



Legislative Report

Deaf and Hard of Hearing Services Division Mental Health Program

Analysis of Potential Costs and Benefits of Billing for Services

Deaf and Hard of Hearing Services Division

March 29, 2018

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Table of Contents

I. Executive summary.....	4
II. Legislation.....	6
III. Introduction.....	7
IV. Report by Management Analysis and Development (MAD).....	8
V. DHS Legislative Report Recommendation.....	61

I. Executive summary

Background

The 2017 Minnesota Legislature directed the Department of Human Services (DHS) to analyze the costs and benefits of implementing an insurance billing system for the mental health services provided through the DHS Deaf and Hard of Hearing Services Division (DHHSD) regional offices. The DHHSD mental health program does not currently bill for its services.

This is a report of that analysis. DHS hired an independent consulting agency, Minnesota Management Analysis and Development (MAD), to analyze the costs and benefits, prepare a report, and make recommendations from its findings.

The report from MAD is contained within this legislative report. The MAD researchers gathered information about the requirements of establishing a system to bill insurance, investigated industry standards for the delivery of culturally affirmative mental health services for people who are deaf and use American Sign Language, and interviewed DHHSD mental health program staff, other mental health providers in Minnesota and providers in several other states.

Limitations of the study

MAD confined its study to the Mental Health Program in DHHSD. Findings should not be generalized to other mental health programs or billing for health services more generally because of some of the unique features of the program and the population served.

Costs and Benefits

MAD identified both known and unknown costs and benefits of billing for mental health services in the DHHSD mental health program.

1. Known costs are those that are certain to occur. This includes those costs and benefits MAD is certain will occur based on its research for this report (reference research, interviews with providers, and state comparison). These include costs such as the need to either hire additional staff to support billing activities or contract with a third party to process insurance billing, costs of enrolling the mental health specialists as providers under Medical Assistance and other insurers, training of mental health specialists on coding and billing for services, negotiating reimbursement contracts with private insurers, and information technology (IT) costs associated with invoicing or accepting copayments from clients.
2. Known benefit is DHHSD will bring in revenue from insurance reimbursements and client fees. However, the exact amount is unknown because the data needed to make accurate revenue estimates is not readily available. While the DHHSD has data used for managing the work and outcomes of the program, the data have not been collected in a way that allows for an accurate estimate of the potential billable service hours.

A benefit to the state would be the capture of federal funding for clients who are covered by Medical Assistance or MinnesotaCare.

3. Unknown costs are those that might occur but have an unpredictable direction and/or size. These include the cost of lost client direct service time because some of the mental health specialists' time would be redirected to billing-related activities such as clinical documentation and coding, filling out paperwork with clients, and periodic training. Another unknown cost to clients is time. For example, clients might have to wait to get service if they first have to demonstrate proof of insurance or their insurance requires pre-authorization. They may have to wait longer to see a clinician if the clinicians have to redirect a portion of their therapy time to billing-related activities. Clients could also have extra costs if they have insurance copays or deductibles.
4. Unknown benefits could be a) new client referrals if insurance companies would refer clients, and b) some clients may take greater responsibility for their therapy. Clients taking greater responsibility is considered unknown because MAD received competing views on this from mental health providers and the academic literature in this topic is inconclusive.

Recommendation

The MAD analysis recommends that DHHS does not start to an insurance billing system for the costs of providing mental health services at this time. The available data from the DHHS mental health program do not allow for a precise analysis of the costs and benefits.

DHS agrees with the recommendation from MAD.

An additional consideration for DHS is that DHHS is currently examining ways to redesign its service delivery structure in keeping with the findings in the [January 2017 DHS report to the legislature on the Analysis of Deaf, DeafBlind and Hard of Hearing Services](#). Possible changes in the division's structure, such as moving to fewer 'bricks and mortar' offices, could occur within the next few years and potentially impact how DHHS delivers its mental health services.

The MAD report notes that if the legislature is interested in reliable revenue and cost estimates, about three years of applicable program data would be needed. Data needed for such estimates would include a breakdown of hours by client, client insurance, and types of activities such as therapy, case management and travel. The DHHS mental health program does not currently have the data breakdown needed to estimate potential revenue from a system of insurance billing.

As DHHS revises its data collection methods, it will explore options that would allow for a more accurate analysis of the costs and benefits of insurance billing.

II. Legislation

This report is submitted to the Minnesota Legislature pursuant to Minnesota Session Laws 2017, 1st Special Session, [chapter 6, article 1, section 50](#).

Sec. 50. **DIRECTION TO COMMISSIONER; BILLING FOR MENTAL HEALTH SERVICES**

By January 1, 2018, the commissioner of human services shall report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health services.

III. Introduction

The Department of Human Services (DHS) Deaf and Hard of Hearing Services Division (DHHSD) offers a variety of programs and services to Minnesotans who are deaf, deafblind and hard of hearing, their families, and others. Within its system of regional offices, the division offers a mental health program with professional mental health staff who are fluent in American Sign Language (ASL) and experienced in providing culturally affirmative mental health services for people who are deaf. The mental health services are provided at no charge and the division does not seek insurance payments or client co-pays for the services provided. Funding for the mental health program comes through the Division's general fund budget.

DHHSD's mental health program was created when a specialized unit for people who are deaf at the St. Peter Regional Treatment Center closed. DHS recognized the ongoing need to make culturally affirmative mental health services in ASL available for adults statewide and shifted resources that had previously supported the St. Peter specialized unit to create a mental health program within the DHHSD regional offices.

The regional DHHSD offices with mental health services are in Duluth, Mankato, Moorhead, St. Cloud, and St. Paul.

The DHHSD mental health program began providing services in state fiscal year 2007. In the first year, 72 people were served and by fiscal year 2017 the total number served more than doubled to 165.

Purpose and limitations of this report

The 2017 legislature asked DHS to analyze the potential costs and benefits of implementing a billing system for the DHHSD mental health services and to prepare a legislative report. In August 2017, DHS contracted with Minnesota Management Analysis and Development (MAD) to conduct an independent analysis.

The findings and analysis are in a report prepared by MAD. The report from MAD is contained within this legislative report and begins on the next page.

MAD confined its study to the Mental Health Program in DHHSD. Findings should not be generalized to other mental health programs or billing for health services more generally because of some of the unique features of the program and the population served.

Additional note from DHS

While the MAD report accurately reflects the perception of some providers that insurance billing is complicated, DHS also wants to acknowledge the work Minnesota has done to make the Medical Assistance billing system easier and efficient for providers.

IV. Report by Management Analysis and Development (MAD)



Billing for Mental Health Services for Individuals Who are Deaf, Deafblind, or Hard of Hearing – Potential Costs and Benefits

Department of Human Services
March 12, 2018

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Management Analysis and Development

Management Analysis and Development is Minnesota government's in-house fee-for-service management consulting group. We have over 30 years of experience helping public managers increase their organizations' effectiveness and efficiency. We provide quality management consultation services to local, regional, state, and federal government agencies and public institutions.

Alternative Formats

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Table of contents

Executive summary	14
Background and purpose.....	14
Research plan and methods	14
Summary of findings.....	15
Current program overview	15
Reference research.....	15
State comparison.....	16
Interviews with DHHS's Program Director and mental health specialists	16
Interviews with private mental health providers	17
Costs and benefits	17
Known costs.....	17
Known benefits.....	18
Unknown costs	19
Costs in lost time to the mental health specialists.....	19
Costs to current and/or prospective clients.....	19
Unknown benefits	20
Benefits to DHHS and its mental health specialists	20
Benefits to current and/or prospective clients	20
Recommendation and potential next steps	20
Introduction	22
Background and purpose.....	22
Research plan and methods	22
Research questions.....	22
Data sources and methods.....	23
Study scope and terminology	24
Current program overview	25

Key points	25
History and current program structure	26
Program funding.....	28
Program activity	29
Population served and program activity	30
Population demographics.....	30
Client insurance information	32
Program outcomes	32
Reference research	33
Key findings	33
Methods	33
Prevalence of mental health needs among individuals who are deaf, deafblind, or hard of hearing	33
Uniqueness of the population	35
Best practices	36
Current state of service providers in Minnesota.....	37
Billing for mental health services	38
State comparison	40
Key findings	40
Methods	40
South Carolina	40
Alabama.....	41
North Carolina	42
Implications for Minnesota	42
Interviews	43
Method.....	43
Interviews with DHHSD’s Program Director and mental health specialists.....	43

Key findings	43
Detailed findings.....	44
Overview of services provided	44
Need for services	44
Potential impact of billing on work	45
Interviews with private mental health providers.....	45
Key findings	45
Detailed findings.....	46
Overview of services provided	46
Need for services	46
Impact of billing on work.....	46
Consultations with DHS staff with expertise in health care, billing, and financial management	47
Need for additional staff	47
Credentialing and negotiating contracts with private insurers.....	47
Other notes on implementing a system of billing	47
Summary of costs and benefits and recommendations	49
Costs and benefits	49
Known costs.....	49
Known benefits.....	50
Unknown costs	51
Costs in lost time to the mental health specialists.....	51
Costs to current and/or prospective clients.....	51
Unknown benefits	52
Benefits to DHHS and its mental health specialists	52
Benefits to current and/or prospective clients	52
Recommendation and potential next steps	52
Other considerations.....	52
References.....	54

Appendix A: List of study participants.....56
Appendix B: Interview questionnaires57

Executive summary

Background and purpose

Through its Deaf and Hard of Hearing Services Division (DHHSD), the Minnesota Department of Human Services (DHS) provides accessible and culturally affirmative mental health services to adults who are deaf, deafblind, or hard of hearing.¹ Currently, these services are funded by the State General Fund and DHHSD provides them at no charge to clients.

The 2017 Minnesota Legislature directed DHS to do the following: “By January 1, 2018, the commissioner of human services shall report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health services.”²

DHS asked Management Analysis and Development (MAD) to prepare the legislative report that identifies and assesses the potential costs and benefits of billing for these services.

MAD confined its study to the Mental Health Program in DHHSD. Findings should not be generalized to other mental health programs or billing for health services more generally because of some of the unique features of the program and the population served.

Research plan and methods

MAD conducted research for this project from September to December 2017. MAD developed a research plan to gather information on potential costs and benefits of billing for services from relevant stakeholders without prejudging whether DHS should continue to provide mental health services at no charge or bill for services. MAD employed the following data sources and methods:

- **Focused literature review** on topics such as the prevalence of mental health challenges among individuals who are deaf, deafblind, or hard of hearing, the availability of mental health providers, best practices in mental health services for people who are deaf, deafblind, or hard of hearing, and the administrative costs of billing for mental health services.
- **Review and analysis of program information** provided by DHHSD, such as program descriptions, budget data, mental health specialist data on reported activities, and output and outcome measures collected by DHHSD.

¹ Culturally affirmative services are defined in Minnesota Statutes 2017, section 256C.23 as “services that are designed and delivered within the context of the culture, language, and life experiences of a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing.”

² Laws of Minnesota 2017, 1st Spec. Sess. chapter 6, article 1, section 50. DHS was granted an extension by the legislature to submit the report by January 31, 2018, instead of January 1.

- **State comparison research** *into the practices and approaches of selected other states in providing mental health services to people who are deaf, deafblind, or hard of hearing.*
- **Interviews with DHHS's Program Director and its five regional mental health specialists** *to learn about their practices, activities, and the potential effect of billing for services on their practices and activities.*
- **Interviews with private mental health providers** *to learn how non-DHHS providers of mental health services to people who are deaf, deafblind, or hard of hearing bill for such services and understand how billing affects their practices.*
- **Consultation with DHS staff with expertise in health care, billing, and financial management** *to understand the startup and ongoing resources (dollars and time) needed were DHHS to start billing for mental health services.*

Summary of findings

Current program overview

- The Mental Health Program's budget for fiscal year 2018 is \$803,220, funded by a general fund appropriation to DHHS.
- Currently, five mental health specialists, who are all fluent in American Sign Language (ASL), are located in five regional offices (Duluth, Mankato, Moorhead, St. Cloud, and St. Paul).
- In fiscal year 2017, the program served 165 clients; 73 percent of these clients are deaf, 16 percent are hard of hearing, and nine percent are deafblind.
- Collectively, the mental health specialists provided about 2,100 hours of individual, family, and couples therapy in fiscal year 2017, which accounted for 40 percent of their reported time.
- After therapy services, travel time is the second most time-consuming activity for the mental health specialists, accounting for almost 1,500 hours, or 28 percent of their reported time, in fiscal year 2017.
- In fiscal year 2017, half of the clients received health insurance through Minnesota's Medicaid program, known as Medical Assistance (MA); 10 percent had Medicare; two percent had a combination of MA and Medicare; 10 percent had private insurance; six percent had no insurance; and 23 percent had some other or unknown form of insurance.

