defend, hold harmless and indemnify Magellan against any and all claims, liability, damages or judgments asserted against, imposed upon or incurred by Magellan that arise out of the acts or omissions of Provider or Provider's employees, agents or representatives in the discharge of its responsibilities under this Agreement." NYSPA asserted that this clause conflicts with transfer of liability provisions in New York Public Health Law §4905(14) for HMO contracts and New York Insurance Law §4905(n) for indemnity plans. In his letter to Magellan, Mr. Stein argued that the cost of defense in a lawsuit brought against Magellan alleging a claim that may ultimately be determined to be the sole responsibility of the psychiatrist is the type of claim that should be borne by Magellan, not the individual psychiatrist. In addition to this legal issue, psychiatrists are unable to obtain coverage for such contractual indemnification because the APA-endorsed professional liability insurance program does not cover contractual indemnification. Therefore, if members sign these contracts, they will be assuming the entire cost of the defense and indemnification of Magellan under this clause on their own without any insurance coverage. While the risk may be small, the potential financial exposure is significant.
- Insurance Requirements - The contracts require providers to maintain three types of insurance coverage: (i) professional liability; (ii) errors and omissions; and (iii) comprehensive general and/or umbrella liability. The APA-endorsed professional liability program does not include coverage for errors and omissions as a distinct category from professional liability. If psychiatrists are unable to secure this type of coverage, they will not be able to comply with this contractual obligation and should not sign the agreements. Mr. Stein requested that this requirement be deleted from all the contracts or, in the alternative, that NYSPA members be permitted to strike the clause from the contract before signing.
- HIPAA Privacy Rule - Another major concern regarding the Magellan agreements is that they fail to make reference to or incorporate any requirements of the federal HIPAA Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule"). The Privacy Rule went into effect on April 14, 2003, and applies to all health plans, health care clearinghouses and managed care companies such as Magellan. As a covered entity under HIPAA, Magellan must comply with all provisions of the Privacy Rule, including specifically, the minimum necessary requirement, the prohibition on conditioning authorizations and the special exception for separately maintained psychotherapy notes. Mr. Stein provided Magellan with guidance on these topics and requested that Magellan revise the agreements to incorporate HIPAA requirements and principles where appropriate.
- "Take it all or leave it all" - The cover letter from Magellan states that unless providers sign and return all of the enclosed contracts, the provider's group will no longer be eligible to provide services as an in-network provider, as of January 1, 2005. However, members should not be presented with a "take it all or leave it all" option.

Other issues raised with Magellan include the right of patients and providers to request external appeal under New York Public Health Law §4910 and New York Insurance Law §4910, clarification regarding billing for non-covered services, use of providers' names in Magellan promotional materials, requirements for retention of records under New York State Education Law §6530(32), and unilateral amendment of the agreements by Magellan.

NYSPA will provide members with regular updates on Magellan's response to the issues raised and how members should proceed with regard to execution of the contracts. In its cover letter, Magellan asks that the contracts be returned within two weeks of the postmarked date on the packet. However, the letter states if the signed contracts are not returned by December 17, 2004, the provider will no longer be eligible to participate as a network provider effective January 1, 2005. Therefore, it appears that there is sufficient time to permit Magellan to respond to the NYSPA comments and for psychiatrists to make an informed decision. ■

Jed Foundation Continued from page 1

Through the foundation's programs, they hope to prevent suicide among young adults and increase awareness of psychiatric disorders. This awareness, should, in turn, decrease the stigma associated with mental illness and lead to earlier recognition of psychiatric illnesses, including bipolar disorder, which, according to Mrs. Satow, manifests around ages 19 to 24 but usually is not diagnosed and treated until age 30.

Mrs. Satow explained how they thought of the idea for starting Ulifeline and the Jed Foundation: "My sons' friends felt if only they had known that Jed was suffering. They saw signs that, maybe, we as parents did not see, because young people tell their parents one thing and exhibit something else in school. His friends said that they had so much knowledge about other health issues like drinking and driving and safe sex, but they didn't even know the symptoms of bipolar disorder, suicidality, or depression—even though depression can affect as many as 15 to 20 percent of college age students. They thought it would be valuable if there was a Web site where all this information could be in one place. We believed that what they were saying was important, and we decided to create it." And shortly after deciding to do this, they started the Jed Foundation.

The Satows—she has retired as the Publisher of the Columbia College's alumni magazine Columbia College Today, and he is a Director of Forest Laboratories and a Director of Crucell, Inc., a publicly traded Dutch biotech company—work ceaselessly, as volunteers, on the foundation's programs: They give lectures, organize fundraisers, write information, provide information to colleges, and speak to the media. They are assisted by several non-paid interns and consultants including Ron Gibori, the Web site manager who was Jed's friend. "We are a very lean organization. We take all the money that we raise and put it directly into programs," said Mrs. Satow.

