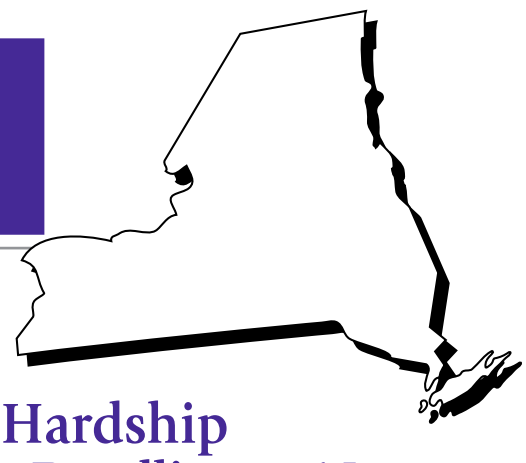
THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

2011, Vol. 55, #3 • Bringing New York State Psychiatrists Together



President's Message

By Glenn Martin, M.D.

Glenn Martin, MD

One of the challenges of a membership organization is trying to assure that the needs and desires of the membership are heard and help guide the organization. NYSPA uses a committee structure focused on obvious areas of interest (e.g., legislation, child and adolescent psychiatry, public psychiatry, etc.) and a system of representatives from the district branches who meet as a Council twice yearly to try to accomplish that goal. In between meetings, an Executive Committee consisting of the elected officers and most recent Past President make decisions that cannot wait until the next full meeting. This coming October 15th the NYSPA Council and all NYSPA committees will host a meeting at the LaGuardia Marriott. I would like to highlight for readers a few upcoming action items before the Council and encourage you to work with your district branch representatives and presidents to make sure your opinions are heard.

First, we will once again take up the reorganization of the Council structure. The proposal, made in March but tabled to the fall meeting to allow for further review, basically adds the district branch presidents to the Council and expands the members of the Executive Committee to include several additional representatives from Council membership. The full proposal can be obtained from your DB representative and is also posted online in the members-only section of the NYSPA website.

The Council also plans to address the adoption of a NYSPA conflict of interest policy. Last Spring, four NYSPA Past Presidents jointly submitted a letter to the Council highlighting the lack of a clear conflict of interest policy for council members, committee members and NYSPA officers and candidates. The letter concluded that such a policy is needed and would benefit the association. As a result, I appointed a small workgroup comprised of Seeth Vivek, M.D. and Herb Peyser, M.D. to work out the details and report back to the Executive Committee. Fundamentally, the work-

[See **President** on page 5]

CMS Finalizes eRx Hardship Exemptions; Extends Deadline to Nov. 1

By Rachel A. Fernbach, Esq.

On September 6, 2011, CMS published a final rule implementing changes to the Medicare Electronic Prescribing (eRx) Incentive Program. The main purpose of the rulemaking was to create additional hardship exemptions to avoid unfairly penalizing physicians who, for a variety of reasons, are unable to meet the requirements of the incentive program.

Under the final rule, physicians who qualify for an exemption will avoid the 1% penalty to be imposed in 2012 on physicians who failed to engage in electronic prescribing between January 1, 2011 and June 30, 2011. Physicians who wish to apply for a hardship exemption must do so prior to November 1, 2011. The proposed rule originally set the application deadline at October 1, but CMS extended the date by one month in order to give physicians additional time to review the exemptions and submit an exemption request.

The eRx Incentive Program provides for a 1% penalty in 2012 for physicians who did not engage in electronic prescribing at least 10 times during the first six months of 2011. However, certain physicians are automatically exempt from the penalty. First, physicians who have fewer than 100 Medicare patient visits between January 1, 2011 and June 30, 2011 are exempt from e-prescribing for 2011 and will automatically avoid the 2012 penalty.

Second, physicians with 90% of their services coded using a CPT code other than the ones included in the incentive program will also automatically avoid the 2012 penalty. The CPT codes that are eligible for the program are for outpatient services only (office, outpatient clinic, nursing home, adult home and patient's home). CPT codes eligible for the program include 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862 and the Evaluation & Management Codes for the outpatient service locations listed above.

Finally, those physicians who engaged in electronic prescribing at least 10 times during the first six months of 2011 will also avoid the penalty. Psychiatrists who did not begin e-prescribing and who had more than 100

[See **Electronic Prescribing** on page 4]

Medicaid, Behavioral Healthcare, and the 2011 NYS Budget: Taking Stock

By Barry B. Perlman, M.D.

Editor's Note: *This article was completed in July, 2011, prior to the resolution of the national debt ceiling debate.*

There can be no question that 2011 has been a tough budget year all around, including in New York State. The end of the legislative session provides an opportune time to take stock and see where we are. When our new governor, Andrew Cuomo, took office in January, New York State was facing a $10.5 billion short fall. Cuts were inevitable and the governor and legislature had to look to Medicaid, education, corrections and state workers' salaries and pensions. In order to balance the budget, the governor and legislators turned to these sectors because they comprised the state's largest expenditures. By mid-April, an on-time budget had been passed which included a two-year cap on Medicaid spending. Inpatient psychiatric costs were targeted and outpatient mental health clinic visit thresholds were established which incorporated decreased payments for visits exceeding those limits. Certainly these changes were not what advocates for persons with mental illness wanted.

