Coalition Input to Health Care Authority Solves UMP Delays

WASHINGTON STATE COALITION OF
MENTAL HEALTH PROFESSIONALS AND CONSUMERS

Advocates for Ethical Mental Health Care www.wacoalition.org **Summer 2011**

From the President

Dear Coalition Members:

I know we are all relieved at the good news shared in this newsletter. The tension among practitioners with the Uniform Medical changes since January related to payments received and sessions covered has been increasing weekly. We feel grateful to all of you who offered specific information that allowed the Coalition to follow up with details of problems encountered in efforts to resolve this problem. Laura Groshong's articles offer more information.

I would also like to thank you for your participation in the Coalition Regence survey. This survey played a crucial role in getting the Health Care Authority to support the changes that we asked for in the way that Regence was managing the UMP benefit. You, our members, are our strongest asset, and we could not succeed without your unwavering support.

This issue, overall, is focused on the fundamental purpose of the Coalition. We are a watchdog organization for quality mental health. The creation of the strongest mental health parity law in the country, advocating on the interpretation of that law by insurers, tracking the experiences of practitioners and patients

(Continued on page 2)

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Results of Regence Survey, April 2011

Laura Groshong, LICSW
Coalition Lobbyist

Laura Groshong

Many thanks to the Coalition members who filled out the survey about Regence administration of the Uniform Medical Plan in April. The Coalition Survey, which ended in April, had a definite impact on the Health Care Authority's decision to require Regence to pay all UMP claims submitted so far, if they had been denied without being reviewed, and to continue to do so until adequate staffing is in place to process treatment reports. The Coalition will continue to let members who are UMP providers know how they and their patients will be affected by further changes.

The Coalition thought you would like to see some of the results of the survey; they can be found below.

- N = 54
- Number of UMP clients seen since 1/1/11 = 204
- Frequency of sessions for current UMP patients:
  Once a month = 9

(Continued on page 4)

In this issue:

From the President, continued from page 1

on the Regence administration of the Uniform Medical Plan—all these areas are examples of how the Coalition has worked for clinicians and patients to promote ethical mental health treatment. It is 16 years of dedication to such issues that has consistently put the Coalition in positions where we could make a difference.

We would like to thank new Coalition members for your support of our agenda and quality mental health, and thank again, loyal renewing members. Each of you increases the strength of our voice and position as advocates of quality mental health.

Lastly, I would like to thank Laura Groshong, our lobbyist, on behalf of the Coalition Board and Coalition members, for her dedicated efforts related to the recent issues with Regence. Laura has been a strong and important voice for the values of the Coalition, and we are all most grateful.

Enjoy this good news, and know we are always on the watch for situations where our mission and vision is at stake. Please continue to let us know if you are aware of any situations that create barriers to ethical mental health treatment.

Sue Wiedenfeld, PhD
Coalition Chair ◊

IF YOU ARE NOT GETTING E-MAILS about our events, please E-mail us with your CURRENT E-mail address: **wacoalition @frontier.com**. This is the best way to get Coalition news.

Letters

Dear Seasoned Therapist,

I am a newly licensed therapist and am wondering about ongoing consultation and supervision. Do you think it's necessary?

Any ideas on how to find a peer group or supervisor for hire?

Eager for any input,

Newly Minted But Still Unseasoned

Dear NMBSU,

What a great topic! Consultation is an important part of any therapist's ongoing training and support. Licensure is just the beginning of becoming a competent therapist. Peer consultation, (ie regularly scheduled meetings with other therapists) is a great way to problem solve a complicated case, get support for a difficult client, and simply connect in a regular collegial atmosphere. It also can serve a legal and ethical purpose in proving that you followed standard procedure, if you find yourself in trouble with the licensing board or insurance. As far as finding a good group, I would talk to other colleagues doing similar work and find out if they are in a group with openings or if they know of one. You can also start your own. I think at least 3 members and not more than 6 is a manageable number. Meeting once or twice a month is probably the most useful schedule.

For more professional consultation, you may want to pay for expertise. You probably know experts in your particular specialty or therapeutic approach. Contact them and find out about opportunities for individual or group consultation. There are also a few specialty quarterly groups of clinicians focused on special populations. For example there are clinical consultation groups for

those treating eating disorders and those working with complex adoption issues. These are great ways to hone your skills and get to know those in your community more deeply and professionally.

Finally, don't look for consultation when you need it! You may very well not need it if you are proactive and develop your professional support system from the beginning.

Yours,

Seasoned
but not Cooked

Have a practice question? Let us know! ◊

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Changes to Regence Administration of UMP Mental Health Benefit

By Laura Groshong, LICSW,
Coalition Lobbyist

The Coalition has been working hard to address the delayed payments, unread treatment reports, and communication problems regarding Uniform Medical Plan, administered by Regence BlueShield, that have arisen in the past three months. Sue Wiedenfeld, PhD (Coalition President), Carolyn Sharp, LICSW (Washington State Society for Clinical Social Work President), and I have been working intensively since May on these problems. More recently, Lucy Homans, Psy.D., of the Washington State Psychological Association has joined us.

