MARYLAND PSYCHIATRIC SOCIETY

MPS NEWS

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In This Issue

Deadline for submitting articles to *MPS News* is the 15th of the month preceding publication. Please email to heidi@mdpsych.org.

MPS News Design & Layout Meagan Floyd

The next MPS Council meeting will be held Tuesday, **January 14** at 8PM in the MPS office.

President's Column

Thirty Years Later, Still Never Bored
Part I: How Did I Pick Psychiatry?

For my last column of 2013, I decided to write a bit about myself and how I chose to become a psychiatrist. My overall sense is that while I picked medicine, psychiatry picked me.

From about age 7, I always knew I wanted to be a doctor. My favorite place in New York City, where I grew up, was the human body exhibit at the Museum of Natural History. While my friends put together model airplanes and cars, I put together models of bodies and brains. With the goal of medical school always in focus, I raced through my early education quickly, skipping the eighth grade and leaving high school after my junior year to enter college before my 16th birthday. Having been a science and math nerd (I was on the Math Team at an all-nerd Stuyvesant High School), college was the first time I learned to appreciate literature, due in part to the humanities-focused Core Curriculum at Columbia College. I was so taken by great books, I wound up double majoring in chemistry and comparative literature. Little did I realize at the time, the combined loves of wonderful complicated human stories and chemistry presaged my career in psychiatry.

When I went off to medical school at Harvard, I assumed I would go into some internal medicine sub-specialty, perhaps endocrinology. My first year of medical school included an introduction to psychiatry course. One day each week we would go to a different medical venue in Boston where we could talk to any of the patients there. One week it would be a spinal cord unit, the next week a facility for the blind, a child psychiatry unit, a drug rehabilitation program, and so on. I looked forward to these excursions each week, which allowed me to learn a bit about the experiences these people had. We would speak to patients in groups of three or four, but I found each week my group got larger. My friend, Izzy Tepler, told me it was because my interviews were so appreciated by my classmates. I decided good interview skills were helpful in internal medicine, but my friends seemed to know before I did that I would be heading off to psychiatry.

During my introductory clinical years, I liked the surgical specialties the most, at least on the rotations where I got to do things—sew wounds, use power tools in orthopedics, but surgeons were not encouraged to actually talk to patients, even the many who had fascinating tales to tell. One morning on orthopedics rounds (in those good old days when patients would be admitted the night before and operated on the next morning), I started my case presentation by reporting that the patient reminded me of Dostoyevsky's Underground Man. The blank looks from the attendings and residents clarified for me in an instant that I was not destined to be an orthopedist. These were not my people.

I loved my psychiatry and neurology rotations. Both specialties seemed to provide an opportunity to solve puzzles and talk to patients. When I made literary references, I had a more appreciative, or at least tolerant, audience. I still could not get my head around the idea of applying for a residency in psychiatry though. It was not my childhood image of what a doctor was.

(Continued on next page)

In a quandary about what residency I would pursue, I had the opportunity to take a fellowship year between my third and fourth years and did research on sleep with Allan Hobson at Massachusetts Mental Health Center. Allan had managed to obtain time lapse video equipment (primarily used for security surveillance), and I set up to video tape people sleeping with polysomnographic electrodes attached. I discovered that the majority of trunkal movements during sleep occur during phase changes between dreaming and non-dreaming sleep. A later study looking at couples sleeping together without polysomnographic monitoring revealed that the vast majority (around 80% depending on bed size) of major postural shifts for one member of a couple was within the same two second epoch for their bed partner. Coupled with the previous study, this suggested that bed partners may be entering and leaving dreaming cycles together, thereby entraining each others' REM cycles. I still have one of the few papers within sleep research that talks about couples' sleep.

Over the course of my research fellowship year, I finally got comfortable with the idea of applying in psychiatry. Psychiatry valued that special interaction with patients in a way that neurology did not. I still chafe at being told on my medicine rotation as a third year student that I was spending too much time talking with my patients and not enough time in the library. The chief of medicine caught me one day talking to one of my patients, a delightful octogenarian, retired public school teacher who was slowly succumbing to liver cancer, about the Red Sox and I was reprimanded for squandering my precious time. Thirty-five years later I am still clear that my patients and not my professors taught me how to be a physician.

I was delighted to be able to stay in my new hometown, Boston, for my residency at McLean Hospital. I did have to make it over the hurdle of five months as a medical intern at Mount Auburn Hospital. That time was frustrating, due mostly to my tendency to question authority (a trait I have still not given up) about such things as why we do a full work-up of a fever of unknown origin at 3am on a patient in the final stage of dementia. On the other hand, I got to meet, talk to and care for Nobel laureates (ah, the rarefied atmosphere of Cambridge, MA), the only surviving child of a prominent German philosopher from the early 20th century, and so many patients who taught me so much about coping with life-threatening illness with and without dignity. The experience did solidify my resolve that psychiatry was the correct direction for me.

