

## ESTIMATING THE COST OF DIRECT REIMBURSEMENT OF MARRIAGE AND FAMILY THERAPY UNDER MEDICARE

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*In this article, we investigated the estimated cost to the Medicare program for covering psychotherapy services provided by marriage and family therapists (MFTs). Historical trends were identified by using psychotherapy cost and utilization data for the years 1999–2001. Using these trends, projections for the years 2002–2006 were made with MFTs included as providers. Employing this methodology, the 5-year estimated net increase and gross increase in cost due to the provision of psychotherapy services by MFTs was found to be approximately \$10.5 million (or \$2.1 million per year) and \$13.9 million (or \$2.8 million per year), respectively. This represents an increase of less than 1/2 of 1% of the Medicare mental health budget, and less than .0015% of Medicare expenditures overall.*

For a number of years, a goal of the Medicare program has been to improve access to services for its beneficiaries. One area that has frequently been discussed is the feasibility of extending coverage to nonphysician providers of services (e.g., Department of Health, Education, and Welfare [DHEW], 1968; Medicare Payment Advisory Commission [MedPAC], 2002). As a result of this interest and the subsequent effort of various professions, clinical psychologists, licensed clinical social workers (LCSWs) and certified clinical nurse specialists have been granted direct reimbursement for psychotherapy services under Medicare. However, despite being recognized by the federal government as one of the core mental health professions (Code of Federal Regulations [CFR], 2000), marriage and family therapists (MFTs) are currently not eligible for direct reimbursement from Medicare. Although a number of studies have analyzed the potential impact on Medicare of providing additional psychotherapy services (e.g., DaVanzo, Dobson, & Sen, 2002; Haber & McCall, 1989), to date no study is known to have examined the cost of adding MFTs as eligible providers. Endeavoring to address this deficit in the literature served as the primary focus of this research.

### *Access to Health Care*

Addressing barriers to health care for older adults is one of the most significant issues that has motivated the investigation of extending coverage to nonphysician providers. Commonly listed among the barriers to mental health care are cost of services (especially prescription drugs), lack of transportation, denial of mental illness, and stigma associated with receiving mental health services (Department of Health and Human Services [DHHS], 2001).

In addition, it is generally recognized that certain localities, especially rural areas, have a shortage of mental health practitioners, which creates additional problems in terms of access (Pion, Keller, & McCombs, 1997). Although some have seen the lack of providers in certain areas to be less problematic than other barriers (MedPAC, 2002), shortages of mental health practitioners in rural areas are startling. Indeed,

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of all the counties in the United States, 55% (all of which are rural) currently do not have any practicing psychiatrists, psychologists, or LCSWs (Lawrence & McCulloch, 2001). Although a number of changes in the Medicare program have improved access to services within the last few years (Rosenbach & Ammering, 1997), significant concerns remain regarding mental health care among older adults (DaVanzo et al., 2002).

A report issued by the Surgeon General through the Department of Health and Human Services argues that 8%–20% of older adults suffer from major depression. Perhaps more sobering is the finding that in primary care settings up to 37% of patients present with symptoms of major depression (DHHS, 1999). Unfortunately, it has been estimated that as many as one-third of older adults who would likely benefit from mental health services are not participating in treatment (Mental Illness, 1996). Of those who actually acknowledge having mental health problems, up to one-half do not receive any intervention, and only 3% of those who participate in treatment receive specialized mental health care (Bartels, 2001). Although many barriers exist to mental health care, it has nonetheless been strongly argued that it is imperative the supply of “effective, evidenced based services” (DHHS, 1999, p. 22) be improved to increase access for older adults.

