

**ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672**

**7406 SENATE HEALTH EDUCATION & SOCIAL SERVICES**

# ALASKA STATE LEGISLATURE

SENATE FINANCE COMMITTEE,  
CO-CHAIR



Senator Pat Pourchet

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## MEMORANDUM

TO: Senator Arliss Sturgulewski, Chair  
Health, Education and Social Services Committee.

FROM: Senator Pat Pourchet.

DATE: April 7, 1992

SUBJECT: SB 153, An Act relating to mental health.

I respectfully request a hearing at the earliest possible date for SB 153, An Act relating to mental health. The purpose of the legislation is to clearly establish procedures for the protection of patient's rights in evaluation and treatment facilities.

Recently, we have been working closely with mental health advocates, the Alaska Mental Health Board, the Department of Law and the Department of Health and Social Services to make revisions to the original bill introduced last session. The most important additions have been in the area of safeguards and oversight on psychotropic medications.

You may recall that the State of Alaska has been involved in litigation over the issue of forced medication at API. The changes to this legislation incorporate the recommendations of the Involuntary Medication Task Force and should settle the legal issues raised in Branson v. State of Alaska.

My staff is preparing back up materials for committee members and the public. Please contact Dan Austin at 465-3879 if you have any questions.

## SB 153, "An Act relating to mental health."

Senator Pat Pourchot

The legislation was introduced in the sixteenth session at the request of mental health services consumers and advocates. The purpose of this Act is to guarantee that patients will have appropriate representation in decisions pertaining to their treatment.

In 1987, a patient at the Alaska Psychiatric Institution brought suit against the state for not providing an opportunity to withhold informed consent to the administration of psychoactive medication. A state task force consisting of mental health professionals, advocates and attorneys met for a year and a half to respond to legal issues raised in Branson v. State of Alaska.

The draft CS presented to the Senate Health, Education and Social Services Committee is a revision of SB 153 incorporating the recommendations of the task force.

### SECTIONAL SUMMARY

**Sec. 1** The Department of Health and Social Services shall set standards under which each designated treatment facility will provide for the psychological, social, vocational, educational and recreational needs of the patient.

**Sec. 2** Requires all evaluation and designated treatment facilities to administer treatment and medication only in a manner consistent with the statutes.

**Sec. 3** A patient ordered to receive involuntary outpatient treatment may be required to undergo inpatient treatment when the provider of treatment determines that an appropriate facility will accept the patient and that the patient is mentally ill and likely to cause serious harm to themselves or others.

In that case, the following statutes relating to notice and hearing apply:

#### **AS 47.30.795 Involuntary outpatient care for committed persons**

(c) If during the commitment period the provider of outpatient care determines that the respondent can no longer be treated on an outpatient basis because the respondent is likely to cause harm to self or others or is gravely disabled, the provider shall give the respondent oral and written notice that the respondent must return to the treatment facility within 24 hours, with copies to the respondent's attorney and guardian, if any, the court, and the inpatient treatment facility. If the respondent fails to arrive at the treatment facility within 24 hours after receiving the notice, the professional person in charge may contact the appropriate peace officers who shall take the respondent into custody and transport the respondent to the facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody.

**Sec. 47.30.745. 90-day commitment hearing rights.** (a) A respondent subject to a petition for 90-day commitment has, in addition to the rights specified elsewhere in this chapter, or otherwise applicable, the rights enumerated in this section. Written notice of these rights shall be served on the respondent and the respondent's attorney and guardian, if any, and may be served on an adult designated by the respondent at the time the petition for 90-day commitment is served. An attempt shall be made by oral explanation to ensure that the respondent understands the rights enumerated in the notice. If the respondent does not understand English, the explanation shall be given in a language the respondent understands.

(b) Unless the respondent is released or is admitted voluntarily following the filing of a petition and before the hearing, the respondent is entitled to a judicial hearing within five judicial days of the filing of the petition as set out in AS 47.30.740(b) to determine if the respondent is mentally ill and as a result is likely to cause harm to self or others, or if the respondent is gravely disabled. If the respondent is admitted voluntarily following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS 47.30.740 or under AS 47.30.685. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request to leave, the professional person in charge may file with the court a petition for a 180-day commitment of the respondent under AS 47.30.770. The 180-day commitment hearing shall be scheduled for a date not later than 90 days after the respondent's voluntary admission.

(c) The respondent is entitled to a jury trial upon request filed with the court if the request is made at least two judicial days before the hearing. If the respondent requests a jury trial, the hearing may be continued for no more than 10 calendar days. The jury shall consist of six persons.

(d) If a jury trial is not requested, the court may still continue the hearing at the respondent's request for no more than 10 calendar days.

(e) The respondent has a right to retain an independent licensed physician or other mental health professional to examine the respondent and to testify on the respondent's behalf. Upon request by an indigent respondent, the court shall appoint an independent licensed physician or other mental health professional to examine the respondent and testify on the respondent's behalf. The court shall consider an indigent respondent's request for a specific physician or mental health professional. A motion for the appointment may be filed in court at any reasonable time before the hearing and shall be acted upon promptly. Reasonable fees and expenses for expert examiners shall be determined by the rules of court.

(f) The proceeding shall in all respects be in accord with constitutional guarantees of due process and, except as otherwise specifically provided in AS 47.30.700 — 47.30.915, the rules of evidence and procedure in civil proceedings.

(g) Until the court issues a final decision, the respondent shall continue to be treated at the treatment facility unless the petition for 90-day commitment is withdrawn. If a decision has not been made within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, the respondent shall be released. (§ 1 ch 84 SLA 1981; am § 14 ch 142 SLA 1984)

**Sec. 4** Expands, at the request of the patient, those persons who may participate in formulating the patient's individualized treatment plan. In addition to the patient's counsel, guardian or designated adult, representatives may now include a mental health professional previously engaged in the patient's care outside of the evaluation or treatment facility and another representative of the patient's choice.

This section also stipulates that the mental health care professionals may not withhold any of the evaluation or treatment information from the patient or others if the the patient has signed a waiver of confidentiality.

**Sec. 5** Amends one sentence in AS 47.30.825(d) to read: "When practicable, the patient shall be consulted as to the patient's preference among forms of adequate, medically advisable restraints including medication, and that preference shall be honored (CONSIDERED)."

**Sec. 6** AS 47.30.825(c) is reenacted to provide that a patient capable of giving informed consent has the right to give or withhold that consent to medication and treatment when it is not a crisis or impending crisis situation as described in AS 47.30.838(a)(1):

**Sec. 47.30.838. PSYCHOTROPIC MEDICATION IN EMERGENCIES.** (a) Except as provided in (c) of this section, an evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, only if

(1) there is a crisis situation, or an impending crisis situation, that requires immediate use of the medication to preserve the life of, or prevent significant physical harm to, the patient or another person, as determined by a licensed physician or a registered nurse; the behavior or condition of the patient giving rise to a crisis under this paragraph and the staff's response to the behavior or condition must be documented in the patient's medical record; the documentation must include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient; and

**Sec. 7** Adds four (AS 47.30.836-.839) new sections pertaining to PSYCHOTROPIC MEDICATIONS IN NON-EMERGENCIES, INFORMED CONSENT, PSYCHOTROPIC MEDICATIONS IN EMERGENCIES and COURT-ORDERED ADMINISTRATION OF MEDICATION.

**AS 47.30.836 PSYCHOTROPIC MEDICATION IN NON-EMERGENCIES:** Facilities may not administer psychotropic medication in a situation that does not involve a crisis without the patient's informed consent unless the court

determines that the patient lacks the capacity to give informed consent and the court approves use of the medication.

AS 47.30.837 INFORMED CONSENT: Defines informed consent for the purposes of the section and describes the facility's responsibility to provide necessary information for the patient's decision. "Competent," "voluntary," and "informed" are defined in detail.

AS 47.30.838 PSYCHOTROPIC MEDICATION IN EMERGENCIES: Describes "crisis" situation, who determines, and requires documentation and consideration of alternatives. Limits "crisis" period to 24 hours, requires that conditions, medication, dose and method of administration be specified. May extend to 3 "crisis" periods for a total of 72 hours. Requires post-"crisis" consultation and discussion with patient. Without court approval, psychotropic medications may not be administered without the patient's informed consent for more than 3 "crisis" periods.

