The Coalition

April 2002

Editor's Corner

Peter N. Moore, Psy.D.

This issue presents a potpourri. Coalition members met again earlier this year to discuss the potential of life after managed care and how to start down that road. A report of that meeting begins to your immediate right. This issue also has an announcement of another meeting in May on this very topic.

Calls to our Helpline have dropped off for a number of months. Consequently, John Powers who along with Jeanette Dyal "answer the call" reviews the history and purpose of the Helpline to remind members and others of how it can help with insurance and managed care questions and concerns.

Also in this issue, Laura Groshong, our lobbyist reviews the recently ended legislative session.

Again, we welcome your letters, comments, and submissions. Send to pkmoore@compuserve.com or mail to the Coalition.

INSIDE THIS ISSUE

1	Coalition Roundtable: Brown Bad Redux
3	Helpline Report by John Powers
4	Summary of Legislative Session by Laura Groshong

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

Managed Care Free Practice: Brown Bag Redux

Peter N. Moore, Psy.D.

This is beginning to become a pattern. Once again a group of Coalition members, interested others and a representative sample of the Coalition board, gathered in the at Wallingford's Good Shepherd Center to continue November's discussion of how to practice outside of managed care and even outside of insurance. Some of the February 8's lunch time attendee's were veterans of last November's "kick off" event. A few had been practicing managed carefree if not completely insurance free. All seemed interested in growing and continuing this forum on some sort of regular basis. So if this is the first you have heard of this group, or if you regret your absence, then you will have another opportunity on May 10 to lend your advice, get some support, and address your questions.

Circled comfortably in a small room in the quintessentially Seattle landmark, the nearly dozen attendees for two hours shared questions and lessons from the school of practice hard knocks. Issues addressed included the pros and cons of sliding scales, the importance of location, the relative importance of having a practice niche, the advantages of a managed care free practice.

As could be expected, some of the discussion focused on the hassles of manage care. Many bemoaned the fees, Rubric's Cube bureaucracy and attendant labyrinthine voice mail and time consuming paperwork for only a seemingly meager allotment of sessions. Participants were reminded by the Coalition

Board President, Sue Wiendenfeld that the managed care practice survey mailed to members was an excellent vehicle to voice these concerns. Companies such as Regence and Aetna had already expressed interest in the results. (*so keep those surveys coming ! Lost yours ? Call the Coalition or contact me via e-mail)*

Others raised perhaps more subtle but nevertheless insidious issues. They noted that the managed care system, by its inherent assumption that less is better, can enable clients' minimization and resistance to more "depth" therapy. It can also subtly promote a client's lack of appropriate entitlement and importance of their mental health concerns.

One participant said that getting sessions authorized was not a problem if one was willing to "play the game." However this produced a dilemma for her practice which is part fee for service and part managed care. If she has an open slot, who does she pick? If she chooses to fill it with a fee for service client, who gets left out? If she gives it to a managed care client, will she subtly resent receiving a lower fee that could affect the work that she does with that person?

A couple of "old hands" from the previous brown bag who have managed care free practices shared the freedom that have gained. One noted that he has "only so many hours to think about case and clinically related material." To him working outside of managed care cost him less and benefited him more. He can devote more time to refining his skills and does not have to make room in the hour for an interested third party.

Once people had a chance to vent, they increasingly focused on what many wanted to know – how does one extricate oneself from the seductiveness of managed care and insurance. Two major ideas emerged from the discussion. First, put yourself out there. Second, start slowly.

One woman came to Seattle "cold" from California. Hardly knowing a soul, she began meeting with clinicians in the community to tell her about herself and learn about their practices. She put up flyers telling the public about her practice. With a child and family based practice, she served on the board of Youth and Family Services. She talked with school guidance counselors. She had lots of lunches with colleagues. She landed a part time teaching job. She probably bought lots of shoes until three years later, she had a successful managed care free practice.

"Aha!", some wondered. She had a market niche that was easy to fill. Certainly being one of a few folks that can fill a need for the many can help fill a schedule. But our successful clinical entrepreneur countered, "passion" is the key. If one "really digs" this kind of work, the enthusiasm will attract business. Having confidence in one's skills and a belief in the value of therapy gives heart and soul to whatever form your message takes.

No one pretended that making a leap form insurance based to insurance free practice is a skip across a puddle. You can think of the endeavor as akin to starting a practice; and in a sense you are. So, for example, find a "buddy" with whom to "kibitz." Start changing your practice with new clients. Resign from the more noxious panels one at a time. Where insurance contracts allow, tell new clients that you will no longer be submitting forms for them but ask them to do that for themselves. Start educating new clients about the threats to choice, confidentiality and privacy that choosing to use insurance poses. (*Note: The Coalition has a brochure Insurance Quandaries &Questions that address these issues)* For example, using insurance for could affect a person's ability to buy life insurance.

