HB
274

HOUSE COMMITTEE REPORT

File

(11)
Date Referred: March 13, 1990 FURTHER REFERRALS:

Date of Committee Action: 4/24/90

The FINANCE Committee considered: HB 274

HOUSE BILL NO. 274 MEDICAID PAYMENT FOR PSYCHOLOGISTS

"An Act relating to psychologists' services under the state medical assistance program; and reordering the priorities for eliminating coverage under Medicaid."

RECOMMENDATIONS:
[✓] be replaced with CS HB 274 (FIN) [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Date/Dept)

[ ] fiscal impact _____ [ ] fiscal note(s) _____
[✓] zero fiscal note HFC [ ] zero fiscal note(s) _____
[ ] zero with analysis _____ [ ] zero fn/analysis _____

SIGNING DO PASS:

Larson
SWACKHAMMER
BROWN
KOPPERUD
ULMER
BARNES
Shultz
Phillips
Rieger

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend

Larson
CO Chairman's Signature
Hoffman

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSHB 274 (FIN)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: 2/13/90
Title: An Act Relating to Psychologists' Services.
Sponsor: House HESS Committee
Requestor: House Finance Committee

Agency Affected: Health and Social Services
BRU: Medical Assistance
Medical Assistance Administration
Components: Medicaid Non-Facility Claims Processing

Adopted

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: House Finance Committee
Division: Co-Chairman Ron Larson
Phone: 465-3727
Date: April 24, 1990

Approved by Commissioner: Co-Chairman Lyman Hoffman
Agency: _____
Date: April 24, 1990

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Original sponsor(s): HESS Committee

IN THE HOUSE BY THE FINANCE COMMITTEE

CS FOR HOUSE BILL NO. 274 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to psychologists' services under the state medical assistance program; and reordering the priorities for eliminating coverage under Medicaid."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 47.07.030(b) is amended to read:

(b) In addition to the mandatory services specified in (a) of this section, the department may offer only the following optional services: case management and nutrition services for pregnant women; personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; prescribed drugs; <u>clinical services of a psychologist licensed by the Board of Psychologist and Psychological Associate Examiners;</u> physical therapy; occupational therapy; chiropractic services; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care.

* Sec. 2. AS 47.07.035 is amended to read:

Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the department finds that the cost of medical assistance for all persons

eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

(1) clinical services of a psychologist licensed by the Board of Psychologist and Psychological Associate Examiners;

(2) chiropractic services;

[(2) ADULT DENTAL SERVICES];

(3) emergency hospital services;

(4) treatment of speech, hearing, and language disorders;

(5) optometrists' services and eyeglasses;

(6) occupational therapy;

(7) prosthetic devices;

(8) medical supplies and equipment;

(9) clinic services;

(10) adult dental services;

(11) physical therapy;

(12) [(11)] personal care services in a recipient's home;

(13) [(12)] prescribed drugs;

(14) [(13)] long-term care noninstitutional services;

(15) [(14)] inpatient psychiatric facility services;

(16) [(15)] intermediate care facility services for the mentally retarded;

(17) [(16)] intermediate care facility services;

(18) [(17)] pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level;

(19) [(18)] individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children

program because they are not deprived of one or more of their natural or adoptive parents;

(20) [(19)] skilled nursing facility services for persons under age 21;

(21) [(20)] aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility, to receive an optional state supplementary payment;

(22) [(21)] individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;

(23) [(22)] individuals under age 21 under supervision of the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
House Bill No. 274

"An Act relating to psychologists' services under the state medical assistance program; and reordering the priorities for eliminating coverage under Medicaid."

This Act would amend AS 47.07.030(b) to add psychologists' services to the services available for needy persons who are eligible for Medicaid, and it would amend AS 47.07.035 to place this new coverage tenth in the priority listing of all optional Medicaid services authorized by the Legislature for Alaska.

Currently, there are 115 licensed psychologists in Alaska, all of whom would be eligible to enroll as Medicaid providers were House Bill No. 274 to pass. A substantial number of these psychologists are already providing services to Medicaid recipients, and indirectly receiving Medicaid payments, in work settings such as physicians' clinics or community mental health clinics where they are supervised by a physician or psychiatrist who is enrolled.

