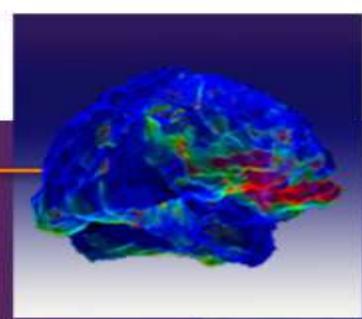




Massachusetts  
Neuropsychological  
Society



## **Special Professional Affairs Report: Transparency and Joint Advocacy Find a Home in Massachusetts**

by Michelle L. Imber, Ph.D., ABPP

*The recent passage of Chapter 224 of the Acts of 2012, “An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation,” marked several broad changes in the landscape of health care in the Commonwealth. Among its many provisions lies an important leap forward for the scientific integrity of criteria used to make decisions about medical necessity. Dr. Michelle L. Imber, chair of the MNS Professional Affairs Committee and current member of the MPA/MNS Joint Advocacy Group, sat down with some of psychology’s busiest advocates to bring you this behind-the-scenes glimpse into the unexpected twists and turns of the advocacy process, the recent history of psychology’s contributions to health-care reform, and why dozens of heads are better than one.*

Transparency has always been a touchstone for men and women of science. Objectivity, consideration of existing evidence, peer review, and independent verification are pillars of the scientific method. So when psychologist advocates in Massachusetts began to suspect that clinical care was being denied in defiance of these scientific principles, they became concerned. Four years later, their investigations have spawned an interdisciplinary coalition of local and national experts, the fruits of whose labors will ensure that all patients have the advantage of current scientific knowledge in accessing their health-care benefits.

### *The Roots of a Cause*

It was fall, 2008. Barack Obama’s first presidential campaign was drawing to a successful close, and “ObamaCare” had yet to enter widespread use in the national vocabulary. Blue Cross Blue Shield of Massachusetts (BCBSMA), the largest private health-insurance carrier in the Commonwealth, had recently announced that it was planning to revise its longstanding Policy and Procedure document for neuropsychological assessment services. The existing document had stood for two decades and was badly in need of an update. BCBSMA and the Massachusetts Psychological Association (MPA) had been meeting on a quarterly basis to address issues of mutual concern; at one such summit, BCBSMA requested input from

psychologists in order to help them bring the document up-to-date. Over the ensuing months, volunteers from the MPA Assessment Committee researched the latest standards in order to propose revisions to the document, with the aim of providing an evidence-based update and a reformatting of the policy to reflect developments in the field. Both MNS and MPA had provided such input at various times in the past, with good reason: Massachusetts managed-care law 211 CMR 52.08(3)(a) requires that utilization-review criteria “shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating providers.” According to a letter from then-MPA-President Dr. Karen S. Postal, and MPA Executive Director Dr. Elena Eisman, dated November 2008, BCBSMA had advised MPA that no changes would be implemented until at least the summer of 2009.

As the working group prepared to finalize its recommendations, BCBSMA abruptly notified MPA that its assistance in revising the old policy would no longer be required. Instead, the company had decided to rely upon a set of medical-necessity guidelines, known as the InterQual Criteria®, which they had purchased from the McKesson Corporation. These Criteria were already being used by insurance carriers around the country, and BCBSMA itself had been using many of the InterQual® policies to manage medical benefits in other disciplines. The neuropsychological-testing criteria were slated to take effect in January 2009, in advance of the summer timeline initially discussed. MPA would be permitted three weeks to review the Criteria and suggest any “modifications.”

Concerned about the implications of this decision, the MPA Psychological Assessment Committee (which comprises neuropsychologists and assessment psychologists) decided to confer with MNS leadership. Leaders from both groups met with BCBSMA in late 2008, in order to gather more information about the new policies. BCBSMA initially offered a truncated version of the Criteria for review, citing the proprietary nature of the material as a rationale for withholding the full document. They eventually agreed to grant access for a handful of leaders from MPA and MNS in advance of the company’s formal adoption of the policy, under the condition that the leaders sign a non-disclosure agreement. Faced with the possibility that they would have no input at all otherwise, individuals from MNS and MPA agreed to sign the document and were thus granted access to the InterQual® policy on neuropsychological assessment.

