



Nebraska Psychiatrists Newsletter

2nd Quarter 2010

Letter from the NPS President

Michele Marsh, M.D.



The Annual meeting of the Nebraska Psychiatric Society was held at Spezia's on April 21st. We were fortunate to have Dr. Laurence Greenhill as our guest speaker. He is Professor of Clinical Psychiatry and Medical Director of the Disruptive Behaviors Clinic at Columbia Presbyterian Medical Center. He is also the President of the American Academy of Child Psychiatry. His talk regarding proposed changes for the upcoming DSM-5 was both informative and timely.

DSM-5

The APA posted the Proposed Draft Revisions for the DSM-5 on the www.dsm5.org website. The site was open for comments through last week. The updates regarding any changes to draft criteria are now available on the website.

A request for proposals to participate in DSM-5 field trials is now available at the website. Trials will be held at academic centers, and mental health and medical specialty centers. Separate trials will be held in clinical practice settings. Field trial protocols are now available for review on line.

Parity

An interim final rule was released January 29, 2010 and explains how the federal government will interpret the law. Employers who have more than 50 employees and offer mental health coverage are required to provide on an equal basis to other medical services. This includes out of pocket costs, benefit limits, prior authorizations, and utilization review. The new rules will apply to plans as of 7/1/2010. More information can be found at: www.regulations.gov/

CMS Payments to Physicians

The federal government delayed implementing the Medicare payment cuts of 23.1% to physicians. A short term extension was passed through June 1, 2010. Medicare payments to physicians are adjusted yearly based on a formula known as the sustainable growth rate (SGR). The ongoing controversy relates to the formula having significant flaws.

Congratulations to our new elected officials of the Nebraska Psychiatric Society:

Dr. Matt Egbert: President
Dr. Jane Theobald: President Elect
Dr. Ashish Sharma: Treasurer

The Executive Board has an opening for a representative from rural Nebraska. Contact Cindy Hamilton at Cindy.Hamilton@OmahaMedical.com if interested.

As my year of serving as President of the NPS concludes I sincerely thank the many members of our organization that have also given of their time and support.

Sincerely,
Michele Marsh, MD
President, NPS

Letter from the NMA for Nebraska Psychiatrists

Dating back several years, the Nebraska Medical Association (NMA) was invited to the table as a participant in a discussion about the ever increasing pharmacy costs associated with our Behavioral Health services with the Medicaid Division. In 2007, the NMA together with the Medicaid Division participated in a Pilot Program for patients receiving three or more atypical antipsychotics with communication and feedback to the prescribing physicians. The Pilot Program provided us some insight into the lack of awareness among physicians across the state about the number of patients receiving prescriptions from multiple sources.

The NMA's agreement with Care Management Technologies (CMT) will require the need for physicians to be in place for consultations with prescribing physicians identified by CMT and Medicaid per the Quality Indicators selected for "provider education" in a peer to peer setting. The peer reviewer will make a minimum of 2 attempts to contact the prescriber over a 10 day period, with the results of the conversations entered into the Web base tracking database. Our contract requires us to attempt or complete 12 referrals per month and there is an hourly reimbursement of up to \$250 per hour for the consulting physician, paid in 15 minute increments.

It is our strong belief having Nebraska physicians consulting with the prescribing physicians will provide the best outcomes of providing the education expected of this agreement. We hope the physicians of the Nebraska Psychiatric Society will assist us in this effort.

Dale Mahlman
Executive Vice President
Nebraska Medical Association

Insurance Chair Report

The health care crisis is over! Health insurance reform has been signed into law. The legislation is said to help reduce the federal deficit. Insuring an extra 30 million people -- many of whom are poor or have pre-existing conditions -- and removing lifetime limits for certain illness, won't cost the average person any extra money in insurance premiums or taxes. Businesses will be protected from the ever increasing cost of providing health insurance. Health insurance company profits will be controlled. Those of us who already have insurance and like what we have will be allowed to keep it. Doctors, hospitals, and the pharmaceutical industry will be better compensated because the new plan will virtually eliminate charity work. The legislation was supported by the AACAP, the AMA and the APA. What's not to like? What could go wrong? Listed below are some of my concerns about the legislation.