The Division of Medical Assistance has long believed that this situation is far from ideal, for these reasons:

(1) The Division has no evidence that the supervision requirement generally results in more effective, higher-quality care. However, there is a strong conviction, here and in other states' Medicaid agencies, that supervision increases the cost of care.

Many states have specified exactly how much and what types of supervision are required, but as a practical matter, there is no cost-effective way to enforce such rules, and there is considerable disagreement over whether such rules do in fact result in any measurable improvement in the care provided. Federal Medicaid rules allow for any type of M.D. to be a supervisor, so it's frequently the case that a general practitioner, who may or may not have any formal training in psychology, is being paid to consult with and guide a certified mental health professional. This may be helpful in cases in which a persons' mental problems are caused by or accompanied by physical problems, but in many cases, the only advantage in such a relationship is a financial one to the doctor, resulting in an unnecessary cost to the taxpayer

(2) Not only does the Division pay physicians for supervisory duties that may or may not enhance the quality of care, the "screening" effect in clinical settings which result from the supervision requirement means that Medicaid pays for services that are actually provided by any licensed person the supervisor deems appropriate. This means that Medicaid pays the rate appropriate for a psychiatrist/M.D., but the patient often gets

POSITION PAPER/Department of Health & Social Services

services from someone whose credentials would justify a lower rate.

House Bill No. 274 would enable the Division to directly enroll psychologists, which would allow the Division to better measure, monitor, and control the use and costs of psychologists' services. House Bill No. 274 offers a good possibility of slightly lowering the costs per unit of services without decreasing the quality of the service.

From the provider's point of view, adding psychologists' services to Alaska's Medicaid Program would create equity between psychologists who practice independently and those who practice under the supervision of a physician or in a community mental health clinic.

From the Medicaid recipient's point of view, adding psychologists' services would make it easier to obtain care because it would increase the number of Alaska providers offering this service. It would also make it easier for them to directly access the person who gives them care, as they would no longer have to pass through a physician's examination or a clinic's screening process.

Position:

From the Department's perspective, House Bill No. 274 is a highly desirable bill that provides a simple solution to a long-standing and growing problem. The only objection we believe could be raised to House Bill No. 274 is that it will result in new providers enrolling in Medicaid, which in turn means that more recipients may use these provider's services, which may increase the program costs. These costs are detailed in the Department's Fiscal Note. However, these same cost increases appear to be occurring to some degree already, and House Bill No. 274 would give us the administrative structure in which we could measure and control them.

The Department supports the passage of House Bill No. 29.

Recommended By: Kim Busch
Kim Busch, Director
Division of Medical Assistance

Date: 2-13-90

Approved By: Myra M Munson
Myra M. Munson, Commissioner
Department of Health and
Social Services

Date: 2-14-90

Alaska State Legislature

Please enter into the record my testimony to the House HESS
committee name

committee on CSHB 274, dated 3/9/90.
bill/subject

I ask that this testimony be entered in the record. The addition of psychologist services under the state medical assistance program likely will help make available the mental health services of licensed professionals to parts of the state and at levels not presently served or underserved. The Alaska Mental Health Board has supported enhanced availability of professional mental health services. While not the greatest unmet need in the state mental health program, enhanced availability of psychologist services is consistent with recommendations of the Mental Health Board.

Signed: _____ Exec Director
Testifier

Alaska Mental Health Board
Representing (Optional)

419 6th St, Suite 124, Juneau 99801
Address

465-3071
Phone No.

COST-SAVINGS AS A RESULT OF PSYCHOTHERAPY

A number of studies have discussed the fact that overall medical costs are dramatically reduced one year after a patient has been in psychotherapy. The following are a few of those studies. Specific references will be provided upon request:

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1. Nicholas Cummings, Ph.D., with Kaiser-Permanente mental health programs stated in the October 15, 1982 Psychiatric News that "...Dispite two decades of research...showing that brief psychotherapy dramatically reduces utilization of other medical resources, policymakers continue to ignore these findings when designing health care systems...." He found in his study that resolving financial problems of HMO's was done "...by relying on brief psychotherapy to reduce the high incidence of unnecessary medical care....medical utilization declined significantly--and stayed down for the five years studied...[and]...amoung patients who completed brief psychotherapy, medical utilization dropped 75 percent." This was seen as important when, as he indicated, "...60 percent of all patient care could not be attributed to organic illness but was due, instead, to psychological problems." Patients many times reported not liking their therapists, and that therapy did not help them, but they did dramatically change their overall medical overutilization and no longer had symptoms. There have been over 28 replications of these studies.