Once I got to my psychiatry residency, my earlier challenges disappeared. My assigned preceptor, Alan Schatzberg, was a gracious and thoughtful advisor. He found my constant questioning amusing rather than threatening. More than a few times in response to yet another challenge from me he would say, "Aaronson, Aaronson, no one can teach you anything," and would proceed to give me a rationale for our clinical intervention. During my residency my curiosity was allowed to flourish and it still continues to drive my activities as a psychiatrist.

In the next issue I will talk a bit about my career path since residency from research to clinical care and back to research.

Scott T. Aaronson, M.D.

SAVE THE DATE!

MPS Advocacy Days in Annapolis

January 29 and 30, 2014
9:00 AM to 4:00 PM
Annapolis House and Senate Buildings in Annapolis

Members are needed for MPS Advocacy Days in Annapolis. **Come for the morning, the afternoon, all day or both days**. Our lobbyist coordinates appointments for House and Senate leadership to talk with MPS members about pending legislative issues. We also answer any other questions that Delegates or Senators may have.

We have found communicating with elected officials in person to be very effective. Please consider participating! Of course psychiatrists are busy, but this is just once a year and it takes the place of the legislative reception held previously. There is help available for those who do not have experience. Contact Kery Hummel at khummel@mdpsych.org if you can attend or if you have questions.

Join the MPS Listserv!

MPS members are urged to join the listserv to easily share information with colleagues. An email message sent to the listserv goes to all the members who have joined. Here is a recent member post in response to a question...

*...about whether unencrypted emailing with patients is in violation of the final HIPAA rule that went into effect in September … Bottom line, the Rule declares that patients have a *right* to receive unencrypted emails from us containing Protected Health Information (PHI) if that is their preference. We have an obligation to inform them that an unencrypted email can be intercepted and read; if we have done that and they still want it, we are not responsible for unauthorized access to whatever we send. …*

To join the listserv, please go to: http://groups.google.com/group/mpslist. You will need to wait for membership approval and will be notified by email. If you have trouble negotiating this, please call the MPS office at 410-625-0232.

2013 AMA Interim Meeting Highlights

The AMA Interim Meeting was held at the Gaylord Hotel in the National Harbor area in PG County, Maryland just outside of DC. This is the first time that the AMA has met near DC since I have been a delegate, although the Capitol figures prominently in AMA discussions and the President and members of Congress have addressed past AMA meetings, including President Obama.

This year the top item on the agenda for the AMA House of Delegates was reform of the Medicare Sustainable Growth Rate (SGR) formula, which has required repeated "fixes" over the years since its adoption in 1997. The intent of the original legislation was to curb the escalating costs of Medicare by establishing a fixed sustainable inflation rate in this sector. This was *tricky* because the overall cost of Medicare is tied to 2 factors: the *aggregate of fees* for procedures physicians perform multiplied by the *total number of procedures* being performed. Procedures here means all activities that physicians, including psychiatrists, bill for.

Since health care rationing (limiting procedures) is an anathema to both parties and the country, the target became limiting increases in the physician fee schedule. The AMA took the lead in getting Congress to authorize annual "fixes" that prevented fee reductions under the SGR. That said, the average annual fee increases since 2003 has only been slightly greater than zero and less than the overall inflation rate. The divergence between the expected cost, based on the formula, and the actual cost, which was "borrowed" using fee reductions for the next year, remained in single digits until 2008. But since that time it has escalated so that it is now estimated to require a 24.4% *reduction* in fees across the board for 2014. [See page 6 for more details and updates.]

Why is this so? The cynics say that physicians are performing more procedures to make up for less revenue from the modest fixed fee schedules. The professional organizations point to an older population, plus more interventions that benefit patients, and argue that if physician practices cannot at least break even, they will either go out of business or stop seeing Medicare patients. Congress and the country have been living in a dangerous fantasy land where what was intended in the original legislation is happening: the fixes are temporary, will be offset in subsequent years, and will eventually stop, and no one will be hurt in the process, neither patients nor physicians.

At this time there is substantial support within both parties (which don't agree on much of anything else) and both chambers (likewise) for some kind of permanent fix to the SGR. But as always there is debate about the quid pro quo which is the bitcoin of politics. Options that have been discussed are: 1. A 10 year freeze on the physicians' fee schedule; 2. Increases in the regulatory requirements, e.g. Quality Performance Standards, Meaningful Use of EHR standards, etc., 3. Some combination. There was debate about how to proceed, with some delegates advocating for letting the system fail, others advocating for repeal of the SGR, but sticking to AMA policy on regulatory requirements and advocating for alternative payment models, including private contracting.

