

SB 156

SENATE FINANCE COMMITTEE REPORT

DATE: 4/10/91

FURTHER:

DATE TURNED INTO OFFICE: 4/29/91

The Finance Committee considered SENATE BILL NO. 156

"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."

and recommended:

- replace with _____ CS _____
- or adopt _____ CS SB 156 (HESS)
- attached amendment(s)
- _____ letter of intent adopted

- same title
- new title
- technical title change (HB only)

do pass

do not pass

no recommendation

individual recommendations

further referral to _____

ATTACHES NEW FISCAL NOTE(S):

fiscal note(s) Dept/Date: DHESS 4/24/91
165.2 GF / 190.6 FF

zero fiscal note(s) _____

appropriation-no fiscal note

APPROVES PREVIOUS:

fiscal note(s) Dept/Date: _____

zero fiscal note(s) _____

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

[Handwritten signatures and recommendations follow]

1.

2.

Co-Chairs: Signatures and Recommendations

FISCAL NOTE

STATE OF ALASKA

BILL NO. CS SB 153

1991 LEGISLATIVE SESSION

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

Sponsor: Senate HESS Component: (1) Non-Facility

Requestor: _____ (2) Medical Assistance Admin. Claims Processing

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 B. Busch Phone: 465-3355

Division: Medical Assistance Date: 4-24-91

Approved by Commissioner: [Signature]

Agency: Health and Social Services Date: 4-24-91

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

Rev 10/90

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CS SB 156 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 CS SB 156. 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).

CS FOR SENATE BILL NO. 156 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 4/10/91
 Referred: Finance

Sponsor(s): SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

A BILL

FOR AN ACT ENTITLED

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

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

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

6 (b) In addition to the mandatory services specified in (a) of this section, the department
 7 may offer only the following optional services: case management and nutrition services for
 8 pregnant women; personal care services in a recipient's home; emergency hospital services;
 9 long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient
 10 psychiatric facility services for individuals age 65 or older and individuals under age 21;
 11 psychologists' services; clinical social workers' services; prescribed drugs; physical therapy;
 12 occupational therapy; chiropractic services; treatment of speech, hearing, and language disorders;
 13 adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care
 14 facility services, including intermediate care facility services for the mentally retarded; skilled

1 nursing facility services for individuals under age 21; and reasonable transportation to and from
2 the point of medical care.

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

4 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the department finds that
5 the cost of medical assistance for all persons eligible under this chapter will exceed the amount
6 allocated in the state budget for that assistance for the fiscal year, the department shall eliminate
7 coverage for optional medical services and optionally eligible groups of individuals in the
8 following order:

9 (1) chiropractic services;

10 (2) adult dental services;

11 (3) emergency hospital services;

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

13 (5) optometrists' services and eyeglasses;

14 (6) occupational therapy;

15 (7) prosthetic devices;

16 (8) medical supplies and equipment;

17 (9) clinical social workers' services;

18 (10) psychologists' services;

19 (11) clinic services;

20 (12) [(10)] physical therapy;

21 (13) [(11)] personal care services in a recipient's home;

22 (14) [(12)] prescribed drugs;

23 (15) [(13)] long-term care noninstitutional services;

24 (16) [(14)] inpatient psychiatric facility services;

25 (17) [(15)] intermediate care facility services for the mentally retarded;

26 (18) [(16)] intermediate care facility services;

27 (19) [(17) REPEALED

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

31 (20) [(19)] skilled nursing facility services for persons under age 21;

1 (21) [(20)] aged, blind, and disabled individuals who, because they do not meet
2 the income requirements, do not receive supplemental security income under Title XVI
3 of the Social Security Act, but who are eligible, or would be eligible if they were not in
4 a skilled nursing facility or intermediate care facility, to receive an optional state
5 supplementary payment;

6 (22) [(21)] individuals in a hospital, skilled nursing facility, or intermediate care
7 facility whose income while in the facility does not exceed 300 percent of the supplemental
8 security income benefit rate under Title XVI of the Social Security Act, but who, because of
9 income, are not eligible for the optional state supplementary payment;

10 (23) [(22)] individuals under age 21 under supervision of the department, for
11 whom maintenance is being paid in whole or in part from public money and who are in foster
12 homes or private child-care institutions.

