MARYLAND PSYCHIATRIC SOCIETY

MPS NEWS

Volume 32, Number 4 **Editor: Heidi Bunes** **August 2018**

In This Issue

Deadline for articles is the 15th of the month preceding publication. Please email heidi@mdpsych.org.

MPS News Design & Layout
Meagan Floyd

The next MPS Council meeting will be held at 8 PM Tuesday, September 11th in the MPS office

President's Column

It's a "Go," But Where Is It Going?

Governor Hogan recently signed a new 5-year contract for the Maryland All-Payer model. For psychiatrists in Maryland, the implications of this, for now, apply mostly to those who work for or with hospital systems, not including the so-called Institutions of Mental Disease (IMDs, which are free-standing psychiatric hospitals). In its most recent reconfigurations, the model has been shaped by what Medicare and others see as a number of innovative approaches to reimbursement, to "lower costs and improve quality for consumers" and move away from the traditional fee-for-service payment scheme. The latest iteration of the All-Payer model is called a "Total Cost of Care" approach, dubbed the "Maryland Model." This means that hospitals will now be reimbursed and accountable not just for inpatient care, but for "total cost," including outpatient care.

An early problem of the model that all hospitals will confront is attribution. Who is responsible for a patient who gets a knee replacement at hospital A, gynecologic care at hospital B and psychiatric care at hospital C? How can hospitals control costs and utilization by trying to influence variables they may not control at all? The trend of these changes is toward reimbursement for caring for populations and away from incentivizing hospitals, via fee-for-service, to devote resources only to remunerative fields, while diminishing or doing away with less lucrative but important and needed services. Despite the intent of these new models, some efforts by hospitals to date are focused on revenue maximization (or, more accurately, loss minimization) and accusations of "gaming" by hospitals have emerged. This is not terribly surprising given the challenges in coming up with metrics to hold hospitals accountable that represent actual improvements in care delivery. The number of reported hospital-acquired conditions, for example, has plummeted in the state, but one can ask if this is true improvement in care or merely more purposeful documentation (or its lack) aimed at avoiding financial penalties.

Further skepticism is merited about these changes leading to expansion of needed inpatient psychiatric bed capacity. Inpatient psychiatric care is a critical component in the spectrum of care but, because of low reimbursement and high overhead, is a perennial target of hospital administrators more loyal to the bottom line than to patient and community needs. These changes also come in the setting of a state psychiatric hospital system which has devolved into a primarily forensic program, despite increasing demand for services in EDs, long stays and diminished access to inpatient beds, particularly in Baltimore.

Will this new approach incentivize hospitals to take up the slack? Odds are good it won't lead to a dramatic expansion of inpatient beds, but one can hope that these moves toward improving patient care will, in some unforeseen way, finally lead to a realignment of priorities and expansion of psychiatric services in the settings where it is most needed.

Patrick T. Triplett, M.D.

[See related training on page 11 and more info on page 4.]

Would You Prefer Printed MPS Newsletters?

The MPS now offers members the option to receive printed black and white copies of *MPS News* (12 issues) and *The Maryland Psychiatrist* (3 issues). Newsletters will be mailed to members upon request for an additional annual fee of $50 and will arrive in an envelope sent by first class mail. Members will continue to receive emailed copies, which they can use to access the links to online information referenced in the newsletter text. This offer is only available to active MPS members. Print subscriptions must be paid in advance, renewable annually and non-refundable. Members must notify the MPS promptly of address changes. To order, please send a check and a brief note to: MPS, 1101 St. Paul Street #305 Baltimore, MD 21202. Please email mps@mdpsych.org or call 410-625-0232 with questions.

LAST CALL - Special Member Rate for 2018 MPS Directory Ad

MPS members can advertise their practice, change in location, specialty, new book, etc. in the 2018 membership directory for just $100 for 1/3 page. Contact Meagan Floyd at 410-625-0232 or mfloyd@mdpsych.org.

ORDER NOW—the Directory goes to print at the end of this month!

Become an APA Fellow— It's Easy to Apply!

Are you ready to take the next step in your professional career? Members pursue Fellow status as one of the first steps to enhancement of their professional credentials. Members who apply and are approved this year will be invited to participate in the Convocation of Distinguished Fellows during APA's 2019 annual meeting in San Francisco. **The deadline is September 1**. Visit the APA website for more details and a link to the application.

Maryland Psychiatric Society Psychopharmacology Symposium

Saturday November 17, 2018
The Conference Center at Sheppard Pratt

Don't miss this highly anticipated event. More information & registration materials coming soon.

LAST CALL - 2018 Member Survey

Time is running out! Please take a few minutes to complete this survey to help guide how your committees, Council and staff will work for you in the coming year. Responses will be published in the September *MPS News*. The survey closes **August 15th**. Thank you for your response!

PARTICIPATION INCENTIVE: Three respondents who complete the entire survey and include their names will be chosen at random for a **$100 credit** that can be applied toward MPS dues or an MPS event.

Click here to take the survey now.

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.

Sarah R. Clancy Van Remmen, M.D.

Transfer Into Maryland
Max Spaderna, M.D.

Advanced to General Member
Ellen Breen, M.D.
Marissa Flaherty, M.D.
Julia Merti, M.D.
Chinenye Onyemaechi, M.D.
Dina Sztein, M.D., M.P.H.
Elizabeth Wise, M.D.

Come Join Us for an OPEN HOUSE

Join us **October 9th 5:30pm–7:00 PM** for an open house! Meet MPS leadership, tour the MPS office, meet staff, learn interesting MPS history and network with other MPS members.

Drinks and appetizers will be served. Watch for more information and registration details coming soon.

Hope to see you there!