Ulifeline

While anonymously browsing Ulifeline, students can visit the mental health library, which features Harvard Medical School's consumer health information and is offered in cooperation with InteliHealth. Ulifeline also features a database of questions and answers concerning mental health issues called "Go Ask Alice," and an interactive mental health screening tool developed by Duke University that screens students for mental illness and determines if they are at risk for attempting suicide. Medical professionals have vetted the entire site. In the near future, the Web site will have a section where counselors can share information about their mental health programs with other counselors.

The Jed Foundation does not charge colleges to participate in Ulifeline. "If we charged money, it would be a self-selection process, and we don't want that to happen because our goal is to maximize the number of student who benefit from these initiatives," said Mrs. Satow.

The Jed Foundation's Web site

The Jed Foundation's Web site has a section for parents, which includes a comprehensive checklist of the essential mental health services that colleges should offer. The parents' section features links to each college's health center. Once there, they can use the checklist to review the center's offerings.

"I don't think many parents think about a college's mental health services. When a young person goes away to college, their support system is interrupted. And it's important to know what the school offers in case they [students] run into difficulties," said Mrs. Satow. She continued, "Also as parents become more knowledgeable, they will demand that schools offer better mental health services."

Suicide Prevention Program

As part of a partnership with Education Development Center, Inc., the Jed Foundation has started a suicide prevention program on six campuses: Cornell, Harvard, MIT, Yale, Columbia, and NYU. Mrs. Satow explained, "We have adapted the Air Force Model [of suicide prevention] for colleges. It is a comprehensive model for suicide prevention programs. …We are in the process of setting up a rigorous evaluation study [of the program]."

National College Suicide Registry

Mrs. Satow emphasized that it is very important to obtain accurate data on the number of suicides and attempted suicides at colleges. "This is difficult," she said, "because not all suicides are reported as such."

As part of their effort, they have developed a pilot program involving 12 colleges. These schools are sending the Jed Foundation copies of their mental health intake forms. The foundation's consultants will assimilate this information and create a model mental health intake form with a section on suicide attempts. The 12 schools will test this form and then collect data for themselves. They will also send this data to the Jed Foundation, which will build a national registry.

New York University

For the last three years, the Jed Foundation has been affiliated with New York University. NYU's main campus is in Manhattan, and 48,000 students attend the school.

Ernesto Ferran Jr., M.D., the Executive Director of N.Y.U.'s University Health Center, said, "About three years ago, we first met with the Jed Foundation, and we began talking with them about issues of college student depression and suicide prevention. During these discussions …, we were gathering information from them and learning from them. Then the University Counseling Service included a link [on the center's Web site] where students could visit Ulifeline."

Dr. Ferran, who is an adult and child and adolescent psychiatrist, continued, "During this past academic year when the NYU community coped with several student suicides and deaths, and well before the last death, we met with the Jed Foundation, and they provided us with a wealth of information that helped us during our process of self-study."

Also, this fall, information about the Jed Foundation will be available at wellness workshops held--for the first time ever--during new undergraduate and transfer students mandatory orientation.

Reflecting on their relationship, Dr. Ferran, said, "The thing that comes to mind vis-à-vis the Jed Foundation--and what they have done for us-- is that they gave us a great head start on benchmarking other university programs and the benchmarking approaches that exist in the general area of suicide prevention. This is helping us look at other aspects of students' academic experience including the education we want to give them on the personal and emotional issues important to them."

He continued, "Overall, it's been a long-standing relationship … that has gotten stronger and stronger during the past three years."

City College of the City University of New York

City College (CUNY) is also affiliated with Jed Foundation. Located in Manhattan, City College is a commuter school that 12,000 students attend. The college's Wellness and Counseling Center features a "Suicide Prevention" link. This link takes students to a Web page featuring information about the Jed Foundation and links to Ulifeline.

Pereta Rodriguez, CSW, DSW, the Director of City College's Wellness and Counseling Center, said, "I liked the way it [Ulifeline] was organized. I liked the fact that it was sensitive and … direct."

This fall, the campus will feature advertising about the Jed Foundation and the college's relationship with the organization. Additionally, the staff from the Wellness and Counseling Center's staff will be working with the Jed Foundation to offer mental health workshops for students and faculty, respectively. The latter workshops will help faculty identify psychiatric disorders, increase their sensitivity to mental health issues, and educate them about the importance of quickly referring students to the Center.

Although City College has only been affiliated with the Jed Foundation for three months, their alliance already saved one student's life. Dr. Rodriguez explained, "One of our students was at risk for committing suicide. The student went on the Jed Foundation's Web site and eventually made contact with someone at the Jed Foundation and that person called me. I immediately called the student, and I've been working with the student since that time.

"I would say it saved a life. To me that's a direct result and that speaks volumes about the Jed Foundation," said Dr. Rodriguez. ■

For more information, contact The Jed Foundation, 53 Broadway, New York, NY, 10012, (212) 343-0016.

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Medicaid Psychiatric Hospital Fairness Act of 2003

By Liz Lipton, M.A.