In terms of working with older adults who face mental health problems, MFTs are in a unique position to be successful among this population. In view of the knowledge that factors related to aging are imbedded in reciprocal interactions within the family system, intergenerational counseling and family therapy are recognized as a necessary part of intervention (Silver, 2001). In addition, MFTs are often located in rural areas in which a disproportionate number of older adults live. Miller (2002) cites data from the American Association of Marriage and Family Therapy (AAMFT) that show that MFTs are represented in 36% of rural counties and that roughly one-half of these counties do not have any psychiatrists. Miller goes on to argue that “with the acute shortages of mental health professionals in rural settings, where the population is disproportionately elderly, recognizing MFTs will dramatically increase the availability of qualified providers” (p. 25). Given the availability of MFTs in those areas that are underserved, extending Medicare coverage to services provided by MFTs would increase accessibility of mental health services for Medicare participants.

### *Marriage and Family Therapists as Mental Health Providers*

As early as 1968, efforts have been endorsed to investigate the impact of extending coverage to nonphysician providers of mental health services (DHEW, 1968). Efforts by other professions have been influential in promoting direct reimbursement of various providers of psychotherapy services (Rosenbach & Ammering, 1997). As a result, the list of eligible providers under Medicare now includes, in addition to psychiatrists and other physician specialties, clinical psychologists, LCSWs, and certified clinical nurse specialists. Although the training of MFTs is in many ways comparable to that of LCSWs and clinical psychologists (MedPAC, 2002), they have not received the same recognition under Medicare (Hartley, Ziller, Lambert, Loux, & Bird, 2002).

In a report to congress recommending that MFTs should not be reimbursed directly for psychotherapy services under Medicare, the MedPAC (2002) nevertheless argued that MFTs are qualified providers of mental health care. This report states that MFTs are “trained in psychotherapy and family systems, and they diagnose and treat mental and emotional disorders within the context of marriage, couples’ relationships, and family systems” (p. 15). The report goes on to explain that the Department of Health and Human Services also recognizes MFTs as one of the core mental health professions (see also CFR, 2000).

The only argument provided by the MedPAC (2002) against MFTs being qualified providers under Medicare is that state laws, to which Medicare carriers are required to defer, may not provide sufficient guidance for carriers to make coverage decisions regarding services provided by MFTs. However, a recent study by Hartley et al. (2002) reviewed state laws and argued that there is no basis for determining whether a profession is entitled to reimbursement, because the intent of state legislation is only to determine professions eligible to practice. Furthermore, Hartley et al. show that although MFTs and LCSWs are not treated significantly different under state law, only LCSWs are eligible for direct reimbursement from Medicare.

### *Cost Implications*

Despite recognizing difficulties associated with Medicare participants' access to different provider types, some have argued that the biggest problems result from financing constraints currently present in the Medicare program (MedPAC, 2002). In particular, the copay for mental health services is set at 50% of the amount allowable for a given service, whereas the copay for general medical services is only 20% (Centers for Medicare and Medicaid Services [CMMS], 2002a). In a report to congress the MedPAC strongly argued that the funds needed to provide direct reimbursement for MFTs would be better used to reduce the copay to the level set for other general health care services. Although this is an effort that many therapists would likely support, the cost of increasing the amount paid by Medicare for psychotherapy services is apt to be substantial.

A common argument against direct reimbursement for MFTs is the contention that increasing the number of providers will increase the cost of services overall. However, there may in fact be a "substitution effect" from adding lower cost providers to the provider panel. For example, Fairbank (1989) showed that when laws in Massachusetts provided direct reimbursement for LCSWs, a substitution effect occurred, and no measurable increase in overall demand for services was observed. Fairbank goes on to argue that overall increases in cost were mostly neutral and what increase was observed may have been due in large part to "accounting shifts," given that a number of LCSWs had previously billed from within a physician's practice. In another example, Haber and McCall (1989) found that direct reimbursement of LCSWs in California also did not significantly increase costs. However, they did find that more services were provided by LCSWs, as opposed to the more costly providers previously available, which resulted in comparable overall costs.