Reference research

- An estimated 20 percent of Minnesota's population experience some form of hearing loss; up to one-third of them may have mental health needs.
- Most research finds a greater need for mental health services, both for hearing adults and adults who are deaf, deafblind, or hard of hearing, than is currently met; however, the exact need for mental health services among individuals who are deaf, deafblind, or hard of hearing is unknown.
- Best practices in the area of mental health services for people with a hearing loss are services that are culturally affirmative and linguistically accessible, including ASL-fluent therapists.
- Providing mental health services to people who are deaf, deafblind, or hard of hearing presents unique challenges, such as a need for alternative means of communication and sensitivity to the problems caused by information deprivation.

- Most private mental health providers serving Minnesotans with hearing loss are located within the seven-county Twin Cities metropolitan area; Greater Minnesota has relatively few mental health specialists who provide culturally affirmative services.
- Research suggests billing for mental health services is complex and time consuming.
- Research and anecdotal evidence shows that insurance reimbursements for mental health services for populations with low incomes typically do not cover the true costs of such services.

State comparison

- States vary widely in how they offer and fund mental health services to people who are deaf, deafblind, or hard of hearing; only a few other states provide mental health services through state-employed mental health practitioners fluent in ASL similarly to Minnesota.
- Due to their statewide approach, Alabama, North Carolina, and South Carolina are three states that serve as comparisons to Minnesota:
 - Like Minnesota, most clients using state-funded mental health services in these three states have health insurance through Medicaid or Medicare.
 - Of the two states that MAD contacted that bill for services (South Carolina and North Carolina), both supplement funding from insurance reimbursements with other sources of funding.
 - State officials in these three states confirmed the severe shortage of mental health professionals who can provide culturally affirmative services.

Interviews with DHHSD’s Program Director and mental health specialists

- Compared to other providers, DHHSD mental health specialists spend more time on activities other than therapy services, such as travel to see clients, case management,³ consultations, and giving presentations or providing training.⁴ Mental health specialists in Greater Minnesota in particular spend a significant amount of their time on travel.
- The current no-charge model provides the mental health specialists with greater flexibility to adjust their schedules and activities to the needs of their clients.
- DHHSD’s mental health specialists perform most administrative duties themselves; for instance, they communicate directly with their clients and schedule most of their own appointments.
- DHHSD’s current mental health specialists have limited or no experience with billing for services; all indicated they would need training on billing and insurance-related activities, such as coding services provided.

³ DHHSD uses the term “case management” to capture a set of activities conducted by its mental health specialists to support clients. While there may be overlap, this term should not be confused with DHS’s more precisely defined “Adult Mental Health Targeted Case Management.” See <https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/mh-targeted-case-management/>, Accessed February 26, 2018.

⁴ Some of these services, such as travel and case management, are likely billable, at least under certain insurance plans such as Medical Assistance (MA).

- All five mental health specialists expressed concerns about the impact billing for services would have on their clinical work.

Interviews with private mental health providers

- All private mental health providers that MAD interviewed bill for services.
- All providers absorb some unbillable costs, such as travel, consultation, or services provided to clients without insurance or with insurance plans that cannot be billed.
- Estimates for how much time is spent on activities related to billing range from 2.5 to four hours per week.
- Support staff greatly reduce the amount of time a provider has to spend on billing and insurance-related activities.
- Billing for mental health services is complex and there are unique billing challenges when serving individuals who are deaf, deafblind, or hard of hearing due to longer therapy sessions, changes in disability or insurance status, and challenges with provider credentials.
- Providers need regular training on coding and other billing-related activities as insurance codes and rules change periodically.

Costs and benefits

To summarize the potential costs and benefits of billing for mental health services, MAD divided costs and benefits into *known* and *unknown*:

1. **“Known costs and benefits”**: This includes those costs and benefits MAD is certain will occur based on its research for this report (reference research, interviews with providers, and state comparison). Some of these costs and benefits are quantifiable, whereas others are not.
2. **“Unknown costs and benefits”**: This includes those costs and benefits MAD believes might occur but have an unpredictable direction (for instance, will more or fewer individuals seek therapy from DHHS under a system of billing?) and/or size.

Known costs

- **DHHS will need to hire additional staff to support its billing activities, most likely a 0.5 to 1 FTE⁵ position (ongoing cost)**. Current DHHS staff lack the capacity and expertise to successfully complete all activities related to billing for services, such as processing insurance claims or credentialing the providers. Depending on the position’s classification, hiring additional staff could be a potential cost of *at least* about \$50,000 for 0.5 FTE or \$100,000 for 1 FTE in the first year, and \$42,500 for 0.5 FTE to \$85,000 for 1 FTE after the first year.⁶ These numbers are based on the

⁵ Full-time equivalent.

⁶ These costs will likely qualify for Federal Financial Participation (FFS), where 35 percent of the state’s costs are reimbursed by the federal government. The net fiscal impact to the state of an additional position would thus be 35 percent lower.

average salary of Reimbursement Specialist positions (MAPE level 5) within DHS' Direct Care and Treatment (DCT) Financial Operations and include fringe and overhead. Some DHS staff believe a higher job classification might be needed, especially if this person would be in charge of both billing and credentialing.⁷

- **DHHSD and its five mental health specialists will need to enroll as providers with DHS to be able to bill for services under Medical Assistance (MA) (startup cost).** The current enrollment fee is \$560 per provider location.
- **DHHSD and its five mental health specialists will need to enroll as providers with other insurers (Medicare, private insurers) (startup cost and potentially ongoing costs).** DHS has experience with this in other areas, such as Direct Care and Treatment, and this could be a responsibility of the additional staff. It is unclear, however, what the exact costs in time and dollars would be.
- **DHHSD or DHS will have to negotiate reimbursement contracts with private insurers (startup and ongoing cost).** Similar to the previous cost, this could fall under the responsibilities of the additional staff but might be time consuming as there are many insurance companies, all potentially with different rules and credentialing guidelines.
- **The mental health specialists will need training on how to code and bill for services (startup and ongoing cost).** DHS can provide staff for this so the cost for training to DHHSD would be minimal except for the time it would take on the part of the mental health specialists.
- **The mental health specialists will spend a non-negligible amount of time each week on coding and other billing and insurance-related activities (ongoing cost).** The exact amount of time is uncertain and will depend on the amount of support DHS or DHHSD can provide to the mental health specialists. Based on interviews with private providers, a reasonable expectation might be that the specialists will spend five to 10 percent of their working hours on such activities. That would translate into about two to four hours per week, or about \$21,750 to \$43,500 annually for the five MH specialists combined (five percent or 10 percent of the fiscal year 2017 salary amount).
- **DHHSD will face other startup and ongoing costs such as information technology (IT) costs, costs associated with invoicing or collecting copayments from clients, and change management costs.** IT costs would include setting up a system for the mental health specialists to code services to be billed. DHHSD will also need a system to collect payments from clients at the regional offices for copayments. Whenever functions or staff are moved or added, the organization's structure may change. Such a change would require an investment of staff resources and likely lead to some initial loss in productivity. These costs are known as change management costs. The exact amounts of these costs are unknown.

Known benefits

- **DHHSD will bring in revenue from insurance reimbursements and client fees such as copayments (ongoing benefit).** The exact amount is unknown given the lack of reliable and readily available data to conduct revenue estimates. A substantial portion of the revenue would likely come from the

⁷ If this position were a MAPE level 8, first year costs for 1 FTE would be \$85,000 to \$110,000.

federal government as 50-94 percent of services covered by MA⁸ are federally funded. As of fiscal year 2019, MinnesotaCare is nearly federally funded.⁹

Table 1: Known startup and ongoing costs and benefits

Startup costs	Ongoing costs	Ongoing benefits
Provider enrollment costs	Additional staff (at least 0.5 to 1.0 FTE)	Revenue from insurance reimbursements
Training of mental health specialists	Training of mental health specialists	
Training of the new reimbursement specialist	IT costs	
IT costs		
Change management costs		

Unknown costs

Costs in lost time to the mental health specialists

- The mental health specialists will likely have less time available for clients due to time spent on billing-related activities, such as providing coding services, filling out paperwork with clients, and training, which would lead to a reduced number of billable hours.
- The mental health specialists might lose (some of) their flexibility in terms of meeting clients' needs. This would probably depend on whether the program would continue to receive general fund dollars, which would allow the specialists to provide services at no charge when they cannot be billed.

Costs to current and/or prospective clients

- Under a system of billing, clients might have to wait longer to see a mental health specialist if they first have to show proof of insurance, or their insurance requires pre-authorization or a referral. Currently, DHHSD does not require clients to show proof of insurance or be referred. Similarly, when clients reach their maximum allowable number of sessions under their insurance, authorization for additional sessions would be needed, which might take time. If denied, clients might not be able to

⁸ The state's current MA federal matching rate (FMAP) is 50 percent. Under the Affordable Care Act (ACA), Minnesota receives an enhanced federal match of 94 percent in 2018 for the costs of services provided to enrollees who are newly eligible. This enhanced federal match gradually decreases to 90 percent under the ACA. For more detail, see Minnesota House of Representatives Research Department's information brief on Medical Assistance. <http://www.house.leg.state.mn.us/hrd/pubs/medastib.pdf>, Accessed February 28, 2018.

⁹ See the information brief on Minnesota Care by the Minnesota House of Representatives Research Department. <http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf>, Accessed February 28, 2018.

continue therapy unless DHHS D can continue to use general fund dollars to provide certain services at no charge.¹⁰

- Some current clients might stop seeing their mental health specialists because of a copay, a deductible, or the stress of financial burden.
- Clients in Greater Minnesota will likely be impacted at a greater rate than those in the Twin Cities metropolitan area due to the lack of alternative options for accessible and culturally affirmative mental health services and/or a lack of broadband for telehealth.

Unknown benefits

Benefits to DHHS D and its mental health specialists

- Insurance companies or other providers might refer more clients to DHHS D's Mental Health Program. Billing for services could lead more insurers to become aware of DHHS D's services and thus refer individuals to the mental health specialists. However, interviews with private providers suggest only a few clients come to providers in this fashion so the effect might be small or negligible.

Benefits to current and/or prospective clients

- If revenue from insurance reimbursements exceeds the costs for billing, DHHS D could use these additional funds to expand its services and potentially serve more clients. The challenge is that before DHHS D would be able to bring in insurance revenue, it would first have to implement a system of billing, which is associated with significant startup and ongoing costs. This could negatively affect the number of billable hours provided by the mental health specialists and thus the potential revenue.
- Some clients might take greater responsibility for their therapy if a copayment is required or they are only allowed a maximum number of sessions under their insurance. MAD received competing views on this from the mental health specialists and providers. The academic literature is also inconclusive on this point.

Recommendation and potential next steps

Based on the known costs and benefits, MAD provides the following recommendation to the legislature:

At this time, DHHS D should not start to bill for the costs of providing mental health services. Given the amount of uncertainty that exists around potential revenue from insurance reimbursements and, to a lesser extent, the costs of implementing a system of billing, it is difficult to predict whether revenue from insurance reimbursements will cover the costs of billing, especially during the start-up period.

¹⁰ Another alternative is a hybrid model in which DHHS D bills whenever possible combined with a sliding fee scale for clients who are un- or underinsured. For this model to work, the division would still need another funding source, such as the General Fund, to fund the program's costs that are not covered by insurance reimbursements.

If the legislature is interested in reliable revenue and cost estimates, interviews with DHS financial staff suggest about three years of complete and accurate program data would be needed. Such data is currently unavailable because DHHS did not collect data for this particular purpose. Data needed for such estimates would include a breakdown of hours by client and client insurance. Further breakdowns by type of activities, such as case management and travel would also be needed.

Introduction

Background and purpose

Through its Deaf and Hard of Hearing Services Division (DHHSD), the Minnesota Department of Human Services (DHS) provides accessible and culturally affirmative mental health services to adults who are deaf, deafblind, or hard of hearing.¹¹ DHS currently employs a Mental Health Program director and five full-time mental health specialists, who are all fluent in American Sign Language (ASL). The program, including salaries for these six positions, is funded through a general fund appropriation to DHHSD.¹² The mental health services provided by the mental health specialists are at no charge to clients.

The 2017 Minnesota Legislature directed DHS to do the following: “By January 1, 2018, the commissioner of human services shall report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health services.”¹³

DHS asked Management Analysis and Development (MAD) to prepare the legislative report that identifies and assesses the potential costs and benefits of billing for these services.