What the advocates read provoked immediate concerns. The Criteria limited access to neuropsychological services in a manner that seemed to defy clinical logic. As most neuropsychologists are aware, neuropsychological assessment is billed in hourly units based upon the time required to assess a patient face-to-face, as well as the additional time required to score the tests, integrate the patient’s history with the results, formulate conclusions and recommendations, and prepare a report of the findings. Instead of relying upon the complexity of the patient’s condition, the number of issues under diagnostic consideration, or other practical

factors such as slowness of movement, specialized communication needs, or extreme anxiety, the Criteria specified time constraints for neuropsychological evaluations based solely upon diagnosis and age group. The age boundary separating children and adults did not align with the cutoff-points of common neuropsychological test instruments. The Criteria were silent on the disposition of cases in which the patient was being evaluated for more than one diagnosis. Furthermore, the range of hours supplied by the Criteria represented a large reduction from BCBSMA's prior policy; clinicians applying for pre-authorization could expect to receive about 38 to 62 percent of the time they had formerly been granted to conduct a full evaluation. No evidence of scientific reasoning was provided for the number of hours assigned to any given condition, nor for the drastic reduction in time allotted compared with the previous policy.

When the advocates raised these considerations, BCBSMA asserted that the Criteria were in fact scientifically based, but that the proprietary nature of the product they had licensed prohibited them from discussing any details about its scientific justification. Citing Massachusetts law, the psychologists refused to accept the vague references to an evidence base. According to a letter penned from MPA to BCBSMA criticizing the Criteria, "[W]e asked for data on the validity of the instrument and the criteria to assess claims made that it was evidence based, [but] nothing was forthcoming except for a claim that it was 'written by four or five neuropsychologists.'" Quipped the letter, "This is like saying that we should take the 'miracle cures' adverti[s]ed on late night television because the salesperson claims to be an MD."

#### *The Seeds of Collaboration: Joint Interests in Patient Protection*

Initially, representatives from MPA and MNS met separately with BCBSMA in late 2008. However, both organizations quickly recognized the alignment of their interests, and each contributed delegates to a newly-formed Joint Advocacy Group. Each organization sent separate but coordinated letters detailing in writing their problems with the Criteria. In addition to raising objections to the process by which the policy change was adopted, the letters detailed four major failings of the Criteria: 1) They focus primarily on diagnostic purposes, and largely ignore many other validated uses of neuropsychological assessment; 2) the qualifying criteria for some of the conditions conflict with the definitions in the latest scientific literature; 3) the number of allowable hours conflicts with current standards of care and appears to lack scientific support; and 4) multiple conditions for which neuropsychological assessment is clinically-indicated are not addressed at all in the Criteria. Furthermore, the letters charged, the policy failed to provide any means for taking individual patient factors (such as linguistic barriers, motor impairments, shortened attention spans, slowed processing speed, and other individual differences) into account. One letter included a 12-page, partial listing of excluded diagnostic conditions for which neuropsychological assessment might be medically-necessary, together with detailed background material about the stages of assessment and the utility of neuropsychological

assessment for a wide range of purposes (including differential diagnosis and treatment planning).

A December 2008 letter from the advocates stressed the overarching concerns about the declining quality of care for a particularly vulnerable portion of the population: “It is important to consider the fact [that] those individuals receiving neuropsychological assessment services are a unique subset of the health care consumer. These patients are, after all, very likely to have neurologically-based impairments of their cognitive abilities that compromise their ability to function effectively. Their neurological and psychological deficits are likely to make it harder for them to understand and access health care and to advocate effectively for themselves as their ability to engage in effective problem solving and decision-making may be compromised.” In a follow-up letter, the professional organizations questioned the methodology used to determine the number of hours authorized for testing, and noted that updates to the 96118 CPT code – which as of 2006 began to allow billable time for administration, scoring, interpretation, integration of information, and reporting—did not appear to have been considered in the policy, which was developed before the updates were published.

BCBSMA leadership continued to respond that they would not be able to provide answers to these questions, because the McKesson/InterQual Criteria® are proprietary and constitute trade secrets. They directed the frustrated psychology advocates to the McKesson Corporation, which in turn redirected them to BCBSMA. Eventually a bibliography was offered for review, but these articles—one of which was co-authored by a member of the Joint Advocacy Group!—appeared to address more general issues about the utility of neuropsychological testing and did not contain evidence for restriction of the number of hours based upon age or condition.