However, as with so many things in life, in order to know how one is doing one must view one's position relative to others. From that perspective, New York State behavioral health providers and advocates must count themselves as relatively fortunate. A quick glance around the nation makes clear that due to the fiscal consequences of the recession, Medicaid, a large and rapidly growing part of most states' expenditures, is under assault at both the state and federal level.

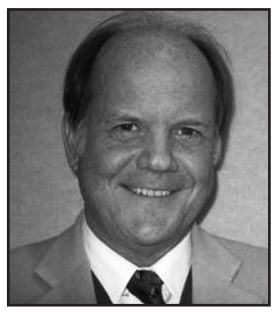
A brief tour of the states highlights why New Yorkers should feel relatively sanguine about how Medicaid has been dealt with in our state. Across the country, governors from liberals such as Jerry Brown of California and Deval Patrick of Massachusetts to conservatives such as Jan Brewer of Arizona and Rick Scott of Florida, are resorting to a wide array of approaches in their efforts to significantly reduce their state's Medicaid budgets. Their strategies include capping Medicaid enrollment, taxing 'unhealthy' behaviors, rolling back reimbursement rates to levels below those which already discourage provider participation, eliminating non-required services such as dental, vision, podiatric, and hospice, targeting women's reproductive services, capping numbers of doctor visits, raising enrollee co-payments, and hastily enrolling eligibles into managed care plans in order to cap costs for the state. The states mentioned above are only a few of the many worthy of notice in their attack on Medicaid.

To some extent, the current attacks on Medicaid have to do with the two-year, $90 billion federal subsidy of Medicaid that sunset on July 1, 2011. As a result of that reduction as well as a political "ideological" antipathy to the program as currently constituted, 29 Republican governors wrote a letter requesting radical changes to Medicaid which included a call for use of payment methodologies such as 'block grants' with the goal of capping state expenditures. These attacks on Medicaid seem especially problematic in view of recently published research by the National Bureau of Economic Research documenting the multidimensional benefits which accrue to enrollees in the areas of health, outlook, and financial stability. On the

[See **NYS Budget** on page 4]

Area II Trustee's Report: APA Practice Guidelines: Where We've Been, Where We're Going

By James Nininger, MD



James Nininger, MD

Practice guidelines are systematically developed patient care strategies intended to assist physicians in clinical decision making. The American Psychiatric Association (APA) began developing evidence-based practice guidelines for the treatment of psychiatric disorders in 1989 under the leadership of Area II's Jack McIntyre, M.D. The current Committee Chair is Joel Yager, M.D. I serve as Vice-Chair and the Medical Editor is Laura Fochtmann, M.D., also from Area II. Marvin Koss, M.D. is Area II's current liaison to the Practice Guidelines Steering Committee. He was preceded by Deborah Cross, M.D. The development process followed recommendations by the American Medical Association and the Institute of Medicine to result in guidelines with scientific backing, validity, reproducibility, and clarity.

The first evidence-based APA Practice Guideline developed under this process, addressed Eating Disorders and was published in 1993. APA guidelines now available on PsychiatryOnline address fourteen different mental disorders or topics and include many second and third editions, such as the third edition guideline on Major Depressive Disorder published in 2010. Each guideline is accompanied by a quick reference guide. For many guidelines, a continuing medical education (CME) course is also available at APA's website for CME and lifelong learning, www.apaeducation.org. Some guidelines also include a "watch" describing major developments in the scientific literature since original guideline publication. Watches represent opinion of the authors rather than official policy of the APA.

These documents are indeed "guidelines" and are not intended to be "standards of care." APA guidelines do not necessarily include all possible effective methods of care for a particular patient. The ultimate judgment concerning the selection and implementation of a specific plan of treatment must be made by the psychiatrist based on the clinical data presented by the patient, the practicality of diagnostic and treatment options available, and after considering the preferences of the patient.

APA's ultimate goal in developing practice guidelines is to assist psychiatrists in their clinical decision making and improve the care of patients.

Psychiatrists are challenged in keeping up with the explosion of research based knowledge in our field. For busy clinicians, practice guidelines summarize a vast number of studies, synthesize the findings, and provide clear statements about which treatments are supported by evidence or expert opinion and which require further research.

Guidelines can also serve as useful policy documents. In reforming the U.S. health care system, systematically developed guidelines and performance measures derived from these guidelines can be used both to improve healthcare quality by promoting effective interventions and to control costs by discouraging the use of inappropriate or ineffective interventions. Though

[See **Trustee's Report** on back page]

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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 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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FROM THE EDITOR'S DESK... By Jeffrey Borenstein, MD


Jeffrey Borenstein, MD

We are living in a time of great change and this edition of the *Bulletin* focuses on a number of important issues. The Albany Report describes the 2011 Legislative Session as "historic and transformational." We have an article which takes stock of the 2011 NYS Budget and its impact on Medicaid and behavioral healthcare. We also have information about exemptions for the Medicare Electronic Prescribing Incentive Program. In addition, the Area II Trustee Report focuses on APA Practice Guidelines. Finally, we have an update on the important topic of parity implementation. ■

Update On Parity Implementation

By Rachel A. Fernbach, Esq.