In addition to arguments concerning the direct effect of increased coverage on costs, claims have also been made suggesting that additional savings could result from the influence of mental health services on general medical care utilization. For example, in a review of 91 articles investigating individual psychotherapy, Chiles, Lambert, and Hatch (1999) found that 90% of the articles showed a decrease in general medical use after mental health services were provided. This phenomenon, called a "medical use offset," showed a reduction on average of 23.6%. O'Farrell et al. (1996) found in the treatment of alcoholics that family therapy was likewise associated with decreases in medical use and that the overall cost was less than the usual course of treatment. In the only study known to investigate the influence of contemporary marriage and family therapy (MFT) practices on general health care use, Law and Crane (2000) found that those who participated in MFT showed an overall decrease in utilization of 21.5%. The possibility exists, therefore, that MFT treatments are also effective in reducing medical utilization.

The link between reduced medical utilization and the overall cost of medical treatments is not clear. Some studies have not found cost savings in conjunction with the introduction of mental health services (e.g., Goldberg et al., 1981). However, there is at least enough evidence to suggest that the inclusion of mental health services would improve overall quality of care, and any reductions in medical use would at least temper (if not reduce) cost increases from MFTs providing mental health services.

Although the cost impact of including other mental health professions in Medicare has been studied (e.g., DaVanzo et al., 2002; Fairbank, 1989; Haber & McCall, 1989), little is known concerning the effect including MFTs as providers would have on Medicare costs. Given that access to care would likely improve as a result of allowing direct reimbursement of psychotherapy services by MFTs, efforts are needed to determine the fiscal impact of such a policy change. The purpose of this study, therefore, was to arrive at a 5-year estimate of the cost to Medicare of including MFTs as providers.

## METHOD AND RESULTS

The methodology first focused on projections for the cost of psychotherapy services as provided under current policy. The cost projections for current policy were then altered to include projections for psychotherapy services provided by MFTs. To ensure that the findings from this study are comparable to those for other mental health professions, the methodology outlined by DaVanzo et al. (2002) was followed closely. In their study, DaVanzo et al. examined the fiscal impact that covering services provided by mental health counselors would have on Medicare. Throughout the analysis, calculations were based on the most

conservative information available. Accordingly, the results are anticipated to err on the side of overestimating costs as opposed to underestimating.

*Estimated Cost of Psychotherapy Services under Current Medicare Policy without MFTs*

To estimate the cost of services under current policy, the total number of psychotherapy services expected to be provided from 2002 through 2006 was estimated. Then, using national trends found in the proportion of services supplied by the various provider groups (e.g., clinical psychologists, psychiatrists, etc.), the number of services expected to be provided by each provider group was projected. Finally, by multiplying the number of services projected for each provider group by an estimated cost per visit, the expected total cost for the provision of psychotherapy services under current coverage was established.

*Estimated total number of psychotherapy services to be provided for 2002–2006 without MFTs.* Data from the National Procedure Summary File, available from the Center for Medicare Services, were used to determine the number of psychotherapy services provided under Medicare Part B from 1999 through 2001. Medicare Part B is also referred to as Supplementary Medical Insurance and covers nonhospital outpatient services. The available data provided information about the number of psychotherapy claims processed by different Medicare carriers. Carriers are agencies used by Medicare to process medical claims submitted by physicians and other providers, and they typically only handle claims filed in a single state. Carriers were selected for inclusion in this analysis only if they processed claims for a particular state where MFTs are licensed.

Trends in the provision of services between the years 1999 and 2001 were used to project the number of services that could be expected to be provided in 2002–2006. Given that coverage of services provided by MFTs would only be expected to affect costs in states in which MFTs are licensed, only states with MFT licensure were included in the analysis. At the time the data were analyzed, 44 states had enacted licensure laws. (Ohio, West Virginia, New York, North Dakota, Montana, and Delaware were excluded.)

In one instance, a single carrier serviced both a state with licensure and a state without licensure. In this case, the total number of claims (i.e., for all Medicare services; Beacon Health Care Solutions, 2003) typically submitted by the state with MFT licensure, was divided by the total number of claims typically submitted by both states represented by the carrier. Doing this allowed for the determination of what proportion of the claims processed by the carrier would characteristically be from the state with MFT licensure. The percentage was then used to determine the number of claims that should be included from the carrier.

