HB

248

Joel B. Wieman Ph.D.
Licensed Psychologist

1345 W. 9th Suite 200
Anchorage, Alaska 99501
(907) 276-7374

March 5, 1991

Senator Arliss Sturgulewski
Chair of the Senate Health,
Education and Social
Services Committee
PO BOX V STATE SENATE
Juneau, AK 99811

Dear Senator Sturgulewski:

I am writing you concerning SB 156, the Senate bill to include psychologists and socialworkers as independent providers in the Medicaid system. The Alaska Psychological Association is pleased the Senate Health Education and Social Services committee has introduced this needed legislation.

Historically psychologists or social workers wishing to provide service to Medicaid recipients have been required to work for a psychiatrist who holds a Medicaid group billing number. There are several effects of this practice. First, the choice of who the client may receive services from is dictated by who received group billing number when they were issued years ago, not by who is best qualified to provide the service, or who the client prefers to see.

Secondly, the cost of medicaid services is increased due to the necessity of requiring psychiatric supervision. In the private sector, to my knowledge, there are no insurance companies that require that a psychologist be supervised by a psychiatrist in order to provide services. Though a few companies require that social workers be supervised by either a psychologist of a psychiatrist, this is changing and social workers are generally treated as a valuable and independent group that are directly reimbursed by many insurance companies. Psychologists are included as independent providers under the federal Medicare regulations as well, and on a state level are now covered as independent providers of children services under the Early Prevention, Diagnostic, and Treatment (EPSDT) program as mandated by federal Medicaid regulations. To require that a psychologist of social worker

be supervised by a psychiatrist in order to provide Medicaid services not only waists state dollars, but the time of the professionals involved as well.

The issue of cost is one that has become increasingly more important as the economy changes in Alaska. With the federal mandate that psychologists and social workers be included in the EPSDT children's services, the additional costs of including provider status of adult services should be minimal. Many of the adult recipients of mental health services funded by Medicaid are the chronically mentally ill. These people are most often treated in either hospitals, day treatment facilities or other programs associated with community mental health centers, and are already receiving medicaid services from those agencies and in most cases would not be treated by independent practitioners. After having read the new regulations, my understanding is that services to adults that are related to family problems or that have a direct effect on children are to a great extent covered under the EPSDT program.

The majority of those who would be treated by independent psychologists or social workers would include low income individuals needing mental health services that will aid them in rejoining the work force, those injured on the job who need psychological evaluations to assist in new job placements, and individuals with head injuries or chronic neurological disease needing neuropsychological evaluations. In addition, others with mental disorders that impair their ability to function would be eligible to receive services.

The goal of most mental health work is to enable clients to become functioning human beings. This includes the ability to work, and provide for one's self. It is my belief that good mental health services serve to hold down the over all cost of caring for low income individuals, and that mental health services reduce the number of those receiving other governmental monies.

Hopefully this has clarified the some of the questions you may have had concerning this matter. I would be delighted to discuss this with you in person or over the phone. I will be out of town for the next week, but should be back in my office by March 13.

Thank you for your support on this matter,

Joel B Wieman Ph.D

Joel B. Wieman Ph.D
Legislative Coordinator
Alaska Psychological Association

March 15, 1991

I support Senate Bill 156 which allows for medicaid reimbursement to include psychologists and clinical social workers.

I have researched what happens when licensed clinical social workers are reimbursed by insurance companies for provision of mental health services. I have found that when this occurs, there is no proof of any increases in utilization or cost of services and that there is no decrease in the quality of services provided.

The following includes some of the information I located regarding this issue:
A 1982 Champus study reports a cost avoidance of $457,071.00 after allowing reimbursement to licensed clinical social workers.
A 1986 FEHB study out of the U. S. Office of Personnel Management reported no increase in cost or utilization of services when Licensed clinical social workers are reimbursed.
A 1989 survey of twenty insurance companies report no cost or utilization increases when licensed clinical social workers were reimbursed.
A NIMH study of Massachusetts Blue Shield for 1980,1981 and 1982,shows no overall cost or utilization increases when clinical social workers were reimbursed.
Data from 1982 and 1983 for Mass. Blue Shield shows no increase in utilization after including clinical social workers in reimbursement.
A study of Mass. Blue Shield for 1987 showed no increase in mental health reimbursements after including clinical social workers as providers.
An American Airlines spokesperson in 1990 stated that there was no increased cost when clinical social workers were included as providers and added that utilization did not increase either.
AT&T found no increase in cost when including clinical social workers as providers.

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Some factors which seem to contribute to lack of increase in cost and utilization of services when clinical social workers are included as providers include the following:
The American Journal of Psychiatry in 1980 states a study which shows a cost differential of $12 or 28% between psychiatrists and social workers' fees. That study indicates that the treatment course for social workers clients is shorter in term.
Mutual of Omaha confirmed that clinical social workers' fees are lower than those of psychiatrists.
In Maryland, where clinical social workers have been included as providers for over ten years, the fees of clinical social workers remain 33% lower than those of psychiatrists.
The American Psychological Association reports that clinical social workers consistently charge less than psychiatrists.

In general, mental health coverage is seen to lead to cost avoidance in overall medical care.
The CAlifornia Psychological Health Plan reports 20-24% reduction in utilization of surgical, hospital and medical treatment when mental health services are provided.
Group Health reports that users of mental health services reduce non-mental health benefits by 30.7% and lab/Xray services by 29.8%.
In Oregon, a study after a state mandate requiring provision of mental health services showed a savings in cost for the public,
A 1983 study in the Journal of Psychiatry indicated significant reduction in use of medical services, primarily inpatient, when individuals over 65 were provided mental health services.
According to IBM, one-half of the patients seen in their medical department had complaints that were emotional or psychiatric in nature.
Twelve studies in 1987 showed that mental health services treatment cut medical costs 26-69% and reduced sick days by 38-42%.

I will now address the quality of care issue when non-medical personnel are included as providers.
A 1985 survey of 7 treatment outcome studies reports therapeutic behavior and outcome of therapy equivalent among the three major mental health providers, clinical social workers, psychologists and psychiatrist.
(These studies include ones in Illinois, Canada and at the Veterans Administration.)
Studies indicate that there are more similarities than differences between services provided by the three disciplines and this needs to be considered when considering consumer choice.
Champus states that no quality of care problems arose when including clinical social workers as providers.
In Maryland, the Attorney General upheld the right of clinical social workers to diagnose.(A study out of NIMH indicated that the three main provider groups are equivalent as diagnosticians.)

This concludes my statement regarding my support of Senate Bill 156. .

Yvonne Micheli

Yvonne Micheli, LCSW #172
6526 Rodgers Pass STG
Ketchikan, Alaska 99901
(907)225-7558

WIC-CA

TO: Representative Georgianna Lincoln
FROM: Sherry Byers, Child Therapist

DATE: April 22, 1991

This letter is in support of the passage of House Bill 248 which would allow for medicaid payment for psychological services and clinical social work services.

Since the start of the '90-'91 school year we have had a waiting list of children seeking therapy services. Because of program financial limitations we are able to see only a limited number of individuals. Attempts have been repeatedly made to refer children to other agencies in the community, yet they always have a waiting list. Approximately 50% of those on the waiting list are medicaid recipients. If licensed private practitioners in the community were eligible to provide these services many doors would open for these children. All waiting lists would be shortened and some children in need of services would be able to receive psychotherapy.

