The Summer of Our Discontent:

The Coalition Fights Regence Reimbursement Reductions

WASHINGTON STATE COALITION OF
MENTAL HEALTH PROFESSIONALS AND CONSUMERS

Advocates for Ethical Mental Health Care www.wacoalition.org Fall 2015

From the President

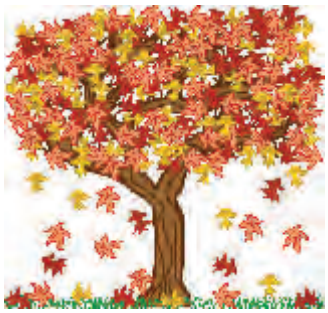
By Sue Wiedenfeld, PhD

Welcome new members! We are so happy to have each of you on board. Every new member increases the power of the Coalition to have an even stronger voice in support of quality psychotherapy with insurance companies, in Olympia, with the public.

Case in point. This last several weeks have been quite intense for the Coalition. I am sure you have gotten several emails from us. I am going to summarize here both how the "Regence issue" emerged and the Coalition involvement. Key documents will be included in this newsletter.

For those of you who are Regence providers, you likely received an email about the intention for Regence to collapse codes 90837 and 90834, resulting in a single payment amount, slightly higher than the current reimbursement for 90834 and about 26% lower than the current 90837. This was to start October 1 and was a disregard of mental health parity. The psychologists first challenged Regence's action as a violation of parity, and the Office of the Insurance Commissioner (OIC) asked Regence to describe similar actions in their medical settings. As we waited to see how Regence would respond to the OIC, we began our own effort.

The Coalition **organized a press release (see below), which went out on August 26.**



REGENCE SLASHES MENTAL HEALTH REIMBURSEMENT RATES;
75% OF SURVEYED PROFESSIONALS INDICATE THEY MAY OR WILL LEAVE THE REGENCE NETWORK;
PRACTITIONERS AND CONSUMERS ADVERSELY AFFECTED.

Seattle, WA (August 26, 2015) – On July 1, Regence Blue Shield sent notice to its network of mental health providers that they would be combining payment for the two most-used mental health procedure codes, effectively cutting the reimbursement rate for their most commonly used mental health code by almost 30%. This decision has practitioners indicating a willingness to drop off of insurance panels, with consumers paying the price.

The Washington State Coalition of Mental Health Professionals and Consumers, a consumer advocate group, recently conducted a survey of mental health practitioners in Washington State that asked, "If the proposed policy of equalizing the reimbursement for [the procedure codes] was put in place, would you leave the Regence panel?"

Three-quarters of the 300 respondents paneled by Regence answered "Yes" or "Maybe."

Sue Wiedenfeld, Ph.D., a licensed psychologist and President of the Coalition, states that, "Seventy-five percent is a very high percentage of practitioners who are considering leaving the panel, and those most likely to leave are our more experienced

(Continued on page 3)

In this issue:

Meet New Coalition Board Member Abby Smith, MA, LMHC

I joined the Board in early 2014 soon after attending my first Coalition training. At the training I had a chance to talk to Laura Groshong and I was energized by the Coalition's goals, advocacy and enthusiasm. I felt the same excitement after Sue Wiedenfeld called to talk to me about joining the Board. Sue recently asked me to write a short bio for the newsletter, so here it is.

I've specialized in substance abuse counseling for over 25 years, including 18 years in Substance Use Disorders (SUDs) treatment. I also taught most of the classes required for CDP licensure while a part-time instructor for 10 years at Edmonds Community College. My abiding love of this work has not changed, but the field certainly has, and that's a very good thing. Given half a minute I'll talk your ear off about why I believe it needs even more research and change.

I have an MA in psychology from Antioch University, an LMHC and a CDP. In 2006 I started a private practice, A Common Language Counseling. At A Common Language I offer services to people in recovery, particularly those who don't find the 12-steps a good fit, and I also do moderation (harm reduction) work with clients who want to explore their choices about drinking. My clients also include partners/spouses and adults who grew up in addicted/alcoholic families – as a result, I also work with trauma. I'm very concerned that so few resources are provided in treatment for the families of addicts/alcoholics and I've begun to work more with this population.