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2. In 1977 Sten and Young in completing a Masters degree (M.S.W.) thesis at Portland State University found that clinical social work psychotherapy of patients at Kaiser Permanente in Portland, helped to significantly reduce patient over-utilization of other medical services. There was a "...47.1% decrease in physician office visits; a 48.6% decrease in the number of physicians seen for office visits; a 31.2% decrease in telephone contacts; a 48.6% decrease in the number of prescriptions written; a 45.3% decrease in emergency room

visits; a 66.7% decrease in frequency of hospitalizations and a 77.9% decrease in the average length of stay in the hospital...intervention appeared to be positively assocated with an over-all change rate of some 53 percent....."

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3. Jones and Vischi (1979), in reviewing twenty-five (25) research projects, showed that after an individual was in psychotherapy reductions in medical/surgical expenditures averaged 57% in one study to 62% in out-patint medical visits and 68% in in-patient care.

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4. A Kaiser-Permanente study of 152 patients showed that over a five year period there was a reduction in out-patient visits of 62% and 68% for in-patients. The most important aspect of this study is that the matched non-treatment controls, also a psychologicall distressed group, showed no change in their health care utilization over the same five year period.

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5. A West German study utilizin a five year follow-up period after mental health treatment found an 85% reduction in in-patient utilization.

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6. Other studies indicated that waiting list, non-treated, groups demonstrated the highest levels of medical care over-utilization, with even increases seen in their request for more doctors appointments and hospitalizations. Other findings revealed that even one psychotherapy session was effective in reducing medical care utilization. However, greater reductions in medical utilization rates were noted with increasing frequency of psychotherpy contacts. Weekly therapy sessions, particularly on a short-term basis of 12 sessions, lead to the greatest psychotherapeutic benefits.

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7. Research conducted by Blue Cross/Blue Shield, reported in the New York Times and by the Psychotherapy in Private Practice Journal , with joint sponsorship by the National Institutes of Mental Health, found that "...psychotherapy can

significantly reduce hospital costs for physical ailments among people with heart disease--ischemic and hypertensive, air-flow limitations disease and diabetes." the findings indicated "...that people who had at least 7 visits of out-patient psychotherapy after the diagnosis of one of these 4 diseases incurred costs for medical services that were 66% lower than the costs for those who did not have psychotherapy....They found that psychotherapy was most effective when it involved moderate amounts of out-patient visits ranging from 7 to 20."

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8. A University of Colorado study reported in the September 21, 1984 Psychiatric News reviewed claims for Blue Cross/Blue Shield patients. The findings indicated that psychotherapy significantly reduced medical services, and particularly inpatient services. "...after mental health treatment, inpatient hospitalizations were approximately 1.5 days shorter than those of the control group's average of 8.7 days.....The average change after psychotherapy was -73.4 percent for inpatient and -22.6 percent for outpatient care.....After the initial year, the psychotherapy group had significantly lower inpatient medical care costs in each of the other four years analyzed."

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9. Emily Mumford, Ph.D. in the October, 1984 issue of the American Journal of Psyhiatry presented her findings of reviewing over 58 research projects on pschotherapy. The results demonstrated that patient costs dropped dramatically after involvement in psychotherapy. Again there were significant reductions in in-patient stays for medical problems for those patients who received psychotherapy. "...following mental health treatment, the medical care charges of the treatment group increased more slowly than the average inflation rate of 13.6% per year....In contrast, the charges of the comparison group increased faster than the inflation rate."

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10. A study reported in Psychotherapy Finances in 1983 reported in findings by the U. S. Steel Company that there was a savings of $5.00 for every $1.00 spent on mental health services. Polaroid and several other large companies have reported similar results at the same time.

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11. Federal Employees health insurance programs, which have generous mental health benefits, showed that only 5 - 7% of the total health care costs are for emotional disorders.

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12. Studies at the local HMO, SelectCare, in studying 31 Ph.D. and M.S.W. providers, in computer analysis of records demonstrated that the average number of visits over a 3 year period was only 5.4 visits for all providers. A year later it was 4.3 visits. The analysis also indicated that mental health benefits are a very small part of their benefit package, i.e., 7/10th of 1% of their entire budget.