I believe it's important to note that the majority of licensed agency staff currently serving children in our community are clinical social workers. Certainly the Medicaid Assistance Program should include services provided by both clinical social workers and psychologists.

I view the passage of this bill as a wonderful opportunity to serve the children in this community and state. Please remember that our children are our future.

FAX TRANSMITTAL MEMO

TO: Rep. Georgianna Lincoln

DEPT: FAX #: 465-2652

FROM: Sherry Byers PHONE: 452-2293

CO: WIC-CA. FAX #: 452-2613

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United Way

Fairbanks Counseling and Adoption

753 Gaffney Road
P.O. Box 71544
Fairbanks, Alaska 99707
(907) 456-4729

April 23, 1991

Dear Health, Education and Social Services Committee Members,

The clinical staff at Fairbanks Counseling and Adoption supports HB 248 which would increase the options and services for children. We believe this bill will help to improve the quality of life and allow for healthier functioning which all of society will benefit from.

Sincerely,

Janna Eyer Stough

Janna Eyer Stough, LCSW
Family Treatment Coordinator

ALASKA STATE LEGISLATURE

Representative Georgianna Lincoln

HESS Committee, Co-Chair
Resources Committee, Vice-Chair

Budget Subcommittees
Health and Social Services
Revenue

P.O. Box V
Juneau, Alaska 99811

Phone: (907) 465-3732
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Alatna
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Manley Hot Springs
Marshall
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Minto
Mountain Village
Nikolai
Nulato
Pilot Station
Pitka's Point
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St. Mary's
Stevens Village
Stony River
Takotna
Tanana
Telida
Tuluksak
Tyonek
Venetie
Wiseman

MEMORANDUM

TO: House Health Education and Social Services Committee

FROM: Representative Georgianna Lincoln geo

DATE: April 24, 1991

RE: HB 248 - Medicaid Payment for Psychologists/Others

This bill will add psychologists and clinical social workers as approved medicaid providers. Adding these providers will expand access to mental health services, especially in rural Alaska where there are virtually no private psychiatric clinics and the community mental health programs all have long waiting lists. Many community mental health centers cannot see any children or new adult clients unless there is an emergency like a suicide attempt. Outpatient mental health services offered by licensed psychologists and clinical social workers have been demonstrated to be of similar quality to those supervised by physicians and to cost no more. Expanded outpatient services often help prevent far more expensive psychiatric hospitalizations.

Many private and public insurance programs , including medicare, CHAMPUS, and the federal employees insurance, cover these providers as independent providers. They have determined in studies that there was no cost increase when these providers were added and that the quality of services remained at least as good.

Permitting psychologists and clinical social workers to provide services directly under medicaid will also permit the Department of Health and Social Services to regulate their services and the cost.

The proposed **CS HB 248 (HES)** makes one change to the bill, on page 2, at line 17. The original bill places clinical social workers as number (10) and psychologists as number (11) in priority order changes the placement of these services . The CS moves them to (10) and (11) respectively, below clinic services which includes community mental health clinics. Advocates for this bill support this change.

Sponsor Statement

Alaska Native Health Board

1345 Rudakof Circle, Suite 206
Anchorage, Alaska 99508

Phone: (907) 337-0028
FAX: (907) 333-2001

March 27, 1991

The Honorable Arliss Sturgulewski, Chair
Committee on Health, Education, & Social Services
The Alaska Senate
P.O.Box V
Juneau, AK 99811

RE: Senate Bill 156

Dear Senator Sturgulewski:

At its March 5-7, 1991 meeting, the Alaska Native Health Board (ANHB) passed a motion in support of SB 156. ANHB is made up of the twelve regional Native health providers. The members are constantly faced with the impacts of mental health problems that demand professional services. SB 156 will add licensed clinical social workers and licensed psychologists as approved medicaid providers. This change will gradually improve access to community based mental health services and, as importantly, allow clients to choose a mental health provider who can best meet their needs.

Since the bill does not expand mental health coverage, its fiscal impact will be minimal. Outpatient mental health services are a critical component of preventing expensive crisis situations and decreasing avoidable hospitalizations. In addition, cost management opportunities are improved by direct enrollment of these providers since the Division of Medical Assistance can regulate utilization and payment levels.

In rural Alaska we are almost exclusively reliant on licensed psychologists and licensed clinical social workers. It is very hard to recruit and retain psychiatrists who command very high salaries.

We hope this bill will receive early and favorable consideration by the Senate HESS committee and the full body.

Sincerely,

Anne M. Walker
Executive Director

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

APA Position Paper.

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 ~~22~~ 156, which allows Medicaid recipients access to psychological services.

POSITION PAPER

House Bill 248

"An Act requiring the Medical Assistance program to cover psychologists' services and clinical social workers' services; and reordering the priorities granted to services covered under the Medical Assistance program."

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

I. Psychologists and Psychological Associates

Currently, there are about 115 licensed psychologists in Alaska, all of whom would be eligible to enroll as Medicaid providers were HB 248 to pass. A substantial number of these psychologists are already providing services to Medicaid recipients, and indirectly receiving Medicaid payments in community mental health clinics, or in physicians' 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 and can make it harder for clients to obtain care.

   Many states, including Alaska, have specified exactly how much and what types of supervision are required, but 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 is 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 person's mental problems are caused by or accompanied by physical problems, but in many cases, this arrangement only results in an unnecessary cost to the taxpayer.

Position Paper - DHSS

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 <u>any</u> licensed person the supervisor deems appropriate. This means that Medicaid pays the rate appropriate for a psychiatrist/M.D., but the patient often gets services from someone whose credentials would justify a lower rate.

The Federal Omnibus Reconciliation Act of 1989 (OBRA '89) mandated that states offer Medicaid-eligible children (under 21 years of age) any Medicaid-approvable service that they are found to need, even if a state has not previously chosen to offer that service. Since AS 47.07.030 requires us to offer all federally-mandated services, it is our present intent to add psychologists' services for children under 21 by regulations that will soon be published, on the grounds that children will not have sufficient access to mandatory mental health services without their addition, and sufficient access is a federal mandate.

HB 248 would therefore have the effect of adding psychologists' services just for adults.

From the provider's point of view, adding psychologists' services for adults 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, and between those who serve children and those who serve adults.

From the Medicaid recipients' point of view, adding psychologists' services would make it easier to obtain care, because it would increase the number of enrolled Alaska providers offering these services. 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 process in order to receive therapy.

Unfortunately, HB 248, by adding new providers to Medicaid, and by therefore making it easier for recipients to obtain the services psychologists are licensed to provide, is very likely to result in more recipients using mental health services, which will in turn increase program costs.

There is both data and informed opinion that indicates that adding a comparatively lower-cost provider group can actually save money, both by providing the same service at a lower cost and by easing access to a type of care which can prevent an illness from worsening to the point of requiring institutionalization, producing family dissolution, etc. However, this is hard to quantify and may be so much a direct function of a locale's or a state's total health care matrix as to not apply to a different location. We are convinced that Alaska, as many other states' past experiences have

indicated, will add costs by adding new providers.

There are only 26 psychological associates in Alaska, nearly all of whom practice in clinic situations. It is doubtful that Medicaid enrollment and reimbursement would be sufficiently appealing to entice any significant number of them into becoming independent providers. We do not anticipate that their inclusion will significantly improve access to services or substantially increase program costs. However, given the scope of their licensure in comparison to the scope of licensure of psychologists and of licensed clinical social workers, we believe it is reasonable and equitable to include them in HB 248.