I had an opportunity to discuss the SGR with MPS colleague Allan Anderson, M.D. from Cambridge, who represents the American Association of Geriatric Psychiatry at the AMA (AAGP has recently gained Observer Status on the way to representation in the AMA House of Delegates). We agreed that it made sense for the AMA to try to repeal the SGR now, but not at a high cost in terms of the political quid pro quo because the political momentum within Congress is now for change. Bruce Smoller, M.D., a Montgomery County psychiatrist and member of the Med Chi delegation, sat on the Reference Committee that heard the SGR debate before it came to the floor of the AMA House of Delegates. He has been endorsed by the Southeast Caucus in the AMA to run for the Council on Science and Public Health in 2015. Maryland was also well represented by Robert Phillips, M.D. from Annapolis, who represents the American Academy of Psychiatry and the Law in the AMA and is Vice Chair of the APA delegation, and Carolyn Robinowitz M.D., past APA President and Chair of the APA delegation. Maryland resident Saul Levin, M.D., a past member of the APA's AMA delegation and now APA Medical Director/CEO, was there as well and organized a very nice farewell for Jay Scully, M.D. who recently retired.

Thomas E. Allen, M.D.
AMA Delegate – Med Chi
MD Delegate to SE Executive Committee

Forensic Psychiatry Committee News

The MPS Forensic Psychiatry Committee met to begin preparation for the next legislative session. The committee discussed follow-up to last year's gun legislation as well as potential bills with forensic implications that could be introduced during this year's session. In light of the implementation of the Affordable Care Act, Maryland is taking steps to integrate behavioral health, somatic and mental health services. We also discussed the integration process and the potential impact on forensic practice. Interested members are encouraged to contact the MPS office to help review bills of forensic interest during the next legislative session [see next page for more info].

Annette Hanson, M.D., Chair

Maryland News & Information

Anticipated 2014 Maryland Legislation

The General Assembly will reconvene Wednesday, January 8.

Outpatient Commitment is an issue that divides the mental health community. The Treatment Advocacy Center has stated publicly its intent to introduce an Involuntary Outpatient Commitment (IOC) bill in 2014. The Continuity of Care Advisory Panel that has been meeting for several months did not recommend IOC because it felt more study is necessary. Coalition member organizations will surely join the debate during session, but the Coalition as a whole will not take a position, focusing instead on issues its members can unify around. More information is available in the Continuity of Care for Persons with Mental Illness section beginning on page 129 of the 2014 Legislative Session Issue Papers.

Telepsychiatry/Telemedicine may be an issue again in 2014. Legislation from 2012 requires commercial insurers to provide the same coverage for health care delivered in person or through telemedicine, but it exempted Medicaid from the bill requirements and required the Department to study and report on the issue. The study did not recommend requiring telemedicine for Medicaid recipients statewide, and so the program only provides the service on a limited basis. Initially, some voiced concern that increased telemedicine in rural areas would discourage the state from working to build an actual provider network. However, workforce development has not improved anyway, so there is now more interest in expanding telemedicine. More information is available in the Telemedicine and Telehealth section beginning on page 133 of the 2014 Legislative Session Issue Papers.

Maryland Health Connection Update

The Maryland Health Benefit Exchange has reported progress in addressing the issues surrounding its launch; however, some problems remain for some users, and as of December 7 only 5179 individuals had enrolled in health plans using the site. Users are encouraged to visit the Consumer Information Update page for important notices before beginning. They offer advice on how to navigate some of the issues on the website as they are being addressed. In addition, MedChi has two staff people officially trained and licensed as assistors. Call Allison Bogsted at 1-800-492-1056, ext. 3311 for help.

Free Screening

On **January 22**, Maryland's addiction recovery and mental health communities will join forces to screen **"**The Anonymous People,**"** followed by a panel discussion to encourage action to promote recovery, dispel stigma, and end discrimination toward those with addiction and mental health concerns. The event will be in Annapolis so Maryland's legislators will have a chance to attend. The event will be held at St. John's College- Frances Scott Key Theater. Doors open at 6:00 pm for light refreshments, with the movie beginning at 6:30 pm. To reserve FREE tickets click here

Leadership Meeting on Legislation

On December 4, the leadership of the MPS and the Suburban Maryland Psychiatric Society (SMPS) met at Ricciuti's Restaurant in Olney. SMPS Chair, Dr. Marilou Tablang-Jimenez hosted the meeting. The purpose was to discuss last year's General Assembly Session with our mutually shared lobbyist firm, Harris Jones and Malone. Last year's legislative highlights were reviewed, from Lynette's Law, child abuse reporting, gun legislation, and outpatient commitment to concerns over the definition of dangerousness, the merging of mental health and substance abuse administrations at DHMH and an increase in psychiatrist Medicaid reimbursement to meet Medicare rates. Several of these issues are expected to resurface during the 2014 General Assembly. The two organizations, in coordination with our lobbyists, will monitor prefiled bills and those submitted during the session involving the aforementioned issues and any others of importance to psychiatry.