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13. In 1977 there were 118,767 patient contacts with 45 physicians at The Eugene Hospital and Clinic. Of these out-patients only 2,900, or 2.44% were diagnosed as having mental or emotional disorders by the physicians.

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14. The Group health Association of Washington, D.C., showed a reduction in usage of general medical care by as much as 30.7%, and a 29.8% drop in Lab and X-ray use the year after psychotherapy services were received.

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15. Kaiser Plan of California saved 250.00/yr, in the following year, for each patient who received psychotherapy services.

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20. Blue Cross of Western Pennsylvania noted a 50% decline in monthly costs per patient in the use of medical-surgical procedures/services for those patients who had received psychotherapy services.

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21. Studies of coverage of clinical social work psychotherpy services in private health insurance programs in new York State only costs $0.00 - $0.15 per month/premium (NASW in Washington

D.C. study).

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22. A 1972 study in West Germany of Insurance coverage for 1,004 patients, also in a five year follow-up study, who had averaged 100 hours of psychotherapy found that 81% felt strongly they were helped by treatment. Further, their hospital rage usage was reduced to 0.78 hospital days/year. Pre-treatment usage averaged 5.3 days/year, with the general population average being 2.5 days/year. This included hospitalization for any illness.

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23. Otto Jones, M.S.W., a clinical social worker, developed a mental health program for employees at Kennecott Copper in Utah. Before the program employees averaged 5.8 working days/month absence, weekly indemnity costs averaged $70.67/person/month, and hospital/medical/surgical costs averaged $109.04/person/month. One year after psychotherapy significant reductions were noted: Absenteeism decreased to a 2.98 average working days/month, weekly indemnity costs averaged 25.33/person/month, and hospital/med/surg. costs averaged $56.91/person/month. <u>THIS IS A 49.5% REDUCTION IN ABSENTEEISM, A 64.2% REDUCTION IN WEEKLY INDEMNITY, AND A 48.9% REDUCTION IN HOSP.-MED.-SURGERY COSTS!!</u> Those employees not invoved in psychotherapy tended to get worse and showed increases of: 2.9% increase in absenteeism, a 28.5% increase in weekly indemnity costs, and a 7.7% increase in hospital, medical and surgical costs.

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24. A 1980 letter from Blue Cross of California indicated that psychotherapy coverage for clinical social workers is "...a small part of their total health care package...[and]...have little impact on the total rates for health coverage."

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25. A 1979 study reported in <u>Psychiatric News</u> states that "...mental health claims are not a substantial portion of total claims dollars." Again the findings were that only between 5 to 7% of the claims dollars were paid out for mental heath care of all types including inpatient services. In general "...costs of mental health care...have lagged behind the increases in other health services."

26. A 1984 NIMH study (AMA News, November 9, 1984); which is the largest and most comprehensive survey to date of mental disorders indicates that 20% of all adult Americans suffers from at least one mental disorder. Such disorders were equally divided between males and females. However, only 1/5th of those so identified ever saw a mental health professional for treatment. The rest were seen by their family physician only and never referred for serves.

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27. A 1980 article in American Medical News (10/10/84) statec that "...A prepaid mental health care program...appears able to cut healh expences...." As a result of this intervention and cost-savings, "...for the first time in three years, Stationers Corp. did not have an increase in its health insurance premiums."

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28. McDonnell Douglas (and several other companies like Xeros, Hallmark Cards, Pitney Bowes, and IBM) in providing in-house mental health services for employees "calculates that it saved $4 million over 10 years...and other companies also report lowered costs for medical and disability insurance, fewer accidents and reduced absenteeism...."

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29. A 1980 article in the American Journal of Psychiatry indicates that only 7.3% of insured patients had services for mental health disorders. Of these, over half the claims for such services were submitted by general physicians and not mental health professionals.

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30. A 1981 study reported in American Medical News (9/4/81) found that treatment for alcoholism resulted in a savings of $1.5 million, with "alcoholism rehabilitation programs [having] an 85% success rate." A Stress management and health back programs also saved further money. "...the $2.7 million estimated savings are "conservative figures..." for New York Telephone employees.