The federal regulations issued pursuant to the Mental Health Parity and Addiction Equity Act of 2008 apply to group health plans with more than 50 employees for new plan years starting on or after July 1, 2010. For most calendar year plans, the compliance date was January 1, 2011. Since the beginning of this year, NYSPA, in collaboration with its members, has been closely monitoring health plans' compliance and activities with regard to federal parity implementation. The following is an update of NYSPA's advocacy efforts on behalf of members to ensure that health plans doing business in New York are complying with the federal parity law and regulations.

ValueOptions

One of the first plans to issue guidance regarding the parity law was ValueOptions. In a letter to providers, ValueOptions announced that, in an effort to comply with the regulations, it would be eliminating its prior authorization requirement for outpatient and inpatient behavioral health in favor of a 24-hour notification requirement for inpatient admissions and an outlier care management model for outpatient care. NYSPA wrote to ValueOptions requesting clarification regarding these changes, specifically about the new outlier care management model and whether similar limitations were in place with respect to medical or surgical benefits. Under the rules, plans may not impose financial requirements or treatment limitations upon mental health that are more restrictive than those same limitations placed upon other kinds of treatment. On behalf of its members, NYSPA also requested a copy of ValueOptions' written criteria for medical necessity determinations, which plans are required to provide to participating providers. ValueOptions' response to NYSPA failed to adequately address the questions and concerns posed and despite several follow up letters, NYSPA has not received any further response from ValueOptions, nor has ValueOptions provided a copy of its medical necessity criteria.

In addition, a member shared with NYSPA a copy of the ValueOptions Group Participation Agreement currently being distributed to participating providers. The Group Participation Agreement establishes a fee schedule that has not been updated for many years and fails to include any outpatient/office evaluation and management (E/M) codes (99211-99215). The member in question is a participating provider with EmblemHealth, which recently contracted with ValueOptions to provide behavioral health benefits to its beneficiaries. NYSPA recently sent an inquiry to EmblemHealth regarding the failure of ValueOption's current fee schedule to provide for the submission of E/M claims by psychiatrists. In its letter, NYSPA pointed out that although Emblem has entered into an agreement to "carve out" its behavioral health benefit to ValueOptions, Emblem remains legally responsible for compliance with both state and federal law and regulations applicable to insurance coverage of the treatment of mental illness.

NYSPA also plans to file an official complaint with CMS, DOH and the State Insurance Department regarding ValueOptions and its compliance with the federal parity law and regulations.

Hudson Health Plan

At the request of seven psychiatrists who are directors of the psychiatry departments in Westchester County, NYSPA sent an inquiry to Hudson Health Plan, a managed care plan, regarding its compliance with the federal parity regulations. Hudson contracts with Beacon Health Strategies to provide behavioral health benefits. The seven psychiatrists had sent an initial letter to Hudson regarding its parity compliance, specifically, the requirement that a psychiatrist complete an outpatient treatment report following exhaustion of initial pass-through visits and the requirement for prior authorizations and continuing authorizations for inpatient behavioral admissions.

Hudson and Beacon's joint response did not adequately address the psychiatrists' concerns and even intimated that, as a Medicaid managed care plan, Hudson is not currently required to comply with the parity regulations because separate regulations for Medicaid managed care organizations have not yet been issued. However, in September, 2010, DOH issued guidance clarifying that all Medicaid managed care organizations must be in compliance with the current regulations, despite the fact that federal regulations specifically addressing government programs are still anticipated. In its guidance DOH also requested that Medicaid managed care plans review any relevant policies and operations to ensure parity between medical and behavioral health benefits. Despite this directive, Hudson and Beacon failed to identify any internal policies or procedures that are not in compliance with the parity law or regulations. It seems unlikely that Hudson and Beacon would be in full compliance with the parity rules without any modification of its existing policies or procedures whatsoever. NYSPA is awaiting a response to its letter.

The Empire Plan

NYSPA recently confirmed that the NYS Health Insurance Program for State and Local Government, the health plan offered to government employees and their families, also known as the "Empire Plan," is not required to comply with the federal parity law or regulations until January 1, 2012. The Empire Plan's behavioral health benefit is administered by OptumHealth.

NYSPA contacted OptumHealth in response to reports from several members that the Empire Plan is still requiring prior authorizations and treatment plan reviews prior to the payment of mental health claims. OptumHealth responded that, under the parity regulations, plans that are subject to the terms of a collectively bargained agreement will not become subject to the new requirements until the date the last of the collective bargaining agreements relating to the plan terminates.