Graduating Residents Make Their Debut

Natalie Beaty, M.D. (JH)– Dr. Beaty will remain in Maryland in Private Practice in Towson in addition to working as a psychiatrist at the Early Psychosis Intervention Clinic (EPIC) at Johns Hopkins Bayview. She will also do Quality Improvement Residency Teaching at Johns Hopkins Psychiatry Residency Program. She has special interests in Women's Health and Reproductive Psychiatry, and consultation services for mood and psychotic disorders. Dr. Beaty sees adolescents, adults and geriatric patients. While she will not participate with insurance, she accepts referrals in her private practice.

Marissa Flaherty, M.D. (UM) – Dr. Flaherty is staying in the state as a Unit Director Psychiatrist at Springfield Hospital Center admissions unit. She practices inpatient psychiatry and specializes in working with psychotic spectrum disorders, depressive disorders and anxiety disorders in the state hospital setting.

Julia Merti, M.D. (UM)– Dr. Merti is practicing at Gladstone Psychiatry and Wellness in Columbia. She sees adult patients for general psychiatry with a special interest in addiction psychiatry. Dr. Merti is accepting patient referrals.

Paul Nestadt, M.D. (JH) – Dr. Nestadt practices at Johns Hopkins Hospital. He sees anxiety patients in the outpatient consult clinic, and general/ dual diagnosis inpatients a few months a year. He plans to specialize in research on suicide, firearms, and opiates with a clinical focus on CBT for anxiety as well as inpatient care in general. Dr. Nestadt accepts referrals through the Hopkins Anxiety Clinic.

Chinenye Onyemaechi, M.D. (JH)- Dr. Onyemaechi ventured into locum tenens work in July 2018, although Maryland will remain her home base. Her first assignment includes work as an emergency psychiatrist at a behavioral health facility in Portland, Oregon.

Rebecca Sokal, M.D. (UM) – Dr. Sokal will be moving to Dubuque, Iowa where she will work in Inpatient/Outpatient/ ECT setting which will focus on adult patients.

Dina Sztein, M.D., MPH (UM) – Dr. Sztein is practicing at Gladstone Psychiatry and Wellness in Columbia. She sees largely child and adolescent patients with general psychiatric concerns and specializes in child and adolescent psychiatry, including but not limited to ADHD, Depression and Anxiety disorders. Dr. Sztein is accepting referrals.

Elizabeth Wise, M.D. (JH) – Dr. Wise is staying in Maryland and primarily practices at Johns Hopkins Bayview. She works in community psychiatry and sees geriatric patients and adults with autism spectrum disorder and intellectual/developmental disabilities. She specializes in aging with autism spectrum disorder and geriatric psychiatry. Dr. Wise accepts referrals within the community psychiatry program at JHBMC.

Graduates: please email news about your plans following completion of residency to Meagan Floyd for a future issue.

Don't Forget to Check PDMP When Prescribing Benzodiazepines and Opioids

See the July issue for details

What if I don't know if I'm registered, or can't find my PDMP Registration Confirmation Code?

Go to the PDMP Auto-Registration front page (https://crisphealth.force.com/crispregkeydata), select Physician for Member Title, and enter license and DEA numbers. Then enter the red characters displayed in the gray window and hit "Submit." If you are already registered, the system will let you know and show your PDMP Registration Confirmation Code and your email account on record will also be emailed a copy of your Confirmation Code.

PDMP Use Mandate Call Center

PHONE: From 8 AM to 6 PM, please call **800-492-1056 X3324** or **410-878-9688** to speak with a staff member. If you call after hours or on weekends, please leave a message and a staff member will return your call within two business days.

EMAIL: **pdmp@medchi.org**, and someone will reply within two business days.

Resource for Checking the PDMP

The Power of Perceptions & Understanding: Changing How We Deliver Treatment and Recovery Services

A four-part webcast series educates healthcare professionals about the importance of using approaches that are free of discriminatory attitudes and behaviors in treating individuals with substance use disorders and related conditions, as well as patients living their lives in recovery. The one-hour webcasts feature discussions among experts in addiction treatment, research, and policy and carry free CME credits. Each webcast recording includes a resource guide. Access the webcasts.

License Renewals for Last Names (A-L)

Renew medical licenses that expire September 30 online.

A Criminal History Records Check (CHRC) must be submitted prior to renewing. Click here for CHRC instructions. If you applied for a license or reinstatement **after 10/1/2016** your fingerprints are already on file and you do not need to submit a second set.. Do not apply for CHRC more than **6 weeks prior** to when you renew. Start the application immediately after submitting your fingerprints.

The one-hour CME for opioids is no longer required, but there is a new question about medical liability insurance.

There is no grace period after September 30. You are not authorized to practice if your license is not renewed. For more information, see the MBP physician renewals page.

Maryland News

Maryland Model All-Payer Contract Signed

On July 9, Governor Hogan and CMS Administrator Seema Verma held a ceremony at the Maryland State House to sign and officially enact Maryland's Total Cost of Care All-Payer Model. The Maryland Model is an innovative approach to healthcare provider payment that is unique to Maryland and made possible via a contract between CMS and the state. The new contract, which takes effect on January 1, 2019 and extends through the end of 2023, is expected to provide $1 billion in savings over five years.

Maryland's 2014 All-Payer Model has already saved Medicare more than $586 million through 2016, compared to national spending. Under this model, hospitals have successfully reduced unnecessary readmissions and hospital-acquired conditions while decreasing the growth in hospital cost per capita. **The new Maryland Model will expand this approach across the healthcare system. It aims to control the growth in healthcare costs, both at hospitals and community providers, while improving patient outcomes and quality of care.** To achieve this comprehensive coordination across the entire healthcare system, the Maryland Model will:

- Coordinate care across both hospital and non-hospital settings, including mental health and long-term care
- Invest resources in care that is focused on the patient and enhance primary-care teams to improve individual patient outcomes
- Set a range of quality and care improvement goals and provide incentives for providers to meet them
- Concentrate system and community resources on population health goals to help address opioid use and deaths, diabetes, hypertension, and other chronic conditions
- Encourage and facilitate programs focusing on the unique needs of Marylanders across geographic settings and other key demographics

As the only state to operate under an all-payer model, Maryland is positioned for healthcare innovation. The Maryland Model provides a significant incentive across the health system to provide greater coordinated care, expanded patient-care delivery, and collaboration of chronic disease management, while improving the quality of care at lower costs to the consumer. It is a step towards aligning the entire delivery system by adopting the first alternative payment model to shift hospital payments to full global budgets. Success will require both hospital and physician commitment to payment transformation and care redesign. The Model is expected to reward quality over quantity through a focus on how to best manage a patient's care. Emphasis is on improved primary care outcomes, coordinated, quality care, prevention and wellness.