The analysis showed that approximately 14 million psychotherapy services were provided annually in the 44 states in which MFTs were licensed. When the total number of psychotherapy services in the 44 states was divided by the overall total number of Medicare Part B beneficiaries in the United States, a ratio of approximately 0.38 was typically observed. The ratio was found to be relatively constant between 1999 and 2001 (Table 1).

Employing this ratio in a basic algebraic expression allows the total number of psychotherapy services to be projected for 2002–2006. Although using the total number of U.S. Medicare beneficiaries decreases the ratio, the solution to the algebraic equation is not affected so long as total U.S. Medicare beneficiaries are consistently employed. For example, below is an example of this equation using data for the year 2002:

$$\text{Number of Psychotherapy Services} = 0.38 * 38,029,000 = 14,451,020$$

Utilizing this equation with projections of total U.S. Medicare Part B beneficiaries, as available from the Center for Medicare Services, an estimated total of 73.7 million psychotherapy services will be provided from 2002 through 2006 (Table 2).

*Proportion of services expected to be provided by mental health provider groups without MFTs.* As noted previously, psychotherapy services are currently provided under Medicare coverage by physicians, psychiatrists, clinical psychologists, LCSWs, and certified clinical nurse specialists (Table 3). In the cost analysis, estimated trends were used to calculate the number of psychotherapy services expected to be delivered based on provider group. To account for the possibility of future fluctuations in the proportion of services provided by provider group, historical trends in the yearly percent increase or decrease per group were reduced by one-half for projections. This resulted in a conservative estimated increase of 0.25% per

**Table 1**  
*Ratio of Total Services over Total Number of U.S. Beneficiaries*

	Year		
	1999	2000	2001
Medicare psychotherapy services	14,060,251	13,804,580	14,294,737
Medicare beneficiaries	37,022,000	37,315,000	37,657,000
Ratio services to beneficiaries	38%	37%	38%

*Note.* Medicare psychotherapy services = Number of Medicare psychotherapy services in the 44 states with MFT licensure. Medicare beneficiaries = Number of U.S. Medicare beneficiaries. Ratio of services to beneficiaries = Ratio of Medicare psychotherapy services in the 44 states to the number of U.S. Medicare beneficiaries.

**Table 2**  
*Sample Items from the Cost Estimation Calculations*

	Year					Totals
	2002	2003	2004	2005	2006	
A Total number of Part B beneficiaries in the U.S.	38,029,000	38,365,000	38,766,000	39,194,000	39,683,000	194,037,000
B Ratio of Medicare psychotherapy services in the 44 states to the number of Medicare beneficiaries	0.38	0.38	0.38	0.38	0.38	
C Number of psychotherapy services estimated under current coverage	14,451,020	14,578,700	14,731,080	14,893,720	15,079,540	73,734,060
U Number of psychotherapy services estimated to be provided proposed coverage	167,647	215,120	265,339	318,285	351,029	1,317,420
KK Gross cost of psychotherapy services provided by MFTs under the proposed coverage	\$1,540,580	\$2,098,285	\$2,744,088	\$3,486,353	\$4,068,470	\$13,937,775
NN Net cost <sup>a</sup> for psychotherapy services provided by MFTs under the proposed coverage	\$1,155,435	\$1,573,714	\$2,058,066	\$2,614,765	\$3,051,352	\$10,453,332

*Note.* The complete cost estimation calculations are available from the authors.

<sup>a</sup>Net cost is calculated as gross cost minus the proportion covered by Medicare premiums.