Since the current collective bargaining agreement, which covers the period April 1, 2007 to December 31, 2011, was ratified prior to October 3, 2008 (the date the federal parity law was enacted), the Empire Plan will not become subject to the parity law or regulations until the new collective bargaining agreement and related plan go into effect on January 1, 2012. Therefore, the Empire Plan will continue to be permitted to require prior authorizations and treatment plan reviews through the end of 2011. NYSPA will continue to monitor OptumHealth's policies to ensure that the Empire Plan begins implementation of the federal parity law and regulations starting January 1, 2012.

Healthfirst and Fidelis Care

NYSPA also contacted Healthfirst and Fidelis Care regarding the use of E/M codes by psychiatrists. Under the federal rules, health plans must provide both coverage and reimbursement for E/M services when provided by psychiatrists to the same extent and in the same amount as the same E/M services are covered and reimbursed for the treatment of non-mental illnesses and conditions. The illustrative list of nonquantitative treatment limitations contained in the regulations includes "standards for provider admission to participate in a network, including reimbursement rates" as well as "plan methods for determining usual, customary and reasonable charges." This section of the regulations makes clear that plans must provide the same reimbursement rates for E/M claims submitted for the treatment of mental illness as for E/M claims submitted for the treatment of all other medical conditions. In preliminary discussions, both Healthfirst and Fidelis Care have indicated that they do not dispute that psychiatrists may submit claims for E/M codes and have agreed to further investigate their current practices.

Members are encouraged to contact NYSPA with any issues or problems regarding health plans' compliance with the federal parity law and regulations. ■

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other side, Senator Jay Rockefeller and 36 Senate colleagues have written to President Obama commending him for his opposition to arbitrary "block grants" which would undermine the "fundamental guarantee of Mediciad coverage" to the program's 68 million beneficiaries. The Obama administration is also pushing back by trying to maintain access by proposing rules which would make it more difficult for states to reduce reimbursement to doctors and hospitals by fulfilling the program's mandate for access to care comparable to others. Unfortunately, it has been reported that the administration also may be willing to entertain steep reductions in funding for Medicaid as part of the negotiations related to raising the nation's debt ceiling.

At this time, it is impossible to know how things will work out, especially as they are playing out against the multi-year phase-in of the Patient Protection and Affordable Care Act. However, for New Yorkers concerned about behavioral healthcare, it seems that we are fortunate that our leaders approached their task thoughtfully and with balance. Certainly serious 'hits' have occurred, such as reduction in payments to institutions which treat a 'disproportionate' share of uninsured patients, reimbursement cuts which have led to the closing of many Continuing Day Treatment (CDT) programs and perhaps dooming those remaining, the creation of preferred drug lists for psychotropic medications and the ending of "physician prevails" in prescribing, continued reductions of numbers of beds in state psychiatric centers, and payment thresholds for clinic level of care.

While we would have hoped for less severe reductions to CDT programs, which represent a modern form of "asylum" for many fragile persons with serious and persistent mental illness (SPMI), and for a continuation of "provider prevails" in prescribing in order to better protect our patients, from a macro perspective, we appreciate that there will be no enrollment limitations and most core services have been reasonably preserved. Even where thresholds have been initiated, regulators have been able to preserve and extend access to services by counting multiple clinic visits on a given day as a single encounter for purposes of reaching threshold trigger points.

Indeed, it is possible that some of the items of concern in the 2011 budget may be revisited next year, such as the loss of the "provider prevails" requirement for prescribing within the Medicaid formulary. Furthermore, Congress established a two-year transition period for transfer of persons currently insured under existing Medicaid fee-for-service into managed care arrangements. A new Behavioral Medicaid Redesign Taskforce will oversee the process, in an effort to create a more seamless system of care within regional behavioral networks while avoiding the depredations which have occurred too frequently when persons with SPMI have been forced into managed care plans. The Taskforce's members represent a broad array of stakeholders from advocacy groups for persons with SPMI, their families, and provider organizations. Other interested parties, such as NYSPA, will also be watching the process closely and working to improve its outcome. It is the resort to a public process which will play out over time, rather than one which is rushed, secretive, and radical, which gives interested New Yorkers hope that the end result will be one that reasonably serves both those receiving and those providing services in our state. Advocates of all stripes will also need to closely monitor and vigorously advocate at the federal level to avoid draconian reductions which would inevitably adversely limit the preservation of adequate services in New York and other states. ■

Dr. Perlman is the Director of the Department of Psychiatry at Saint Joseph's Medical Center in Yonkers, New York. He is the current Legislative Chair and a Past President of the New York State Psychiatric Association. Dr. Perlman is also a past Chair of the NYS Mental Health Services Council.

Electronic Prescribing continued from page 1

cases during the first six months of 2011 may still be able to avoid the 2012 1% penalty if they are eligible for one of the new hardship exemptions listed below.