MAD confined its study to the Mental Health Program in DHHSD. Findings should not be generalized to other mental health programs or billing for health services more generally because of some of the unique features of the program and the population served.

Research plan and methods

MAD developed a research plan to gather information on potential costs and benefits of billing for services from relevant stakeholders without prejudging whether DHS should continue to provide mental health services at no charge or bill for services.

Research questions

MAD formulated the following questions for research and analysis by four topic areas:

- 1. Current program overview and broader Minnesota context**
 - What is the structure of the current program?

¹¹ Culturally affirmative services are defined in Minnesota Statutes 2017, section 256C.23 as “services that are designed and delivered within the context of the culture, language, and life experiences of a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing.”

¹² Occasionally, DHHSD receives additional funds that may supplement the general fund appropriation. However, the overwhelming share of funding is from the General Fund.

¹³ Laws of Minnesota 2017, 1st Spec. Sess. chapter 6, article 1, section 50. DHS was granted an extension by the legislature to submit the report by January 31, 2018, instead of January 1.

- What are data trends on participation, funding, provider activities, and outcomes?
 - What other mental health services for people who are deaf, deafblind, or hard-of-hearing are provided in MN?
2. **Mental health services for people who are deaf, deafblind, or hard of hearing**
 - What are best practices in this area?
 - What are key considerations, needs, and/or challenges in this area, broadly and in Minnesota specifically?
 3. **State comparison**
 - What other states offer mental health services for people who are deaf, deafblind, or hard of hearing?
 - How do these states cover the costs for services?
 - What costs and benefits do these states identify as a result of their funding model?
 - Are mental health services for people who are deaf, deafblind, or hard of hearing (or other populations with special needs) handled differently than mental health services for the general population?
 4. **Costs and benefits**
 - What are expected costs and benefits under a system of billing for mental health services?
 - What other considerations should be taken into account?

Data sources and methods

MAD employed the following methods to assess potential costs and benefits of DHHSD billing for mental health services:

- **Focused literature review**, including academic research, government reports, and other relevant research on the prevalence of mental health problems among individuals who are deaf, deafblind, or hard of hearing, the availability of mental health providers, best practices in mental health services for people who are deaf, deafblind, or hard of hearing, and the administrative costs of billing for mental health services.
- **Review and analysis of program information** provided by DHHSD, such as program descriptions, budget data, mental health specialist data on reported activities, and output and outcome measures collected by DHHSD.
- **State comparison research** into the practices and approaches of selected other states in providing mental health services to people who are deaf, deafblind, or hard of hearing.
- **Interviews with DHHSD's Program Director and its five mental health specialists** to learn about their practices, activities, and the potential effect of billing for services on their practices and activities.
- **Interviews with private mental health providers** to learn how non-DHHSD providers of mental health services to people who are deaf, deafblind, or hard of hearing bill for such services and understand how billing affects their practices.
- **Consultation with DHS staff with expertise in health care, billing, and financial management** to understand the startup and ongoing resources (dollars and time) needed were DHHSD to start billing for mental health services.

MAD conducted research for this project from September to December 2017. Further detail on the methodologies is included in each section of this report.

Study scope and terminology

Billing for the cost of providing mental health services – MAD understands the language from the guiding legislation to refer to billing insurances for the costs of providing mental health services wherever possible. This includes insurance through public plans (e.g., Medicare, Medicaid), group plans (e.g., employer plans), and individual plans (e.g., MNsure).

Costs and benefits – Within the context of the legislation that guides this study, MAD has interpreted “potential costs and benefits” to include both qualitative and quantitative costs and benefits. When using the term “the costs of billing” in this report, MAD refers to both the cost of submitting an insurance claim and the costs that allow for this claim to happen, such as coding services, credentialing mental health specialists, and verifying client insurance information. Given the available data for this study, a formal cost-benefit study, in which all monetary benefits of a business decision are estimated and estimated monetary costs are subtracted, was neither feasible nor appropriate.

Culturally affirmative services – Defined in Minnesota Statutes 2017, section 256C.23, subdivision 1a as “services that are designed and delivered within the context of the culture, language, and life experiences of a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing.”

Deaf, deafblind, and hard of hearing – In the literature and the community, individuals with hearing loss are referred to—and have preferences for—different qualifiers. Some people prefer the term “Deaf” to self-identify or refer to someone else as culturally deaf, others use the term “deaf individuals,” while others prefer person-first language, such as “persons who are deaf.” This report uses the language used by DHS and DHHSD: “individuals who are deaf, deafblind, or hard of hearing.” When quoting other sources, MAD leaves intact the language in the original document.

Current program overview

This section summarizes relevant information about DHHSD’s mental health program, including key points, the history and current structure of the program, program funding, and program outcomes.

It is important to note that the data presented in this section was not collected with the research questions from this study in mind. For instance, DHHSD currently does not have complete and readily available data on the amount of specialist hours spent by activity *and* type of client insurance coverage. To produce reliable and realistic revenue estimates of insurance reimbursements, this type of data is needed (for further discussion on this topic, see the section “Summary of costs and benefits and recommendations” starting on page 49).

Similarly, comparing outcomes across different funding models for services (such as billing versus no charge) could further highlight potential costs and benefits. However, a comparison between DHHSD’s Mental Health Program and private providers on program outcomes should take into account other factors, such as differences in the response rates, type of clients served, and types of services provided. Again, this data was not readily available and, as such, any comparison should be made with caution.

Key points

- Operated by the Deaf and Hard of Hearing Services Division (DHHS), the Mental Health Program started in 2007 and provides specialized and culturally affirmative mental health therapy and counseling at no charge to adults who are deaf, deafblind, or hard of hearing and have mental health challenges.
- The Mental Health Program’s budget for fiscal year 2018 is \$803,220, funded by a general fund appropriation to DHHS.
- Currently, five mental health specialists, who are all fluent in American Sign Language (ASL), are located in five regional offices (Duluth, Mankato, Moorhead, St. Cloud, and St. Paul).
- In fiscal year 2017, the program served 165 clients; 73 percent of these clients are deaf, 16 percent are hard of hearing, and nine percent are deafblind.
- Collectively, the mental health specialists provided about 2,100 hours of individual, family, and couples therapy in fiscal year 2017, which accounted for 40 percent of their reported time.
- After therapy services, travel time is the second most time-consuming activity for the mental health specialists, accounting for almost 1,500 hours, or 28 percent of their reported time, in fiscal year 2017.
- In fiscal year 2017, half of the clients received health insurance through Minnesota’s Medicaid program, known as Medical Assistance (MA); 10 percent had Medicare; two percent had a combination of MA and Medicare; 10 percent had private insurance; six percent had no insurance; and 23 percent had some other or unknown form of insurance.

History and current program structure

DHHS's Mental Health Program began in 2007 after the Deaf Unit at the St. Peter Regional Treatment Center closed. The state shifted resources that were spent on St. Peter's inpatient services to DHHS, allowing the division to hire a Mental Health Program director and set up mental health services across the state.

Per Minnesota Statutes 2017, section 256C.233, subdivision 2, DHHS is required to:

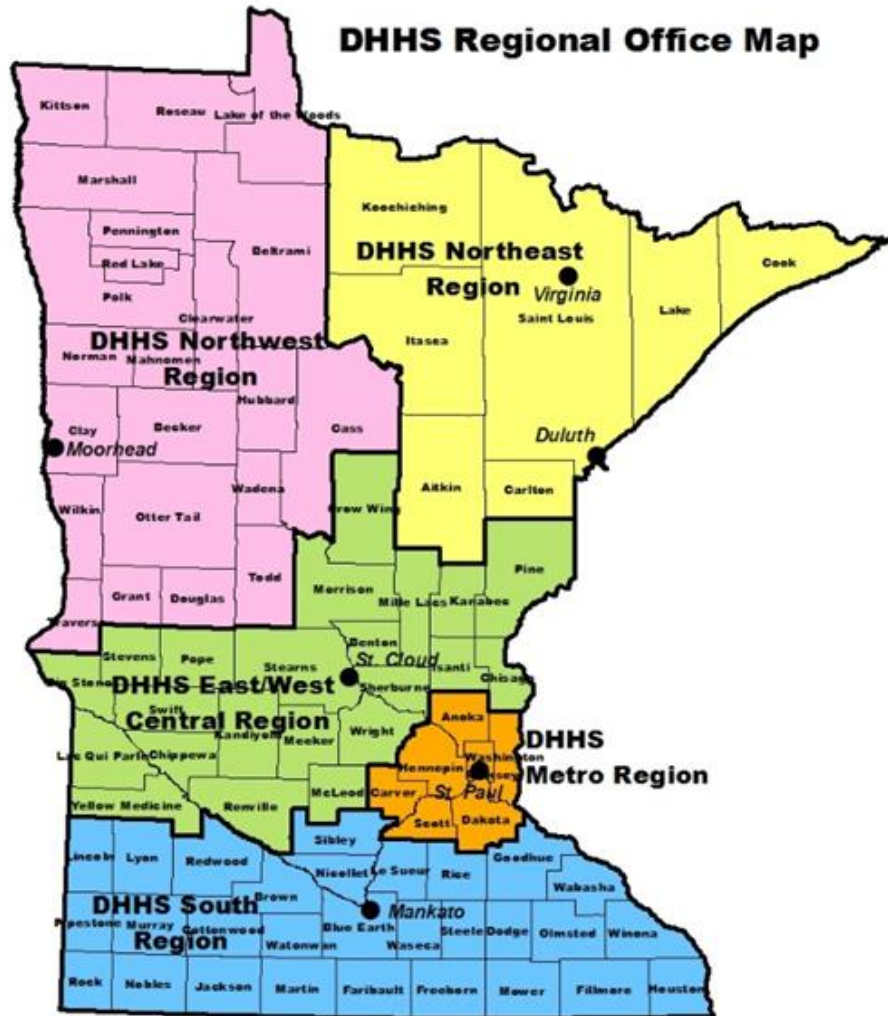
(5) provide culturally affirmative mental health services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing who:

(i) use a visual language such as American Sign Language or a tactile form of a language; or

(ii) otherwise need culturally affirmative therapeutic services;

Currently, five American Sign Language-fluent (ASL) mental health specialists provide services at no charge to adults who are deaf, deafblind, or hard of hearing and have mental health concerns. They are located in DHHS's five regional offices (Duluth, Mankato, Moorhead, St. Cloud, and St. Paul). The services provided include (1) crisis intervention and stabilization, (2) counseling services and treatment, (3) individual and family consultation, (4) case coordination, (5) aftercare planning, and (6) community placement assistance. Since the program provides statewide services, each mental health specialist serves a large part of the state, with some covering over two dozen counties (see Figure 1).

Figure 1: Map of the DHHS regions and offices



As discussed further in this report (see page 52), DHHSD does not require its mental health specialists to have the professional licenses, such as an LPCC, LP, or LICSW,¹⁴ at time of the hire that are typically needed to bill for services. Three out of the five current mental health specialists have a license (LPCC) that would allow them to enroll as providers with the state's Medical Assistance (MA) program, and thus bill for services, and possibly with Medicare and private health insurers, which can have stricter requirements.

The degrees, professional licenses, and certifications held by the current mental health specialists are as follows:

- East-West Central region mental health specialist (St. Cloud): Master of Arts (MA), National Certified Counselor (NCC), and Licensed Professional Clinical Counselor (LPCC).
- Twin Cities metropolitan region mental health specialist (St. Paul): Master of Arts (MA), National Certified Counselor (NCC), and Licensed Professional Clinical Counselor (LPCC).
- Northeast region mental health specialist (Duluth): Master of Arts (MA) and National Certified Counselor (NCC).
- Northwest region mental health specialist (Moorhead): Master of Social Work (MSW) and a Licensed Graduate Social Worker (LGSW).
- South region mental health specialist (Mankato): Master of Arts (MA), National Certified Counselor (NCC), and Licensed Professional Clinical Counselor (LPCC).

Program funding

DHHSD has an annual operating budget between \$3 million and \$3.5 million, funded by the General Fund. Funds are used to serve Minnesotans who are deaf, deafblind, or hard of hearing through a network of regional offices and the Mental Health Program, and the management of grant-funded programs provided by community partners. Within its fiscal year 2018 budget, DHHSD allocated about \$800,000 to the Mental Health Program for salaries and operating expenses (see **Error! Not a valid bookmark self-reference.**). The salaries cover five full-time mental health specialists, the Mental Health Program director, a portion of the DHHSD director, and a half-time administrative assistant. In addition to the funding mentioned above, the division also receives a general fund appropriation for its grants and special revenue funding to operate the Telephone Equipment Distribution program.