Finally, the issue of fees reared itself. Some felt that sliding one's fees could cheat the clinician out of income. They argued that clients who want therapy will make the financial sacrifice will do so. Others submitted that some clients however motivated, will need a lower fee schedule. These clinicians

use their judgment to determine who deserves a financial break. Another idea was to allot so many slots in one's schedule to a sliding scale and stick to that allotment.

Despite the varying views and different perspectives of working within and moving outside of insurance and managed care, all agreed that filling two hours on a pleasant Friday afternoon was not at all hard. And all felt the meeting stimulated and energized them. Consequently these meetings will continue. Look for announcements about future meetings and come participate, lend support, and feel support in growing your practice in a more fulfilling direction.

Helpline Report

John Powers

The Coalition Helpline was founded in 1995, initially as a joint project with the Clinical Social Work Society, to help practitioners and consumers deal with the mounting concerns and questions regarding the advent of managed care organizations in mental health care.

Questions over the years have covered a range of issues: complaints over how audits by MCO staff were handled; inquiries about protracted time lags from carrier reimbursement; outraged consumers dealing with the shock of denied or suddenly curtailed treatment; what to do with authorization requests that required information that seemed irrelevant or inappropriate to the treatment. Although many clinicians and patients have come to terms with the MCO reality over the years, the requests for some organization to respond to individual cases, and offer a safeguard to the therapist/client alliance, still arrive via the Helpline.

IF YOU CALL, a volunteer will get back to you to field questions, hear what you have done to address the situation, and suggest a plan of action. Often issues are staffed at a Board meeting to generate other directions or resources, such as contacting the Office of the Insurance Commissioner in Olympia. *The number is (206)444-4304*. It is the general Coalition business number, so please specify your request for a call back.

Managed Care Reframe

Peter N. Moore, Psy.D.

The March/April issue of *Psychology Today* had an interesting article Battling for Benefits that highlights the difficulties some families encounter accessing inpatient mental health benefits. The article begins with the tragic saga of a family whose 16 year old daughter suicided a week after "Pacificare ruled hospitalization was no longer necessary, forcing her into a partial-treatment program."

The article talks about the battles on the state and local level over benefit access. It also discusses what consumers can do. It quoted Jacqueline Fox, a Washington D.C. based attorney "who deals strictly with health-insurance appeals" who said 'Get the contract between your employer and the insurance company, *not* your member-benefits handbook.

The article also includes a revealing interview with the president and CEO of Cigna, Keith Dixon, Ph.D. When asked "what is managed behavioral healthcare?" he reframes the issue of one of "stewardship." He likens managed to care as the "private application of community mental health concepts." He contends that no longer are "caregivers (the) unbridled advocates for their individual patient" but rather the clinician is a part of a "team" stewarding and coordinating care.

This is a clever and very appealing reframe. It allies managed care to the values of cooperation and coordination and aligns it with the more noble ideals of the community mental health movement. It implies that mental health professionals are equal members of a team. (Funny, but at best I feel like the waterboy and more often like the opposing side.) The mental health community will need to highlight the Orwellian aspects of this notion. If we are indeed on the same

team then some members are indeed more equal than others. Clients and clinicians have limited power to direct the play and often use a very different playbook than managed care. This notion also assumes that the treatment "team" has access to information about the client and that this is a *good* thing.

Dixon made another interesting reframe when asked about law suits against companies of his ilk. Expressing astonishment about the very existence of law suits he said "managed care companies don't deny care; they sometimes deny payment for a level of care that is inappropriate… is not a covered benefit or violates professional standards." How interesting that companies that only determine payment then want to determine level of care or suggest using ancillary services. This time the rules of *1984* apply to those of us on the managed care animal farm.

Summary of Legislative Session

Laura Groshong Coalition Lobbyist:

The Legislative Session for 2002 ended on March 15 at 12:59 a.m., only 59 minutes later than it was scheduled to end. As you know, though the Democrats have a slim majority in the House and the Senate and hold the Governor's office, they were unable to pass many bills that would have been beneficial to increasing access to mental health treatment or limit the ways managed care intrudes on our providing ethical mental health treatment. The primary problem was the $1.6 billion deficit which meant anything that cost money would likely be defeated. On the positive side, we were able to defeat several bills that would have further interfered with the right to privacy and access to treatment. Here's a summary of the bills I have followed.