Table 3  
*Proportion of Psychotherapy Services Provided by Profession*

	Year (%)		
	1999	2000	2001
Clinical psychologists	22.90	23.30	23.34
Psychiatrists	57.68	55.29	53.39
Licensed clinical social workers	12.42	12.90	13.61
Certified clinical nurse specialists	0.67	1.03	1.23
Physicians of unknown specialty	6.33	7.49	8.44

year for services provided by LCSWs and a conservative estimated decrease of 0.25% per year for psychiatrists and other physician specialties, whereas the proportion of services provided by clinical psychologists was expected to remain constant.

Applying the proportions to the total number of psychotherapy services expected to be provided showed that of the estimated 73.7 million total services for the 5-year period, approximately 11 million would be expected to be provided by LCSWs, 17 million by clinical psychologists, and 46 million by psychiatrists and other physician specialties.

*Estimated cost per visit for psychotherapy services without MFTs.* In general, Medicare's allowable charge for each of the various psychotherapy services is based on the figures found in the Physician Fee Schedule, which is available from the Center for Medicare Services. In the fee schedule, a basic rate is adjusted according to locality to account for local economic variation (e.g., cost of living). Localities in which MFTs had licensure were selected and the mean charge for each of the different psychotherapy services (e.g., individual, group, etc.) was calculated. The estimated allowable charges were then weighted against the distribution of the various psychotherapy services provided during 2001 to determine the overall average charge for psychotherapy services. Using this methodology, the weighted average price allowed for psychotherapy services was estimated to be approximately \$81.42 per visit.

Under current coverage, beneficiaries are responsible for 50% of the allowed charge for psychotherapy services. To make projections, the amount of \$81.42 was reduced by 50% to account for the effect of copayment required by beneficiaries (leaving \$40.71 to be paid by Medicare). The basic conversion factor used by Medicare to convert payment rates for the 2001 Physician Fee Schedule into the rates used for the 2002 fee schedule was then located (CMMS, 2002b). By applying the conversion factor (1.026) to the reduced average allowable charge (i.e., \$40.71 \* 1.026), the average allowable amount for 2002 was calculated as \$41.77. This factor was also used to increase the average allowable cost per visit for each year thereafter through 2006.

According to the Medicare Carrier Program Manual (Center for Medicare Services [CMS], 2002), physicians are eligible to receive the full amount of the allowed charge less copayments by the patient. Furthermore, clinical psychologists are reimbursed 80% of the allowed payment for physicians and LCSWs receive 75% of the amount paid to clinical psychologists. For the year 2002, the application of these rules showed an average allowable charge for clinical psychologists of \$33.42 and \$25.06 for LCSWs. These figures were also increased by the conversion factor of 1.026 for each year that followed through 2006.

After arriving at the various components listed, the projected number of services provided by various mental health providers and the corresponding cost per visit was then used to determine estimates for overall costs over the 5-year period under current policy. This was accomplished first by calculating the cost per provider groups and then summing the total for all providers to arrive at an annual cost. The annual cost for each of the 5 years was then summed to determine overall expected expenditures.

*Final estimate of cost of services under current Medicare policy without MFTs as providers.* By determining the product of price per visit and number of services for each of the various mental health

providers, it was estimated that the total cost for psychotherapy services during the 5-year period would be approximately \$2.9 billion. Of this amount, \$288 million was attributable to LCSWs, \$597 million to clinical psychologists, and slightly more than \$2 billion to psychiatrists and other physician specialties.

#### *Estimated Cost of Psychotherapy Services with MFTs Included as Providers*

To determine the impact of the inclusion of MFTs on Medicare, the number of services that would be expected to be provided by MFTs was estimated first. Next, the idea that the inclusion of MFTs would affect demand for services was assessed. It was assumed that the provision of services by MFTs would affect demand in two ways. First, the overall demand for services was assumed to increase to some extent solely as a result of more service providers being available. This phenomenon is referred to as induced demand (e.g., DaVanzo et al., 2002). Second, demand for services from other providers (e.g., clinical psychologists) was assumed to decrease to a certain extent as some beneficiaries can be expected to switch from other providers to MFTs. A change in provider of services is described as a substitution effect (e.g., Fairbank, 1989; Haber & McCall, 1989). After accounting for the potential effect of induced demand and substitution, the cost of psychotherapy services was estimated.

