SB

29

Dear Paul,

APR 0 3 1989

Please pass note Bill # 79

Thank-You

Robin Lavoie

Lavoie
P.O. Box 242031
nchorage, AK 99508

America the Beautiful USA 15

Hon. Paul Fischer
P. O. Box V
Juneau, AK 99811

ten
Ct
AK 99504

ANCHORAGE, AK
1 PM
31 MAR
1989

Senator Paul Fischer
P. O. Box V
Juneau, AK 99811

er: 3/31/89

APR 0 4 1989

te in regards to Senate Bill 29 which
te Registered/Licensed Psychologist
irectly.

be able to make a choice as to which
see. Their freedom of choice is non-
ly under current procedures - at least

is one of the basic human rights we
the most. Please expedite the passage

Thank you.

Dennis Tweeten
907-333-0379

O. Clark
330 Princeton Dr
Anchorage, AK
99508

Done

File with

Sen. Pra Bill - No

P.C response needed

Su

Dear Paul, 3/29/89.

Please pass Senate
Bill #29.

Thank you
Victoria Clark

Thomas L. Jewitt MD
4001 Dale St., #101
Anchorage, AK 99508

America the Beautiful USA 15

Sen. Paul Fischer
P.O. Box V
Juneau
Alaska 99811

29 Mar 89

Dear Mr Fischer,

I respectfully request that you refer Senate Bill 29 expeditiously to the House-Senate committee, and support its passage. As a psychiatrist, I have good faith in the professional caliber of doctoral level clinical psychologists, and firmly believe that as a group they are entitled to the same reasonable reimbursements as physicians.

Sincerely, Thomas J Jewett M.D.

Tim Kaderman
1548 Summit View St
Anchorage, AK
99504

America the Beautiful USA 15

Sen. Paul Fischer
PO Box V
Juneau, Ak
99811

Senator Fischer,

It has come to my attention that you are at this time sitting on Senate Bill 29 - that which would allow Psychologists to accept Medicaid payments, and thus not allowing it to come to the floor. I feel that this is not a wise stance and urge you to reconsider. Please get this bill moving so that individuals of lower income can get the valuable services of a Psychologist as needed. Sincerely, Tim Kastens

America the Beautiful USA 15

Sen. Paul Fisher
P.O. Box Y
Juneau AK 99811

3-29-09

Dear Sen Fisher

I respectively request that Sen Bill 29 be passed through committee & request your support.

Randall G. Jones a.k.a.
4001 Date st #101
Anchorage AK 99508

America the Beautiful USA 15

Paul Fisher
P.O. Box V
Juneau, AK 99811

I support SB 29.

I see a lot of foster parents working with many foster youth in Anchorage, Kenai, & Palmer. Many of these are Medicaid reimbursed. I specialize with delinquent youth. I am an expert in this. No M.D. is necessary to supervise one in this.

M. Mathops, Ph. D. Anchorage, AK

America the Beautiful USA 15

Paul Fisher
P.O. Box V
Juneau, AK 99811

Dear Senator Fisher,

Please support Senate Bill # 29. Thank you.

Janet W. Converse
Box 3223
Palmer, AK 99645

D Haden, PhD
4001 Dale St. Ste 101
Anchorage, AK 99520

America the Beautiful USA 15

Paul Fisher
P.O. Box V
Juneau, AK 99811

3/29/89

Dear Senator Fisher:

This is to inform you that I strongly support the opportunity for individuals with limited income to receive needed & appropriate mental health services.

Please pass Senate Bill 29 through your committee and help our needy citizens.

Deborah A. Bolen, Ph.D
Anchorage

America the Beautiful USA 15

Hon. Sen Paul Fisher
P.O Box V
Juneau, AK 99811

Dear Sen Fuller,

I understand S.B 29 needs to be sent next to The House-Senate Committee from your Committee. I support this bill & hope it will soon be enacted into law.

Donald Pearson
2050 Woodrow
Anchorage AK
99507

Tamagdelena
1311 W. 72nd Cir
Anchorage
99518

ANCHORAGE, AK
PM
MAR
1989

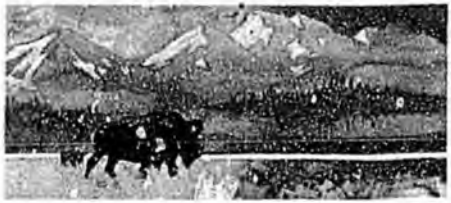
America the Beautiful USA 15

Paul Fischer
Box V
Juneau AK 99811

I support the passage
of S. 29.

Debra
Lamaqdel
VT

Dr. Madigan
550 E. Tudor Rd
Anch AK 99508



America the Beautiful USA 15

PAUL FISCHER
BOX V
JUNEAU AK 99811

I support passage of S.B. #29, to allow medicaid coverage for treatment by psychologists.

Thank You

James Madigan DC

2703 Aspen Drive
Anchorage AK 99517

ANCHORAGE, AK 995
5 PM
31 MAR
1989

America the Beautiful USA 15

Paul Fisher
Box V
Juneau AK
99811

I Support passage of
S 29 for medicade
payment, to phychaloqist

Jusa Little
2703 ASpen Drive
Anchorage AK 995_7

M Terrell
3432 Loussac
Anch AK 99

America the Beautiful USA 15

Paul Fischer
Box V
Juneau, AK.
99811

Dear. Mr Fischer,

I support passage of F-29 for Psychologists.

-Melissa Tirrell

America the Beautiful USA 25

Senator Paul Fischer
P.O. Box V
Juneau, AK 99811

It has come to my attention that Senate Bill 29, which would provide Medicaid payments to psychologists, has been sitting idle in committee for some time. This is an extremely important bill & immediate action should be taken to ensure its passage into law.

Chrystal Stanleves

L. Magowan
12431 Arc Ct.
Anch ak
99515

America the Beautiful USA 15

Paul Fischer
Box V
Juneau Ak
99811

I support passage of
S-29 for Medicaid
payment, to ~~Podiatry~~ Physicalogists

Laura Mayowa

N. Tuberculosis
Box 2282
Fairbanks, Ak 99709

FAIRBANKS, AK 99701
PM
30 MAR

America the Beautiful USA 15

Senator Pearl Fischer
Alaska State Legislature
P.O. Box U
Juneau, Ak. 99811

er Senator Fischer

Mental Health Trust Lands funds
could be used to benefit the elderly who
suffer from Alzheimer's or related dementia.
As included in the governor's budget,
$5,500 for day care, $7,500 for respite
care, and $50,000 for training. There is
much less expensive than long-term
nursing home care

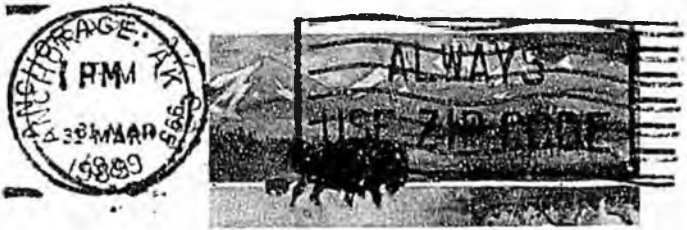
Sincerely,

Patty K. Anderson

Paul Fosha
PO Box [illegible] V
Juneau, AK 99811

Please pass the Senate Bill S-29 !!! Please allow the medicaide payment.

Donna Carlo



Paul Fischer
Box V
Juneau, AK 99811

I support the passage of SB 29!!

I believe medicaid recipients should be allowed a choice.

Please, don't just sit on it & start to do something about it!

Sincerely, June Duncan

America the Beautiful USA 15

Sen. Paul Fisher
P.O. Box V
Juneau, AK 99811

Dear Senator Fisher -

Please support Senate Bill # 9 through your committee.

Thanks,

Terri Locke
4541 E. 6th Ave.
Anch AK. 99508

America the Beautiful USA 15

Sen. Paul Fisclter
P.O. Box V
Juneau. AK. 99811

Please support SB 9 AND MOVE it in committee. It's important

David A Fletcher

DAVID FLETCHER
4641 MT View Dr
ANCH. AK.

Alaska State Legislature

FEB 0 9 1989

SENATOR
ARLISS STURGULEWSKI
Senate President Pro Tempore
Chairman, Senate Rules Committee

2957 SHELDON JACKSON STREET
ANCHORAGE, ALASKA 99508

While in Juneau
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3818

Senate

M E M O R A N D U M February 9, 1989

TO: Senator Paul Fischer, Chairman
Senate Health, Education, and Social Services Committee

FROM: Senator Arliss Sturgulewski, Chairman
Senate Rules Committee

RE: SB 29 "An Act relating to psychologists' services under the state medical assistance program; and reordering the priorities for eliminating coverage under medicare."

Senate Bill 29 would provide for the enrollment of psychologists as providers under the Alaska Medicaid program.

I would appreciate your consideration of this bill for scheduling before the Senate HESS Committee.

Frank Homan of my staff will provide your office with background information. Thank you.

Attachment

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

P.O. BOX D-LIC
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2534

August 16, 1988

Honorable Arliss Sturgulewski
Alaska State Senate
3111 C Street, Ste. 540
Anchorage, AK 99503

Dear Senator Sturgulewski:

The Alaska Board of Psychologist and Psychological Associate Examiners appreciates and applauds your desire that quality mental health services be made available to as many Alaska citizens as possible.

The board has noted that the State of Alaska has a policy of making psychologists (Ph.D diploma) and psychological associates (Master's diploma) ineligible to receive Medicare and Medicaid payments. Psychologists and psychological associates are, in fact, qualified to deliver many of the same mental health services currently available for Medicaid or Medicare reimbursement only if provided by psychiatrists (i.e., medical doctors). If psychologists and psychological associates were eligible for payment under Medicare or Medicaid, there would be a significant change in the number of providers available to assist those of the low income population who need mental health services. Currently, there are often no services available or there are long waiting lists at clinics which accept Medicare/ Medicaid patients.

The board would appreciate any assistance you may be able to provide Alaska's licensed psychology professionals in becoming eligible to receive payments from Medicare and Medicaid for the counseling services they provide.

Sincerely,

Linda Oslen-Webber

Linda Oslen-Webber, Ph.D.
Secretary
Board of Psychologist and
Psychological Associate
Examiners

LOW/WF/lt9771t
081088a

ALASKA
TREATMENT
CENTER
Medical Rehabilitation Services

April 10, 1989

Arliss Sturgulewski
Capitol Room 427
Senate
P.O. Box V
Juneau, Ak 99811

Dear Senator Sturgulewski,

I am writing in support of your Senate Bill 29 which provides for the inclusion of professionals licensed under the Board of Psychologists and Psychological Associate Examiners to become enrolled providers under the Alaska Medicaid Program.

I am a clinician and the Program Manager in the Pediatrics' Program at the Alaska Treatment Center. We have a PhD. level child psychologist on our staff who adds tremendously to the services we offer families and special needs children. Very often the psychologists' care enhances the other services offered to these families and always makes these other services (physical therapy, speech-language therapy and occupational therapy) more effective. We frequently find that emotional issues must be taken care of in order for our families to be able to focus on other therapy needs their child may have.

I applaud your effort to include funding for these professionals' care under the Medicaid Progam.

Sincerely,

Sandra McKinnis

Sandra McKinnis, M.A., CCC
Speech-Language Pathologist
Program Manager, Pediatrics

3710 E. 20th Avenue Anchorage, AK 99508 (907) 272-0586

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI
Senate President Pro Tempore
Chairman, Senate Rules Committee

2957 SHELDON JACKSON STREET
ANCHORAGE, ALASKA 99508

While in Juneau
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3818

Senate

M E M O R A N D U M March 23, 1989

TO: Senator Paul Fischer, Chairman
Senate Health, Education & Social Services Committee

FROM: Senator Arliss Sturgulewski, Chairman
Senate Rules Committee

RE: SB 29 "An Act relating to psychologists' services under the state medical assistance program."

I appreciate your courtesy in allowing Dr. Paul Craig to testify on this bill when he was in Juneau. After his testimony, the Department of Health and Social Services revised the fiscal note. The revised fiscal note is now available and has been delivered to your office. Because of the lateness of the session, I would request an early hearing on this bill before the Senate Health, Education and Social Services Committee.

Thank you for your consideration.

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI
Senate President Pro Tempore
Chairman, Senate Rules Committee

2957 SHELDON JACKSON STREET
ANCHORAGE, ALASKA 99508

State Capitol
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3618

Senate

M E M O R A N D U M March 16, 1990

TO: Senator Paul Fischer, Chairman
Senate Health, Education, and Social Services Committee

FROM: Senator Arliss Sturgulewski
Senate District F

RE: SB 29 "An Act relating to psychologists' services under the state medical assistance program; and reordering the priorities for eliminating coverage under medicare."

I appreciated the discussion regarding SB 29 and would like to follow up with a formal request for a HESS Committee hearing.

I am very encouraged by the new position paper and support for this legislation. I have attached a copy for your files. Senate Bill 29 would solve an ongoing problem for the Department of Health and Social Services and treat all psychologists equally.

Thank you for your interest in this legislation.

Enclosure

Copy

Alaska State Legislature

Senator Paul Fischer
Senate District D
Box 784
Soldotna, Alaska 99669
(907) 262-9420 W
262-9269

State Senate

While in Juneau
P.O. Box V
Juneau, Alaska 99811
(907) 465-3791

4/11/89

Kathleen Dinius
P.O. Box 4158
Soldotna, Ak 99669

Dear Kathleen:

Thank you for your p.o.m. regarding Senate Bill 29. This bill did have a brief hearing on March 9, 1989 in which Dr. Paul Craig testified before the Senate HESS Committee on the merits of this bill. This bill will be scheduled for another hearing during the week of April 17th - 21st in the HESS Committee.

The Dept. of Health and Social Services has submitted two fiscal notes on this bill. This first fiscal note was higher than the second (Revised) fiscal note. None the less, this bill is going to cost the state money for a new program. While money will come in part from the federal government, state general funds will also be needed to fund this program.

While I am not necessarily opposed to this bill, it does require additional state spending for a new medicaid program. And, as you are aware, this is a deficit year in which it will be very difficult to maintain existing programs. The social benefits of this bill will have to balanced with fiscal realities in state spending.

Kathleen, thanks again for your comments on SB 29, and I will take them under consideration in the future.

Cordially,

Senator Paul A. Fischer

PAF/dcm

Sent 4/12/89

PUBLIC OPINION MESSAGE

DEAR: SENATOR FISCHER

APR 0 7 1989

NAME: KATHLEEN DINIUS
TITLE: LICENSED PSYCHOLOGIST
DRESS: PO BOX 4158
CITY: SOLDOTNA ZIP: 99669
PHONE: 262-1260
LL NO: SB 2?
JBJECT: MEDICAID PAYMENT FOR PSYCHOLOGISTS
ESSAGE: I URGE YOUR SUPPORT OF SB29 TO INCLUDE COVERAGE OF PSYCHOLOGISTS BY
DICAID. CURRENTLY MEDICAID CLIENTS IN NON-CITY AREAS HAVE NO ALTERNATIVES OR
OICES FOR PSYCHOTHERPY SERVICES WHEN MENTAL HEALTH CENTERS CANNOT PROVIDE CARE
R THE CLIENT WOULD CHOOSE ALTERNATE CARE PROVIDERS.

POMID: 13094426
DATE: 04/06/89
TIME: 09:44:26
IONAME: SOLDOTNA LIO

COPIES: REPRESENTATIVES SENATORS

NAVARRE DUNCAN
SWACKHAMMER ADAMS
JONES
KELLY

Teleconf.
April 19th

LIO Soldotna

Dave

Alaska State Legislature

Senator Paul Fischer
Senate District D
Box 784
Soldotna, Alaska 99669
(907) 262-9420 W
262-9269

State Senate

While in Juneau
P.O. Box V
Juneau, Alaska 99811
(907) 465-3791

Sent 4/12/89

4/10/89

Richard L. Nault, M.A.
P.O. Box 1242
Kenai, AK 99611

Dear Richard:

Thank you for your letter of 4/4/89. First, let me say that I hope your problem with the Division of Family and Youth Services was cleared up, and you finally received payment from them. If you are still having problems, feel free to contact my office, and we will pursue the problem further.

In regards to your comments on Senate Bill 29, this bill did have a brief hearing in which Dr. Paul Craig testified before the Senate HESS Committee on March 9, 1989. This bill has not been rescheduled since that date.

I think we all recognize the need for our populace to have access to mental health services. But, this must also be balanced with the need to trim state spending and live within our means. Currently, the fiscal note on this bill is high, and will cost the state additional money from the general fund. Also, this bill will be adding a new service to the medicaid budget, which will be competing with existing programs.

Richard, I am not necessarily opposed to this bill, but I am sure that you are aware of the state's current fiscal position. This fiscal year looks to be a deficit year. It is very difficult for legislators to propose spending new money that we do not have. And, I might add, that the State of Alaska is not like the federal government. We must have a balanced budget at the end of each fiscal year.

Again, thanks for your comments regarding this bill, and I will keep them under advisement.

Cordially,

Paul A. Fischer
Senator

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

January 30, 1989

Senator Arliss Sturgulewski
Pouch V
Juneau, Alaska 99801

Dear Senator Sturgulewski:

Please be advised that the Alaska Psychological Association (ALPA) fully supports passage of Senate Bill 29, providing for enrollment of psychologists as providers under the State of Alaska Medicaid program.

The Alaska Psychological Association hopes that Alaska will join the majority of the other states in the Union who already include psychologists as providers under Medicaid. Psychologists are properly trained and licensed to provide psychological services as defined by state law. Inclusion of psychologists under the Medicaid program will allow psychologists to practice on a compassionate care basis rather than discriminating against the economically less fortunate citizens of our state.

Thank you for your support of Senate Bill 29.

Sincerely,

Margit Gorton, Ph.D.
President, Alaska Psychological Association

MG:ph

R.Clark Davis, D.C.
Ketchikan Chiropractic Center
320 Bawden, Suite 306
Ketchikan, Alaska 99901

MAR 1989

March 2, 1989

Senator Lloyd Jones
Alaska State Capitol
Room 103
P.O.Box V
Juneau, Alaska 99811

Dear Lloyd:

I am writing in regards to three additions to the Medicaid system presently proposed before the legislature. These are SB 118 (adult day health care assistance), SB 29 (Psychological services) and HB 70 (pharmacological medical assistance). When chiropractic care was added to the Medicaid system several years ago we were added to the system with the idea of "Last on, first off". This referrs to the situation if there is a shortage of funds for Medicaid the last profession added to the Medicaid list shall be the first to be cut from the list. The three bills I mentioned above do not go along with this idea of priorities and fairness. SB 118 puts the adult day health care assistance as #13 and chiropractors as #1 to be cut in event of budget shortfalls. SB 29 puts pyschological services as #10 to be cut and chiropractors as #1. HB 70 places pharmacological medical assistance as the 12th to be cut. I am respectfully requesting a placement of each of these newly added programs to be added to Medicaid with the "last on, first off" idea in mind if indeed they are included into the Medicaid system.

If you have any questions feel free to call.

Sincerely,

Clark

R. Clark Davis, D.C.

PS #1. There is an additional Bill, SB 116, which is before the legislature that the podiatrists are requesting to be added to the Medicaid system. The podiatrists are requesting to be added with the idea of "last on, first off" and are requesting to be the #1 to be cut in the event of budget shortfalls. This appears to be consistent with common sense, good judgment and fairness.

#2. I have enclosed a phamplet which includes some of the latest information reqarding modern chiropractic treatment. You may wish tc refer to it as future bills concerning chiropractic come before the legislature.

If you have any questions at any time feel free to call.

Thank you.

enc: 1

RCD/kk

RUSSELL A. HUFFMAN, JR., M.D.
POST OFFICE BOX 9435
KETCHIKAN, ALASKA 99901
(907) 225-8900

April 14, 1989

APR 17 1989

The Honorable Paul Fischer, Chairman
Alaska State Senate
Health, Education & Social
Services Committee
P.O. Box V
Juneau, Alaska 99811

RE: A Letter In Opposition To Senate Bill No. 29

Dear Senator Fischer:

My name is Russell Huffman. I am writing you in strong opposition to Senate Bill No. 29. I have been a physician in Alaska for a number of years (Medical License No. 1134). In the past seven years, I have practiced psychiatry in Ketchikan.

There is sometimes confusion among most of us as to the differences between psychologists and psychiatrists. It may be helpful for me to attempt a clear definition of these two important mental health providers in our system, as well as a more complete identification of who I am.

"Psychiatrists" are initially educated as fully qualified and licensed physicians. Then, those physicians spend four or more years of training and choose to specialize in "medical psychology and neurology." Psychiatrists are medical doctors who practice under the same legal and medical rules that apply to any physician, whether they be surgeon, internist or family practitioner.

"Psychologists" are mental health providers who have had advanced academic degrees, at the Masters or Doctor of Philosophy level. Usually, they have had further clinical training, i.e., in a hospital or medical setting, working with their medical specialist colleagues to deliver a more complete understanding of individual patients. Psychologists are those who often use standardized testing, i.e., intelligence tests or personality inventories, to aid in the evaluation and the treatment of their patients.

With those definitions of the professions in mind, I write you as a "Board Certified Psychiatrist" who has been practicing medicine and doing "psycho-therapy and counseling" for almost 30 years. After several years experience in the mental health field, most of which has been in Alaska, I write in strong opposition to including psychologist services under the State Medical Assistance Program for two important reasons.

1. Provision for Standard of Care:

The Administrative Code, as it is now stated, mandates that a mental health center to receive payment from Medicaid must either be "headed by a psychiatrist/physician" or if a psychologist or psychiatric social worker or psychiatric nurse is the head "must be supervised by a psychiatrist or physician."

The wisdom of this requirement has to do with "standard-of-care" issues. Since physicians take full responsibility for their patients medical/legally, the State charges physicians with the responsibility of supervising the colleagues who are working in such a soft science as "psycho-therapy" or the other kinds of "treatment for human change."

Psychological treatment is a very labor-intensive individual complex process. The outcomes are difficult, if not impossible, to measure over any short time period. To establish a "standard of care" by which any individual treatment is measured becomes very difficult.

Therefore, it seems vitally important to continue the attempt of having physicians help their psychologically trained colleagues affect whatever approximation to "standard of care" is possible in the joint venture. We all recognize the difficulty of establishing a standard of care within medicine itself and physicians all receive similar training. How much more caprice is any standard among psychologists who are trained in a variety of ways and apply an array of "treatment modalities."

2. Access to Public Monies for "Psychological Treatments":

This second opposition is really a corrollary of the first, for if we cannot standardize treatment in mental health, how can we possibly estimate the costs of those treatments. For example, I, as a physician, can state with 80 to 90% accuracy how long it will take for a given fracture to heal. After an examination with reasonable accuracy, I can project to the "payor" the number of treatments which will facilitate that healing.