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

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

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

Alaska State Legislature

SENATOR ARLISS STURGULEWSKI, Chairman
SENATOR PAUL FISCHER, Vice Chairman
SENATOR SAM COTTEN
SENATOR LYMAN HOFFMAN
SENATOR CURT MENARD



P.O. BOX V
ROOM 427
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JUNEAU, ALASKA 99811
(907) 465-3762

Senate Committee on Health, Education and Social Services

MEMORANDUM

April 11, 1991

TO: Senator Pat Pourchot, Co-Chairman
Senate Finance Committee

Senator Jay Kerttula, Co-Chairman
Senate Finance Committee

FROM: Senator Arliss Sturgulewski, Co-Chairman *AS*
Senate Health, Education, & Social Services Committee

RE: Hearing request for CSSB 156(HES) "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 legislation would provide for coverage of psychologists' and clinical social workers' services under the state medical assistance program.

Passage of this legislation would allow these two groups to provide needed services directly to medicaid patients. Under the current situation it is a requirement that these services be provided under the sponsorship of a clinic or M. D. This legislation would allow these two groups to provide independent services.

A packet of information is enclosed for your information. If there are any questions, please contact Frank Homan (465-3818) on my staff. Thank you.

Enclosure

POSITION PAPER

Committee Substitute for Senate Bill 156

"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 CS SB 156 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.

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

CS SB 156 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, CS SB 156, 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 CS SB 156.

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 committee substitute expresses good fiscal sense by placing the new services proposed by CS SB 156 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 after we have some exposure to the effects of OBRA '89 changes and the addition of psychologists proposed by CS SB 156.

Recommended by:

Kimberly B. Busch

Kimberly B. Busch

Acting Director

Div. of Medical Assistance

Date:

4-24-91

Approved by:

Jay Luey Lor

Theodore A. Mala, MD, MPH

Commissioner

Date:

4-24-91

ALASKA
PSYCHOLOGICAL
ASSOCIATION

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

POSITION PAPER

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

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

Current statutes create a situation which:

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

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

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

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

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

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

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

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

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

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

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 Employees 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 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 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)

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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.

Spending to Cut Mental-Health Costs

WSJ 12/13

Employer Finds Quality Care The Best Buy

By RON WINSTON

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 shorten 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

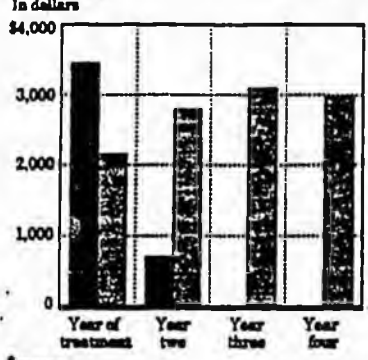
Treatment for such afflictions as depression, marital or job-related stress and drug and alcohol abuse can account for up to 20% of employer health costs. Last year alone, according to benefits consultant Foster Higgins, such expenses jumped 27%, making them a prime target for cost-cutters. Meanwhile, 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."

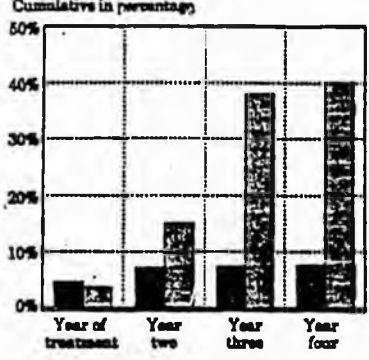
Shrinking the Costs of Mental Illness

Employee Assistance Program (EAP) vs. Alternative Treatment

Excess Family Medical Claims, Employee with Psychiatric Condition



Excess Termination Rate, Employee with Drug or Alcohol Dependency



* Excess is the amount above the average for employees who weren't treated for psychiatric or chemical dependency problems.

Source: Alexander & Alexander Consulting Group; McDonnell Douglas Corp.

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 in higher first-year costs in many cases. "It seems to be a very important aspect of long-term recovery and long-term health cost management," Mr. Smith says.

Family Impact

Indeed, the study offers dramatic evidence of the broad impact of psychiatric problems or substance abuse: Families of employees treated for chemical dependency outside of the EAP consumed an average of \$8,400 more in medical services over four years than families with no mental-health treatment. For psychiatric treatment, the excess medical costs averaged \$11,000. Under the EAP, these added family costs were reduced by more than half.