The new Maryland Primary Care Program, which includes co-located Psychiatry, will expand service and access to thousands of Marylanders. **Practice applications for the program will be open from August 1 through 31.** Please click here for complete details. See page 11 for a training opportunity.

Maryland now has the potential to create a model of healthcare integration that results in better healthcare outcomes while also bending the cost curve. To the extent that this new agreement aligns payment across providers to move from vendorship to partnership, it could create a quality care model for the nation; however, much work remains following this first step.

Maryland Navigator Program Funding

The recent reduction in federal funding for the federal navigator program does not pertain to Maryland. Maryland Health Connection is a state-based marketplace. Therefore, the funding that supports our navigator program has been maintained for our navigators, who provide help for enrollment into free and low cost health coverage and private health plans. Outreach and communication to the 6% of Marylanders who still lack health coverage is vital.

Michele Eberle, Executive Director
Maryland Health Benefit Exchange

Public Behavioral Health System Rates Effective July 1

The rates for community-based behavioral health services in Maryland were increased as of July 1. Rates were initially posted incorrectly on the Beacon Health Options website. New rates are now listed. The MPS is in the process of confirming that these are the correct amounts for E&M services. For more information, visit the Maryland Beacon Health Options website or the Maryland Behavioral Health Administration site.

Save The Date

This year's annual **Kolodner Memorial Lecture** will be held at MedChi on **Thursday September 20th**. Watch for the September edition of *MPS News* for more information, including how to register.

Maryland News

Court Decision on Discharge following Involuntary Admission

A July 12, 2018 decision from the Maryland Court of Appeals (COA), the highest court in the State, provides some level of comfort to psychiatrists working on acute admission units. The case was brought by the estate of a man who committed suicide shortly after being discharged from a psychiatric hospital claiming a negligent action against the hospital and the decedent's treating physician. The estate argued that the hospital and physician breached the standard of care for discharging an involuntarily admitted patient with a history of attempted suicides. The patient was discharged after he had been certified for involuntary admission by two physicians and admitted to the inpatient unit, but *before* the mandatory civil commitment administrative hearing scheduled by statute within 10 days of admission.

In short, the court said: "*We hold that the process of involuntary admission begins with the initial application for involuntary admission of an individual and ends upon the hearing officer's decision whether to admit or release that individual. During that process, if a physician applies the statutory criteria for involuntary admission and concludes* ***in good faith*** *that the individual no longer meets those criteria, the facility must release the individual. That decision is immune from civil liability and cannot be the basis of a jury verdict for medical malpractice." (emphasis added)*

In other words, if a patient is released after the point of involuntary admission but prior to the ALJ hearing, based on a good faith decision that the patient no longer meets involuntary admission criteria, the psychiatrist is statutorily protected from civil liability.

Essentially, the COA held that the statute allows the time between the certificates and admission and the later hearing to be used to continuously assess the patient against the civil commitment criteria. If the patient improves during that time and no longer meets those criteria, he MUST be released.

Note that an earlier decision provided similar protection to those working in ERs who decide in good faith not to certify for admission. The current case extends that good faith protection to decisions made throughout the involuntary admission process: the decision in the ER to admit or not admit, and, for those admitted, decisions made on each day up to the date of the hearing.

What this case does not address is the situation where the patient was involuntarily committed by the ALJ at a hearing, and at some later point a decision is made to release the patient who no longer meets civil commitment criteria. Such decisions are not statutorily protected under current law.

MedChi and the AMA filed an amicus brief defending the hospital and the physician.

Erik Roskes, M.D.

MDH Requests Expanded Medicaid Coverage for IMDs

On July 2, the Maryland Department of Health (MDH) submitted an amendment to its §1115 HealthChoice demonstration waiver to the Centers for Medicare and Medicaid Services (CMS). The proposed amendment covers five areas, one of which is a request that Maryland's Institute of Mental Disease (IMD) exclusion waiver amendment cover ASAM Level 4.0 services in private IMDs for participants diagnosed with a primary substance use disorder (SUD) diagnosis and a secondary mental health diagnosis. If approved, the new coverage would begin on January 1, 2019.

Maryland's drug- and alcohol-related intoxication deaths increased in 2016 for the sixth year in a row, reaching an all-time high of 2,089 deaths, a 66% increase over 2015 (the largest recorded single-year increase). The number of opioid-related deaths increased by 70% between 2015 and 2016 and has nearly quadrupled since 2010.

MDH is requesting expenditure authority for otherwise-covered services provided to Medicaid-eligible participants 21 through 64 years of age who are residing in a private IMD and have a primary SUD diagnosis and a secondary mental health diagnosis. It seeks to extend coverage for ASAM Level 4.0 (Medically Managed Intensive Inpatient services) for up to 15 days in a month. The days authorized would be based on medical necessity, but would not exceed 15 days per month and would be limited to in-state facilities only. For the large cohort of Medicaid adults with co-occurring disorders, private IMDs can deliver specialized services for participants whose active psychiatric symptoms limit their access to many SUD treatment programs.

MDH estimates that 1,130 Medicaid participants will receive ASAM Level 4.0 services for co-occurring SUD and mental health disorders in private IMDs under this proposed expansion at a cost of approximately $16.2 million annually. Adventist Behavioral Health, Brook Lane Health Services, Inc., and Sheppard Pratt Health Systems are the three Maryland private psychiatric hospitals to which this proposal would apply.