AS 47.30.839 COURT-ORDERED ADMINISTRATION OF MEDICATION: Allows a facility to obtain court approval for the administration of psychotropic medication under specific circumstances and in a specified manner. The court must appoint a court visitor to help determine if the patient is capable of informed consent. Describes documentation the visitor must include in the report to the court. Requires hearing within 72 hours. The court determines the competency of the patient to give informed consent. If the court rules that the patient is incapable of informed consent, the court shall approve the proposed medication. This applies to the initial commitment period and is reconsidered if the facility files a petition to extend or continue commitment. If the patient becomes competent and gives informed consent, it shall be documented in writing in the patient's file.

**Sec. 8** AS 47.30.840(a)(9) is amended to read: "A person undergoing evaluation or treatment under AS 47.30.660-47.30.915 has the right to reasonable opportunity for indoor and outdoor exercise and recreation;

**Sec. 9** New section AS 47.30.847 PATIENT'S GRIEVANCE PROCEDURES: Establishes a patient's grievance procedure and requires each facility to designate a staff member trained in mental health consumer advocacy to serve as the patient's advocate, upon patient's request, in bringing grievances and pursuing redress.

**Sec. 10** Adds a final sentence to AS 47.30.850 EXPUNGEMENT OF RECORDS: Upon the filing of the motion and full release, the court shall order the court records expunged.

**Sec. 11** Repeals AS 47.30.825(e): "A patient has the right to be free from unnecessary or excessive medication. Psychotropic medication may be administered only on the order of a licensed physician when the physician determines that this medication is in the best interest of the patient or will prevent serious harm to others." Previous sections supercede.

SB 153

Fiscal

Brent McGee - OPA - <sup>-O- will fax</sup>  
John Salemi - Public Defender } teleconf.

Chris Christenson - Coerts - here

Richard Piques - Dept. Law - ON ITS WAY

H+SS - Margaret Lowe - here

Faint handwritten notes, possibly including "T. ...", "5/23/12", and "11:11".

A M E N D M E N T

OFFERED IN THE SENATE

BY SENATOR POURCHOT

TO: CSSB 153( )

Page 1, after line 2:

Insert a new bill section to read:

"\* Section 1. AS 44.21.410(a) is amended by adding a new paragraph to read:

(8) provide visitors in proceedings under AS 47.30.839."

Page 1, line 3:

Delete "Section 1"

Insert "Sec. 2"

Renumber the following bill sections accordingly.

Page 7, after line 31:

Insert a new subsection to read:

"(j) In this section, "visitor" means a visitor provided by the office of public advocacy under AS 44.21.410(a)(8)."

A M E N D M E N T

OFFERED IN THE SENATE

TO: CSSB 153( )

BY SENATOR POURCHOT

Page 7, line 7, after "all":

Insert "evidence presented at the hearing, including"

Page 7, line 8, after "litem,":

Insert "the petitioner,"

WALTER J. HICKEL, GOVERNOR

**DEPARTMENT OF LAW**

OFFICE OF THE ATTORNEY GENERAL

April 14, 1992

REPLY TO:

1031 W 4th AVENUE SUITE 200  
ANCHORAGE, ALASKA 99501-1994  
PHONE: (907) 276-3550  
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1st NATIONAL CENTER  
100 CUSHMAN ST. SUITE 400  
FAIRBANKS, ALASKA 99701-4679  
PHONE: (907) 452-1568  
FAX: (907) 456-1317

P.O. BOX K—STATE CAPITOL  
JUNEAU, ALASKA 99811-0300  
PHONE: (907) 465-3600  
FAX: (907) 463-5295

465-3603

Honorable Pat Pourchot  
Alaska State Senate  
P.O. Box V  
Juneau, AK 99811

Re: SB 153

Dear Senator Pourchot:

Dan Austin called this morning to request a fiscal note from the Department of Law regarding SB 153. As fiscal information was needed in a very short period of time, I am responding to his request in this letter format rather than with a fiscal note. If a formal fiscal note is required, please let me know and our Division of Administrative Services will prepare one.

SB 153 establishes the requirement that there be a judicial determination regarding the use of psychotropic medication over a patient's refusal to take the medication. These judicial hearings will require additional attorney time not currently required. It is our understanding that Alaska Psychiatric Institute (API) estimates that there will be about 20 "refusals" per year. I am not certain if the hospital believes that all of these refusals will result in judicial hearings, but even if they don't there will be attorney consultation time regarding the matter. The estimate from API does not include the hearings or consultations which will be required for the designated treatment beds at Fairbanks Memorial Hospital or Mt. Edgecumbe Hospital, or the proposed designated treatment beds at Bartlett Memorial Hospital. We would estimate that an additional 10 hearings or consultations would be needed each year to accommodate these facilities. Of course there will also be the general requirement that the attorney general's office provide training to treatment staff regarding issues such as treatment refusal procedures.

We estimate that an average of one attorney day would be spent on each judicial hearing. The estimate is predicated on the assumption that not all 30 of the refusals will end in a court hearing and that some of the refusals will result in seriously

Honorable Pat Pourchot  
Alaska State Senate  
Re: SB 153

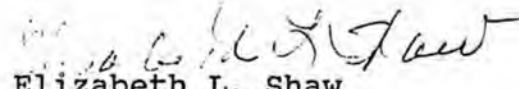
April 14, 1992  
Page 2

contested hearings. The addition of 30 additional attorney days throughout the Department of Law cannot be quantified in a particular monetary sum. However, we do note that the Department of Law would be called on to represent the Department of Health and Social Services in the hearings and to consult and train regarding these issues on an ongoing basis. We caution that the addition of new duties at a time when budgets and staff are being drastically reduced should be avoided. It is doubtful that the Department of Law, which faces the loss of several civil division attorneys in the House Finance budget plan, will be able to respond to this new request for services without it adversely affecting other statutory requirements for representation.

Sincerely,

CHARLES E. COLE  
ATTORNEY GENERAL

By:

  
Elizabeth L. Shaw  
Assistant Attorney General

ELS/bap

cc: Dick Pegues  
Paul Fuhs  
Deborah E. Behr

TUESDAY, April 14, 1992

# Drugged patient wins jury ruling

## API to pay \$225,000 in 1987 case

By SHEILA TOOMZY  
Daily News reporter

A mentally ill woman, injured against her will with a potent psychiatric drug that left her permanently disfigured, has won a \$225,000 jury verdict against the Alaska Psychiatric Institute.

The verdict, returned Friday in Anchorage Superior Court, comes as the legislature considers new rules governing forced medication of involuntarily committed patients, particularly the use of powerful anti-psychotic drugs, which can have serious side-effects.

In general, Alaska doctors

have a legal right to force-medicate patients who have been involuntarily committed.

Barbara Novelli, a 44-year-old Anchorage woman, suffers from bipolar disease, which is characterized by alternating cycles of depression and extreme mania. She has been treated for years with lithium carbonate, a mood "leveler" routinely used in such cases.

Lithium is not an antipsychotic drug and does not generally produce extreme side-effects.

But periodically, Novelli

Please see Page B-3, API

# API: Woman wins lawsuit against state hospital

Continued from Page B-1

would stop taking her lithium and deteriorate into an acute psychotic state, according to court records. The 1987 incident that the jury examined occurred during her sixth admission to API. At the time, API staff knew that the drug they gave her, an antipsychotic called Navane, caused her to have muscle spasms, including facial twitching and involuntary limb and trunk movements.

At issue was whether API ever tried to persuade Novelli to voluntarily resume her lithium doses or, instead, caused permanent injury by forcibly injecting her with a drug that she had good reason to refuse.

API Director Dr. Norwood Knight-Richardson said Monday that he was not surprised by the verdict. "A lot of the issues around this (forced medica-

tion) are very, very difficult to understand," Knight-Richardson said.

The choice facing his staff, he said, was to leave Novelli in a deteriorating psychotic state, which, according to the court record included writhing on the floor and inappropriate sexual touching of other patients, or to bring her out of the psychosis and risk what they believed would be temporary side effects.

API staff claimed Novelli was offered lithium first and refused it, but there was no note to that effect in any hospital record. Knight-Richardson agreed.

Laurel Peterson, Novelli's attorney, said no such effort was made.

