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January 26, 2016

Senator Johnny Isakson  
Senator Mark Warner  
United States Senate  
Senate Committee on Finance  
Washington, DC  
[chronic\\_care@finance.senate.gov](mailto:chronic_care@finance.senate.gov)

Dear Senator Isakson and Senator Warner:

The Clinical Social Work Association (CSWA) would like to thank you for the opportunity to comment on the work of the Chronic Care Task Force. CSWA serves as the Voice of Clinical Social Work, representing the 240,000 licensed clinical social workers in the country, the largest single group of independent mental health clinicians.

As clinicians who regularly work with patients who have chronic mental health disorders, we have long been aware of the inadequate coverage of these conditions on the inpatient and outpatient level. We are concerned, as well, that the critically-important integration of medical/surgical care and mental health/substance use care continues to be elusive. We hope that our on-the-ground experience, outlined below, will be helpful to the Task Force in its important mission.

Many medical and mental health conditions are chronic in nature. Just as chronic medical conditions such as diabetes and heart disease generally require more intensive ongoing treatment than do acute or moderate conditions, so, too, do chronic mental health conditions such as Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), and various psychotic disorders and personality disorders. Further, it is well-documented that untreated or undertreated behavioral health problems often exacerbate the above and other medical conditions. That coverage for mental health conditions continues to be less broad than

what is offered for medical conditions turns logic on its head, ultimately increasing overall health care costs.

A major CSWA concern is all-too-frequent denial of mental health treatment for severe chronic conditions. Whether the plan is Medicare, Medicare Advantage, or private insurance, in our experience, a “medical necessity” provision is often used to justify denial; even in the most serious cases, clinician determinations of treatment needs are overridden by bureaucratic decision-makers. In 2014, “Sixty Minutes” explored this issue, finding that insurer attitudes significantly limited access to needed mental health treatment (see <http://www.cbsnews.com/news/mental-illness-health-care-insurance-60-minutes/>). CSWA can confirm that this practice continues to be a significant problem today.

Closely related to treatment denials, and of equally grave concern to CSWA, is the ongoing unjustified bias toward medication over psychotherapy, with psychotherapy often allowed only at a minimal, sub-therapeutic level. We can surely assume that insurers would not override a physician’s order by limiting a patient prescribed daily medication to an every-other-day regimen, yet clinicians are regularly second-guessed on the need for psychotherapy, and treatment is denied. Even in the face of evidence that psychotherapy alone and/or psychotherapy with medication can be *more effective in the long term* than medication alone, insurers continue to favor medication. The well-researched report, the American Psychological Association Resolution on the Recognition of Psychotherapy Effectiveness, released in 2012 provides considerable evidence (Cuijpers, et al., 2008, Lambert, 2004; Karver, et al., 2006; Norcross, 2011; Shirk & Karver, 2003; Wampold, 2007), and there is evidence, as well, that psychotherapy that is *longer term* has *more significant and continuing impact* on improved mental health (Levy, et.al., “The Efficacy of Psychotherapy”, *Psychodynamic Psychiatry*, 42(3) 377–422, 2014.) Additionally, the cross-discipline surveys done by *Consumer Reports* (1995, 2004 and 2008) show that psychotherapy provided by psychologists and licensed clinical social workers have widely positive results in treating depression, anxiety, trauma-based disorders, and even psychotic disorders.

Another area of CSWA concern is the general lack of attention to diversity that we believe has been a major factor in the successful delivery of health care and mental health treatment. Cultural competence is fundamental to our clinical social work approach to treatment: understanding of the patient’s ethnicity, gender, sexual orientation, economic levels, race, age, religion, and other areas of personal identity is essential. For this reason, CSWA would like to add cultural competency to the extensive (and excellent) list of policies being considered by the Task Force in the area of patient and family engagement outlined on pages 21 and 22 of the Task Force report.

There is no doubt that there must be a realistic assessment of what it will cost to provide adequate mental health care and physical health care, and we understand that budgetary consequences must be addressed. However, we would be remiss if we failed to point out that any discussion of gaps in mental health treatment for chronic and severe conditions must acknowledge and address the limitation to 190 days of inpatient treatment for psychiatric reasons. There is no such limitation on medical conditions; it is a long-standing violation of our mental health parity law (MHPAEA). Equally, such discussion must address the lack of ANY

coverage for Medicaid beneficiaries who need inpatient mental health care in what are called Institutes for Mental Disease. These restrictions are unfair and cause harm to those who need inpatient care for mental health conditions. We ask that the Task Force add these two limits – limits which have a devastating effect on individuals coping with chronic mental health conditions (as well as their families and communities) - to the range of issues under consideration.

Finally, CSWA can see that Accountable Care Organizations, with their goal of creating delivery systems that would share profit and loss with providers, have great potential for controlling overall healthcare costs in America. However, mental health treatment is, at present, seriously underfunded, and we fear that ACOs will not be viable as health care delivery systems for treatment of chronic mental health conditions without a significant increase in funding. The fiscal targets that are to be met must be realistic or this form of funding mental health treatment is likely to fail. The suggestion that a beneficiary who “voluntarily elects to be assigned to an ACO should be allowed to receive services from providers that are not participating in the ACO” (Task Force report, p. 21) would be a help. But unless the “upfront collective payments” to an ACO were increased, CSWA has doubts about this way of providing adequate mental health treatment for chronic conditions.

Thank you again for the opportunity to comment on the Task Force report, and thank you as well for the critically important work your committee is undertaking.

Sincerely,

Susanna Ward, LCSW, President  
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