New Hardship Exemptions

- **Inability to Electronically Prescribe due to Local, State or Federal Law or regulation:** This hardship exemption may apply to New York psychiatrists who prescribe controlled substances (i.e., benzodiazepines), but who are unable to engage in electronic prescribing because New York State Department of Health regulations currently prohibit physicians from electronically prescribing controlled substances. (DOH has announced that it is working to revise its regulations to permit electronic prescribing of controlled substances). This hardship exemption will assist psychiatrists who prescribe benzodiazepines but are otherwise unable to avoid the eRx penalty because they had more than 100 cases during the first six months of 2011. **The justification statement portion of the exemption application must include a citation to the applicable regulation.**
- **Limited Prescribing Activity:** This exemption will apply to physicians who prescribed fewer than **10** prescriptions between January 1, 2011 and June 30, 2011, regardless of whether the prescriptions were sent electronically or on paper. For example, a psychiatrist who performs a consultation at a nursing home and bills for a subsequent nursing home visit (under the new Medicare rules), yet does not write any prescriptions associated with that claim because a consulting psychiatrist is not privileged to write orders. The justification statement portion of the exemption application must indicate the exact number of prescriptions written during the first six months of 2011 (paper or electronic), which number must be fewer than 10.
- **Insufficient Opportunities to Report the Electronic Prescribing Measure Due to Limitations of the Measure's Denominator:** This exemption will apply to physicians who engage in electronic prescribing and who submit claims for the eligible CPT codes, but do not customarily write prescriptions associated with any of the eligible CPT codes. This exemption will assist certain physicians who were unable to report the eRx G-code at least 10 times during the first six months of 2011 because the bulk of their prescribing activity is associated with CPT claims that are not eligible for the incentive program. This particular hardship exemption may not prove all that useful for psychiatrists.
- **Registration to participate in the Medicare or Medicaid EHR Incentive Program and adoption of certified EHR technology:** This exemption will apply to physicians who (i) register for the Medicare or Medicaid EHR Incentive Program and (ii) adopt certified EHR technology no later than October 1, 2011. According to the final rule, the term "adopt" means have certified EHR technology available for immediate use.

Please note that the current incentive program already included two hardship exemptions (for physicians in rural areas without high speed internet access or sufficient available pharmacies for electronic prescribing), which are not likely to apply to physicians in New York State.

Applying for a Hardship Exemption

CMS has created a web-based tool for physicians to submit their requests via the Internet. **All physicians seeking to request a hardship exemption MUST utilize the web-based tool. Exemption requests will NOT be accepted via U.S. mail or electronic mail.**

How to access the web-based tool:

1. Go to http://www.cms.gov/erxincentive/.
2. On the left hand side, click on **Payment Adjustment Information.**
3. At bottom of page, click on **Communication Support Page,** which is listed under "Related Links Outside CMS."

The exemption request must include identifying information about the physician, an indication of which exemption is being applied for, a justification statement, and an attestation of the accuracy of the information provided.

To assist members, NYSPA has posted sample language on its website which can be used in the justification statement section. NYSPA has prepared sample language only for hardship exemptions numbers 1 and 2 listed above. NYSPA feels it is unlikely that psychiatrists will be able to take advantage of hardship exemption number 3 and hardship exemption number 4 is self-explanatory. To review the sample language, please visit the Members Only Section of the website (www.nyspsych.org) and click on the Electronic Prescribing Tab.

NYSPA Comments on Proposed Rule

On behalf of its members, NYSPA timely submitted comments to CMS generally expressing support for the proposed hardship exemptions. In addition, NYSPA proposed that CMS create an additional hardship exemption for physicians whose patients will not consent to the use of electronic prescribing. When a prescription is entered into an eRx system, the prescribing physician will have access to all other past and present electronic prescriptions written for that patient, for understandable medical safety reasons. Members have reported that some patients, due to privacy concerns, have refused to grant consent to the use of electronic prescribing and the psychiatrist is then constrained by that limitation and will have no choice but to issue a paper prescription for that patient. If this happens on a regular basis, this may create a significant disadvantage for psychiatrists who have adopted qualified eRx systems, but whose patients direct them to use paper prescriptions only. First, these psychiatrists will be unable to qualify for the incentive payment because they will have fewer opportunities to write electronic prescriptions for patient visits within the measure's denominator codes. Second, if these psychiatrists do not qualify for any other type of hardship exemption, they will become subject to the penalty.

Although CMS declined to create any additional hardship exemptions at this time, NYSPA was pleased that CMS mentioned NYSPA's suggestion in the comment and response section of the final rule. CMS acknowledged that the category of "patients who do not consent to the use of electronic prescribing" could be an unforeseen circumstance that may prevent a physician from reporting the eRx measure, but also stated that it believes such circumstances are already addressed by the four newly created hardship exemption categories.