In early 2009, leaders from MNS and MPA continued to meet with BCBSMA officials before the Criteria went into effect. The psychologists argued that there were numerous logistical problems with the proposed system, which they feared would block patients from accessing medically-necessary services requested by their treating doctors. In response to BCBSMA’s requests for additional information, the MNS Professional Affairs Committee and the MPA Assessment Committee compiled a series of short, research-based documents detailing the problems with the current InterQual® guidelines for some of the most common conditions and diagnoses, including dementia, traumatic brain injury, brain tumors, multiple sclerosis, and cases of epilepsy requiring pre-surgical evaluation. The committees cautioned, “[M]odifying a flawed and ascientific system [i.e., the McKesson/InterQual Criteria®] will lead to a flawed and ineffective product.” In this vein, they reiterated their request that BCBSMA delay the adoption of the InterQual Criteria® for one year in order to permit a more careful consideration of the scientific literature. The advocates also strongly recommended that older adolescents be included in the pediatric age category rather than subsumed into the more restrictive adult category, since their brains are actively continuing to develop and since they face unique

biological, psychological, and social factors that often necessitate nuanced, detailed, and complex assessments.

In response to the documentation provided by MNS and MPA, BCBSMA agreed to some changes in their implementation of the new policy. They increased by two the maximum number of hours allowable for each condition. They defined 18 as the age of adulthood for the purposes of interpreting the neuropsychological testing policy, which then granted older teens access to the same range of hours authorized for younger children. BCBSMA also changed their implementation of the McKesson/InterQual® requirement that head injury must be accompanied by loss of consciousness in order to qualify for access to assessment. Since the Criteria's definition of head injury, the grouping of adolescents with adults, and the linkage between hours and diagnosis were clearly inconsistent with the existing evidence base, the advocates grew increasingly troubled that the unaltered aspects of the policy might be similarly unfounded in science. However, BCBSMA declined to address any further issues of scientific dispute, announcing that they had decided to fast-track the policy for implementation on May 01, 2009.

Although meetings with BCBSMA continued through December of 2010, ongoing efforts to address the scientific validity of the Criteria seemed to be at a standstill. After advising BCBSMA that legislative and regulatory actions would be sought if necessary, advocates began to explore these avenues in earnest. MPA had previously worked with the Commonwealth's Office of Patient Protection (OPP) during the development of the external review process, the procedure which permits patients to appeal an adverse determination if they are not satisfied with the results of an internal appeal pursued through their insurance carrier. MPA asked whether OPP would help to provide a scientifically-grounded review of the Criteria. Although OPP shared providers' concerns about maintaining the quality of patient care, they explained that they did not have the authority to review entire sets of criteria and could only consider the facts on a per-patient basis.

However, as the policy took effect, very few denied cases ultimately reached the OPP appeals process. Patients often required assessment for the very cognitive problems that made it difficult for them to coordinate an appeal. Family members, already overwhelmed with caregiving responsibilities, were reluctant to expend resources to complete the paperwork, pay the \$25 fee that must accompany a request for external appeal, and endure further delays in receiving services. Providers reported that many people whose assessments were not authorized were simply giving up, and were therefore not receiving the evaluations ordered by their doctors. Other patients and families paid out of their own pockets in order to access services. If regulatory avenues were insufficient to protect these patients, it was time to seek legislative change.

## *A Legislative Approach*

MPA and its lobbyists approached Representative Ruth B. Balser (D-Newton), herself a psychologist with a strong record of protecting patient rights, to see if she might introduce some legislation that would require transparency in medical necessity guidelines for all carriers. These requirements would apply not only to criteria for psychological and neuropsychological care, but to all aspects of medicine. At the advent of the 2009-2010 Legislative Session (the 186th General Court), Rep. Balser filed H.3558, “An Act Relative To Access To Mental Health And Addiction Services.” The bill would amend Chapter 176O of Massachusetts General Law to require the availability of medical necessity guidelines, and any scientific evidence underlying such guidelines, to participating providers and subscribers upon request. Additionally, it would grant the Office of Patient Protection the authority to review, challenge, and alter the guidelines as needed to ensure “evidence basis and clinical appropriateness.” The bill further stipulated that health-care carriers must report the number and resolution of internal grievances to an external agency for oversight.

Beginning in 2009, MPA representatives worked with colleagues in related fields to build backing for the legislation. Early support was tendered by some member groups of the Massachusetts Mental Health Coalition, a broad assemblage of patient and provider advocates that includes representatives from MPA as well as from the Mass. Psychiatric Association, the National Association of Social Workers—Mass. Chapter, The Mass. Association of Registered Nurses, Mass. Mental Health Counselors, Nurses United for Responsible Services, the Association for Behavioral Healthcare, the Mental Health Legal Advisors Committee, and the Mass. Association for Behavioral Health Systems. A grassroots campaign developed alongside the official one; Dr. Postal (then the president of MPA, today the president of MNS) made a standing offer to help bashful psychologists address their senators and representatives directly: “I will accompany ANYONE, in ANY corner of the state[,] to have this conversation with their legislator if that’s what it takes.” Members of the MPA and MNS Joint Advocacy Group developed a set of sample talking points to demonstrate how the bill will protect patient care, and Dr. Postal and Dr. Joel Rosenbaum starred in a video that modeled the process of conversing effectively with a legislator.