II. Licensed Clinical Social Workers

There are approximately 155 licensed clinical social workers in Alaska, with about 78 practicing independently. Most of what we have noted about psychologists applies as well to licensed clinical social workers. However, this provider group , like psychological associates, was not included in the FY91 budget increment for the OBRA '89 expansion of services for children.

The department is currently examining whether their inclusion as a children's services provider group is necessary under federal law. It may well be that community mental health centers (all of which are Medicaid providers') Medicaid-enrolled psychiatrists, and the coming inclusion of psychologists as children's providers in Medicaid together offer sufficient access to basic non-institutional mental health services so that the access requirements of federal law are met without adding other provider groups.

Apart from the obvious fact that the department has no statutory authority under AS 47.07.030 to add provider groups or services which are not federally-mandated, the department does not believe the purpose of the Medicaid program is to provide access of provider groups to Medicaid reimbursement. Rather, the purpose of the Medicaid program is to provide needy Alaskans reasonable access to necessary medical care.

Unlike many other medical services, where an excess of available services can exist without producing negative fiscal effects, mental health outpatient services, if they expand too rapidly, can pose a fiscal risk to the state. Community mental health clinics, which the state is committed to support with state funds, depend in significant measure on Medicaid (50% federal) funding. A rapid shift of Medicaid patients toward other sources of treatment could result in the clinics losing revenue, which would most likely have to be compensated for by an increase in state-only funding.

For this reason, we favor a slower, incremental approach to any expansion of Medicaid mental health services. Also, because the state is committed to funding community mental health clinics, we

believe the bill expresses good fiscal sense by placing the new services proposed by HB 248 above "clinic services" in the priority list of AS 47.07.035. (The department would support even higher placement on the list, such as second and third.)

Position:

Given the rapid growth of Medicaid, we believe it is essential to be sure that each new service Alaska adds is clearly necessary to comply with federal law or to remedy an identified coverage gap which poses a real threat to the health of Medicaid recipients. We also believe that the discussion of adding any service which does not pass either of these tests must include consideration of the comparative importance of other optional services we do not provide.

The department does not oppose the addition to Medicaid of psychologists' services for adults, nor does it oppose the addition of psychological associates' services for both children and adults. We do not oppose the addition, at some future time, of licensed clinical social workers' services, provided that the need for this service is clear <u>after</u> we have some exposure to the effects of OBRA '89 changes and the addition of psychologists proposed by HB 248.

Recommended by: Kimberly B. Busch

Kimberly B. Busch
Acting Director
Div. of Medical Assistance

Date: 4-24-91

Approved by: Jay Livey for

Theodore A. Mala, MD, MPH
Commissioner

Date: 4-24-91

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. HB 248

Revision Date: 4/24/91
Department Affected: Health and Social Services
Title: An Act requiring the medical assistance program to cover psychologists'....
BRU: Medical Assistance - Medicaid
Component: (1) Non-Facility
Sponsor: Lincoln, Gruenberg
(2) Medical Assistance Admin. Claims Processing
Requestor:
COMPONENT SERIAL NO. 0230

Expenditures/Revenues: Thousands of Dollars

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	86.7	140.7	167.2	198.6	235.9	280.2
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS CLAIMS	269.1	664.2	819.6	1,011.4	1,248.1	1,540.2
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	355.8	804.9	986.8	1,210.0	1,484.0	1,820.4
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

GENERAL FUND	165.2	370.5	455.4	559.9	688.4	846.6
FEDERAL FUNDS	190.6	434.4	531.4	650.1	795.6	973.8
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	355.8	804.9	986.8	1,210.0	1,484.0	1,820.4

POSITIONS:

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year impact: none

ANALYSIS: (Attach a separate page if necessary.)

See attached

Prepared By: Kimberly A. Burch
Phone: 465-3355
Division: Medical Assistance
Date: 4-24-91
Approved by Commissioner: Jay Livey for
Agency: Health and Social Services
Date: 4-24-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impact Agency(ies).

HB 248 Analysis

I. Contractual Costs

a. The Alaska Medical Payments System will require modification to pay psychologists, psychological associates, and licensed social workers as a new service. The contractual costs include such items as the following: provider manuals, training, a new claims form, tables included in the system for psychologists' services for adults and licensed social workers' services, computer programming, computer reports, the addition of collocation codes, and a computer system test. Since Psychologists' services and Licensed Clinical Social Workers' services have already had most of this effort completed as part of the OBRA '89 project of expanding services for children, the only additional work needed to provide for adult services will be 6 new edits for psychologists, and 6 new edits for social workers, at $1080 per edit ($6480 each, $12,960 total). Psychological Associates are an entirely new provider type and will require $23,914 in contractual costs.

Total one-time FY92 cost = 36.9 (18.5 Fed, 18.4 SGFM)

b. The Division of Medical Assistance must pay the claims processing contractor $6.23 for each claim processed. Estimated claims volume for FY92 is 8,000, assuming a January 1, 1992 start date. FY92 processing costs = 49.8. (36.2 Fed, 13.6 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 one-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 billings per year, X 12 psychologists = $14,400 Medicaid savings). However, we assume that 37% of the caseload is children, who could receive psychologists' services through Medicaid under EPSDT regardless of SB 156. Therefore, the net savings related to this legislation is $9,100 ($14,400 X 63%) for 12 months.

(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 20 patients per week for a total of 30 hours per week, and that they charge $90 per hour for private sessions. Vacations, holidays, and continuing education reduce their work time to 46 weeks per year.

(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. We also assume that 37% of their Medicaid billings will be for children, who would be covered by Medicaid under EPSDT regardless; therefore, 63% of the cost of the new caseload would be attributable to HB 248. Cost for the new psychologists' services will be 30 hours per week X 46 weeks X $90 per hour X 15% X 63% X 26 psychologists = $305,200.

(6) The cumulative margin of error in all these assumptions for psychologists' services is such that we do not feel it is necessary to separately cost psychological associates' services. We believe that one, two, or possibly three new providers will initially enroll, and the net costs of so few providers can be covered by the funding requested for psychologists.

(7) 39 licensed clinical social workers will enroll as providers in the first year (The actual number is likely to be higher, but because many licensed clinical social workers do not practice full time, we have assumed 39 "full-time equivalents" to simplify calculations.)

(8) Approximately 19 of these new providers are currently providing services indirectly, supervised by and/or billing through a physician or psychiatrist. About one-half of these are billing Medicaid at a rate 20% lower than the rate charged by psychiatrists. Payments to the 10 now billing at the higher rate will be reduced by $16,000 (20% reduction X 8,000 current average psychiatrist's Medicaid billing per year, X 10 licensed clinical social workers = $16,000 Medicaid savings for a full year). We assume no coverage of licensed clinical social workers through EPSDT.

(9) We have assumed that billings from physicians and psychiatrists who supervise the licensed clinical social workers now providing services to Medicaid eligibles will not decrease if licensed clinical social workers were to enroll directly.

(10) Approximately 20 licensed clinical social workers in private practice who are not currently serving Medicaid recipients will enroll. We assume that these new providers will see an average of 21 patients per week. Industry sources indicate that they will bill, on average, 22 hours per week. We assume that they charge $85 per hour for private sessions, and that they will work 46 weeks per year.