¹⁴ LPCC: Licensed Professional Clinical Counselor. LP: Licensed Psychologist. LICSW: Licensed Independent Clinical Social Worker.

Table 2: Mental Health Program budget, fiscal years 2015-2018¹⁵

Fiscal year	MH Program Salaries	MH Program Operating	Funds returned	MH Program total	DHHS total budget (salaries and operating)
2018	\$669,956	\$133,264	n/a	\$803,220	\$3,497,049
2017	\$730,862	\$61,610	\$56,619	\$849,091	\$3,088,047
2016	\$608,621	\$76,439	\$44,950	\$730,010	\$3,280,000
2015	\$525,345	\$39,457	\$598	\$565,400	\$2,686,432

Program activity

The mental health specialists’ time is divided among providing direct mental health therapy, intake, case management activities,¹⁶ travel, and other development activities. On a quarterly basis, the mental health specialists report their activities on direct services and related services to the Mental Health Program director in the form of the number of contacts with clients and the actual hours spent on client services. It is important to note that contacts do not equate to the number of individuals served; one client may account for multiple contacts. Moreover, the hours reported do not account for all hours worked. For instance, scheduling activities and time spent on internal meetings and writing client progress notes and treatment plans are not included. Table 3 displays the mental health specialists’ total activities by contacts and hours for fiscal years 2015-2017. The year-to-year increases in total contacts and hours reflect the increases in the number of clients served over the three-year period.

¹⁵ Unless otherwise noted, DHHS provided MAD all program data.

¹⁶ DHHS uses the term “case management” to capture a set of activities conducted by its mental health specialists to support clients. While there may be overlap, this term should not be confused with DHS’s more precisely defined “Adult Mental Health Targeted Case Management.” See <https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/mh-targeted-case-management/>, Accessed February 26, 2018.

Table 3: DHHS mental health specialist activities by contacts and hours, fiscal years 2015-2017, with the top 3 most time-consuming activities shaded and starred

Activity type	FY 2015		FY 2016		FY 2017	
	Contacts	Hours	Contacts	Hours	Contacts	Hours
Intake	52	72.00	62	88.00	68	98.50
Psychological evaluation	0	0.00	0	0.00	63	141.50
Individual therapy*	1,469	1,588.25	1,498	1,626.00	1,798	2,010.50
Family therapy	31	34.50	24	43.75	19	38.75
Couples therapy	45	53.00	21	20.75	40	57.50
Group therapy	0	0.00	7	6.50	0	0.00
1:1 telehealth sessions	445	471.50	390	409.00	324	326.25
Couples telehealth sessions	0	0.00	5	4.00	0	0.00
Clinical case management*	537	602.50	672	765.75	741	758.00
Statewide travel*	686	857.25	861	1,250.50	1,072	1,477.75
Presentation	11	26.00	35	71.75	30	63.75
Consultation	435	276.00	485	296.00	455	258.75
Referrals	67	30.25	60	37.00	89	37.50
Totals	3,778	4,011.25	4,120	4,619.00	4,699	5,268.75

As interviews with the mental health specialists confirm, the specific types of mental health and case management services provided are unique to a client’s level of need, their communication preferences, and their physical mobility. However, the three largest categories in each fiscal year were individual therapy, statewide travel, and clinical case management, which, when combined, accounted for about four-fifths of reported hours. During fiscal year 2017, for instance, the mental health specialists spent 40 percent of their reported hours on therapy, 28 percent on statewide travel, and 14 percent on clinical case management.

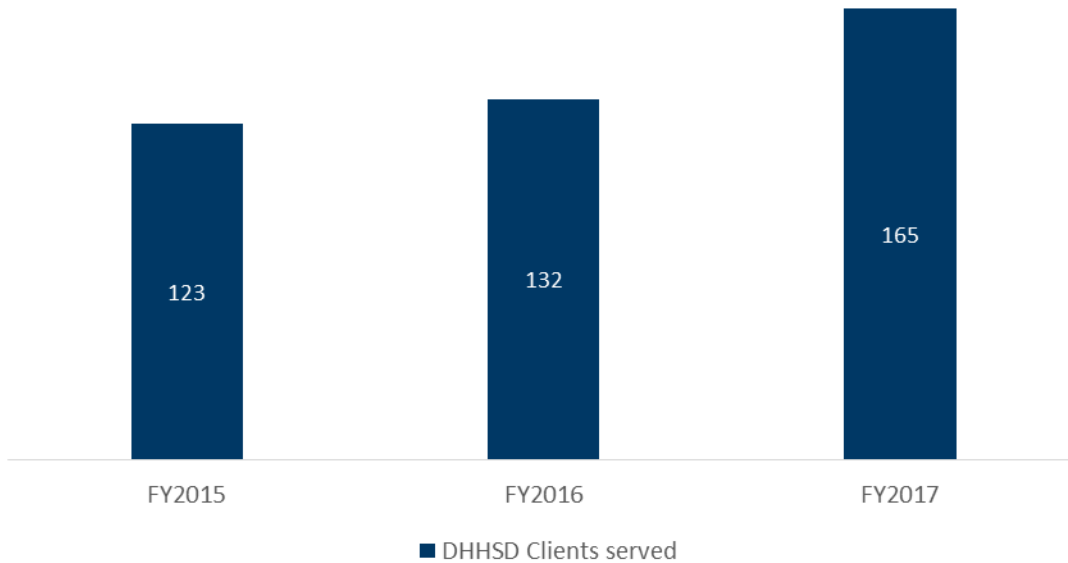
There are important variations by region. For example, in fiscal year 2017, the mental health specialist located in the Twin Cities metropolitan area spent 44 percent of her time providing individual therapy, while the specialist in the Northwest region spent 23 percent. This is partly due to differences in travel time, which accounted for 19 percent of the Twin Cities specialist’s reported hours, but 48 percent of the Northwest region’s specialist’s time. Since the Twin Cities metropolitan region is smaller and the population more concentrated, the mental health specialist is able to hold more therapy sessions in her office and spend less time on travel to see clients, make presentations, or provide consultations.

Population served and program activity

Population demographics

The Mental Health Program has grown in terms of the number of clients it serves on an annual basis. In fiscal year 2017, the DHHS mental health specialists provided services to 165 people statewide, up from 123 people in fiscal year 2015 (see Figure 2).

Figure 2: Count of clients served by DHHS mental health specialists



The mental health specialist in the Twin Cities metropolitan region serves about one-third of clients, with the mental health specialists in Greater Minnesota serving the remaining two-thirds (see Table 4).

Table 4: Number of unduplicated person served by region for fiscal years 2015-17

Regional office	FY 2015	FY 2016	FY 2017
Duluth	19	18	21
Mankato	26	31	39
Twin Cities Metro	45	41	51
Saint Cloud	32	28	31
Moorhead	1	14	23
Total	123	132	165

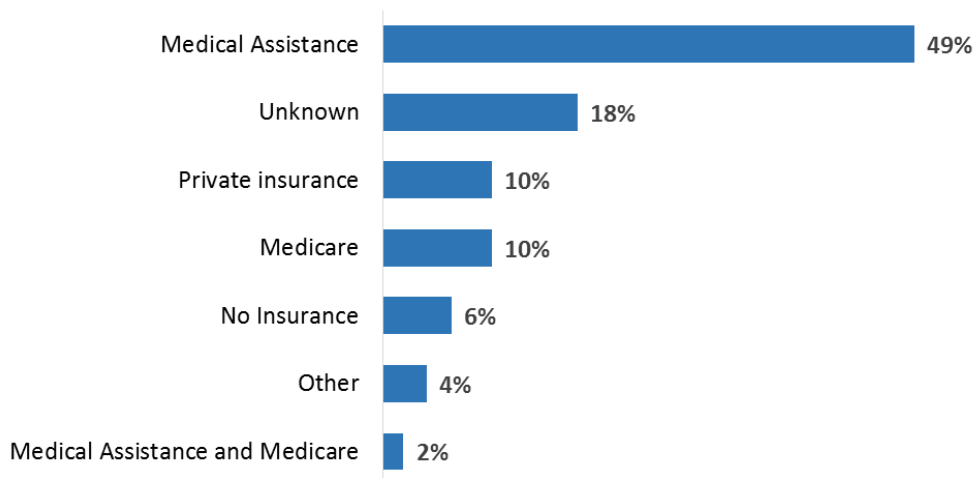
The people receiving services had different types of hearing statuses: about 73 percent were deaf, 16 percent were hard of hearing, and nine percent were deafblind.¹⁷ Over 80 percent of the clients communicated using ASL or ASL in combination with another communication type. The rest used a variety of communication modes including spoken English.

¹⁷ The remaining three percent was hard of hearing/blind, hearing, or hearing with no speech.

Client insurance information

The mental health specialists also record information on the insurance status of clients receiving services, although this information is not available for all clients. For fiscal year 2017, nearly half of the clients (49 percent) received health insurance through Minnesota’s Medicaid program, known as Medical Assistance (MA). Medicare and private insurance coverage each made up about 10 percent of clients and six percent of clients were reported to have no insurance (see Figure 3). About 23 percent had some other form of insurance or their status was not known. Additionally, 41 percent of clients received county medical assistance.

Figure 3: Clients’ type of insurance coverage, for fiscal year 2017



Program outcomes

DHHS collects information on client progress toward meeting goals set in individualized treatment plans. In fiscal years 2015-2017, the mental health specialists reported that over 90 percent of clients completed or made progress toward their treatment goals. These outcomes are either similar to or better than similar outcomes reported by private providers to DHHS. In 2016, DHHS also conducted a customer satisfaction survey, which included a set of questions to measure client satisfaction with their counselor. On all measures, over 90 percent of clients showed satisfaction with their counselor. Additionally, 93 percent of respondents (53 out of 57) indicated they believe their lives have improved because of counseling.

Reference research

Key findings

- An estimated 20 percent of Minnesota’s population experience some form of hearing loss; up to one-third of them may have mental health needs.
- Most research finds a greater need for mental health services, both for hearing adults and adults who are deaf, deafblind, or hard of hearing, than is currently met; however, the exact need for mental health services among individuals who are deaf, deafblind, or hard of hearing is unknown.
- Best practices in the area of mental health services for people with a hearing loss are services that are culturally affirmative and linguistically accessible, including ASL-fluent therapists.
- Providing mental health services to people who are deaf, deafblind, or hard of hearing presents unique challenges, such as a need for alternative means of communication means and sensitivity to the problems caused by information deprivation.
- Most private mental health providers serving Minnesotans with hearing loss are located within the seven-county Twin Cities metropolitan area; Greater Minnesota has relatively few mental health specialists who provide culturally affirmative services.
- Research suggests billing for mental health services is complex and time consuming.
- Research and anecdotal evidence shows that insurance reimbursements for mental health services for populations with low incomes typically do not cover the costs of such services.

Methods

MAD conducted reference research to better understand the context of evaluating the potential costs and benefits of billing for mental health services for individuals who are deaf, deafblind, and heard of hearing. MAD focused on the prevalence of mental health problems among Minnesotans who are deaf, deafblind, or hard of hearing and the need for services, best practices, the current state of mental health services provided in Minnesota, and billing for mental health services.

For research in these areas, MAD consulted data from DHHS, national associations (such as the National Association of the Deaf), academic articles, reports from research institutes, and government reports.

Prevalence of mental health needs among individuals who are deaf, deafblind, or hard of hearing

The exact number of Minnesotans who are deaf, deafblind, or hard of hearing is unknown, but estimates suggest they make up 20 percent of the general population.¹⁸ The prevalence of mental health problems in the

¹⁸ See, for instance, the Commission of Deaf, Deafblind, and Hard of Hearing Minnesotans, <https://mn.gov/deaf-commission/>, Accessed December 15, 2017.

general population is 20 percent, with about five percent of Minnesotans experiencing a serious mental illness.¹⁹ While the degree of hearing loss has not been proven to correlate with mental health issues, a higher prevalence of mental health problems has been documented in people who are deaf, deafblind, or hard of hearing.²⁰ For example, one research study found that 34 percent of people who are deaf had either depression or anxiety, while seven percent of hearing individuals experienced those symptoms.²¹ Research also suggests individuals who are deaf are disproportionately victims of trauma²² and the prevalence of serious mental illnesses may be three to five times greater among individuals who are deaf than among hearing individuals.²³

People who are culturally deaf can also face challenges in language acquisition, which can affect their cognitive development. According to data on the Minnesota Deafblind Project's website, about 80 to 90 percent of information normally comes to people through vision and hearing. When hearing and vision are impaired, any of the following development areas can be affected:²⁴

- Communication and language development;
- Movement and motor development;
- Cognitive development and the ability to learn;
- Emotional and social development; and
- Body image and self-concept.