In the psychological treatment modalities, we are so individuated that there is almost no "end-point" which can be estimated. It will take the Senate committee very little reflection to look at our Drug and Alcohol problems in the State of Alaska. The fact that a very few number of individuals through the "revolving door treatment" are utilizing vast amounts of health care dollars with "little apparent effect on their basic personality or behavior."

As I understand the purpose behind Medicaid, it is to provide basic medical services to the "under-served." At this time of severe fiscal limits in our State Budget, it seems unwise to add psychologist services which may well take monies from much more basic needs from the many and give it to the few.

I shall be available to testify at the Senate Health, Education & Social Services Committee hearing on this bill on Wednesday, 19 April 1989. At that time, I will be happy to answer any questions concerning this letter from you and any other members of the committee.

These are very difficult decisions, especially at budget time, and I respect the efforts that you and the rest of the committee are making to arrive at some kind of fair and equitable judgment. If you wish to use any of my experience of several years in mental health in Alaska, I would be honored if you would call on me.

Respectfully,

Russell A. Huffman, Jr., M.D.

RAH:pas

DIPLOMATE,
AMERICAN BOARD
OF
PSYCHIATRY & NEUROLOGY, INC.

RUSSELL A. HUFFMAN, JR., M.D.

POST OFFICE BOX 9435
KETCHIKAN, ALASKA 99901 (907) 225-8900

OHLSON PSYCHOLOGICAL SERVICES
4045 LAKE OTIS PARKWAY, SUITE 201
ANCHORAGE, ALASKA 99508

TELEPHONE (907) 563-3162

RONALD W. OHLSON, PH.D.
DIPLOMATE IN CLINICAL PSYCHOLOGY
AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY

THERAPISTS:
DAVE SANDBERG, M.S.
KATY BARLOON, M.S.
CATHY BIGGERSTAFF, M.S.

March 27, 1989

Senator Arliss Sturgulewski
3111 C Street
Anchorage, AK 99503

Dear Senator Sturgulewski:

I would like you to join in sponsoring and supporting Senate Bill 29 which would include licensed psychologists and psychological associates as approved providers under the Medicaid program. For some reason, psychologists were omitted as approved providers when the legislation was originally enacted, while other far less qualified practitioners were included. Please note that we are asking for inclusion only of licensed psychological practitioners in order that there would be appropriate quality control in the services delivered to the Medicaid program. Inclusion of psychologists in the Alaska Medicaid law would be consistent with national policy with respect to Medicaid.

At this time due to staff availability, I can only forecast an approximate 5% increase in our client load by the addition of Medicaid recipients. However, I believe that it is extremely important that Medicaid persons have the freedom to choose the high quality of service providers which we have available in this agency.

Warmly and sincerely,

Ronald W. Ohlson, Ph.D.
Clinical Psychologist

RWO/jc

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
Senate Bill No. 29

"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 SB No. 29 to pass. Currently, approximately ten of these psychologists are already providing services to Medicaid recipients, and indirectly receiving Medicaid payments, in work settings 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 results in more effective, higher-quality care. However, there is a strong subjective conviction, here and in other states' Medicaid agencies, that supervision increases the cost of care.

(2) Not only does the Division pay physicians for supervisory duties that may or may not enhance the quality of care, the "screening" effect of the supervision requirement means that Medicaid pays for services that are actually provided by any credentialed person the supervisor deems appropriate. This means that Medicaid pays the same rate for a Ph.D. psychologist or even a M.S.-degreed counselor as for a psychiatrist or other physician.

SB No. 29 would enable the Division to better measure, monitor, and control the use and costs of this service, and it offers at least a possibility of slightly lowering the costs per unit of service with no decrease in quality of the service.

POSITION PAPER/Department of Health & Social Services

Position:

Psychologists' services would be a logical addition to the services offered by Alaska's Medicaid Program as it would create equity between psychologists who practice independently and those who practice under the auspices of a physician or in a community mental health clinic. However, because the cost of this service is not included in the current budget, we cannot support its addition at this time without the appropriation of sufficient funds.

Recommended By: Kim Busch

Kim Busch, Director
Division of Medical Assistance

Date: March 1, 1989

Approved By: Myra M Munson

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

Date: March 1, 1989

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: SB No. 29
PUBLISH DATE: 1/9/89

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to psychologists' services.
Sponsor: Sturgulewski and Kerttula
Requestor:

Agency Affected: Health and Social Services
BRU:

Components: Medicaid Non-facility/Claims Processing/Central Administration

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0	29.5	29.5	29.5	29.5	29.5
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	66.5	69.5	71.4	73.4	75.5
SUPPLIES	0	1.5	1.5	1.5	1.5	1.5
EQUIPMENT	0	5.4	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	475.0	1051.5	1163.8	1288.1	1425.7
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	577.9	1152.0	1266.2	1392.5	1532.2
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	281.1	559.9	616.5	679.2	748.5
FEDERAL FUNDS	0	296.8	592.1	649.7	713.3	783.7
OTHER	0	0	0	0	0	0
TOTAL	0	577.9	1152.0	1266.2	1392.5	1532.2

POSITIONS:

FULL-TIME	0	1	1	1	1	1
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, SB No. 29 has no effective date. The starting date of the addition of psychologists' services to the Medicaid Program is assumed to be January 1, 1990.

Prepared by: Kim Bruce
Phone: 465-3355
Division: Division of Medical Assistance
Date: 3-1-89

Approved by Commissioner: (R) Myra M Munson
Date: 3-1-89
Agency: Dept. of Health and Social Services

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

SB No. 29
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 FY90 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 FY90 is 5,000, assuming that January 1, 1990 start date. FY90 processing costs = 31.2. Claims volume increases by 3% each year, but the $6.23 per claim cost will not increase. All costs of claims processing are 75% FED, 25% SGFM.

II. Personnel and Related Costs

The Medical/Surveillance and Utilization Review Unit (SURS) has six staff, including a medical doctor, two RN's, a health planner and a research analyst. The unit has a dual focus:

1. Medical review, which is primarily prior authorization of specific medical services which often require extensive verbal and/or written exchange of information.

2. Pre-payment and post-payment review of claims, a review which often requires extensive verbal and/or written exchange of information.

Prior to completion of the Medicaid Management Information System (MMIS), the Division did not have a dedicated Surveillance and Utilization Review Unit. The staff responsible for medical review received clerical support from the Clerk Typist III, which also supported the nine staff in the system management unit. The addition of the increased claims volume and the associated required medical review functions necessitates the addition of a dedicated Clerk Typist III to the SURS/Medical Review Unit to provide efficient support to the unit. The dedicated clerical support will provide typing, filing, phone/reception, travel, supply, MMIS and Alaska State Accounting System (AKSAS) report monitoring and distribution, a MMIS system change order preparation and monitoring. This position will require a personal computer to function effectively.

This position and supporting costs are requested in the FY90 budget to cover the current and projected needs of the unit. If that request is granted, the amount indicated for this position can be deleted from this fiscal note.

SB No. 29
Fiscal Note Attachment
Cost Analysis for Psychologists' Services

		FY90	FY91	FY92	FY93	FY94
Personal Services						
Clerk Typist III (PFT)						
Range 8/A ($1631/mo.						
plus $549 benefits)		29.5	29.5	29.5	29.5	29.5
Travel		-0-				
Contractual						
Communications	.5					
Risk Management	.3					
Office space	4.5					
Total Contractual		5.3	5.3	5.3	5.3	5.3
Supplies		1.5	1.5	1.5	1.5	1.5
Equipment						
Microcomputer						
Hardware & software	4.0					
Desk, chair, file						
cabinet & bookcase	1.4					
Total Equipment		5.4	-0-	-0-	-0-	-0-
TOTAL		41.7	36.3	36.3	36.3	36.3

These costs are 50% FED, 50% SGFM.

III. 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, and this number will not change in the future years.

(2) The statewide average cost per hour of service is currently $95, and this will not change substantially in future years.

(3) Each enrolled psychologist will bill Medicaid for four hours per week, 200 hours per year. (This 10% average is consistent with the percentage of gross income Medicaid represents for most major types of medical providers in Alaska.)

(4) There is no data to suggest the current Medicaid costs for psychiatrists' services will either increase or decrease as a result of adding psychologists' services.

(5) The time required for data system changes, promulgation of regulations, and provider enrollment activities necessitate a starting date no earlier than January 1, 1990. FY90: 50 psychologists X 4 hours per week X $95 X 25 weeks = 475.0. 237.5 SGFM
237.5 Fed

SB No. 29
Fiscal Note Attachment
Cost Analysis for Psychologists' Services

(b) Costs for FY91 through FY94 are computed from the FY90 base estimate, increased each year by 3% for increases in utilization and by 7.46% for the costs of service. (7.46% is the percentage change in the Anchorage CPI from 1988 to 1989.)

Once a full year of data is available, future costs of this option can be influenced by further regulating the maximum amounts Medicaid will pay for each type of service and by imposing service maximums, such as per-client caps on total dollar usage of a particular service in any calendar year. Most states offering this coverage impose such controls. However, the states we contacted confirmed that, as is true in Alaska, mental health services utilization and costs tend to increase more rapidly than any other Medicaid services, and even stringent controls can do little more than retard this growth.

ALASKA PSYCHOLOGICAL ASSOCIATION
3211 PROVIDENCE DRIVE
ANCHORAGE, AK 99508
907-786-1711

March 5, 1989

To: Senator Arliss Sturgulewski

From: Paul L. Craig, Ph.D.
Clinical Neuropsychologist

Re: Senate Bill 29 Fiscal Note.

Thank you for sending me a copy of the fiscal note regarding SB 29 which was promulgated by the Alaska Department of Health and Social Services on March 1, 1989.

Philosophically, the Alaska Psychological Association agrees with most of the points raised by the Department. Currently there are several Psychologists in Alaska who have a mechanism to bill for services provided to Medicaid recipients. These include:

-Psychologists employed at Community Mental Health Centers,

-Psychologists who work through one of the 15 private clinics who were issued clinic numbers several years ago,

-Psychologists who bill under the supervision of a physician, and

-a Psychologist who was enrolled in the Medicaid program as part of the settlement of a suit brought against the State of Alaska during 1988. (The settlement apparently specified that the terms of the settlement could not be discussed although it is common knowledge that this Psychologist can now accept Medicaid patients.)

Clearly, the current situation is fraught with inequity and will simply lead to additional litigation if not corrected. As stated by the Department, the current arrangement does not improve quality of care. In fact, it may add unnecessary costs due to supervision requirements and the fact that supervising physicians apparently are billing for services at physician rates although the provider may not be a physician.

The Alaska Psychological Association agrees with the Department's position that, "Psychologists' services would be a logical addition to the services offered by Alaska's Medicaid program..."

Paul Craig Letter/ Fiscal Analysis

However, the Association believes that some of the data presented in the fiscal note is not an accurate reflection of the programmatic and fiscal implications of enactment of SB 29. Specifically:

1. A staff person and supporting costs are listed as a financial consequence of SB 29. As noted in the narrative, this position is already in the Governor's budget for FY 90. A new staff position is already deemed necessary irrespective of SB 29.

2. The Department states that, "Currently, approximately ten...Psychologists are already providing services to Medicaid recipients, and indirectly receiving Medicaid payments..." In fact, there are at least 30 licensed providers of psychological services in Alaska who meet this criterion based upon a review of the names listed in the October, 1988 Directory of Licensees published by the Division of Occupational Licensing. One psychologist is probably reimbursed directly although terms of the settlement of her suit against the State of Alaska Medicaid program have not been made public as mentioned above. More than 30 Psychologists currently bill for services provided under the Medicaid program. Although the Department is probably correct that 50 Psychologists will enroll in the Medicaid program, many are already billing for services under Medicaid. As a result of SB 29, most enrolled providers will simply be altering the mechanism through which they bill thereby reducing the additional fees to the State for supervision.

3. When justifying the largest line item in the fiscal note (claims costs), the Department conceded that there is no accurate method to project costs. The Alaska Psychological Association would recommend that the State use the existing data base relative to the cost of mental health services provided by Psychiatrists in Alaska through the Medicaid program. The Division of Medical Assistance has recently reviewed these costs and concluded that each Psychiatrist bills an average of $8,000.00 per year through Medicaid (one provider was excluded from this statistic insofar as he/she does exclusively hospital work and is considered an anomaly relative to other providers). It would be expected that Psychologists would bill less per year insofar as the average charge per hour of service is 10 to 20 percent lower. Also, Psychologists typically do not admit patients to the hospital, one of the more expensive modes of mental health service delivery. In light of this data, the Alaska Psychological Association contends that the average charge for services per Psychologist enrolled in the Medicaid program would be less than $8,000.00 per year (probably $6,000.00).

4. The Department contends that SB 29 will require "modification" of the Medicaid program to accomodate this

new class of services. In fact, the Medicaid program has been paying for psychological services for many years as stated elsewhere in the position paper. No new services are being proposed. Rather, SB 29 simply provides for direct reimbursement to Psychologists for services which are already being reimbursed indirectly through the options described above. The Department refers to the need for new claim forms. The Department could use the same claim forms that they have been using for mental health services during the past several years. A Utilization Review Unit exists which would provide the necessary audit mechanism to assure that Psychologists were not billing for services which they are not licensed to provide (e.g., medication reviews). No new administrative procedures will be required other than enrolling Psychologists who request to become providers under the Medicaid program and to provide the same orientation materials provided to any other new enrollees. Otherwise, billing for mental health services can procede in the same manner enjoyed by the Medicaid program during recent years.

5. Regarding effective date, the Alaska Psychological Association assumes that SB 29 will become effective 60 days from when it is signed into law by the Governor as is the case with other new legislation.

6. The Department contends that 50 new providers will be enrolled in Medicaid as a consequence of SB 29. The Alaska Psychological Association believes that 50 licensees may enroll but that many of these Psychologists are already providing services under Medicaid (at least 30 have already been identified). Many of these 50 enrollees will not pose a new fiscal impact. Another 35 Psychologists licensed in Alaska have moved to the lower 48 but their licenses have not yet expired. Several others work for the Division of Mental Health, Department of Corrections, Alaska Psychiatric Institute, University of Alaska, and other institutions. It is highly unlikely that they would become enrollees. If they do enroll, their part-time private practice will have minimal impact on the Medicaid program. It is the Association's position that there will be very few new providers of mental health services under Medicaid as a consequence of SB 29. Most enrollees will simply be shifting from indirect to direct reimbursement.

POSITION: Using the liberal assumptions and data provided by the Department of Health and Social Services, the Alaska Psychological Association contends that the annual cost of SB 29 to the State of Alaska would be no more than $400,000.00. Using more realistic assumptions, the annual cost of SB 29 is thought to range from $150,000.00 to $200,000.00. Insofar as 50% of the revenue is derived from federal match, the actual cost to the State of Alaska could range from $75,000.00 to $100,000.00.

Note: The lower estimates are based on the assumption that the average psychologist will bill $6,000.00 per year (rather than the $8,000.00 average billed by Psychiatrists per year) and that there will only be 25 to 33 new providers under SB 29. There may be more enrollees but most will be transferring from indirect to direct reimbursement for services rendered. The higher estimate is based on the assumption that there will be 50 new providers each billing at the same level as Psychiatrists who engage in outpatient and inpatient work.

These predictions do not account for the overall cost savings to the health care system associated with having Psychological services available to treat emotional and behavioral disorders. The American Psychological Association in Washington D.C. has access to reports regarding the cost effectiveness of inclusion of Psychological services in the health care system. Please feel free to contact Sharon Plunkett at the APA Practice Directorate Office for further information (800-233-1834).

Thank you. I hope these comments will be of assistance to the Alaska Legislature as deliberations regarding SB 29 proceed.

ALASKA PSYCHOLOGICAL ASSOCIATION
3211 PROVIDENCE DRIVE
ANCHORAGE, AK 99508
907-786-1711

March 12, 1989

To: Senator Arliss Sturgulewski

From: Paul L. Craig, Ph.D.
Clinical Neuropsychologist

Re: Senate Bill 29

Thank you for your very supportive stance during my visit to Juneau last week. I think we made some progress.

Upon returning to Anchorage, I contacted the American Psychological Association regarding the costs associated with inclusion of psychologists in the Medicaid program as direct providers of mental health services. They express mailed a large packet which I have distilled for your use.

The data from Colorado suggests that the cost for psychological services decreased measurably when this service was available without medical supervision (see pilot project report from Colorado). Quality of care was not impacted.

Hawaii data indicates that about 9% of Medicaid recipients seek some form of mental health care at some time while they are enrolled in the program. These medicaid recipients are also the individuals within medicaid who utilize general health care services to a much greater degree than the medicaid recipients who do not use mental health services. As referenced in the attached fact sheet, several studies have demonstrated the effectiveness of psychological services in reducing the inappropriate over-utilization of expensive health care services. The data collected in Hawaii indicates that inclusion of psychologists as direct providers in Medicaid does result in a reduction in overall health care services utilization among the segment of the Medicaid population which makes use of psychological services. There is no suggestion that inclusion of psychologists in the Medicaid program results in an increased level of utilization of mental health services among Medicaid recipients.

Freedom of choice (FOC) states have laws requiring that health care plans allow the consumer to choose whether to get their mental health services from a psychologist or a psychiatrist. More than 30 states have enacted FOC legislation. In FOC states, the more competitive

environment has resulted in approximately a 10% decrease in the "usual and customary" rates charged for psychiatric services as compared with states like Alaska that don't have an FOC statute. Freedom of choice in Medicaid could not only increase the availability of qualified providers for Medicaid recipients who need mental health care, it could also reduce the rates charged for these services by various categories of providers.

In summary, data from other states indicates:

1. Inclusion of psychologists in the Medicaid program does not result in any increase in utilization of mental health services among Medicaid recipients. The same 9% of this group will seek mental health services whether it is provided by a psychologist or other provider.

2. Medicaid recipients who use mental health services consume a disproportionate amount of general health care services through Medicaid. In other words, this same 9% of the Medicaid population referred to above also are heavy users of a broad array of inpatient and outpatient health care services through Medicaid.

3. Psychological services have been demonstrated in a variety of cost-containment studies to result in an overall decrease in utilization of general health care services.

4. In light of the preceding information, it is contended that direct access to cost effective psychological services under the Medicaid program will improve access to high quality providers of mental health services, will not change the rate of utilization of mental health services, may decrease the rates charged for mental health services, and will result in a decrease in the over-utilization of expensive general health care services including both inpatient and ambulatory care.

Based upon the experience of other states, there is no data to support the contention that inclusion of psychologists as direct participants in Medicaid will substantially increase the cost of delivery of mental health services and may result in a measurable decrease in the cost of other health care services delivered to Medicaid recipients who make appropriate use of psychological services.

If the Division of Medical Assistance has concerns about abuses within the system, these concerns should be dealt with through effective utilization review and development of standards applicable to all providers of mental health services. Alaskan psychologists would welcome accountability within the Medicaid funded mental health system. The discriminatory policy of inclusion of some, but not all, providers of psychological services under the Alaska Medicaid program represents a capricious restraint of trade which could be nicely solved through SB 29. Thank you.

Colorado

The Medicaid Psychologists Pilot Project Overview

I. The Provider Group

There will be a Participating Provider Group of Psychologists who will be enrolled in the Medicaid Psychologists Pilot Project under the specific agreement that they will provide appropriate, cost effective psychological services to eligible Medicaid recipients. The participating psychologists will agree to provide such services within specified benefit parameters and they will be subject to a peer review of their work. In order to qualify for the Project, psychologists must hold a current Colorado license. In addition, applicants must have graduated from a doctoral psychology program approved by the American Psychological Association (APA) and completed an internship in clinical or counseling psychology. A waiver from the APA-approval of a doctoral program any be granted if the psychologist is currently listed in the National Register of Health Service Providers in Psychology.

II. Cost Containment System

The Medicaid project is designed to provide quality psychological services while not escalating the costs for such services. There are six cost controlling elements incorporated into the program, there elements are:

1. Participation in the Primary Care Physician Program
2. Specific Provider Agreement Criteria
3. Capping of services
4. Fixed reimbursement rates
5. Information management system
6. Utilization review

Participation in the Primary Care Physician Program (PCP) means that the psychologist will have to coordinate services with this gatekeeper and clinical manager of health care services. Where appropriate medicaid clients will be assigned a PCP.

The provider agreement form requires that all participating psychologists follow the guidelines set forth in the program. Failure to comply with the guidelines will result in the exclusion of the psychologist from the program.

Ambulatory Psychotherapy, Outpatient hospital services, inpatient hospital services and psychological testing are limited to a pre-determined number of hours per benefit period. Any patient that requires services beyond the specified limits must have prior approval by the the PCP and must conform to PRO criteria.

The reimbursement rate for all services is a fixed fee determined by the Department of Social Services.

All participating providers are required to maintain a written individualized plan or care for all clients. In addition mandatory mental health reports are submitted to the PCP on a scheduled basis.

Utilization review process will be implemented in order to evaluate benefit parameters and standards of care. The process will address the issues of necessity, appropriateness and quality of psychological treatment. The review process will consist of the completion of a UR check list, random review of cases, and automatic review of providers who are exceeding the specified benefit parameters.

III. Population Served

The pilot project will serve all eligible medicaid recipients who have need for mental health services. The specific populations to be served include:

1. SSI Recipients
2. AFDC
3. Foster Care
4. Abused and Neglected Children

IV. Services Provided

The services to be provided by participating Psychologists include the following areas:

1. Ambulatory Psychotherapy
2. Psychological Testing
3. Inpatient Psychotherapy
4. Hospital Outpatient Psychotherapy

V. Referral Procedures

Medicaid recipients may exercise freedom of choice in selecting a participating psychologist on their own initiative, or they may be referred through other sources such as physicians, social workers, nurses, agency representatives or case managers. In those cases where a Medicaid recipient has an assigned Primary Care Physician, prior authorization for psychological services must be obtained from the physician as specified in Department of Social Services rules.

VI. Quality Control

In addition to serving as a cost containment element, the UR process is also a check for quality of diagnostic and treatment services. Participating psychologists will be subject to both random and scheduled reviews by peer psychologists to ensure necessity, timeliness, appropriate focus and intensity of services. Cases involving sub-standard care will be referred to Department of Social Services for appropriate action.

VII. Reimbursement System

The reimbursement for psychological services will follow current Social Services procedures and requirements. The payment for the services will be made in accordance with the procedure codes defined by the Department of Social Services. In addition, a Utilization Review form must be completed by the participating Psychologist and attached to claim form being submitted.