(11) We assume that licensed clinical social workers 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 the new licensed clinical social workers' services will be 22 hours per week X 46 weeks X $85 per hour X 15% X 20 licensed clinical social workers = $258,100.

(12) Combined new costs for psychologists and licensed clinical social workers = $563,300 ($305,200 + $258,100). Combined savings = $25,100 ($9,100 + $16,000). Net costs = $538,200 ($563,300 - $25,100) for a full year. The time required for data system changes, promulgation of regulations, and provider enrollment activities necessitate a starting date no earlier than January 1, 1992. FY92 benefits will therefore be 50% of a full year:

134.5 SGFM
134.6 FED
269.1 Total

(13) Benefits costs for FY93 through FY97 are computed from the FY91 base estimates, adjusted for a full year, and increased annually by 23.4% (4.6% for price increases, 7.0% for increases in the number of eligible recipients, and 11.8% for utilization increases).

(14) Claims processing costs are billed at $6.23 per claim. For FY93 through FY97, FY92 costs, adjusted for a full year, are increased by 18.8% annually (7.0% for increases in the number of eligible recipients and 11.8% for utilization increases).

(7)

[redacted] OUSE COMMITTEE REPO[redacted]

Date Referred: April 2, 1991 FURTHER REFERRALS: Finance

Date of Committee Action: _____

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 248

HOUSE BILL NO. 248 MEDICAID PAYMENT FOR PSYCHOLOGISTS/OTHERS

"An Act requiring the medical assistance program to cover psychologists' services and clinical social workers' services; and reordering the priorities granted to services covered under the medical assistance program."

RECOMMENDATIONS: [X] the same title
be replaced with CS HB 248 (HES) [ ] a new title

[ ] have attached amendments(s)
[ ] do pass
[ ] do not pass
[ ] no recommendations
[X] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

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

[X] fiscal impact Dept of HHSS 4/24/91 [ ] fiscal note(s) _____

[ ] zero fiscal note _____ [ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Cheri Davis	✓				
Mary Miller	✓	Marie Hadley		X	
John E. Gonzales	✓				
Betty L. Davis	✓				
[redacted]	✓				
[redacted]	✓				

CHAIRMAN'S SIGNATURE

7-LS1026\D
Lauterbach
4/24/91

CS FOR HOUSE BILL NO. 248 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES LINCOLN, Gruenberg

A BILL

FOR AN ACT ENTITLED

"An Act requiring the medical assistance program to cover psychologists' services and clinical social workers' services; and reordering the priorities granted to services covered under the medical assistance program."

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>psychologists' services; clinical social workers' services;</u> prescribed drugs; 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) **clinical social workers' services;**

(10) psychologists' services;

(11) clinic services;

(12) [(10)] physical therapy;

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

(14) [(12)] prescribed drugs;

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

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

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

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

(19) [(17) REPEALED

(18)] individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;

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

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

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

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

* **Sec. 3.** AS 47.07.900 is amended by adding new paragraphs to read:

(11) "clinical social workers' services" means clinical social work services provided by a person licensed as a clinical social worker under AS 08.95;

(12) "psychologists' services" means services within the practice of psychology provided by a person licensed as a psychologist or psychological associate under AS 08.86.

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 psychologic problems that may be affecting the elderly patients.

Misc. Back-up

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."

MENTAL HEALTH BENEFITS: NEED AND COST EFFECTIVENESS

NEED

- NIMH estimates that 23 million American adults have a serious mental disorder other than substance abuse. These mental illnesses cost society an estimated $73 billion annually, about half of which is attributable to lost productivity in the workplace (NIMH, 1989).

- NIMH further estimates that in any one-month period almost 8 million people experience depression at an estimated annual cost of $16 billion, $10 billion of which is attributable to absenteeism from the workplace (NIMH, 1989).

- A recent Gallup survey reveals that stress causes American worker to miss an average of 16 days on the job each year, and nearly three-fourth of the corporate medical directors and human resources managers surveyed called it "very pervasive" or "fairly pervasive." The managers reported that 13% of their employees suffer from symptoms of depression, including difficulty in concentrating (36%), sleep problems (35%), loss of energy (27%), and loss of interest in work (18%). (American Medical News, Nov. 10 1989)

- Researchers at the Rand Corporation concluded that mental illness including depression, can be as functionally disabling as a serious heart condition and more disabling than other chronic physical illnesses such as lung or gastrointestinal problems, angina, hypertension, and even diabetes (Journal of American Medical Association, 1989).

- Investigations have found that 60% of all health care visits are by people with no physical problem. This figure rises to 80%-90% when stress-related illnesses (e.g., peptic ulcer, ulcerative colitis, hypertension, etc.) are also included (Cummings & VandenBos, 1981).

COST OFFSET AND COST EFFECTIVENESS

The cost of including mental health benefits in health insurance plans must be evaluated in light of the substantial savings that accrue from making qualified mental health services available. A growing body of empirical research demonstrates that even brief, limited mental health intervention can substantially reduce the utilization and cost of more expensive medical care:

- Numerous studies show a decrease from 5 to 80 percent in medical service use following mental health treatment. Of 22 studies examining the impact of alcohol and mental health treatments, 21 presented medical utilization decreases, with average reductions of 46% after alcohol treatment and 26% after treatment for mental illness (Jones & Vischi, 1979)

-over-

N.W.
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- An examination of the medical care records of 400 patients for a five-year period show that patients receiving ambulatory mental health care have lower utilization of medical services than patients not receiving mental health treatment. By the second post-treatment year, the untreated group used 1.53 as much non-psychiatric medical care as the treated group, and averaged more than $94 per year in increased non-psychiatric medical costs compared to the treated group (Borus, et al., 1985)

- A comprehensive analysis of a collection of 58 controlled studies and claims files for the Blue Cross/Blue Shield Federal Employees Plan from 1974 to 1978 concluded that, following mental health treatment, the average 8.7-day inpatient hospitalization was reduced by 1.5 days (Mumford, et al., 1984).

- Other Blue Cross and Blue Shield data show that following outpatient mental health care, the monthly cost per patient for medical services dropped from $16.47 to $7.06. Inpatient and outpatient medical visits decreased by more than 54% (Blue Cross of Western Pennsylvania, 1976).

- A comparison was made of three groups of persons, all diagnosed as having one of four chronic illnesses, covered by the Blue Cross/Blue Shield Federal Employees Program from 1974 to 1978. One group received 7 to 20 mental health visits within three years, the second was seen for more than 21 visits and the third group had no mental health treatment. By the third year, the 7 to 20-visit group had annual medical charges $309 lower, and those with more than 21 visits had medical expenses $284 lower than the no-mental-health-treatment group (Schlesinger, et al., 1983).

- Corporations are increasingly finding that employee assistance programs that include psychological care can decrease employee medical costs. For example, General Motors had 11,813 referrals to its EAP in 1986. During the same period, sickness payments were reduced by 40% (The New York Times, 8/30/87).

- Studies of subscribers to the Kaiser-Permanente health insurance plan show that medical bills of heavy users of health services decreases anywhere from 37% to 75% after short-term psychotherapy. (The New York Times, 8/30/87).