In parallel, the Massachusetts psychologists had begun to fortify connections with organizations at the national level. McKesson/InterQual Criteria ® were in broad use throughout the country, so a challenge in Massachusetts would likely have national implications. Fortunately, Massachusetts psychologists play major roles in advocacy in the national arena. Dr. Celiane Rey-Casserly is a member of the Joint Advocacy Group who was then the president of Division 40 (the Division of Clinical Neuropsychology) of the American Psychological Association (APA). Dr. Eisman, not yet elected to her current role as an APA board member, was involved in other echelons of APA governance at that point. Other local advocates, such as Dr. Kira Armstrong and Dr. Postal, were involved in the stewardship of the American Academy

of Clinical Neuropsychology (AACN). Several advocates were active members of the National Academy of Neuropsychology (NAN). These connections proved fruitful. Dr. Eisman raised the possibility of a national peer review of the Criteria by the APA Committee on Psychological Tests and Assessment. Many of the national groups, including NAN, AACN, and Division 40, wrote their own letters directly to McKesson to express their concerns about the Criteria. Dr. Neil H. Pliskin, Director of the Practice Advisory Committee for Division 40, flew into Boston to attend one of the early BCBSMA meetings along with MNS. Because of the far-reaching implications of transparency, parallel efforts through national organizations are still underway to engage McKesson in productive conversations about scientific updates to the Criteria.

After a public hearing in December 2009 before the Joint Committee on Financial Services, the first incarnation of the transparency bill was eventually referred for a Study Order. As MPA lobbyist Atty. Ben Fierro III explains, a study order is “a polite way for a committee to kill a bill.” Occasionally such an order does result in further, formalized study of the issue at hand, but more commonly the matter lurks quietly on a languishing to-do list that remains untouched for the remainder of the legislative session. In fact, such a fate is typical for most successful bills, which often endure multiple iterations, several rounds of legislative-session filings, and scores of tweaks before a version of the bill is finally passed. Only a few percent of bills appearing before the legislature are ultimately codified into law.

In January 2011, when the 187<sup>th</sup> General Court was convened, Rep. Balser re-filed the bill as H.1463. This time, the bill was titled “An Act Relative To Transparent Evidence-Based Mental Health Care.” The new title helped to land the bill before the Joint Committee on Public Health, and again a public hearing was held. The bill remained mired in Committee proceedings while the legislature slogged through the state’s budget proposal. Months elapsed with no word on the fate of transparency in the Commonwealth.

Around the same time, the leadership of the Mental Health Coalition noted a new bill (S.2270) gaining ground in the Massachusetts Senate that would overhaul the health-care delivery system in order to maximize efficiency, streamline patient care, and promote transparency on a grand scale. Versions of the bill ping-ponged between the Senate and the House. Observing the rapid ascension of the new legislation, proponents of transparency quickly recognized an opportunity for strategic advocacy. Dr. Eisman, a veteran of legislative efforts that advocate for the practice of psychology, joined forces with MPA lobbyists and the Mental Health Coalition to ask the House and Senate leaders to incorporate the text of the transparency bill into the payment reform language. The transparency language dovetailed nicely with other sections of the bill, whose cause was championed by individuals sympathetic to patient rights.

A group of MPA and MNS psychologists, including members of the Joint Advocacy Group as well as MNS PAC members Dr. Mary Coakley-Welch and Dr. Claudia Rutherford, had the opportunity to view and comment on the fledgling payment reform bill in the late spring and

summer of 2012. Although at first it seemed that the transparency issue was gaining traction, a proposed amendment was quietly inserted that would actually exempt proprietary criteria sets such as the McKesson/InterQual Criteria® from public disclosure (leading it to be dubbed “the Anti-Transparency Bill” among the vigilant psychologists who recognized the meaning of the language). The group worked quickly to bring this amendment to the attention of the MPA lobbyists, and the language was revised to state, in no uncertain terms, that *all* medical-necessity (aka “utilization review”) criteria must be made publicly available. With additional backing from Rep. Balsler, and letters of support from mental health providers, physicians, occupational therapists, the Mass. Hospital Association, the Mass. Association of Psychiatric Health Systems, and the Association of Behavioral Health, the language was ultimately incorporated into the final version of the bill. Senate Bill 2400 was passed on July 31, 2012, and signed into law by Governor Deval Patrick on August 06, 2012.