Practicing a Wellness Lifestyle

Baltimore City Medical Society and Baltimore County Medical Association will offer a CME activity, *Practicing a Wellness Lifestyle: What Physician and Non-Physician Leaders Should Know,* Saturday, **September 8 from 8:30 AM to 12:30 PM**. Hear from national and local leaders on the impact of stress and burnout on physicians and their practices, and strategies to prevent or ameliorate stress and burnout throughout the physician lifecycle. For information and registration: 410-539-0872, extension 3351 or 3317, or info@bcmsdocs.org.

Maryland News

Minority Mental Health Update

The Maryland Office of Minority Health and Health Disparities July 2018 newsletter notes that according to the Substance Abuse and Mental Health Services Administration (SAMHSA):

- Over 70 percent of Black or African American adolescents with a major depressive episode did not receive treatment for their condition
- Almost 25 percent of adolescents with a major depressive episode in the last year were Hispanic/Latino
- Asian American adults were less likely to use mental health services than any other racial/ethnic groups
- In the past year, nearly one in 10 American Indian or Alaska Native young adults had serious thoughts of suicide
- In the past year, one in seven Native Hawaiian and Pacific Islander adults had a diagnosable mental illness

While health equity is increasing in some health areas, according to the Agency for Healthcare Research and Quality's report on quality and disparities, racial and ethnic minority groups in the U.S. are still less likely to have access to mental health services, less likely to use community mental health services, more likely to use emergency departments, and more likely to receive lower quality care.

Regulations to Impact Individual Health Premiums

In July, the Maryland Health Benefit Exchange (MHBE) announced hearings on state reinsurance regulations. The purpose of the reinsurance program is to hold down consumer cost and bring greater certainty to Maryland's individual health insurance market for plan years 2019 through 2023. If approved by the federal government, the program should reduce premium increases for plans sold in the individual health insurance market both on and off Maryland Health Connection, the state marketplace. The following hearings will allow public input on how to shape regulations that would implement the 2018 legislation:

- **Aug. 2**, 2-4 p.m., MHBE, 750 E. Pratt St., Baltimore, MD 21202
- **Aug. 9**, 1-3 p.m., Maryland Department of Transportation, 7201 Corporate Center Drive, Hanover, MD 21076
- **Aug. 16**, 2-4 p.m., MHBE, 750 E. Pratt St., Baltimore, MD 21202

Interested parties may send written comments to mhbe.publiccomments@maryland.gov. More information on the state reinsurance program is available at MarylandHBE.com. The Department of Health and Human Services and the Department of the Treasury announced they have accepted Maryland's application to create a reinsurance program. Public comments on Maryland's application are being accepted through **August 4**. More information on the federal review is available online.

Proposed increases for some Carefirst and Kaiser individual plans are particularly concerning. Public comments are being accepted until 5 PM on Wednesday, August 15—email healthinsurancerateview.mia@maryland.gov.

Medicare News

CMS E&M Coding Initiative

As part of its "Patients Over Paperwork" initiative, CMS has proposed an overhaul of the Evaluation & Management (E&M) documentation and coding system to reduce time spent entering unnecessary information into patient records. E&M visits make up 40 percent of all physician charges for Medicare, so the proposed changes are expected to have wide-reaching impact.

Current codes have 5 levels for office visits, physicians use levels 2-5, whose differences can be difficult to discern. Each level has unique documentation requirements that are time-consuming and confusing. **CMS has proposed to move from separate documentation requirements for each of the 4 levels that physicians use to a system with just one set of requirements, and one payment level each for new and established patients.** APA reports that an AMA study shows the impact is a small increase in psychiatry E&M payments, but certain subspecialties would see a 2-3% decrease. CMS believes that any small negative payment impact would be outweighed by the reduction in documentation burden.

In addition to streamlining documentation, CMS is advancing the MyHealthEData Initiative which promotes the interoperability of electronic medical records so that all patient information can be available to inform clinical decisions. To this end, CMS proposed a redesign of the incentives in the Merit-Based Incentive Payment System (MIPS) to reward sharing of health care data securely with patients and their providers.

Proposed Year 3 MIPS Opt-in criteria are if clinicians meet or exceed one or two, but not all, of the low-volume threshold criteria, which are proposed to be: Dollar Amount of $90,000, Number of Beneficiaries 200, or Number of Covered Professional Services 200.

A New York Times article provides more information. CMS requests feedback on these and other Physician Fee Schedule proposals that are summarized here and available in detail here. CMS also seeks feedback on changes proposed for Year 3 of the Quality Payment Program (QPP), which includes MIPS. The QPP proposals are summarized here. Comments are due **September 10.**

MIPS 2017 Performance Feedback

CMS has posted the 2017 Performance Feedback User Guide to help eligible clinicians and groups understand their 2017 Merit-based Incentive Payment System (MIPS) performance feedback. It explains who can access MIPS performance feedback, the differences between preliminary and final performance feedback and how to access your feedback. Please see the 2017 Performance Feedback Fact Sheet for more info.

Medicare News

October 1 Deadline for Requesting MIPS Targeted Review

If you participated in the Merit-based Incentive Payment System (MIPS) in 2017, your final score and performance feedback is available on the Quality Payment Program (QPP) website. Your 2019 payment adjustment is based on this final score. A positive, negative, or neutral adjustment will be applied to the Medicare payment for your services under the Medicare Physician Fee Schedule in 2019. MIPS eligible clinicians and groups, including those who are subject to the APM scoring standard, can request that CMS review their performance feedback and final score through a process called targeted review.

When to Request a Targeted Review
If you believe an error has been made in your 2019 MIPS payment adjustment calculation, you can request a targeted review **until October 1**. Following are examples of why you may want to request a review:

- Errors or data quality issues on the measures and activities you submitted
- Eligibility issues (**e.g., you fall below the low-volume threshold and should not have received a payment adjustment**)
- Being erroneously excluded from the APM participation list and not being scored under APM scoring standard
- Not being automatically reweighted even though you qualify due to the 2017 extreme and uncontrollable circumstances policy

Note: This is not a comprehensive list; CMS encourages review requests for any reason that may be warranted.