- Mental health services combined with treatment for physical disorders results in decreased hospital costs at least equal to the cost of the mental health services. A recent study of several chronic diseases showed that the use of mental health services "improves the quality and appropriateness of care and also lowers costs of providing it" (Schlesinger, et al., 1983).

- Demand for mental health services would not rise dramatically with needed, responsible increases in insurance coverage. A recent study showed only 9% of those with generous mental health coverage sought treatment. (Wells, et al., 1982)

Psychologists

Training and Expertise As Health Care Providers

PRESENTED BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION

- No other mental health profession requires as high a degree of education and training in mental health as psychology. Accredited doctoral programs in clinical psychology, including practicums and internships at clinics and hospitals, take an average of 5 1/2 years to complete. Over two-thirds of these clinical internships are in hospital settings.

- All 50 states and the District of Columbia have enacted laws regulating the practice of psychology. Licensure is required for independent practice. Most state laws require, as a minimum, a doctoral degree from an accredited institution and at least two years of supervised experience by a senior psychologist. To further ensure quality, an ethical code has been adopted as part of all state licensing laws.

- Accredited clinical psychology programs emphasize a basic core that includes biological, cognitive, emotional, and social bases for human behavior, diagnostic evaluation and assessment, research, as well as intervention and treatment techniques. Among these techniques are individual, child, family and group therapies.

- Since the mid-1980s, psychologists have provided more outpatient psychotherapy and psychological diagnostic evaluations than any other doctorally-trained mental health professional. In fact, psychology has been in the forefront of the leading psychological and biological research on the mind/body interface, including the diagnosis and treatment of stress disorders, neurological impairments, brain disease and psychosomatic illness.

- Diagnostic tests performed by psychologists and neuropsychologists are state-of-the-art tools. Increasingly, physicians and other health care professionals turn to psychologists for their diagnostic capabilities.

- Increasing numbers of psychologists are providing education and training in diagnosis and treatment for residents, interns and students in the field of internal medicine, family practice, neurology, obstetrics, oncology, pediatrics, physical medicine and rehabilitation, as well as trainees in other fields.

Psychologists

In The Health Care System

PRESENTED BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION

- There are approximately 50,000 doctorally-trained psychologists licensed to independently diagnose and treat mental and nervous disorders.

- Forty-one states have enacted freedom of choice laws requiring that insurance companies reimburse psychologists for their services if those services are covered by the insurance contract and are within the scope of psychologists' licenses.

- The recognition of psychologists as independent providers increases competition to reduce and control costs. Costs for both psychologists and psychiatrists are significantly lower in all states that have freedom of choice.

- Psychologists are currently recognized in federal programs including the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Veterans Administration, the Federal Employees Health Benefit Plan (FEHBP), HMOs, community mental health centers, comprehensive outpatient rehabilitation facilities (CORFS), and the Medicaid plans in over half of the states. In addition, psychologists are now recognized as independent providers in rendering services to Medicare/HMO enrollees, and to Medicare patients in community mental health centers and in rural health clinics.

Item #1

Spending to Cut Mental-Health Costs

WSJ 12/13

Employer Finds Quality Care The Best Buy

By Ron Winslow
Staff Reporter of The Wall Street Journal

When it comes to surgery for employees, companies can save millions of dollars with a few pointed questions: Is any alternative available? Can it be an outpatient procedure? Can a hospital stay be shortened by a day or two?

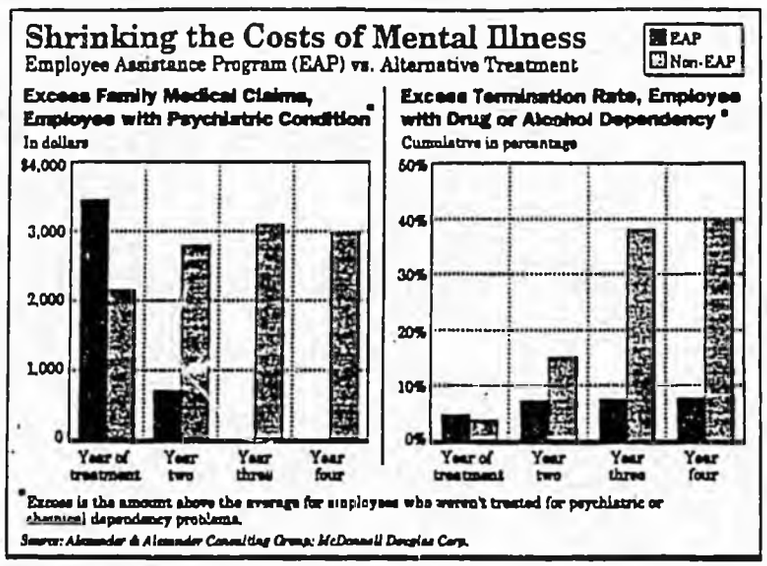
But when applied to psychiatric care or treatment for drug and alcohol abuse, such narrow cost-cutting efforts can *cost* a company millions of dollars. Instead, employers can shrink their bill for mental-health care by taking the long view, even if that means spending more in the early stages of treatment.

That's the conclusion of a four-year study of mental-health treatment at McDonnell Douglas Corp. By assessing individual cases carefully and emphasizing quality care from the outset, the St. Louis aerospace and defense company expects to save more than $5 million over the next three years—just for people who began care last year.

Prime Target

Treatment for such afflictions as depression, marital or job-related stress and drug and alcohol abuse can account for up to 20% of employer health costs. Last year alone, according to benefits consultant Foster Higgins, such expenses jumped 27%, making them a prime target for cost-cutters. Meanwhile, a new study at Westinghouse Electric Corp. suggests that depression is much more prevalent among white-collar workers than previous studies indicated, with worrisome implications for productivity.

"Many companies are wrestling" with mental-health care, says Veronica Vaccaro, manager of mental-health promotion for the Washington, D.C., Business Group on Health. "It's a very squishy area. Benefits managers don't know much about it. There's very little agreement on how long treatments should last."



Without a consensus, specialists say, a patient may receive, say, 28 days of care in a psychiatric hospital because that's what an insurance policy covers instead of what a diagnosis calls for. With such hospital costs running at $1,000 a day, employers want to shorten hospital stays or move cases to outpatient care.

"The prevailing winds these days are to cut [mental-health] benefits," says Dr. John J. Mahoney, managing director at Alexander & Alexander Consulting Group, who conducted the McDonnell Douglas study. "But we found the company gets the best mileage by providing the best possible service on the front end."

Different Results

The study compared employees who sought mental-health care on their own with those who chose to use the company's employee assistance program, or EAP. Though coverage was essentially the same in either case, the study found the EAP, which screens troubled patients confidentially and refers them for appropriate treatment, much more cost-effective.

The study, designed to adjust for differences in employees seeking the two kinds of care, is based on medical claims and absentee records for more than 20,000 of McDonnell Douglas's 125,000 employees. It is particularly unusual in its comparison of the long-term effectiveness of different approaches to treating mental illness.

Already, EAPs are used by 70% of Fortune 500 companies, according to the Employee Assistance Program Association, and about one-third of U.S. employees have access to the programs. Marketers of EAPs are likely to use the study as evidence that they are effective, but researchers caution that the programs vary widely in design and quality.

"This program saved money because it was run in a certain fashion, not because it was an out-of-the-box EAP program," says Dr. Mahoney. Adds Ms. Vaccaro: "Companies are beginning to use their EAPs as cost-management programs, but for that to be effective, it has to be a comprehensive approach."

