Samuel Schaperow, MSMFT, LMFT
567 Vauxhall Street Ext.
Waterford, CT 06385
(860) 447-2047

Caren Anselmi
370 Bassett Rd.
North Haven, CT 06473

Dear Caren:

Within the last year, I have received many requests by local people for me to join your network. I am writing to you today to discuss the possibility of doing so. I contacted Roberta Adison to find out if we can resolve the fee issue *prior to* the lengthy credentialing process. I was happy to find out from her that it is possible to do so, and that I should contact you to work on this matter.

Late last year I decided to stop my charity clinic work and devote full attention to my private practice. I have been seeing people on a cash basis, receiving *$150-$225* per session. I accepted some out-of-network insurance clients as well. I did not intend on joining any insurance panels for two reasons. First, your rates are less than one-half of my usual fees. Second, you put my license at the bottom of a three-tier pay-scale. However, as many Anthem policyholders have expressed to me a desire within the last year for me to join your network, I thought it would benefit Anthem as well as Anthem's policyholders for me to try to negotiate a fee for me to join your network. I believe that my fee should reflect the high demand for my specialized services, my level of training and skill, as well as my actual fee rates for out-of-network and cash clients. I also believe that pay should be commensurate with the quality of services, which is difficult to capture through licensing categories alone. There are many factors that contribute to quality psychotherapy that cannot be captured by licensing requirements alone. Licensing requirements provide only the crudest guides to the expected (and actual) level of services.

An analogy might help. Teaching is both an art and a science, with the former being the most difficult to measure. Teachers vary significantly in their ability to engage and educate their students, and this is true whether they teach English, history, or another subject. While they are all teachers, they are teachers in different academic subjects. Studies indicate that some academic subjects tend to engage a higher percentage of students than others. Therefore, it might appear to make sense to use the academic discipline as a proxy of teachers' abilities to engage their students. However, while the engagement level does statistically vary from subject to subject, the *largest variation occurs from one teacher to another*, regardless of the subject taught. Thus, where schools are free to vary pay based on performance rather than tying it to some rigid degree-based grid, the best schools carefully calibrate their pay based on actual quality of teaching and place their greatest hiring and retention efforts into what makes them the best schools: their teachers.

Just as the best schools seek out and hire skilled teachers to conduct the best teaching, patients and healthcare providers recruit and retain good psychotherapists to provide the best treatment. Capturing the most current full-fee schedules of local therapists primarily in the towns of New London, Waterford[1], and East Lyme, my spring 2005 poll of nearly fifty psychotherapists shows that patients and the market recognize the enormous range of difference in quality of service within the same disciplines. As the attached chart shows, the full-fee range is $100-$150. This is a *50% increase* from the lowest to the highest charging therapists, even within the same disciplines! Other useful data from this poll shows that L.M.F.T.s charge anywhere from somewhat less than to significantly more than psychiatrists for psychotherapy, again showing that the market values a training *directly* dedicated to psychotherapy. And lastly, the group with the least face-to-face client contact training hours, L.C.S.W.s, on average charge less than the rest of the groups. But despite these differences, some insurance panels would initially lump me in with this group.

As I mentioned earlier, there is a high demand for therapists with my specialties. Despite the great need, few therapists in this area work with *children*, especially *down to age three*, as I do. Even fewer work with the particular disorders that I treat. These disorders include: *severe* cases of *Oppositional Defiant Disorder* (ODD),

[1] I excluded myself from being included in the results of the poll so as to obtain the most objective data.

elimination disorders (e.g., nocturnal and diurnal enuresis and encopresis), *developmental disorders* such as *Asperger's Disorder* and Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS). I also work with the more commonly diagnosed depression, anxiety, and *attention deficit disorders*.

In order to complete graduate school and to be eligible to enroll in a residency, I had to complete an extensive case study as my capstone project. I chose to focus on a family with a fifteen-year-old boy diagnosed with PDDNOS and ADHD. My extensive research of the latest case studies and literature allowed me to develop a specialty area in these two disorders. He binged on junk food, never showered on his own, often spoke in "baby-talk", and had a history of reactive attachment disorder, enuresis, and fire setting. I was his clinician at St. Francis Hospital, and I was up for the challenge of stabilizing him. Group therapy was used for my patient to talk about his underlying feelings and cognitions. The supervisor who did the intake stated that a case this severe would likely have only small improvements, especially since he has been in and out of PHP and IOP for years with only small gains each time. My school supervisor said from seeing the first videotaped session that his attention level was so severely impaired, as evidenced by how he *appeared* to not retain what he heard, that he would not be making any changes in the near future. Additionally, his father said that the majority of his issues would remain with my patient for the long-term.