On October 22, 2003, identical versions of the Medicaid Psychiatric Hospital Fairness Act of 2003 were introduced in the House (H.R. 3363) by Representatives Jim McCrery (R-LA) and Tom Allen (D-ME), and in the Senate (S.1771) by Senators Olympia Snowe (R-ME) and Kent Conrad (D-ND). The American Psychiatric Association, NAMI, the National Association of County Behavioral Healthcare Directors, the American Hospital Association, and the National Association of Psychiatric Health Systems support this measure.

Marcia Goin, M.D., who at the time was the APA President, wrote an October 2003 letter on behalf of APA members to Senator Snowe supporting this proposed legislation. In it, Dr. Goin explained why this measure is needed:

"The Emergency Medical and Labor Treatment Act (EMTALA), which requires hospitals to stabilize patients in an emergency medical condition directly conflicts with the Medicaid Institution for Mental Diseases (IMD) exclusion. The IMD exclusion prevents non-public hospitals from receiving Medicaid reimbursement for Medicaid patients between the ages of 21-64 that have required stabilization as result of EMTALA regulations.

"Your legislation will allow non-public psychiatric hospitals to receive appropriate reimbursement for Medicaid beneficiaries between the ages of 21-64 who require emergency treatment and stabilization as required by EMTALA," she wrote.

According to Mark Covall, the Executive Director of National Association of Psychiatric Health Systems, which represents more than 300 non-public psychiatric hospitals and psychiatric units of general hospitals, "It [this legislation] will resolve an unintended and unfair conflict in federal law."

This act would provide greater access to emergency care for people with serious mental illness and "would relieve some of the growing uncompensated burden on these hospitals," said Mr. Covall.

This proposed legislation does not include state psychiatric hospitals. And general hospitals already receive this reimbursement.

Before providing the details of why the Medicaid Psychiatric Hospital Fairness Act of 2003 was proposed and how it would improve access to psychiatric acute care, here is some background information on the IMD exclusion.

IMD Exclusion

What exactly is the IMD exclusion? Mary Zdanowicz, J.D., Executive Director of the Treatment Advocacy Center (Arlington, VA), said, "According to the Medicaid statute, Medicaid will not cover individuals 21 to 64 years of age if they are in an Institution for Mental Disease. An IMD is a hospital, nursing facility, or other institution that has more than 16 beds which is primarily engaged in providing diagnosis, care, or treatment for persons with mental diseases, including medical attention, nursing care, or related services."

"This means that the state has to pay the entire cost of adult hospitalization in a state psychiatric hospital or private psychiatric hospital for Medicaid eligible patients; whereas, if these patients receive treatment in the community, Medicaid usually can be used to pay for some of their care," said Ms. Zdanowicz, noting that the TAC is in favor of repealing the IMD exclusion.

Lack of Acute Care; Logjam of Patients

Why is this proposed legislation needed? One reason is the lack of acute psychiatric care.

"From 1992 to 2000, the number of state mental hospitals declined by 29 percent, private psychiatric hospitals declined by 38 percent, and general hospital units declined by 14 percent," according to the NAPHS white paper, "Challenges Facing Behavioral Health Care."

"The reductions in facilities and beds have resulted in substantial increases in admissions to the remaining hospitals. According to a survey of members of the NAPHS, admissions per facility on average have increased 11 percent (from 2,113 in 2000 to 2,354 in 2001)," according to this white paper.

Keeping these trends in mind, it's not surprising that "the President's New Freedom Commission on Mental Health … identified the lack of acute care as a serious concern. The Commission noted that many communities are experiencing severe problems with access to short-term inpatient care—with some areas reporting that the shortage has risen to crisis proportions. The result is that many emergency rooms are overwhelmed with patients in extreme psychiatric distress who have nowhere to go," according to an NAPHS press release.

This lack of acute care is related to another problem: There is a logjam of psychiatric patients at some hospitals. In New York State, some NYSPA members have reported a logjam of psychiatric patients who are waiting to be transferred from voluntary and private hospitals to state psychiatric beds, according to Seth Stein, NYSPA's Executive Director and General Counsel.

Mr. Stein said, "There is no short answer to this problem. … The voluntary hospitals are asked only to do acute care. To have enough beds to fulfill that mission, they have to be able to move people-- who no longer need acute care but require continued hospitalization--out of their beds and into state beds. If they can't do this, the system will break down."

Asked about this logjam, Mr. Covall replied, "The logjam in general hospital and psychiatric hospitals due to state mental hospital closings … is occurring in many communities across the United States. The factors affecting this logjam are that the supply of inpatient psychiatric beds in voluntary and private psychiatric hospitals over the last decade has declined, while the number of patients seeking services in these settings has increased—i.e. patients that used to receive care in state mental hospitals are now in the community and more people are seeking mental health services than a decade ago."

Mr. Covall explained why this influx of patients created difficulties for private psychiatric hospitals: "The problem with more emergency patients coming to private psychiatric hospitals is that many of these patients have no insurance or they are adult Medicaid patients for which the hospital can not get paid because of the IMD exclusion."

He continued, "If uncompensated care continues to increase due to more Medicaid adult patients being cared for in private psychiatric hospitals, these hospitals will be forced to close or downsize. … And if more hospitals close their doors then the problem will get much worse."