VIII. Project Evaluation

The pilot project will contain several levels of evaluation. The program's effectiveness will be measured by collecting data on the utilization rate, length of stay, cost for each service and total cost to the Medicaid Program. This information will be compared to other Medicaid Provider Groups

The project is designed to not raise the cost of mental health services to the Medicaid program.

Pilot Project started in 1986.

11. Colorado Psych. Ass. Bulletin; Feb 88

Executive Officer Report

Professional Issues Update

by John Nicoletti

The 1988 Legislative session opens with psychologists actively involved in several key areas. The most important area is the licensing bill which is H.B. 1026. The bill to make the Medicaid Project a permanent program is also starting in the House (H.B. 1106) and being sponsored by Representative Betty Neale. The statistics for the pilot project are positive for controlling the cost of Medicaid services. The preliminary data shows that the average cost per recipient who was seen during the project was $196.61 as compared to $245.36 before the project. Hopefully, the legislature will view this as a significant cost control. The other bills that we are actively involved in are the Mental Health Insurance Reimbursement Bill and the Sexual Assault by Psychotherapists Bill. In addition, there are several other bills that relate to either mental health or social issues that we will be monitoring and/or taking action on during the session. We will be asking for your help in lobbying the various bills in the near future. If you have any questions about legislation, please contact either Charlie Hebler (756-5513), Toni Helfrich (756-6565) or me (986-2164).

The Worker's Compensation Guidelines for non-physicians providers were adopted and will go into effect March 3, 1988. A copy of the guidelines to be adopted are printed below. The modifier code to be used by psychologists is 03. If you have any questions about procedures or rates, please call me at 986-2164. The change in the guidelines is a positive one for psychologists. In other positive news, the Colorado Business Coalition for Health will be sponsoring another workshop on mental health benefits. Their interest in the workshop is showing a positive trend on the part of business towards mental health. Unlike last year's workshop, providers will be allowed to attend this meeting along with the corporate representatives.

At the National level, psychologists were able to maintain the ground gained in the Medicare Legislation. As I mentioned in previous issues, psychologists were included in the Medicare bill. The psychology provisions were approved by the joint Senate/House Budget Reconciliation Conference Committee. The bill will allow for Medicare beneficiaries to obtain the services of psychologists when seeking care through community mental health centers and federally defined rural health clinics. Psychologists' services will not be subject to physician supervision or referral. Thanks to all of you who contacted your federal representatives around this issue. The federal grass roots network is becoming an integral part of affecting policy. Toni Helfrich will be taking over as the State Coordinator for the network. If you are interested in taking part, please contact one of us.

Guidelines Regarding Non-Physician Providers Under the Colorado Workers' Compensation Medical Fee Schedule: Who May Provide Services?

GUIDELINES REGARDING NON-PHYSICIAN

A) Physicians licensed by the Board of Medical Examiners, the Board of Dental Examiners, the Board of Chiropractic Examiners, and the Colorado Podiatry Board may be designated as authorized treating physicians.

B) Persons in the following professional categories shall be reimbursed at the rate of 75% of the fee paid to a physician according to the Workers' Compensation Medical Fee Schedule under the following conditions:

1. The insurer is not required to reimburse the non-physician provider for treating a disabling injury or illness unless the worker has been referred for treatment by the worker's authorized treating physician, who will remain the authorized treating physician;
2. The non-physician provider is not an authorized treating physician and, therefore, cannot conduct disability evaluations, render opinions or other similar functions which may only be performed by the authorized treating physician;
3. The non-physician provider is independently practicing; i.e., is not in the employment of a physician.

Recognized non-physician providers shall be:
1. Physician Assistants licensed under CRS 12-36-106 (5)(a). This includes university trained Surgeon Assistants;
2. Registered Professional Nurses licensed under CRS 12-38-101;
3. Licensed Social Worker IIs who are licensed under CRS 12-63.5-101;
4. Optometrists licensed under CRS 12-40-101;
5. Respiratory Therapists certified by the National Board of Respiratory Care;
6. Audiologists certified by the American Speech and Hearing Association;
7. Orthopedic Technologists certified by the National Organization of Orthopedic Technologists;
8. Surgical Technologists certified by the Association of Surgical Technologists.

C) Psychologists licensed under CRS 12-43-101 shall be reimbursed at a rate of 90% of the fee paid to a physician according to the Workers' Compensation Medical Fee Schedule. Psychologists shall be subject to the limitation in B (1) and (3) above.

FRIDAY FORUMS - Internal Affairs Committee is initiating a series of Friday Forums, informal sessions late on Friday afternoon, sometimes with invited presenters, sometimes not. The first one will be Friday, February 26th at 4 p.m. This is a chance for you to sit down and talk with the Committee about CPA issues that concern you. Call the office, 759-3683, if you would like to attend.

Professional Practice Committee Seeks Volunteers

The Committee on Professional Practice is looking for volunteers to be our "eyes and ears" inside HMOs and PPOs. We need current information about the inclusion of psychologists in these organizations and the range of practice allowed. Comments about the general atmosphere within the organization and the efficiency of the operations would also be welcomed. Your commitment would be to fill out a brief questionnaire addressing these concerns on a quarterly basis. Information from all the organizations will be shared with the membership in the BULLETIN. Since there are more than forty such groups in Colorado, your help would be greatly appreciated. Please call the CPA Office (759-3683) and leave your name, the name of the group to which you belong, and a phone number. Or you may contact me by writing to volunteer: Stuart Adelman, Ph.D.; 3489 W. 72nd Ave.; Westminster, CO 80030.

Fall Conference Correction

Dear Editor:

I wanted to thank you for your excellent coverage of the recent CPA conference and particularly for your report about the cognitive viewpoint on anxiety disorders. Unfortunately, there was one misquote attributed to me that I want to correct. The article stated that I had warned about the addictive quality of Xanex (Alprazolam) which I had done, but went on to say that it could lead to convulsions for some patients. I believe that this was a comment from the audience, not something I had said. While all medications need to be carefully monitored by a physician, I personally have had no reports of patients suffering such severe side effects as convulsions. Thank you for noting this correction.

Sincerely,
Andrew A. Sweet, Psy.D.
Clinical Psychologist

CPA Retains Seat on APA Council

Thanks to all CPA members who gave us their votes on the APA Apportionment ballot; CPA has managed to retain a seat on Council of Representatives for another year. This was especially good news in a year when more than one State Psychological Association lost their representation. CPA Representative Steven Warner will be attending the Council session in Washington the end of this month and will have a report for the membership in the next issue of the Bulletin.

We have also received word from APA that it is time for us to submit names of candidates for election as CPA's representative on the APA Council - term to begin in 1990. Qualifications include membership in CPA and APA, ongoing interest and leadership in state association affairs. If you are personally interested, or wish to

Colorado

PSYCHOLOGY PILOT PROJECT REPORT

1. Membership as of February 22, 1988:
   - 165 psychologists located in 25 Colorado Cities.
   - 60 psychologists have received reimbursement for Medicaid services rendered in quarter 07/01/87 to 09/30/87.*

2. Individual Utilization Summary Profile Report: Used to analyze 36 Pilot Project providers and compare "before and after" services 07/84 to 09/84 and 07/87 to 09/87. The 36 Providers are 60% of Pilot Project Psychologists receiving reimbursement:

07/01/84 to 09/30/84	
Total Dollars Paid:	$64,666.00
Total Recipients Served	255
Average payment per recipient	$253.59
07/01/87 to 09/30/87	
Total Dollars Paid	$48,691.00
Total Recipients served	200
Average payment per recipient	$243.45

   These data indicate that for these 36 providers the total recipients served and the total dollars paid decreased even though the providers had the ability to bill for services independent of M.D. supervision. These providers operated under the utilization controls outlined in the Psychologist Pilot Project.

3. Summary Field Totals: This report addresses all non-physician practitioners. Providers who are not enrolled in the pilot project are included. Providers most often using a psychiatric diagnosis are:

   A. Non-licensed (Ph.D) psychologists
   B. MA psychologists
   C. ACSW Social Worker
   D. MS psychiatric nurse
   E. MSW Social Worker
   F. BS psychiatric nurse
   G. Psychiatric Tech.

These providers are reimbursed on a sliding scale. Non-licensed psychologists are paid at the highest end of the scale at a rate equal to those psychologists in the pilot project. Those at the lowest end the scale include the psychiatric technician.

07/01/84 to 09/30/84

Total recipients = 853
Total dollars paid = $166,311
Average payment per recipient $194.96

07/01/87 to 09/30/87

Total recipients = 1646
Total dollars paid = $227,637
Average payment per recipient = $138.27

Both analyses show that the average payment per recipient has decreased since 1984.

The group of non-physician practitioners described above operated without the utilization controls specified in the pilot project.

* The reports used in the following analysis are produced by the Surveillance Utilization Review subsystem of the MMIS. Two reports have been utilized in compiling this data: MNADR-1 is an aggregate summary of all services provided; MNAER-1 is an individual provider report demonstrating Medicaid Utilization. A third report available, but not used in this report, the MNDDR025 provides definitive, claim by claim answers regarding services rendered.

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

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.

POSITION PAPER
Senate Bill No. 29

"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 SB No. 29 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

POSITION PAPER/Department of Health & Social Services

the rate appropriate for a psychiatrist/M.D., but the patient often gets services from someone whose credentials would justify a lower rate.

SB No. 29 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. SB 29 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, SB No. 29 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 SB No. 29 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 SB No. 29 give us the administrative structure in which we could measure and control them.

The Department supports the passage of SB No. 29.

Recommended By: Randy Hagan
For: Kim Busch, Director
Division of Medical Assistance

Date: January 29, 1990

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

Date: Feb 1, 1990

STATE OF ALASKA
1990 LEGISLATIVE SESSION

PUBLISH DATE: 01/23/90

SB29

FISCAL NOTE

REQUEST:

Revision Date: 1/23/90
Title: An Act relating to Psychologists' Services
Sponsor: Sturgulewski and Kertulla
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	808.2
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, SB No. 29 has no effective date. The starting date of the addition of psychologists' services to the Medicaid Program is assumed to be January 1, 1991.

This has no FY90 impact.

Prepared by: [signature] Phone: 465-3355
Division: Division of Medical Assistance Date: 1/29/90

Approved by Commissioner: Mona M Munson Date: 2/1/90
Agency: Department of Health and Social Services

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

SB No. 29
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).

ALASKAN PSYCHOLOGISTS 1988

Bruno M. Kappes and Sonya M. Plourde
University of Alaska
Anchorage

During the past year members of the Alaska Psychological Association (ALPA) and other psychologists in the state received a questionnaire and address update in the mail. The survey was administered in October 1987 with a second request for follow up ending February 1988. This survey of mental health professionals in Alaska was conducted to assist in identifying some specific characteristics of psychologists state-wide. In addition, the information was to serve as a profile of current ALPA membership and help establish particular priorities for potential political action. This report presents the results of those who participated and were inclusive to only those who met the following criteria. First, the data represents professionals who are registered active members of the American Psychological Association (APA), the parent organization to ALPA. An address list was provided from the home offices of APA in Washington D.C.. Secondly, psychologists who were members of ALPA but not current members of APA were also included. The information herein was also restricted to only those who currently reside in Alaska. This data is most likely a fair representation of what is typical for most psychologists in the state. APA and ALPA is not responsible for the content or implications contained within this article. The design, data reduction, collection and analyses were conducted in the Psychology Department at the University of Alaska Anchorage. Special thanks to graduate students Richard Miller and Steven Hendricks for their contribution to data collection and reduction.

A total of 140 professionals met the above criteria and were sent a request for information. Each person was mailed an anonymous 46-item questionnaire and a separate information request form to update ALPA files. Each packet contained two

individual self-addressed stamped envelopes therefore data would be completely anonymous and remain confidential. A 3-month follow-up second request was sent to those without a prompt return on the form update. A final total of 90 returns were available for analysis. This 65% return rate indicates a remarkably high rate of response for mailed questionnaires.

The Statistical Package for Social Science (SPSS-X) on the university Vax system was utilized for analysis and the results are presented as follows. Table 1 lists the descriptive statistics for the majority of responses. Each set of statistics are followed by the specific N or total number of individuals choosing to respond to the variable in question. Alaska is sometimes referred to as the land of extremes, therefore use of the mode (frequent scores) as an index of the typical response rather than the mean (average), which is easily influenced by extreme scores, may be preferred.

Figure 1 shows over 40% or a majority of Alaskan psychologists to be engaged in private practice. Interestingly, educational institutions, non-profit organizations and the state of Alaska are virtually tied and in second place with each sharing 15% of the employment pie. The smallest employment statistics are shared by the municipality, U.S. Government and corporations with the latter representing the smallest share of 2%.

Regarding annual salary, the results demonstrated no statistically significant differences between male and female psychologists' salaries irrespective of degree (male=$64K, female=$55K means, $52K, $50K medians respectively $p < .22$, see figure 2.). Although the means suggests a $10k difference, there are sufficient numbers of both sexes who earn substantially higher or lower in either case to suggest a relatively equal parody. Above all however, a subsequent regression analysis revealed the most important variable predictive of salary seems to be the number of hours worked per week with a correlation of $r=.50$, $p<.001$. An exceptional example showed up to 65 hours of work activity per week while most reported 40 clinical hours worked based on an average of 20 clients per week. Nationally, the average client load is 20-25 clients per week. A second variable related to larger salaries was found for those

psychologists who frequently provide expert witness testimony, where greater increases in salary related to the frequency of court appearances r=.41, $p < .001$. Interestingly, the data revealed no statistically significant differences between masters and doctoral level psychologists ($p < .26$) (M.S.=$52K, Ph.D.=$63K, and $50K, $51K medians respectively). Doctoral level psychologists earn larger mean salaries overall, however median salaries are practically identical. This suggests advanced academic training may reflect higher income, but does not necessarily limit master's earning capacity. The results also showed state licensure to be a better discriminator regardless of gender or degree when predicting a psychologist's average earning in Alaska. Licensed psychologists' mean income was $63K while non-licensed professionals average income was $48K. This difference was significant at the .05 level, independent of degree level. Medians were $52K and $50K respectively. Salary results for licensure by degree are presented in figure 3. There was no interaction.

Figure 4 presents the results for the Issue Prioritization with workers compensation reflecting the strongest agreement among those polled followed by Medicare coverage and privileged communication. Those issues with moderate agreement include the USSR joint research project with Alaskan psychologist participation, malpractice issues and tort reform. The most disagreement and split on opinion occurred on the limitation of the Ph.D. as the practicing degree and mixed neutral to strong oppositon for manditory Aids testing of employees in the workplace. Overall, third party issues seem to have a 60 to 70 percent agreement as an important priority for ALPA legislative efforts. Not surprisingly, the old age national controversy between masters versus doctoral level therapists is still alive and well with strong opposing opinions within as well as between degree levels.

Figure 5 displays interesting professional practice issues concerning fee structure, computer use and outside or lower 48 licensure. Sixty-five percent provide a sliding fee option for clients and 90% did not raise fees last year. Fifty-five percent or one out of two psychologists have a computer at home while 65% or two out of three use computers at the office. Only, 30% of psychologists or one-

third are licensed in one or more states other than Alaska. The majority or two-thirds of those licensed only maintain licensure in Alaska.

In summary, a typical Alaskan psychologist is likely to be either male or female, approximately 45 years of age and has lived in Alaska 7 to 10 years. This professional earns about $50 to $60 thousands annually, likely to possess a doctorate degree, maintain licensure and engages in full-time private practice. He or she counsels 20 clients per week, charges $90 per session and finds 10% of fees uncollectable. Professionally, subscribes to 2-3 journals, attends 3 in-state conferences per year, travels to one out-of-state conference annually, and has a 33% chance of possesing a license outside of the state of Alaska. You may find these statistics interesting and useful in planning your practice and or establishing a career as a psychologist in Alaska.

Bruno M. Kappes, Ph.D, is a Licensed Psychologist and a Professor of Psychology and Health Sciences at the University of Alaska Anchorage. He also serves as Executive Officer for the Alaska Psychological Association.

Sonya M. Plourde, is a Research Assistant in the Department of Psychology, University of Alaska Anchorage.

Senator: 3/8/89.

Paul Craig -
Came by and thanked
the committee for
hearing his testimony.
&
Dropped off this packet
for you.

DCM.

1988 ALPA SURVEY STATISTICS

TOPIC	x	S.D.	Mode	Median	Range	N
AGE	43.8	8.4	45	43.5	29-68	90
# OF YEARS IN PROFESSION	14.0	8.3	10	12.5	2-45	86
YEARS LIVED IN ALASKA	13.0	10.1	7	10	1-50	88
SALARY IN THOUSANDS OF $	60.0	30.8	50	50	14-175	80
POPULATION IN CITY OF RESIDENCE	145.6	98.7	225	225	1-225	85
IF IN PVT. PRACTICE; % FULL TIME	90.9	20.7	100	100	10-100	85
# OF WEEKLY CLIENTS	20.4	11.3	20	20	1-55	71
# OF HRS./WK.	33.8	16.0	40	40	1-65	70
# OF MIN. IN INDIVIDUAL SESSION	55.0	9.5	50	55	30-90	67
# OF MIN. IN GROUP SESSION	89.4	25.9	90	90	45-150	33
% OF TIME SEEING CLIENTS IN HOSPITAL	25.5	34.8	5	10	1-100	35
% OF TIME SEEING CLIENTS IN OFFICE	82.5	23.4	100	90	10-100	63
% OF TIME SEEING CLIENTS IN HOME	16.6	12.2	30	15	3-30	8
% OF TIME SEEING CLIENTS IN SCHOOL	18.1	25.9	5	10	1-90	11
% OF TIME SEEING CLIENTS IN OTHER	29.0	29.3	5	20	5-100	18
% ALASKA NATIVE CLIENTS	14.8	21.9	5	5	0-100	73
% MINORITY (NOT NATIVE) CLIENTS	6.8	6.3	5	5	0-30	66
# OF TIMES EXPERT WITNESS/3 YRS.	4.5	7.5	0	2	0-40	76
# OF PROF JOURNALS SUBSCRIBE/YR.	3.2	2.6	2	3	0-15	87
# OF PROF. CONF. ATTENDED/ 3 YRS.	5.2	4.0	3	4	0-20	87
# 0F PROF. MTGS OUTSIDE AK LAST YR.	1.4	1.9	0	1	0-10	83
# OF PROF PAPERS IN JOUR/3 YRS.	1.0	2.3	0	0	0-17	79
# 0F PUB. PAPERS IN JOUR/3 YRS.	0.5	1.4	0	0	0-8	80
CHARGE FOR INDIV. SESS. $/HR.	89.4	11.1	90	90	60-125	57
CHARGE FOR GROUP SESS. $/HR.	44.0	15.2	40	45	20-95	27
% OF CHARGES UNCOLLECTED	8.3	10.0	10	5	0-50	50
% OF CLIENTS IMMEDIATE PMT. FOR SVCS.	68.5	76.1	50	50	10-100	52
% OF INCOME FROM INSURANCE COVERAGE	43.4	27.3	50	50	0-100	52

SEX	46 MALES	43 FEMALES		89
FULL/PART TIME	75.3% FULL	24.7% PART		85
DOCTORAL	77.6% LIC	22.4% NONLIC		58
MASTERS	53.0% LIC	46.9% NONLIC		32
LICENSED OUTSIDE	31.5% YES	68.5% NO		73
IND/GP/BOTH WORK ENVIRONMENT	59.2% IND	0% GP ONLY	40.8% BOTH	71

Figure 1.

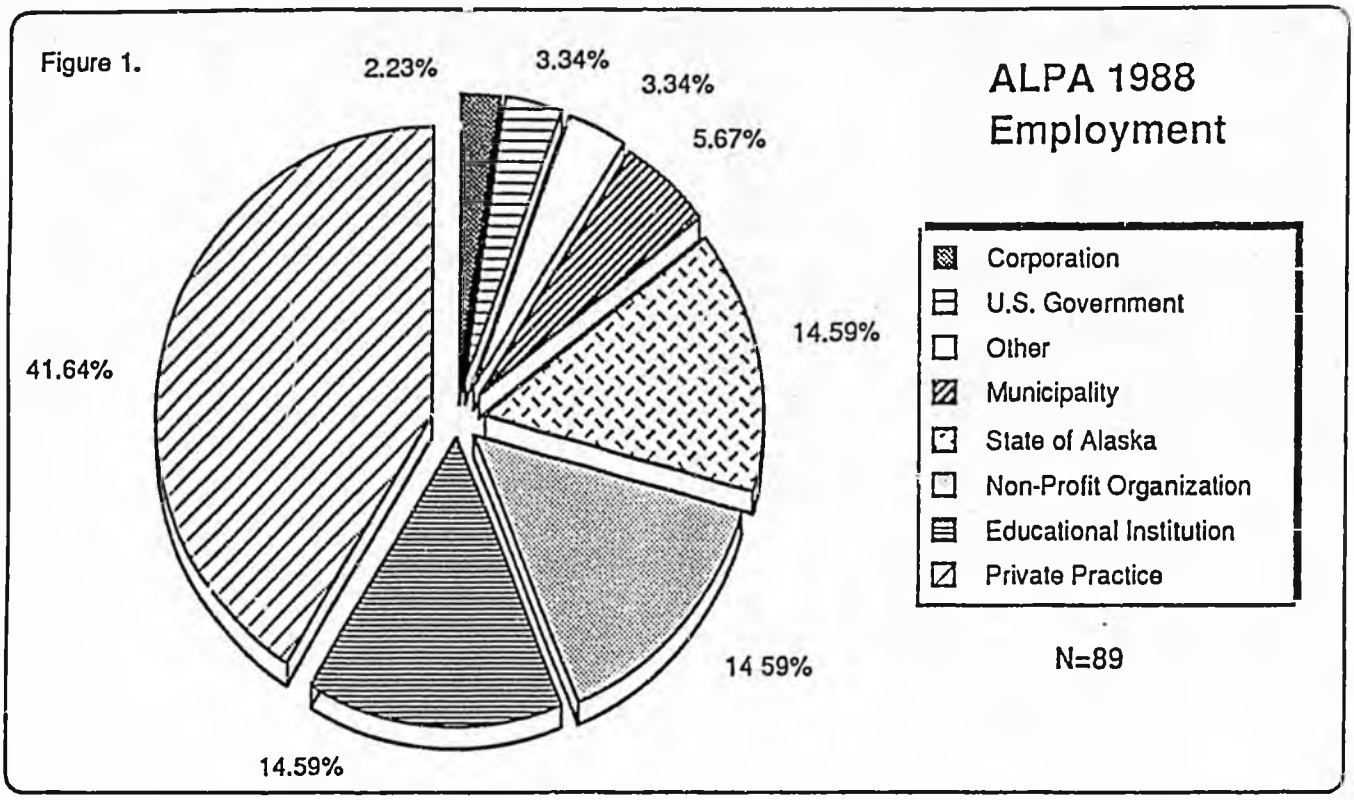


Figure 2.