Among the study's other highlights

—Over four years, employees who used the EAP for chemical dependency treatment missed 44% fewer workdays, had 81% lower attrition and filed \$7,300 less health-care claims than those who did not use the EAP. Savings were somewhat smaller in all categories for psychiatric care.

—Forty percent of employees treated outside the EAP for drug or alcohol abuse left the company within four years, compared with just 7.5% of those who used the EAP. The study didn't factor in costs of replacing an experienced employee, but reducing attrition is a corporate goal because of a decline in the availability of qualified new workers. Mr. Smith says "Retaining valued employees has a who new significance today."

—Employees who sought mental-health care through their health maintenance organizations were four to five times more likely to quit or be fired within four years than those who used the EAP. That "staggering 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 plan to require employees seeking care to use the EAP, but it hopes the program's effectiveness will attract people. The company's estimated \$5.1 million in savings over the next three years is based on 1,032 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, \$5 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:

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

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

visits; a 66.7% decrease in frequency of hospitalizations and a 77.7% decrease in the average length of stay in the hospital...intervention appeared to be positively associated with an over-all change rate of some 53 percent....."

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-patient medical visits and 68% in in-patient care.

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 psychological distressed group, showed no change in their health care utilization over the same five year period.

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

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 psychotherapy contacts. Weekly therapy sessions, particularly on a short-term basis of 12 sessions, lead to the greatest psychotherapeutic benefits.

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."

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 3.7 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."

9. Emily Mumford, Ph.D. in the October, 1984 issue of the American Journal of Psychiatry presented her findings of reviewing over 58 research projects on psychotherapy. 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."

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.

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.

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.

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.

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

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.

21. Studies of coverage of clinical social work psychotherapy 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).

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 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.

23. Otto Jones, M.S.W., a clinical social worker, developed a mental health program for employees at Kennecott Copper in Utah. Before the program employees averaged 5.8 working days/month absence, weekly indemnity costs averaged \$70.67/person/month, and hospital/medical/surgical costs averaged \$109.04/person/month. One year after psychotherapy significant reductions were noted: Absenteeism decreased to a 2.93 average working days/month, weekly indemnity costs averaged \$25.33/person/month, and hospital/med/surg. costs averaged \$56.91/person/month. THIS IS A 49.5% REDUCTION IN ABSENTEEISM, A 64.2% REDUCTION IN WEEKLY INDEMNITY, AND A 48.9% REDUCTION IN HOSP.-MED.-SURGERY COSTS!! Those employees not involved 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.

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."

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

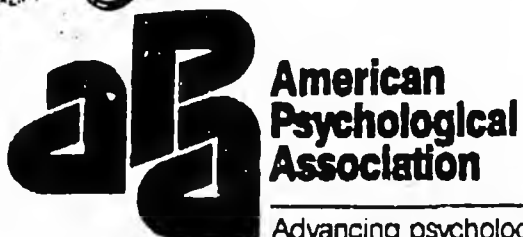
26. A 1984 NIMH study (AMA News, November 9, 1984); which is the largest and most comprehensive survey to date of mental disorders indicates that 20% of all adult Americans suffers from at least one mental disorder. Such disorders were equally divided between males and females. However, only 1/5th of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

27. A 1980 article in American Medical News (10/10/84) states that "...A prepaid mental health care program...appears able to cut health expenses...." 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."

28. McDonnell Douglas (and several other companies like Xerox, 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...."

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.

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.



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 \$15 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).

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 & Blase, 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).