1. **Medicaid Waiver** (SB 6716 and HB 2461) – those of you with long memories (or who have studied history) will recall that in the 1950's there were a number of states that were given money for education or social services and promptly spent it for other purposes, leaving many citizens without basic services. Medicaid money was created in the 60's as money that could only be used for health care and thus formed a safety net states could not take away for children and those in poverty. Last summer, the Federal government offered a "waiver" to states who could prove the money would be used better for other purposes. Only two states applied for the waiver, Washington and Arizona. This bill would have prevented DSHS from doing this without consulting with the legislature. In a major disappointment, the bills were **defeated.**

2. **Hospital Overtime** (SB 6675 and HB 2601) – there is such a shortage of qualified hospital staff that many nurses and E & Ts have been forced to work overtime, along with staff at community mental health agencies. These bills would put limits on this practice (exact limits to be determined). The bill was **passed** and hospital staff can no longer be compelled to work more than 12 hours a day or 80 hours in 14 days.

3. **Parental Commitment** (HB 2371) – this would have allowed parents to commit children for inpatient mental health treatment up to 16 *without professional evaluation*. It was **defeated** and in a positive outcome, I have been asked by Judiciary Committee Chair Mary Lou Dickerson to work on developing more reasonable privacy standards for adolescents.

4. **Title 18 and Injured Workers** (SB 6724) – this bill would have allowed all licensed mental health clinicians to treat injured workers through Department of Labor and Industries. It was **defeated** on the basis of a campaign of misinformation by the Association Washington

Continued on p. 5

Businesses (AWB) and the Washington State Medical Association (WSMA), claiming it would increase usage and open the door for LICSWs and others to become gatekeepers. We will be working in the interim to try to correct these misstatements and pass a rule allowing licensed master's level clinicians to be providers.

5. .Mentally **Ill Offenders** (HB 2298) – the mental health treatment of the mentally ill who are also in the criminal system is fragmented and inadequate. This bill would have set up a pilot project to develop a better more integrated system. Unfortunately, it was **defeated** because of the financial crisis.

6. **SB 6589 (Advanced Directives)** –The purpose of this bill is that folks with serious mental health disorders who cycle in and out of hospitals can sign an "advanced directive" that would allow them to be hospitalized voluntarily even if they cannot make that decision at the moment because of their psychosis. The directive would be describing symptoms and the preferred form and length of treatment. Because of the potential for abuse of any 'directive' about treatment to be offered when a patient is stabilized, fortunately this bill was **defeated**.

7. **SB 6368 (Drug Utilization)** – this bill is in the House after passing the Senate and would create a state formulary which requires generic drugs to be used whenever possible. It would not include anti-psychotics, i.e., the atypicals can still be used and covered, but would cover anti-depressants and anti-anxiety agents. After a bitter fight, the bill, which would have resulted in significant cost reduction, was unfortunately **defeated** and will continue to be reviewed in the interim.

8. **HB 2430 (Small Business Insurance)** – this bill would have offered new plans to small business that eliminated mental health and the majority of state mandates, e.g., mammography, diabetes treatment, etc., fortunately was **defeated** in the House.

The budget which was adopted was a temporary fix of the deficit and will depend on a referendum to be sent to the voters in November which would raise gas taxes $.09 a gallon. This allowed cuts to social services programs to be minimized, only a third of what was originally proposed. Many thanks to the unceasing work of many social service lobbyists that saved this funding. The gas tax will not solve the deficit and next year legislators will be faced with as big, if not worse, a deficit problem as this year. In my view the only solution will be increased taxes of other kinds, ideally an income tax, the least regressive tax. I hope to have better news for you in the future. Sometimes preventing legislation that would harm mental health treatment delivery and clinicians is a success and to that extent I think we achieved a modest one.

Join Us for Another Great Meeting:

<u>Successful Practice Outside of Managed Care</u>

When: Friday, May 10, 12Noon to 2:00

Where: Good Shepherd Center

4649 Sunnyside Avenue (Wallingford)

Room 221

The Coalition of Mental Health
Professionals and Consumers
PO Box 30087
Seattle, WA 98103

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Join or Renew Your Commitment to Protect Mental Health Care

Name: ____

Address: ____

____

Phone: ______-______-________________ Fax: _____-______-__________

E-mail____

Member: $65
Student: $15
Consumer: Free
Organization: $124

Willing to help with specific tasks (mailings, phone work): YES ______

OK to publish information in a directory ? YES _______
NO _______

Please remember to fill out your Insurance/managed care survey

Thanks if you have already sent it in