Finally, NYSPA noted that some members have expressed concerns regarding the confidentiality of patient information entered into an electronic prescribing or electronic health records system. National news media have reported on the government's own concerns regarding security measures currently in place for electronic health records systems. As a result, some psychiatrists have declined to participate in electronic prescribing and other HIT initiatives for fear that doing so might lead to a breach of their duty of patient confidentiality. Such physicians may be unduly penalized for failing to participate in electronic prescribing for no reason other than concern for the privacy of their patients. NYSPA suggested that CMS undertake efforts to build confidence and comfort on the part of health care providers, particularly those in the field of mental health, with the use of health information technology. ■

Albany Report By Richard J. Gallo, Barry B. Perlman, MD and Jamie Papapetros

Governor Appoints Drs. Martin & Sullivan to Public Health and Health Planning Council

The New York State Senate unanimously confirmed Governor Cuomo's nominations of Glenn Martin, M.D., NYSPA President, and Ann Sullivan, M.D., former Area II Trustee, as members of the Mental Health Services Council and the Public Health and Health Planning Council. In the confirmation process, Senator Shirley Huntley (D-Queens), former chair of the Senate Mental Health Committee, applauded Governor Cuomo on making a "very good choice" with his nomination of Dr. Martin, while Senator Roy McDonald (R-Rensselaer), current chair of the Senate Mental Health Committee, lauded the "tremendous credentials" of Dr. Sullivan.

The Public Health and Health Planning Council, formed through the merger of the State Hospital Review and Planning Council and the Public Health Council, effective December 1, 2010, is a 24-member body that considers and approves or disapproves Certificate of Need applications for the establishment of hospitals, diagnostic and treatment centers and nursing homes in New York. Chapter 58 of the Laws of 2010, which provided for the establishment of the Public Health and Health Planning Council requires that two of its members be members of the Mental Health Services Council.

End of Session Report

Historic and transformational are probably the best two words to describe the 2011 Legislative Session. By the time the Legislature banged the gavel for adjournment in late June, the Governor had seen the signature pieces of his agenda enacted including an on-time budget closing a $10 billion deficit, a two percent property tax cap, extension of New York City rent regulations, marriage equality for same sex couples and the most substantial ethics reform in a generation. Caught up in this tidal wave of transformation are changes to the way health care will be provided and delivered in New York. These changes are well underway with the adoption of the budget for the 2011-12 fiscal year, which projects that the State will obtain $2.3 billion in savings in State Medicaid spending through the Medicaid Redesign Team's recommendations. In fact, as envisioned, every Medicaid beneficiary – more than 5 million currently – will be in some form of "care management or coordination" within three years.

As far as psychiatry and NYSPA are concerned, it was a particularly active session with NYSPA fully engaged on several fronts including working to protect prescriber prevails under the Medicaid preferred drug program, the redesign of services for those with serious and persistent mental illness under Medicaid, advancing legislation that would allow independent practicing physicians to collectively negotiate, and staunchly opposing dramatic scope of practice expansions for allied health care professionals (such as nurse practitioners seeking the authority to voluntarily or involuntarily admit patients to mental health units.)

Prescriber Prevails/Pharmacy Benefit Under Medicaid

The 2011-12 budget included a recommendation made by the Medicaid Redesign Team to require Medicaid fee-for-service pharmacy benefits for those currently enrolled in Medicaid managed care plans to be transitioned to such plans effective October 1, 2011, thereby eliminating the "prescriber prevails" provisions as they currently exist for this population. In addition, the budget eliminated the exemption that several classes of medications, including atypical antipsychotic and antidepressant medications, had from prior authorization under the Medicaid Preferred Drug Program.

Despite these changes, the prescriber's decision will prevail for nearly 1.5 million Medicaid beneficiaries who will continue to receive their pharmacy benefit through fee-for-service, including those with serious and persistent mental illness pending their transition into behavioral health organizations or some other form of managed/care coordination by 2013.

At the same time, legislation to maintain prescriber prevails within Medicaid managed care, which was strongly supported by the provider and consumer communities, was introduced in both houses of the Legislature and passed the Senate but died in committee in the Assembly. Nevertheless, going forward, NYSPA will monitor these developments to ensure that Medicaid managed care beneficiaries have access to the medications they need and that there are appropriate safeguards in place.

Medicaid Redesign: Work Groups Established As Redesign Enters Phase II

As we reported in our last Albany Report, the 2011-12 budget maintained Medicaid Fee-for-Service for persons with serious and persistent mental illness pending the establishment of behavioral health organizations over the next two years. NYSPA vigorously opposed an alternate proposal which would have permitted Medicaid Managed Care health maintenance organizations to carve-in this population immediately.

Implementation of the first phase of the redesign includes the establishment of a global Medicaid spending cap, a three year phase-in of care management for all Medicaid beneficiaries while doing away with fee-for-service, and expanding patient-centered medical homes and health homes. To give readers a better idea of the sheer magnitude of the process--the 2011-12 budget included 73 of the Medicaid Redesign Team's recommendations, which have required 34 state plan amendments to be filed with the Centers for Medicare and Medicaid.

Meanwhile, Phase II of the Medicaid redesign process is underway, which includes the establishment of ten work groups that are tasked with preparing recommendations for long-term savings to be considered by the Medicaid Redesign Team and possibly included in the 2012-13 budget. The behavioral health reform workgroup, one of the first to be established and begin meeting, is chaired by OMH Commissioner Michael Hogan, and Deputy Mayor of New York City for Health & Human Services, Linda Gibbs, and includes representatives from counties, hospital associations and health plans. With a late October deadline, the work group is charged with advancing the Redesign Team's goal of moving all beneficiaries into some form of managed care within three years, exploring opportunities for the co-location of services and providing guidance on the Department of Health's initiative for health homes that will provide a 90/10 FMAP rate for eight quarters.