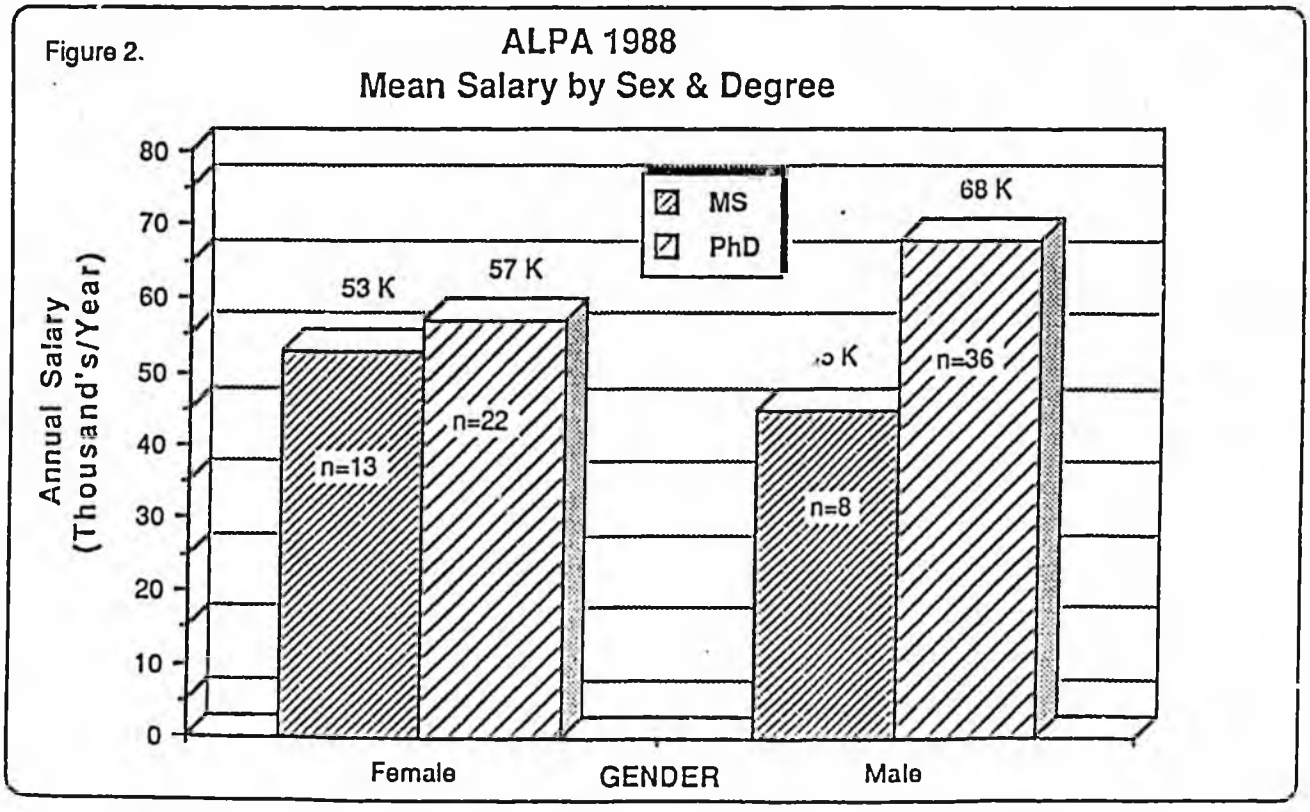


Figure 3.

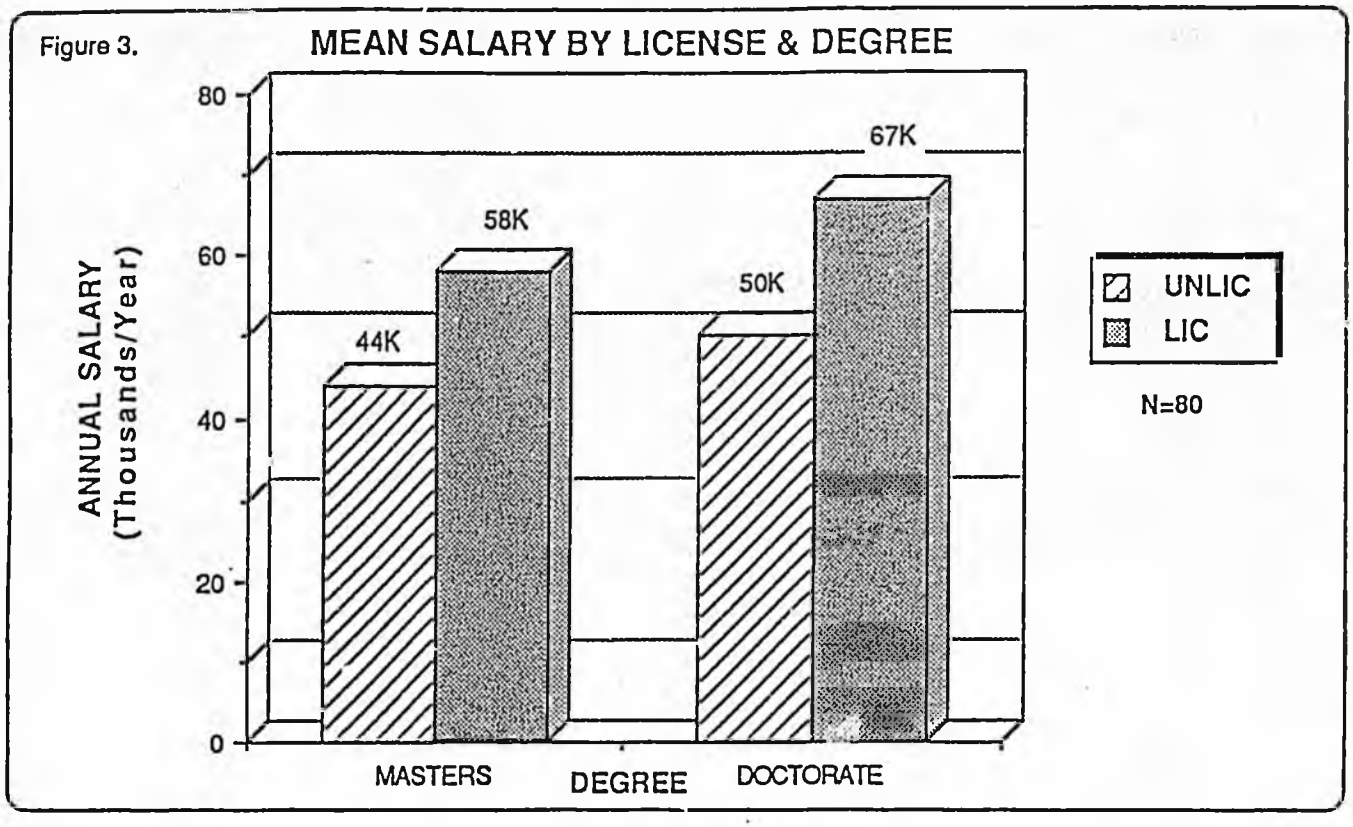


Figure 4.

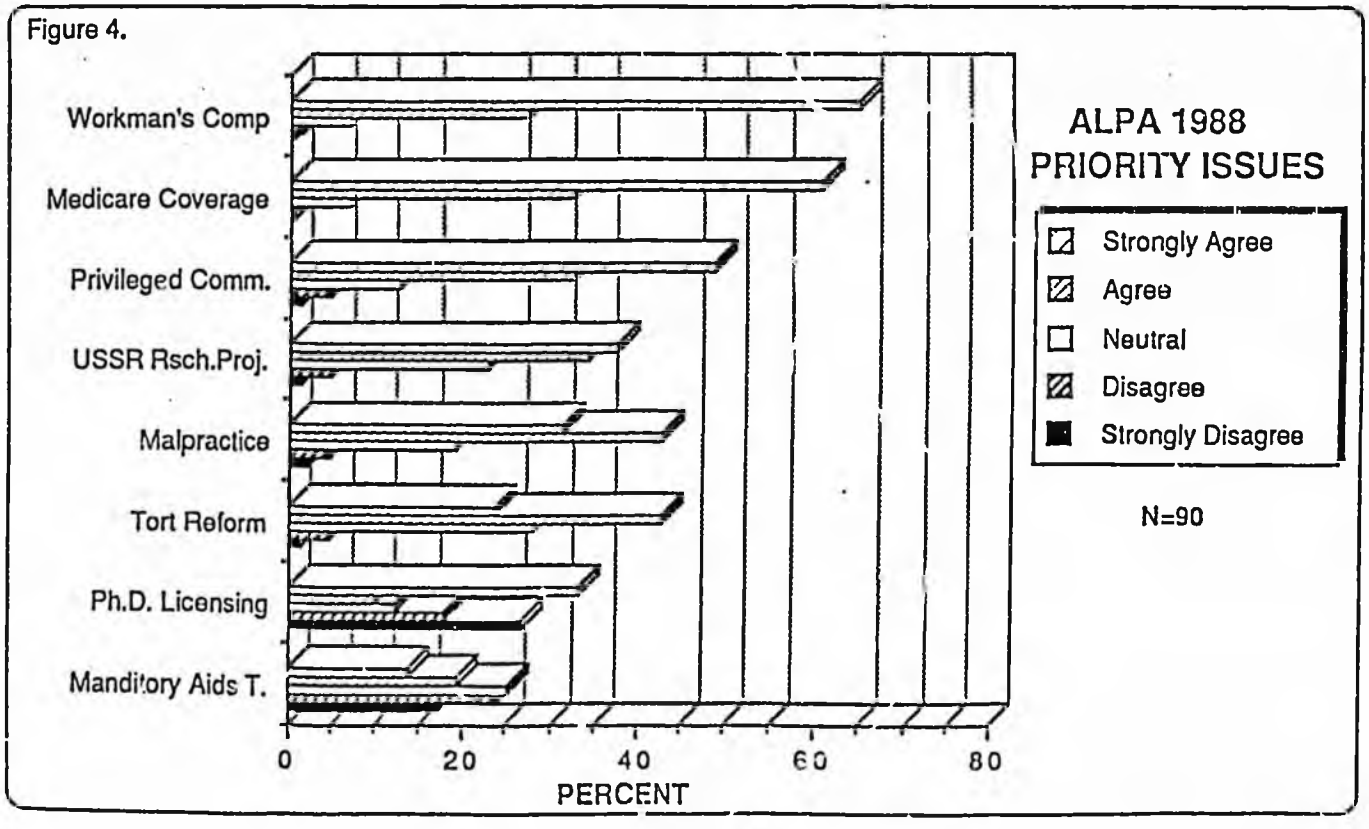
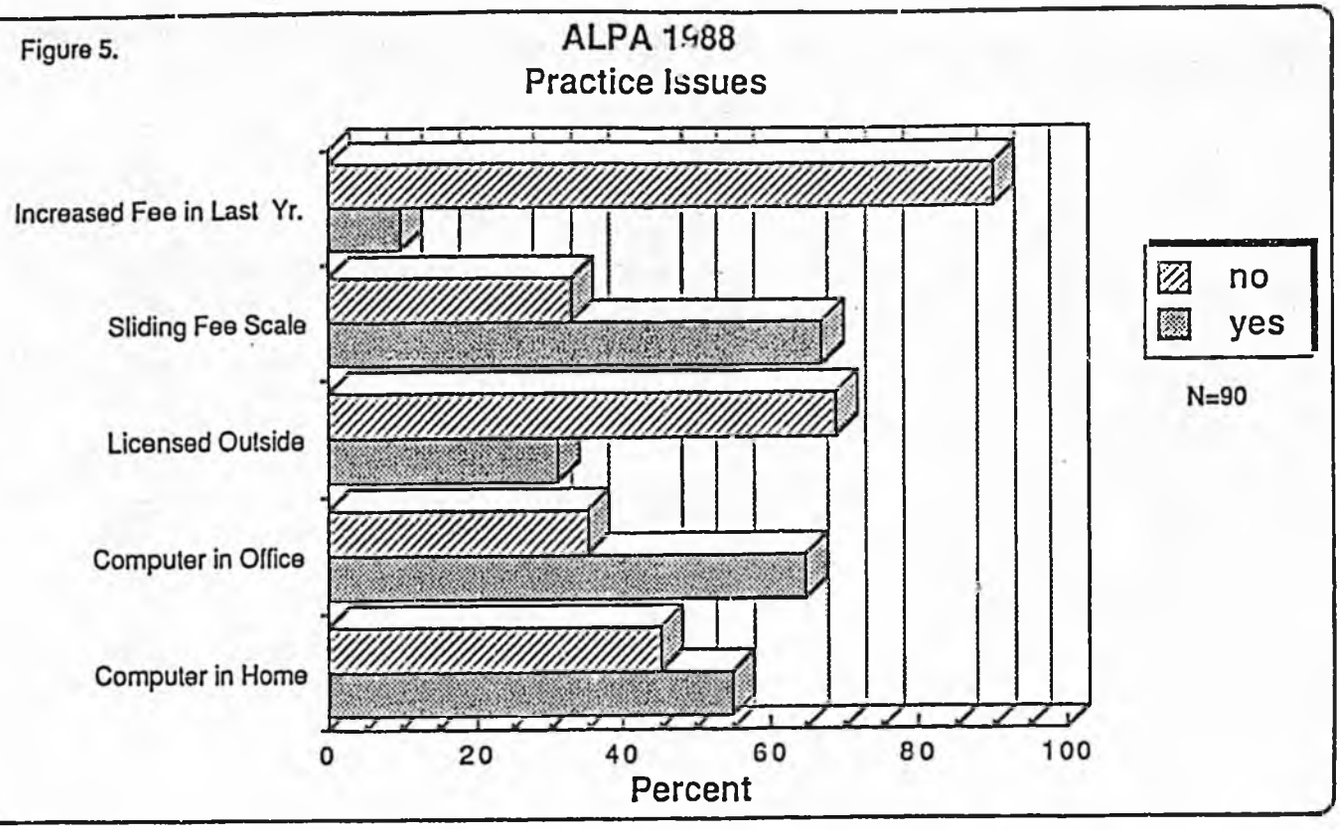


Figure 5.


ALPA 1988
Practice Issues
Increased Fee in Last Yr.
Sliding Fee Scale
Licensed Outside
Computer in Office
Computer in Home
0
20
40
60
80
100
Percent
no
yes
N=90

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: SB No. 29
PUBLISH DATE: 1/9/89

FISCAL NOTE

REQUEST:

Revision Date: 3/21/89
Title: An Act relating to psychologists' services.

Agency Affected: Health and Social Services
BRU:

Sponsor: Sturgulewski and Kerttula
Requestor:

Components: Medicaid Non-Facility/Claims Processing/Central Administration

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0	29.5	29.5	29.5	29.5	29.5
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	66.5	67.6	69.5	71.5	73.5
SUPPLIES	0	1.5	1.5	1.5	1.5	1.5
EQUIPMENT	0	5.4	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	291.2	644.5	713.4	789.6	874.0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	394.1	743.1	813.9	892.1	978.5
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	189.2	356.0	390.9	429.5	472.1
FEDERAL FUNDS	0	204.9	387.1	423.0	462.6	506.4
OTHER	0	0	0	0	0	0
TOTAL	0	394.1	743.1	813.9	892.1	978.5

POSITIONS:

FULL-TIME	0	1	1	1	1	1
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, SB No. 29 has no effective date. The starting date of the addition of psychologists' services to the Medicaid Program is assumed to be January 1, 1990.

Prepared by: Kimberly B. Busch
Phone: 465-3355
Division: Division of Medical Assistance
Date: 3/21/89

Approved by Commissioner: Mona M Mercer
Date: 3/21/89
Agency: Dept. of Health & Social Services

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

New

SB No. 29
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 FY90 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 FY90 is 5,000, assuming that January 1, 1990 start date. FY90 processing costs = 31.2. Claims volume increases by 3% each year, but the $6.23 per claim cost will not increase. All costs of claims processing are 75% FED, 25% SGFM.

II. Personnel and Related Costs

The Medical/Surveillance and Utilization Review Unit (SURS) has six staff, including a medical doctor, two RN's, a health planner and a research analyst. The unit has a dual focus:

1. Medical review, which is primarily prior authorization of specific medical services which often require extensive verbal and/or written exchange of information.

2. Pre-payment and post-payment review of claims, a review which often requires extensive verbal and/or written exchange of information.

Prior to completion of the Medicaid Management Information System (MMIS), the Division did not have a dedicated Surveillance and Utilization Review Unit. The staff responsible for medical review received clerical support from the Clerk Typist III, which also supported the nine staff in the system management unit. The addition of the increased claims volume and the associated required medical review functions necessitates the addition of a dedicated Clerk Typist III to the SURS/Medical Review Unit to provide efficient support to the unit. The dedicated clerical support will provide typing, filing, phone/reception, travel, supply, MMIS and Alaska State Accounting System (AKSAS) report monitoring and distribution, and MMIS system change order preparation and monitoring. This position will require a personal computer to function effectively.

This position and supporting costs are requested in the FY90 budget to cover the current and projected needs of the unit. If that request is granted, the amount indicated for this position can be deleted from this fiscal note.

Cost Analysis for Psychologists' Services

		FY90	FY91	FY92	FY93	FY94
Personal Services						
Clerk Typist III (PFT)						
Range 8/A ($1631/mo.						
plus $549 benefits)		29.5	29.5	29.5	29.5	29.5
Travel		-0-				
Contractual						
Communications	.5					
Risk Management	.3					
Office space	4.5					
Total Contractual		5.3	5.3	5.3	5.3	5.3
Supplies		1.5	1.5	1.5	1.5	1.5
Equipment						
Microcomputer						
Hardware & software	4.0					
Desk, chair, file						
cabinet & bookcase	1.4					
Total Equipment		5.4	-0-	-0-	-0-	-0-
TOTAL		41.7	36.3	36.3	36.3	36.3

These costs are 50% FED, 50% SGFM.

III. 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, and this number will not increase in future years.

(2) Approximately 24 of these new providers are currently providing services indirectly, supervised by and/or billing through a 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) Approximately 26 new providers will enroll, psychologists in private practice who are not currently serving Medicaid recipients. 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.

(4) 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.

(5) $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, 1990. FY 90 costs will therefore be 50% of a full year:

145.6	SGFM
145.6	Fed
291.2	Total

(b) Costs for FY91 through FY94 are computed from the FY90 base estimate, increased each year by 3% for increases in utilization and by 7.46% for the costs of service. (7.46% is the percentage change in the Anchorage CPI from 1988 to 1989.)

Once a full year of data is available, future costs of this option can be influenced by further regulating the maximum amounts Medicaid will pay for each type of service and by imposing service maximums, such as per-client caps on total dollar usage of a particular service in any calendar year. Most states offering this coverage impose such controls. However, the states we contacted confirmed that, as is true in Alaska, mental health services utilization and costs tend to increase more rapidly than any other Medicaid services, and even stringent controls can do little more than retard this growth.

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: SB No. 29
PUBLISH DATE: 1/9/89

FISCAL NOTE

REQUEST:

Revision Date: 3/21/89
Title: An Act relating to psychologists' services.
Sponsor: Sturgulewski and Kerttula
Requestor:

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0	29.5	29.5	29.5	29.5	29.5
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	66.5	67.6	69.5	71.5	73.5
SUPPLIES	0	1.5	1.5	1.5	1.5	1.5
EQUIPMENT	0	5.4	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	291.2	644.5	713.4	789.6	874.0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	394.1	743.1	813.9	892.1	978.5
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	189.2	356.0	390.9	429.5	472.1
FEDERAL FUNDS	0	204.9	387.1	423.0	462.6	506.4
OTHER	0	0	0	0	0	0
TOTAL	0	394.1	743.1	813.9	892.1	978.5

POSITIONS:

FULL-TIME	0	1	1	1	1	1
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, SB No. 29 has no effective date. The starting date of the addition of psychologists' services to the Medicaid Program is assumed to be January 1, 1990.

Prepared by: Kimberly B. Buscher
Phone: 465-3355
Division: Division of Medical Assistance
Date: 3/21/89

Approved by Commissioner: Myra M Munson
Date: 3/21/89
Agency: Dept. of Health & Social Services

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

SB No. 29
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 FY90 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 FY90 is 5,000, assuming that January 1, 1990 start date. FY90 processing costs = 31.2. Claims volume increases by 3% each year, but the $6.23 per claim cost will not increase. All costs of claims processing are 75% FED, 25% SGFM.

II. Personnel and Related Costs

The Medical/Surveillance and Utilization Review Unit (SURS) has six staff, including a medical doctor, two RN's, a health planner and a research analyst. The unit has a dual focus:

1. Medical review, which is primarily prior authorization of specific medical services which often require extensive verbal and/or written exchange of information.

2. Pre-payment and post-payment review of claims, a review which often requires extensive verbal and/or written exchange of information.

Prior to completion of the Medicaid Management Information System (MMIS), the Division did not have a dedicated Surveillance and Utilization Review Unit. The staff responsible for medical review received clerical support from the Clerk Typist III, which also supported the nine staff in the system management unit. The addition of the increased claims volume and the associated required medical review functions necessitates the addition of a dedicated Clerk Typist III to the SURS/Medical Review Unit to provide efficient support to the unit. The dedicated clerical support will provide typing, filing, phone/reception, travel, supply, MMIS and Alaska State Accounting System (AKSAS) report monitoring and distribution, and MMIS system change order preparation and monitoring. This position will require a personal computer to function effectively.

This position and supporting costs are requested in the FY90 budget to cover the current and projected needs of the unit. If that request is granted, the amount indicated for this position can be deleted from this fiscal note.

		FY90	FY91	FY92	FY93	FY94
Personal Services						
Clerk Typist III (PFT) Range 8/A ($1631/mo. plus $549 benefits)		29.5	29.5	29.5	29.5	29.5
Travel		-0-				
Contractual						
Communications	.5					
Risk Management	.3					
Office space	4.5					
Total Contractual		5.3	5.3	5.3	5.3	5.3
Supplies		1.5	1.5	1.5	1.5	1.5
Equipment						
Microcomputer Hardware & software	4.0					
Desk, chair, file cabinet & bookcase	1.4					
Total Equipment		5.4	-0-	-0-	-0-	-0-
TOTAL		41.7	36.3	36.3	36.3	36.3

These costs are 50% FED, 50% SGFM.

III. 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, and this number will not increase in future years.

(2) Approximately 24 of these new providers are currently providing services indirectly, supervised by and/or billing through a 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) Approximately 26 new providers will enroll, psychologists in private practice who are not currently serving Medicaid recipients. 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.

(4) 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.