The Medicaid Psychiatric Hospital Fairness Act of 2003

Mr. Covall explained how the Medicaid Psychiatric Hospital Fairness Act of 2003 would affect these problems. "Our legislation would at least allow for the private psychiatric hospitals to receive reimbursement for these Medicaid adult patients. … Also, if hospitals are stable financially then they may be able to expand their capacity to meet the growing demand for inpatient psychiatric services in certain communities," he said.

Consequently, this proposed act would improve access to acute psychiatric care: "This legislation would be a way to make sure that these patients had access to emergency psychiatric services in private hospitals and [therefore] ease the logjam for emergency departments in general hospitals," said Mr. Covall.

History of the IMD Exclusion

Mr. Stein provided information on the history of the IMD exclusion, which is part of the original Medicaid law enacted in 1965. "The IMD exclusion in the Medicaid program was intended to prevent Medicaid funds from being used to finance the cost of state psychiatric hospitals in states such as New York that had large psychiatric hospital systems with thousands of patients.

"When the Medicaid law was being considered in Congress, the IMD exclusion was added to prevent millions of federal dollars from flowing into states with large state psychiatric systems to offset the costs of those services."

He continued, "Without the IMD exclusion, this expense [state psychiatric hospitals]--which the state was shouldering on its own--would automatically have become a 50 percent Medicaid-aided expense. Therefore, the IMD exclusion was inserted specifically to avoid what was characterized as cost shifting."

Mr. Stein explained the overall effect of the IMD exclusion: "It essentially cut off the state psychiatric hospital systems from the Medicaid program. And that is what it was intended to do. It was not a policy decision based on any medical considerations. It was a political decision and a financial decision. It was part of the political compromise that got the Medicaid program enacted into law."

Asked about the role that the IMD exclusion played in deinstitutionalization, Mr. Stein replied, "Clearly, the IMD exclusion, which eliminated Medicaid reimbursement [for adults age 21 to 64], was a factor in closures because the state was saving 100% state dollars, but it was not a direct cause."

He continued, "It made deinstitutionalization easier to sell to government because it was reducing its costs. This was particularly true in the early days of deinstitutionalization because the dollars that were saved were not reinvested in community services."

He continued, "It made the state look at state psychiatric beds differently … than they would have looked at them if 50 percent of the cost had been paid by Medicaid." ■

Links to information about the IMD exclusion

1. NAMI's Paper: "IMD Exclusion: Implications of Repeal" <http://www.nami.org/Content/ContentGroups/E-News/20013/February_20012/IMD_Exclusion__Implications_of_Repeal.htm>
2. Treatment Advocacy Center's Main Web page on the IMD exclusion <http://www.psychlaws.org/HospitalClosure/Index.htm>
3. "An Analysis of the Medicaid IMD Exclusion," by Sara Rosenbaum JD; Joel Teitelbaum, JD, LLM; and D. Richard Mauery, MPH, DrPH (Cand.), December 19, 2002 <http://www.gwhealthpolicy.org/downloads/behavioral_health/reports/IMD%20Report%201202.pdf >
4. NAPHS Executive Summary: <http://www.naphs.org/WhatsNew/documents/ExecutiveSummary3.pdf>

New York City Mental Health Coalition

by Michael M. Scimeca, M.D.

The New York City Mental Health Coalition was formed over ten years ago in an effort to bring together key local and national organizations committed to lessoning the stigma attached to mental illness, raising awareness about the prevalence of mental disorders across the life span, and encouraging and aiding individuals and families to access mental health and substance abuse services. The coalition, which meets bimonthly, is co-chaired by Rachelle Kammer, Ph.D. of the Mental Health Association of New York City and Michael M. Scimeca, M.D., New York State Psychiatric Association Representative from the Bronx District Branch of the APA.

In addition to the APA and MHA of NYC involvement, the coalition comprises a diverse membership of over 35 organizations committed to disseminating information about mental health and mental illness and encouraging early identification and treatment of mental health and substance abuse problems. Other member organizations include the New York City Department of Health and Mental Hygiene, the New York City Department of Education, the Black Nurses Association, the American Public Health Association, the National Alliance for the Mentally Ill, The New York City Department for the Aging, Columbia University TeenScreen, Freedom from Fear, the American Foundation for Suicide Prevention, and the New York Public Library.

One of the primary areas of focus is mental health screening and education. Each year members of the New York City Mental Health Coalition coordinate citywide screening efforts in tandem with national events. Our key screening days include National Depression Screening Day in October, Child and Adolescent Depression Screening Day and Anxiety Disorders Screening Day in May and National Alcohol Screening Day in April. We also coordinate year-round mental health screening for youth and older adults. In the last two years alone we have screened over 1,500 teens in NYC Public Schools for a variety of problems including depression, OCD, Panic Disorder, PTSD, and substance abuse disorders. We identified students whose scores demonstrated a need for services, and connected them to treatment.