The bottom line: there is a great deal of uncertainty and pressure to act quickly given the tight deadlines that exist. Starting October 1, 2011, the Department of Health plans to begin identifying individuals eligible for designation into a health home by virtue of the fact that he or she has at least two chronic conditions or one serious or persistent illness.

Physician Collective Negotiation

For the first time ever, the Legislature acted on a bill that would permit independently practicing physicians to come together under close state supervision to collectively negotiate their participation contracts with health insurers – a tool that would restore some balance in negotiations in which health maintenance organizations, who have merged into a handful of large conglomerates, have held the upper hand for many years and rendered physicians powerless.

The Senate overwhelmingly passed this legislation before it adjourned the 2011 Legislative Session and we anticipate further progress in the near future. NYSPA, in conjunction with MSSNY, seeks member assistance in making this legislation a reality by scheduling meetings with local Assemblymembers to express support for the bill and to have him or her urge the Assembly leadership to bring it the floor for a vote.

Scope of Practice Legislation: Bill Allowing Nurse Practitioner to Admit Patients Defeated

NYSPA is proud to report that it was successful in defeating legislation that would have amended Article 9 of the Mental Hygiene Law, relating to commitment of individuals in need of mental health care, to permit nurse practitioners to voluntarily or involuntarily admit mentally ill patients by adding the term "nurse practitioner" wherever the word physician appeared in the statute. This legislation would have set a dangerous precedent and encouraged other allied health care professionals to use a "back door" approach for expanding their scopes of practice into areas heretofore considered the practice of medicine.

The following is a brief summary of other scope of practice bills that are of interest:

- Legislation allowing licensed clinical social workers and licensed nurse practitioners to evaluate a defendant's fitness to stand trial by adding them to the definition of a "psychiatric examiner" under the Criminal Procedures Law. Died in committee. **(Opposed by NYSPA)**
- Legislation allowing a nurse practitioner to practice without a written practice agreement with a physician. Died in committee. **(Opposed by NYSPA)**
- Legislation that would amend the Public Health Law to permit the establishment of retail/convenient care clinics. Died in committee. **(Opposed by NYSPA)**
- Legislation regulating the practice of naturopathic medicine was amended to require naturopathic practitioners to be supervised by physicians at all times. Subsequently passed the Senate. **(Opposed by NYSPA prior to amendment, Neutral thereafter)**
- Legislation expanding the scopes of practice of dentists and podiatrists. Passed the Senate, died in committee in the Assembly.**(Opposed by NYSPA)**

NYSPA is especially thankful to Assemblywoman Deborah Glick, Chair of the Assembly Higher Education Committee, for her commitment and appreciation of advanced education. She was instrumental in ensuring that several of the bills listed above were held in committee for further consideration.

Other Legislative News

- Legislation that would provide due process protections to Medicaid providers who are investigated by the Office of the Medicaid Inspector General (OMIG) passed the Assembly and Senate. **(Supported by NYSPA)** Additionally, NYSPA will be urging the Governor to sign this bill when it is delivered to him by the Legislature.
- Legislation (6 bills in all) that would have dramatically increased medical liability premium rates for physicians – including one bill that would prohibit ex-parte interview of plaintiff's treating physician and another that would require a non-settling defendant to elect, prior to trial, to reduce their liability by either the balance of the jury award to the plaintiff or by an equitable share determined by the jury – died in committee or on the calendar. **(Opposed by NYSPA)**
- Legislation establishing the New York Health Benefit Exchange, as a public benefit corporation governed by a nine-member Board of Directors - passed the Assembly by a vote of 95-43 but was not taken up by the Senate before it adjourned. **(No position taken by NYSPA)**

For further information on any of the matters discussed in this article, please contact Richard Gallo at (518) 465-3545 or richardgallo@gallo-associates.org. ■

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group proposed that NYSPA adopt a policy similar to the one currently used by national APA, with the same disclosure forms and instructions. After deliberation, the Executive Committee accepted the report with the proviso that all disclosure forms submitted would be made available only to NYSPA members via the members-only section of the NYSPA website. The report of the workgroup will be presented to the full Council for review and hopefully, approval this October. The workgroup also strongly recommended that individual district branches in the state formally address the conflict of interest issue, as it is at least as important locally as it is on a state or national level.

The Council will also begin a review of proposed changes to the rules for national elections that have recently been submitted to the Board of Trustees by the APA Election Committee. Dr. Robert Kelly, Chair of the APA Election Committee, will address the Council at our October meeting to provide further rationale and background. The report and proposed changes are comprehensive and far reaching and recommend removing many of the restrictions on print and electronic communications currently in place. A plan to foster candidate debates will also be discussed. Once again, you can find this material online in the members-only section of the NYSPA website.