(5) $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, 1990. FY 90 costs will therefore be 50% of a full year:

145.6	SGFM
145.6	Fed
291.2	Total

(b) Costs for FY91 through FY94 are computed from the FY90 base estimate, increased each year by 3% for increases in utilization and by 7.46% for the costs of service. (7.46% is the percentage change in the Anchorage CPI from 1988 to 1989.)

Once a full year of data is available, future costs of this option can be influenced by further regulating the maximum amounts Medicaid will pay for each type of service and by imposing service maximums, such as per-client caps on total dollar usage of a particular service in any calendar year. Most states offering this coverage impose such controls. However, the states we contacted confirmed that, as is true in Alaska, mental health services utilization and costs tend to increase more rapidly than any other Medicaid services, and even stringent controls can do little more than retard this growth.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

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

FISCAL NOTE

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. Busch
Phone: 465-3355
Division: Division of Medical Assistance
Date: 2-13-90

Approved by Commissioner: Bruce Tangeman
Date: 2-16-90
Agency: Department of Health and Social Services

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 FY 92 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).

Senate Health, Education and Social Services Committee

Senator Paul Fischer, Chairman

Senator:

According to Occupational Licensing, the Dept. of Commerce has 147 current Licensed psychologists.

Out of 147 licensed psychologists, 19 are licensed to work as Psychological Associates.

H&SS

The Department accounts for only 50 psychologists to enroll as providers in the first year.

Of this figure of 50 new providers, they claim that 24 are currently enrolled.

The actually number, or potential number of psychologists able to enroll if far greater than what is stated in the fiscal note.

DCM 3/20/90

Senate Health, Education and Social Services Committee

Senator Paul Fischer, Chairman

SB 29

Dr. Russell Huffman

P.O. Box 9435

Ketchikan, AK 99901

225-8900

1. No oversight or Accountability.

2. Disclaimers before treatment

3. Telecommunications Act.

4. State Medical Act.

the division before admission to the hospital; failure to obtain authorization will result in nonpayment regardless of the eligibility of the recipient or the appropriateness of the services.

(b) Except as provided in this subsection, the division will not pay for more than one physician visit in a 30-day period for a patient in either a skilled nursing or an intermediate care facility. The division will, in its discretion, pay for additional visits if written justification, acceptable to the division, accompanies the bill for the physician visit. (Eff. 8/18/79, Register 71; am 3/25/83, Register 85; am 7/1/85, Register 95; am 9/25/85, Register 95)

Authority: AS 47.05.010
AS 47.07.030
AS 47.07.050

7 AAC 43.120. X-RAY SERVICES. Diagnostic and follow-up X-rays do not require prior approval by the division, but films must be made available to the division on request. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010
AS 47.07.030
AS 47.07.050

7 AAC 43.125. LABORATORY SERVICES. (a) A physician using his or her own laboratory to provide necessary laboratory services will be reimbursed according to the medicare fee schedule in 42 C.F.R. 405.515.

(b) A physician using the services of an independent laboratory shall request services for a recipient in the same manner that services are requested for a private patient.

(c) An independent laboratory certified by the department, or certified by the state medicaid agency or medicare if located out-of-state, may bill the division directly. Reimbursement for clinical laboratory tests will be made by the division according to the medicare fee schedule in 42 C.F.R. 405.515. (Eff. 8/18/79, Register 71; am 3/30/88, Register 106)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.130. PSYCHIATRIC SERVICES. (a) Payment to a physician for psychotherapy services will be provided without prior authorization for services to recipients on an outpatient basis.

(b) Services by a psychologist, social worker or nurse are not covered outside of a psychiatric facility or general hospital except when provided through a community mental health clinic enrolled as a provider in the medicaid program. (Eff. 8/18/79, Register 71)

(b) If the department provides or pays for medical assistance for injury or illness under this title, the department is subrogated to the rights of the recipient of that medical assistance for any claim arising from the injury or illness and to the proceeds of an insurance policy covering the injury or illness to the extent of the value of the medical assistance provided.

(c) If a recipient of medical assistance under this title settles a claim or obtains an award of judgment arising from the injury or illness for which the medical assistance was received, the department shall reimburse the recipient for attorney fees and costs commensurate with the amount of the settlement, award, or judgment to which the department is entitled under (b) of this section. Regardless of the manner in which the amount of the attorney fees is derived, reimbursement of attorney fees shall be in accordance with the applicable rules of court governing the award of attorney fees in civil matters.

(d) The department is authorized to enter into contracts for the collection of medical expenses already paid by Medicaid from potential third-party payors. The department may pay, from the funds recovered by the contractor, any amounts owing to the federal government as its share of the Medicaid paid claim, and the costs of collecting the funds. (§ 2 ch 105 SLA 1986)

Chapter 07. Medical Assistance for Needy Persons.

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children) or 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income);

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for

assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, 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;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal aid to families with dependent children program;

(10) 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.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b) (4) of this section, a person is not eligible for medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act). (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA

1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988)

Effect of amendments. — The 1986 amendment in subsection (b) in paragraphs (3), (5) and (7) substituted "age 21 who are" for "21 years of age," in paragraph (8) substituted "age 21 and not covered under (a) of this section," for "21 years of age" and "except that they have the care and support of both their natural and adoptive parents" for "but who do not qualify because they are not dependent children," in paragraph (9) deleted "women who are" at the beginning of the paragraph and added the language beginning "women not covered," made minor punctuation changes in paragraph (3), inserted "and" following "mentally retarded" in paragraph (5), and inserted "and" following "psychiatric hospital" in paragraph (7).

The 1988 amendment inserted subsection (b)(10).

Sec. 47.07.030. Medical services to be provided. (a) The department shall offer all mandatory services required under 42 U.S.C. 1396 — 1396p (Title XIX of the Social Security Act).

(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; 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. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982; am § 1 ch 20 SLA 1986; am § 4 ch 105 SLA 1986; am § 2 ch 119 SLA 1988)

Cross references. — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted "case management and nutrition services for pregnant women" in subsection (b).

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) 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) physical therapy;
(11) personal care services in a recipient's home;
(12) long-term care noninstitutional services;
(13) inpatient psychiatric facility services;
(14) intermediate care facility services for the mentally retarded;
(15) intermediate care facility services;
(16) 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;
(17) 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;
(18) skilled nursing facility services for persons under age 21;
(19) 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;
(20) 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;
(21) 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. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986; am § 3 ch 119 SLA 1988)

Cross references. — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted present paragraph (16) and redesignated former paragraphs (16)-(20) as present paragraphs (17)-(21).

MEDICAID SERVICES STATE BY STATE

October 1, 1987

Basic Required Medicaid Services

Medicaid recipients receiving federally supported financial assistance must receive at least these services

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Other laboratory and X-ray services
- Skilled nursing facility services and home health services for individuals 21 and older
- Early and periodic screening, diagnosis, and treatment for individuals under 21
- Family planning services and supplies
- Physician services
- Nurse Midwife services

Federal financial participation is also available to States electing to expand their Medicaid Programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on the chart.

Optional Services in State Medicaid Programs

• CN
• Both CN and MN[1]

FMAP	Basic Required MN-Based Services Set Above		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitation Services	Services for Age 65 or Older in Mental Institution: A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Services for Under Age 22	Christian Science Nurses	Christian Science Sanatoria	SNF for under Age 21	Emergency Hospital Services	Personal Care Services	Transportation Services	Case Management Services	Hospice Services	Total Additional Services	
72.29	•	Alabama		•				•					•			•													•	•	•			10	AL
50.00	•	Alaska		•	•			•	•	•	•	•	•			•	•				•								•	•	•	•			16	AK
50.00		American Samoa[2]																																		AS
63.13	•	Arizona[3]	•	•				•	•	•		•	•	•	•	•													•		•			12	AZ
74.21	•	Arkansas		•	•	•		•	•				•	•	•	•				•	•	•	•	•	•	•			•	•	•	•		21	AR
50.00	•	California	•	•	•	•	•	•	•	•	•	•	•	•	•	•				•	•	•	•	•	•	•	•	•	•		•			26	CA
50.00	•	Colorado	•	•		•		•	•				•			•					•	•	•	•	•	•			•		•			14	CO
50.00	•	Connecticut	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•		•				24	CT
51.95	•	Delaware	•	•		•	•	•					•		•		•				•	•	•	•	•	•			•	•	•				16	DE
50.00	•	DC	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			•	•	•				26	DC
55.38	•	Florida	•	•		•		•	•				•	•	•	•				•	•			•	•	•			•		•		•		13	FL
63.84	•	Georgia	•	•		•		•	•				•	•	•	•		•						•	•	•			•		•	•			15	GA
50.00	•	Guam		•	•			•	•				•		•														•						6	GU
53.71	•	Hawaii	•	•				•	•	•	•	•	•	•	•	•	•	•	•	•				•	•	•			•		•				23	HI
70.67	•	Idaho	•	•	•	•		•	•				•							•			•	•	•	•			•	•	•				14	ID
50.00	•	Illinois	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•	•			•		•				26	IL
63.71	•	Indiana	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			•	•	•	•	•	•	•	•				25	IN
60.79	•	Iowa	•	•	•	•		•	•	•	•	•	•	•	•	•	•			•	•			•	•	•			•		•				22	IA
53.36	•	Kansas	•	•	•	•		•	•	•	•	•	•		•	•	•			•	•		•	•	•	•			•	•					21	KS
72.27	•	Kentucky	•	•		•		•	•	•	•	•	•		•		•	•	•	•	•	•	•	•	•	•			•	•	•		•		24	KY
49.36	•	Louisiana		•				•	•				•	•	•					•	•			•	•	•			•			•			14	LA
67.08	•	Maine	•	•	•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•			•	•	•	•	•	•		•	•			17	ME
50.00	•	Maryland	•	•				•	•	•		•	•	•	•	•				•				•	•	•			•	•	•				18	MD
50.00	•	Massachusetts	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•				31	MA
56.45	•	Michigan	•	•	•	•		•	•	•	•	•	•	•	•	•				•	•	•	•	•	•	•			•	•	•	•	•		28	MI
53.98	•	Minnesota	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			•	•	•		•		26	MN
79.86	•	Mississippi						•	•				•		•	•			•	•								•	•	•	•				14	MS
58.37	•	Missouri	•	•				•	•				•	•	•	•				•	•			•	•	•			•		•				14	MO
68.45	•	Montana	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			•	•	•	•			17	MT
50.72	•	Nebraska	•	•	•	•	•	•	•	•		•	•	•	•	•				•	•	•	•	•	•	•			•	•	•				23	NE
50.25	•	Nevada	•	•	•	•	•	•	•	•	•	•	•	•	•	•				•	•	•	•	•	•	•			•	•	•	•			16	NV
50.00	•	New Hampshire	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•		•	•	•	•	•	•	•	•	•	•			28	NH
50.00	•	New Jersey[4]	•	•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•			26	NJ
71.53	•	New Mexico	•	•		•		•	•	•			•	•	•	•				•				•	•	•			•	•	•				16	NM
50.00	•	New York	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			•	•	•			•	•	•	•			26	NY
68.66	•	North Carolina	•	•	•			•	•				•	•	•	•	•	•	•	•	•		•	•	•	•			•	•	•	•			22	NC
64.87	•	North Dakota	•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			•	•	•			•	•	•		•		20	ND
50.00	•	N. Mariana Islands		•				•	•	•			•	•	•	•													•	•	•				11	MP
50.10	•	Ohio	•	•	•	•	•	•	•	•	•	•	•	•	•	•				•	•	•	•	•	•	•		•	•	•	•	•			26	OH
63.33	•	Oklahoma	•	•		•		•	•				•	•	•	•		•		•	•			•	•	•			•	•	•				17	OK
63.11	•	Oregon	•	•	•	•	•	•	•	•	•	•	•	•	•	•				•	•			•	•	•		•	•	•	•				20	OR
57.36	•	Pennsylvania	•	•	•			•	•				•	•	•	•				•	•	•	•	•	•	•			•	•	•				17	PA
50.00	•	Puerto Rico						•																											1	PR
54.86	•	Rhode Island	•	•					•				•	•	•	•				•	•	•	•	•	•	•			•	•	•				17	RI
72.46	•	South Carolina	•	•				•	•				•		•	•				•	•	•	•	•	•	•			•	•	•				17	SC
70.43	•	South Dakota			•			•	•	•		•	•	•	•	•				•	•	•	•	•	•	•			•	•	•	•			17	SD
70.64	•	Tennessee						•	•				•		•					•	•	•	•	•	•	•	•		•	•	•				18	TN
56.81	•	Texas	•	•	•	•							•		•	•				•				•	•	•		•	•	•	•				18	TX
72.73	•	Utah	•	•		•		•	•	•		•	•	•	•	•				•	•	•	•	•	•	•			•	•	•	•	•		22	UT
64.23	•	Vermont	•	•	•	•		•	•	•	•	•	•		•	•				•	•		•	•	•	•			•	•	•	•	•	•	24	VT
50.00	•	Virgin Islands[5]						•																											1	VI
51.34	•	Virginia	•	•				•	•	•	•	•	•		•					•	•	•	•						•	•	•				17	VA
53.21	•	Washington	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			•	•	•	•	•	•	•			•	•	•	•			26	WA
74.84	•	West Virginia	•	•	•	•	•	•	•	•		•	•	•	•	•	•			•	•	•	•	•	•	•			•	•	•	•			26	WV
58.95	•	Wisconsin		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•				•	•	•		•	•	•	•	•			27	WI
57.88	•	Wyoming		•				•		•			•		•					•	•														6	WY
•	15	•	10	15	8	8	5	10	10	8	4	7	14	10	13	13	4	4	4	8	10	10	11	21	10	10	1	4	17	14	8	12	1	6		
•	40	•	32	31	20	26	15	36	36	27	21	26	37	27	36	34	17	16	17	29	24	11	18	29	26	27	4	12	30	25	15	33	14	6		
	55	Total	42	51	28	35	20	52	46	35	25	33	51	37	49	47	21	16	21	37	34	21	29	50	36	37	5	16	47	44	23	45	15	6		

Federal Medical Assistance Percentage (FMAP) Rate of Federal Financial Participation in a States Medical Assistance Program under Title XIX of the Social Security Act. Effective October 1, 1987 through September 30, 1988 (Fiscal Year 1988)

[1] Categorically Needy: Individuals receiving federally supported financial assistance

Medically Needy: Individuals who are eligible for medical but not for financial assistance

[2] American Samoa operates a special Medicaid waivered program

The data shown were supported by individual Regional Offices and compiled by the Office of Intergovernmental Affairs.

HCFA Pub. No. 03159-84

[3] Arizona operates a federal assistance program under a Section 1115 Demonstration Project

[4] All services are provided through public health facilities

[5] Services indicated as available to the Medically Needy are not available to all Medically Needy Groups

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Intergovernmental Affairs

Other States

ARKANSAS continued

mental health clients. In addition, he/she evaluates quarterly treatment plans for each client. The MD psychiatrist is the one ultimately responsible for the quality of treatment each client receives at the mental health center.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital (see inpatient).
- SNF.
- ICF.

INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR INDIVIDUALS UNDER 22

- Provided with limitations—Patients must be certified as needing intensive psychiatric care by an independent team as mandated in federal regulations.

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* Includes coverage for the medically needy. However, SNF, ICF, are not included under this group.

Mental Health Benefits Under Medicaid

January 1984

Intergovernmental Health Policy Project
George Washington University
Washington, D.C.

CALIFORNIA

INPATIENT HOSPITAL

- Patients over 65 in institutions for mental diseases—No limits.
- Inpatient general hospital including psychiatric units—Limitations on length of stay are set by the state's Hospital Length of Stay Schedule unless additional stay authorized; authorized extentions of up to 1 month for acute care; nonemergency care requires prior authorization; emergency care must obtain authorization on the day of admission or 1st working day thereafter.

OUTPATIENT HOSPITAL

- Psychology services—Limited to a maximum of two services, or as part of any combination of 2 services per month. Services include: psychodiagnostic testing; individual, group, and family therapy; medication; crisis intervention; and day care (day care intensive or day care habilitative).

PHYSICIAN SERVICES

- More than 8 psychiatric visits in a 120-day period require prior authorization except in emergencies.

NONPHYSICIAN SERVICES

Psychologists—With limitations noted in outpatient section.

CLINIC SERVICES

- In California there are two paralled publicly funded mental health systems. One is the fee-for-service Medi-Cal System (Title XIX) administered by the State Department of Health Services. California's other system is the Short-Doyle System administered by the State Department of Mental Health. Specified medically supervised outpatient services rendered to Medi-Cal eligibles by certified clinics or licensed hospitals directly operated by or under contract with the county government and approved by the department are paid for by Short-Doyle/Medi-Cal. Identical services rendered to noneligibles are paid for by the state (90 percent) and county (10 percent) government. A broad range of mental health rehabilitation services are offered to both Medi-Cal eligibles and noneligibles by county-operated and contract providers. These services are underwritten in their entirety by state and county general funds.
- Mental health clinics certified by the Department of Health Services—Basic services include:

a) psychiatric/psychological diagnosis;
b) prescription of psychotropic medications;
c) individual and/or group therapy.

continued on next page

[redacted] Indicates states with Medicaid reimbursement for psychologists

CONNECTICUT

INPATIENT HOSPITAL

- Acute care and psychiatric care in a general hospital—no limits.

OUTPATIENT HOSPITAL

- Services include: psychiatric clinic; psychiatric evaluation; psychiatric day care; psychiatric night care; individual, group and family therapy; psychiatric testing; and electric shock treatment.
- All services require prior authorization in excess of 13 visits in a 90-day period.

PHYSICIAN SERVICES

- Psychiatric evaluation limited to 1 a year.
- Psychiatrists' services limited to 1 visit a day for the same service.

NONPHYSICIAN SERVICES

- Independent Psychologists (Ph.D.)
  - —Diagnostic testing and psychotherapy; limited to 1 visit a day for the same service and 1 psychodiagnostic test of the same type a year.
  - —Counselling and therapy services require prior authorization if treatment plan exceeds 13 visits in a 90-day period.
  - —MD supervision is not required.

CLINIC SERVICES

- Freestanding Mental Health Clinics for Adults 18 and Over—licensed by the Connecticut State Department of Health to provide mental health services.
  - —Service providers: psychologists, psychiatric nurses, psychiatric social workers, and mental health counselors may provide services under the direction of a psychiatrist.
  - —Services include: initial diagnosis; individual group and family psychotherapy; methadone maintenance treatment program.
  - —Limitations: group, family and individual therapy limited to 1 visit a day for the same service; prior authorization required for psychotherapy if treatment plan exceeds 13 visits in 90 days; methadone maintenance programs limited to payment of 1 clinic visit a week regardless of the number of daily clinic visits; maximum of 8 persons per group session.
- Freestanding Mental Health Clinics for Children—Providing psychiatric services for children and their families. Administered by the Connecticut State Department of Children and Youth Services.
  - —Service providers: psychologists, psychiatric nurses, psychiatric social workers, and mental health counselors may provide services under the direction of a psychiatrist.
  - —Services include: In addition to services included for adult clinics—parent interviews in connection with a child's diagnosis and treatment.
  - —Limitations: Same as adult clinics.
- Rehabilitation Centers
  - —Must be licensed by the state and meet federal requirements for 42 CFR 440.90. Psychological/psychiatric services may include evaluation, individual and group psychotherapy related to medical rehabilitation. Prior authorization is required for all treatment services.

DELAWARE*

INPATIENT HOSPITAL
- Patients 65 and older in IMD—no limits.

OUTPATIENT HOSPITAL
- No limits.

PHYSICIAN SERVICES
- No limits.

NONPHYSICIAN SERVICES
- None provided applicable to mental health care.

CLINIC SERVICES
- Provided—none applicable to mental health.

SERVICES FOR OVER 65 FOR MENTAL DISEASES
- Hospital.
- SNF and ICF not provided.

* Categorically needy only. No medically needy program.

DISTRICT OF COLUMBIA

INPATIENT HOSPITAL
- Patients 65 or older in IMD when recommended by a psychiatrist.
- Acute hospital—after 30 days patients transferred to IMD.

OUTPATIENT HOSPITAL
- All psychiatric and psychological services provided by D.C. Medicaid approved outpatient hospital clinic are covered.

PHYSICIAN SERVICES
- Ambulatory psychiatric care requires prior authorization if it is not provided in an approved psychiatric clinic.

NONPHYSICIAN SERVICES
- None provided applicable to mental health care.

CLINIC SERVICES
- Free standing Mental Health Clinics certified by D.C Department of Human Services—Reimbursable services include: a) individual psychotherapy; b) prescription visit; c) family therapy; d) family conference; e) complete psychological testing; f) group therapy.
- M.D. must certify services medically necessary and a treatment plan must be established by a physician or other qualified mental health professional which is periodically reviewed and approved by M.D.

SERVICES FOR OVER 65 FOR MENTAL DISEASES
- Hospital—must have a recommendation by psychiatrist.
- SNF and ICF not provided.

OTHER DIAGNOSTIC, PREVENTIVE, AND REHABILITATIVE SERVICES
- Other than those provided elsewhere in the program.
- Prior authorization is required.
- Performed in freestanding Mental Health Clinics, IMD, or by private physician.

INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 21 OR UNDER 22 IF CONFINED BEYOND 21ST BIRTHDAY
- Provided—no limitations.

FLORIDA*

INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- General hospital—up to 45 days per individual per fiscal year, July 1-June 30, in a participating hospital. Initial length of stay authorized based on PAS limits by diagnosis or based on a review system approved by HHS. Additional days may be authorized by hospital's utilization review committee if deemed medically necessary.

OUTPATIENT HOSPITAL

- Must be under direction of physician—up to $500 per eligible individual per fiscal year to include preventive, diagnostic, therapeutic or palliative care.
- Emergency room service and clinic visits are reimbursable for most diagnostic codes indicating "mental disorders."

PHYSICIAN SERVICES

- Limited to those psychiatrists who have been approved by Medicaid to provide services under the following specialties: psychiatry, child psychiatry, and psychoanalysis. Services must be personally rendered by psychiatrist with the exception of ancillary psychological testing.

NONPHYSICIAN SERVICES

- Advanced registered nurse practitioners (ARNP) may deliver and be reimbursed directly for limited services under protocols developed collaboratively between the ARNP and the physician. Reimbursable services are limited to one ARNP contact a day per recipient except for emergency services.

CLINIC SERVICES

- Limited to psychiatric services by or under the direction of a board-eligible or board-certified psychiatrist. Provider eligibility is limited to community mental health centers/clinics and comprehensive alcoholism treatment centers (defined by state law), and contracted with the state to provide mental health services in the community.
- Services include: day/night services; crisis intervention; individual therapy; multiclient therapy (i.e., group, family, psychodrama); vocational rehabilitation and counseling; sheltered workshop; social rehabilitation; psychiatric, psychological, psychoeducational, developmental, and psychosocial evaluations; precare and after care services.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital (see inpatient hospital).
- SNF and ICF not provided.