These data suggest a great need for mental health services among individuals who are deaf, deafblind, or hard of hearing. Yet, the exact need is difficult to quantify and no statewide survey on this need existed at the time of writing. MAD attempted to understand the existing need for services through interviews with providers (see section starting on page 45).

¹⁹ Epstein, Joan, Peggy Barker, Michael Vorburger, and Christine Murtha. "Serious mental illness and its co-occurrence with substance use disorders, 2002." *DHHS publication No. SMA (2004): 04-3905*.

²⁰ Fellingner, Johannes, Daniel Holzinger, and Robert Pollard. "Mental health of deaf people." *The Lancet* 379, no. 9820 (2012): 1037-1044.

²¹ National Association of the Deaf. "Position Statement on Preservation of Mental Health Services for Deaf People in an Integrated Health Care." <https://www.nad.org/about-us/position-statements/position-statement-on-preservation-of-mental-health-services-for-deaf-people-in-an-integrated-health-care/>, Accessed December 18, 2017.

²² For example, see Sullivan, Patricia M., McCay Vernon, and John M. Scanlan. "Sexual abuse of deaf youth." *American Annals of the Deaf* 132, no. 4 (1987): 256-262. Or, Anderson, Melissa L., and Irene W. Leigh. "Intimate partner violence against deaf female college students." *Violence Against Women* 17, no. 7 (2011): 822-834.

²³ Hamerding, Steven, and D. Murphy, D. "Using the Deaf Community as an Alternative Treatment Strategy: Developing Deaf Treatment Foster Homes." *JADARA* 33(2) (2000): 26-41.

²⁴ Minnesota DeafBlind Project. <http://www.dbproject.mn.org/overview.html>, Accessed December 17, 2017.

Uniqueness of the population

MAD also examined the extent to which individuals who are deaf, deafblind, and hard of hearing are a unique population. The deaf and hard of hearing in the United States and Minnesota comprise a variety of communities, but they are often grouped into the following categories:²⁵

- Culturally deaf: Individuals born deaf or who became deaf at an early age. Individuals in this group may identify themselves as part of a minority community with its own language (American Sign Language) and culture, and self-identify as Deaf (using uppercase “D”).
- Deaf: Individuals with severe hearing loss that must communicate through manual communication methods.
- Hard of hearing: Individuals who have hearing loss ranging from mild to profound.
- Late deafened: Individuals who experienced profound hearing loss after developing speech and language.
- Deafblind: Individuals with a combination of hearing and vision loss affecting their ability to communicate with others.

Reference research suggests that this population is unique in comparison to the general population or other minority populations with disabilities, such as individuals who are blind, and that therefore this population has unique mental health needs. A 2012 report from the National Association of State Mental Health Program Directors points to several reasons, including:²⁶

- **Individuals who are deaf, deafblind, or hard of hearing often have unique cultural and linguistic needs.** Such needs include an ASL-fluent counselor familiar with the culture of the Deaf community.
- **Individuals who are deaf, deafblind, or hard of hearing can experience language deprivation, the failure to develop fluency in any language.** Language deprivation is almost unique to individuals with hearing loss and can have lasting mental health impact as “emotional and social development depends on the acquisition of language.”²⁷
- **Individuals who are deaf, deafblind, or hard of hearing can experience information deprivation.** This happens when information or knowledge about events is not shared with them by hearing people. This can be a traumatic experience.²⁸
- **The deaf community, including individuals with mental health needs, has historically been underserved or misunderstood.** This includes inappropriate psychological testing, misdiagnoses,

²⁵ Stratis Health. “Deaf and Hard-of-Hearing Minnesotans.”

http://www.culturecareconnection.org/documents/InformationSheet_Deaf.pdf, Accessed December 17, 2017.

²⁶ Tate, Candice. *Trauma in the Deaf Population: Definition, Experience, and Services*. (2012). Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD).

http://www.mhit.org/assets/NASMHPD_Deaf_and_Trauma_43175.pdf, Accessed December 15, 2017.

²⁷ Glickman, Neil S., and Sanjay Gulati, eds. *Mental health care of deaf people: A culturally affirmative approach*. Routledge, 2003.

²⁸ Schild, Sven, and Constance J. Dalenberg. "Trauma exposure and traumatic symptoms in deaf adults." *Psychological Trauma: Theory, Research, Practice, and Policy* 4, no. 1 (2012): 117.

and the exclusion of individuals who are deaf, deafblind, or hard of hearing from important (medical) decision making.

As a result of these factors, the report concludes that “the Deaf population faces challenges in navigating the behavioral health system.”²⁹

In interviews with MAD, providers in Minnesota and program directors from other states expressed similar concerns. For instance, the state program director of Alabama’s Deaf Services noted that it is more appropriate to understand individuals with a hearing loss as a linguistic minority than a population with a disability. Some providers stated that communication forms such as ASL are distinct from spoken English with different norms. Providers also mentioned examples of clients filling out paperwork that included terms they were not familiar with or initial intake sessions that take much longer due to limited language competency.

Best practices

Since the 1990s, there is a growing recognition among mental health providers of the importance of culturally affirmative mental health services for people with a hearing loss. Many practitioners recognize that deaf people are a linguistic minority and that the deaf community has a distinct culture.

As a result of some of the factors discussed above, there are unique aspects and challenges to providing mental health services to people who are deaf and hard of hearing. Mental health assessments are more difficult to administer because hearing loss can affect language use, communicative behavior, and cognitive functioning. The risk of misdiagnosis of the mental state of a person who is deaf is also higher because standard mental health assessments are designed for hearing people.³⁰ Additionally, patients who are deaf have reported fear, mistrust, and frustrations when they seek treatment in typical health care settings.³¹

Legal requirements and national associations have set best practices. For instance, the Americans with Disabilities Act of 1990 in part requires access to public services for people with disabilities. Public services are required to ensure effective communication, which may include providing interpreters. However, people who are deaf, deafblind, or hard of hearing often prefer dealing directly with a health care practitioner fluent in American Sign Language (ASL). The Joint Commission on Accreditation of Health care Organizations, therefore, has set the standard that healthcare organizations “provide effective, equitable, comprehensible, and respectful quality care and services that are responsive to the linguistic and communication needs of diverse populations.”³² The American Psychological Association has also said that mental health providers who do not

²⁹ Providers interviewed by MAD also shared that a significant number of their clients have multiple needs in addition to mental health needs. They might experience other physical or cognitive challenges that complicate treatment.

³⁰ Fellingner, Johannes, Daniel Holzinger, and Robert Pollard. "Mental health of deaf people." *The Lancet* 379, no. 9820 (2012): 1037-1044.

³¹ Ibid.

³² National Association of the Deaf. “Position Statement on Preservation of Mental Health Services for Deaf People in an Integrated Health Care.” <https://www.nad.org/about-us/position-statements/position-statement->

have the necessary linguistic or cultural competencies should refer deaf or hard of hearing patients to a specifically trained clinician.³³ Additionally, since 2017, Minnesota Statutes requires DHHSD to provide culturally affirmative mental health services.

Current state of service providers in Minnesota

In addition to DHHSD's five mental health specialists, who specialize in adults only, there are currently fifteen other providers in Minnesota providing culturally affirmative mental health services to people who are deaf, deafblind, or hard of hearing. They vary in terms of the number of deaf clients they serve and their target populations.³⁴ Two specialize in children only; three specialize in children, adolescents, and families; nine specialize in children, families, and adults; and one specializes in assessments for children ages 0-21 only. There are also a handful of special programs, such as the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals at Fairview University Medical Center and Deaf Can, Inc., a non-profit organization with a focus on supporting individuals recovering from chemical dependency.

Twelve of the fifteen private providers are located in the seven-county Twin Cities metropolitan area. The other three providers fluent in ASL are located in Greater Minnesota—in St. Cloud (serving children ages 0-18), Hutchinson (serving adults and children), and Rochester (serving children and adults).³⁵ This means that in large areas of the state, the DHHSD's mental health specialists are the only therapists who provide culturally affirmative mental health services in ASL.

Most national research notes a shortage of mental health professionals, and this is true for Minnesota as well. According to a 2016 report from the Governor's Task Force on Reforming Mental Health in Minnesota, nine of 11 of Minnesota's geographic regions are designated as "Mental Health Professional Shortage" areas, with the Twin Cities metropolitan area and Southeastern Minnesota being the only exceptions.³⁶ This pattern is consistent with where private providers of culturally affirmative mental health services for people who are deaf, deafblind, or hard of hearing are located.

[on-preservation-of-mental-health-services-for-deaf-people-in-an-integrated-health-care/](#), Accessed December 18, 2017.

³³ American Psychological Association. Ethical Principles of Psychologists and Code of Conduct, 2017. <http://www.apa.org/ethics/code/index.aspx>, Accessed January 3, 2018.

³⁴ A full list of mental health resources for deaf and hard of hearing children and adults can be found here: https://mn.gov/dhs/assets/dhhsd_mental-health-resource-list_tcm1053-166284.pdf

³⁵ Interviews with DHHSD's mental health specialists confirmed the lack of ASL-fluent mental health providers in Greater Minnesota.

³⁶ Governor's Task Force on Mental Health. "Reforming Mental Health in Minnesota." PowerPoint presentation, 2016. https://mn.gov/dhs/assets/Overview-Mental-Health-Presentation-ppt_tcm1053-250266.pdf, Accessed December 4, 2017.

Billing for mental health services

In interviews with private providers of culturally affirmative mental health services for people who are deaf, deafblind, or hard of hearing, MAD encountered varying views on the amount of resources it takes to bill for services, as well as the extent to which insurance revenues cover the costs of providing services (see the section that starts on page 40).³⁷ To put these views into a larger context, MAD conducted a focused literature review on the topic of billing for (mental) health services. In general, research indicates billing and insurance-related activities can be complex and time consuming. Moreover, some reports suggest insurance reimbursements might not cover the full costs of providing mental health services to a client population that relies heavily on government programs such as Medicaid or Medicare or lacks health insurance altogether.

Research on national trends in billing for health care reveals that “[t]he U.S. system of billing third parties for health care services is complex, expensive, and inefficient.”³⁸ A 2010 study found that “[p]hysicians reported spending three hours weekly interacting with plans.”³⁹ This is comparable to what private providers shared with MAD during interviews. Other research shows that expenses/costs associated with billing and insurance-related activities can comprise up to 14 percent of physicians’ revenue.⁴⁰ Perhaps as a result of this complexity, as well as the low reimbursement rates for mental health services (in combination with relatively few patients), psychiatrists in particular have relatively low acceptance rates of insurance, private and public, compared to other physicians.⁴¹

A 2001 report from Minnesota’s Office of the Legislative Auditor (OLA) on insurance for behavioral health care found that directors of community mental health centers from around the state believe “insurance reimbursement rates are low and do not cover the cost of services,” and that “they are required to deal with many different plans, different protocols, and people who give them conflicting advice.”⁴² Furthermore, the OLA report found that insurance companies are often too restrictive in allowing non-licensed staff to bill for services, a concern echoed by DHHSD’s mental health director.

It is important to note that the 2001 OLA report was issued before Minnesota’s 2007 Mental Health Act, which expanded the number of mental health services covered under MA. It also predates the passage of the

³⁷ MAD did not interview providers of other health services, who might have different perspectives on the costs and benefits of billing for services.

³⁸ Blanchfield, Bonnie B., James L. Heffernan, Bradford Osgood, Rosemary R. Sheehan, and Gregg S. Meyer. "Saving billions of dollars—and physicians’ time—by streamlining billing practices." *Health Affairs* 29, no. 6 (2010): 1248-1254.

³⁹ Casalino, Lawrence P., Sean Nicholson, David N. Gans, Terry Hammons, Dante Morra, Theodore Karrison, and Wendy Levinson. "What does it cost physician practices to interact with health insurance plans?." *Health Affairs* 28, no. 4 (2009): w533-w543.

⁴⁰ Jiwani, Aliya, David Himmelstein, Steffie Woolhandler, and James G. Kahn. "Billing and insurance-related administrative costs in United States’ health care: synthesis of micro-costing evidence." *BMC health services research* 14, no. 1 (2014): 556.

⁴¹ Bishop, Tara F., Matthew J. Press, Salomeh Keyhani, and Harold Alan Pincus. "Acceptance of insurance by psychiatrists and the implications for access to mental health care." *JAMA psychiatry* 71, no. 2 (2014): 176-181.

⁴² Minnesota Office of the Legislative Auditor. "Insurance for Behavioral Health Care." Program Evaluation Report. Report # 01-04. (2001).