Meanwhile, H.1463, now superfluous, has joined several other health-care policy bills that were referred for a Study Order and discharged to the Committee on House Rules in mid-October of 2012.

#### *Implications of Chapter 224*

Chapter 224 of the Acts of 2012 (aka “the payment reform law”) does, in the end, address the availability of medical necessity criteria. It broadens the role of OPP to oversee such criteria sets, stating, “Utilization review criteria, medical necessity criteria and protocols must be made available to the public at no charge regardless of proprietary claims.” (There is still a provision that permits the OPP and the Division of Insurance to protect the confidentiality of any material that “is proprietary in nature and not in the public interest to disclose.”) The specific interpretation of these passages will be shaped by the regulations that will be developed to enact the bill; hearings for these regulations are already underway. Naturally, the law has wide-reaching implications that will affect all insurers who have adopted proprietary criteria sets.

The transparency effort as psychologists know it is just a small part of the 349-page behemoth that seeks to overhaul health care for the entire Commonwealth. The law is primarily designed as a measure to contain the burgeoning costs of health care in Massachusetts, which is bursting at the seams with hospitals, providers, carriers, and patients. The new law seeks to control the growth of health-care costs by keeping them at or below the rate of economic growth within the state, aiming to save over \$200 billion over the next fifteen years. It assesses a one-time fee on hospitals and insurers, and redistributes this money to aid distressed community hospitals, fund prevention efforts, and finance the eHealth Institute that furthers the conversion of paper medical records to an electronic modality. It also strengthens anti-trust regulation of the largest health-care providers, and discourages fee-for-service contracts by promoting, among other possible approaches, Accountable Care Organizations and Patient-Centered Medical Homes (it remains to be seen how these structures will be implemented in the marketplace).

Medical malpractice will be reformed to ease the burden on providers. Transparency is promoted expansively throughout the law: the newly-dubbed Center for Health Information and Analysis will gather, scrutinize, and publish information about the cost and quality of providers, organizations, and services. There is a significant role for the Attorney General in overseeing patient access and quality as the transitions unfold within the system. The Commissioner of Insurance is charged with overseeing compliance with federal parity law. Providers can expect some simplification of administrative procedures, such as standardization of authorization paperwork and Explanation-of-Benefit statements.

Chapter 224 also provides for the creation of a Behavioral Health Task Force, a 19-member organization in which MPA has a named seat. The Task Force will be consulted to design and implement behavioral, substance abuse, and mental health services and address the integration of these services with primary care. Behavioral health services (such as those addressing the interface between physical health and human behavior) will have a major role in the new system, potentially important news for neuropsychologists who may have to visualize innovative roles for themselves, building on their strengths and experience as active and collaborative members of health-care teams.

#### *What's Next? Collaborations New and Established*

Advocates for neuropsychological services, and indeed for all behavioral and physical health services in Massachusetts, have their work cut out for them over the coming months. Much of this work will blossom from the passage of Chapter 224, which will have provider groups, hospitals, and legislative bodies scrambling to meet the ideals of the new law. As the 2012 elections have made plain, Massachusetts is seen as a proving ground for innovations—and in some cases, leaps of faith—in the health-care industry.

For MNS and MPA, this important achievement cements another tile into the larger mosaic of ongoing advocacy efforts. Some of these reflect specific projects, while others are ongoing advocacy tactics that unfurl over the long haul. Often, says Dr. Eisman, the most effective strategies are a combination of existing regulatory remedies, legislative action, and fostering collaborative, longitudinal relationships with other groups (such as the state organizations of related guilds and the insurance executives responsible for setting and implementing company policies). She explains, “One of the things people need to understand about legislative remedies is that you need to spend approximately one-third of the time getting the bill passed; one-third of the time getting the regulations established so that the language of the bill is effectively implemented, and one-third of the time making sure that the regulations are being followed.” MPA employs two lobbyists, Attorneys Patricia Lynch and Benjamin Fierro III, whose efforts on behalf of Massachusetts psychologists include advancing new legislative initiatives while working to protect the existing rights of providers and patients in response to legislation introduced by other entities.

### *What's Cooking (and Who's at the Stove)*

Joint advocacy endeavors continue beyond the legislative arena, spanning regulatory efforts, outreach to industry groups, and communication with state officials about problems affecting psychologists and patients. Specific local efforts have included formal complaints to the Division of Insurance about violations in notification laws; strengthening communication with test publishers to keep them abreast of factors affecting the field; meeting with multiple insurance carriers to raise concerns and collaborate on issues of mutual interest; and, over the past two years, a multi-part submission to the Attorney General's Office regarding legal violations that are impeding access to care in the Commonwealth.