* Categorically needy only. No medically needy program

GEORGIA

INPATIENT HOSPITAL

- Payment for inpatient hospital services is limited to a per case rate. On January 1, 1983, the Georgia Department of Medical Assistance began implementing a prospective reimbursement system that provides a flat average payment per case to a hospital.

OUTPATIENT HOSPITAL

- Must be prescribed or (in the case of emergency room services) determined to be medically necessary by an MD for preventive, diagnostic, therapeutic, rehabilitative, or palliative care.

PHYSICIAN SERVICES

- Numerous limitations; however, none are applicable to mental health care.

NONPHYSICIAN SERVICES

- Psychologists-psychotherapy limited to that provided by licensed psychologist on written referral of osteopath, physician, or casework agency. Psychological services cannot exceed 5 hours of evaluation and testing, and/or therapy per recipient per calendar year. Diagnostic interviews also covered.
- Services not covered: school psychologists regulated by State Board of Education; sensitivity training, encounter groups, or workshops; sexual competency training; education testing and diagnosis; marriage counseling; biofeedback; hypnotherapy; transcutaneous nerve stimulation.
- Psychologists' services are subject to the following copayments: 50 cents on service costs of $10 or less; $1 on service costs of $11-$25; $2 on service costs of $26-$50; and $3 on service costs of $51 or more.

CLINIC SERVICES

- Limited to services in: qualified outpatient mental health clinics, excluding payment for medication monitoring; and services in qualified family planning clinics. Covered services include: diagnostic assessment; partial hospitalization; day treatment; methadone maintenance; ambulatory detoxification; nursing assessment and care; physical, speech, hearing and occupational therapies; activity therapy; medication administration; individual, family, group and crisis therapy; and crisis management.
- Not covered: mental health services provided by community mental health centers to patients at their residences or in SNFs, ICFs and residential care facilities.

* Categorically needy only. No medically needy program.

HAWAII

INPATIENT HOSPITAL

• Inpatient hospital admission for psychiatric care is initially authorized for 10 days. Approval for extension of hospital stay for psychiatric care is limited to 18 days. Prior authorization is required for nonemergency admission.

OUTPATIENT HOSPITAL

• Outpatient psychiatric services are initially authorized for 4 visits during a 12 month period. Additional visits may be provided following the approval of an extension request.

PHYSICIAN SERVICES

• Provided with limitations however, none are applicable to mental health care.

NONPHYSICIAN SERVICES

• Clinical Psychologists—require referral by the attending physician for testing or for treatments. Testing is limited to emotional disorder, brain damage, mental retardation, or other special purposes and requires prior authorization.

CLINIC SERVICES

• Same limitations as outpatient psychiatric services.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• Hospital, SNF and ICF are not provided.

OTHER DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVIVES

• Other than those provided elsewhere under the program.

IDAHO*

INPATIENT HOSPITAL

• Length of stay in general hospital is subject to professional review for appropriateness and necessity, but may not exceed 40 days per year.

OUTPATIENT HOSPITAL

• All psychiatric and psychological services listed under CLINIC SERVICES are covered in this setting. The same limitations which apply to clinic services apply to outpatient hospital.

PHYSICIAN SERVICES

• Provided with limitations. Mental health services subject to same limitations which apply to clinic services.

NONPHYSICIAN SERVICES

• None provided applicable to mental health care.

CLINIC SERVICES

• Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients by or under direction of M.D.

• May include services provided by community mental health centers which meet the standards and guidelines of the Federal Comprehensive Community Mental Health Act, and by private clinics under the direction and supervision of a physician.

• Mental health clinic services are limited as follows: a) psychotherapy to 45 hours per calendar year; b) partial care services treatment to 30 hours a week; and c) evaluation and diagnostic services are limited to 12 hours per calendar year.

• Above services may also be provided by Adult and Child Development Centers.

• Other mental health professionals covered and reimbursed by clinic include:

—Psychologist—Ph.D., Ed.D., M.A./M.A.
—Social Worker—Licensed Certified, Licensed.
—Psychiatric Nurse—R.N.
—Mental Health Rehabilitation Specialist
—Registered Occupational Therapist—O.T.R. (partial care services only).

OTHER DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

• Medical/social and psychological evaluations (limited to 12 hours per calendar year).

• Psychotherapy services (limited to 45 hours per calendar year).

• Developmental and occupational therapy (limited to 30 hours a week).

* Categorically needy only. No medically needy program.

ILLINOIS

INPATIENT HOSPITAL

• Psychiatric care in general hospital cannot exceed an initial 20 consecutive days, except that a hospital not enrolled to provide this care can provide it for up to 72 hours in emergencies. Days of care beyond 20 require prior approval. Prior approval will not be granted unless psychiatrist certifies that recipient is actively homicidal or suicidal.

• Payment for all types of covered general hospital care cannot exceed the number of days approved for the recipient's care by the appropriate utilization review authority. Day of admission covered but day of discharge is not.

• Patients 65 or over in IMD-no limits.

OUTPATIENT HOSPITAL

• No limits.

PHYSICIAN SERVICES

• Reimbursable psychiatric procedures include:
Medical psychotherapy; continuing medical/psychiatric diagnostic evaluation and psychotropic drug management; supervision and management of the patient's treatment program; relevant communication with significant others and psychiatric consultation; must be personally provided by physcian who submits charges allowed for single service provided on a given day.

NONPHYSICIAN SERVICES

• Psychological services limited to:* (a) psychological examinations & tests to determine disability or incapacity when there is a question of mental illness or defect; (b) an examination needed to determine the suitability of a home for a child, or (c) an examination required for planning or arranging for foster care for a child.

• Payment for these purposes is made to a psychologist in private practice or to state aided community mental health center.

*Those necessary to administer the Medicaid program and initiated at request of the Medicaid agency.

CLINIC SERVICES

• Psychiatric clinics—services include control of medication, individual therapy, family therapy, group therapy, counseling, electric shock treatment, and diagnostic evaluation. Payment is made on a fee-for-service basis to enrolled psychiatrist.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• Hospital
• SNF
• ICF

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR UNDER 21 OR 22 IF CONFINED BEYOND 21st BIRTHDAY

• Active care in JCAH-accredited facilities

INDIANA*

INPATIENT HOSPITAL

• Patients 65 or older in IMD—Admission subject to prior review and authorization by the Department of Public Welfare. Attending staff physician must recertify, in writing every 60 days, the need for inpatient psychiatric hospital services.

• No limits for acute care in general hospital. Same for phychiatric units.

OUTPATIENT HOSPITAL

• Same services and limits as listed under clinic services.

PHYSICIAN SERVICES

• No limits wherever furnished.

NONPHYSICIAN SERVICES

• Psychologists certified for independent practice.

• Payment made for diagnostic services subject to prior review and authorization. However, prior approval is not required for initial evaluation or for psychiatric testing by psychologist certified for independent practice. Prior approval is required for ongoing psychotherapy.

CLINIC SERVICES

• Outpatient mental health centers provide group and individual outpatient psychiatric/psychological testing and evaluation, when services are provided by a physician, a certified psychologist, or an ACSW social worker. Psychiatrist directing service provision must be on site a minimum of 50% of the time. The psychiatrist is responsible for diagnosis and establishing a plan of treatment and for supervising the execution of that plan. He/she is responsible for seeing the recipient during the intake process and again at intervals not to exceed 60 days. Services subject to prior review and authorization. No prior approval required if physician provides service directly.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• Hospital.

• SNF and ICF not provided.

OTHER DIAGNOSTIC, PREVENTIVE, AND REHABILITATIVE SERVICES

• Other than those provided elsewhere in the program.

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 21, OR UNDER 22 IF CONFINED BEYOND 21ST BIRTHDAY

• Plan of care must be developed by interdisciplinary team. Each plan must be updated, in writing, at least every 30 days by the team.

* Categorically needy only. No medically needy program.

IOWA*

INPATIENT HOSPITAL

• Patients 65 or older in IMD—Facility must be licensed by health department to provide inpatient psychiatric care and certified to participate in Medicare.

• No limit on acute care in general hospital except medical necessity. Same for psychiatric units.

OUTPATIENT HOSPITAL

• Medically necessary psychiatric or psychological services normally provided in an outpatient setting. No specific limitations.

PHYSICIAN SERVICES

• Provided with limitations. No mention of psychiatric services.

NONPHYSICIAN SERVICES

• Reimbursement for psychologists' services, who practice independently and do not require M.D. supervision, and who meet the qualifications of the National Register of Health Care Providers in Psychology include:

—individual outpatient psychotherapy or other psychological procedures, not to exceed 1 hour a week or 40 hours per calendar year;

—couple, marital, family, or group outpatient therapy, limited to 1½ hours a week or 60 hours during a calendar year;

—a combination of individual and group therapy may not exceed the cost of 40 individual therapy hours during a calendar year; and

—psychological examinations and testing for purposes of evaluation, placement, psychotherapy, limited to 8 hours during a calendar year.

• Reimbursement for psychologists and social workers are also covered when there is a direct personal supervision by the physician and an employment relationship exists between the physician and the psychologist or social worker. Psychologist's services may be provided in the psychologist's office, the hospital or intermediate or residential care facility. Services in this category would be those incident to a physician.

CLINIC SERVICES

• Community mental health centers that meet the standards of Iowa Mental Health Commission—Includes reasonable and necessary services performed by a psychiatrist, psychologist, social worker, or psychiatric nurse, supervised by the psychiatrist, all of whom are on the staff at the center. Initial patient evaluation must be made by the psychiatrist before submission of first claim. Within 4 weeks of the initial evaluation, the evaluation-therapist and psychiatrist must meet to delineate the diagnosis, treatment needs, and

continued next page

IOWA continued

treatment plan. This must be recorded by the primary therapist and countersigned by psychiatrist and placed in patient's permanent record. Every 4 months thereafter the psychiatrist and primary therapist must review the case to evaluate and revise or change the treatment plan as necessary. The center must report additions or losses of professional staff to the fiscal agent within 10 days.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital—See inpatient hospital.
- SNF and ICF not provided.

OTHER REHABILITATIVE SERVICES

- Social and vocational adjustment counseling for problems arising from the patient's illness or injury provided by psychologists, social workers or professional vocational specialists under employment or supervision of M.D., hospital, home health agency or other providing agency.

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 21, OR UNDER 22 IF CONFINED BEYOND 21ST BIRTHDAY

- JCAH facility—No limitations.

• Categorically needy only. No medically needy program.

KANSAS

INPATIENT HOSPITAL

- Psychiatric care in general hospital limited to 14 days per admission unless preauthorized, as determined by the utilization review committee.
- Patients 65 or older in IMD—No limit.

OUTPATIENT HOSPITAL

- Partial hospitalization limited to 168 hours per calendar quarter.

PHYSICIAN SERVICES

- Limited to 2 hours of psychiatric office visits a month unless in EPSDT program. There can be 3 hours a month for up to 2 years of more extensive psychiatric care by prior authorization for children under EPSDT.
- Psychological testing and evaluation may not exceed 6 hours in any 2 consecutive calendar years and must have prior authorization except 3 hours per year is allowed without prior authorization for admission.
- $1 copayment per visit for these services.

NONPHYSICIAN SERVICES

- Psychologists: program covers limited psychological services by psychologist certified by the Behavioral Science Regulatory Board.

—*Psychological Office Visits*—May not exceed 2 hours of individual therapy, or 2 hours of group therapy, or any combination of these a month unless the recipient is a participant in EPSDT and psychological services do not exceed 3 hours a month. Up to 2 years of more extensive care is provided for EPSDT children under a plan of care. Prior authorization is required for the plan and is subject to a reimbursement limit established by the Secretary. Quarterly progress reports must be submitted to the Division of Medical Programs upon request.

—*Inpatient Hospital*—Limited to those ordered by recipient's physician and may not exceed the allowable days for which the hospital is paid or would be paid except for spend-down requirements.

—*Adult Care Home Visits*—Limited to psychological testing and evaluation and must be ordered by the recipient's physician as a part of the plan of care. Psychological testing and evaluation shall not exceed 6 hours per recipient in any 2 consecutive calendar years, and prior authorization is required, except for the first two hours for admission without prior authorization.

CLINIC SERVICES

- Community mental health clinics must be approved by Medicaid program. Provide inpatient, outpatient, partial hospital, screening, and after

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MAINE*

INPATIENT HOSPITAL

• Acute hospital limited to 30 days; extensions require prior authorization; same limit for psychiatric care.

OUTPATIENT HOSPITAL

• Same coverage and limitations as those services provided in mental health clinics. (See clinic services below.) Outpatient units do not have to meet licensing requirements by the Bureau of Mental Health.

PHYSICIAN SERVICES

• Daily hospital care visits by psychiatrist are provided as medically necessary. Other services are limited to 5 in any consecutive 7 days. If 2 covered services are provided in 1 day, only the highest payment rate of the 2 services is reimbursed.

NONPHYSICIAN SERVICES

• Psychological services include those provided in accordance with a plan of care by a psychologist or psychological examiner, as listed in the state manual. Same limitations as those provided in mental health clinic services.

CLINIC SERVICES

• Mental health clinics must be licensed at the comprehensive service level by the Bureau of Mental Health.

• Service providers include psychiatrists, psychologists, psychological examiners, social workers, and psychiatric nurses.

• Limitations: Services must be provided by or under the direction of a psychiatrist and are limited to diagnosis and treatment of mental, psychoneurotic, or personality disorders. Services are limited to 1 hour a day up to 5 times a week, with the following exceptions: a) psychometric testing is provided up to 4 hours and the 1 hour a day limitation does not apply when such testing is provided on the same day as other services; b) family services may exceed 1 hour a day. If direct services are provided to a parent or foster parent in conjunction with treatment of a child, or to more than 1 family member at the same time, 1 fee for individual therapy is allowed regardless of the number of family members; c) community support services are covered in addition to other clinic services provided on the same day but no more than 7 hours of clinic services per 7 consecutive days are allowed. Payment for group psychotherapy or psychosocial therapy is limited to 10 patients in a group and does not include day treatment or partial hospitalization. If 2 or more services are provided on 1 day, payment is made for only the service with the highest rate. Payment is made to the clinic for hospital daily care by a psychiatrist and for individual community support services; however, other services provided to general hospital inpatients are reimbursed directly to the hospital at its regular rate.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• ICF.

* Coverage for categorical and medically needy persons. However, ICF care for patients 65 or older in IMD and psychological services are not provided to the medically needy group.

MARYLAND

INPATIENT HOSPITAL

• Patients 65 or older in IMD. No limits.

• Length of stay in acute general hospital cannot exceed 20 days per spell of illness as determined medically or administratively necessary by PSRO; additional stay requires a new spell of illness. Same limit for psychiatric units.

OUTPATIENT HOSPITAL

• Individual, family and group therapy covered. Telephone contacts and review of records are not covered.

PHYSICIAN SERVICES

• Must be medically necessary, the same as for Medicare, unless prior authorization is obtained. Same coverage as those services listed in OUTPATIENT HOSPITAL.

NONPHYSICIAN SERVICES

• Provided. None applicable to mental health care.

CLINIC SERVICES

• Community mental health center—Includes freestanding, associated with a general hospital, or part of the local county health department. Providers must meet criteria specified in the Medicaid contract and be approved by the Mental Hygiene Administration. Same services and limitations as those listed in OUTPATIENT HOSPITAL.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• Hospital.

• SNF and ICF not provided.

MASSACHUSETTS

INPATIENT HOSPITAL

• Patients 65 or over in IMD limited to services provided by medical assistance-certified public psychiatric hospitals. Chronic disease and rehabilitation (CD/R) hospital benefits are limited to the period in which the recipient meets CD/R levels of care guidelines unless exceptions are allowed, plus any administrative days that are allowable at SNF and ICF rates, as appropriate, while such lower level care is being sought.

• No limit on inpatient psychiatric care in general hospital.

OUTPATIENT HOSPITAL

• Same services available as those covered in freestanding clinics. (See CLINIC SERVICES for coverage and limitations).

PHYSICIAN SERVICES

• Psychiatric care limited to one psychiatric visit per week except in a crisis or when more than one type of service is medically necessary.

• Psychiatry includes: a) individual psychotherapy; b) couple and family therapy limited to one payment/visit regardless of number of family members; c) group therapy limited to one payment per 90-minute visit, and payment limited to a maximum of 6 persons; d) medication visits; and e) consultation.

NONPHYSICIAN SERVICES

• Psychologists

—Covered services include only psychological testing. Department will not pay for psychological testing by a certified school psychologist or an unlicensed psychologist unless supervised by a licensed psychologist.

—Prior authorization is required for a neuropsychological examination and for more than one repetition of the same test within a 6-month period.

CLINIC SERVICES

• Mental Health Centers—Freestanding clinics and satellite facilities of freestanding clinics certified by the Department of Public Welfare. Prior authorization is required for treatment continuing after 26 consecutive sessions per 6-month period. In rare instances where extenuating circumstances exist, treatment may be extended for one year with one request for prior authorization, if the treatment plan does not extend beyond 26 sessions. Sessions comprise any combination of individual, family, group, or couple therapy, and case consultation. (Psychological testing and medication visits are not counted as sessions).

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MICHIGAN continued

(CMH). The CMH board is defined by Michigan law as the single point of entry to the full array of public mental health services; they provide or arrange for community-based mental health services, serve as the point of referral for persons in need of institutional care, and are responsible for aftercare/follow-up for persons exiting an institution. Thus, each CMH board acts as the case manager for comprehensive mental health services and provides access to such services on a 24-hour basis. Reimbursement for outpatient clinic services includes coverage of diagnosis, testing and evaluation; emergency mental health services; individual and group therapy sessions; and medication review. Reimbursement for medical day treatment includes coverage of diagnostic/evaluation services; habilitation/rehabilitation treatment services; psychological/behavioral treatment services; and transportation. These services must be a part of a goal-oriented care plan authorized by a physician.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital (see INPATIENT HOSPITAL).
- SNF.
- ICF.

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR UNDER 22

- Facilities must be JCAH accredited. Also, "active psychiatric treatment" and prior authorization beyond 18 days are required. Services must meet Medicare standards. The attending physician must periodically recertify need for such care. Psychiatric occupational/recreational therapy is covered when provided by a psychiatrist or a registered occupational therapist and when ordered in writing by a physician as part of the recipient's active treatment plan.

OTHER SERVICES

- Personal care services in homes for the mentally ill. Includes health-related activities or tasks orderd by a physician and provided under the supervision of an R.N. Services include those related to activities of daily living and household services incidental to and consistent with the medical and health care needs of the client.

MINNESOTA

INPATIENT HOSPITAL

- Inpatient psychiatric care in a general hospial is limited to 30 days a year, unless prior authorized.

OUTPATIENT HOSPITAL

- Same coverage and limitations as under PHYSICIAN SERVICES

PHYSICIAN SERVICES

- Psychiatrists' services*—limited to: a) individual psychotherapy—10 clinical units (1 hour or 50 minutes) a year (more with prior authorization), b) family psychotherapy—2 members: 2 clinical units a week for up to 20 weeks; 3 or more members (one under 18 years old): 26 clinical units a year; c) multiple—family and group psychotherapy—2 hours a week for up to a 10 week period; d) inpatient services—30 days; e) outpatient day treatment—prior authorization is required every 30 days; f) psychiatric diagnostic interview examination—once a month, not to exceed three times a year; g) psychological testing—once a month, not to exceed 3 times a year; h) chemotherapy management requiring antipsychotic or antidepressive medication—psychiatrists only, once a week, up to one year; j) environmental intervention on a patient's behalf and interpretation of testing an examination results—one clinical unit a year; k) outpatient chemical dependency—3 clinical units a day, not to exceed 30 days.
- These limits may be exceeded only with prior authorization.
- ECT—shock therapy.

*All of the above services are also covered for psychologists, except where noted.

NONPHYSICIAN SERVICES

- Psychologists' services—limitation: a) up to 10 hourly sessions by a licensed psychologist per recipient a year; b) up to 26 additional sessions are covered if 3 or more family members—at least one of whom is under 18—are seen each time and the sessions extend more than 6 consecutive months; c) family psychotherapy for 2 family members is covered as needed for up to 2 hours a week for up to 20 consecutive weeks; d) multiple-family group psychotherapy is covered up to 2 hours a week for 10 consecutive weeks. Extensions of any of these limits requires prior authorization. (Also see PHYSICIAN SERVICES.)
- Inpatient services not covered for psychologists

CLINIC SERVICES

- Mental health center services facilities must be licensed by the Department of Welfare, nonprofit, and county contracted. Same coverage and limitations as PHYSICIAN SERVICES and NONPHYSICIAN SERVICES.

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MISSOURI*

INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- Covered days of service in acute general hospital limited to the lowest of: a) the number of days indicated as appropriate for the diagnosis at the 75th percentile of PAS; b) the number of days certified as medically necessary by a "Binding Review" PSRO; or c) the number of days billed as covered service by the provider.

OUTPATIENT HOSPITAL

- Limited to three outpatient hospital visits (clinic setting) per provider, per recipient, per month and one emergency room service per day, per provider, per recipient. Additional visits must be shown to be medically necessary. (No specific reference to psychiatric care.)

PHYSICIAN SERVICES

- Limits new patient office visits to one per provider for each recipient and limits established patients extended or comprehensive visits to one per provider per year for each recipient.

NONPHYSICIAN SERVICES

- Provided, none applicable to mental health care.

Clinic Services

- Limited to following provider types: independent clinic, public health department clinic, planned parenthood clinic, teaching institution department, and community health center.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.
- SNF and ICF not provided.

* Categorically needy only. No medically needy program.

MONTANA

INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- No limits on inpatient psychiatric care in a general hospital.

OUTPATIENT HOSPITAL

- No limitations other than medical necessity. No particular mental health services are specified.

PHYSICIAN SERVICES

- No limitations.

NONPHYSICIAN SERVICES

- Psychologists services—covered when provided by a licensed clinical psychologist, limited to: a) 1½ hour sessions with no more than 8 individuals per group; and b) 22 hours of services or the equivalent per patient per fiscal year (applies to both individual and group outpatient therapy). When a child receives these services and the psychologist consults with the parent as part of the child's treatment, such consultation counts toward the 22-hour limit.
- There are no MD supervision requirements and psychologists may provide services through an independent practice, or mental health center. Psychologists practicing independently bill in their own names; mental health center psychologist services are billed by the agency.