Support for the Maryland Psychiatric Political Action Committee was also discussed. The importance of contributing to the PAC was stressed by the Presidents of both organizations. Contributions are solicited 4 times a year through Spring and Fall Phonathons, a Winter Newsletter and a Summer solicitation letter. Members of both the SMPS and the MPS may participate in PAC activities and/or serve on the Legislative Committee. Please contact the Mr. Hummel if interested.

Maryland Mental Health Coalition Update

In recognition of the systemic changes and integration of the MH/SUD systems, and a desire to continue the trend of greater inclusivity and relationship-building across communities, the coalition voted at its November meeting to change its name from the Maryland Mental Health Coalition to the **Maryland Behavioral Health Coalition**

Membership

The following individuals have applied for membership with the MPS. Unless any current members have evidence that an applicant does not meet the criteria for ethical and professional standards, these actions will be approved 14 days after publication.

APA Members Transferring to Maryland
Bhargavi Devineni, M.D.
Harpreet Kaur, M.D.

Congratulations!

With MPS recommendation, the APA has advanced the membership status of the following MPS members.

New APA Fellows
Jodi Krumrine Bond, M.D.
Tracee M. Burroughs, M.D.
Mary Cutler, M.D.
Nancy Diazgranados, M.D.
David Goodman, M.D.
Margo D. Lauterbach, M.D.
Vani A. Rao, M.D.
Jany R. Rose, M.D.
Philipp A. Sack, M.D.
Crystal C. Watkins, M.D.

New APA Distinguished Fellows
This status reflects exceptional abilities, talents and contributions to the psychiatric profession.

Susan W. Lehmann M.D.
Patrick T. Triplett, M.D.

Help Support the MPS!

PRMS, the manager of The Psychiatrists' Program, has a new initiative that benefits APA district branches. For every referral received from one of their insured psychiatrists, PRMS will make a donation of $25 to their client's district branch. Please consider participating if you have colleagues who might want to purchase medical liability coverage. To register your referral and get credit for the MPS, contact Remy Palumbo, Senior Account Manager at 703 907 3849, 1-800-245-3333 or rpalumbo@prms.com.

Give an Hour

Members may want to participate with Give an Hour, which provides mental health services for troops and their families affected by the conflicts in Iraq and Afghanistan. The organization recruits mental health professionals to volunteer their expertise and time to provide this important and much needed care.

APA Information

Minority Fellowships Program Invites Applicants

Psychiatry residents are invited to apply for APA's Minority Fellowships Program. The fellowships provide educational opportunities, not only to minority residents, but to **any resident** interested in providing quality and effective service to minorities and the underserved. Learn more about the APA/SAMHSA, SAMHSA Substance Abuse, and Diversity Leadership fellows on the APA fellowship page or contact Marilyn King at (703) 907-8653 or mking@psych.org. The application **deadline is January 30**.

Members-in-Training are now Resident-Fellow Members

The term "member-in-training" is being replaced in the official APA lexicon with "resident-fellow member," or RFM. The APA Board of Trustees voted to approve the change following a vote by the APA Assembly at its November meeting. The Board agreed that the member-in-training nomenclature is often unclear to residents and fellows who are not APA members and to physician members of other specialty societies. The new membership designation is consistent with the Accreditation Council for Graduate Medical Education use of "resident" and "fellow" to describe physicians in training programs, as well as the AMA's Resident-Fellow Section. The change takes effect immediately.

MOC Explained

To assist members with the maintenance of certification (MOC) process, the APA has published a summary of the ABPN's MOC requirements and a list of tools and products (many are free to members) that APA has developed to help members meet MOC requirements. Included is the ABPN schedule for phasing in various components based on the year of original certification that shows the number of CME credits required and the program units needed. In addition, it describes components and requirements of the Continuous Pathway to Lifelong Learning Program for diplomates certified or recertified in 2012 or later. The APA's self-assessment tools, performance-in-practice modules, and examination-preparation products are listed in the document. Click here to access the APA MOC document (member log-in required). Then click "Maintenance of Certification Explained" under the News tab on the left.

Medicare News & Updates

Overall 2014 Medicare Rates to Increase 0.5%, at least Temporarily

At press time, Congress had postponed for three months the 24% payment reduction for most Medicare services in 2014 required by the Sustainable Growth Rate (SGR) formula. The president is expected to sign the legislation. Because the 2014 Medicare regulation was issued nearly four weeks late due to the government shutdown, CMS has agreed to extend the period in which doctors can change their participation status until the end of January 2014. Meanwhile, the AMA has been actively lobbying for Congress to do away with SGR entirely. There has been bipartisan, bicameral support for legislation addressing this and other problems facing physicians who participate in Medicare. The temporary SGR fix buys time for finishing work on a replacement measure, which is currently a system under which doctors would be rewarded for meeting quality standards.