Affordable Care Act, which includes ten essential health benefits for all insurance plans, among them mental health services.

A more recent 2015 report by the University of Minnesota's Center for Urban and Regional Affairs suggests some of these earlier concerns might still be valid. It concluded that "Minnesota's previously passed Medical Assistance rate increases for mental health providers have not been sufficient to keep pace with medical inflation, and have contributed to a shortage of mental health providers in the workforce."⁴³ According to the report's authors, the same is true for Medicare, a federally administered program: "In 2001, Medicare paid \$102 for a 45 minute psychotherapy session (the most common such service). Today, after a small increase for calendar year 2014, the program pays just \$86, a 35 percent drop from 2001, adjusted for inflation." Moreover, "Medicare is falling far behind psychologists' reimbursement by private insurers; Medicare reimbursement rates are estimated to be 17 percent below private market indemnity insurance rates."⁴⁴

Such low reimbursement rates can lead to a gap between the costs of providing services and the amount of revenue that can be brought in from billing insurances. Governor Dayton's Task Force on Mental Health issued a final report in 2016, which speaks directly to this issue through the following example:

Operating a psychiatric emergency room requires significant patient volume and on-going operational funding, which likely restricts the model to urban areas. [Hennepin County Medical Center] recoups about two-thirds of their operating costs [for its psychiatric emergency room] through billing insurers, leaving a shortfall of approximately \$1 million per year.⁴⁵

The extent to which these findings apply to DHHSD's mental health program is uncertain, given its relatively small size and unique population. However, the fact that billing and insurance-related activities are complex and time consuming was confirmed in interviews MAD conducted with private providers, other states, and DHS financial staff in Direct Care and Treatment.

⁴³ Woelfel, Amanda. "A Review of Minnesota Medicaid Reimbursement Rates: 2004-2014, Impacts on Mental Health Providers." Center for Urban and Regional Affairs, (2015). <http://www.cura.umn.edu/sites/cura.advantagelabs.com/files/publications/KNCBR%201384.pdf>, Accessed December 4, 2017.

⁴⁴ "Congress Should Halt Medicare's Plummeting Psychologist Payments." APA Practice Organization. 2014. <http://www.apapracticecentral.org/advocacy/state/leadership/slc-fact-medicare.aspx>, Accessed December 4, 2017.

⁴⁵ Governor's Task Force on Mental Health. "Final Report." 2016. https://mn.gov/dhs/assets/mental-health-task-force-report-2016_tcm1053-263148.pdf, Accessed December 4, 2017.

State comparison

Key findings

- States vary widely in how they offer and fund mental health services to people who are deaf, deafblind, or hard of hearing, ranging from almost entirely state-provided services (such as South Carolina) to a state-contracted provider (such as North Carolina) to regionally or locally provided services (such as Illinois).
- Few other states provide mental health services through state-employed mental health practitioners fluent in ASL similarly to Minnesota.
- Due to their statewide approach, Alabama, North Carolina, and South Carolina are three states that serve as comparisons to Minnesota:
 - Like Minnesota, most clients using state-funded mental health services in these three states have health insurance through Medicaid or Medicare.
 - Of the two states that MAD contacted that bill for services (South Carolina and North Carolina), both supplement funding from insurance reimbursements with other sources of funding.
 - State officials in these three states confirmed the severe shortage of mental health professionals who can provide culturally affirmative services.

Methods

MAD conducted a focused review of how other states provide mental health services to people who are deaf, deafblind, or hard of hearing. MAD contacted program staff in Alabama, North Carolina, and South Carolina. Alabama and South Carolina were selected because they, like Minnesota, employ a statewide delivery system of mental health services but have different funding models. The program director in South Carolina recommended contacting North Carolina because this state contracts out all of its mental health services for individuals with hearing loss to an independent provider who serves most of the state and bills for services.

South Carolina

South Carolina's Department of Mental Health provides mental health services to "adults, children, and their families affected by serious mental illnesses and significant emotional disorders."⁴⁶ Within this larger mission, the department serves individuals who are deaf or hard of hearing through the Services to Deaf and Hard of Hearing People, the program intends "to provide a statewide system of care for the delivery of mental health services which promote recovery and allow enhanced mental functioning for Adults, Children and Families

⁴⁶ <http://www.state.sc.us/dmh/mission.htm>, Accessed November 28, 2017.

where Deafness presents a significant cultural and/or linguistic barrier.”⁴⁷ Similar to Minnesota, services are provided through regional centers and providers are fluent in ASL.

The Department of Mental Health bills clients’ insurances whenever possible. Of the current clients, approximately 34 percent receive Medicare, 35 percent receive Medicaid or Medicaid through a Managed Care Organization (MCO), and 17 percent have private insurance. The revenue for the budget of the Services to Deaf and Hard of Hearing People is a combination of client fees, state match, state appropriations, and block grants. According to 2016-2017 budget documents provided by South Carolina, about nine percent of the annual revenue comes from client fees; the majority comes from state appropriations (69 percent) and block grants (18 percent).⁴⁸

South Carolina is different from Minnesota in a few important ways. First, as the program director of South Carolina’s Deaf Services shared with MAD, there are very few providers outside the statewide system for individuals with mental health issues. Since its focus is on those with severe mental illness, individuals with milder depression are underserved. Second, South Carolina does not provide grants to non-state providers, as Minnesota does, which likely contributes to the underserving of individuals with milder forms of mental health problems. Third, South Carolina does not require licensure for state providers to bill the state for services. This allows the state more flexibility in hiring mental health professionals who might not (yet) have the licenses typically needed to bill.

Alabama

Alabama’s Office of Deaf Services, housed in the Department of Mental Health, employs clinical staff to provide mental health services to individuals who are deaf or hard of hearing and who have severe mental illness. Salaries are completely state funded and the department does not bill clients’ insurances. Alabama moved to a billing model in the early 2000s, but the state found it was not sustainable because insurance revenue was not enough to cover costs associated with services provided. In 2005, Alabama transitioned from a billing system to a system in which the Deaf Services employees are state employees funded by state dollars. According to the program director, about 40 percent of the residential services, for which the state does bill, are funded by Medicaid reimbursements, and the rest with state dollars.

Again, there are important differences between Minnesota and Alabama. Alabama is more rural than Minnesota. A system of billing might be harder to sustain in rural areas given that the population is sparser and more dispersed. In other words, there are likely fewer potential clients, as well as higher costs due to travel and transportation, than in high-density population areas, such as Minnesota’s Twin Cities metropolitan area.⁴⁹

⁴⁷ <http://www.scdmh.org/deafmh/overview.html>, Accessed November 28, 2017.

⁴⁸ All numbers based on data shared with MAD by the State Program Director of the South Carolina Department of Mental Health’s Deaf Services.

⁴⁹ Gournaris, M. J., Hamerdinger, S., & Williams, R.C. (2013). Creating a culturally affirmative continuum of mental health services: The experiences of three states. In N. Glickman (Ed.), *Deaf Mental Health Care* (pp.138-180). New York, NY: Routledge.

Similar to South Carolina, the state clinical staff mostly see people with severe mental illness, whereas Minnesota’s Mental Health Program provides services to clients on the whole spectrum of mental health needs.

North Carolina

In North Carolina, RHA Behavioral Health, a private company, contracts with the state to provide culturally affirmative behavioral health services for people who are deaf or hard of hearing. These services include therapy and clinical assessments, community supports, outreach, consultation, and education services. RHA Behavioral Health serves the entire state. They have a team of 10 licensed clinicians, six Qualified Professional (QP) level staff who provide peer support, case management (on a limited basis), community outreach, consultation, education, and training, a business manager, an administrative assistant, and a director. Enhanced mental health and substance use disorder services are provided by behavioral health providers separate from RHA via the use of interpreting services.

RHA bills insurance for all services provided whenever possible. They also bill the state and Medicaid for the services they provide. Services are primarily paid for by a mixture of state allocations (70 percent), Mental Health Block Grant funding (20 percent), and insurance payments, including reimbursement from Medicaid and Medicare (10 percent). Among their clients, approximately half receive Medicare, 40 percent receive Medicaid, and seven percent fall into the category “other.” RHA does not currently charge copays since they do not have a system in place to collect them. The RHA contact person confirmed that insurance payments are historically low, for a variety of reasons, but this income is still considered a critical supplement to their state contract dollars.

Many of RHA’s clinicians are Licensed Professional Counselors (LPC). Gallaudet University’s Counseling Program is one of their main sources of staff. The program director stated that LPCs cannot bill Medicare and some private insurances. RHA actively seeks to recruit candidates who have LCSWs and PhDs, but there are few professionals in the dual fields of mental health and deafness—recruitment is competitive.

Implications for Minnesota

Each state examined here has a unique approach to providing mental health services to individuals who are deaf, deafblind, or hard of hearing. Comparisons in terms of reimbursement revenue are difficult as Medicaid fee schedules and licensure requirements vary significantly across states.⁵⁰ Nevertheless, two main points emerged:

1. Insurance reimbursements alone do not cover the costs of providing mental health services to individuals who are deaf, deafblind, or hard of hearing.
2. In general, there are relatively few providers who can provide culturally affirmative services and have the required professional licenses to bill for services.

⁵⁰ Woelfel, Amanda. “A Review of Minnesota Medicaid Reimbursement Rates: 2004-2014, Impacts on Mental Health Providers.” Center for Urban and Regional Affairs, (2015). <http://www.cura.umn.edu/sites/cura.advantagelabs.com/files/publications/KNCBR%201384.pdf>, Accessed December 4, 2017.

Interviews

Method

MAD conducted interviews with the five DHHSD mental health specialist, the Mental Health Program Director, and five private providers in Minnesota who specialize in providing culturally affirmative mental health services to individuals who are deaf, deafblind, or hard of hearing to understand the potential costs and benefits of billing from the perspectives of practitioners.⁵¹ In addition, MAD interviewed a billing professional at Region's Hospital and consulted with a number of DHS staff with expertise in health care, billing, and financial management.

All interviews were conducted between September and December 2017. Appendix A provides a list of organizations and titles of the individuals interviewed and consulted. Appendix B provides the questionnaires used for each set of interviews with mental health providers.⁵²

Interviews with DHHSD's Program Director and mental health specialists

Key findings

- Compared to other providers, DHHSD mental health specialists spend more time on activities other than therapy services, such as travel to see clients, case management, consultations, and presentations.⁵³ Mental health specialists in Greater Minnesota in particular spend a significant amount of their time on travel.
- The current no-charge model provides the mental health specialists with greater flexibility to adjust their schedules and activities to the needs of their clients.
- DHHSD's mental health specialists perform most administrative duties themselves; for instance, they communicate directly with their clients and schedule most of their own appointments.
- DHHSD's current mental health specialists have limited or no experience with billing for services; all indicated they would need training on billing-related activities, such as coding services provided.
- All five mental health specialists expressed concerns about the impact billing for services would have on their clinical work.

⁵¹ MAD sought to interview private providers in both the Twin Cities metropolitan area and Greater Minnesota. However, since there are only a few providers in Greater Minnesota besides the DHHSD mental health specialists, most interviews with private providers were with those located in the Twin Cities metropolitan area.

⁵² In its interview with DHHSD's Mental Health Program Director, MAD asked the Program Director to provide his reactions to a list of potential costs and benefits of billing for services.

⁵³ Some of these services, such as travel and case management, are likely billable, at least under certain insurance plans such as Medical Assistance (MA).

Detailed findings

Overview of services provided

As shown in the section on program overview, on page 30, the mental health specialists spend their hours on a variety of activities. Interviews revealed the following additional information about their work:

- There is no such thing as a typical day, as the mental health specialists engage in many activities throughout the week, including individual therapy sessions, conference attendance, consultations, case management, and travel to and from clients. Interviews revealed that not all activities are directly related to client services; for instance, a mental health specialist might give a presentation to other health providers in the region to increase awareness of the availability of culturally affirmative mental health services.
- Because services are provided at no charge, the mental health specialists have great flexibility when scheduling activities and meeting the needs of clients. Examples provided include the ability to extend therapy sessions beyond the traditional 45 to 60 minutes, rescheduling appointments in case of a client's lack of transportation, or traveling to see a client outside the office.
- Mental health specialists do much of their own scheduling directly with clients. While DHHSD employs an administrative assistant, the mental health specialists indicated it is often more efficient for them to communicate directly with their clients about meetings or case management.
- The mental health specialists located in Greater Minnesota face some unique challenges, such as long travel times, geographically isolated clients, and a lack of peer providers.

Need for services

To understand the need for culturally affirmative mental health services, MAD asked the mental health specialists how clients typically come to them, why clients might choose them instead of another provider, and whether they currently have waiting lists.