How to Request a Targeted Review

- Go to the QPP website
- Log in using your Enterprise Identity Management (EIDM) credentials; these are the same EIDM credentials that allowed you to submit your MIPS data. Please refer to the EIDM User Guide for details.

CMS generally requires additional documentation to support the request. If your request is approved, CMS will update your final score and associated payment adjustment (if applicable), as soon as technically feasible. CMS will determine the amount of the upward payment adjustments after the conclusion of the targeted review submission period. **Targeted review decisions are final and not eligible for further review**.

For more information, please see the Targeted Review of the 2019 MIPS Payment Adjustment Fact Sheet and the Targeted Review of 2019 MIPS Payment Adjustment User Guide.

CMS will host **"Office Hours" on Tuesday, August 14 from 2 – 3 PM** to:

- Provide a brief overview of MIPS 2017 performance feedback and targeted review
- Answer frequently asked questions
- Highlight helpful performance feedback and targeted review resources

Click here to register. CMS encourages emailed questions prior to the Office Hours session. To submit a question, please email CMSQualityTeam@ketchum.com.

Treating Students Away at College

As summer begins to recede, many psychiatrists will have patients heading off to college for the first time. What should you do about a patient who is leaving the area and asks that you continue treating her while she is away at school? On the one hand, it may seem very logical. You know this patient and she trusts you. You have been making excellent progress since you began treating her, so why would you want to end the treatment relationship now? Because 1) it may not be legal to continue to treat, and 2) it may not really be in your patient's best interest. [Continue reading from the PRMS LinkedIn post on August 22, 2014.]

For other helpful perspectives on the decision to continue treating patients who relocate for college, click here, and click here for risks.

Payer Relations Committee Request

Under the leadership of Drs. Tom Krajewski and Bob Herman (new co-chairs), the MPS Payer Relations Committee is looking to assist members regarding third party payers. In general, this group aims to increase access to psychiatrists under insurance plans, as well as improving appropriate psychiatrist reimbursement.

The committee requests that members report issues and concerns that they would like the committee to address by email to Heidi Bunes. Requests should include enough details for a good understanding of the problem as well as the best email address to use for any follow up questions.

In addition, the committee is considering a regular newsletter column that highlights news related to insurance issues. Members are encouraged to submit ideas for the column by email to Dr. Krajewski.

APA News & Information

July APA Board of Trustees Meeting: Selected Highlights

(This information is very unofficial.)

On Ligature Risk and Other Self-Harm Risk Assessments: In a survey as to ligature risks, of 88 facilities, 55 reported receiving citations for ligature self-harm risks. The impact of these citations caused 10 facilities to close inpatient psychiatric units, 14 facilities to close psychiatric beds, and 23 facilities to reduce other psychiatric services, including workforce reductions. The cost to make modifications ranged from $100 to $6,000,000.

On Immigration: APA was one of the first medical associations to publicly oppose the policy of separating children from their parents. APA has led 17 other mental health organizations in sending a letter to the Department of Justice, Department of Homeland Security, and Department of Health and Human Services urging the Administration to end its policy of separating children from their parents.

On the Annual meeting last May in NYC: An impressive number, 16,325, people attended the meeting (13,743 of whom were psychiatrists). Highest number ever since pharm companies stopped funding people to attend.

American Medical Association: APA Member, Dr. Patrice Harris, has been elected as the President-Elect of the American Medical Association. She is the first African-American woman to hold that office.

Finances: For the five months ended May 31, 2018, net income was $13.1 million, compared to $16.0 million through May 2017, a difference of $2.9 million. The lower net income is attributable to lower investment income.

Membership: Total Membership at the beginning of 2018 reached 37,896, the highest level in 15 years. There has been an 11.9% increase in total membership from 2013 through 2017.

Advocacy, Safe Prescribing: I have often found the issue of safe prescribing to be of considerable interest to Members. At this meeting, the Board approved the following wording, which will go to the APA Assembly in November for final approval:

1) The treatment with medication of patients with mental illness requires a foundation of medical education, training, supervision, and care of patients with a broad range and severity of medical problems.

2) The safety of patients and the public must be the primary consideration of each state licensing agencies and legislatures.

Roger Peele, M.D.
APA Area 3 Trustee

Update on APA Efforts Regarding Immigrant Families

The Department of Health and Human Services informed the APA that they have contracted with Lutheran Family Services and Catholic Charities to assist with mental health services and reunification of children with their families. Both organizations are still organizing with multiple volunteer organizations on the ground to determine logistical capabilities. They expect that the children still separated from their parents/ sponsors will be reunified before the end of July. When families are reunited and new immigrant families come into the U.S., they are processed near the border, but proceed to their sponsor somewhere else in the U.S. Most are referred for social and legal services to a local Catholic Charities or Lutheran Family Services nearest to their sponsor.

Since these needs are at the local level and each service area is unique, needing different assistance at each location, Catholic Charities or Lutheran Family Services are reaching out to their individual service providers in the states and cities to determine specific needs. **The APA is posting information from agencies that are looking for pro-bono psychiatric services here. The Esperanza Center in Baltimore is currently the only Maryland group posted:**

Helany J. Sinkler hsinkler@cc-md.org
Esperanza Center, Catholic Charities of Baltimore

The APA and MPS would like to be updated on members who have volunteered. Please email Heidi Bunes.

Other opportunities to assist are the Physicians for Human Rights Asylum Network, a listing where various advocacy organizations look for evaluators, and Stand With Immigrants, a sign up to volunteer as a mental health professional.

APA advocacy has continued; it partnered with 13 other health care organizations on a letter to House and Senate Oversight Committees urging them to hold hearings with officials from the Department of Homeland Security and Department of Health and Human Services on the treatment of children and families who were separated from their parents at the U.S. border.