At McDonnell Douglas, in-house supervisors oversee the program while EAP staff members from outside the company actually meet on a confidential basis with employees—or their dependents—and make an initial assessment of the patient, says Daniel C. Smith, director of employee assistance and human resource risk management services.

"Our approach is to provide whatever level of treatment is warranted by that assessment," Mr. Smith says, "rather than focus on short-term cost-containment objectives." But the company selects only providers with established track records of cost-effective care. And it closely monitors each case, both during treatment and for up to two years after the employee returns to work.

A crucial component of the company's EAP is insisting that the whole family included in treatment. That results higher first-year costs in many cases. "It seems to be a very important aspec long-term recovery and long-term hea cost management," Mr. Smith says.

Family Impact

Indeed, the study offers dramatic e dence of the broad impact of psychiat problems or substance abuse: Families employees treated for chemical dep dency outside of the EAP consumed an erage of $6,400 more in medical servi over four years than families with no m tal-health treatment. For psychiatric tre ment, the excess medical costs averag $11,000. Under the EAP, these added fa ily costs were reduced by more th half.

Among the study's other highlights:

—Over four years, employees who us the EAP for chemical dependency tre ment missed 44% fewer workdays, h 81% lower attrition and filed $7,300 less health-care claims than those who didr use the EAP. Savings were somewh smaller in all categories for psychiatr care.

—Forty percent of employees treate outside the EAP for drug or alcohol abu left the company within four years, com pared with just 7.5% of those who used th EAP. The study didn't factor in costs of r placing an experienced employee, but r ducing attrition is a corporate goal b cause of a decline in the availability c qualified new workers. Mr. Smith says "Retaining valued employees has a whol new significance today."

—Employees who sought mental-healt care through their health maintenance or ganizations were four to five times mor likely to quit or be fired within four years than those who used the EAP. That "star tling difference in outcomes," Mr. Smith says, indicates that "something is wrong, and dramatically wrong," with the quality of mental-health and substance-abuse care that prepaid health plans provide.

McDonnell Douglas says it doesn't plar to require employees seeking care to use the EAP, but it hopes the program's effec tiveness will attract people. The company's estimated $5.1 million in savings over the next three years is based on 1,03 clients who began treatment through the EAP in 1988, comparing their costs with what they would pay had they gone outside the EAP. Of the total, the report says, $2 million will come from reduced employee medical claims, $2.3 million from reduced dependent medical claims, and $800,000 from reduced absenteeism. Savings for employees who began treatment in other years would be cumulative.

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 New 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 c brief psychotherapy to reduce the high incidence of unnecessary medical care....medical utilization declined significantly--and stayed down for the five years studied...[and]...among patient 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 n 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 clinica 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% decreas 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. <u>THIS IS A 49.5% REDUCTION IN ABSENTEEISM, A 64.2% REDUCTION IN WEEKLY INDEMNITY, AND A 48.9% REDUCTION IN HOSP.-MED.-SURGERY COSTS!!</u> Those employees not invoved in psychotherapy tended to get worse and showed increases of: 2.9% increase in absenteeism, a 28.5% increase in weekly indemnity costs, and a 7.7% increase in hospital, medical and surgical costs.

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

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

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

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27. A 1980 article in American Medical News (10/10/84) stated 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."

American Psychological Association

Advancing psychology as a science, a profession, and as a means of promoting human welfare

MENTAL HEALTH BENEFITS: NEED AND COST EFFECTIVENESS

NEED

o 28 million American adults have a serious mental disorder other than substance abuse. These mental illnesses cost society an estimated $129.3 billion annually, about half of which is attributable to lost productivity in the workplace (Rice et al., 1990).

o In any one-month period almost 8 million people experience depression at an estimated annual cost of $16 billion, $10 billion of which is attributable to absenteeism from the workplace (Regier et al., 1988; NIMH, D/ART Office, 1990).

o Stress causes American workers to miss an average of 16 days on the job each year, and nearly three-fourths of the corporate medical directors and human resources managers surveyed call stress "very pervasive" or "fairly pervasive." Managers surveyed reported that 13% of their employees suffer from symptoms of depression, including difficulty in concentrating (36%), sleep problems (35%), loss of energy (27%), and loss of interest in work (18%). (American Medical News, Nov. 10, 1989).

o Mental illness, including depression, can be as functionally disabling as a serious heart condition and more disabling than other chronic physical illnesses such as lung or gastrointestinal problems, angina, hypertension, and even diabetes (Wells et al., 1982).

o 60% of all health care visits are by people with no physical problem. This figure rises to 80%-90% when stress-related illnesses (e.g., peptic ulcer, ulcerative colitis, hypertension, etc.) are also included (Cummings & VandenBos, 1981).

COST OFFSET AND COST EFFECTIVENESS

The cost of including mental health benefits in health insurance plans must be evaluated in light of the substantial savings that accrue from making qualified mental health services available. A growing body of empirical research demonstrates that mental health care can substantially reduce the utilization and cost of more expensive medical care. This economic effect is known as "cost offset".

o Three hundred veterans who received abbreviated mental health treatment following a history of excessive medical health utilization were able to reduce outpatient medical visits by 36%. Control groups, who received no psychotherapy, actually increased outpatient medical utilization. (Massad et al., 1990).

o A comprehensive analysis of 58 controlled studies and claims files for the Blue Cross/Blue Shield Federal Employees Plan from 1974 to 1978 concluded that, following mental health treatment, the average 8.7-day inpatient hospitalization was reduced by 1.5 days. The same study summarized over 60 investigations of psychotherapy effects on medical utilization and found that 85% demonstrated medical utilization decreases following psychotherapy. The average decrease for inpatient utilization was 73.4%, and for outpatient services 22.6%. (Mumford et al., 1984).

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o 400 patients who received ambulatory mental health care had lower utilization of medical services than patients not receiving mental health treatment, over a five year period. By the second post-treatment year, the untreated group used 1.53 as much medical care as the treated group, and averaged more than $94 per year in increased medical costs compared to those who received mental health treatment. (Borus et al., 1985).

o Medicaid patients hospitalized for physical ailments and provided mental health interventions realized average cumulative savings of $1,500 over a subsequent 2 1/2 year period. The cost of the mental health intervention was entirely paid for (i.e., totally offset) by these savings. Patients hospitalized without physical ailments who received mental health treatment realized savings, ranging from $296 to $392 depending on severity of diagnosis. (Fiedler et al., 1989).

o A three year study of over 10,000 Aetna beneficiaries showed that after initiation of mental health treatment, client medical costs dropped continuously over 36 months. The health costs of one mental health treatment group fell from $242 the year prior to treatment to $162 two years post-treatment. Other subject groups demonstrated similarly dramatic offset effects, leading the researchers to conclude that a decrease in total health care costs can be expected following mental health interventions even when the cost of the intervention is included. (Holder & Blose, 1987).

o Research on 20,000 enrollees at the Columbia Medical Plan showed that untreated mentally ill persons increased their medical utilization by 61% during a one year period. In contrast, the mentally ill who received psychological treatment increased their medical expenditures by only 11% during the same period. A mentally healthy comparison group averaged a 9% increase. (Hankin, 1983).

o Numerous studies show a decrease from 5 to 80 percent in medical service use following mental health treatment. Of 22 studies examining the impact of alcohol and mental health treatments, 21 presented medical utilization decreases, with average reductions of 46% after alcohol treatment and 26% after treatment for mental illness (Jones & Vischi, 1979).

o Other Blue Cross and Blue Shield data show that following outpatient mental health care, the monthly cost per patient for medical services dropped from $16.47 to $7.06. Inpatient and outpatient medical visits decreased by more than 54%. (Blue Cross of Western Pennsylvania, 1976).

o A comparison was made of three groups of persons, all diagnosed as having one of four chronic illnesses, covered by the Blue Cross/Blue Shield Federal Employees Program from 1974 to 1978. One group received 7 to 20 mental health visits within three years, the second was seen for more than 21 visits and the third group had no mental health treatment. By the third year, the 7 to 20-visit group had annual medical charges $309 lower, and those with more than 21 visits had medical expenses $284 lower than the no-mental-health-treatment group. (Schlesinger, et al., 1983).