31. A 1983 study in the Journal of Pain found that utilization of EMG Biofeedback treatment in patients with chronic rheumatic back pain resulted in significant positive changes. "...At the end of the treatment phase and at the 4 month followup the patients in the biofeedback group showed significant improvements in the duration, intensity, and quality of their back pain as well as their EMG levels, negative self-statements, and utilization of the health care system." Non-treated, control groups, and traditionally medically treated groups showed no improvements in their conditions at all."

POINT OF VIEW *Ronald Bronow*

Why the Prognosis Is Poor for the HMO System

Just a few years ago, everybody was saying that Health Maintenance Organizations would reshape our entire health-care delivery system.

In theory, it looked pretty good. The patient would pay a single premium and be covered for all of his medical needs, from doctor visits to surgical and hospital fees. The HMOs, by stressing preventative medicine techniques, were supposed to keep people healthy enough that they would need less medical care.

Well, it hasn't exactly worked out that way. The HMOs are in deep trouble; three out of every four plans are losing money.

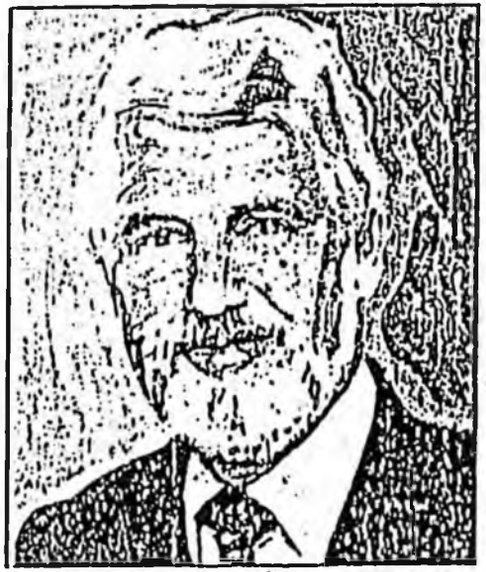
Forbes magazine says, "This once-vaunted scheme for holding down medical costs has turned out to be one of the decade's most over-hyped flops."

Business Week says, "Federal investigators believe they have uncovered a nationwide conspiracy by alleged mob groups to exploit the prepaid health-care industry."

The HMOs were supposed to eliminate unnecessary medical costs without reducing quality of care. What happened?

They simply couldn't do it. The industry is being clobbered because of its inability to hold down costs. By removing medical deductibles in order to get new customers, the patients can go to their doctor any time they want, because it's free.

The end result: All of the companies' health-care costs are rising faster than their incomes. They can't raise their premiums enough to make money, because of tremendous competition from all of the other HMOs and the pressure from employers to keep prices down.



Ronald Bronow is a dermatologist who practices in Los Angeles.

Sixteen HMOs disappeared in 1987, and several states are taking action to protect consumers, forcing solvent HMOs to set up guarantee funds to pay claims of other HMOs who go broke.

The real crisis today is with the HMOs that treat Medicare patients. Twenty-nine plans did not renew their contracts for 1988, resulting in disruption of health care for 84,000 senior citizens. Last year was the first in which there was a decrease in enrollments since the program started in 1965.

So, the HMOs are utilizing some tough options:

- Dump the Medicare patients because they get sick and use more services.
- Increase the premiums and reduce the benefits to patients.
- Renegotiate lower rates for physicians.

At the same time the HMOs are spending millions of dollars on advertising (money that used to go for patient care), trying to attract young and healthy subscribers who don't get sick — and not enrolling those who might. Then they make it inconvenient for those who really get sick to get care. Maybe the patient will quit and go somewhere else.

Finally, they put the pressure on the doctor to perform fewer services. The main way they do that is by assigning the patient to a "gate-keeper" doctor, who evaluates whether the patient needs consultations, X-rays or laboratory tests. A review committee must then rule on the doctor's requests. These judgments are frequently based more on economics than patients' needs.

On top of this, all outside services or consultations approved are deducted from the "gate-keeper's" salary. Many people have called this form of treatment "undercare," the purpose being to delay.

(Note: This discussion does not include Kaiser, a high-quality HMO that does not pay its physicians more money if they provide less care to their patients.)

To us physicians, this is immoral. We did not go to medical school to learn how to ration care so a corporate executive can show a profit to his stockholders. We can't accept inferior quality of care: A Northern California HMO told its physicians to "avoid aggressive or heroic measures such as resuscitating the frail elderly, where a high morbidity or mortality rate can be expected."