New Work Values Could Improve Medicare Payment for Psychiatric Codes

The 2014 fee schedule rule includes some good news for psychiatry. (Fee cuts are to be postponed until April unless Congress takes further action) CMS accepted work values for a number of psychiatric codes (90791/92 and the 908XX codes) that will improve Medicare payments for psychiatrists using those codes. The work values are part of the complex Medicare payment formula that includes practice expense and other variables to determine a fee for every code used by physicians. The APA has posted more details. Please contact hsf@psych.org with any questions.

CMS Extends 2014 Annual Participation Enrollment Period

The 2014 annual participation enrollment period will now end January 31, 2014, instead of December 31, 2013. Visit the Novitas participation center for information about participation and what actions you need to take. The 2014 fees will be posted soon on the Novitas website. They will reflect the 24% reduction in April if Congress has not yet taken action on SGR.

HIPAA Fact Sheet

The CMS "Medical Privacy of Protected Health Information" fact sheet targets health care professionals, providing resources and information regarding the HIPAA Privacy Rule. It includes guidance on common patient encounters and lists online HHS HIPAA resources.

Psychiatric Treatment Covered at 80% Under Medicare

The APA reports that in 2014 the outpatient mental health treatment limitation will be fully terminated, which finally ends the discriminatory practice of reimbursing psychiatric treatment at a lower rate than other medical care. Starting in January, psychiatric treatment will be reimbursed at 80%, which doesn't change the Medicare fee that psychiatrists charge, but patients will have a smaller copay. [See booklet link on next page for info.]

Tools Help Evaluate Medicare Participation

A newly updated toolkit from the AMA can help physicians who wish to review their Medicare participation options for 2014.

For more details about the payment rates for 2014, see the MLN Provider eNews, but keep in mind that the fee reduction will not occur until April, and then only if Congress allows SGR to continue.

Opting Out of Medicare

Since January 1, 1998, physicians have been allowed to opt out of Medicare and enter into private contracts with Medicare beneficiaries that allow them to set their own fees. A physician who opts out of Medicare agrees not to see any Medicare patients (barring emergencies or urgent services), except for those with whom she has entered into private contracts, for a period of two years. This means that if you work in a situation where you must see Medicare patients as a part of your employment, you cannot opt out of Medicare. It also means that if there is any possibility that your life will change in the next two years, and you may have to see Medicare patients as part of new managed care contracts or new employment, you also should not consider opting out of Medicare. The rules for opting out are very specific. Please visit the APA website for more details and templates for private contracting.

To communicate with your representative in Congress about Medicare, send an email via the AMA's Fix Medicare Now site.

Medicare News & Updates

TMS for Treatment of Depression

Novitas has posted a revision in its coverage determination for transcranial magnetic stimulation for the treatment of depression, which took effect on December 5. The revision includes a correction in Cautionary Uses section of Coverage Indications, Limitations and/or Medical Necessity section regarding location of medical device. Please click here for full details.

CMS Extends Meaningful Use Stage 2 Another Year

Stage 2 of the electronic health record (EHR) meaningful use program will be extended an extra year through 2016, building in more time for physicians and vendors to adequately prepare for Stage 3. But it doesn't change deadlines for Stages 1 and 2. Click here for an overview of progress on EHR adoption and related timelines. The December 12 issue of MLN Connects includes more EHR information such as timelines, payment adjustments and security risk analysis.

Protecting Your Medicare Enrollment Record

CMS has posted a fact sheet on how to ensure Medicare enrollment records are up-to-date and secure and actions physicians should take to protect their Medicare enrollment information.

Revised CMS Mental Health Services Booklet

Designed to inform readers about mental health services under Medicare, the booklet includes covered and non-covered mental health services, eligible professionals, outpatient and inpatient psychiatric hospital services, same day billing guidelines, and National Correct Coding Initiative. The Outpatient Mental Health Treatment Limitation's continued applicability in a few specific areas (e.g. partial hospital, psychological testing, etc.) is covered on pages 14 and 15.

Important 2014 PQRS Changes

The CMS 2014 Physician Fee Schedule rule includes several changes important to physicians.