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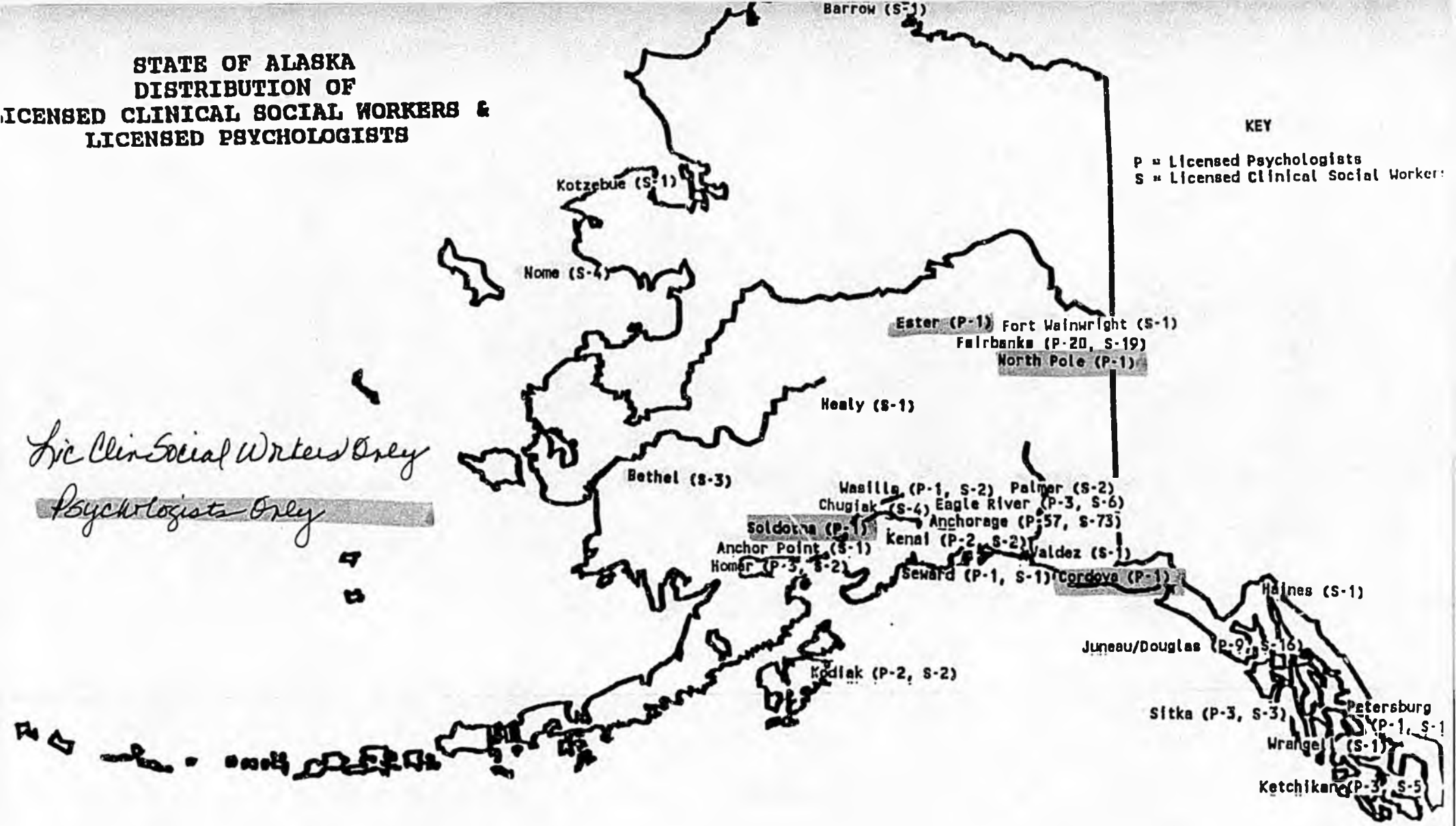
STATE OF ALASKA
DISTRIBUTION OF
LICENSED CLINICAL SOCIAL WORKERS &
LICENSED PSYCHOLOGISTS



KEY

P = Licensed Psychologists
S = Licensed Clinical Social Workers

TOTALS

STATE OF ALASKA

110 Licensed Psychologists
162 Licensed Clinical Social Workers

OTHER STATES

30 Out-of-State Licensed Psychologists
6 Out-of-State Licensed Clinical Social Workers

Information compiled from
State of Alaska
Department of Commerce and Economic Development
Division of Occupational Licensing
Directories of Licensees

Licensed Clinical Social Workers: January, 1991
Licensed Psychologists: October 1990

The Social Worker as Independent Mental Health Practitioner

Cost effective services for the community

The Social Worker as Independent Mental Health Practitioner

Cost-effective services for the community

National Association of Social Workers, Inc.
Office of Quality Assurance
7981 Eastern Avenue
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October 1990

Emerging Recognition

In recent years, there has been an increasing and overdue recognition that social workers are fully qualified mental health professionals. Social work encompasses the value base, body of knowledge, supervised practice experience and demonstrable skills that are the hallmark of a profession.

Because of deeply ingrained cultural stereotypes based on the profession's early history, the public has been slow to let go of its image of the social worker as a non-professional volunteer for charitable causes or an agency worker with a caseload of the poor and underprivileged. Social workers today do provide valuable income support services, but they are also found wherever people have any kind of psychosocial problems; for example, in hospitals, mental health clinics, schools, alcohol and drug dependency facilities and the workplace, and in private, independent practice as well. Social work practice requires skilled practitioners with knowledge of human behavior and development, family interaction, community resources, relevant legislation and more.

The profession of social work is now officially recognized in 50 states and jurisdictions, which provide for legal regulation of professional social workers. Twenty five of these have also enacted vendorship (or consumer choice) laws that provide for the reimbursement of clinical social work services under insurance policies that cover their beneficiaries for mental health services.

As early as 1972, social workers alone represented 44 percent of the professional staff (excluding nurses and non-psychiatric physicians) in mental health facilities in the United States.[1] Now providing the bulk of mental health services in the United States, social workers are finally and deservedly being recognized as fully qualified mental health providers.