Collaboration and a clear mission are key to our success. The coalition helps us to coordinate our local efforts to expand and deepen our reach and impact. For instance, coalition members have teamed to bring art therapists into the New York City Department of Education. We also worked to present the American Foundation for Suicide Prevention's Suicide Awareness video to educate more than 3,000 NYC teens about getting help for depression. Professionals from several organizations taught more than 200 older adults who serve as mentors in senior centers throughout New York City, to understand depression and substance abuse problems in their peers. And we reminded all audiences that they can easily find assistance through MHA of NYC's 1-800-LIFENET 24/7 helpline. In addition, we brought training to New York Public Library staff to help them assist individuals with mental illness, using empathy and understanding. The coalition also coordinated a series of puppet shows, performed by teens throughout the City, to educate children and their caregivers about depression, ADHD and other mental health concerns of youth, as part of Children's Mental Health Month in May.

We welcome organizations that share our vision of a New York community that is well- informed about mental illness and mental health and better prepared to respond to these needs. For further information about joining the NYC Mental Health Coalition, please contact Rachelle Kammer at 212-614-6311 or at rkammer@mhaofnyc.org ■

AREA II TRUSTEE'S REPORT: Board Meeting June 2004 by Ann Sullivan, M.D.

Ann Sullivan, M.D.

As your Area II Trustee, I've been privileged to represent you on a number of key issues for the APA at the June Board Meeting. Our fiscal strength is strong, but there are many battles to be fought for our patients and our profession that are long term and need your ongoing support. Some of those battles, including our gains and our losses are outlined below.

ADVOCACY

Unfortunately, psychologist prescribing is now law in two states: New Mexico and Louisiana. It is an ongoing challenge to convince the politicians and the public of the danger to patients of these programs. The APA is mobilizing, with the AMA and State Medical Societies to defeat legislation that is currently being proposed in over ten more states! Our dues have been well spent in limiting this practice to these two states but the struggle is far from over. We have been successful in New York, with a proactive NYSPA, in preventing, in fact making illegal, psychologist's prescribing. Our continued support, including dollars, is necessary to prevent psychologist prescribing legislation in additional states! In addition, the Legislative Institute will be reinstated for next year, to further this and other advocacy efforts.

The APA has also been extremely active in numerous national and state forums on the Medicaid reductions in service that are occurring in states nationwide. A national communications and public affairs campaign has been undertaken with NAMI and NMHA to advocate for access to publicly funded programs such as Medicaid, including recent media coverage in the Los Angeles Times and US News and World Report.

On the national level the Department of Government Relations has been active in promoting legislation critical to us and our patients. Key legislation includes reduction in the Medicare 50% co- pay, a bill to prevent discrimination based on an individual's genetic profile and family history, legislation to protect a school's ability to discuss with parents a child's emotional difficulties and especially parity legislation through The Mental Health Equitable Treatment Act!

The APA continues to be a major force in shaping the Prospective Payment System for Psychiatric Inpatient Services. This is critical, as a reduction in funding for inpatient services would cripple our service system.

Last but not least, a task force to put into practice the Vision for a Mental Health System passed by the Board and Assembly is active in developing a practical and effective plan. Critical to this vision is real access to adequately funded quality services, including managed care, and public and community services. As a member of the task force, I hope we will have a work product for you to review in the Spring.

FISCAL

The APA has become increasingly financially stable over the past few years. It is projected that this year there will be a 3 million dollar surplus of revenue over expenses in 2004. This is due primarily to increased publishing sales, increased annual meeting revenue, a slight increase in membership dues and a decrease in national operating expenses. The financial oversite committee and the board, with Dr. Scully as the Medical director and Terri Swetnam as the CFO, have kept the finances transparent and on track!

It is currently proposed that the majority of the surplus will again be placed in the reserves as we still have less than a quarter of the 20 million dollars recommended for the Associations reserves. It is expected that the budget will again allocate at least $380,000 for district branch needs, as was allocated this year. The board also approved a merit pool for staff not to exceed $475,000 to be funded from the surplus. This is the first significant merit increase in several years. The Board will also be discussing in October the further diversification of our investments. There has been a recommendation that a small percentage of the investments be in hedge funds, a much riskier and a blind portfolio. While such investments are currently shown to have a good return, placing any assets in a relatively high-risk venture may not be wise. We would also be blind to the actual investments- the nature of hedge funds-which leaves a question as to our policy of non investment in certain enterprises. Let me know your thoughts!

A complete budgetary plan for 2005 will be approved in October. There is a cautionary note however, as the net revenue projections for the annual meeting in Atlanta next year are lower than for this year's meeting in New York. Still not time to celebrate yet!!

MEMBERSHIP

The good news is a small but steady increase in the number of active members in the APA!! Thanks to each of you for your efforts at recruitment, and continue to encourage colleagues to join!

The previous controversy with Washington State DB and the Texas DB about de-linking membership from the national APA has been successfully resolved with Washington State, but is still an issue with Texas. The Board is awaiting a response from Texas as to what the practical issues of their newly proposed "affiliate" include, other than the ability to be a member without paying national dues. Area II has remained opposed to such strategies, which resulted in overall loss of membership to the AMA and other societies that have chosen such a path.