Saul Levin, MD, MPA, FRCP-E
APA CEO and Medical Director

Free Members' Course of the Month

August Course of the Month - Psychotropic Medications and Sleep Disorders. This presentation provides an introduction to common sleep disorders and examines their overlap with psychiatric illnesses. Presented by J. Michael Bostwick, M.D., of the Mayo Clinic College of Medicine. Click here to access the Course of the Month.

APA News & Information

Help for Members Appealing Insurance Denials

At its May meeting, the APA Assembly approved an action paper requesting that APA improve its "Appealing Treatment Denials" webpage to help members be more successful with appeals. Specifically, it requests a user-friendly toolkit describing the steps to follow to maximize the likelihood of success. (The Board of Trustees must agree before the paper is implemented.) According to the action paper, "Fewer than 5 percent of appeals are successful when reviewed by the insurance company issuing the initial denial or by their contracted appeal review agency ... When the appeal review agency is truly independent, the success rate for appeals jumps to nearly 60 percent." Since the process for appealing denials is complicated and often frustrating, this extra assistance could help make a difference.

The experience in Maryland is that while denials of mental health services have increased, the number of appeals of those denials has decreased. Maryland's Appeals and Grievance process begins when a carrier renders an "adverse decision" that care is not medically necessary. If the patient (or his/her representative) protests this decision, it is called a "grievance." If the carrier stands by the original decision, the patient can file a "complaint" with the Maryland Insurance Administration (MIA). Per the December 2017 **MIA annual report**:

- **Adverse decisions for mental health services increased by 70% from 2013 to 2016 (687 in 2013 and 1,169 in 2016).**
- **Despite the rise in adverse decisions, the number of grievances for mental health services decreased by 43% over the same period (238 in 2013 to 136 in 2016).**
- **Adverse decisions for mental health services were highest at Aetna, followed by CareFirst.**
- **For complaints filed with MIA, the carrier decision was upheld by MIA 60% of the time for partial hospitalization for mental health/substance use, 70% of the time for inpatient and 50% of the time for outpatient.** (In other words, half of all outpatient appeals were successful.)

The action paper noted that appeals are most likely to lead to a reversal of a denial when the following factors are included: use of the patient's voice as an active agent in the appeal process; anchoring appeals to third-party resources representing generally accepted standards, such as APA practice guidelines, the Level of Care Utilization System (LOCUS) developed by the American Association of Community Psychiatrists, or relevant published research; *and* ***invocation of the federal mental health parity law****.

***The federal parity law will reach its 10-year milestone in October. Please watch for more related news as the anniversary draws near.**

Comments Invited on *DSM-5* Proposal

The *DSM* Steering Committee invites comments on a proposal to change part of the text under pedophilic disorder. Specifically, the proposal suggested that there is insufficient evidence to support the conclusion that "pedophilia per se appears to be a lifelong condition" and recommended that the statement be replaced with one reflecting that very little is known about the persistence of pedophilia over time. Click here for more details or to comment. The deadline is **Wednesday, August 29**.

Joint Principles for Addressing the Opioid Crisis

The APA and five other medical organizations have proposed policy guidelines to expand access to opioid treatments, increase substance use research and reduce the stigma of addiction. The organizations urge policymakers to implement solutions that focus on the opioid crisis, but also address other serious substance use disorders that devastate families. The joint principles include:

- Align and improve financing incentives to ensure access to evidence-based SUD treatment.
- Reduce the administrative burden associated with providing patients effective treatment.
- Incentivize more providers to treat SUD.
- Advance research to support prevention and treatment of substance abuse disorders.
- Ensure a public health approach to SUDs by addressing childhood stress, access to naloxone, and fair and appropriate treatment for individuals in the criminal justice system and pregnant women.
- Address the maternal-child health impact of the opioid crisis.
- Continue to provide comprehensive pain management for patients

ABMS MOC Commission

There is an 18-month process in place to evaluate the future of maintenance of certification (MOC), which is soon to be referred to as "continuing board certification." The MOC commission is represented by ABMS, ABMS member boards, ACCME, ACGME, CMSS, the Coalition for Physician Accountability, AMA, and the general public. APA provided testimony at the Vision Initiative meeting in Denver in June 2018 and relayed APA's deep concerns about MOC and the path ABMS and its specialty boards are taking, not listening to the diplomates and their dissatisfaction.

From Dr. Levin's CEO Update
July 14-15 APA Board of Trustees

APA News & Information

SAMHSA Minority Fellowship Award

The APA has been awarded a five-year, $7.1 million grant for the SAMHSA Minority Fellowship Program (MFP), one of the oldest federally-funded grants at APA. This MFP grant cycle was highly competitive, and this award almost doubles APA's funding from the last cycle.

The charge for the grant is: 1) to reduce health disparities and improve behavioral health care outcomes for underserved populations and 2) encourage more racial and ethnic minorities to join the behavioral health workforce. While racial and ethnic minorities make up more than 28% of the nation's population, less than 20% of America's mental health workforce consists of racial or ethnic minorities. Since 1974, the APA has had more than 500 MFP graduates. Today, these alumni serve racial/ethnic minority and underserved populations and are leaders in their respective communities, institutions and APA.

Leveraging APA technology and resources, MFP Fellows will have individualized support for their projects on mental health disparities as well as mentorship from fellow MFP recipients, MFP alumni and APA leaders. APA resources include national/state advocacy, media training, cutting-edge research, education, health disparities, telepsychiatry and use of APA's PsychPro registry. MFP will be led by APA Deputy Medical Director Ranna Parekh, M.D., M.P.H., and the Division of Diversity and Health Equity in collaboration with the American Psychiatric Association Foundation.

Saul Levin, MD, MPA, FRCP-E
APA CEO and Medical Director

Help with Practice-Related Questions

APA's Practice Management HelpLine provides one-on-one assistance to APA members on a wide variety of day-to-day practical issues that arise in managing a practice, including reimbursement, managed care contracts, coding, Medicare, Medicaid, and more. Call or email the HelpLine now!