The industry is being clobbered because it can't hold down costs

So, what have the HMOs accomplished? By grabbing the young healthy patients, higher risks are pushed into the other insurance companies. That's why your premiums are skyrocketing.

Hospitals, because they have to discount to these "managed care" plans, are now unwilling to take care of the poor.

What has been saved by all of this? Nothing. Medical inflation continues at the same rate, while an increasing number of American citizens are subjected to rationing and second-rate care.

What should we do about this? We must start over. There should be a national dialogue on the flaws in our health-care system, with proposals to reform it.

Finally, we must protect the freedom and integrity of the physician while extending health care to more people. Don't lose your rights to receive quality care and our rights to practice quality medicine.

Mental care seen reducing medical costs

The provision of necessary mental treatment for many medical patients can lead to a decline in subsequent medical costs, according to a study described in the October issue of the *American Journal of Psychiatry*.

The savings are particularly significant among the hospitalized and the elderly, according to the report.

The two-part study analyzed data from 58 published and unpublished research reports comparing hospitalized patients' medical costs before and after they received mental health services. "Eighty-five percent of all these studies reported a decrease in medical utilization following psychotherapy," wrote Emily Mumford, PhD, of the New York State Psychiatric Institute.

She and her colleagues concluded that the "clearest cost-offset effect appears largely in the reduction of inpatient rather than outpatient costs. . . . Older patients show larger cost-offset effects than younger ones."

Twenty-two of the 58 studies dealt with medical-surgical patients who received emotional, psychological, and educational support during hospitalization. These studies generally found that these patients recuperated faster than those who did not receive such support, with an average reduction in inpatient length of stay of 1.5 days.

ANOTHER 26 studies compared medical utilization before and after psychotherapy. Twenty of the studies showed an average decline of 33% in the use of medical services. Five other studies comparing the use of inpatient and outpatient costs after psychotherapy showed that inpatient costs dropped more dramatically.

Dr. Mumford pointed out that psychological support had a greater effect on people older than 55. A study of elderly patients hospitalized for leg fractures showed that those who received psychiatric consultation left the hospital an average of 12 days earlier than those who did not, and "twice as many of the patients who had been provided [with] consultation returned home rather than being discharged to a nursing home or other institution," the report stated.

The second part of the study was based on a review of data from the files of the Blue Cross/Blue Shield Federal Employes Plan, which covers 6.7 million people.

Dr. Mumford and her associates, comparing claims from individuals who had received psychotherapy with those who had not, found that medical charges for all patients increased during the study. The authors reported, however, that "following mental health treatment, the medical care charges of the treatment group increased more slowly than the average inflation rate of 13.6% per year. . . . In contrast, the charges of the comparison group increased faster than the inflation rate."

Psychotherapy Reduces Costs For Other Care, Study Shows

Support for the contention that psychotherapy leads to lower costs for other medical services was bolstered recently with the completion of a major study at the University of Colorado Health Sciences Center.

Researchers Emily Mumford, Herbert J. Schlesinger, Gene V. Glass, Cathleen Patrick (all Ph.D.'s), and Timothy Cuerdon analyzed 58 cost-offset studies completed since 1978 and the 1974–78 claims files of the Blue Cross and Blue Shield Federal Employees Program (FEP), which contains insurance information on 6.7 million persons. They found that outpatient mental health treatment (including psychotherapy and less intensive interventions) led to significant reductions in utilization of medical services, particularly inpatient services.

Their analyses also indicated a larger cost-offset effect among older people who had received mental health treatment than among young or middle-aged psychotherapy patients. Their findings will be published in the October issue of the *American Journal of Psychiatry*.

The two sets of data the researchers analyzed produced similar results.

Data from the 58 cost-offset studies indicated that in 85 percent of the studies there was a decrease in medical care utilization after psychotherapy. The researchers analyzed only the 22 studies that could not be biased by self-selection as in the naturalistic, time-series ones that compared the individual's medical care use before and after psychotherapy. They found that after mental health treatment, inpatient hospitalizations were approximately 1.5 days shorter than those of the control group's average of 8.7 days.

Most of the experimental (treatment) group received only modest psychotherapeutic intervention, while the control group received just a standard medical regimen.