One way in which the plan will keep the cost of individual and group insurance policies in check is the forced buy-in of the young, the healthy, and the wealthy, who in the past have been willing to gamble that they would not need health insurance. Because of this, the health care reform bill is already facing a constitutional challenge from a number of states' attorney generals. The forced buy-in is thought by many to violate the interstate commerce clause and also the tenth amendment. Even if the law stands, if one counts the cost of extra medical insurance for thirty million more people along with the actual cost of the added medical care, the percent of GNP devoted to the medical insurance and medical care can only increase as the program is fully implemented.

As part of the effort to balance the budget, Medicare payments will be reduced by one-half trillion dollars during the next ten years, not by eliminating fraud and abuse, but primarily by reducing benefits to hospice programs and nursing homes. That was a part of my Medicare insurance which I liked, but apparently won't get to keep.

A portion of the "health care crisis" will go on for another four years. It is the millions of adults who have been uninsured because of their pre-existing conditions and therefore unable to obtain urgently needed medical care. The delay in their coverage was needed to allow enough extra taxes to be collected the first four years to offset the actual added costs for the remaining six

years of the projected ten-year phase in period. (The only way the budget would balance).

As nice as it sounds to cover pre-existing conditions or to eliminate life time coverage limits, to do so makes as much actuarial sense as forcing life insurance companies to sell \$250,000 life insurance policies to the terminally ill. True insurance is a means of protecting participants against a potentially severe, but a relatively low probability of loss. This is done through the voluntary pooling of premiums with the understanding that most participants will be fortunate enough not to collect the benefits. The only way to "insure" against an almost certain loss is to prepay it through high premiums or savings such as for illness or incapacity in old age. "Whole life" or permanent life insurance is the most extreme example of this. It is term insurance early in life, but later it is increasingly a forced savings which can be used either as a death benefit when the inevitable happens or can be used as a source of income late in life. People have mostly stopped buying whole life because it was so much more expensive than term life insurance. The latter is a true insurance policy. It can inexpensively cover the unlikely, but high monetary loss in the event of the death of a young bread winner. Term life becomes prohibitively expensive in late life as the risk of death increases rapidly. Medically insuring the previously uninsurable (those with pre-existing conditions) with no limit and whose increased medical costs has become a certainty, can only increase costs for everyone else in that risk pool.

I have read that public clinics are to be developed as part of the new health care plan. Medicare and Medicaid were developed to provide every one, rich and poor, with the same standard of care. It would seem to me that it would have been more simple and less costly to create a safety net of public clinics and hospitals for the medically indigent (the poor, the unlucky, the imprudent, and the uninsurable) and to let the market determine for everyone else whether or not private insurance and/or privately funded care is worth the cost. Such a system, even now, could in time allow for the phase out of Medicare and Medicaid. It would bring us to a system similar to what has evolved in England and many other European countries. They do have a two tiered system, one of salaried doctors working for the public clinics, the other of private practitioners who serve the well-to-do, the lucky, the prudent, and the insurable. Can we afford to continue our 45 year pretense that all people should have the same medical care? No one expects the same for housing, food, clothing, automobiles, or vacations. As a result of the new health care reform legislation, one would predict that more and more physicians will be leaving private practice to work for larger corporations, universities, or government agencies as they deal



John Donaldson, M.D.