The hospital did not ask Novelli's family or friends to help persuade her to resume taking her lithium, he said, and they ignored specific warnings from her private psychiatrist not to use

an anti-psychotic. API staff rushed to use an anti-psychotic, Peterson said, because it's the easiest way "to control a patient going through a psychotic episode." Such drugs "knock you on your butt... make you mute and catatonic," he said.

Five years after being force-medicated, Novelli's twitching symptoms remain, and she needs six pain-killers a day, he said.

Jurors awarded her \$25,000 for medical expenses and \$200,000 for suffering and disfigurement. Novelli's illness makes her largely unemployable, so jurors did not compensate her for lost wages.

The state is currently the defendant in another lawsuit over forced medication, a class action brought by Advocacy Services of Alaska on behalf of all such patients. Jeff Jesse, an attorney for the agency, said the suit is

on hold while a task force tries to deal with the issue through legislation. A hearing is scheduled today at 8:30 a.m.

Proposed reforms would require that the magistrate who normally holds commitment hearings at API decide if forcing a patient to take a drug is in the patient's best interest. The real purpose of the reforms is to force API to spend more time trying to get patients "to buy into their treatment," Jesse said. "We don't want to burden the system with unnecessary hoop jumping."

The judge will almost always uphold the institution, he predicted, but doctors who know they might have to explain their decision to an impartial outsider will make more considered judgments. "They act too quickly. If there aren't rules making them more accountable for what happens."

S B

156

FISCAL NOTE

STATE OF ALASKA  
1991 LEGISLATIVE SESSION

BILL NO. CS SB 156

Revision Date: 4/24/91 Department Affected: Health and Social Services  
 Title: An Act requiring the medical assistance program to cover BRU: Medical Assistance - Medicaid  
psychologists'.... Component: (1) Non-Facility  
 Sponsor: Senate HESS (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
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REVENUE	0.0	0.0	0.0	0.0	0.0	0.0
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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	FY 97	FY 98
	OLD 463.3 NEW 355.8 \$ 107.5 1/2 yr	1,027.1 804.9 \$ 222.2 FULL yr

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

## 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).

1991 LEGISLATIVE SESSION

Revision Date: 3/22/91 Department Affected: Health and Social Services  
 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
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REVENUE	0.0	0.0	0.0	0.0	0.0	0.0
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FUNDING: (Thousands of Dollars)

GENERAL FUND	236.8	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

Prepared By: [Signature] Phone: 465-3355

Division: Medical Assistance Date: 3/22/91

Approved by Commissioner: Theodore A. Mala, MD, MPH, Commissioner [Signature]

Agency: Health and Social Services Date: \_\_\_\_\_

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

## 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).

# Alaska State Legislature

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



*M. Homan*

P.O. BOX V  
ROOM 427  
STATE CAPITOL  
JUNEAU, ALASKA 99811  
(907) 465-3782

## 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. (1)

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

# Alaska State Legislature



## State Senate

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

*Rec'd June 91  
11:5 Am*

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

### MEMORANDUM

TO: Senator Arliss Sturgulewski, Chairman  
Senate Health, Education and  
Social Services Committee

FROM: Senator Paul Fischer *PF*

SUBJECT: Proposed Committee Draft

DATE: February 27, 1991

---

You have asked me to comment on the attached bill draft to be sponsored by the Senate Health, Education and Social Services Committee.

I have serious concerns regarding the addition of clinical social workers' services and psychologists services taking preference over such services as treatment of speech, hearing and language disorders. For that matter I am concerned about several of the services from sub sections (1) through (9) possibly being eliminated from coverage with the additions being proposed.

Since it is so early in the session, it would be my desire that this legislation be introduced by an individual legislator versus a standing committee.

Your consideration would be greatly appreciated.

PAF/sgn  
Attachment

LAW OFFICES  
SONOSKY, CHAMBERS, SACHSE & MILLER

SUITE 700  
600 WEST FIFTH AVENUE  
ANCHORAGE, ALASKA 99501  
(907) 258-6377  
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JUNEAU OFFICE  
229 FOURTH STREET  
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OF COUNSEL  
LOFTUS E. BECKER, JR.  
ROGER W. DUBROCK

WASHINGTON, D. C. OFFICE  
1250 EYE STREET, N. W.  
WASHINGTON, D. C. 20005  
(202) 682-0240  
TELECOPIER  
(202) 682-0249

February 22, 1991

\*ALASKA AND DISTRICT OF COLUMBIA BARS  
\*\*WISCONSIN BAR  
ALL OTHERS DISTRICT OF COLUMBIA BAR

Hand Delivered: February 22, 1991

Mr. Frank Homan  
Senator Arliss Sturgulewski  
Alaska State Legislature  
P.O. Box V  
Juneau, Alaska 99811

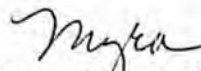
Dear Frank:

Enclosed is a marked-up version of the bill we discussed two days ago with Senator Sturgulewski and you concerning medicaid payment for psychologists and social workers services. Please let me know if you have any questions.

Sharon and I really appreciate Senator Sturgulewski's willingness to work with the Senate HESS Committee to introduce this as a committee bill.

Sincerely,

SONOSKY, CHAMBERS, SACHSE,  
MILLER & MUNSON

  
By: Myra M. Munson

MM:nb

cc: Sharon Macklin

1 IN THE SENATE

~~BY STURGULEWSKI AND~~  
~~KERTFULA~~

2

SENATE BILL NO. ~~22~~

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

SIXTEENTH LEGISLATURE - FIRST SESSION

5

A BILL

6 For an Act entitled: "An Act relating to psychologists' <sup>and social workers'</sup> services under the  
7 state medical assistance program; and reordering the  
8 priorities for eliminating coverage under Medicaid."

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

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

11 (b) In addition to the mandatory services specified in (a) of  
12 this section, the department may offer only the following optional  
13 services: case management and nutrition services for pregnant women;  
14 personal care services in a recipient's home; emergency hospital  
15 services; long-term care noninstitutional services; medical supplies  
16 and equipment; clinic services; inpatient psychiatric facility ser-  
17 vices for individuals age 65 or older and individuals under age 21;  
18 psychologists' services; social workers' services; physical therapy; occupational therapy;  
19 chiropractic services; treatment of speech, hearing, and language  
20 disorders; adult dental services; prosthetic devices and eyeglasses;  
21 optometrists' services; intermediate care facility services, including  
22 intermediate care facility services for the mentally retarded; skilled  
23 nursing facility services for individuals under age 21; and reasonable  
24 transportation to and from the point of medical care.

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

26 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the depart-  
27 ment finds that the cost of medical assistance for all persons eligi-  
28 ble under this chapter will exceed the amount allocated in the state  
29 budget for that assistance for the fiscal year, the department shall

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

6 22 ~~(21)~~ [(20)] individuals in a hospital, skilled nursing  
7 facility, or intermediate care facility whose income while in the  
8 facility does not exceed 300 percent of the supplemental security  
9 income benefit rate under Title XVI of the Social Security Act, but  
10 who, because of income, are not eligible for the optional state sup-  
11 plementary payment;

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

# **CORRECTION**

**THIS DOCUMENT  
HAS BEEN REPHOTOGRAPHED  
TO ASSURE LEGIBILITY**

1 IN THE SENATE

~~BY STURGOLEWSKI AND~~  
~~KERTTULA~~

2

SENATE BILL NO. ~~29~~

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

SIXTEENTH LEGISLATURE - FIRST SESSION

5

A BILL

6 For an Act entitled: "An Act relating to psychologists' <sup>and social workers'</sup> services under the  
7 state medical assistance program; and reordering the  
8 priorities for eliminating coverage under Medicaid."

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

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

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13 services: case management and nutrition services for pregnant women;  
14 personal care services in a recipient's home; emergency hospital  
15 services; long-term care noninstitutional services; medical supplies  
16 and equipment; clinic services; inpatient psychiatric facility ser-  
17 vices for individuals age 65 or older and individuals under age 21;  
18 psychologists' services; <sup>Social workers' services;</sup> physical therapy; occupational therapy;  
19 chiropractic services; treatment of speech, hearing, and language  
20 disorders; adult dental services; prosthetic devices and eyeglasses;  
21 optometrists' services; intermediate care facility services, including  
22 intermediate care facility services for the mentally retarded; skilled  
23 nursing facility services for individuals under age 21; and reasonable  
24 transportation to and from the point of medical care.