We have met with Regence executives regularly since May; have had regular discussions with the Health Care Authority, the oversight agency for Uniform Medical Plan and the Public Employees Benefit Board; and solicited information from Coalition members about these problems. Solutions to the multiple problems that have arisen have been in flux, agreed to by either Regence and/or HCA and then revoked.

As of July 25, 2011, the situation is as follows:

1. All mental health claims that have been submitted and are unpaid since January 1, 2011, for UMP members will be paid in full by August 11 if they are under $500, even if they have been previously denied.

2. Patients who wish to be seen more than once a week should sign a waiver with the provider removing Regence from any responsibility for these sessions. The Coalition will be sending a draft waiver shortly. This practice may be considered an "uncovered benefit" that can be paid for by the patient without jeopardizing the coverage of the UMP mental health benefit at once a week.

3. There are currently 4600 unprocessed mental health claims, about half of which are more than $500. The plan is to have all other claims reviewed and processed by September 1 at the latest. It may be that a higher level of automatic payment will occur soon, following on-going discussions between Regence and the Health Care Authority.

There are still multiple problems to be worked out with how Regence is determining medical necessity, when treatment reports should be filed, coverage of UMP as a secondary insurer to Medicare, and more. I wanted to give you this immediate information as we know that the unpaid Regence claims have been a hardship for many Coalition members. We will continue to advocate strongly for your needs as clinicians and business owners and for the rights of our clients.

Our next call with Regence will be on August 5, and I should be able to give you more information then. I appreciate your patience as we sort through these complicated problems, and your continued professionalism in your dealings with and about Regence in what is a very challenging situation. ◊

BOARD MEMBERS NEEDED

The Coalition represents a multi-disciplinary group of professionals and consumers addressing a broad range of mental health needs in children, adolescents, and adults. Our Board is equally diverse. Board members have included psychiatrists, psychologists, MFTs, LCSW, LMHC, and other professionals. They also bring a wide range of experience and special interests which serve to broaden the knowledge base of our members, such as skills with special populations, use of the internet, and understanding of legal and ethical issues associated with mental health. From time to time, we have a need to replace a Board Member.

Are you interested in:

- Preserving choice, confidentiality, integrity, and quality in our mental health services?
- Lobbying to educate legislators about quality mental health care?
- Educating and supporting mental health professionals and consumers?
- Influencing political and insurance industry policy to include mental health as a vital component of health care?
- Empowering mental health consumers to influence health care reform.

If so, please consider becoming a member of the Coalition Board. No pay but great rewards! Please contact Sue Wiedenfeld, Coalition Chair, swiedenfeld@me.com. ◊

Who Ya Gonna Call !?!?!??!

Coalition Helpline: 206-444-4304

Who's My Legislator: 1-800-448-4881 (State and Federal)

Legislative Hotline: 1-100-562-6000

Member Profile

Meet Peter Moore

I served on the Coalition Board first as membership coordinator (all those friendly reminders to pay your dues—literally!), and then I also served a stint as the editor of our newsletter, *The Coalition*. The Board was so desperate for an editor that they didn't care that I edited the whole thing on just MS Word.

I joined the Coalition and remain a member because it is one of the few, if not only, mental health professional organizations that seeks to reach across guild boundaries to advocate for confidential care with minimum intrusion from managed care and insurance company bureaucracy.

Although I am retired from the Coalition Board, I maintain a full-time private psychotherapy practice four days in Seattle's Hawthorne Hills neighborhood and a day each week in Mill Creek.

I work with adults incorporating Somatic Transformation (ST), a form of somatic psychotherapy taught by local psychologist Sharon Stanley, which is akin to somatic experiencing, popularized by Peter Levine. I also enjoy working with couples using a model developed by Stan Tatkin, PhD, Psychobiological Approach to Couple's Therapy.

I'm very much enjoying ST, which has rejuvenated my practice. The theory makes a lot of sense to me. It is born out of a model that has a lot of empirical evidence that integrates developmental neurobiology, attachment, and the autonomic nervous system to help understand and work with emotional disorders. At its worst, it becomes a technique like a lot of other models. But, at its best, it requires a somatic empathy with a client and tuning into one's physical counter-transference as well. Clients seem to like it and benefit from it, which is the bottom line.