Major 2014 PQRS Program Changes include:

- Total of 284 measures in 2014
- Increase in number of measures reported via claims and registry-based reporting mechanisms from 3 to 9
- Change in reporting threshold for both individuals and groups reporting individual measures via registry to 50% of the eligible professional's (EP's) applicable patients (from 80%)
- Elimination of option to report on claims-based measures groups

Payment Adjustment Updates

In addition, the rule established the following:

- EPs and group practices that meet the criteria for 2014 PQRS incentive will automatically avoid negative payment adjustment in 2016
- EPs using the claims and registry-based reporting mechanisms as well as the newly implemented qualified clinical data registry reporting mechanism may report 3 measures on 50% of their applicable patients to avoid 2016 PQRS payment adjustments
- Elimination of option to report on claims-based measures groups to avoid future payment adjustments

Group Practice Reporting Changes

For groups participating using the Group Practice Reporting Option (GPRO) in 2014, the rule included the following changes:

- Creation of new reporting mechanism, the certified survey vendor reporting mechanism, that allows a group of 25 or more EPs to count reporting of Consumer Assessment of Healthcare Providers and Systems Clinician & Group (CG CAHPS) survey measures towards meeting criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment

For more information about participating in PQRS, visit the CMS PQRS website.

More on the Parity Final Rule

Final regulations for the 2008 Mental Health Parity and Addiction Act were released in November. This news has been covered widely, but members may want to review the Maryland Parity Project's posts:

Final Parity Rule Upholds Strong Consumer Protections
Reactions to Final Parity Ruling
Final Parity Regulations Released

An HHS document discusses the Parity law in conjunction with the Affordable Care Act.

The APA provided the following summary of key provisions:

Effective Date
In general, the final rule is effective for plan years beginning on or after July 1, 2014. In practice, the bulk of plan years end December 31 so the effective date for most insured will be January 1, 2015.

Request for Comments
In the FAQs released with the rule, the Departments requested comments on "what additional steps, consistent with the statute, should be taken to ensure compliance with MHPAEA through health plan transparency, including what other disclosure requirements would provide more transparency to participants, beneficiaries, enrollees, and providers, especially with respect to individual market insurance, non-Federal governmental plans, and church plans." Comments are due by **January 8, 2014** to E-OHPSCA-FAQ.ebsa@dol.gov.

Scope of Service
The final rule clarified the scope of service issue by stating:

1. The 6 classification of benefits scheme (inpatient in and out-of-network, outpatient in and out-of-network, emergency care, and prescription drugs) was never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization, residential).

2. Although neither the Interim Final Rule (IFR) nor the final rule mandate specific services required to be offered by plans under the 6 classification scheme, the final rule clarifies that plans must assign intermediate services in the behavioral health area to the same classification as plans or issuers assigned intermediate levels of services for medical/surgical conditions.

The final rule provides an example on page 27:

> For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

The net effect of this provision is that parity requirements (as clarified by the FAQs issued by the Department of Labor today) extend to intermediate levels of MH/SUD care and that such services must be treated comparably under the plan.

(See examples 9 & 10 on page 193 in the rule for additional detail on how this rule impacts residential SUD facilities)

Non-Quantitative Treatment Limitations (NQTLs)

- The final rule strikes the provision included in the IFR that permitted plans to apply discriminatory limits on mental health/substance use disorder (MH/SUD) treatment if there was a "clinically recognized standard of care that permitted a difference."
- Under the final rule, parity requirements for NQTLs are expanded to include restrictions on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services (including access to intermediate levels of care). The net effect of this is plans will no longer be able to require that a patient go to an MH/SUD facility in their own state if the plan allows plan members to go out of state for other medical services.
- The final rule does not include a new quantitative floor or formula on how plans may apply NQTLs to MH/SUD.
- The final rule maintains the "comparable and no more stringently" standard on NQTLs without defining the term and continues to require plans to disclose the "processes, strategies, evidentiary standards and other factors used by the plan or issuer to determine whether and to what extent a benefit that is subject to an NQTL be comparable and applied no more stringently for MH/SUD than for medical/surgical."
- The improvement in the final rule is that plan participants or those acting on their behalf will now be able to request a copy of all relevant documents used by the health plan to determine whether a claim is paid (see disclosure section for more detail on what documents may be requested. Current or potential enrollees may request this information and plans are required to provide it within 30 days).
- **The final rule confirms that provider reimbursement rates are a form of NQTL**. The preamble clarifies that plans and issuers can look at an array of factors in determining provider payment rates such as service type, geographic mar-

More on the Parity Final Rule (Continued)

ket, demand for services, supply of providers, provider practice size, Medicare rates, training, experience and licensure of providers. The final rule reconfirms that these factors must be applied comparably and no more stringently on MH/SUD providers. Additional comments will be solicited if questions persist with respect to provider reimbursement rates.

Disclosure and Transparency
MHPAEA requires that the criteria for medical necessity determinations be made available to any current or potential enrollee or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available upon request. New disclosure requirements in the final rule will require plans to provide written documentation within 30 days of how their processes, strategies, evidentiary standards and other factors used to apply an NQTL were imposed on both medical/surgical and MH/SUD benefits.

Under the final rule, regulations under the ACA and FAQs issued by the Department of Labor (DOL) today, plans and issuers must provide the claimant, free of charge, during the appeals process with any new additional evidence considered relied upon or generated by the plan or issuers in connection with a claim.