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

26 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the depart-  
27 ment finds that the cost of medical assistance for all persons eligi-  
28 ble under this chapter will exceed the amount allocated in the state  
29 budget for that assistance for the fiscal year, the department shall

1 eliminate coverage for optional medical services and optionally eligi-  
2 ble groups of individuals in the following order:

- 3 (1) chiropractic services;
- 4 (2) adult dental services;
- 5 (3) emergency hospital services;
- 6 (4) treatment of speech, hearing, and language disorders;
- 7 (5) optometrists' services and eyeglasses;
- 8 (6) occupational therapy;
- 9 (7) prosthetic devices;
- 10 (8) medical supplies and equipment;
- 11 (9) clinic services;
- 12 <sup>(10)</sup> ~~(11)~~ [(10)] Social workers' services;  
psychologists' services;
- 13 12 (11) physical therapy;
- 14 13 (12) [(11)] personal care services in a recipient's home;
- 15 14 (13) [(12)] long-term care noninstitutional services;
- 16 15 (14) [(13)] inpatient psychiatric facility services;
- 17 16 (15) [(14)] intermediate care facility services for the  
18 mentally retarded;
- 19 17 (16) [(15)] intermediate care facility services;
- 20 18 (17) [(16)] pregnant women, and children five years of age  
21 or younger, with a household income that does not exceed 100 percent  
22 of the federal poverty level;
- 23 19 (18) [(17)] individuals under age 21 who are not eligible  
24 for benefits under the federal aid to families with dependent children  
25 program because they are not deprived of one or more of their natural  
26 or adoptive parents;
- 27 20 (19) [(18)] skilled nursing facility services for persons  
28 under age 21;
- 29 21 (20) [(19)] aged, blind, and disabled individuals who,

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

6 22. ~~(21)~~ [(20)] individuals in a hospital, skilled nursing  
7 facility, or intermediate care facility whose income while in the  
8 facility does not exceed 300 percent of the supplemental security  
9 income benefit rate under Title XVI of the Social Security Act, but  
10 who, because of income, are not eligible for the optional state sup-  
11 plementary payment;

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

SENATE BILL NO. \_\_\_

\* Section 3. AS 47.07.900 is amended by adding new sections to read:

(11) "psychologists' services" means services provided by a person licensed as a psychologist under AS 08.86.130 -- 08.86.150 or as a psychological associate under AS 08.86.160 -- 08.86.164 and authorized to practice as a psychologist or psychological associate under regulations adopted in accordance with AS 08.86.080.

(12) "social workers' services" means services provided by a person licensed to practice clinical social work under AS 08.95.100 -- 08.95.130 and authorized to practice as a clinical social worker under regulations adopted in accordance with AS 08.95.030(5).

# WORK ORDER REQUEST FORM

# W.O. [17] LS-0844

KEYWORDS: HEALTH AND SOCIAL SERVICES ASSIGNED: Lauterbach

INSURANCE

MEDICAL CARE

REQUEST FOR: New Bill

TAKEN BY: Barnes

SUBJECT: Medicaid & Psychologists/Social Wrkrs.

REQUESTED FOR: SC SHES BY: Frank Homan PHONE: 465-3818

DELIVER TO: Sen. Sturqulewski, Cap 427

INSTRUCTIONS: Draft bill reintroducing SB 29 - 16th legislature, with changes per attached.

<p>OBTAIN</p>	<p>SPECIAL DRAFTING INSTRUCTIONS ATTACHED [ ] AUTHORIZED TO CONFER WITH _____ _____ RETURN _____ _____ TO REQUESTOR APPROVED: <input checked="" type="checkbox"/> DIRECTOR, LEGAL SERVICES</p>
<p>REVIEWED _____ IN <u>02/25/91</u> DUE _____ TYPED: Draft _____ Date _____ Final _____ Date _____ PROOFED _____ DELIVERED _____</p>	<p>SPECIAL INSTRUCTIONS to TYPING/PROOFING _____ _____  Request for DRAFT</p>

SENATE FINANCE COMMITTEE REPORT

*Sturgulowski*

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 psynchologists' 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):

APPROVES PREVIOUS:

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

fiscal note(s) Dept/Date: \_\_\_\_\_

zero fiscal note(s) \_\_\_\_\_

zero fiscal note(s) \_\_\_\_\_

appropriation-no fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

*[Handwritten signatures]*

*[Handwritten signature]*

1. *[Signature]* 2. *[Signature]*  
Co-Chairs: Signatures and Recommendations

*Resubmitted by Senator Harguluck*  
ALASKA STATE LEGISLATURE  
*Representative Georgianna Lincoln*

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

P.O. Box V  
Juneau, Alaska 99811

Budget Subcommittees  
Health and Social Services  
Revenue

Phone: (907) 465-3732  
FAX: (907) 465-2652

MEMORANDUM

Alatna  
Allakaket  
Aniak  
Anvik  
Arctic Village  
Beaver  
Bettles  
Birch Creek  
Chalkyitsik  
Chuathbaluk  
Crooked Creek  
Evansville  
Fort Yukon  
Galena  
Grayling  
Holy Cross  
Hughes  
Huslia  
Kalskag  
Kaltag  
Koyukuk  
Lake Minchumina  
Lime Village  
Lower Kalskag  
Manley Hot Springs  
Marshall  
McGrath  
Minto  
Mountain Village  
Nikolai  
Nulato  
Pilot Station  
Pitkas Point  
Rampart  
Red Devil  
Ruby  
Russian Mission  
Shageluk  
Sleetmute  
St. Mary's  
Stevens Village  
Stony River  
Takatna  
Tanana  
Telida  
Tuluksak  
Tyonek  
Venetie  
Wiseman

TO: All Senators  
FROM: Representative Georgianna Lincoln *georg*  
DATE: May 9, 1991  
RE: House Bill 248 - Medicaid Payment for Psychologists/Others

CS HB 248 (FIN) will add psychologists and clinical social workers as approved medicaid providers. Adding these providers will expand access to mental health services, especially in communities 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.

Under direction of the House Finance Committee the Department of Health and Social Services reduced the fiscal note to reflect a projected delayed start-up of January 1, 1992. The House Finance CS moved the placement of psychologists and clinical social workers to number (1) and (2) respectively on the list of optional services to be eliminated if Medicaid demand exceeds available funding.

I would urge your support of this bill.

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES

### DIVISION OF MEDICAL ASSISTANCE

WALTER J. HICKEL, GOVERNOR

P.O. BOX H-07  
JUNEAU, ALASKA 99811-0660  
PHONE : (907) 465-3355

February 26, 1991

Honorable Senator Sturgulewski  
P.O. Box V,  
Capital Building, Room 427  
Juneau, Alaska 99811

Dear Senator Sturgulewski:

You asked us for an estimate of the costs of including adult dentures as a covered service in Medicaid. As you may know, we currently provide adult dental services only for the immediate relief of both pain and infection. Children (anyone under 21) can receive all dental services, including dentures, as these are federally mandated services.

We estimate that the annual unduplicated number of adults (over 21) eligible for Medicaid during FY91 to be 20,125. This number has been increasing by 6.4% per year, so it will total approximately 21,412 in FY92.

The American Dental Association and the Alaska Dental Society estimate that 10.8% of the total adult population will need an average of 1.5 "units" of dentures. They define a "unit" as either a complete upper or complete lower set of dentures. (Note that this excludes partial plates, caps, and crowns, all of which can be quite expensive, and about which good arguments can be made that these can often forestall or prevent the need for full dentures.

We believe each unit can be purchased at \$1000, well below the usual charge, without causing providers to refuse to provide the service.

The first full year of implementation, FY92, would therefore look like this:

2174 recipients x 1.5 units x \$1000/unit = \$3,261,000  
(\$1,630,500 state general funds, \$1,630,500 federal funds)

This particular service is by far the most frequently requested by our providers, our recipients, and staff of agencies serving the elderly and disabled needy, so we expect the pent-up demand would produce expenditures of this magnitude, starting immediately. However, dentures have a useful life of perhaps five years, so after the initial demand is met, expenditures would fall from a catch-up mode to a maintenance and caseload-turnover level, which might perhaps be between 50% to 70% of the initial amount.