When not trying to pay for our son's tuition and the mortgage, I enjoy "stargazing." As an amateur astronomer, I recharge my batteries by sightseeing in the universe or at least our galaxy, with my telescopes. Exploring the craters and mountains of the moon, the rings of Saturn, the expanse of the Andromeda Galaxy, watching the birth of stars in the Orion Nebulae, or the diamonds on black velvet look of a star cluster never ceases to give me a sense of awe and wonder and the joy of discovery. I also get a kick out of sharing this passion with others at public star parties. It's very rewarding to hear the "Oooohh" or "WOW!" from someone looking at the moon or Saturn up close and personal for the first time. Drop me an e-mail if you're interested in learning more at pkt6533@hotmail.com. ◊

Regence Survey, continued from page 1

Twice a month = 15 Once a week = 60 Twice a week = 30 More than twice a week = 6

- Number of patients who received additional sessions after initial 20 sessions = 16 [this survey took place before many patients had used the full initial 20 sessions]
- Other insurers who are allowing mental health coverage for more than 20 sessions
  FCHN
  Lifesync
  Value Options
  Medicare
  Premera Lifewise
  United Behavioral Health
  Cigna
  Group Health
  Aetna
  Premera First Choice
- Other insurers who are covering mental health treatment on a twice-a-week basis if needed:
  Value Options
  Medicare
  Premera Lifewise
  United Behavioral Health
  Cigna
  Group Health
  Aetna
  Premera First Choice

There were many comments about the inconsistency of information received from Regence staff including clinical decision making ("Frequency should be limited to prevent dependence"; "Regence does not cover psychodynamic/ psychoanalytic treatment"; "Only suicidal patients need extended treatment"); the fairly consistent refusal of Regence to allow coverage of twice-a-week treatment; fairly consistent difficulties with payment; and fairly consistent denial of treatment plans that conformed to Regence's requirements for additional sessions.

Now that Regence will be paying all claims and approving additional sessions, many of the problems that members have experienced should be resolved. The Coalition will be tracking closely the way that Regence reviews and/ or limits UMP benefits when they have their staff in place, sometime in the next month.

The Coalition will do another survey in the next couple of months to assess whether the problems with UMP coverage have been solved. ◊

Psychotherapy Practice, Evidence-Based Practice, and Outcome Tools

Laura Groshong, LICSW, Coalition Lobbyist

This article was part of a presentation made to Regence BlueShield on May 2, 2011, regarding psychotherapy practice.

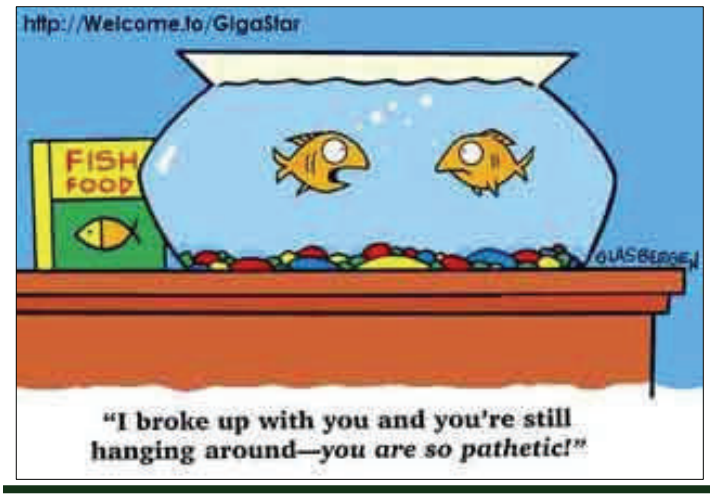
The concept of "evidence-based practice" (EBP) has become a major determination of effective medical care. The application of EBP to psychotherapy, a field that straddles medical care and psychosocial care, has been evolving over the past five to ten years. There are more than 200 psychotherapy treatment approaches (*Psychotherapy Networker*, 2010) and more than 400 mental health diagnoses in the *Diagnostic and Statistical Manual-IV-TR* (2000).

With this diversity of disorders and treatment, there is bound to be some confusion about the appropriate treatment for the appropriate disorder. As medical costs have soared over the past 20 years, mental health treatment has become more widely included as a basic benefit in most health care plans. The implementation of mental health parity at the federal and state levels has contributed to this process. However, there is still disagreement about a 'formula' for parity between mental health benefits and medical/surgical benefits. This paper is an effort to clarify the issues that should be considered in determining how to assess valid psychotherapy evidence-based practice and how it can be integrated with true mental health parity.

Basic Principles of Psychotherapy

The literature on "what works" in psychotherapy is growing by leaps and bounds. Some of the most important points are summarized below:

- The longer a patient is in psychotherapy, the more progress is made (*Consumer Reports*, 2004).
- Treatment that includes psychotherapy and medication is more likely to have successful outcome, especially for the depression spectrum, than treatment by medication alone (Levy and Ablon, 2009).