*Number of services estimated to be provided by MFTs.* DaVanzo et al. (2002) used a mathematical equation to determine the number of services that could be expected to be provided by mental health counselors. Using this study as precedent, the equation for services expected to be provided by MFTs is as follows:

$$\text{Number of Services Estimated to be Provided by MFTs} = \# \text{ of Services Provided by LCSWs} * (\# \text{ MFTs} / \# \text{ LCSWs}) * (\text{Expected Average Medicare Caseload of MFTs} / \text{Expected Average Medicare Caseload of LCSWs})$$

The first term in this equation (i.e., # of Services Provided by LCSWs) is derived from the previously mentioned estimates for current coverage costs. Mental health counselors were not included in this analysis, because they are not eligible providers.

The second term in the equation (i.e., # MFTs/# LCSWs) was filled by dividing the number of MFTs who are not dually licensed by the number of LCSWs. The number of MFTs includes only persons not dually licensed, because those who hold additional licenses are likely already eligible to receive reimbursement. The AAMFT estimates that 39,243 MFTs fit these criteria. The number of LCSWs (192,814) was determined using estimates from the Center for Mental Health Services (Manderscheid & Henderson, 2001). Although it is possible that the number of providers will increase in the future, no adjustments were made, because the number used for LCSWs in our study was conservative (i.e., 192,814 vs. 250,000 in DaVanzo et al., 2002). By using a conservative number for LCSWs the number of services expected to be provided by MFTs is likely overestimated and thereby compensates for potential fluctuations in the number of providers.

The third term (i.e., Expected Average Medicare Caseload of MFTs/Expected Average Medicare Caseload of LCSWs) factors in the assumption that MFTs will not immediately provide the full number of services that are potentially available for them to provide. Instead it was assumed that the average number of Medicare patients seen by MFTs would increase over the 5-year period. As in the study by DaVanzo et al. (2002), it was assumed that during the first year of coverage the average number of Medicare patients being seen by MFTs would only be 40% of the average number for LCSWs. This percentage was increased incrementally over the 5 years until the estimated average number of Medicare patients seen by MFTs was 75% of the caseload for LCSWs.

Using the equation it was estimated that for the years 2002–2006, MFTs would provide a total of approximately 1.3 million services (Table 2).

*Estimated gross cost and net cost of psychotherapy services provided by MFTs.* Because both groups are licensed at the master's-degree level, it was assumed that the payment allowable for MFTs would be equal to the amount allowable to LCSWs. To arrive at the estimation for the full cost, the cost for services that would be expected to be induced was calculated first. Next, the cost for services expected to be substituted was calculated. The sum of these estimations allowed for a determination of the total expected gross cost.

Following the methods of DaVanzo et al. (2002), it was assumed that in the first year of coverage 50% of the total Medicare services provided by MFTs would be a result of induced demand, and for each year thereafter the percentage of services assumed to be induced was increased by 1%. The gross cost of psychotherapy services assumed to be induced was then calculated as the number of induced visits multiplied by the likely payment amount for MFTs' services.

Again following the methods of DaVanzo et al. (2002), it was assumed that in the first year of coverage, 50% of the total Medicare services provided by MFTs would be due to substitution. For each year thereafter, the percentage of services assumed to be substituted was decreased by 1%. Of the total number of services substituted, the majority was assumed to be substituted from clinical psychologists and LCSWs, given that the services supplied by these providers are most similar to those provided by MFTs. Psychiatrists were assumed to be affected somewhat less.

The gross cost of services assumed to be substituted is calculated as the number of services expected to be substituted from a specific provider multiplied by the payment differential between MFTs and the corresponding provider type. The payment differential is calculated as the amount allowable to the other provider subtracted from the amount allowable to MFTs. Given that the majority of MFTs are master's-level practitioners, most would be paid at a lower rate than psychiatrists and clinical psychologists. The product of the number of services substituted and the payment differential returns a negative number. This can be seen as savings resulting from a less expensive provider supplying substituted services.