Our local organizations are particularly fortunate to have the benefit of collaboration with the APA Practice Organization (APAPO), which has offered ongoing expert consultation on legal matters of interest to psychologists throughout the country. Two attorneys— Shirley Higuchi, J.D., Assistant Executive Director of Legal and Regulatory Affairs, and Alan Nessman, J.D., APA's Senior Special Counsel for Legal and Regulatory Affairs—have provided integral support and strategy to Massachusetts efforts; they flew to Boston to join advocates in a meeting with representatives from the Attorney General's Office this spring. Further, APAPO has recently renewed its commitment to neuropsychology advocacy in light of Division 40's strong representation within APA. According to Dr. William Barr, the immediate Past President of Division 40, Clinical Neuropsychology is currently the largest Division (3,993 members) within APA, as compared with close runners-up Division 42 (Psychologists in Independent Practice, 3,772 members); Division 12 (Society of Clinical Psychology, 3,562 members); and Division 39 (Psychoanalysis, 2,665 members). Furthermore, neuropsychologists are ahead of their colleagues in the percentage of division members paying the Practice Assessment: 60.5 percent of Division 40 pays its practice assessment (compared with 60.1% of Division 42, 57.1% of Division 39, and 49.6% of Division 12). The level of commitment expressed by neuropsychologists, in terms of vocal advocacy efforts as well as financial support of APA Practice initiatives, has not escaped the attention of national leaders who direct the allocation of resources. Says Dr. Katherine C. Nordal, Executive Director for Professional Practice of the American Psychological Association, "The dividends of collaboration paid off in Massachusetts with the inclusion of the transparency language in the Payment Reform Act. The APA Practice Organization is very happy to have contributed to this effort along with MPA and MNS members and will continue to support the advocacy efforts of neuropsychologists at the national and state level."

Meanwhile, the working relationship between MNS and MPA is the envy of other states. In a challenging climate that has brought conflict to so many other groups, the effective teamwork of our organizations has garnered national attention. At the 2012 business meeting of Division 40, Dr. Barr publicly commended Massachusetts for its smooth internal collaboration

on so many issues, praising the Commonwealth as a national paragon for efficacy in joint advocacy work.

Dr. Roger Cohen, who has held major roles in the governance of both MPA and MNS, has been formally recognized by both organizations for his contributions in building positive working relationships among psychologists of all stripes in our Commonwealth. For him, collaboration is a necessity. “I think that everything that can possibly be available is far more available when we build networks of collaboration than if we work individually. By bringing the two organizations together, we greatly expand our credibility and our effectiveness.”

Dr. Rosenbaum, the president of MNS during the 2007-2008 year, past chair of the MNS Professional Affairs Committee, a Fellow of NAN, and also a recent member of the Board of Directors of MPA, has been another key player in mobilizing the productive teamwork among MNS, MPA, and national organizations. In the Fall 2007 edition of the MNS Newsletter, Dr. Rosenbaum reminded members, “...as the largest [state neuropsychological] organization in the country, perhaps we have a responsibility not only to neuropsychologists in Massachusetts but to neuropsychologists in the region and that we need clear and direct channels of communication within the area and nationally? Perhaps we need to raise our profile locally and within a broader playing field?” To that end, during his presidency, he worked to establish and strengthen key relationships between MNS and organizations such as MPA, the National Academy of Neuropsychology (NAN), the International Neuropsychological Society (INS), the American Academy of Clinical Neuropsychology (AACN), and the Federation of Associations in Brain and Behavioral Sciences (FABBS). He worked to ensure bi-directional channels of communication such that national organizations knew what providers were facing in day-to-day practice, while providers benefited from the wisdom of the national groups. Today, he is proud of MNS for its blossoming role in state and local advocacy, with a diverse and ambitious mission statement adopted under the direction of our immediate Past President Sigmund Hough that openly recognizes a commitment to “educate and advocate on behalf of the profession, practitioners[,] and consumers.”