The specialists revealed that clients come to them through a variety of ways, including referrals from friends or family, through the central DHHSD office, or through other providers.⁵⁴ Whether services are billed might be one reason for clients to choose a mental health provider, but the specialists indicated other considerations also factor in, such as the availability of other culturally affirmative mental health services, client preference for seeing a hearing or deaf counselor, location, or other personal reasons.

With the exception of the mental health specialist in the Twin Cities metropolitan area, none of the mental health specialists currently have a waiting list.⁵⁵ When asked why, the mental health specialists emphasized that they make efforts to see each person who comes to them and avoid putting anyone on a waiting list. If they cannot see a client right way, they might refer them to another provider or see them less frequently during an initial period until they (the therapist) have more availability.

⁵⁴ When MAD asked the same question of the private providers, answers were very similar.

⁵⁵ This was true as well for the private providers MAD interviewed.

Mental health specialists in Greater Minnesota mentioned that they are often the only provider in the region who can provide services to signing individuals and therefore provide a whole range of services beyond what a typical therapist might provide.

Potential impact of billing on work

Each mental health specialist expressed concern about the impact billing for services would have on their work, which were shared by the Program Director. Common concerns included:

- Additional time spent on billing and insurance-related activities will take away from time spent with clients.
- Having to bill for services would mean abiding by rules set by insurance companies, such as a maximum allowable number of sessions or maximum allowable time for individual sessions. This would reduce the current flexibility employed by the mental health specialists in providing services to clients.
- The additional paperwork clients are required to fill out under a system of billing would take away from time spent on counseling and might also be a source of stress for clients.
- Some clients will not qualify for services under a system of billing because they do not have a formal diagnosis, they receive more or longer sessions than would likely be allowed by insurers, or they do not have insurance or cannot pay copays.
- Some clients might forego services because of the lack of insurance or the inability to pay copays.

All five mental health providers shared potential costs rather than potential benefits of a system of billing for services. When MAD asked whether they believed that billing for services might lead clients to take greater responsibility for their therapy, the mental health specialists were not convinced this would be true for many of their current clients. Rather, as one mental health specialist shared, whether they show commitment early on and whether they have access to transportation are greater predictors of following through with therapy.⁵⁶

Interviews with private mental health providers

Key findings

- All private mental health providers that MAD interviewed bill for services.
- All providers absorb some unbillable costs, such as travel, consultation, or services provided to clients without insurance or insurance that cannot be billed.
- Estimates for how much time is spent on activities related to billing range from 2.5 to four hours per week.
- Support staff greatly reduce the amount of time a provider has to spend on billing and insurance-related activities.

⁵⁶ Academic research is also inconclusive as to whether co-pays or deductibles lead people to take greater responsibility for their health.

- Billing for mental health services is complex and there are unique billing challenges when serving individuals who are deaf, deafblind, or hard of hearing due to longer therapy sessions, changes in disability or insurance status, and challenges with provider credentials.
- Providers need continuous training on coding and other billing-related activities as insurance codes and rules change periodically.

Detailed findings

Overview of services provided

The providers MAD interviewed varied widely in terms of the number of clients who are deaf, deafblind, or hard of hearing they served. Some served fewer than 10 (in addition to hearing clients), while other providers' sole target population is individuals who are deaf, deafblind, or hard of hearing. This range makes comparison to the DHHS's Mental Health Program somewhat difficult. Furthermore, no other practice or provider serves a particular region of the state in the same way DHHS's mental health specialists do.

Interviews with non-DHHS providers suggest their workday is more "traditional" in the sense that many therapy sessions are 45-60 minute client meetings, in addition to traveling far less to meet with clients and engaging in fewer activities such as meetings with other providers and case management. Some providers shared that they go beyond what they would do for hearing clients, for instance, helping to fill out paperwork or coordinating care with other providers.

Need for services

When asked whether providers refuse clients or put them on a waitlist, most said that they take all people who come to them (unless they are not the right therapist). Similar to DHHS's mental health specialists, they expressed a strong commitment among the private providers to serve any individual who needs support. The interviews did not suggest the need for services currently exceeds what is being offered; however, as one interviewee put it, "If you build it, they will come."

Impact of billing on work

MAD asked each provider how billing for services affects their work. One provider described it as follows: "Because we rely on insurance, we adhere pretty strictly to the limits [set by the insurance companies]. Most of our sessions are 45-50 minutes long. When we go longer, and we want to bill for that, we need to have specific criteria met; every insurance has their own policy and we follow those."

Additional themes were:

- Coding and billing takes time. Some providers who have support staff mainly have to enter codes and everything else is taken care of by support staff. The presence of support staff greatly helps to reduce the amount of time providers have to spend on billing-related activities.
- Billing for services, interacting with insurance companies, and keeping up with ever-changing rules are complex. Providers shared that it is certainly doable but does require a level of expertise and commitment to ensure all billable activities are indeed billed. One provider shared that rather than try to enroll as a provider with a particular insurance, she serves clients with this type of insurance free of charge (she is reimbursed through a state grant).

- Once a system of billing is in place, it is workable but continuous training of providers is needed and startup costs might be considerable.

Consultations with DHS staff with expertise in health care, billing, and financial management

MAD also consulted with DHS staff with expertise in billing and financial management to understand what costs might be involved if DHHSD started billing for mental health services. They highlighted two main issues: a need for additional staff and a need for additional attention to credentialing and negotiations with insurers. They also shared other considerations on implementing a system of billing.

Need for additional staff

To process insurance claims, get the mental health specialists credentialed and navigate the rules set by insurance companies, DHHSD would need to hire additional staff with expertise in this area. It is unclear whether one person could be responsible for both the billing activities and credentialing, or if DHHSD would need to hire two separate people (or contract with an entity to provide such services). At the very least, DHHSD would need an additional 0.5 full-time equivalent (FTE), but it is more likely they would need 1 FTE, especially in the first year or so as they are transitioning to billing for services.

DHS staff also stressed the importance of having this new staff person be present from the start of the transition to facilitate the process and reduce the potential for delays or unforeseen challenges.

Credentialing and negotiating contracts with private insurers

To be able to bill for services, DHHSD and its five mental health specialists would need to enroll with DHS to bill Medicaid and be credentialed with other insurers. DHS staff told MAD it is unlikely that all mental health specialists would be able to be credentialed by all insurers given the current licenses of the mental health specialists and the many rules that govern the insurance industry. It is possible that DHHSD could take advantage of some of the existing expertise within DHS to negotiate contracts with private insurers, as is done in DHS's Direct Care and Treatment (DCT).

Other notes on implementing a system of billing

- **Using DHS staff and resources versus a third party for billing:** MAD asked DHS staff with expertise in billing about the options of 1) employing DHS staff and resources to do all billing versus 2) outsourcing some or all billing activities to a third party, such as a private billing company. DHS staff told MAD either would be a viable option but recommended that one entity be responsible for all billing activities rather than splitting up this responsibility, for instance by billing Medical Assistance

in-house and billing other insurers through a third party. This partition of responsibility could complicate tracking of claims and general oversight.⁵⁷

- **Ease of billing:** Multiple DHS staff noted that the actual process of submitting a claim to an insurer is not complicated; most work (and costs) happens before that claim can be submitted, such as ensuring providers have entered the correct codes, verifying clients' insurance information and possible authorization, and negotiating contracts with insurers.
- **Differences between insurers:** DHS staff with expertise in billing shared that billing MA is typically the most straightforward to bill because reimbursement fees and requirements are known. Billing private insurers or Medicare can be more cumbersome. DHS staff suggested knowing who the major payers are and prioritizing contracts with those. They added that it typically is not possible to contract with every insurer in the field.
- **Filing claims electronically:** DHS staff in DCT also noted that all claims to insurers have to be submitted electronically and manual claims are no longer accepted. DHS has billing software DHHSD could use at no charge although there might be added costs for infrastructure to link medical records with this billing software.

⁵⁷ Regardless of the option, DHHSD's mental health specialists would still need to be trained and spend time on tracking and coding services provided to allow for billing to happen.

Summary of costs and benefits and recommendations

Costs and benefits

To summarize the potential costs and benefits of billing for mental health services, MAD divided costs and benefits into *known* and *unknown*:

1. **“Known costs and benefits”**: This includes those costs and benefits MAD is certain will occur based on its research for this report (reference research, interviews with providers, and state comparison). Some of these costs and benefits are quantifiable, whereas others are not.
2. **“Unknown costs and benefits”**: This includes those costs and benefits MAD believes might occur but have an unpredictable direction (for instance, will more or fewer individuals seek therapy from DHHS under a system of billing?) and/or size.

Known costs

- **DHHS will need to hire additional staff to support its billing activities, most likely a 0.5 to 1 FTE⁵⁸ position (ongoing cost)**. Current DHHS staff lack the capacity and expertise to successfully complete all activities related to billing for services, such as processing insurance claims or credentialing the providers. Depending on the position’s classification, hiring additional staff could be a potential cost of *at least* about \$50,000 for 0.5 FTE or \$100,000 for 1 FTE in the first year, and \$42,500 for 0.5 FTE to \$85,000 for 1 FTE after the first year.⁵⁹ These numbers are based on the average salary of Reimbursement Specialist positions (MAPE level 5) within DHS’ Direct Care and Treatment (DCT) Financial Operations and include fringe and overhead. Some DHS staff believe a higher job classification might be needed, especially if this person would be in charge of both billing and credentialing.⁶⁰
- **DHHS and its five mental health specialists will need to enroll as providers with DHS to be able to bill for services under Medical Assistance (MA) (startup cost)**. The current enrollment fee is \$560 per provider location.
- **DHHS and its five mental health specialists will need to enroll as providers with other insurers (Medicare, private insurers) (startup cost and potentially ongoing costs)**. DHS has experience with this in other areas, such as Direct Care and Treatment and this could be a responsibility of the additional staff. It is unclear, however, what the exact costs in time and dollars would be.

⁵⁸ Full-time equivalent.

⁵⁹ These costs will likely qualify for Federal Financial Participation (FFS), where 35 percent of the state’s costs are reimbursed by the federal government. The net fiscal impact to the state of an additional position would thus be 35 percent lower.

⁶⁰ If this position were a MAPE level 8, first year costs for 1 FTE would range from \$85,000 to \$110,000.

- **DHHSD or DHS will have to negotiate reimbursement contracts with private insurers (startup and ongoing cost).** Similar to the previous cost, this could fall under the responsibilities of the additional staff but might be time consuming as there are many insurance companies, all potentially with different rules and credentialing guidelines.
- **The mental health specialists will need training on how to code and bill for services (startup and ongoing cost).** DHS can provide staff for this so the cost for training to DHHSD would be minimal except for the time it would take on the part of the mental health specialists.
- **The mental health specialists will spend a non-negligible amount of time each week on coding and other billing and insurance-related activities (ongoing cost).** The exact amount of time is uncertain and will depend on the amount of support DHS or DHHSD can provide to the mental health specialists. Based on interviews with private providers, a reasonable expectation might be that the specialists will spend five to 10 percent of their working hours on such activities. That would translate into about two to four hours per week, or about \$21,750 to \$43,500 annually for the five MH specialists combined (five percent or 10 percent of the fiscal year 2017 salary amount).
- **DHHSD will face other startup and ongoing costs such as information technology (IT) costs, costs associated with invoicing or collecting copayments from clients, and change management costs.** IT costs would include setting up a system for the mental health specialists to code services to be billed. DHHSD will also need a system to collect payments from clients at the regional offices for copayments. Whenever functions or staff are moved or added, the organization's structure may change. Such a change would require an investment of staff resources and likely lead to some initial loss in productivity. These costs are known as change management costs. The exact amounts of these costs are unknown at this time.

Known benefits

- **DHHSD will bring in revenue from insurance reimbursements and client fees such as copayments (ongoing benefit).** The exact amount is unknown given the lack of reliable and readily available data to conduct revenue estimates. A substantial portion of the revenue would likely come from the federal government as up to 94 percent of services covered by MA61 and 95 percent of services covered by MinnesotaCare are federally funded.⁶²

⁶¹ The state's current MA federal matching rate (FMAP) is 50 percent. Under the Affordable Care Act, Minnesota receives an enhanced federal match of 94 percent in 2018 for the costs of services provided to enrollees who are newly eligible. For more detail, see the information brief on Medical Assistance by the Minnesota House of Representatives Research Department. <http://www.house.leg.state.mn.us/hrd/pubs/medastib.pdf>, Accessed February 28, 2018.

⁶² See the information brief on Minnesota Care by the Minnesota House of Representatives Research Department. <http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf>, Accessed February 28, 2018.