The total gross cost of Medicare psychotherapy services expected to be provided by MFTs was then calculated by factoring together the cost for induced services and the expected savings resulting from the substitution of services from more expensive providers.

A net cost to Medicare was also calculated, because the total gross cost paid for psychotherapy services is offset by annual premiums paid by Medicare beneficiaries. At the current time, premiums are used to cover 25% of expenditures (Financial Outlook, 2001).

Factoring premiums into the gross cost for psychotherapy services by MFTs provided an estimation of the overall net cost to Medicare.

*Final estimate of total gross cost and net cost of including MFTs as Medicare providers.* The total gross cost of psychotherapy services provided by MFTs was determined by combining the cost from induced services and the savings due to substitution. From the previously outlined calculations, it was estimated that the gross cost for induced services would be approximately \$18.4 million. It was also estimated that the total saving resulting from the substitution of services would be approximately \$4.4 million. Combining these estimates, it was estimated that the total increase in cost due to the provision of psychotherapy services by MFTs would total approximately \$13.9 million over the 5-year period (Table 2). In the cost analysis, the net cost of psychotherapy services provided by MFTs was found to total approximately \$10.5 million over the 5-year period (Table 2).

#### *Effect of Proposed Coverage on Market Share of Services*

Finally, the number of services expected to be provided by each provider type if MFTs were added was used to determine the market share MFTs could be expected to hold. This was determined by calculating the percentage of total services MFTs, as well as other providers, could be expected to provide.

As shown in Table 4, the proportion of services estimated to be provided by MFTs increases from 1% of all services in 2002 to 2% in 2006. The percentage of total services expected to be provided by different professions is also found in Table 4. Given the limited number of services that could be expected to be provided by MFTs, the proportion of services provided by other professions would not be significantly affected.

## DISCUSSION

This study is the only known attempt to investigate the cost of extending Medicare coverage to services provided by MFTs. It can be persuasively argued that the findings are primarily appropriate for the attention of policy makers, not clinicians and researchers. Although presenting these findings to policy makers is

Table 4  
*Expected Proportion of Services Provided by Provider Groups Under Proposed Coverage*

	Year				
	2002	2003	2004	2005	2006
Psychiatrists and other physicians	62%	62%	62%	61%	61%
Clinical psychologists	23%	23%	22%	22%	22%
Licensed clinical social workers	14%	14%	14%	>14%	15%
Marriage and family therapists	1%	1%	2%	2%	2%
Total number of psychotherapy visits expected to be provided	14,534,844	14,688,411	14,869,056	15,062,411	15,269,096

unquestionably necessary, it is also important that all those who have an interest in promoting the profession take the cause forward themselves. Only then will their collective voice be heard by those who are in a position to effect changes in the Medicare system. Consequently, it is hoped that the results of this study will be used by clinicians and researchers in the presentation of an informed and convincing argument for the inclusion of their services under Medicare.

Though the total cost of psychotherapy services provided by MFTs would at first glance appear to be noteworthy (increasing costs by approximately \$13.9 million over 5 years), the relative cost to the Medicare program is inconsequential. When included in the previously mentioned \$2.9 billion estimated cost for psychotherapy services in the 44 states, services by MFTs would be estimated to account for less than 0.5% of expenditures. Furthermore, when the average for a single year (\$2.1–\$2.8 million) is considered against the \$257 billion in projected Medicare spending for 2002, the proposed inclusion of MFTs as Medicare providers would account for less than 0.0015% of all Medicare expenditures.