As a *New York Times* article noted, "A quiet revolution is going on in psychotherapy. . . . Three major groups offering psychotherapy are psychiatrists, psychologists and social workers. . . . But the new shift is most pronounced in the comparison between psychiatrists and social workers. . . . Although social workers provide the bulk of therapy in institutions, growing numbers are treating more affluent, private clients, thus moving into the traditional preserve of the elite psychiatrists and clinical psychologists, as well."[2]

Social workers are also being recognized as expert witnesses in an increasing number of court cases. The American Bar Association's standards identify clinical social workers as qualified mental health professionals who should be recognized as expert witnesses.[3] Justice Benjamin Altman of the New York County Supreme Court recently wrote that "even though they are not physicians, certified social workers who demonstrate appropriate training and supervised clinical experience in the diagnostic assessment of mental disorders may, within the scope of their license, make diagnostic assessments of a person's mental condition and may qualify as experts in the diagnosis of mental health disorders."[4]

Justice Stephen G. Crane of the New York Supreme Court decided in 1985 that "a properly qualified certified social worker may be appointed to act as 'psychiatric examiner'. . . . Clinical social workers, who provide the

majority of the psychotherapeutic services rendered in the United States . . . are particularly suited to be of assistance to the courts in resolving clinical-legal issues and in facilitating the effective administration of individualized justice in cases where issues relating to psychosocial dysfunction and mental disorders are involved."[5]

There have been many other decisions which recognize social work as a legitimate member of the learned professions. In 1976, the Montgomery County (Maryland) Board of Appeals, for instance, ruled that "an accredited social worker who has earned a Master's degree, practices in a field licensed and regulated by state statute and is a bona fide member of a professional group having powers to adopt a code of ethics and to discipline members for unethical conduct meets all the standards established by the County Attorney's Opinions, and therefore should be considered a member of a 'recognized profession'."[6]

Research on the Cost-Effectiveness of Clinical Social Work

In the competition for market share among mental health professionals, cost efficiency of services takes on decisive importance. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which provides medical care for military dependents, military retirees and members of the Commissioned Corps of the U.S. Public Health Service, conducted a study on the cost-effectiveness of using clinical social workers as reimbursable providers of mental health services to its beneficiaries. Following an 18-month study of such services from 1981 to 1982, CHAMPUS decided to include social workers as independent reimbursable mental health providers.[7]

The Senate Report on the Department of Defense Appropriation Bill of 1983 stated that, "Based on the successful pilot program the Committee has included bill language to permit direct reimbursement of clinical social workers who provide mental health services. . . . No quality of care problems have arisen, and reimbursement of clinical social workers costs less than the traditional physician gate keeper approach."[8]

Many companies who provide insurance for federal employees under the Federal Employees Health Benefits Act (FEHBA) have for many years voluntarily included social workers as reimbursable providers of mental health services.

In February 1986, President Reagan signed into law an amendment to FEHBA which requires that such coverage be included in health plans provided for some 10 million federal employees, retirees and dependents. It further provides that insurance carriers may not require that social workers be supervised by any other health professional. As of July 1, 1990, Congress enacted legislation to include clinical social workers as reimbursable mental health providers under Medicare Part B outpatient mental health coverage (P.L. 101-239).

Thus, clinical social workers are covered mental health providers for all programs under the jurisdiction of the federal government.

There is also a considerable body of research which indicates that providing mental health services has the effect of reducing other health care costs (called "cost-offset"), particularly those related to hospitalization. Since over one half of all health dollars (government, insurance and private) are funneled to hospitals and physicians,[9] reduction of these costs must be a major consideration in any health care cost containment effort. A recent analysis of cost-offset literature concluded, "The widespread and persistent evidence of reduced rate of increase of medical expense following mental health treatment argues for the inseparability of mind and body in health care, and it also argues specifically for the likelihood that mental health treatment may improve patients' ability to stay healthy enough to avoid hospital admission for physical illness. The clearest cost-offset effect appears largely in the reduction of inpatient rather than outpatient costs. As . . . inpatient charges account for 75 percent of total medical charges . . . substantial savings would have to result from reduced hospitalization."[10]

Research on the impact of a Massachusetts vendorship law implemented in July 1982 indicated that the total dollar amount paid out by the major insurer (Blue Shield of

Massachusetts) for mental health services over the previous two years stayed virtually constant, correcting for inflation, but there was a slight shift in payments from psychiatrists to psychologists and social workers. It may be that previously social workers were billing through the psychiatrists for reimbursement, and thus this shift may not reflect any actual dollar change.[11]

A study conducted by Actuarial Services of Blue Cross and Blue Shield of Utah from 1980 to 1982 indicated that following the Utah vendorship law (implemented in 1978), the number of social workers licensed as providers of mental health services increased by over 50 percent from 1978 to 1982. The data indicate that social workers had not taken "any significant amount of business from either psychiatrists or psychologists but rather have drawn from a pool of patients which previously did not receive care covered by mental health insurance benefits."[12]

The situation in Utah resulted in an increased number of people receiving mental health services, very likely because social workers are usually found in greater numbers in rural areas than are other mental health professionals.

Their services are also attractive because they usually charge lower fees than other mental health providers and also have fewer visits per individual case.[13]

The National Institute of Mental Health conducted a survey of Blue Cross reimbursements for mental health services in the Washington, D.C. area. At its completion in 1976, they found that social workers provided about 12 percent of the mental health services for which claims had been submitted, but received only 9 percent of the revenues. Social work fees were found to be about 73 percent of the average of those charged by other mental health professionals.[14]

The *New York Times* article noted, "Psychiatry finds itself in a price war with other therapy professions. . . .

The national median fee for psychiatrists in private practice is estimated to be $90 a session. In contrast, clinical psychologists average $65 a session and social workers average $50."[15]

Opposition to Social Work Recognition

The emergence of social work as a fully recognized mental health profession has not come without resistance, as indicated by the reaction of other professions to social work vendorship legislation.

In some cases those arguing against the passage of such laws seem to be motivated by the economics of shifting power; that is, the rewards of the mental health "business," once reaped almost solely by psychiatrists under the medical model, must now be shared with psychologists, social workers and psychiatric/mental health nurses.

Insurance companies may also argue against attempts to pass vendorship legislation. Their concern seems to be that insurance costs and payments will escalate if social work services are sanctioned as reimbursable. But that position flies in the face of the well-documented cost-offset phenomenon mentioned above. Both the Massachusetts study and the national CHAMPUS study indicate that when social workers are approved as independent mental health providers, there is no increase in total utilization of mental health benefits. A recent study found that including clinical social workers as reimbursable providers had no measurable effect on overall quantity of psychotherapy demanded. It did, however, seem to have a "substitution" effect, reducing the market share of other providers.[16] There is, in fact, some cost saving both for the insurance company and for the consumer, whose copayment is usually lower for social workers than for other mental health providers.

Summary

Legislation which recognizes social workers as fully qualified mental health providers is sometimes opposed. This opposition is usually grounded in turf issues. "Whenever a new mental health professional vies for payments, it cuts down on the number who can get that same therapy dollar."[17]

When a profession is fully qualified by education and training to provide a sanctioned service, and when that service can be demonstrated to contribute to the reduction of costs to the community, then it should be encouraged to take its place as a recognized and reimbursable provider of mental health services, a step in the best interest of all consumers. Adequate knowledge of social work qualifications and sufficient data regarding costs will be persuasive arguments for such recognition.

All people should be free to select the most appropriate qualified mental health providers for themselves and should not be restricted in their choice because of lack of protective legislation.

Social work is an autonomous profession, and full recognition of this will enhance its contribution to the delivery of cost-effective mental health services to the public.

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