- Attending to the overt symptoms of mental health disorders, as well as the underlying conflicts, is likely to have the best outcomes (Olfson and Marcus, 2010).
- Some chronic disorders, e.g., personality disorders, psychotic disorders, major depression, etc., are likely to require ongoing psychotherapy for a period of years (Shedler, 2009).
- Evidence-based research has shown that psychodynamic psychotherapy in particular is an effective treatment, along with cognitive behavioral therapy, dialectical behavioral therapy, psychopharmacology, and other mental health treatments (Roth and Fonagy, 2005).

Over time, the most effective treatments for specific disorders may become clearer. For now, acknowledging the validity of all evidence-based mental health treatments should be the criteria for mental health treatment.

Outcome Measures for Mental Health Treatment

Finding outcome measures that show progress is being made in mental health treatment is more challenging than in medical/surgical treatment. Identification of progress is often less clear cut than seeing an infection cured or a broken arm healed. The Global Assessment of Functioning (GAF) score, based on an assessment of four separate criteria, is one of the most common forms of determining progress in mental health treatment. Other measures are available.

The primary difficulty with these measures is for assessing progress in chronic mental health conditions. Maintaining emotional stability and functionality and/or keeping a patient from decompensating, requiring hospitalization, are not easily measurable in terms of progress; they are more significant in preventing the mental health problems that would ensue without treatment. Chronic mental health conditions, including Axis II conditions, need psychotherapy as much or more than acute mental health conditions, and should be accepted as requiring longer-term psychotherapy.

Another set of outcome tools has been developed in the past 10 years by the International Center for Clinical Excellence. The Center (http://www.centerforclinicalexcellence.com/) is run by Scott Miller and has two primary simple outcome tools: 1) Outcomes Rating Scale (ORS), and 2) Session Rating Scale (SRS). The tools have been used internationally with more than 20,000 patients and are starting to become accepted as an alternative

(Continued on page 6)

to GAF scores. These tools are less medically/more clinically based and may become a new way to demonstrate therapy outcomes.

Federal Mental Health Parity Laws

Formal outcomes for mental health treatment under state and federal parity laws will definitely be needed, as the formulas for implementing mental health parity—still in development—become reality. Applying mental health parity laws to actual insurance plans has been a challenge. State and federal parity laws have different requirements and are interpreted differently by different plans. All clinicians should educate themselves about our state mental health parity laws, which may differ from federal parity laws. A summary of federal laws follows:

Federal Mental Health Parity Laws (apply to companies of 50 or more and/or self-insured plans)

1) MHPAEA applies to the insurance plans of all large businesses (50 or more employees), both self-funded ERISA plans and non-self-insured large business insurance plans. MHPAEA does not require that mental health and substance abuse treatments be covered, but that they be 'offered.' If a mental health/substance use disorder (MH/SUD) benefit is included, it must be 'at parity' with medical/surgical benefits (MED).

2) The formula for comparing the two sets of benefits is that any MED benefit that covers at least 2/3 of all MED procedures must be applied at the same level to MH/SUD benefits. There cannot be separate deductibles for MED and MH/SUD services.

3) All six types of coverage, or 'classifications', must be covered equally for MED and MH/SUD, i.e., inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care, and prescription drugs. A health plan must provide out-of-network MH/SUD benefits, at parity, when it provides out-of-network MED benefits.

4) Limits on coverage based on diagnosis are prohibited, so long as mental health conditions and disorders are consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *Diagnostic and Statistical Manual of Mental Disorders*).

Summary

The implementation of psychotherapy in mental health parity may require the use of outcome tools to demonstrate the value of treatment and the ways in which it is evidence-based. This will give clinicians the research basis for being able to determine what level of psychotherapy is needed, depending on diagnoses, level of distress, and treatment orientation. Outcome measures may vary depending on whether treatment is resolution of acute conditions, treatment of chronic conditions, and/or treatment of multiple conditions.

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Coalition members and friends!

Renew your membership today! Keep yourself up to date regarding changes in mental health related to health care reform, and state issues like the changes in the Uniform Medical Plan. Read the several articles in this newsletter about these topics. Don't miss a future Newsletter! This is a time when you will want to track what the Coalition is doing to preserve and protect quality psychotherapy.

Invite a friend to join the Coalition. Forward the on-line newsletter that describes what we do. Remember, The Coalition represents all disciplines. **More members strengthen our message.** ◊

RENEW TODAY!!

Be sure to give us all your information so we can update our membership for the new directory.

Renewal form, page 7

It's Time to Renew Your Membership

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of Mental Health Professionals and Consumers

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Your dues support the Coalition's efforts to preserve ethical mental health treatment. Your dues also provide funding that supports legislative efforts, continuing education programs, our Web site, a Helpline, the newsletter, brochures, and our on-line member directory.

Thank you for your continued support! It makes possible what we do. Please renew promptly. With this year's renewal, you will be included in our on-line directory.

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Summer 2011

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