The Association Management Information System is being implemented! The system should enable improved membership processing and communication with members. It is critical that the DB's be actively involved in the implementation, and all DB execs will be invited to join conference calls in the fall about the system and its implementation. Herb Peyser, myself, Rosie Landy and Linda Majowka are members of the Task force, so Area II is well represented. But now is the time for all the DB Execs to become involved!

Finally, the monies allocated for District Branch needs ($380,000) should be distributed this fall. A proposal for requesting funds will be sent to the DB's in the fall, and requests can include infrastructure needs and special projects such as membership recruitment, public affairs and advocacy. This is an opportunity to put our creative ideas into practice!!

OTHER BOARD ACTIONS INCLUDED:

*A proposal by the APA to the National Institutes of Mental Health to assume publication of the Schizophrenia Bulletin in 2005.

*Approval of the Practice Guidelines for the Assessment and Treatment of Patients with Post- Traumatic Stress Disorder and Acute Stress Disorder.

*Approval for the APA to join an amicus brief in the Supreme Court Case of Roger vs. Simmons, supporting the position that the Constitution's ban on cruel and unusual punishment forbids the execution of offenders who committed their crimes at the age of 16 or 17.

Hope you had a great summer and it should be an interesting and productive year! Once again, let me know your comments, ideas and suggestions! 718-334-3536 or ann.sullivan@mssm.edu ■

Ann Sullivan, MD
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Speaker of the Assembly of the APA By James Nininger, M.D.

James Nininger, M.D.

I am honored to have been elected to serve as Speaker of the Assembly of the APA and am particularly proud to hail from Area II where I had valuable experience as your NSYPA President from 1998 to 2002. NYSPA is in capable hands under the leadership of Dr. Barry Perlman who is served by an excellent body of officers and council members. This paper has chronicled a continuing array of significant contributions by NYSPA benefitting the practitioners and patients in our state. Our lobbyist, Richard Gallo, and our Executive Director of more than 20 years, Seth Stein, remain abreast of legislative issues, and Seth has made important contributions also on a national level, working in tandem with APA in Washington on several important initiatives.

The Speaker serves as a voting member on the Board of Trustees, as a member of their Executive Board, on the Budget and Finance Committee, and attends meetings at the other six Areas across the country during the year. New York is also well represented in the Assembly by its Recorder, Michael Blumenfield of the Westchester DB, and by its parliamentarian, Ed Hanin, of the New York County DB and himself a Past Speaker. I am additionally provided excellent counsel by our Area Trustee, Ann Sullivan and our prior Area Trustee, Herb Peyser.

I would like to take this opportunity to provide a brief review of the Assembly's history and function and then mention some of my goals for the Assembly for the coming year.

The Assembly, with representatives from all district branches of our association, is meant to debate and represent the concerns of you, the members, and to generate action papers for approval and action by the Board of Trustees on the full range of issues facing psychiatrists today. Any APA member can propose an action paper for his or her representative to bring forward for consideration by the Assembly. Consultation from relevant components on action papers is encouraged, and Assembly members are broadly represented on APA councils and committees to facilitate the process. The Assembly meets just before each annual meeting and again each November. The seven area councils additionally meet at least once before each Assembly meeting.

In 1952, from an interest of district branch members to have their representatives begin to influence the direction of the association, the bylaws of the association were changed to create an Assembly of District Branches. In 1953, the Assembly represented 16 district branches and 8,000 members. Representation for the first 25 years was entirely geographic. Then in 1978, minority/underrepresented groups gained representation, and 10 years later members-in-training were added. In 1994, a district branch with Assembly representatives from the uniformed services was organized, and in 1996 early-career psychiatrists joined. Over the next several years, other psychiatric organizations, especially those representing subspecialties, were encouraged to provide non-voting liaisons, and now 17 "allied organizations" are represented in the Assembly, and each has a vote. There have been many discussions about the optimal size and representational structure of the Assembly, and currently each district branch has at least one voting representative, and larger district branches have one voting representative for every 450 voting members or portion thereof (e.g., a district branch of 1,100 would have three voting representatives). Currently, three states (California, New York, and Missouri) have more than one district branch. Geographical area councils were formed shortly after the Assembly was constituted (originally five, now seven) and the areas gradually began to meet between Assembly meetings.

This past year the Assembly devoted a plenary session to the topic of access to treatment, and as part of that focus my Speaker-Elect forum addressed "Treatment of Mental Illness in Jails and Prisons" with a panel including our President, Dr. Marcia Goin, who subsequently convened a summit in Washington, D.C., that involved key advisory groups and experts and addressed delivery of care to this population. A working resource document has been developed to raise public awareness and educate policy makers at local, state, and federal levels. At least 2500 of our state's approximately 8000 people with mental illness in jails and prisons are in the New York City prison system, making Rikers Island, de facto, the state's largest psychiatric facility!