Honorable Senator Sturgulewski  
February 26, 1991  
page -2-

I hope this initial assessment meets your needs. If you intend to pursue this issue, we'd appreciate advance notice, so that we could have time to research and revise this very rough estimate with some input from the profession.

Sincerely,



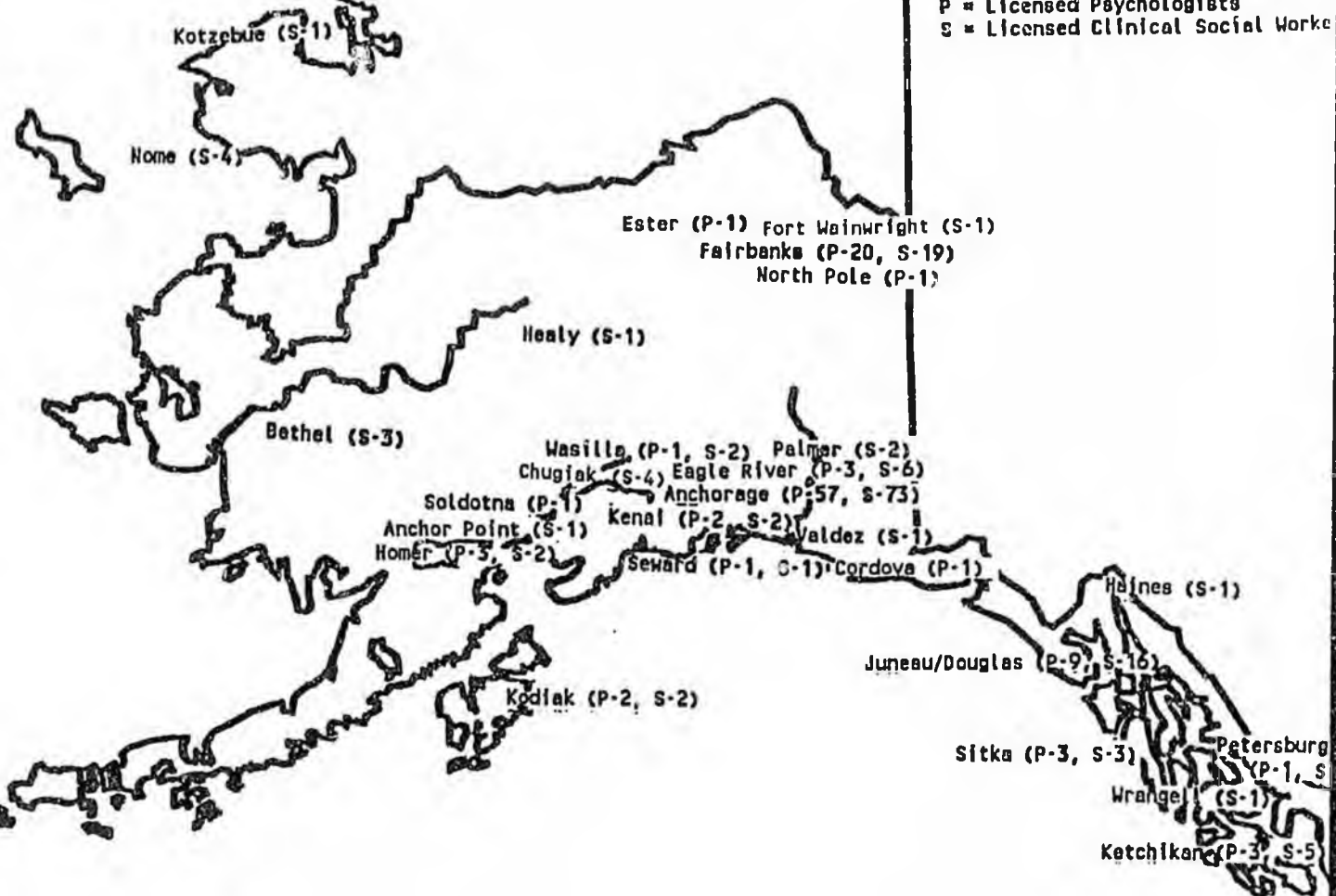
Kimberly B. Busch  
Acting Director

KBB:GL:jeg

**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

4/24/91  
NOW  
CHANGES  
MARKED  
IN YELLOW

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

*one*

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

POSITION PAPER  
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 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.

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Unfortunately, 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 SB 156.

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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 childrens' 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.

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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 a loss of 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 it makes good fiscal sense to place the new services proposed by SB 156 above "clinic services" in the priority list of AS 47.07.035.


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 SB 156.

The department recommends amending SB 156 to place the proposed new services above "clinic services" in AS 47.07.035.


Recommended by:

  
For: Kimberly B. Busch  
Acting Director  
Div. of Medical Assistance

Date:

3/22/91

Approved by:

  
Theodore A. Mala, MD, MPH  
Commissioner

Date:

8 April 1991

ATTN: Melissa - crank.

## MEMORANDUM

TO: Kim Busch, Director  
Division of Medical Assistance  
Department of H&SS

FROM: Senator Drue Pearce

DATE: March 6, 1991

RE: SB 40, Marital and Family Therapy

Questions were asked in the Senate HESS Committee about medicaid and federal requirements in regards to SB 40 which would regulate the practice of marital and family therapy.

Senator Arliss Sturgulewski and members of her committee would like you to address the following questions. Senator Sturgulewski is planning to hear this bill again early next week to review these concerns.

How does the medicaid payment presently work for marital and family clients?

How will medicaid payments work when the new state and federal regulations goes into effect? And if this bill passes?

What is the amount that the state pays for medicaid coverage for marital and family clients? A breakout of federal coverage also.

Who qualifies to receive medicaid coverage?

Do practitioners bill the clients or directly to Medicaid?

Does marital and family therapy need to be on the medicaid list in statutes in order to receive coverage? Or do they fall under "clinical services"? Does it need to be a separate bill?

Do federal medicaid requirements cover children for family therapy or psychological therapy?

Does federal law require us to make changes to our system?

~~Is psychiatric care going to be required under state regulations for marital and family therapy? —~~

Does the new federal law require standards for licensure of marital and family therapists? Or is it left up to each state?

In advance, I thank you for your prompt reply.

DP:tej

cc: Senator Sturgulewski, Chair, Senate HESS Committee

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900 WEST FIFTH AVENUE  
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MARVIN J. SONOSKY  
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LLOYD BENTON MILLER\*  
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OF COUNSEL  
LOFTUS E. BECKER, JR.  
ROGER W. DUBROCK

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1250 EYE STREET, N. W.  
WASHINGTON, D. C. 20005  
(202) 682-0240  
TELECOPIER  
(202) 682-0249

March 6, 1991

\*ALASKA AND DISTRICT OF COLUMBIA BARS  
\*\*WISCONSIN BAR  
ALL OTHERS DISTRICT OF COLUMBIA BAR

Hand Delivered: March 6, 1991

Honorable Arliss Sturgulewski  
Alaska State Senate  
P.O. Box V  
Juneau, Alaska 99811

Dear Senator Sturgulewski:

I have just received a copy of a letter sent by Frank J. Gold to you concerning my registration as a lobbyist. I have consulted fully with the Department of Law, orally and in writing, concerning my past state employment and current activities to insure that they are permissible under Alaska law. I received a written opinion from the Department of Law which confirms that I am free to engage in both administrative and legislative advocacy and that in fact, there are few restrictions on my post-employment activities -- all of which I will of course observe. The Department's opinion is consistent with past opinions from the Attorney General concerning the activities of other former state officials.

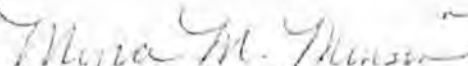
For your information and to assist you in responding to Mr. Gold's letter, I am enclosing a copy of the Memorandum of Advice issued by the Attorney General's Office.