CLINIC SERVICES

- Covered in licensed regional community mental health centers with subcontracts from the State Department of Institutions to provide mental health clinic services. Included are day care, group and individual therapy.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospitals—Length of stay is determined by a designated review organization.
- SNF and ICF provided. Admissions must be approved by a preadmission screening team.

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided—no limits.

NEBRASKA

INPATIENT HOSPITAL

• General Hospitals—Emergency or diagnostic psychiatric care up to 5 days under a general physician or up to 13 days if a psychiatrist is consulted.

• Psychiatric Hospitals—Reimbursement for hospitalization of patients whose primary needs are psychiatric is limited to facilities licensed by state health department to give psychiatric care, except as noted above under General Hospitals. Reimbursement for care in Nebraska state regional centers for mental diseases is limited to age groups 65 and older and 21 and younger.

OUTPATIENT HOSPITAL

• Partial Hospitalization—Half or full day; same services and limitations as those listed under CLINIC SERVICES (Day Treatment).

• Also provided are those services normally rendered in a physician's office, including: psychiatric testing/evaluation, individual, family group psychotherapy; psychotherapy subject to $500 limit per year except by prior authorization; testing and evaluation is exempt from $500 limit; all services must be medically necessary and be a part of an active treatment plan.

PHYSICIAN SERVICES

• Limited to $500 per patient a year for psychotherapy, except by prior authorization. However, inpatient services are exempt from the $500 limit.

NONPHYSICIAN SERVICES

• Ph.D.-licensed psychologist—May provide testing and evaluation without supervision; however, psychotherapy must be supervised by an M.D. psychiatrist.

• Ph.D.-licensed and certified clinical psychologist—Operates independently without supervision for all services rendered.

• Psychotherapy limited to $500 per patient per year, except by prior authorization.

• Services provided by other mental health professionals are eligible if services are supervised or reviewed by a physician.

CLINIC SERVICES

• Day treatment—Available in community mental health centers. Centers must be licensed as a mental health clinic by the Nebraska Department of Health and and accredited by the Joint Commission on Accreditation for Community Mental Health Centers or certified by the Nebraska Department of Public Institutions. Programs of psychiatric day treatment and psychiatric partial hospitalization must provide the following mandatory services: individual, group and family psychotherapy; conference with family or other responsible persons advising them on how to assist client; medically necessary nursing services; medically necessary psychological testing; pharmaceutical and dietary services. The programs may include the following optional services: physical, speech, occupational and inhalation therapy; social work; dietary; recreation therapy; and self-care.

• Reimbursement for psychiatric services is limited to medically necessary primary psychiatric diagnoses.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• Hospital

• SNF

• ICF

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

• Provided—No limits.

NEVADA*

INPATIENT HOSPITAL

- Patients 65 or older in IMD—admissions must be certified by the Nevada Professional Review Organization.
- No limits on acute care in general hospital. Same for psychiatric units.

OUTPATIENT HOSPITAL

- Payment limited to the same extent as PHYSICIAN SERVICES; no specific mention of psychiatric services.

PHYSICIAN SERVICES

- May not exceed 2 office or nursing facility visits and 2 therapeutic injections per patient per month—unless prior authorized.
- Emergency care and inpatient hospital care are not limited.

NONPHYSICIAN SERVICES

- None applicable to mental health.

CLINIC SERVICES

- Mental health clinic services—Provided only in state-operated community mental health clinics; Each nonexempt recipient subject to a copayment of $1 per visit. Clinic visits are counted as physician office visits and may not exceed 2 per month. Services provided at clinic option.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital. (See INPATIENT HOSPITAL.)
- SNF and ICF.
- Copayment of one-half the first day's cost for patients over 65 in IMD.

* Categorically needy only. No medically needy program.

NEW HAMPSHIRE

INPATIENT HOSPITAL

- Patients 65 or older in public or private IMDs subject to prior authorization for services provided out-of-state.
- No limits on psychiatric care in an inpatient general hospital.

OUTPATIENT HOSPITAL

- Limited to 12 visits per recipient per fiscal year, including psychiatric services.

PHYSICIAN SERVICES

- Coverage is limited to 12 inpatient hospital services and 18 outpatient or ambulatory physician services per recipient a year (includes psychiatric services).

NONPHYSICIAN SERVICES

- Psychologist services—treatment by a certified clinical psychologist, who is not on the staff of a community mental health center, is covered up to 12 services a year per recipient (see CLINIC SERVICES for limitations on psychologists who are on staff at CMHCs).
- Psychologist services must be prescribed by an attending physician.
- MD supervision is not required.

CLINIC SERVICES

- Community mental health centers—mental health services covered up to $500 a year per recipient, except for recipients certified as severely mentally disabled and certified to receive long-term care treatment. Services include: individual and group psychotherapy; family therapy; medication check; emergency visit; comprehensive psychiatric evaluation; psychological testing; and partial hospitalization. Any of these services are covered beyond the $500 long-term care limit for recipients certified as severely mentally disabled (individuals whose primary disability results from mental illness).

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.
- SNF not provided.
- ICF—for categoricaly needy only. Prior authorization is required for a specified amount of stay based on the amount and period of care recommended by patient's physician. Certification and recertification required by physician every 60 days. Extensions require a request by facility based on UR report completed by physician.

NEW JERSEY*

INPATIENT HOSPITAL

• Patients 65 or older, or 21 or younger in IMDs.

• Psychiatric care in a general hospital is limited to 40 days per admission unless the physician certifies a need for additional services; any additional psychiatric care requires prior authorization.

OUTPATIENT HOSPITAL

• Psychiatric services in a hospital outpatient department are covered without prior authorization; however, a physician's certification and plan of treatment are required after 30 days. Partial hospitalization (PH) for psychiatric care is covered as an outpatient service. PH may be day, evening, or night care, and does not require prior authorization for the first 30 days. Prior authorization is required for PH after 30 days, and each authorization may be granted for up to 6 months. Additional authorizations may be requested.

PHYSICIAN SERVICES

• Prior authorization is required for psychiatric and psychological services that exceed $300 in payment to a physician or psychologist in a 12-month period, commencing with the patient's initial visit. This applies to psychiatric services in settings other than inpatient or outpatient hospital, and to psychological services in settings other than inpatient hospital.

NONPHYSICIAN SERVICES

• Psychologist services are covered (see limitations under PHYSICIAN SERVICES). Not a covered out-of-state service.

CLINIC SERVICES

• Mental health clinics must be approved to provide psychiatric services by the New Jersey Department of Human Services, Division of Mental Health and Hospitals. Psychiatric services require prior authorization (see other limitations under PHYSICIAN SERVICES). Services include individual and group therapy, partial care, medication monitoring, and personal care (beginning 2/84).

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• SNF and ICF provided—prior authorization is required from the local medical-assistance unit for admission except when the patient is transferred to the facility directly from an acute care hospital or a Class A special hospital, or a Medicaid-certified psychiatric hospital.

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 21

• Provided in private psychiatric hospitals. Limited to 20 days per admission unless the physician certifies a need for up to 20 additional days, and any additional care requires prior authorization.

OTHER DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

• Other than those provided elsewhere under the program.

* Categorically needy only. No medically needy program.

NEW MEXICO*

INPATIENT HOSPITAL

- Payment is made only for acute hospital care, except for 1 day (or up to 3 days as certified by the PSRO) needed to secure alternate care.
- No limits on psychiatric care in a general hospital.

OUTPATIENT HOSPITAL

- See NONPHYSICIAN SERVICES, psychologists.

PHYSICIAN SERVICES

- Payment will not be made to physicians for more than 2 hourly visits a day per recipient.

NONPHYSICIAN SERVICES

- Psychologist services—services of certified and licensed psychologists are covered subject to prior authorization by the PSRO for all outpatient psychiatric and psychological services beyond initial evaluation.

CLINIC SERVICES

- Limited to payment of medical necessity. Payment not made for more than 1 clinic visit a day.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- None.

* Categorically needy only. No medically needy program.

NEW YORK

INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- Psychiatric care in a general hospital limited to 20 days unless more time is authorized by the Department of Health.
- Care in a rehabilitation hospital or rehabilitation unit of a general hospital is limited to 40 days unless more time is authorized by the Department of Health.

OUTPATIENT HOSPITAL

- The hospital may provide clinic treatment, day treatment, and continuing treatment programs. No specific mention of psychiatric services.

PHYSICIAN SERVICES

- Psychiatric Care—by a psychiatrist in office, patient's home, clinic, hospital, medical facility, or for person 65 or older or under 21 in a mental disease hospital. Includes psychiatric clinic, day, evening, or overnight care.

NONPHYSICIAN SERVICES

- Ph.D.-licensed clinical psychologists—services include psychological evaluation, standard testing, group therapy, clinic sessions, and therapeutic encounter sessions. Private practicing psychologists may receive Medicaid reimbursement only for services they provide on a private practitioner basis and will not be reimbursed for services rendered in a facility from which the psychologist receives a salary. New York City Medicaid recipients are not eligible for services provided by private practicing clinical psychologists.

CLINIC SERVICES

- Mental health services provided in CMHCs, state-operated facilities, rehabilitation centers, freestanding clinics, and hospital-based clinics. Covered services include clinic treatment, day treatment, and continuing treatment. Providers must be certified to provide mental health services, and must be given a certificate by the Office of Mental Health to provide examination, diagnosis, care, treatment, rehabilitation, or training to people who suffer from mental illness.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.
- SNF—provided. Prior authorization is required for admission except when the patient is admitted directly from a hospital, another nursing home, or another health-related facility.
- ICF—provided. Prior authorization is required for admission. Authorization must be renewed every 90 days or in accordance with utilization review regulation of the health commissioner.

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided—no limits.

NORTH DAKOTA

INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- No limit on psychiatric care in general hospital.

OUTPATIENT HOSPITAL

- Emergency room care is covered only in a medical or surgical emergency or when medical necessity is documented by special report, except that emergency room care can also include certain screening/examination services.
- No specific mention of psychiatric services.

PHYSICIAN SERVICES

- No mention of psychiatric services.

NONPHYSICIAN SERVICES

- None provided applicable to mental health care.

CLINIC SERVICES

- Provided—no limits.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.

OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

- Other than those provided elsewhere in the program.

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided—no limits.

OHIO*

INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- Care in a general hospital will not be paid for days exceeding the number approved by PSRO or other appropriate review committee as medically necessary, except that up to three extra days may be preauthorized. Sixty inpatient hospital days are covered in a spell of illness, but the patient may be hospitalized more than once during a spell of illness (60-day limitation does not apply to state-operated facility).
- Psychiatric units in a general hospital limited to 30 days.

OUTPATIENT HOSPITAL

- Prior authorization is required for more than four visits by a recipient in a month and may be granted up to 10 visits for physician, EPSDT, family planning, and emergency dental services; however, a visit involved in preadmission testing may be covered outside the four visit limit (no specific reference to psychiatric services).

PHYSICIAN SERVICES

- Prior authorization is required for more than four office visits per patient per month. In no instance are more than 20 visits per patient per month covered whether the patient is in a hospital, nursing home, or at home, or whether visits are made by more than one physician. Services must be medically necessary.

NONPHYSICIAN SERVICES

- Psychologists services limited to those provided by licensed psychologists. Services include: psychological psychotherapy in office, clinic, hospital, home; and psychological group psychotherapy in the same settings with psychological augmentation or other methods. Psychological testing is limited to eight hours a year per case unless prior authorization is obtained for additional testing. Visits cannot exceed (a) four per month in an outpatient setting, or (b) more than 10 visits per month regardless of physical location of the patient.
- Noncovered psychologist services include: services provided by school psychologists in facilities regulated by the State Board of Education; educational testing and diagnosis; retreats or marathons for mental disorders; sensitivity training; encounter groups; and sexual competency training.
- There are no state requirments for supervision for a licensed psychologist.

CLINIC SERVICES

- Limited to nonprofit public or proprietary community mental health

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TEXAS*

INPATIENT HOSPITAL

• General hospital limited to 30 days "per spell of illness" which begins when the patient enters a hospital and ends when he has not been an inpatient in any hospital for 60 consecutive days.

OUTPATIENT HOSPITAL

• Same services and limitations listed under PHYSICIAN SERVICES.

PHYSICIAN SERVICES

• Limited coverage for physician services for a diagnosis or treatment of a mental, psychoneurotic or personality disorder. The limitation is 62.5% of reasonable charge for the service or $312.50, whichever is less, in any calendar year. However, this limitation can be exceeded when prior authorized on a case by case basis. The specific services provided are: group therapy; psychological evaluation and testing; family therapy; psychotherapy; electroshock therapy; Metrazol convulsive shock treatment.

NONPHYSICIAN SERVICES

• Provided, none appropriate to mental health care.

CLINIC SERVICES

• None provided.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• None provided.

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* Categorically needy only. No medically needy program.

UTAH

INPATIENT HOSPITAL

• Patients 65 or older in institutions for mental diseases, i.e., the program reimburses the Utah State Hospital for the care of eligible elderly psychiatric patients in its geriatric ward—no limits.

• No limits for general hospital care.

OUTPATIENT HOSPITAL

• Limited to 12 visits a year. Additional visits reimbursed with prior authorization.

PHYSICIAN SERVICES

• Psychiatric care limited to 12 hours of treatment for each acute illness unless prior written approval for additional care is obtained.

• Chronic care is limited to 1 visit a month for the chronically mentally ill.

NONPHYSICIAN SERVICES

• Psychologists' services—mental health services by a licensed psychologist in private practice outside an inpatient or outpatient facility. They include: a) diagnostic testing which requires prior authorization; and b) individual or group psychotherapy (6-10 in a group), both limited to a specific number of visits within a specific treatment time period per individual spell of illness.

CLINIC SERVICES*

• Community Mental Health Clinics—services include: a) intake, evaluation, diagnosis, and initiation of treatment plan; b) individual therapy limited to 12 visits for each acute episode of illness and to 1 visit a month for a chronic psychiatric disorder (additional visits may be obtained on written request); c) group therapy; d) day hospital programs—limited to treatment expected to lead to full or partial recovery (includes individual, group, and family therapy, chemotherapy and services provided by other healing arts practitioners); e) day treatment—limited to treatment to promote emotional or psychological change to alleviate the effects of mental disorders (includes, under the supportive counseling, preventive or restorative physical exercise and instruction in self-care relating to health maintenance; includes a more than 2 but less than 12 hour per day service; all day treatment must be prior authorized; approval is granted for 90 day periods); and f) medication management. New or unusual treatment procedures require prior authorization.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• Hospital (see INPATIENT HOSPITAL).

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WASHINGTON continued

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

• For categorically needy only—Limits are the same as those for INPATIENT HOSPITAL.

' Same benefits for medically needy except these recipients must pay, for each hospital admission, a deductible not exceeding ½ of the Medicaid rate for 1 inpatient hospital day.

WEST VIRGINIA

INPATIENT HOSPITAL

• Psychiatric care in a general or psychiatric hospital is limited to 20 days a year except for foster children under 18, where the limit can be waived if medically indicated, or except for a specialized program of inpatient psychiatric services for individuals 21 or under, which has no limit.

OUTPATIENT HOSPITAL

• Psychiatric and psychological services include psychotherapy, chemotherapy, partial hospitalization in approved programs, group therapy, biofeedback, hypnotherapy, conjoint therapy, and consultation.

PHYSICIAN SERVICES

• Psychiatrists—limited to 10 sessions of psychotherapy without prior approval.

NONPHYSICIAN SERVICES

• Licensed psychologists—therapy requires prior authorization after 10 sessions. There is no MD supervision requirement.

CLINIC SERVICES

• Provided in mental health clinics licensed by the Department of Health, and by other clinics meeting standards of the state's Medicaid program.

• Services include those listed under outpatient hospital.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

• Not provided.

WISCONSIN*

INPATIENT HOSPITAL

- Patients 65 and older in IMDs—copayment charge of $3 a day up to a maximum of $75 per stay.
- Patients 22-64 are covered in IMDs for a calendar month, with episodes of care occurring at least 90 days from the date of last discharge (no federal financial participation). Prior approval by county mental health boards required. Copayment of $3 a day up to a maximum of $75.
- General Hospital—No limit (same for psychiatric care).

OUTPATIENT HOSPITAL

- Day treatment services in excess of 120 hours for outpatients, 40 hours for nursing home patients, or 20 hours for inpatients require prior authorization.
- Prior approval by county mental health boards is required for reimbursement of all outpatient mental health services.
- Psychotherapy limited as noted under PHYSICIAN SERVICES.

PHYSICIAN SERVICES

- Prior authorization required for psychiatrists to provide psychotherapy in excess of 15 hours or $500 in a 12-month period. No therapy may be provided in the home.
- Psychiatric evaluations are limited to 6 hours per recipient per lifetime and must be approved by county mental health board.
- Copayments required as follows:
  - —Individual Therapy—$.50/15 minutes per recipient;
  - —Evaluations—$1.00/hour per recipient;
  - —Group Therapy—$.50/hour per recipient;
  - —Family Therapy—$2.00/hour per family.

NONPHYSICIAN SERVICES

- Licensed psychologists and certain masters level mental health clinicians (masters of social work, psychology, and psychiatric nurses) may provide psychotherapy. Same limits as apply to psychotherapy as noted under PHYSICIAN SERVICES. Certified alcohol and other drug abuse (AODA) services counselors may provide AODA counseling. Same limits as apply to psychotherapy. Same copay requirements as noted under PHYSICIAN SERVICES.

CLINIC SERVICES

- Covered only in clinics approved by Medicare or state Medicaid agency.
- All services except emergency require prior approval by county mental health board and all services require prior authorization for services exceeding 15 hours or $500.
- Clinic must provide or arrange for the following services: diagnosis, evaluation, outpatient, residential facility placement, partial hospitalization, pre-care prior to hospitalization, after-care, emergency care, rehabilitation, habilitation, supportive transitional services, and professional consultation.

SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided, no limits.

OTHER DIAGNOSTIC SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

- Psychiatric services for problems discovered under EPSDT covered.

WAIVERS

- Wisconsin has received a waiver to implement a case management and gatekeeping system for mental health services under Section 2175 of the Omnibus Budget Reconciliation Act of 1981. Wisconsin is attempting to expand the range of service options by using local mental health boards as case managers and prudent purchasers, with the notion that better case management will reduce inappropriate institutionalization and provide the opportunity to develop less costly community-based care.

Wisconsin's 1983-85 Budget Act (SB 83, Act 27) contains a provision which expands Wisconsin's medical assistance-mental health gatekeeper program. Under the current statewide program, established in 1981, community mental health boards authorize payment for inpatient mental health and AODA services for individuals age 22 to 64. The boards may use any portion of their funds not applied to their medical assistance liability to fund noninstitutional community programs.

Under the new mental health pilot project, the roles of the boards participating in the program are expanded in two signigicant ways: 1) prior authorization for medical assistance payment by the boards is required for all mental health and AODA services (inpatient, outpatient, day treatment, etc.), and for persons of all ages. The local boards direct Medicaid recipients to those providers of mental health services who adhere to locally established guidelines and criteria for the care and mental health treatment of recipients in their jurisdictions; and 2) the participating boards are liable for the entire state share (43 percent) of the medical assistance payment. As in the current gatekeeper program, boards may use any portion of their allocations not applied to their medical assistance liability to fund noninstitutional programs.

continued next page

1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988)

Effect of amendments. — The 1986 amendment in subsection (b) in paragraphs (3), (5) and (7) substituted "age 21 who are" for "21 years of age," in paragraph (8) substituted "age 21 and not covered under (a) of this section," for "21 years of age" and "except that they have the care and support of both their natural and adoptive parents" for "but who do not qualify because they are not dependent children," in paragraph (9) deleted "women who are" at the beginning of the paragraph and added the language beginning "women not covered," made minor punctuation changes in paragraph (3), inserted "and" following "mentally retarded" in paragraph (5), and inserted "and" following "psychiatric hospital" in paragraph (7).

The 1988 amendment inserted subsection (b)(10).

Sec. 47.07.030. Medical services to be provided. (a) The department shall offer all mandatory services required under 42 U.S.C. 1396 — 1396p (Title XIX of the Social Security Act).

(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; 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. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982; am § 1 ch 20 SLA 1986; am § 4 ch 105 SLA 1986; am § 2 ch 119 SLA 1988)

Cross references. — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted "case management and nutrition services for pregnant women" in subsection (b).

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:

1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988)

Effect of amendments. — The 1986 amendment in subsection (b) in paragraphs (3), (5) and (7) substituted "age 21 who are" for "21 years of age," in paragraph (8) substituted "age 21 and not covered under (a) of this section," for "21 years of age" and "except that they have the care and support of both their natural and adoptive parents" for "but who do not qualify because they are not dependent children," in paragraph (9) deleted "women who are" at the beginning of the paragraph and added the language beginning "women not covered," made minor punctuation changes in paragraph (3), inserted "and" following "mentally retarded" in paragraph (5), and inserted "and" following "psychiatric hospital" in paragraph (7).

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(1) 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) physical therapy;
(11) personal care services in a recipient's home;
(12) long-term care noninstitutional services;
(13) inpatient psychiatric facility services;
(14) intermediate care facility services for the mentally retarded;
(15) intermediate care facility services;
(16) 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;
(17) 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;
(18) skilled nursing facility services for persons under age 21;
(19) 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;
(20) 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;
(21) 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. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986; am § 3 ch 119 SLA 1988)

Cross references. — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted present paragraph (16) and redesignated former paragraphs (16)-(20) as present paragraphs (17)-(21).

the division before admission to the hospital; failure to obtain authorization will result in nonpayment regardless of the eligibility of the recipient or the appropriateness of the services.

(b) Except as provided in this subsection, the division will not pay for more than one physician visit in a 30-day period for a patient in either a skilled nursing or an intermediate care facility. The division will, in its discretion, pay for additional visits if written justification, acceptable to the division, accompanies the bill for the physician visit. (Eff. 8/18/79, Register 71; am 3/25/83, Register 85; am 7/1/85, Register 95; am 9/25/85, Register 95)

Authority: AS 47.05.010
AS 47.07.030
AS 47.07.050

7 AAC 43.120. X-RAY SERVICES. Diagnostic and follow-up X-rays do not require prior approval by the division, but films must be made available to the division on request. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010
AS 47.07.030
AS 47.07.050

7 AAC 43.125. LABORATORY SERVICES. (a) A physician using his or her own laboratory to provide necessary laboratory services will be reimbursed according to the medicare fee schedule in 42 C.F.R. 405.515.

(b) A physician using the services of an independent laboratory shall request services for a recipient in the same manner that services are requested for a private patient.

(c) An independent laboratory certified by the department, or certified by the state medicaid agency or medicare if located out-of-state, may bill the division directly. Reimbursement for clinical laboratory tests will be made by the division according to the medicare fee schedule in 42 C.F.R. 405.515. (Eff. 8/18/79, Register 71; am 3/30/88, Register 106)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.130. PSYCHIATRIC SERVICES. (a) Payment to a physician for psychotherapy services will be provided without prior authorization for services to recipients on an outpatient basis.