Since joining the Board I've been involved in the Coalition's work to end unnecessary barriers which deter Mental Health Professionals who want to obtain CDP licensure from pursuing that. As a result of participating in the CDP Certification Committee process this past year on behalf of the Board, particularly after the rather harsh reactions we experienced at some committee meetings, I want to join with others to help bridge the gap between mental health professionals and licensed treatment center staff (CDPs) in Washington State. It's an unfortunate fact that there are too few CDPs to provide the range of services consumers need now and in the future, but that can be remedied. I want to invite other professionals who share my concerns to join the Coalition and make your voice heard. The Coalition needs your voice and your support, join now!

Coming Events

Suicide Assessment and Treatment Workshop

by

Robin Shapiro, LICSW

Select one of these two dates:

October 24, 2015
December 5, 2015

Glaser Auditorium
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Space is limited
so sign up today.

Get your required continued education through the Coalition-sponsored (and bargain-priced) program!

Might you be our next treasurer?

New Coalition treasurer needed!

Our current treasurer, Cynthia Stover, has been a dedicated board member for more than 10 years, and it is time for her to tend to some other volunteer interests. Thank you for a most valued and amazing job, Cynthia! We are so grateful.

This is a straightforward job for a person with the right skills. Might you have the skills to keep the Coalition books? Cynthia has the system all worked out—very streamlined—but we do need someone to do it. Think if that someone might be you? Contact Vanya at drvanya1@gmail.com if you might like to talk about this. It would be a much appreciated service to the Coalition.

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Newsletter
Published by The Word Shop

Coalition Fights Regence, *continued*

practitioners. This will lead to Regence having a preponderance of inexperienced practitioners, severely limiting the types of mental health problems that can be addressed."

"In psychotherapy procedure, codes are time-based codes," notes Wiedenfeld, "The average length of the shorter code is 45 minutes, and the average length of the longer code is 55 minutes. What Regence did was to say it doesn't matter whether you see someone for 45 or 55 minutes, we're going to pay the same for both codes."

Wiedenfeld concludes that this decision was an excuse by Regence to cut reimbursement rates and increase their profits. "They raised the rate for the shorter code by 4% and cut the rate for the longer code by 30%. This is a direct hit on the income of practitioners."

Kevin Host, Director of Wellspring Employee EAP (Employee Assistance Program), which provides service to nearly 200 companies and covers over 180,000 people, is also worried.

"People use their EAP benefit when issues in their personal lives start affecting their work life. To best serve our corporate clients, we refer their covered employees to highly capable professionals. If the most experienced practitioners leave the Regence panel, we will have real problems finding qualified practitioners to take cases. This is a big deal since some of our largest client companies use Regence for their major medical benefit."

Sean Corry, a veteran of the mental health parity wars and President of Sprague Israel Giles, an insurance brokerage firm, expresses different concerns.

"As an insurance broker, my job is to make sure the health plans that clients offer to their employees actually deliver the care that is promised. When a health plan restricts access by severely limiting the number of available mental health providers, that health plan does not get recommended by our firm."

Each medical procedure code carries what is known as a "relative value unit" or RVU. The RVUs indicate the degree of difficulty that a given procedure has. A higher RVU indicates a more complex procedure requiring more effort and training. The higher the RVU, the higher the reimbursement for the procedure.

According to Laura Groshong, LICSW, a licensed independent clinical social worker and mental health advocate, "The 55-minute procedure code carries with it about a 50% higher RVU than the 45-minute code. It goes against standard practice in medicine to pay the same amount for two different codes." She adds, "Mental health clinicians have had positive interactions with Regence over the years when we have disagreement. This ultimatum from Regence is a disappointment after all the time we have worked together collaboratively. This is the first time that Regence has refused to respond to mental health groups at all, and it's been going on since July 1."

Psychologists are also concerned. The Washington State Psychological Association sent a letter to Regence asking them to identify what *medical* procedure codes with different RVUs Regence has collapsed into one reimbursement rate.

This issue points to state and national mental health parity laws that require mental health and physical health be treated the same by insurance companies. Collapsing

(Continued on page 4)

Classifieds

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codes for mental health without doing the same for medical codes would be in direct violation of parity laws.

The Office of Insurance Commissioner (OIC) is also curious to learn the answer to this question. They, too, sent a letter to Regence asking them to identify which medical procedure codes they've done this with.