In five of the controlled experimental studies, Mumford and her colleagues were able to analyze data on both inpatient and outpatient medical utilization. The average change after psychotherapy was -73.4 percent for inpatient and -22.6 percent for outpatient care.

Inflation Rate

The researchers also compared the FEP data with inflation rates for the five-year study period. They found that while medical charges for all groups increased during this period, the total care charges for the psychotherapy treatment group—all of whom had at least seven outpatient and no inpatient visits—increased more slowly than the average inflation rate of 13.6 percent. Similar charges for the comparison group increased faster than did the inflation rate.

After the initial year, the psychotherapy group had significantly lower inpatient medical care costs in each of the other four years analyzed. In each year the treatment group outspent the comparison group for outpatient care, and the differences remained constant throughout the period. The cost reductions were thus attributable primarily to lower inpatient costs.

Age

Age turned out to be a significant factor in the degree of cost-offset following mental health treatment.

Twenty-three of the 58 studies reported the mean age of the subjects, including 15 studies of inpatients, four of outpatients, and four of alcoholic outpatients. In all three settings older people had greater reductions in medical care use after mental health treatment.

Comparable results were evident when they analyzed the FEP data for age differences. Patients 55 years of age or older showed the greatest decrease in hospital charges after psychotherapeutic intervention. Their average inpatient medical charges in 1974, the first year of the study period, were more than $160 higher than those of the comparison group. By 1978 the treatment group was spending $70 less than the comparison group. Differences in outpatient expenses were not significant.

Using research showing that elderly persons suffer more emotional distress than younger ones—due largely to chronic illnesses, loss of friends, loved ones, or income, and forced relocation—yet receive proportionally less psychiatric care, Mumford and colleagues suggest that "underutilization of mental health services by the elderly may result in needless suffering among the elderly and needless cost to society."

Physicians spend less time with their older patients, the researchers point out, and thus offer little emotional support to the group that could benefit most from a sympathetic ear. Nonpsychiatric physicians are often unaware of how important it is for them to boost the determination of older patients to continue taking medication as prescribed and to follow other medical advice.

The problem is compounded and the cost of medical care increased, they suggest, by the frequent reluctance of older patients to confide emotional problems to younger physicians, who may in turn neglect to ask about emotional and psychological problems that may be affecting their elderly patients.

ALASKA
PSYCHOLOGICAL
ASSOCIATION 3211 Providence Drive, Anchorage, Alaska 99508 (907) 786-1711

HB 274

POSITION PAPER

Issue: Alaskan Psychologists, although licensed by the State of Alaska, are omitted from the statutes which determine the type of care allowed by and covered under the Medicaid program.

Position: The Alaska Psychological Association is proposing changes in the current statutes to allow Medicaid patients to receive psychological services with consumer choice regarding the licensed provider of the service.

Current statutes create a situation which:

1) Discriminates against the needy and those in remote locations;
2) Is more costly to the Medicaid system;
3) Limits the quality of care available to all Alaskans;
4) Results in a restraint of trade.

The proposed changes would correct this situation and allow psychologists to receive compensation for services provided to Medicaid patients. Currently, a number of psychologists provide needed care to Medicaid patients without compensation, or they are forced to resort to the courts in legal action against agencies of the State of Alaska to receive compensation. It is currently the practice of the Alaska Attorney General's office to settle such suits out of court when possible. Many psychologists feel that reasonable changes in the statutes by the legislature are the only

recourse left to them, short of joining the growing number of costly and time-consuming suits. They have elected to pursue these changes through their professional Association.

The Federal Medicaid program allows the various states to determine eligibility and types of care covered by the program.

A variety of other professional health services are provided for under Alaska statutes pertaining to Medicaid. These include optometrists, physical therapists, nurse midwives, physicians and others.

A growing number of states, currently about half, provide for Medicaid recipients to receive independent psychological services.

People covered by private insurance and even employees of the State of Alaska covered by Alaska's employee health care plans are able to receive the services of an independent psychologist.

However, Alaskans who are Medicaid recipients may not choose freely between equally qualified providers. They are also denied equal access to treatment by care providers offering non-drug approaches.