### *Lessons Learned*

If the past few years have taught us anything about how to get things done in the world of advocacy, it's that each organization has a unique role to play in achieving powerful results for our practice and our patients. Our own MNS is an organization composed of specialist experts. Neuropsychologists tend to be more attuned to billing issues than many of our colleagues in related disciplines, due perhaps to the relatively limited number of codes used for neuropsychological assessment and to the relatively recent, well-publicized updates to these codes. We are also by nature masters of the complex, whizzes at synthesizing a massive body of interdisciplinary data into a logical and practical formulation. Neuropsychologists who are

representatives to MNS/MPA advocacy efforts have donated thousands of hours of time, crafted hundreds of pages of written work, and offered expertise on diverse topics such as billing, clinical, and scientific issues.

Yet MNS, which is set up as a Section 501(c)(3) nonprofit organization, is extremely limited in its ability to engage directly in advocacy activities without jeopardizing its tax-exempt status. A partnership with MPA, a Section 501(c)(6) organization, is a natural solution because MPA can advocate more broadly for the good of all psychologists in the Commonwealth and is structured to have a constant and powerful political presence to advocate for psychologists and their patients. MPA employs two lobbyists and a small staff, including Dr. Eisman (who serves as both Executive Director and Director of Professional Affairs). The lobbyists represent the interests of psychology in the state legislature, working to advance new legislation that will benefit psychologists and patients at the same time as they maintain vigilance to offer protection from potential threats to our profession, practice, and patients' rights. "Success in advocacy is something that's built up over time based on developing relationships and a history of working together, so that you can [offer] mutual support" for causes that are simultaneously beneficial to several groups, says Dr. Eisman. The needs and desires of groups that represent patients and families often align neatly with those of various provider organizations; cultivating supportive relationships can extend the reach of our work and keep us seated at the proverbial table even when we cannot be physically present at every hearing or legislative meeting. Thanks to such collaborations, affirms Dr. Eisman, "We have a presence—and a consistent presence."

Because of limited humanpower at the state level, it is similarly important for our local organizations to work together with national groups, such as APA, NAN, and AACN. National organizations can harness and mobilize resources quickly and effectively, since they represent a larger number of people, employ a dedicated staff, and are led by national experts. These groups can also offer a broader perspective, from a vantage point that tracks similar struggles as they unfold throughout the country, and can lend their expertise in order to conserve local resources and prevent redundant efforts. Successful advocacy in one region can often be parlayed into similar approaches elsewhere. In the case of Massachusetts, APAPO has offered priceless resources such as expert legal counsel and consultation in the strategic architecture of advocacy efforts.

Meanwhile, other national collaborations are coalescing that will advance and crystallize ongoing advocacy efforts in Massachusetts and elsewhere. Division 40 has recently announced the advent of a new Federal Advocacy Network, whose mission will be to connect and mobilize advocates who are active in their home states by providing an infrastructure to facilitate communication. The Clinical Neuropsychology Synarchy (CNS) has delegates from major neuropsychology organizations throughout the world. The CNS is working on projects that will globally enhance advocacy within the field. Our own Dr. Postal is chairing the new Inter-Organizational Practice Committee (IOPC), a super-committee of AACN, NAN, APA Division

40, and the American Board of Professional Neuropsychology (ABN), whose goal is to maximize the precious and limited resource of volunteer time by sharing strategies and extending the scope of individual advocacy efforts by echoing them in other areas. The IOPC plans to become directly involved in the transparency endeavor in the near future; it has already begun to amass a subcommittee of national experts that will review major criteria sets for medical necessity as they pertain to the practice of neuropsychology. Once the regulations about transparency are codified, the IOPC subcommittee will present a formal appeal complaint to the Office of Patient Protection along with state-of-the-art science and guidelines for widely-accepted clinical practice.

Dr. Postal, who has helmed both MNS and MPA and who currently serves on several national boards and committees, is a firm believer in a multi-tiered model of advocacy. She asserts, “The vast majority of the laws, regulations, and insurance company edicts that shape our practice climate occur at the state level.” She reasons that having strong organizations at the state level will permit us to use practitioners in the trenches as “radars: picking up on new laws and reg[ulation]s, lobbying for better rules, [and] personally interacting with insurance exec[utive]s.” At the same time, “The power to change the state issues often comes from our national organizations...[which can provide] compelling letters...coordinated action...[and] access to top tier legal opinions. We need to support ‘local’ to be our eyes and boots on the ground, and ‘national’ to be our muscle.”