If you have any questions or concerns, I hope you will contact me at:

Sonosky, Chambers, Sachse, Miller & Munson  
229 Fourth Street  
Juneau, Alaska 99801  
(907) 586-5880

Sincerely,

SONOSKY, CHAMBERS, SACHSE,  
MILLER & MUNSON

  
By: Myra M. Munson

MM:nb  
Attachment (1)

1000 6-04-11

WALTER J. HICKEL, GOVERNOR

**DEPARTMENT OF LAW**

OFFICE OF THE ATTORNEY GENERAL

February 25, 1991

Myra Munson, Esq.  
Sonosky, Chambers, Sachse,  
Miller & Munson  
229 4th Street  
Juneau, AK 99801

REPLY TO:

1031 W 4th AVENUE SUITE 200  
ANCHORAGE, ALASKA 99501-1994  
PHONE: (907) 276-3550  
FAX: (907) 276-3697

KEY BANK BUILDING  
100 CUSHMAN ST. SUITE 400  
FAIRBANKS, ALASKA 99701-4679  
PHONE: (907) 452-1568  
FAX: (907) 456-1317

P.O. BOX K - STATE CAPITOL  
JUNEAU, ALASKA 99811-0300  
PHONE: (907) 465-3600  
FAX: (907) 463-5295

Re: Executive Branch Ethics Act  
Our file 663-91-0291

Dear Ms. Munson:

This letter is in response to your request for advice respecting post-state employment, advice this department is authorized to render under AS 39.52.240.

Your letter of January 28, 1991, details a range of activities you engaged in as Commissioner for the Department of Health and Social Services. Briefly summarized, these activities included:

- a. general oversight of department policy, including budget, regulations and legislation;
- b. award of grants and certain contracts;
- c. decision on appeals respecting certain medicaid rate settings and licensing;
- d. release of audits;
- e. supervision of an appeal of a decision of the federal Health Care Financing Administration before the Department of Health and Human Services' grant appeals board;
- f. review of state mental health lands trust policies;
- g. formulation of a model state-tribal agreement under the Indian Child Welfare Act; and
- h. award of certain grants relating to the Exxon Valdez litigation.

Myra Munson, Esq.  
Sonosky, Chambers, Sachse & Miller  
Our file: 663-91-0291

February 25, 1991  
Page 2

You are currently employed as a partner of a law firm and have been approached by prospective clients who have had direct or indirect dealings with your former department. You have requested that we determine whether any proposed representation would violate AS 39.52.180.

AS 39.52.180(a) provides that

a public officer who leaves state service may not, for two years after leaving state service, represent, advise, or assist a person for compensation regarding a matter that was under consideration by the administrative unit served by that public officer, and in which the officer participated personally and substantially through the exercise of official action.

The subsection goes on to define "matter" as follows:

For purposes of this subsection, "matter" includes a case, proceeding, application, contract, or determination, but does not include the proposal or consideration of legislative bills, resolutions and constitutional amendments, or other legislative measures; or the proposal, consideration, or adoption of administrative regulations.

The sectional analysis accompanying the legislation provides a further explanation of this provision:

Specifically, AS 39.52.180 prohibits certain types of representation by former public officers for two years after leaving their public positions. The two-year ban is narrowly drawn: an officer is only prohibited from representing, advising, or assisting a person for compensation regarding a matter (1) that was under consideration by the administrative unit directly served and (2) in which the officer participated personally and substantially through the exercise of official action. A "matter" is precisely defined to include a case, proceeding, application, contract, or determination, and does not include activities related to legislation or regulations.

(Emphasis in original.)

This department has consistently applied this provision in accordance with the apparent legislative intent that AS 39.52.180(a) be restrictively applied. 1986 Inf. Op. Att'y

Myra Munson, Esq.  
Bonosky, Chambers, Sachse & Miller  
Our file: 663-91-0291

February 25, 1991  
Page 3

Gen. (Sept. 24; 663-87-0109). Later, the department approved a former high level official's post-employment representation of a company whose activities were the subject of that individual's policy review. In that instance this department opined:

[T]he Ethics Act would bar this person from participating in discussions concerning the lawsuit itself, since that was a specific case involving the state in which this person took a personal and substantial official action. This person would also be barred from discussing with or advising the company on particular state contracts, cases, determinations, proceedings or applications that came before this person while he was with state service.

On the other hand, this person would not be barred from giving advice or consulting with the company on matters concerning its battle with its competitors, even though there were policy discussions and decisions made by the state during this person's tenure concerning the state interest in this area. As long as those decisions did not coalesce into a particular and specific contract, case, application, determination, proceeding or other similar action which involved determining the rights of third parties or the disposition of state property (including money), this person is not barred from dealing with future subjects or matters even though they may be the outgrowth of those policy decisions.

1986 Inf. Op. Att'y Gen. at 3-4 (Nov. 13; 663-87-0203).

Similarly, we authorized a former state employee to represent taxpayers who had previously appeared before him in his official capacity so long as he refrained from representing them on matters he had under consideration while a state employee. 1987 Inf. Op. Att'y Gen. (May 12; 663-87-0427). See also 1988 Inf. Op. Att'y Gen. (June 30; 663-88-0495).

Your letter of January 28 sets forth in some detail specific issues that have arisen or may arise. Rather than repeat them here, we have simply summarized our conclusions, based upon the discussion outlined above.

The Alaska Native Health Board (ANHB). You would be prohibited from representing ANHB respecting issues arising out of the two grants issued to ANHB by your department. You could otherwise represent ANHB as counsel and as lobbyist. You would be per-

Myra Munson, Esq.  
Sonosky, Chambers, Sachse & Miller  
Our file: 663-91-0291

February 25, 1991  
Page 4

mitted to assist it in applying for future grants from the Department of Health and Social Services.

Regional Health or Non-Profits Native Corporations. Because there were no matters pending before your department respecting these entities, there appears to be no bar to your representation of them in any attorney capacity or as a lobbyist, except as noted. You would not be prohibited from representing these entities or a hospital or nursing home concerning prospective rate setting. You are barred from representing a client in rate or audit appeals that were pending while you were a state employee. You may advise these or any other clients concerning Medicaid policy, including negotiations with the Health Care Financing Administration, about upper limits.

Other Hospitals and Nursing Homes. You would not be precluded from working on modifications to or extensions of a certificate of need or on construction projects undertaken by a facility whose certificate you issued. You would be barred from representing a client respecting a dispute about the terms and conditions of, or compliance with, a certificate you issued. You could exercise full representation of any client respecting certificates issued by your successor.


Tribes concerned with ICWA. There is no bar to your providing training regarding state-tribal relations nor to your representation of clients in specific ICWA cases.

Generally. AS 39.52.180 specifically excludes legislation and regulations from the definition of "matters" covered by that section. Accordingly, you may advise your clients and advocate on their behalf matters pertaining to regulations and legislation (including budgetary issues), regardless of your prior involvement.

Should you have any questions regarding this determination, please do not hesitate to contact this office.

Very truly yours,

CHARLES E. COLE  
ATTORNEY GENERAL

By: 

Bruce M. Botelho  
Assistant Attorney General

BMB:tg

ALASKA PSYCHOLOGICAL ASSOCIATES  
3098 Airport Way  
Fairbanks, Alaska 99709  
(907) 474-9292

February 28, 1991

TO: Senators & Representatives  
Alaska State Legislature

FROM: Frank J. Gold, EdD

RE: Lobbying  
Conflict of Interest



I have been informed that the former Commissioner of the Alaska Department of Health & Social Services, Myra Munson, is now a paid registered lobbyist in Juneau. Such might be of only minimal import except for the fact that she is apparently attempting to influence legislation that is specifically in those areas from which she recently was dismissed. Understand that the woman was not simply a minor participant during the previous four years, but was rather the top-level executive in charge. I submit that Munson is not selling her "professional expertise" alone (i.e., lobbying for the welfare of her profession), but rather is selling, for her own profit, the insider knowledge which was gained at public expense (i.e., lobbying for those health and social service agencies with which her department had and still has contracts). Such I find inexcusable.

Your interest is solicited. At the very least, accept her current efforts for what they are. Thank you.

**DEPARTMENT OF LAW**

OFFICE OF THE ATTORNEY GENERAL

February 25, 1991

Myra Munson, Esq.  
Sonosky, Chambers, Sachse,  
Miller & Munson  
229 4th Street  
Juneau, AK 99801

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REPLY TO:

- 1031 W 4th AVENUE SUITE 200  
ANCHORAGE, ALASKA 99501-1994  
PHONE: (907) 276-3550  
FAX: (907) 276-3897
- KEY BANK BUILDING  
100 CUSHMAN ST. SUITE 400  
FAIRBANKS, ALASKA 99701-4878  
PHONE: (907) 462-1568  
FAX: (907) 458-1317
- P.O. BOX K - STATE CAPITOL  
JUNEAU, ALASKA 99811-0300  
PHONE: (907) 485-3600  
FAX: (907) 483-5235

Myra Munson, Esq.  
Sonosky, Chambers, Sachse & Miller  
Our file: 663-91-0291

February 25, 1991  
Page 2

You are currently employed as a partner of a law firm and have been approached by prospective clients who have had direct or indirect dealings with your former department. You have requested that we determine whether any proposed representation would violate AS 39.52.180.