The Alaska Psychological Association hereby requests your support of Senate Bill 29, which allows Medicaid recipients access to psychological services.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSHB 274(HESS) NO..
PUBLISH DATE: HOUSE 3/13/90

FISCAL NOTE

CC

REQUEST:

Revision Date: 2/13/90
Title: An Act Relating to Psychologists' Services
Sponsor: House HESS Committe
Requestor:

Agency Affected: Health and Social Services
BRU: Medical Assistance
Medical Assistance Administration
Components: Medicaid Non-Facility Claims Processing

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	61.2	71.4	81.8	93.7	107.4	123.1
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	291.2	708.8	862.6	1,049.8	1,277.6	1,554.9
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	352.4	780.2	944.4	1,143.5	1,385.0	1,678.0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	168.4	372.2	451.7	548.3	665.6	803.2
FEDERAL FUNDS	184.0	408.0	492.7	595.2	719.4	869.8
OTHER	0	0	0	0	0	0
TOTAL	352.4	780.2	944.4	1,143.5	1,385.0	1,678.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

See attached analysis. As published, HB No. 274 has no effective date. The starting date of the addition of psychologists' services to the Medicaid Program is assumed to be January 1, 1991.

Prepared by: Kimberly A. Burden
Division: Division of Medical Assistance
Phone: 465-3355
Date: 2-13-90

Approved by Commissioner: [illegible]
Agency: Department of Health and Social Services
Date: 2-14-90

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

House Bill No. 274
Fiscal Note Attachment
Cost Analysis for Psychologists' Services

I. Contractual Costs

a. The Alaska Medical Payments System will require modification to pay psychologists as a new service. The contractual costs include the following: provider manuals, training, a new claims form, tables included in the system for psychologists' services, computer programming, computer reports, the addition of collocation codes, the provision of notice to providers, provider relations, and a computer system test. This is a one-time FY91 cost of 30.0. (15.0 FED, 15.0 SGFM)

b. The Division of Medical Assistance must pay the claims processing contractor $6.23 for each claim processed. Estimated claims volume for FY91 is 5,000, assuming a January 1, 1991 start date. FY91 processing costs = 31.2. All costs of claims processing are 75% FED, 25% SGFM.

II. New Grants/Claims Costs

a. There is no accurate method for determining the numbers of Medicaid eligibles who will use this new coverage, the numbers of providers who will choose to enroll, and the initial costs per type of service that they will provide. Cost estimates are based on the following assumptions:

(1) 50 psychologists will enroll as providers in the first year.

(2) Approximately 24 of these new providers are currently providing services indirectly, supervised by and/or billing through a physician or psychiatrist. About half of these are billing Medicaid at a rate 15% lower than the rate charged by psychiatrists. Payments to the 12 now billing at the higher rate will be reduced by $14,400 (15% reduction X $8,000 current average psychiatrist's Medicaid billing per year, X 12 psychologists = $14,400 Medicaid savings).

(3) Logic suggests that billings from physicians and psychiatrists who supervise the psychologists now providing services to Medicaid eligibles would decrease if these psychologists were to enroll directly. However, experience in other states that have added psychologists' services has varied so much on this point that we cannot safely assume any decrease in current billings.

(4) Approximately 26 psychologists in private practice who are not currently serving Medicaid recipients will enroll. Alaska Psychological Association data indicates these new providers will see an average of 21 patients per week for a total of 34 hours per week, and that they charge $90 per hour for private sessions.

(5) We assume that psychologists will not differ from other medical professionals enrolled as Medicaid providers, in that Medicaid patients will, on average, not exceed 15% of their total patient load. Cost for new providers will be 34 hours per week X $90/hour X 15% X 50 weeks/year X 26 psychologists = $596,700.

(6) $596,700 new costs minus $14,400 savings = $582,300 net costs for a full year of psychologists' services. The time required for data system changes, promulgation of regulations, and provider enrollment activities necessitate a starting date no earlier than January 1, 1991. FY91 costs will therefore be 50% of a full year:

145.6 SGFM
145.6 FED
291.2 Total

(b) Costs for FY92 through FY96 are computed from the FY90 base estimate, adjusted for a full year, and increased annually by 21.7% (7.1% for price increases, 4.2% for increases in the number of eligible recipients, and 10.4% for utilization increases).

Claims processing costs are billed at $6.23 per claim. For FY92 through FY96, FY91 costs, adjusted for a full year, are increased by 14.6% annually (4.2% for increases in the number of eligible recipients, and 10.4% for utilization increases).