At the Fall meeting, the Council will also review a selection of action papers that have been submitted to the Assembly for vote at the November meeting in Washington, D.C. It is possible that NYSPA may choose to endorse one or more of the submitted papers, but since the deadline for submission is after the publication of this Bulletin, it is not possible to list them here. Once again, I encourage you to communicate with your district branch representative or President. And of course you can always contact me directly at doctor@GlennMartinMD.com. We eagerly await your input. ■

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there are concerns that performance measures may not always be clinically meaningful and may have unintended consequences such as reducing patient satisfaction or leading physicians to more likely avoid difficult-to-treat patients, performance measures for psychiatry are now being developed by managed care organizations, health care systems, government agencies, and others including the American Medical Association's Physician Consortium for Performance Improvement. To ensure that such measures are acceptable to psychiatrists, APA has advocated that measures on psychiatric treatments should be based on APA practice guidelines.

To date, the guideline development process has included appointment of an expert work group who are APA members, adherence to disclosure and conflict of interest policies intended to minimize bias from competing interests especially from industry relationships, systematic review of available evidence including creation of evidence tables, broad review of drafts by other experts, the APA membership, allied organizations and patient and family advocacy groups, final approval of guidelines by the APA Assembly and Board of Trustees, and regular review and revision. Development of the guidelines is funded solely by APA. No direct industry or commercial funding for APA guideline development has ever been accepted.

In 2011, at the request of the United States Congress, the Institute of Medicine published companion reports recommending standards for the development of "trustworthy" clinical practice guidelines and for the development of systematic reviews of evidence that inform guidelines. In response to these reports, APA's Steering Committee on Practice Guidelines has begun to pilot changes to APA's guideline development process. These include ensuring multidisciplinary expertise on guideline work groups, organizing guidelines around focused clinical questions rather than broad categories of illness, obtaining input on the questions from patient and family representatives, using independent raters to screen literature search results, and using the GRADE system to separately rate recommendations according to strength of recommendation and strength of supporting evidence.

In addition to these changes intended to address the Institute of Medicine standards, the Steering Committee is piloting other technical and process innovations intended to further improve the quality of APA guidelines, make them more user friendly, and facilitate our efforts to keep up to date. These innovations include use of formal surveys of large panels of clinical and research experts to assess expert consensus around potential recommendations, use of a modified Delphi method to determine consensus of work groups, use of medical informatics principles to streamline screening of literature search results, formatting guidelines as modules to facilitate their integration into electronic media including health records, and use of standing work groups to continuously review new evidence and update recommendations on an as needed basis. Some of these innovations are being funded by a medical informatics grant from the National Library of Medicine that was awarded in 2010.

Keeping guidelines current and updated is challenging, time consuming and potentially very expensive! This goal is even more daunting if the recent standards proposed by the Institute of Medicine are to be met. Roger Peele, M.D., a member of the APA Assembly, and others have urged that the guidelines be more frequently updated, ideally to be "living" documents, but to attain this end adequate resources for staff time and even further commitment by APA volunteers, such as those comprising the work groups, must be established. How high a priority is this to our members?

Guidelines on psychiatric evaluation and management are now being developed using the pilot process described above with first publication anticipated in 2013.

In addition to improving patient care, APA guidelines are used to educate psychiatrists, other physicians, mental health professionals, and the general public about evidence-based psychiatric treatments. They also contribute to the credibility of the field by demonstrating the ever-increasing quality of evidence for psychiatric treatments, at times meeting or exceeding the quality of evidence for treatments of other medical specialties. Guidelines also identify gaps in critical information where additional research is needed. Finally, good guidelines provide a scientific and clinically sensitive basis for decision-making by policymakers and resource regulators.

Evidence-based practice has been defined as the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient, integrating individual clinical expertise with the best available external clinical evidence from systematic research. Some have raised concerns that guidelines could be misinterpreted or misused by third parties, such as insurers or regulatory agencies, in ways that might constrain care. The risk is less likely with APA guidelines than with guidelines developed outside the profession, especially those developed to control healthcare costs without rigorous review of available evidence or consideration of clinical consensus about best practices.

The medicolegal impact of APA practice guidelines has not been studied in detail and there are mixed opinions about the impact of guidelines on the volume of malpractice suits and the magnitude of compensation to plaintiffs. Some medical specialties report that guidelines seem to have reduced malpractice claims, and at least one specialty (anesthesiology) has noted lower malpractice insurance premiums. Since the publication of APA's first practice guideline in 1993, no clear trends have emerged that would suggest either an increase or decrease in the related number of malpractice claims.

Conclusions

Practice guidelines represent an important step in enhancing the evidence-based practice of psychiatry. Guideline development is evolving into a more evidence-based field, with methodologies such as those proposed by the GRADE Working Group and the standards of the Institute of Medicine representing important advancements. APA will continue to explore and test these and our own innovations, with the goal of producing guidelines that are as good, authoritative, and carefully considered as can be practically achieved.

Psychiatrists who use APA guidelines and quick reference guides are encouraged to submit suggestions for improvement of these tools. A feedback form is available at http://mx.psych.org/survey/reviewform.cfm. ■

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