Perhaps the greatest opposition to allowing MFTs to be directly reimbursed under Medicare has come from those arguing that limited funds are better spent reducing the copay for mental health services to 20%. Simple adjustments to the calculations used for current policy show that such a policy change would result in additional costs to Medicare of \$1.7 billion over 5 years. Even when assuming that coverage for MFTs would be included along with such legislation, the total for services provided by MFTs would only increase to approximately \$22 million in expenditures for the 44 states. When included as part of the increased costs to lower the copay for psychotherapy, Medicare services provided by MFTs would account for less than 1.5% of the increase. Regardless of the manner in which spending for Medicare patients treated by MFTs is framed, the overall costs remain negligible.

Although the increase in cost to Medicare would be unremarkable, any increase is likely to be seen negatively. However, the fiscal consequences of extending coverage are often tempered by other considerations. For example, improving access to care can also be seen as a meaningful investment. In fact, the MedPAC (2002) has argued that previous measures providing Medicare coverage to nonphysician providers (e.g., psychiatric nurses) were primarily motivated by the desire to increase access to care in underserved and rural areas. Nonetheless, the commission notes that many providers were reluctant to relocate and access may not have been substantially increased. Even if more providers had relocated to rural areas it is unlikely that other mental health fields (e.g., psychiatry and psychology) would even be able to produce enough providers to meet the needs of rural areas (Pion et al., 1997).

Regardless of whether MFTs are willing to relocate to rural areas, extending Medicare coverage to MFTs would have a positive impact on access to care. As mentioned, MFTs are currently represented in 36% of rural counties, and about one-half of the same counties do not have any psychiatrists (Miller, 2002). Because MFTs are already represented in many rural areas of the United States, extending coverage to MFTs has the potential to enhance access to care for many Medicare beneficiaries greatly. Thus, although

Medicare expenditures could be expected to increase somewhat if MFTs were granted coverage, the benefit of increased access would likely compensate for the monetary impact.

Although these findings present a compelling argument for the provision of coverage for MFTs under Medicare, some important limitations merit mentioning. First, since the time the data were analyzed for this study, New York and Ohio have both enacted laws providing licensure for MFTs. Though the impact on financial projections would probably be minimal, changes in state law such as this would likely influence cost estimations. Second, privacy laws requiring some data to be excluded make it difficult to determine precise numbers of mental health services in the states that license MFTs. Although unlikely, such limitations could potentially have an influence on trends used to make projections. Third, the current study did not determine the extent of MFTs currently being reimbursed under physician billings. Incorporating this type of information would allow for a much greater understanding of the overall affect direct reimbursement for MFTs would have on Medicare. Finally, it is important to note that the figures presented in this research fail to incorporate unique effects of MFT. For example, since MFTs typically treat more than one person at the same time, added savings are likely. Given that the effect of unique contributions of MFT on costs is relatively unknown, it will be important for future investigations to incorporate this factor.

One final consideration relates to the possibility of a medical offset effect following participation in MFT. Crane (1995), in a review of the impact of health care reform on MFTs, argued that the provision of mental health services may actually result in savings to managed care. At the time Crane's review was published, most of the literature describing medical offset findings was focused on individual psychotherapy. Since that time impressive findings have been reported with respect to the influence of MFT on health care utilization (e.g., Law & Crane, 2000; Law, Crane, & Berge, 2003). As mentioned, Law and Crane's (2000) findings concerning the use of general health care suggest that MFT has the potential to exert a 21.5% reduction in other health care utilization. Perhaps more importantly they also found a potential reduction of 30.5% for family members who are not even the focus of therapy. In addition, when Law et al. (2003) examined changes in medical use for higher utilizers of health care, they found a 53% reduction following MFT. Moreover, family members of the identified patient showed a 57% reduction in health care utilization following therapy. Given the impressive reductions found in these studies, it is entirely possible that the addition of MFT services would actually result in a net savings to the Medicare program. However, this argument is largely theoretical at this time and related findings require replication. Future studies should investigate the potential impact of medical offset when more is known regarding this phenomenon within MFT. Nevertheless, it seems clear that the addition of MFTs to Medicare could result in more than just increased quality of care. There may also be significant financial benefits to the Medicare program as well.

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