APA Receives $14.2 M Grant to Improve Treatment for Serious Mental Illness

The APA has been awarded a five-year, $14.2 million SAMHSA grant to create an educational and support system, known as the Clinical Support System for Serious Mental Illness (CSS-SMI), to expand access to care for the 11 million adults in this country who have serious mental illness. At least one-third of people with these diagnoses do not receive treatment.

The project will offer expert consultation services and learning opportunities nationwide to enable clinicians—such as physicians, nurses, recovery specialists, peer-to-peer specialists, and others—to provide evidence-based care using state-of-the-art technology to treat or assist people with serious mental illness. Components include a call center as well as sophisticated internet- and app-based technologies to promote best practices, including the use of APA's PsychPRO mental health registry.

In addition to APA, 29 partner organizations and individuals will provide expertise on clinical content, educational resources, and strategic guidance. Partners include the Academy of Consultation-Liaison Psychiatry, American Academy of Addiction Psychiatry, American Academy of Child and Adolescent Psychiatry, and the American Association of Community Psychiatrists.

Guide to Surviving Psychiatric Residency

This great resource for psychiatry residents is written by residents and fellows for residents and fellows to help with the day-to-day challenges of training. The online Guide offers practical advice on more than 50 topics – ranging from surviving on call and writing effective notes, to subspecialty training and negotiating for that first post-residency job. View the Guide using your APA login.

Building a Career in Psychiatry

This two-part guide will help medical students, residents, fellows, and early career physicians successfully prepare for career transition points. Get the scoop on important non-clinical topics that are not often included in undergraduate or graduate medical curricula. The first two links require member login, but the table of contents is an open link.

Part 1: Medical School and Residency
Part 2: Transitioning to Practice
Table of Contents

CLASSIFIEDS

EMPLOYMENT OPPORTUNITIES

Bel Air: Well established outpatient private group practice looking for a part time Psychiatrist, A supervisory position, no weekends, no calls, medical, dental and vision benefits, 401k benefits, part time work with full time pay. Contact: contact@americanpsychcare.com Phone: 318-344-3109

Psychiatrist – Full or part-time psychiatrist wanted for a well-established, reputable, growing private practice in Anne Arundel County, MD. Position includes premium office space, attractive compensation, comprehensive administrative support, professional freedom, and collegial interaction with a multi-disciplinary staff in a desirable location. Opportunity to become involved in the TMS program (Transcranial Magnetic Stimulation) if desired. For more information please visit www.spectrum-behavioral.com or call Scott E. Smith, Ph.D. at 410-757-2077 X 7102 or email to director@spectrum-behavioral.com.

Maryland State Dept. of Education, Division of Rehabilitation Services, is recruiting for a part-time Child and Adolescent Psychiatrist to review child/adolescent psychiatry disability claims through the Dept. of Disability Determination Services for the State of Maryland. For more information and to apply for this position go to: https://www.jobapscloud.com/MD/sup/bulpreview.asp?R1=18&R2=006805&R3=0001

PSYCHIATRIST – full or part time, independent contractor position with thriving multidisciplinary practice. PsychCare has three desirable locations (Pikesville, Columbia, & Silver Spring), congenial colleagues and comprehensive administrative support. Competitive salary and flexible schedule. For more information about PsychCare, visit our website: www.PsychCareMD.com To discuss this opportunity, please call Levi Breuer at 410-343-9756 x 700 or email Hiring@PsychCareMD.com.

PSYCHIATRIST—The Inpatient Psychiatric Unit at MedStar Franklin Square Medical Center is looking for an adult psychiatrist to work full time. Our unit treats voluntary and involuntary patients. The psychiatrist would be responsible for a maximum of 12 patients. On call responsibility is one weekend per 8. Our unit is very well established and has 29 beds. We offer 7 weeks paid time off, 403 B match, CME reimbursement, medical benefits, and paid malpractice ins. Please email CV to stephen.pasko@medstar.net or call 443-777-7925 for details.

AVAILABLE OFFICE SPACE

OWINGS MILLS OFFICE FOR RENT: Full-Time Office, with window, available in five-office suite of therapists & psychiatrists. One mile from 695. Amiable group of colleagues. Referral opportunities. included: Utilities, WiFi, Fax, Copier, Supplies, Parking. Contact Lori Hollander, 410-868-2039

Aberdeen MD- Close to Route 40 in a busy shopping area. Free parking and close to bus line. Fully furnished. Large reception area , 2 large furnished offices, 2 bathrooms, supply room and lunch room. Email hafiz2010@comcast.net or call 410-456-3954.

BETHESDA: Offices for rent in psychotherapy suite. FT unfurnished space available. Lots of amenities: free WiFi, beverages, color copier. Very friendly and professional clinicians. Contact Keith Miller: 202-360-9996 or keith@keithmillercounseling.com.

SAVE THE DATE!
Prepare for Maryland All Payer 2.0

Collaborative Care: Improving Access to Mental Health Care Services

8 AM - 2 PM Saturday, October 13

APA Office Building
800 Maine Ave, SW, Suite 900
Washington, DC 20024

The **Collaborative Care Model** integrates effective psychiatric care into primary care practices. The care team consists of a care manager, psychiatric consultant, and a primary care provider (PCP). The course describes the delivery of mental health care in primary care settings with a focus on the evidence-base, guiding principles, and an introduction to implementation strategies.