(b) Services by a psychologist, social worker or nurse are not covered outside of a psychiatric facility or general hospital except when provided through a community mental health clinic enrolled as a provider in the medicaid program. (Eff. 8/18/79, Register 71)

(b) If the department provides or pays for medical assistance for injury or illness under this title, the department is subrogated to the rights of the recipient of that medical assistance for any claim arising from the injury or illness and to the proceeds of an insurance policy covering the injury or illness to the extent of the value of the medical assistance provided.

(c) If a recipient of medical assistance under this title settles a claim or obtains an award of judgment arising from the injury or illness for which the medical assistance was received, the department shall reimburse the recipient for attorney fees and costs commensurate with the amount of the settlement, award, or judgment to which the department is entitled under (b) of this section. Regardless of the manner in which the amount of the attorney fees is derived, reimbursement of attorney fees shall be in accordance with the applicable rules of court governing the award of attorney fees in civil matters.

(d) The department is authorized to enter into contracts for the collection of medical expenses already paid by Medicaid from potential third-party payors. The department may pay, from the funds recovered by the contractor, any amounts owing to the federal government as its share of the Medicaid paid claim, and the costs of collecting the funds. (§ 2 ch 105 SLA 1986)

Chapter 07. Medical Assistance for Needy Persons.

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children) or 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income);

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for

assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, 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;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal aid to families with dependent children program;

(10) 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.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b) (4) of this section, a person is not eligible for medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act). (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA

(1) 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) physical therapy;
(11) personal care services in a recipient's home;
(12) long-term care noninstitutional services;
(13) inpatient psychiatric facility services;
(14) intermediate care facility services for the mentally retarded;
(15) intermediate care facility services;
(16) 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;
(17) 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;
(18) skilled nursing facility services for persons under age 21;
(19) 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;
(20) 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;
(21) 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. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986; am § 3 ch 119 SLA 1988)

Cross references. — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted present paragraph (16) and redesignated former paragraphs (16)-(20) as present paragraphs (17)-(21).

TABLE 1
NUMBER OF LICENSED HEALTH CARE PROVIDERS OF VARIOUS TYPES RESIDING IN EACH HOUSE ELECTION DISTRICT

HOUSE ELECTION DISTRICT	1985 POPULATION	SUMMARY: NUMBER OF HEALTH CARE PROVIDERS TOTAL	SUMMARY: NUMBER OF HEALTH CARE PROVIDERS PER 1,000	SUMMARY: AS PERCENT OF STATEWIDE PROVIDERS	SUMMARY: AS PERCENT OF STATEWIDE POPN	NUMBER OF LICENSED HEALTH CARE PROVIDERS: PARAMEDICS	PHARMACISTS	PHYSICAL THERAPISTS	OPTOMOLOGISTS	CHIROPRACTORS	PSYCHOLOGISTS	REGISTERED NURSES	PRACTICAL NURSES	ADVANCED NURSE PRACTITIONERS	NURSE ANESTHETISTS	PHYSICIANS	OSTEOPATHS	PODIATRISTS	DENTISTS	DENTAL HYGIENISTS
ED 1	18,397	307	16.7	4.1	3.4	1	13	9	0	5	3	175	41	7	3	30	0	0	15	5
ED 2	10,782	40	3.7	0.5	2.0	0	0	2	0	0	0	24	4	1	0	3	0	0	4	2
ED 3	8,770	202	23.0	2.7	1.6	1	9	5	0	2	4	130	22	1	2	16	0	0	6	4
ED 4	26,270	401	15.3	5.4	4.9	1	14	10	5	6	6	224	38	7	1	49	1	1	17	21
ED 5	32,670	464	14.2	6.2	6.1	13	15	8	4	14	6	260	73	6	2	33	1	0	12	17
ED 6	9,717	140	14.4	1.9	1.8	0	3	2	0	4	3	81	28	2	0	10	0	0	4	3
ED 7-15	237,796	3,906	16.4	52.3	44.1	45	100	74	33	52	52	2,155	454	66	14	491	24	6	181	159
ED 16	36,833	457	12.4	6.1	6.8	8	8	15	2	10	2	276	62	8	2	33	2	1	15	13
ED 17	11,737	93	7.9	1.2	2.2	1	2	0	0	2	0	64	15	2	0	2	1	0	2	2
ED 18-21	72,614	1,005	13.8	13.5	13.5	17	37	28	10	12	21	542	126	9	4	127	4	1	44	25
ED 22	11,454	55	4.8	0.7	2.1	0	2	0	0	0	0	38	4	5	0	4	1	0	0	1
ED 23	11,104	58	5.2	0.8	2.1	1	2	0	0	0	0	37	3	2	0	6	1	0	5	1
ED 24	11,503	22	1.9	0.3	2.1	0	0	0	0	0	0	17	1	4	0	0	0	0	0	0
ED 25	11,018	95	8.6	1.3	2.0	0	1	1	3	0	1	58	6	5	0	10	1	0	8	1
ED 26	15,563	73	4.7	1.0	2.9	0	1	0	1	1	1	48	5	4	0	6	1	0	2	3
ED 27	13,483	150	11.1	2.0	2.5	1	5	6	2	3	3	85	16	0	2	13	2	0	8	4
STATEWIDE	539,711	7,468	13.8	100	100	89	212	158	60	111	102	4,214	898	129	30	833	39	9	323	261
PERCENT OF TOTAL						1.2	2.8	2.1	0.8	1.5	1.4	56.4	12.0	1.7	0.4	11.2	0.5	0.1	4.3	3.5

NOTES:

1. Population figures are from the Alaska Department of Labor for July 1, 1985.

2. Health care provider numbers were provided by the Department of Commerce and Economic Development, Division of Occupational Licensing.

3. In addition to the medical occupations shown in the table, the State of Alaska licenses naturopaths. Currently six naturopaths are licensed to practice in Alaska: 2 Anchorage residents, 1 Wasilla resident, 1 Juneau resident and 2 nonresidents.

Prepared by the House Research Agency, November 1988 (89.020)

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 utilizing 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 2.93 average working days/month, weekly indemnity costs averaged 25.33/person/month, and hospital/med/surg. costs averaged $56.91/person/month. 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!! 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 Psychiatric News 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 1985.

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 morbility 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.

No Psychatr in out lying areas.

Extensive waiting lists (Jean Beck Ketchikan)

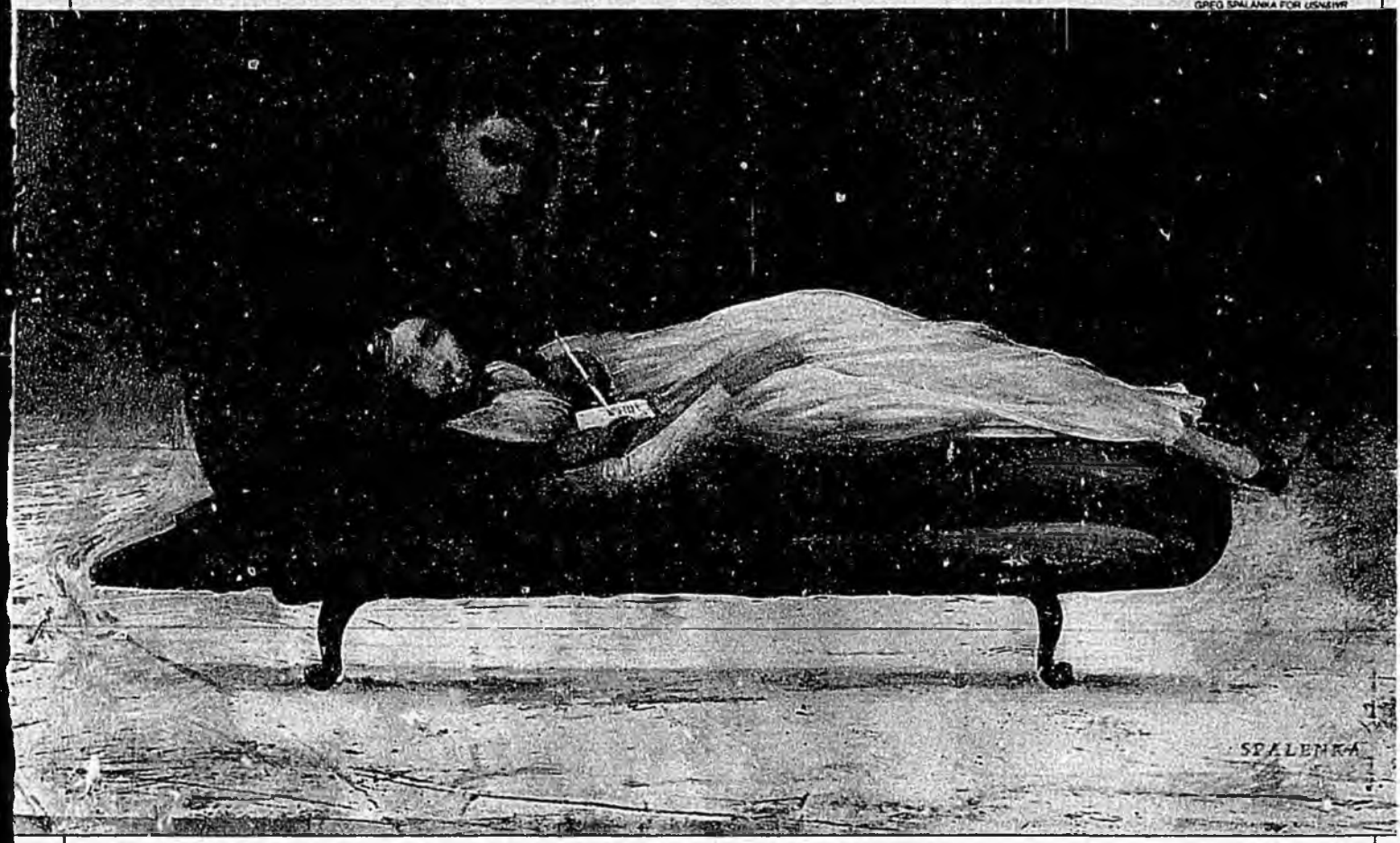
"under supervision"

some care better than no care

Shannon Kohler SB 148
Kathleen Divis SB 29

Fed Match.

GREG SPALANKA FOR USN&WR



The ultimate betrayal

BEHAVIOR ■ When sex enters the equation, psychotherapy is over

This is how it begins: An attractive young woman goes to see a psychotherapist for the first time. Perhaps she is having trouble with men. Perhaps she is overly impulsive or drinks too much or has nightmares. She relaxes inside the quiet consulting room, with its Persian rugs and tall bookshelves. She tells her deepest secrets, opening up to the middle-aged man who sits across from her, his brown oxfords polished, his eyes intent, listening. Yet there is something not quite right. Is it that he is a little too personal? That he is so willing to talk about himself? She can't quite put her finger on it. She begins to dream about him. If he mentions a book, she runs out to buy it. At night, she calls his answering machine just to hear his voice. He has become her protector, her father.

This is what she does not know: The therapist has problems of his own. He is lonely. His children have left home, and in his eyes his wife is old and unappealing. To make matters worse, he is bored with his work, with the hourly grind of listening to unhappy people who never seem to change. There are medical problems—nothing life threatening, but enough to remind him of the possibility that life will end. He is losing his sense of professional boundaries, but he doesn't know it yet. At night, he pours himself a glass of brandy. Then another. Still, he cannot fall asleep.

This is what happens: One day the young woman who has come to him for help is upset at the end of the hour. She is crying, and as he ushers her to the door, he leans forward and gives her a lingering hug. Or one day she brings him an expensive gift, a pen-and-ink drawing for his wall, and he accepts it and then, suddenly, begins to talk about his own depression. What could be the harm? She is such a good listener. A few weeks later, he changes her appointment to late in the day. At the end of the hour they walk to the waiting room, then to the corner Italian restaurant for dinner and then, when he mentions that his wife is away, to his house. He makes her promise she will not tell anyone what has happened between them. Afterward, fighting waves of panic, she feels suddenly that she will never recover from this.

Freudian warning. Almost a century ago, Sigmund Freud cautioned his followers not to become romantically involved with the patients they treated. Freud knew that, by its very nature, the relationship between therapist and patient is unequal, a re-creation of the inequality between parent and child. As the therapy progresses, the therapist takes on a larger-than-life quality. He becomes a powerful, idealized figure, and the patient develops exaggerated feelings for him, for a time even falling in love. But these emotions are artificially created, fueled in part by the inequality in power, and the therapist's job is to help sort them out. If, instead, he turns them to his own sexual advantage, Freud warned, the result will be disas-

trous for both treatment and patient.

Yet a startling number of modern psychotherapists ignore the injunction against sexual involvement, even though it is now written into the ethical codes of professional groups such as the American Psychiatric Association and served up to beginning therapists along with the first lessons on diagnosis and treatment. Anonymous surveys of psychiatrists, psychologists, social workers and other mental-health professionals indicate that up to 12 percent of practitioners in these groups have had sexual contact with patients, many citing "client welfare" as the rationale for their actions. And these numbers, experts say, are almost certainly underestimates, since many offending therapists will not admit to their actions—even anonymously. The true incidence could be as high as 15 or even 25 percent.

Links to incest. In part, the figures are alarming because studies have borne out Freud's predictions, demonstrating that sexual misconduct by a therapist can have severe and long-lasting effects for the patient. Not without reason have some researchers compared the plight of sexually exploited patients to that of incest victims. The situations have much in common: Both involve a deep betrayal of trust, a demand for secrecy, a conflict between loyalty and the knowledge that something is very wrong. California psychologist Kenneth Pope has described a syndrome that is often seen in patients who have been sexually abused by a therapist. The complaints include a worsening of previously existing psychiatric symptoms, increased difficulty in personal relationships, feelings of guilt, emptiness and suppressed rage, an inability to trust and an increased risk of suicide.

Perhaps not surprisingly, the vast majority of therapists who coax or coerce their patients into bed are male, while those they prey upon are overwhelmingly female. The victims are often women who suffer from low self-esteem and who sought therapy to begin with because their sense of self was tenuous, their personal boundaries uncertain. Sometimes these women also have a history of sexual abuse by a relative or neighbor. Once inside the therapist's office, they find it difficult to assert themselves against the man to whom they have already confided their most private thoughts and feelings. The therapist, for his part, finds such patients easy to bully into keeping the relationship a secret.

Who are these men? At the extreme, they can be sadistic and mentally unbalanced, like the "Svengali" who drugs his patients into submission, or the psychiatrist—a devotee of author Ayn Rand—who re-enacted rape scenes with his patients to teach them the "positive value" of sexual submission. Some have what are termed character disorders and are blinded to the needs and feelings of others by their own narcissism and self-absorption. Yet much more common, says Dr. Robert Simon, director of the program in psychiatry and law at Georgetown University School of Medicine, is the middle-aged therapist whose marriage is in trouble and who—feeling old and isolated—turns to an attractive female patient for the intimacy missing from his own life.

Dr. Peter Rutter, author of the 1989 book *Sex in the Forbidden Zone* (Jeremy Tarcher; $17.95), argues that therapists who break the rules are acting on temptations that many—perhaps most—men feel. "To me, and to all men in power, the woman can easily become a sympathetic, wounded, vulnerable presence who admires us and needs us in an especially feminine way," he writes. For men, the allure of sex with a woman who trusts and depends on them reflects a wider, cultural imbalance in power between women and men that is "epidemic," Rutter asserts.

Yet some men are more vulnerable. Georgetown's Simon has found that professionals who are poorly trained, who abuse drugs or alcohol, who have not been in psychotherapy themselves or who are unable to manage the intense "countertransference" feelings that psychotherapy often evokes in those who practice it are more likely to engage in sexual relationships with patients. Nor is high achievement a deterrent: A 1988 survey by Pope and his colleagues found that the incidence of sexual abuse among prominent practitioners—tenured professors and chairmen of ethics committees—was actually higher than among therapists in general.

GREG C. ALANKA FOR USN&WR

A violation of trust, a demand for secrecy

Rarely does the sexual interlude occur abruptly or without prelude. Instead, there is a gradual erosion of professional boundaries, a move from handshake to hug, a period of self-confession by the therapist, an agreement to allow the patient to "pay" for sessions by cleaning the office or editing manuscripts. Says Simon: "The problem is that when you're crossing boundaries a little bit here and a little bit there, and before you know it you're on a slippery slope to sexual malpractice." A typical case, he says, is the widowed 63-year-old therapist who slowly began to talk more about his own feelings during sessions with a 45-year-old patient. The patient took on the role of confidante, sometimes putting her arm around her therapist when he broke down crying. Eventually, they began a relationship outside the office. Observes Simon: "The therapist's depression improved."

There are also cases that strain credibility. One therapist, to prove to his patient he was not attracted to her, suggested that they both disrobe. Another professional described in Rutter's book listened to a female patient talk about the pain and horror she had suffered as a child when a man forced her to perform fellatio on him. Later, the therapist approached her sexually. His first request was that she repeat the humiliation of her childhood.

Not one of the more than 400 brands of talking therapy proliferating in the U.S.

recommends sex with patients as a beneficial treatment. Yet therapists as a group have until recently upheld a kind of "code of silence," turning a blind eye to colleagues who overstepped the bounds of professional involvement. Professional associations and licensing boards have been slow to take action against violators, experts claim. Many practitioners—among them some of Freud's disciples—even married former patients or conducted lengthy affairs with them in full public view. Even when there was blatant abuse, the private nature of psychotherapy has worked against victims of sexual exploitation who came forward to complain. It was, after all, their word against the therapist's.

Shifting tide. In the last few years, however, an increasing number of highly publicized sexual-malpractice suits have forced the attention of both professionals and the public. The ethics committees of several professional associations have noted an increase in sexual-misconduct claims, which in one study accounted for approximately 30 percent of total ethics complaints to the American Psychological Association. And juries are now more apt to believe the patient's charges rather than the therapist's denials—even in the rare trial cases where a therapist is unjustly accused. Large awards to victims are also common. Last October, Giant Food heiress Fredrica Lehrman Carmichael won a $1 million judgment in a combination malpractice and divorce suit against her husband and former therapist, psychologist Douglass Carmichael.

In response to public concern, a growing number of states have passed laws specifically addressing sexual malpractice, rather than subsuming it under the general category of professional misconduct. In California, for instance, a victim has cause to recover damages from a therapist if the sexual involvement takes place within two years after psychotherapy ends. Four states—Wisconsin, Colorado, Minnesota and North Dakota—have made sexual intimacy with patients a criminal offense, punishable with a fine and prison term. Other states are considering similar statutes.

Although the legal system may offer the prospect of redress, it can also prove a harrowing ordeal for victims. Witness the case of Cathy Nugent, 37, who was given drugs and sexually exploited by the psychiatrist she had been seeing for five years. In 1987, Nugent filed a malpractice suit against her therapist, Baltimore psychiatrist Dr. Francesco DiLeo. Two years later, a jury found DiLeo negligent in several areas, including having sexual contact with a patient and improperly administering drugs, and awarded Nugent $700,000 in damages. (The psychiatrist is appealing the judgment.) But Nugent says she cannot forget the defense lawyers' cross-examining her about her sexual history. Says LaVonna Vice, Nugent's attorney: "I felt like I was defending a rape victim. The whole strategy was to attack the plaintiff." Not so, replies William Taylor, one of DiLeo's attorneys, who maintained during the trial that Nugent took drugs and had sexual intercourse with the psychiatrist of her own free will. "You don't become a zombie because you are in psychotherapy."

Yet Nugent's case illustrates that even a successful courtroom battle will not ensure that an offending therapist is barred from practice altogether. DiLeo, for example, is still practicing psychiatry in Maryland. The state's Commission on Medical Discipline banned him from seeing patients privately and required that he undergo drug screening and enter therapy himself. But the commission only briefly suspended his license; after restoring it, the commission sent him to work, under supervision, at the state hospital in Sykesville.

Perhaps most disturbing, Nugent says that no amount of money can erase the damage that is the result of having her trust betrayed. She has given up her career as a mental-health worker for a less stressful job as an administrator. She continues to see another psychiatrist, a woman, in hopes that she can regain the life she once had. "Before this happened, I was a competent, confident person," she says. "This has undercut all of that." ■

by Erica E. Goode

The politics of seduction

Any issue that brings together sex and power can quickly turn into a political hot potato, and sexual entanglement between therapists and patients is no exception. Just how inflammatory the subject has become, even among therapists, is illustrated by a recent exchange of letters to the editor of the *American Journal of Psychiatry*, a cross fire inspired by a May, 1989, article by Harvard University psychiatrist Dr. Thomas Gutheil.

Broken boundaries. In his article, Gutheil describes a class of psychotherapy patients who seem especially susceptible to sexual abuse. These patients, carrying the psychiatric diagnosis of "borderline personality disorder," have difficulty maintaining appropriate social boundaries between themselves and others. In addition, they are frequently manipulative, are intensely needy and often have a history of sexual abuse—all qualities, the psychiatrist argues, that increase their risk of exploitation.

JOHN LOGE FOR U.S.NEWS

Gutheil's foray into print produced instant outrage and a flurry of letters to the journal. Psychologist Judith Jordan and four female colleagues objected: "We are gravely concerned that many courageous women who have been abused by therapists, women who are struggling with shame and guilt and who are just now beginning to find a way to voice their complaints, will be further victimized and silenced by the kind of bias represented in this article."

Gutheil's response was tart. For reasons he "cannot fathom," the psychiatrist wrote, his critics act as if treatment of patients does not occur in a situation where two people influence one another. "Can Dr. Jordan and her associates accept the complex possibility that the clinicians I described committed ethical and legal violations, malpractice, breaches of the fiduciary relationship ... *and* that the patients played some role in this—a role that can be studied without shifting the slightest culpability from the doctor?"

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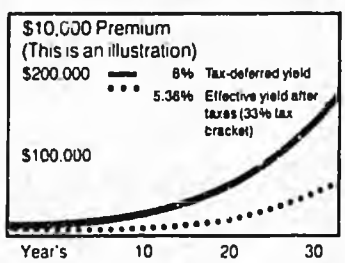

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IN THE SENATE

CS FOR SENATE BILL NO. 29 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to services of psychologists and psychological associates 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; <u>services of psychologists and psychological associates;</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) 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) services of psychologists and psychological associates;

(11) physical therapy;

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

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

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

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

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

(17) [(16)] 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;

(18) [(17)] 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;

(19) [(18)] skilled nursing facility services for persons

under age 21;

(20) [(19)] 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;

(21) [(20)] 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;

(22) [(21)] 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.