Table 5: Known startup and ongoing costs and benefits

Startup costs	Ongoing costs	Ongoing benefits
Provider enrollment costs	Additional staff (at least 0.5 to 1.0 FTE) Training of mental health specialists IT costs	Revenue from insurance reimbursements
Training of mental health specialists		
Training of the new reimbursement specialist		
IT costs		
Change management costs		

Unknown costs

Costs in lost time to the mental health specialists

- The mental health specialists will likely have less time available for clients due to time spent on billing and insurance-related activities, such as providing coding services, filling out paperwork with clients, and training, which would lead to a reduced number of billable hours.
- The mental health specialists might lose (some of) their flexibility in terms of meeting clients’ needs. This would probably depend on whether the program would continue to receive general fund dollars, which would allow the specialists to provide services at no charge when they cannot be billed.

Costs to current and/or prospective clients

- Under a system of billing, clients might have to wait longer to see a mental health specialist if they first have to show proof of insurance, or their insurance requires pre-authorization or a referral. Currently, DHHS does not require clients to show proof of insurance or be referred. Similarly, when clients reach their maximum allowable number of sessions under their insurance, authorization for additional sessions would be needed, which might take time. If denied, clients might not be able to continue therapy unless DHHS can continue to use general fund dollars to provide certain services at no charge.⁶³
- Some current clients might stop seeing their mental health specialists because of a copay, deductible, or the stress of financial burden.
- Clients in Greater Minnesota will likely be impacted at a greater rate than those in the Twin Cities metropolitan area due to the lack of alternative options for accessible and culturally affirmative mental health services and/or a lack of broadband internet access for telehealth.

⁶³ Another alternative is a hybrid model in which DHHS bills whenever possible combined with a sliding fee scale for clients who are un- or underinsured. For this model to work, the division would still need another funding source, such as the General Fund, to fund the program’s costs that are not covered by insurance reimbursements.

Unknown benefits

Benefits to DHHS and its mental health specialists

- Insurance companies or other providers might refer more clients to DHHS's Mental Health Program. Billing for services could lead more insurers to become aware of DHHS's services and thus refer individuals to the mental health specialists. However, interviews with private providers suggest only a few clients come to providers in this fashion so the effect might be small or negligible.

Benefits to current and/or prospective clients

- If revenue from insurance reimbursements exceeds the costs for billing, DHHS could use these additional funds to expand its services and potentially serve more clients. The challenge is that before DHHS would be able to bring in insurance revenue, it would first have to implement a system of billing, which is associated with significant startup and ongoing costs. This could negatively affect the number of billable hours provided by the mental health specialists and thus the potential revenue.
- Some clients might take greater responsibility for their therapy if a copayment is required or they are only allowed a maximum number of sessions under their insurance. MAD received competing views on this from the mental health specialists and providers. The academic literature is also inconclusive on this point.

Recommendation and potential next steps

Based on the known costs and benefits, MAD provides the following recommendation to the legislature:

At this time, DHHS should not start to bill for the costs of providing mental health services to individuals who are deaf, deafblind, or hard of hearing. Given the amount of uncertainty that exists around potential revenue from insurance reimbursements and, to a lesser extent, the costs of implementing a system of billing, it is difficult to predict whether revenue from insurance reimbursements will cover the costs of billing, especially during the start-up period.

If the legislature is interested in reliable revenue and cost estimates, consultation with DHS financial staff suggested about three years of complete and accurate program data would be needed. Such data is currently unavailable because DHHS did not collect data for this particular purpose. Data needed for such estimates would include a breakdown of hours by client *and* client insurance. Further breakdowns by type of activities, such as case management and travel would also be needed.

Other considerations

MAD identified another set of considerations the legislature should take into account as it evaluates the current funding model of DHHS's Mental Health Program against billing for services.

- **Two out of the five mental health specialists are currently not licensed at the level that would allow them to enroll as providers with DHS.** From conversations with DHS staff, MAD learned that

these two specialists could potentially bill for services if supervised by a clinician with the necessary license. However, this might prove challenging for the mental health specialists in Greater Minnesota where there already is a general lack of mental health providers, let alone providers specialized in services to individuals who are deaf, deafblind, or hard of hearing.

- **A provider shortage exists in the area of mental health.** This is true in mental health more generally, and is even more acute among professionals who provide culturally affirmative and accessible mental health services to individuals who are deaf, deafblind, or hard of hearing.
- **The current mental health specialists all expressed concern about a system of billing and the negative affects this might have on their ability to provide services.** In interviews with MAD, all five mental health specialists indicated they had no or limited experience with billing for services and strongly preferred the current model of offering services at no charge over a system of billing.
- **The mental health specialists currently perform activities that are not billable but can be considered valuable services to their practices and the community, such as provide consultations to other providers, give presentations to the community, conferences attendance, and travel time for meetings with other providers.** Billing for services might affect the ability to deliver these services and have a secondary effect on their practices—for example, the ability to identify individuals in need of mental health services (i.e., potential new clients).
- **There is much uncertainty around the possibility of DHHS billing for case management.** The five mental health specialists currently spend a considerable amount of time on case management. This service is typically provided at the county-level by agencies that are enrolled as targeted case management providers, and can bill for such services. It is unclear whether the mental health specialists could enroll as providers of targeted case management and what portion of their case management, if any, they would be able to bill.
- **Some clients' mental health concerns might not fall within the existing DSM-5 diagnoses and thus services to them would not be billable.** Both private providers and DHHS's mental health specialists mentioned this as a concern when billing for services.
- **A greater reliance on telehealth might cut down on mental health specialists' travel time but caution is warranted.** Travel time is especially high in Greater Minnesota and the use of telehealth might be a promising alternative to in-person counseling. Yet, broadband access is a considerable challenge in Greater Minnesota. Moreover, as one DHHS's mental health specialists in Greater Minnesota noted, telehealth is not appropriate for all mental health services, especially when serving clients who already have unique linguistic and communication needs.
- **Current output and outcome data suggest DHHS's services provided at no charge have similar or better outcomes in terms of meeting treatment plan goals than services provided by non-DHHS providers (who bill).** However, more detailed data would be needed to test whether billing for services is associated with better or worse outcomes among clients.

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Appendix A: List of study participants

The names of individuals who participated in this study are private. The list below includes the names of the organizations that employ these individuals. The list does not include organizations or individuals who declined to participate. Interviews solely for background information are not included in this list.

An organization's presence in the list below does not indicate that comments or ideas included in this report represent the official position of any organization.

Department of Human Services

- Deaf and Hard of Hearing Services Division
- Direct Care and Treatment
- Health Care Operations
- Continuing Care and Community Supports Administrations
- Financial Operations
- Budget Analysis Division

Private providers

- Bluestem Center for Child and Family Development (Rochester)
- Deaf Can, Inc. (St. Paul)
- Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals – Fairview University Medical Center (Minneapolis)
- Private practice (St. Paul)
- Regions Hospital's Health and Wellness Program (St. Paul)
- Vona Center for Mental Health (New Hope)

States

- Deaf Services in the Alabama Department of Mental Health
- Behavioral Health for the Deaf and Hard of Hearing—RHA Behavioral Health Services, Inc. (North Carolina)
- South Carolina Department of Mental Health Services for the Deaf and Hard of Hearing

Appendix B: Interview questionnaires

Interview guide for DHHS mental health specialists

The following questions can serve as a guide to our conversation. If there is any additional information you think might be helpful to the research question, please let me know. The key question the legislative study is addressing is “What are the potential costs and benefits of having DHHS bill for the costs of providing mental health services?”

1. Can you describe to me what a “typical day” at work looks like? For instance, how many counseling sessions do you do on an average day, how much time do you spend on preparing for counseling sessions, how much time is devoted to travel?
2. How do clients typically come to you? For instance, do they come to you through referrals, other providers, or directly?
3. How often do you have to refuse clients because you are too busy or for some other reason? If you have to refuse a client, do you refer them to other providers or put them on a waitlist?
4. Do certain services you provide require additional preparation time beyond the contact hours? Which types of services are the most time intensive in terms of preparation?
5. Are there types of clients who require more work or attention than others? Can you explain in more detail what additional services or attention you might provide or how this impacts your work in other ways?
6. When services are free of charge, some research suggests that this leads to people not taking them as seriously. For instance, they might not show up for appointments, or show up late. To what extent do you find that this is true in your practice?
7. Other research suggests having services be free of charge helps people gain access to services they might otherwise not be able to use. To what extent do you find that this is true in your practice?
8. How familiar are you with a system of billing for mental health services? For instance, have you billed for services in a previous job?
9. If DHHS moved to a system of billing clients or their insurance for services, would you need training on how to work in such a system?
10. From your perspective as a mental health provider to individuals who are deaf, deafblind, or hard of hearing, what are the main advantages of having your services be free of charge? What are some disadvantages?
11. Is there anything else you would like to add?

Interview guide for private mental health providers

MAD interview guide for mental health providers serving people who are deaf, deafblind, or hard-of-hearing

The following questions can serve as a guide to our conversation. If there is any additional information you think might be helpful for the legislative study, please let me know. The key question the legislative study is addressing is “What are the potential costs and benefits of having DHS’ Deaf and Hard of Hearing Services Division (DHHS) bill for the costs of providing mental health services?”

Questions about your work and practice

1. About what proportion of your clients are deaf, deafblind, or hard of hearing?
2. Can you describe to me what a “typical day” or “typical week” at work looks like? For instance, how many counseling sessions do you do on an average day and are they all with clients who are deaf, deafblind, or hard of hearing? How much time do you spend on preparing for counseling sessions, how much time is devoted to travel, how much time is devoted to other activities?

[The next questions refer specifically to your work with clients who are deaf, deafblind, or hard of hearing]

3. Are all of your sessions hour-long sessions? If they are longer than an hour, what are some the reasons for longer sessions?
4. How do clients typically come to you? For instance, do they come to you through referrals, other providers, directly, or some other way?
5. How often do you have to refuse clients because you are too busy or for some other reason? If you have to refuse a client, do you refer them to other providers or put them on a waitlist?
6. What might be reasons that clients come to you versus going to one of DHHS’s mental health specialists?
7. Are there types of clients who require more work or attention than others? Can you explain in more detail what additional services or attention you might provide or how this impacts your work in other ways?
8. Do you collect data on outcome measures for the services you provide, for instance how many clients improve on certain metrics over the course of therapy? Would you be willing to share these with us?
9. (If you know) What are some of the differences between rural and urban areas in terms of mental health services for people who are deaf, deafblind, or hard of hearing?

Questions about your or your organization’s funding model and billing for services

10. Can you tell me more about the funding model of your organization or your practice? For instance, which services or activities do you bill to the client/the client’s insurance? What other funding sources do you or your organization rely on?

11. If you or your organization bill for services, which services or activities do you **not** bill (or can you not bill) to your clients or their insurances?
12. If you or your organization work mostly in the metro area, do you think your funding model would work in Greater Minnesota? Why or why not?
13. On average, what portion of your workweek is spent on paperwork so that you can bill for the services you provide? Do you have support staff who helps with this?
14. From your perspective as a mental health provider to individuals who are deaf, deafblind, or hard of hearing, what are the main advantages of billing for your services? What are some disadvantages?
15. To what extent do you think billing for mental health services facilitates or impedes access to services?
16. To what extent do you think DHHSD mental health specialists billing for mental health services might facilitate or impede access to these services?

General questions

17. To what extent do you think the population of deaf, deafblind, and hard of hearing is unique or has unique needs in terms of mental health services? Can you tell me more about that?
18. Is there anything else you would like to add?

End of Minnesota Management and Budget Management Analysis and Development report.

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V. DHS Legislative Report recommendation

Recommendation

The DHS Deaf and Hard of Hearing Services Division should not start to bill for the costs of providing mental health services at this time.

The DHS recommendation is based on the MAD analysis and its recommendation. An additional consideration for DHS is that DHHSD is currently examining ways to redesign its service delivery structure in keeping with the findings in the [January 2017 DHS report to the legislature on the Analysis of Deaf, DeafBlind and Hard of Hearing Services](#). Possible changes in the division's structure, such as moving to fewer 'bricks and mortar' offices, could occur within the next few years and potentially impact how DHHSD delivers its mental health services.

The MAD report notes that if the legislature is interested in reliable revenue and cost estimates, about three years of applicable program data would be needed. Data needed for such estimates would include a breakdown of hours by client, client insurance, and types of activities such as therapy, case management and travel. The DHHSD mental health program does not currently have the data breakdown needed to closely estimate potential revenue from a system of insurance billing.

As DHHSD revises its data collection methods, it will explore options that allow for a more accurate analysis of the costs and benefits of insurance billing.