The Assembly is urging financial and organizational help to district branches needing assistance in funding their infrastructure, recruiting and maintaining members, and fighting legislative battles such as attaining nondiscriminatory insurance coverage for mental illness and substance abuse and preventing prescription privileges for psychologists.

Though the role of the Assembly is to advise the Board of Trustees, its approved action papers and initiatives can have a profound effect on influencing APA policy and direction. The Assembly was instrumental in increasing definition of and attention to our organizational priorities, increasing fiscal oversight and open communication regarding our activities, and improving collaboration and coordination among the Assembly, the councils and components, and our Board.

In the coming year, I would like to maintain the focus of the Assembly on actions that improve access to treatment for our patients and that facilitate education of our members in legislative advocacy and public relations. I plan to hold a focused plenary at the fall Assembly meeting on workforce issues in psychiatry, including the use of telemedicine and the provision of care to our patients in rural areas.

Assembly members volunteer much time and work hard for our members and patients. Our representatives need to have a high profile and to be better utilized by our members. We need to create a culture where all psychiatrists contribute time and/or funds as they are able, to achieve these strategic goals of providing the best possible care for our patients.

I look forward to working with you in the coming year as your Speaker, and I urge members to be in touch with me and your district branch Assembly representatives. Call them for information or to initiate an action paper. ■

James Nininger

MEDICATION GRANT PROGRAM By Liz Lipton, M.A.

In Oneida County, this used to be a common scenario: "People with serious mental illness would get out of the hospital or jail, and they would have to wait for their Medicaid to kick in—which is on average 4 to 6 weeks. They would go that length of time without their medication, and, more often than not—because their mental health deteriorated--they would end up recommitting a crime or end up back in the psychiatric unit of the hospital," said Deborah Gibbs, a Principal Clerk for Oneida County and the Principal Clerk for the Oneida County Department of Mental Health.

This is less likely to occur now. Why?

One key reason is that Oneida County participates in NYS OMH's Medication Grant Program. Via this program, New York State provides grants to participating counties, which, in turn, purchase psychiatric medications and other services needed to prescribe and administer medication. (This includes psychiatric visits related to prescribing or administering medication.)

Counties who elect to participate provide medication grant cards to eligible individuals. These cards can be used to obtain medications and these services while they wait for their Medicaid determination. Currently, 3,800 pharmacies in NYS participate in the program. There is no co-pay. After their Medicaid eligibility is determined, they are disenrolled from the Medication Grant Program.

"The Medication Grant Program was established as part of Kendra's Law. And the legislation established its funding," said Robyn Katz, NYS OMH's Director of Field Services in the Division of Community Care Systems Management. Ms. Katz, who manages the Medication Grant Program for OMH, emphasized that each participating county administers the program themselves.

"The goal of the program is to ensure that individuals who require psychotropic medication have access to those medications while they are pending a Medicaid eligibility determination," said Ms. Katz.

Currently, 35 out of 62 counties have chosen to participate. And approximately 11,000 individuals have used medication grant cards since the program started on September 5, 2000. Over half the participants are from New York City. Other counties with a large number of participants include Westchester County, Suffolk County, Erie County, and Oneida County.

Ms. Katz explained, "When we initially rolled the program out, our first priority was to get the jails and prisons to participate because that is where we perceived the greatest problem to be. That's the place where people were most likely to be … eligible for Medicaid but are not currently active for Medicaid because their Medicaid is deactivated while they are incarcerated."

Reflecting on the feedback she has received from county officials and others, Ms. Katz said, "I think it [the Medication Grant Program] has been very successful. We have gotten testimonials from a number of counties that think this is one of the best things the state ever did. It does address a very real need."

Ms. Gibbs agreed. "I can not imagine not having this program. I can't imagine the faces of the people if they didn't have this program—how they would react, what would happen to them. I think it is a wonderful human interest program," she said.

She added, "I'm sure that the fact the individual does not decompensate as a result of receiving their medicine has a direct relationship to them not returning to the ER or jail."

Ms. Gibbs noted, "The whole reason the program even came to our county was because of the awareness of our mental health commissioner, Phil Endress, CSW, ACSW, MBA, in addressing this issue and the needs of these people to get their medications. He believes it's an opportunity to enhance the lives of individuals."

Basic Information

The enrollment process is slightly different for individuals leaving prisons, jails, or hospitals. Basically, designated employees from the county, jail, prison, or hospital assist these individuals in completing and submitting their Medicaid application and their one-page Medication Grant Program application.

Who is eligible for the Medication Grant Program? According to Ms. Katz, individuals must meet the following criteria:

- They must be about to be discharged from a hospital inpatient unit or released from jail or prison.
- A designated employee, who helped the individual fill out a MGP enrollment form, must sign it, thereby, verifying that they believe the person is Medicaid eligible.
- The individual's Medicaid application and MGP form must be submitted to the county Department of Mental Hygiene prior to or within seven days of leaving the jail, prison, or hospital.

Once the county has received the MGP application, it is forwarded to First Health, the Pharmacy Benefit Manager that OMH contracted with to help the counties administer the program. First Health enrolls the individual and then notifies the county. The county provides the individual with a medication grant card.