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NPS 2010 MEETING SCHEDULE

May 4	Executive Committee Meeting	MOMS Boardroom
June 1	Executive Committee Meeting	MOMS Boardroom
July 6	Executive Committee Meeting	MOMS Boardroom
Aug 3	Executive Committee Meeting	MOMS Boardroom
Sept 7	Executive Committee Meeting	MOMS Boardroom
Oct 5	Executive Committee Meeting	MOMS Boardroom
Oct 19	NPS Membership Meeting	TBD

Insurance Chair Report—cont'd.

with the 2,700 pages of new laws and the creation of over 100 new regulatory commissions. Most private M.D.'s, who cannot afford their own compliance officer, will choose to be paid a salary so they won't have to deal with the increased regulations and the endless cash flow uncertainties involved in collecting reduced fees from various third party payors. Unfortunately, being salaried reduces the incentive for physicians to work more hours or to squeeze in one more patient at the end of a long day. Care not rationed by medical necessity review commissions will in effect be rationed by longer waits as 30 million additional patients ask to see a relatively fixed number of physicians who no longer have an incentive to work harder and longer. Through a series of steps including Medicare, Medicaid, EMTALA, HIPAA, and the new health care legislation, it would appear that our government has created a system that causes our physicians to be more tightly regulated than is the case anywhere else in the free world. This adds to the risk of a decrease in the quantity and quality of new physicians.

Large corporations have projected higher cost dues to the loss of government subsidization of retiree medical benefit plans. Industries with large numbers of retirees, such as AT&T and Verizon, have estimated their added costs to be as high as one billion dollars per year. These costs might in part be passed on to consumers as higher fees, to workers as lower wages, or to stock holders as lower dividends; but it is anticipated that some companies will be forced to reduce or eliminate future health care benefits as they project a significant erosion in profitability. So much for everyone being able to keep his or her own insurance.

John Donaldson, M.D.

Assembly Representative Report

Area 4 APA Assembly Representatives and Legislative Representatives met in Chicago over the March 6/7th weekend. MITs also attended the meeting. The following are highlights from my report.

The Area 4 Legislative Representative, Bob Batterson, reported on the March 6th legislative morning meeting to the Area 4 group. The issues for Area 4 states were identified as:

- 1) Scope of practice
- 2) Budget cuts
- 3) Formulary issues

Discussions from the District Branch reports included the following:

Illinois warned of a resolution to create Psychotropic Substances Suicide Risk Task Force to "protect the public". It is being sponsored by scientists under the organization name of CCHR. BCBS seemed to be clamping down with pre-certification, but more with therapy/therapist than psychiatrists. Psychologists prescribing privileges were once again in a bill, but the bill should be defeated because of other priorities of the legislators. The Illinois Supreme Court ruled the 2005 litigation reform, which included a \$500,000 cap for non-economic damages, was ruled unconstitutional. A prison Medicaid bill was passed which allows inmates to remain eligible for Medicaid benefits during incarceration.

Ohio is seeing dramatic cuts in state services including mental health and substance abuse services. Psychologists made their first attempt at prescribing privileges by an amendment in a criminal justice reform bill that would grant prescribing privileges to psychologists that worked in certain prisons.

OPPA continues to address concerns of managed care companies denying care based on "lack of medical necessity." OPPA is also working with primary care physicians to discuss collaboration and coordination of care issues.

Iowa is feeling the revenue crunch with 10% across the board cuts for all state agencies. The state hospitals are feeling a big pinch with this. Next year there will be a 20% cut for 4 state hospitals. IPA will have a CME program at the spring meeting April 10 titled "Mood Disorders Through the Life Cycle."

The 3 District Branches in Missouri will be combined into one. They are in the process of forming this district branch.

Minnesota MPS, AACAP and Pediatrics received a \$250,000 block grant to develop a pilot program for treating depression in children. I am uncertain what organization gave out the block grant.

Public Affairs committee is no longer. It is reconstituted as a new Council. We debated whether to have a Area 4 Public Affairs representative or not, and decided against it.

The MITs presented an idea to have district branch members accompanying MITs at a community organization to promote mentoring, mental health awareness and as community service. I am not sure where it stands as a suggestion or if it will be developed into an action paper.

I will be attending the annual meeting in New Orleans in a few weeks. It will be a smaller group of attendees because of budgetary cuts. I will report back in June.

Amy Schuett, M.D.