AS 39.52.180(a) provides that

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The sectional analysis accompanying the legislation provides a further explanation of this provision:

Specifically, AS 39.52.180 prohibits certain types of representation by former public officers for two years after leaving their public positions. The two-year ban is narrowly drawn: an officer is only prohibited from representing, advising, or assisting a person for compensation regarding a matter (1) that was under consideration by the administrative unit directly served and (2) in which the officer participated personally and substantially through the exercise of official action. A "matter" is precisely defined to include a case, proceeding, application, contract, or determination, and does not include activities related to legislation or regulations.

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This department has consistently applied this provision in accordance with the apparent legislative intent that AS 39.52.180(a) be restrictively applied. 1985 Inf. Op. Att'y

Myra Munson, Esq.  
Sonosky, Chambers, Sachse & Miller  
Our file: 663-91-0291

February 25, 1991  
Page 3

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Similarly, we authorized a former state employee to represent taxpayers who had previously appeared before him in his official capacity so long as he refrained from representing them on matters he had under consideration while a state employee. 1987 Inf. Op. Att'y Gen. (May 12; 663-87-0427). See also 1988 Inf. Op. Att'y Gen. (June 30; 663-88-0495).

Your letter of January 28 sets forth in some detail specific issues that have arisen or may arise. Rather than repeat them here, we have simply summarized our conclusions, based upon the discussion outlined above.

The Alaska Native Health Board (ANHB). You would be prohibited from representing ANHB respecting issues arising out of the two grants issued to ANHB by your department. You could otherwise represent ANHB as counsel and as lobbyist. You would be per-

Myra Munson, Esq.  
Sonosky, Chambers, Sachse & Miller  
Our file: 663-91-0291

February 25, 1991  
Page 4

mitted to assist it in applying for future grants from the Department of Health and Social Services.

Regional Health or Non-Profits Native Corporations. Because there were no matters pending before your department respecting these entities, there appears to be no bar to your representation of them in any attorney capacity or as a lobbyist, except as noted. You would not be prohibited from representing these entities or a hospital or nursing home concerning prospective rate setting. You are barred from representing a client in rate or audit appeals that were pending while you were a state employee. You may advise these or any other clients concerning Medicaid policy, including negotiations with the Health Care Financing Administration, about upper limits.

Other Hospitals and Nursing Homes. You would not be precluded from working on modifications to or extensions of a certificate of need or on construction projects undertaken by a facility whose certificate you issued. You would be barred from representing a client respecting a dispute about the terms and conditions of, or compliance with, a certificate you issued. You could exercise full representation of any client respecting certificates issued by your successor.

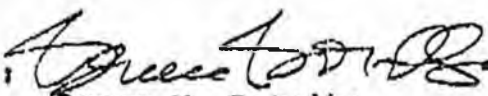
Tribes concerned with ICWA. There is no bar to your providing training regarding state-tribal relations nor to your representation of clients in specific ICWA cases.

Generally. AS 39.52.180 specifically excludes legislation and regulations from the definition of "matters" covered by that section. Accordingly, you may advise your clients and advocate on their behalf matters pertaining to regulations and legislation (including budgetary issues), regardless of your prior involvement.

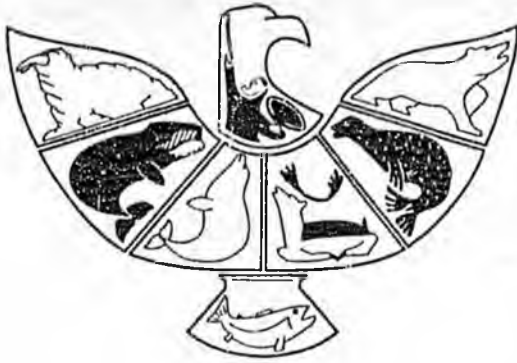
Should you have any questions regarding this determination, please do not hesitate to contact this office.

Very truly yours,

CHARLES E. COLE  
ATTORNEY GENERAL

By:   
Bruce M. Botelho  
Assistant Attorney General

BMB:tg



# 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

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.  
BRISTOL BAY AREA HEALTH CORPORATION  
COPPER RIVER NATIVE ASSOCIATION  
KODIAK AREA NATIVE ASSOCIATION

MANILAQ ASSOCIATION  
THE NORTH PACIFIC RIM  
NORTH SLOPE BOROUGH HEALTH DEPARTMENT  
NOITON SOUND HEALTH CORPORATION

SOUTHCENTRAL FOUNDATION  
SOUTHEAST ALASKA REGIONAL HEALTH CORPORATION  
TANANA CHIEFS CONFERENCE  
YUKON KUSKOKWIM HEALTH CORPORATION

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.

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~~ <sup>lower</sup> 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

①

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.

2  
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.

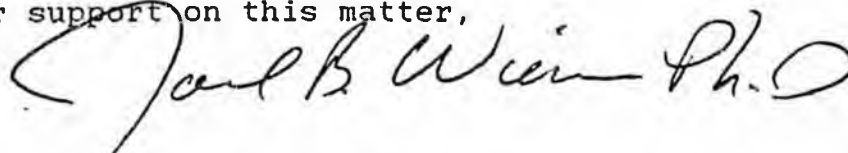
The issue of cost is one that has become increasingly more important as the economy changes in Alaska. With the federal mandate that psychologists and social workers be included in the EPSDT children's services, the additional costs of including provider status of adult services should be minimal. Many 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  
Legislative Coordinator  
Alaska Psychological Association

Joel B. Wieman Ph.D.  
Licensed Psychologist

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

February 26, 1991

Representative Georgianna Lincoln  
Chair of the House Health, Education  
and Social Services Committee  
PO BOX V STATE HOUSE  
Juneau, AK 99811

Dear Representative Lincoln:

I am writing to you on behalf of the Alaska Psychological Association with regard to the Alaska statutes as they relate to the Psychological Associate license. Specifically, I am requesting that the educational requirement for the Psychological Associate be increased from a minimum of a Masters Degree consisting of twenty four semester hours to a minimum of a Masters Degree consisting of forty eight hours.

As you may know, the Psychological Associate license allows those holding a Masters Degree in psychology to practice psychology in Alaska. Alaska is one of approximately five states in the country that allow those holding the Masters Degree in psychology to be licensed, thus providing quality control with regard to whom may practice.

In order to be licensed, Psychological Associates must first practice under the supervision of a Psychologist (someone who holds a Doctorate Degree and is licensed by the the state) for a period of three years. After successfully completing the supervision requirement they are then eligible to sit for the written examination. This examination consists of two parts, an objective portion that is used throughout the country, and an essay portion which covers ethics and legal issues specific to the practice of psychology in Alaska. The test is the same as that taken to be licensed as a Psychologist, but the passing score is substantially lower. After being licensed, Psychological Associates must remain under the supervision of a Psychologist for five years after which they may apply to practice independently.

The difference between Psychologists and Psychological Associates is that Psychologists have two to three more years

of formal training at the graduate level, and have a far broader base of education and thus typically perform a wider variety of services. These include evaluations based upon information derived from psychological testing, and therapy to individuals, groups and families. In addition many Psychologists serve as expert witnesses in court, and do evaluations in the correctional system. Some Psychologists specialize in rehabilitation of those with brain injuries or disease and evaluate neurological capabilities. Psychologists provide services in hospitals, as well as out patient settings.

Psychological Associates may do any of these activities provided they have the necessary training. As a general rule however, most Psychological Associates limit their practice to psychotherapy, and generally restrict their practice to outpatient work.

The Alaska Psychological Association is recommending that the educational requirement for Psychological Associates be increased for two reasons. The first is that when first written, the statute required that Psychological Associates remain under the supervision of a psychologist in order to practice. With the higher level of responsibility that comes with completely independent practice that the law now allows, should come a higher level of training.