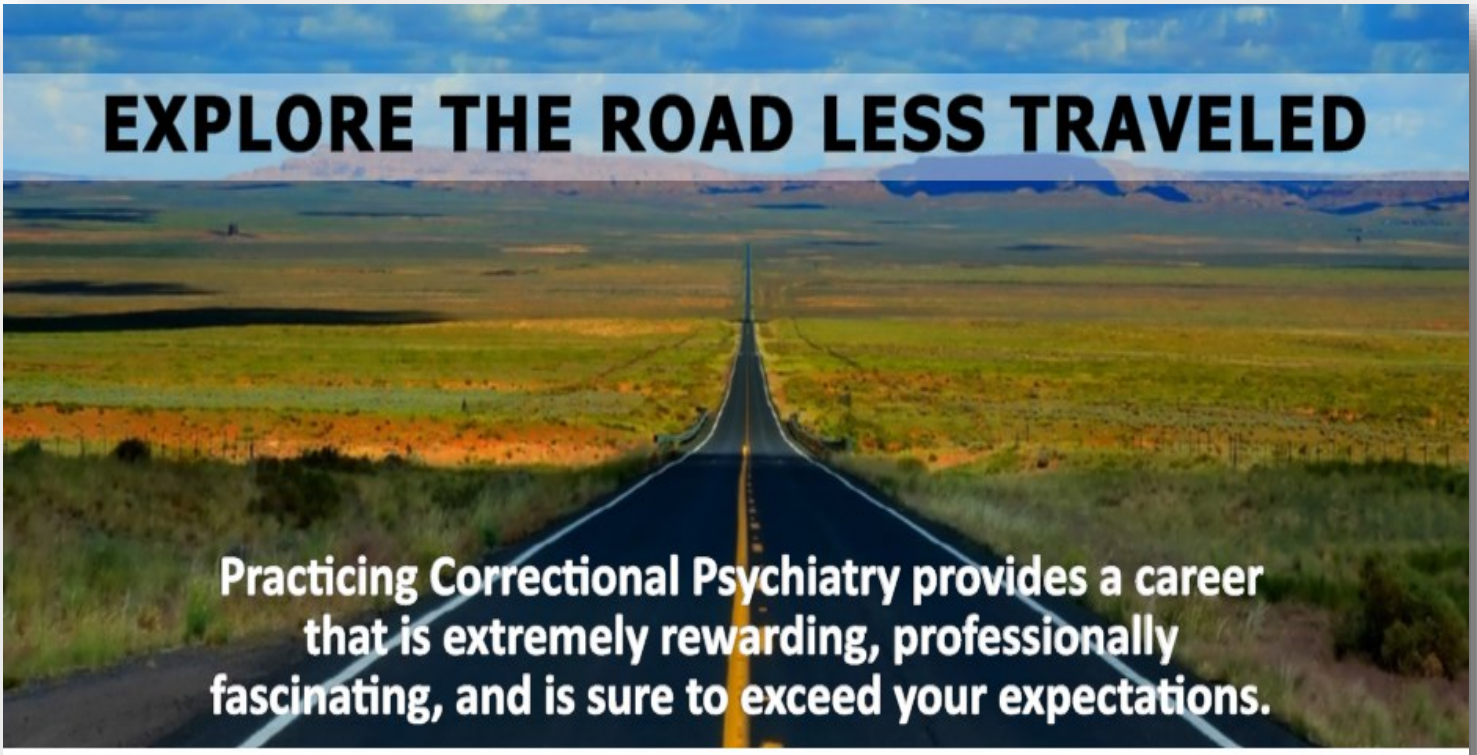
In addition, you will hear from experts on:
Using Collaborative Care to Reduce Physician Burnout
and
The Virtual Consult: Current Trends and the Future of Telepsychiatry/Telemedicine Best Practices.

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians.

The APA designates this live activity for a maximum of 6 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Registration Information Coming Soon

EXPLORE THE ROAD LESS TRAVELED



MHM Services is a leading provider of healthcare services to correctional facilities,state hospitals, and community health centers nationwide. Today we employ over 7,000 healthcare professionals across 16 states. Since 2005, we have proudly served as the exclusive provider of psychiatric services to the Maryland Department of Public Safety & Correctional Services.

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*Serving a Population in Great Need

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Jane Dierberger | 844.477.6420 | jane@mhmcareers.com

Rewarding Opportunities for Psychiatrists Across Maryland

Sheppard Pratt
HEALTH SYSTEM

Sheppard Pratt Health System is seeking psychiatrists to work in multiple Sheppard Pratt programs across Maryland.

Opportunities Include:

Crisis services psychiatrist
Sheppard Pratt-Towson Campus
Baltimore County

Child & adolescent crisis services psychiatrist
Sheppard Pratt-Towson Campus
Baltimore County

Trauma psychiatrist
Sheppard Pratt-Towson Campus
Baltimore County

Geriatric psychiatrist
Sheppard Pratt-Towson Campus
Baltimore County

Child & adolescent psychiatrist
Sheppard Pratt-Towson Campus
Baltimore County

Child & adolescent psychiatrist
Sheppard Pratt-Ellicott City Campus
Howard County

Outpatient child & adolescent psychiatrists
Behavioral Health Partners of Frederick
Frederick County

School psychiatrist - autism focus
Position serves multiple locations

Requirements:

- Must be board-certified or board-eligible
- Must have a current license to practice in Maryland at the time of hire
- Individuals hired for inpatient, PHP, and residential school services participate in a call schedule

Why Sheppard Pratt Health System?

- Physician-led organization
- Generous compensation package with comprehensive benefits, including medical, dental, vision, and life insurance; an extensive wellness program; and ample leave
- Relocation assistance
- Sign-on bonus
- A network of the brightest minds in psychiatry
- Grand rounds, CME opportunities, on-site lectures
- State-of-the-art research and technology
- Cross-discipline collaboration

About Sheppard Pratt Health System

Consistently ranked as one of the top ten psychiatric hospitals by *U.S. News & World Report*, Sheppard Pratt is the nation's largest private, non-profit provider of mental health, substance use, special education, and social services. We employ more than 95 doctors who all share a passion for providing the best care to those we serve. To learn more about our services, visit sheppardpratt.org. EOE.

For more information, please contact Kathleen Hilzendeger, Director of Professional Services, at **410.938.3460** or **khilzendeger@sheppardpratt.org**.

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