In Oneida County, the whole enrollment process takes just several minutes. Ms. Gibbs explained, "I complete my portion of the paperwork which takes a few minutes and fax the application to First Health, and then they fax it back to me within a couple of minutes. Finally, I type up the card, which is only four lines."

She continued, "All recipients either have their card before they are discharged or released or shortly afterwards. After patients are discharged from the hospital, they come here and pick up the card. With inmates, usually the transitional case manager from the jail will come here and pick up the card. That way the inmates have their card upon their release, which most often occurs at midnight."

Outcomes: Oneida County

When asked about measuring the program's success, Ms. Katz emphasized that the Medication Grant Program, alone, does not prevent people from being rehospitalized or reincarcerated. "Having the medication grant card is very helpful, but it ... isn't sufficient to address recidivism. The program is a piece of an effort to stop this [individuals cycling in and out of jail, prison, or the hospital]," she said.

For example, Ms. Katz pointed out that another piece of this effort is a provision in Kendra's Law that provides funding to counties for jail-based case managers. "These managers help people who are being released from jail by linking them to community services, helping them

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al health information may be used or disclosed without specific patient permission for treatment, payment or health care operations purposes. Clearly, a CERT review falls under the category of health care operations. However, under the Rule, *psychotherapy notes* are treated differently from other types of health information. Psychotherapy notes may be not be used or disclosed under any circumstances unless accompanied by the prior written authorization of the person who is the subject of the notes. The authorization of the patient must be a HIPAA-compliant authorization and must include specific details about the information to be released, the name of the person receiving the information and an expiration date or event, among other things.

The Privacy Rule defines psychotherapy notes as: "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical record." The definition excludes the following: "medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date."

For a CERT audit, non-psychotherapy note material may be released under HIPAA without specific patient authorization because it falls under the category of health care operations. In contrast, separately maintained psychotherapy note material may be released only pursuant to a valid HIPAA authorization signed by the patient.

In addition, it is important to note that health plans, managed care companies, Medicare carriers and CERT contractors are all covered by HIPAA and are prohibited from conditioning the provision of treatment or payment on the provision of an authorization by the patient in question. In other words, health plans and Medicare may not withhold payment for treatment or take any adverse action in the event a patient refuses to sign an authorization for the release of separately maintained psychotherapy notes.

NYSPA also contacted the APA Office of Healthcare Systems and Financing to request its assistance in raising the issue with the federal Centers for Medicare & Medicaid Services (CMS). It was evident that CERT contractors were unaware of the HIPAA privacy protections for psychotherapy notes and unaware that HIPAA applied to Medicare and Medicare contractors.

As a result of APA efforts, CMS officials agreed to send an e-mail message to all CERT contractors and local Medicare carriers to instruct them not to deny claims solely on the basis that the provider refused to provide separately maintained psychotherapy notes. CMS also agreed that within the next three months it would issue a manual instruction to the same effect.

The GHI Medicare has agreed to reverse the disallowance issued against Dr. Paley and refund her the sum in question. The action of one psychiatrist has resulted in greater privacy protection for all Medicare beneficiaries. Please contact NYSPA Central Office if you are experiencing or have experienced a similar problem with Medicare or any other health plan regarding the disclosure of separately maintained psychotherapy notes. ■

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process their Medicaid application and their application for benefits, and helping them get their medication grant card," she said.

With that caveat in mind, here is information about some outcomes related to the program. In Oneida County, Ms. Gibbs has tracked the number of individuals who have reactivated their card a second time. This means of course that they have been reincarcerated or rehospitalized. According to Ms. Gibbs' data, Oneida County projects that 444 individuals will have enrolled from 2000 through the end of 2004. Twenty-nine individuals have reactivated their card since the program began. No one has reactivated more than once.

Ms. Gibbs offered some additional results: If instead of participating in the MGP, an individual had wound up rehospitalized for a week or incarcerated for an extended period of time, the annual estimated average cost would be $6,763. On the other hand, in Oneida County, the state's annual average cost for an individual to participate in the Medication Grant Program is $500. This is an overall savings of $6,263 per individual.

Ms. Gibbs projects that in 2004, alone, 160 individuals will have participated. Of these about 6 percent (N=10) will end up reactivating their card. The overall estimated annual savings for these 150 individuals (150 x $6,263) will be $939,450.

Outcomes: OMH

Ms. Katz said that OMH expects to recoup most of the program's medication cost from Medicaid. Ms. Katz explained, "At least 70 percent of the people who get a medication grant card eventually do get full Medicaid benefits. The cost of their medications supplied through MGP can then be recovered from Medicaid."

Non-Participating Counties

When asked about counties that don't participate in the program, Ms. Katz replied, "Some counties choose not to participate because they already have money allocated to provide medication coverage to individuals. There are other ways of getting people access to medication. In some cases, it's the treatment provider who absorbs the cost, there are scholarships that drug companies give, and there are other mechanisms. In addition, some non-participating counties have worked out agreements with their local social services departments to process Medicaid applications before individuals are released from jail or prison." ■

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