Enforcement
The final rule clarifies, as codified in federal and state law, that states have primary enforcement authority over health insurance issuers. As such, states will be the primary means of enforcing implementation of MHPAEA.

The Department of Health and Human Services (HHS), through its Centers for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in a state that does not comply. The Department of Labor (DOL) has primary enforcement authority over self-insured ERISA plans.

State Preemption
More consumer protective state laws are not preempted.

Medicaid Managed Care, CHIP and Alternative Benefit Plans
The final rule does not apply to Medicaid Managed Care Organizations, Children's Health Insurance Program (CHIP) or Alternative Benefit Plans (i.e. Medicaid Expansion Plans under the ACA) even though the rule states the statute applies to these entities. As stated, the January 2013 CMS State Health Official Letter will continue to govern implementation of Medicaid managed care parity. The final rule states more guidance on this will be forthcoming. The PIC will be requesting this additional Medicaid guidance be issued within 180 days.

Cost Exemption for Plans and Issuers
The final rule provides a formula for how plans and issuers can file a cost exemption if the changes necessary to comply with the law raise costs by at least 2% in the first year.

Tiered Networks
The final rule allows plans and issuers to use multiple provider network tiers but only if they are not imposing these tiered networks more stringently on MH/SUD subject to the general test provided for NQTLs.

Application to the Individual Market
The final rule applies to the individual market to both grandfathered and non-grandfathered plans for plan year beginning on or after July 1, 2014.

Non-Federal Governmental Plans
Local and state self-funded plans may continue to apply to CMS for an exemption from MHPAEA's requirements.

Multi-Tiered Prescription Drugs
A plan may have multi-tiered prescription drug programs (applies different levels of financial requirements to different tiers of prescription drugs in accordance with the NQTL rules). A plan may not apply these tiered prescription drug programs more stringently on MH/SUD prescription drugs.

Links to key materials:

- Final regulation, available at www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf
- FAQs about ACA Implementation Part XVII and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/faqs/faq-aca17.html
- U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf

News release, available at http://www.dol.gov/ebsa/newsroom/2013/13-2158-NAT.html

Classifieds

EMPLOYMENT OPPORTUNITIES

PSYCHIATRIST - full or half time, independent contractor position with well-established & growing multidisciplinary practice. Spectrum Behavioral Health is an Annapolis area private practice with three desirable locations, congenial colleagues and comprehensive administrative support. For more information about SBH, visit our website: www.spectrum-behavioral.com. To discuss this opportunity, please call Barbara Usher, Operations Administrator, at 410-757-2077 x7121 or email barbara.usher@spectrum-behavioral.com.

Springfield Hospital Center is seeking Board-certified or Board-eligible general psychiatrists for our 230-bed MHA adult inpatient facility. Salary is negotiable, within MHA guidelines. Our rural, tobacco-free campus is 22 miles west of Baltimore, convenient to the Chesapeake Bay, Washington, and a variety of cultural, historic, sports, and recreational venues. Benefits include 27 paid days off in the first year, subsidized health insurance, free parking, a generous retirement program, and a truly pleasant workplace. A Medical Services physician is always on campus to attend to patients' somatic needs. Staff psychiatrists are not expected to work after hours, but some choose to supplement their salary by providing evening and weekend/ holiday coverage under contract. In addition, we offer after-hours coverage contracts to psychiatrists who are not full-time staff members. Please send CV to Paramjit Agrawal, M.D. Clinical Director, 6655 Sykesville Road, Sykesville, MD 21784. For questions, call (410)970-7006 or e-mail paramjit.agrawal@maryland.gov. EOE

Adult psychiatrist needed for contract work as consultant for busy private practice in Severna Park, MD. No overhead, scheduling, billing. Set your own hours and negotiated hourly rate. Friendly staff, newly renovated office suite. Contact Dr. Driscoll at babh1@verizon.net or call 410-315-9350.

PMHS OMHC needs Adult Psychiatrist(s). W-2 OR 1099. Strong team emphasis, flexible schedules. Optional evenings, no on call. Dundalk location. Send resume/ CV to Linda Wilkens, LCPC at lindawilkens@keypoint.org or call 443-216-4800.

PSYCHIATRIST NEEDED- Full or Part Time. Private practice in Columbia and/or Towson without hassles. Full administrative support. Flexible hours. Plenty of patients. Contact Abdul Malik, M.D. at 410-823-6408 x13 or email to Drmalik.baltimore@gmail.com

Springfield Hospital Center in Sykesville, MD is accepting applications for a Forensic Psychiatrist. Eligible candidates must have board certification including added qualifications in forensic psychiatry (or equivalent). Duties include pretrial evaluations of competency to stand trial and criminal responsibility, competency restoration, and training of residents and students. Please forward a CV and inquiry to Erik Roskes, MD, Director, Forensic Services, Springfield Hospital Center, by fax (410.970.7105) or email (erik.roskes@maryland.gov)

AVAILABLE OFFICE SPACE

Beautiful part-time office space in Columbia for fully licensed mental health professional. Avail Mondays, Fridays, Saturdays & Sundays. 15x17 (255 sq ft) w/windows. Free parking, utilities included. Bathroom in suite w/ copier & refrigerator. Access to I-70 & I-95. Avail immediately. Prices neg. by day/by hour. Contact jvizzini@puppettherapy.com.