Regence is required to respond by August 25.

Corry, who understands insurance from the insurer's point of view, says, "This is yet another example of some insurance companies taking the decisions about mental health treatment out of the hands of the practitioners and patients, an ongoing issue for years. Some insurers look for hidden treatment limitations. Many insurance companies interfere with the doctor-patient relationship, through the use of proprietary review criteria, to determine what mental health treatments will be approved or denied. Patients are routinely forced through bureaucratic review procedures to get authorization for treatment, and are often subject to arbitrary limits on diagnostic work and therapeutic care."

In the meantime, mental health groups and practitioners are busy marshalling their members and resources. Practitioners have sent letters to the Insurance Commissioner's office complaining about this change. The OIC wants to hear directly from clients that might be affected by this decision.

"Practitioners are often hesitant to ask their clients to advocate on their behalf," says Wiedenfeld. "But Regence's decision may lead to our doing just that to avoid having to leave the Regence panel to make a living."

The people who will bear the brunt of Regence's decision are mental health practitioners, who will take a 26% cut in income and clients who will have less access to qualified clinicians. Both parties can let their voice be heard:

Contact the Office of Insurance Commissioner

Write a letter to the Insurance Commissioner (a template that enrollees can use may be found at the Coalition website).

# # #

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The following day we heard that Regence was not going to collapse the codes into a single payment schedule on October 1, and later, that they would not collapse them at all. We felt a moment of relief as it appeared that some public pressure had helped. Unfortunately, and quickly, Regence essentially found a way to do the same thing (almost) by not making the reimbursement for the two exactly the same—leaving 90834 alone and lowering 90837 about 25% beginning December1. Clearly, their intentions were the same. We then drafted and sent out a second press release **which led to our first coverage by the *Puget Sound Business Journal*:**

http://www.bizjournals.com/seattle/blog/health-care-inc/2015/09/regence-cuts-reimbursement-rates-for-mental-health.html

Some of you may have attended the two meetings we had to talk about these issues with Regence. In the meeting we began organizing a number of work committees to coordinate follow-up. One of the groups developed **the following position paper to clarify the Coalition's issue with Regence's violations of mental health parity.**

(Continued on page 5)

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Washington State Coalition of Mental Health Professionals and Consumers

Mental Health Insurance Coverage: The Good, the Bad, and the Ugly

September 2015

Since December of 2014 Federal mental health parity rules have been in effect, requiring insurers to cover mental health/substance use disorders "at parity" with medical/surgical disorders. Over the past eight months, efforts by many insurers to avoid covering mental health/substance use disorders have been steadily escalating. This paper will summarize the ways that insurers have been attempting to refuse coverage, resulting in harm to patients, families, and providers, while insurers benefit.

History

Mental health coverage has been lower traditionally than medical/surgical coverage, when it was part of an insurance plan at all. Until the 1997 Mental Health Parity Act, a weaker version of the current parity law, a token amount was offered for mental health treatment. Over the past 20 years, mental health advocates have fought to gain coverage of mental health disorders, principally for psychotherapy and psychotropic medication. The coverage of psychotropic medication has increased steadily, as coverage of psychotherapy has declined. Many studies show that most mental health conditions respond best to a combination of psychotherapy and medication. The decrease in coverage of psychotherapy has led to increased medical conditions caused by untreated mental health disorders (Russ, T. *et al.*, 2012).

Newer psychotropic medications have been taken off formularies by insurers, or restricted, as well, but the primary way that insurers have tried to restrict mental health treatment was and is by restricting access to psychotherapy (Essig, T., 2012).

Mental Health Disorders

Mental health disorders are diagnosed by the Diagnostic and Statistical Manual, Fifth Edition. There are approximately 500 diagnoses, divided into about 20 categories. The DSM-5 does not provide treatment recommendations for a given diagnosis because a mental health diagnosis does not define its treatment any more than a medical diagnosis defines medical treatment. Treatment recommendations must be defined by a mental health clinician's expert assessment of all the factors influencing an individual patient's condition and by the clinician's decision-making over a wide variety of treatment methods.