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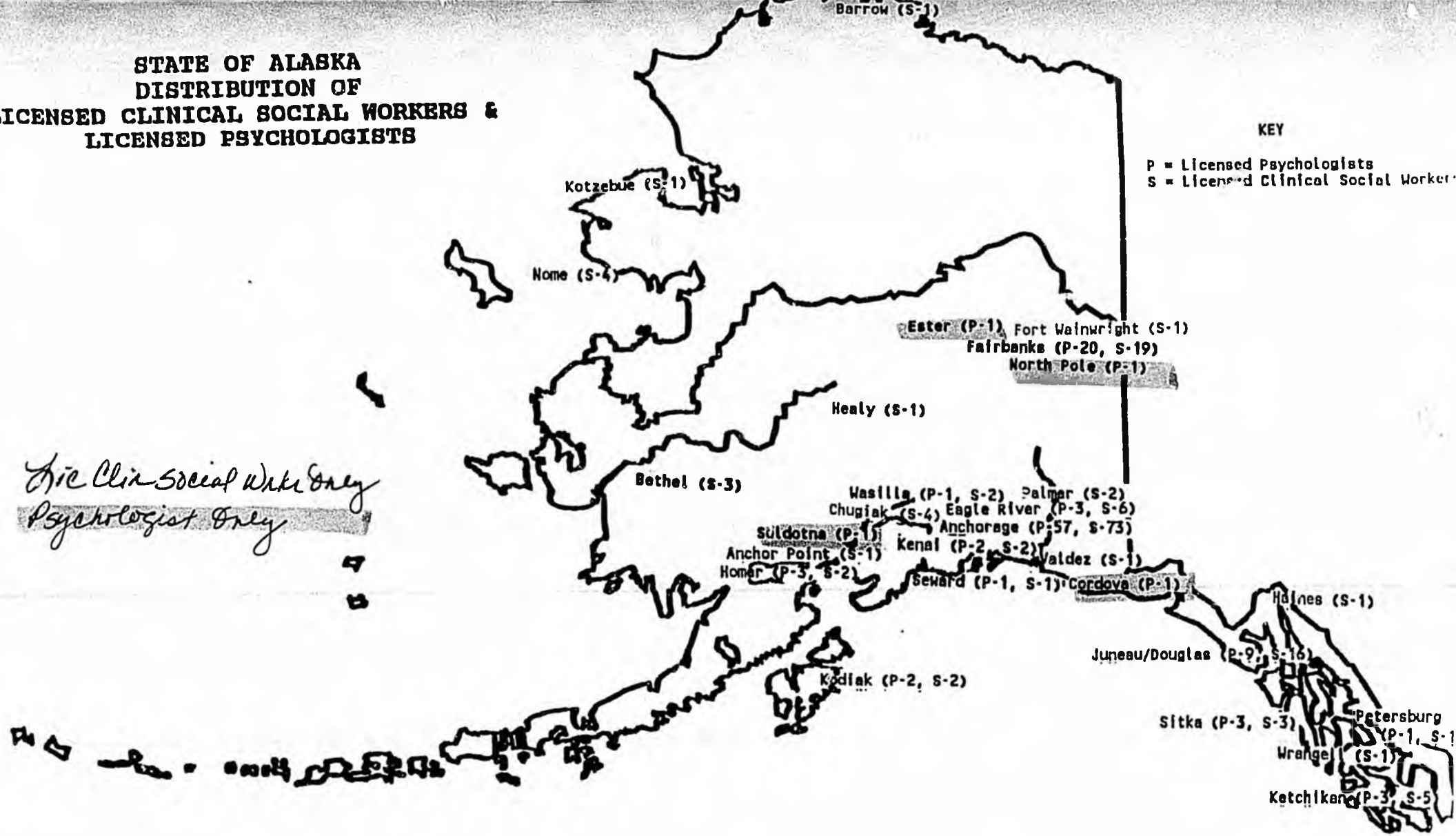
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**STATE OF ALASKA
DISTRIBUTION OF
LICENSED CLINICAL SOCIAL WORKERS &
LICENSED PSYCHOLOGISTS**

KEY

P = Licensed Psychologists
S = Licensed Clinical Social Workers



Handwritten: Lic Clin Social Worker Only
Handwritten: Psychologist Only

TOTALS

STATE OF ALASKA

110 Licensed Psychologists
162 Licensed Clinical Social Workers

OTHER STATES

30 Out-of-State Licensed Psychologists



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

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SR 156
 (S) Publish Date: 4/10/91

Revision Date: 3/22/91 Department Affec
 Title: An Act requiring the medical assistance program to cover BRU: (1) Medical Assistance Medicaid
psychologist clinical social workers' services Component: Non-Facility
 Sponsor: Senate HESS (2) Medical Assistance Admin. Claims Processing
 Requestor: _____ COMPONENT SERIAL NO. _____