The second reason for the requested change is that since the law was written, the amount of knowledge has expanded sufficiently to warrant an increased educational requirement. There continues to be a wide disparity between the requirements for earning a masters degree. While some schools require as many as ninety semester hours of credit, others require less than the twenty four specified for licensure. Twenty four hours of credit is the equivalent of only eight classes, seven classes if credit is given for writing the masters thesis. When viewed in that respect it is apparent that one can just begin to scratch the surface of the current body of knowledge with only twenty four hours of credit. It is clearly not enough to practice independently.

The University of Alaska has increased its requirements for the masters degree to forty eight hours. Those trained in that program will be able to meet this requirement. Those pursuing licensure without the required course work can enroll in graduate courses offered at The University of Alaska and Alaska Pacific University. For those living in rural areas, there are several extended degree programs that a number of Alaskans are enrolled in which allow their

students to do much of the required work independently and attend short intensive seminars Outside on a regular basis. While these programs require a high degree of commitment and time, that is the price that anyone holding an advanced degree has been required to pay.

The Board of Psychologists and Psychological Associates is in support of this change, and has in fact been working toward it for some time now. They have advised me that they have experienced problems doing so due to time constraints and difficulty arranging the necessary hearings to make the change administratively. Because this is a year that the Psychology License is being reviewed for continuation by the legislature, it is a good time to consider this change legislatively. The bill for continuation is HB 163 to extend the Psychology License for another four years. Please consider amending to bill to include an increase in the educational requirement for Psychological Associates to forty eight semester hours as I have discussed above.

I hope that this letter has clarified the position the Alaska Psychological Association is taking with regard to this issue. Please feel free to contact me or our lobbyist, Sharon Macklin, if you have any questions.

Thank you for your consideration on this matter,

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

cc: Arliss Strugulewski

Joel B. Wieman Ph.D.  
Licensed Psychologist

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

February 26, 1991

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

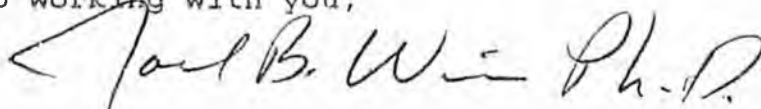
Dear Senator Sturgulewski:

I am writing you on behalf of the Alaska Psychological Association with regard to two legislative issues.

The first is the bill to be introduced by your committee affecting the status of psychologists, psychological associates and social workers as independent providers of mental health care for Medicaid recipients. We are pleased and excited to have the social workers join us in this effort and are looking forward to working with you on this issue again. I am the Legislative Coordinator for the Alaska Psychological Association this year, and will be organizing our support of this bill. We are anxious to have it passed this year and will be available to provide whatever assistance you may need.

The second issue is the continuation of the statutes that define the scope of practice of Psychologists and Psychological Associates, as well as the requirements for licensure in Alaska. We are advising that the educational requirements for the Psychological Associate license are less than adequate, and suggesting that they be increased to 48 semester hours. Enclosed is a letter to Representative Lincoln explaining our position. We would greatly appreciate your support on this issue. Please feel free to contact me if you would like to discuss this. I will be in Washington D.C. on other Association business during the first part of March but will be back in my office after the thirteenth.

Looking forward to working with you,



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



## 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).

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 & Blöse, 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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# The Fireweed Therapy Center

1227 West 9th Avenue, #200, Anchorage, Alaska 99501

10/22/90

Dear Arliss Sturgelewski:

I am writing to wish you well in your campaign. I am President-Elect of the Alaska State Psychological Association, and while I cannot speak officially for the organization, I know that many Psychologists are pleased with your record of supporting mental health issues.

I am personally indebted to you for helping me in 1983 when I was having trouble getting my license because of a bureaucratic error. I later served on the State Licensing Board for 5 years to try to streamline the process and correct some larger problems.

A major challenge now for Psychology is expanding Medicaid services. This is a national issue, and is also especially important for Alaska because we do not have enough providers for Medicaid patients in Anchorage or the rural communities. There is a long waiting list at Southcentral for these people. We hope that Medicaid will be expanded to cover Psychologists and Psychological Associates. I have enclosed our position paper and

Janet Crawford, M.S.W. • Janet Lindeman, Ph.D.

Elaine Molchanov, B.C.C.S.W. • Linda Olsen Webber, Ph.D. • Keith Wiger, Ph.D.

# The Fireweed Therapy Center

1227 West 9th Avenue, #200, Anchorage, Alaska 99501

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some information on costs which may be helpful. We are finding evidence that mental health care decreases overall healthcare costs.

I would also like to call your attention to a hearing on Medicaid regulations Oct. 29 10am at the Frontier Building. At this meeting, more restrictive Medicaid regulations are being considered. I feel it is vitally important that both Psychologists and Psychological Associates have easy access to Medicaid patients.

Thank you again for your past support and I wish you well.

Sincerely,  
Linda Webber

ALASKA  
PSYCHOLOGICAL  
ASSOCIATION

3211 Providenco 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 large cost-offset effect among older people who had received mental health treatment than among young or middle-aged psychotherapy patients. Their findings will be published in the October issue of the *American Journal of Psychiatry*.

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

Data from the 58 cost-offset studies indicated that in 85 percent of the studies there was a decrease in medical care utilization after psychotherapy. The researchers analyzed only the 22 studies that could not be biased by self-selection as in the naturalistic, time-series ones that compared the individual's medical care use before

and after psychotherapy. They found that after mental health treatment, inpatient hospitalizations were approximately 1.5 days shorter than those of the control group's average of 8.7 days.

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

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

## Inflation Rate

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

After the initial year, the psychotherapy group had significantly lower

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

## Age

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

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

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

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

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

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

## 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."



**American  
Psychological  
Association**

## 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).

**Legislative  
Briefing  
Sheet**

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0- 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)

0- 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).

0- 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).

0- 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).

0- 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).

0- 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).

0- 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).

0- 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. (Wetts, 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 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?

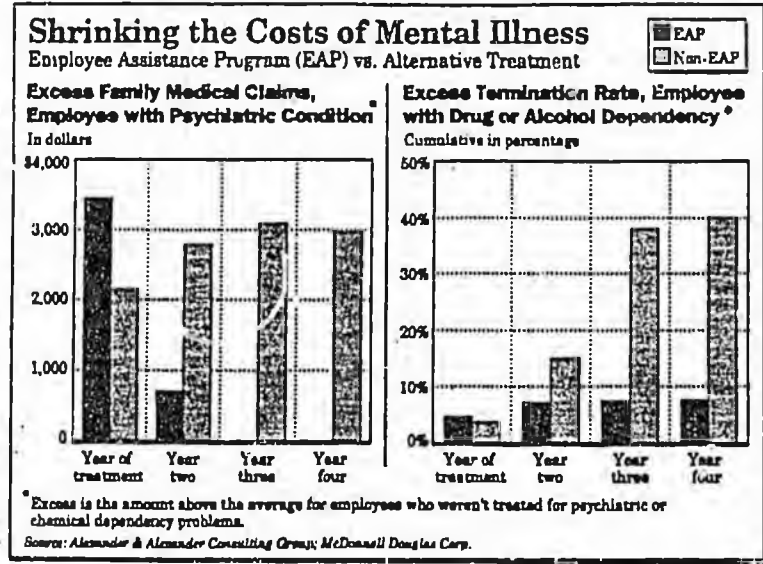
But when applied to psychiatric care or treatment for drug and alcohol abuse, such narrow cost-cutting efforts can cost a company millions of dollars. Instead, employers can shrink their bill for mental-health care by taking the long view, even if that means spending more in the early stages of treatment.

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 (insisting that the whole family included in treatment. That results higher first-year costs in many cases, but "It seems to be a very important aspect 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 average \$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 use the EAP for chemical dependency treatment missed 44% fewer workdays, had 81% lower attrition and filed \$7,300 less in health-care claims than those who didn't 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 whole 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 "startling 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, \$7 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 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.

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

visits; a 66.7% decrease in frequency of hospitalizations and a 77.9% decrease in the average length of stay in the hospital...intervention appeared to be positively associated 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-patient medical visits and 69% 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 psychological 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 psychotherapy 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 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 13.5% 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 psychotherapy services in private health insurance programs in new York State only costs \$0.00 - \$0.15 per month/premium (NASW in Washington