NAMI Toolkit for Mental Health Education on Campus

The National Alliance on Mental Illness (NAMI) is offering college students and others free tools to increase mental health education on college campuses. The special toolkit also supports the National Dialogue launched by the recent White House Conference on Mental Health. The toolkit is based on NAMI's College Students Speak survey report, which indicated that stigma surrounding mental illness is the greatest barrier to college students seeking help. As part of the National Dialogue, NAMI also is supporting the National Association of Broadcasters public service campaign, www.ok2talk.org, encouraging young adults to talk about mental health concerns.

MPS Members Out & About

On December 10, **Mark S. Komrad M.D**. was a guest on WYPR's "Midday with Dan Rodricks" discussing increases in suicide. To listen to the program, click here.

On December 11, **Steven S. Sharfstein, M.D**. was quoted in a *New York Times* article, "Fewer Psychiatrists Seen Taking Health Insurance."

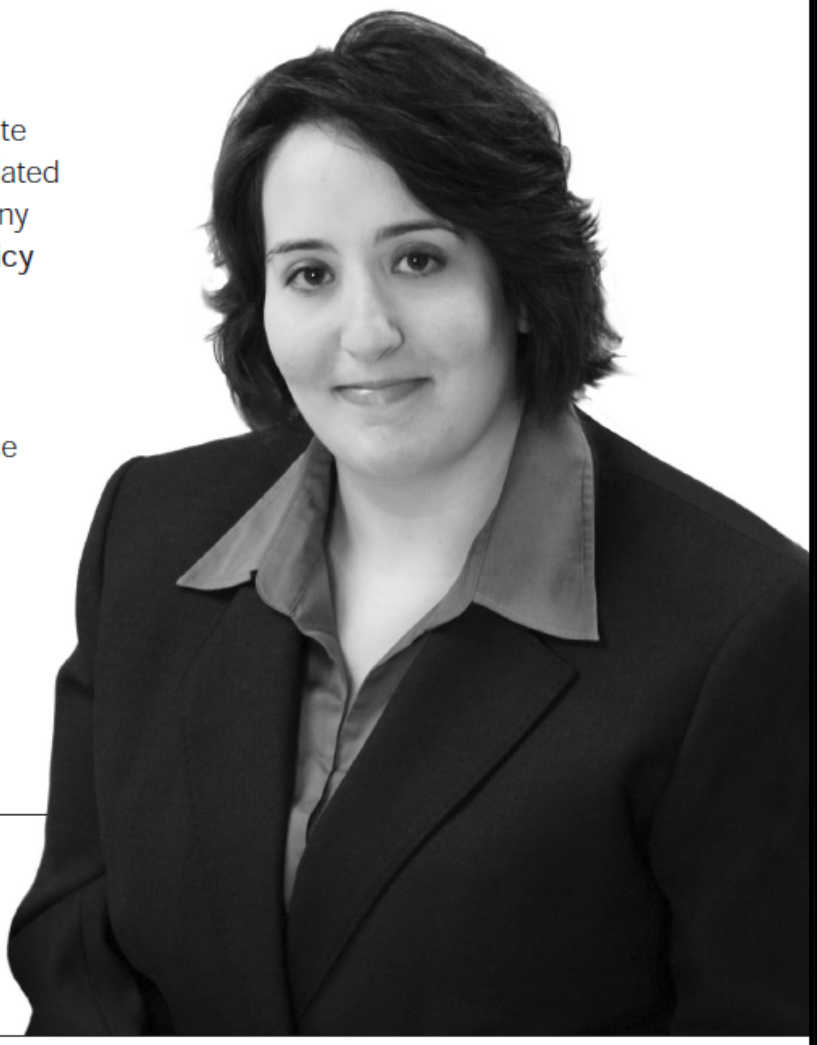
Help us spotlight MPS members who are out and about in the community by sending info to mps@mdpsych.org.

How much is your reputation worth?

You are more than likely to have an administrative action brought against you than a lawsuit. And, this can cost you.

Should you face an investigation from a state licensing board or governmental agency related to billing, a professional society inquiry or any other administrative defense issue, **our policy provides $50,000 administrative defense coverage at no additional charge.**

We have the comprehensive coverage you need to protect your reputation and practice setting. There is no deductible and we assign you an attorney so you don't pay out-of-pocket expenses.



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