Against all odds, I successfully used an innovative combination of the Solution Focused and Structural Family Therapy models to tackle his problems. For the showering issue, I *gently* discussed it with him to find what would be a powerful motivating reward. He said he wanted to play *Magic: The Gathering*, a trading card game, with his dad. His dad agreed to do this with him if he showered on his own just one time. He ended up showering on his own, played with his dad; then he did it again and again, until he was completely showering on his own without even any prompting! After observing the family, I came to the conclusion that in his case, the ADHD was more likely an expressed need for positive parental attention rather than a biological disorder that would respond well to medication. Medicating, in his case, would have cost him and his medical insurer more money and likely would have produced little positive result. For the speech problem, I noticed that he received criticism for speaking in "baby-talk". This criticism served to feed him the attention he had a deficit in. I worked with the father and step-mother to ignore his "baby-talk" and complement him when he talked more like his age. His "baby-talk" behavior gradually declined. Lastly, for the binge eating, the parents learned better ways to control the portions of food he could eat, and to limit the junk food, but the child was given control over which health foods would be purchased for his consumption. This intervention began to curb his binge eating, more than sufficiently preparing him to return to the outpatient level of care.

- In addition to individual work, I do **family therapy**. I do *not* just try to "fix the kid" and send the child back into the same system that may have created or maintained the symptomology in the first place. Based on research, the vast majority of practitioners and insurers support my methodology but are often prevented from putting the methodology in practice due to lack of training or support. For example, MHN's web site now even officially encourages "practitioners to appropriately involve family members in order to prevent relapse or to support treatment goals".[2] Consequently my patients will recover faster and retain their improvements with a far greater consistency than under providers without this extra training *and* the willingness to use it, even in the face of the most difficult family dynamics.
- I have one of the few bachelor degrees that truly helps prepare a therapist for effective counseling: a four and a half year "Bachelor of Science degree in Human Development and Family Relations, Concentrating in Counseling", including multiple graduate-level courses and one-and-a-half-years of clinical internships.
- I then proceeded to do a *four-year* combined psychotherapy and residency graduate training program.
- I have *thorough training in* cognitive-behavioral, both verbal and non-verbal expressive models of psychotherapy, family systems therapy, and brief therapy models such as Solution Focused and Strategic.

[2] See: https://www.mhn.com/practitioner/content.do?mainResource=pracNewsFamily&key=pracNews

- I have completed a certification program in stress disorders through the University of Connecticut.
- I was a member of the Catholic Charities and Family Service's ASAT program, which focuses on drug and alcohol treatment for adolescents.
- I currently supervise a Psy.D. Licensed Clinical Psychologist.
- I have five clients who come from over an hour away to see me, from two different states, and multiple out-of-network clients from whom I collect my full fee, which is $225 for the initial diagnostic session, and I typically slide down to $150 for follow-up visits.
- I have seen children that even the local partial hospitalization program, which I used to intern at, was unable to discharge with significant progress, and I have been able to stabilize a large number of these patients. And, kids deemed *beyond the scope of the milieu*, are sometimes referred directly to me by the PHP intake clinician(s).
- Already other insurance companies have either acknowledged my training level or the need for my specializations. Ahead are just a fraction of the many examples:
    - IE Shaffer, the behavioral health management company for Local 351, set up my contracted rate at $150 per session, which set their contribution at *$135*.
    - On February of this year, two boys were referred to me, the *four-year-old* for ODD, and the other for Asperger's and ODD. The out-of-network plan they had through Pequot, managed at the time by Multiplan, had a $300 deductible, then a flat $50 reimbursement rate. Pequot reviewed my unique credentials and then waived the entire deductible. They then raised their contribution from $50 to $69, therefore my *minimum total rate of pay was $89*.
    - Blue Care Family Plan, set up to pay $55 per session, agreed to pay *$75* to the sessions for all five of the patients I saw under their plan. This agreement was made in January. They even agreed to retroactively change all previously paid $55 contributions to $75, so that I would not consider referring the clients out. They knew that paying me more would more than pay for itself, and they followed through on their agreement.
    - Blue Care State POS verbally informed me, on 5/6/05, that the fee-schedule for family therapy is set at the rate of *$139 per session, and that Anthem will be contributing 80% of this figure*. This arrangement applies to all people on this plan, with varying deductibles.

I believe Anthem will find me to be a very valuable therapist to have on board its plans, as my hard work and dedication will enhance Anthem's good name, fulfill a need for the treatment of the difficult disorders I work with, and save Anthem a lot of money because often issues such as severe ODD end up requiring costly partial hospitalization because there are not enough therapists who can successfully manage these disorders in the outpatient setting. Altogether, I have more psychotherapy training and education than many psychiatrists. I would really like to become a part of the Anthem team because of Anthem's high level of professionalism and extremely efficient administration and wide reach. If my pay rate can be negotiated to be as high or higher than your top rate for psychiatrists, some of whom may not have the same kind of expertise or experience that I have, I would be especially appreciative. I do earn as much as *$150-$225 for cash and out-of-network sessions.* Of course, I understand market realities and the pressures on insurers. Thus, I would also be willing to work out a rate not greatly below my customary out-of-network and cash rates. I look forward to hearing from you an equitable offer in consideration of my specific expertise and qualifications and the market need for my unique services.

Sincerely,

Samuel Schaperow