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 | 104.1 | 59.2 | 70.3 | 83.6 | 99.3 | 117.9 |
| CONTRACTUAL | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 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 | 392.2 | 967.9 | 1,194.4 | 1,474.0 | 1,818.9 | 2,244.5 |
| MISCELLANEOUS | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| TOTAL OPERATING | 496.3 | 1,027.1 | 1,264.7 | 1,557.6 | 1,918.2 | 2,362.4 |
| 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 | 236.3 | 498.8 | 614.8 | 757.9 | 934.2 | 1,151.7 |
| FEDERAL FUNDS | 259.5 | 528.4 | 650.0 | 799.6 | 983.9 | 1,210.7 |
| OTHER | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| TOTAL | 496.3 | 1,027.2 | 1,264.8 | 1,557.5 | 1,918.1 | 2,362.4 |

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: _____

ANALYSIS: (Attach a separate page if necessary.)

See attached

Changes in CS5B 156 (HESS)
 reflect NO FISCAL CHANGE from the original
 fiscal note. This fiscal note is appropriate.

4/10/91
 date Comte Aide (initial)

Prepared By: [Signature] Phone: 465-3355

Division: Medical Assistance Date: 3/22/91

Approved by Commissioner: Theodore A. Mala, MD, MPH, Commissioner

Agency: Health and Social Services Date: _____

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impact Agency(ies).
 Rev 10/90 Page 1 of 4

SB 156 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. Psychologists services for adults will require only 6 edits, at \$1080/edit (\$6480). Licensed clinical social workers and psychological associates are totally new provider types, each of whom will require \$23,914.
Total one time FY92 cost = 54.3 (27.2 fed, 27.1 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 billing 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%).
 - (3) Logic suggests that billings from physicians and psychiatrists who supervise the psychologists now providing services to Medicaid eligibles would decrease if these psychologists were to enroll directly. However, experience in other states that have added psychologists' services has varied so much on this point that we cannot safely assume any decrease in current billings.
 - (4) Approximately 26 psychologists in private practice who are not currently serving Medicaid recipients will enroll. Alaska Psychological Association data indicates these new providers will see an average of 21 patients per week for a total of 34 hours per week, and that they charge \$90 per hour for private sessions.

- (5) We assume that psychologists will not differ from other medical professionals enrolled as Medicaid providers, in that Medicaid patients will, on average, not exceed 15% of their total patient load. 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 SB 156. Cost for the new psychologists' services will be 34 hours per week X 50 weeks X \$90 per hour X 15% X 63% X 26 psychologists = \$375,900.
- (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). 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 for a total of 34 hours per week, and that they charge \$85 per hour for private sessions.
- (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 34 hours per week X 50 weeks X \$85 per hour X 15% X 20 licensed clinical social workers = \$433,500.

(12) Combined new costs for psychologists and licensed clinical social workers = \$809,400 (\$375,000 + \$433,500). Combined savings = \$25,100 (\$9,100 + \$16,000). Net costs = \$784,300 (\$809,400 - \$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 costs will therefore be 50% of a full year:

196.1 SGFM
196.1 FED
392.2 Total

(b) 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).

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).

THE FOLLOWING DOCUMENT HAS NOT
BEEN FILMED BUT IS AVAILABLE IN THE
ORIGINAL FILE.

PLEASE MICROFILM TOP PAGE ONLY.

The Social Worker as Independent Mental Health Practitioner

Cost effective services
for the community

NASW

7981 Eastern Avenue
Silver Spring MD 20910

PLEASE MICROFILM TOP PAGE ONLY

**DOCUMENTS WHICH HAVE NOT BEEN FILMED BUT ARE
AVAILABLE IN THE ORIGINAL FILE INCLUDE:**

CORRESPONDENCE IN SUPPORT OF SB 156 FROM:

1. NORTON SOUND HEALTH CORPORATION, 4/15/91
2. ALASKA NATIVE HEALTH BOARD, 3/27/91
3. YVONNE MICHELI, KETCHIKAN, 3/15/91
4. JOEL B. WEIMAN, PHD, ANCHORAGE, 3/05/91
5. JOEL B. WEIMAN, PHD, ANCHORAGE, 2/26/91
6. THE FIREWEED THERAPY CENTER, 10/22/90