Integration of parity for mental health disorders and medical/surgical disorders through insurance coverage is one of the primary goals of the Affordable Care Act. However, mental health treatment is an uneasy fit with medical/surgical treatment. Mental health treatment is based on a therapeutic relationship that leads to resolution of symptoms of mental health disorders. Medical treatment is more directly focused on

(Continued on page 6)

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alleviating physical symptoms. Many mental health conditions are chronic in nature, e.g., PTSD, OCD, psychotic disorders, personality disorders, etc., and require extended ongoing treatment much the way that diabetes, heart disease, or other chronic illnesses do. Insurers have begun attempting to redefine mental health treatment of chronic disorders by conceptualizing mental health disorders as needing treatment only when there is a crisis, denying the existence of chronic conditions that require ongoing treatment (MCG/Milliman Guidelines, 2011).

Insurance Coverage of Mental Health Disorders

As stated above, there have always been attempts by insurers, public and private, to restrict psychotherapy as a treatment modality for mental health disorders. It was not until 2014 that Medicare had the same co-pay for mental health treatment that was allowed for medical/surgical treatment, 20%. Previously, the co-pay had been 50%. The agonizingly slow implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 did not occur until rules were approved in December, 2014. Though MHPAEA has many strong elements regarding mental health coverage, the enforcement of the Act was delegated to state attorneys general. This has led to confusion and lack of follow-through when a complaint has to be made in a given state.

Until the CPT psychotherapy code changes in 2013 (from 90806 and 90808 to 90834 and 90837), mental health clinicians provided 10-20 minutes of uncompensated care as a matter of course. The new CPT codes provided a way to begin to submit for the actual work being done. Mental health treatment provides a service unique within the medical community, that is, the amelioration of intense and pervasive emotional and psychological pain. The capacity to administer this outcome effectively demands of the practitioner a great deal of clinical acumen, emotional depth, and, above all, time. The ongoing pressure from many insurers to dictate the length of a psychotherapy session should be ended. Mental health providers, as the experts in mental health treatment, should take their rightful place in the health care world and make length-of-session decisions.

There are numerous ways that insurers have tried to minimize the time needed to treat mental health disorders. Though MHPAEA has required non-quantifiable treatment limits (NQTL) to be at parity with medical/surgical limits, most insurers do not comply with this requirement.

(Continued on page 7)

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Here are some of the ways that insurers have regularly refused to comply with the MHPAEA:

1. Insurers refuse to allow mental health clinicians to make clinical decisions about the treatment that they provide, ignoring the ethical standards and clinical expertise that guide those decisions.
2. Insurers have refused to compensate mental health clinicians for needed care for decades and want to continue to do so using restriction of payment level of new CPT codes.
3. Insurers continue to deny treatment for mental health conditions beyond a certain number of sessions (typically 20). This is inadequate for treating chronic conditions.
4. Insurers continue to deny more than one session a week when the patient needs more frequent sessions
5. Insurers try to "combine" reimbursement for codes with different value. The basis for reimbursement is a formula called Relative Value Units (RVUs), created by the American Medical Association and Center for Medicare and Medicaid Services (CMS). Some insurers arbitrarily refuse to pay the value of a given code, insisting that the length of a session does not increase the value of the session even though the AMA and CMS say it does.
6. Insurers simply reduce reimbursement for given codes, knowing that mental health clinicians are prohibited by the Taft-Hartley Act from jointly opposing any move on the part of third-party payers.
7. Insurers continue to require co-pays for mental health services that differ from those for medical /surgical services.

While some insurers support good clinical standards and the judgment of mental health clinicians, many more do not.

Summary

Mental health treatment provided by licensed mental health clinicians is being undermined by insurers systematically by replacing clinical judgment with their own profit margins, restricting length of treatment and length of sessions, lowering reimbursement in spite of RVU standards, increasing co-pays for mental health treatment, restricting psychotherapy by diagnosis, or by redefining mental health treatment options.

The time has come for clinicians and patients to get the equal parity promised by the MHPAEA, and to end the unfair restrictions—by insurers—on fair compensation for providers and needed access to mental health treatment for consumers.

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(Continued on page 8)

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We so appreciate those who have come forward to help on these committees and in other ways. Do let us know if you have some time/energy to share. This is the time for all of us to work together. Watch for new updates and ways to be involved!

Thank you,

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Thank you for your continued support! It makes possible what we do. Please renew promptly.
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