Health-care reform is here, and if the recent presidential debates are any indication of national sentiment, all eyes are firmly fixed on Massachusetts as a pilot state for the incubation of innovative, cost-saving plans involving massive reorganizations in the fabric of healthcare. Change is coming fast, and it will be up to the rising generation of neuropsychologists to plot a course through this uncharted territory by boldly stepping up to represent our field. As Dr. Nordal has said in her now-famous version of the popular political quip, “If we’re not at the table, it’s because we’re on the menu.” Meanwhile, the advocates for neuropsychological and psychological services in Massachusetts will keep pushing forward on your behalf—sometimes through slow and painful “baby steps,” and at other times, as with the passage of Chapter 224, through joyful leaps and bounds. As the great anthropologist Dr. Margaret Mead has said, “Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever does.”

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## HOW TO HELP MAKE A DIFFERENCE

1. **Join up.** Each organization—psychology, neuropsychology, local, national—has its individual role to play in advocacy efforts. Although it may be tempting to pick and choose who gets your dues when times are tight, you will be the biggest help to yourself and others in the field if you contribute to all the organizations who promote our work. MNS acts through a variety of channels to support neuropsychology in the Commonwealth and neighboring states. MPA offers legislative advocacy that MNS cannot directly provide, and advocates broadly for all aspects of psychological practice in the state. The Practice Assessment, which is the major source of funding for the APAPO, helps to subsidize efforts like ours at the national level. It advocates for psychologists in national matters (such as Medicare rates, the definition of a psychologist, etc.), and also has offered resources directly to Massachusetts advocacy efforts among those of other states. NAN, INS, Division 40, and AACN (and their sister political organizations) each work to support different aspects of practice, including research that is vital to documenting the value of our field. Keep your memberships up-to-date. If you're struggling with whether to support the politics of a given organization with your dues, please see #2.
2. **Suit up.** There's never been a better time to join a committee, serve on a Board of Directors, or participate in a seminar or roundtable. Aside from a handful of paid representatives, most of the folks working on behalf of our profession are volunteers. No prior experience in advocacy is necessary. Contrary to what some may think, advocates aren't bored socialites looking for something to do as we sip tropical beverages from the decks of our yachts. We are clinicians just like many of you, trying to juggle personal lives with busy clinical schedules, and trying to stay afloat in an uncertain practice climate (but sadly, not afloat on a yacht). Getting involved can be one way to stave off "learned helplessness" and to educate oneself about the issues facing our profession today. The voices that get heard are the ones in the room! The ubiquitous quote often attributed to Mahatma Gandhi applies here: "We must be the change we want to see in the world."
3. **Stay informed.** Since there are just a few boots on the ground here in Massachusetts, it can be a struggle to find time to tell the world about all the great advocacy that is going on—all the advocates are too busy doing it! When news is released, don't miss it. Sign up for the electronic mailing lists, the Practice Alerts, and the newsletters, and take the time to read them. Social media is increasingly used to disseminate bite-sized chunks of up-to-the-minute news within a field, so consider creating a professional account that you use to follow organizations and leaders through

- Facebook and Twitter. Learn who is running for positions in your local and national organizations and why they want to hold a seat, and don't forget to vote!
4. **Keep us informed.** If you notice something awry in the world of practice, speak up and let us know! While we cannot guarantee immediate results in most cases, we do take seriously everything that is shared with us and we keep it in mind throughout our advocacy. You never know when a particular meeting will create a serendipitous situation to address a problem! Some concerns brought to us by members, including committee members, have gone straight to the ears of local and national policymakers in ways that will produce real change.
  5. **Complain productively.** Don't underestimate the importance of filing complaints on behalf of patients, pursuing the appeals process, and documenting your efforts along the way. Yes, it takes additional time, but if you accept fewer than the number of hours you need to complete an assessment, or a 'no' verdict for a patient whom you know needs help, you may be shortchanging your patient as well as yourself. Not only will appeals help your individual patients; those data are considered in aggregate by government officials and insurance executives whose only information about the problems may be represented in the complaints that are filed or the actual hours that are accepted for an evaluation. Keep track of your paper trail, for your own reference and in case the information is needed to support a later effort.
  6. **Answer the call.** When you get a request for information from one of your professional organizations, please respond. Complete a survey; vote in the elections; reply to requests for sample cases; participate online. Perhaps most importantly, when you hear of grassroots legislative efforts, pay close attention and contact your legislators promptly! Online applications make it easier than ever to contact all of your elected officials with a few swishes of your mouse. If you'd like to leave a more personal impact by contacting legislators directly, there are many members of MNS and MPA who would be glad to help you figure out how to approach a senator or representative efficiently and effectively.

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*The Joint Advocacy Group of MNS and MPA currently consists of Drs. Kira Armstrong, Roger Cohen, Elena Eisman, Michelle Imber, Dana Penney, Karen Postal, Celiane Rey-Casserly, and Joel Rosenbaum.*

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