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Third Party Payments for Mental Health, Chemical Dependency and Social Services and their Relationships to Occupational Regulation

Prepared for the Human Services Occupational Advisory Council
by the Manpower Division • Minnesota Department of Health

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EXECUTIVE SUMMARY

THIRD PARTY PAYMENTS FOR MENTAL HEALTH, CHEMICAL DEPENDENCY AND SOCIAL SERVICES AND THEIR RELATIONSHIP TO OCCUPATIONAL REGULATION

Manpower Division
Minnesota Department of Health
March 1980

This study describes the third party payment systems for mental health, chemical dependency, and social services in Minnesota and their impact upon providers and the different occupational groups. The findings help us to understand the pressures on groups to seek state licensure and how third party reimbursement policies help shape the delivery system. These findings may be helpful to planners, third party payers, related state agency personnel, mental health professionals and the legislature.

Chapter I describes the changes in mental health funding, leading toward expanded third party reimbursements for mental health, chemical dependency and social services. Chapter II is an analysis and summary of the study.

Chapter III details each of the types of third party payers and their policies affecting occupations. Chapter IV details each of the types of providers of treatment services and their experience with third party payers and the impact upon the various occupations. Chapter V details which of the occupations are generally affected by third party payment policies and practices.

The Appendix is a separate document. It contains the detailed methodology, a list of the persons interviewed, descriptions of programs and rules, lists of licensed facilities, data on programs, and other materials. The major third party payers are the Welfare Programs (Medical Assistance, Cost of Care, and Community Social Services), and the private insurance programs, (the large private carriers, Blue Cross/Blue Shield, the HMOs; and self insured companies). These tend to set the pattern of third party payments to service providers and occupational categories within welfare law and insurance law. Generally, these third party payers separate mental health and chemical dependency for reimbursement purposes. Residential treatment of children in group residential facilities (Rule 5 and 8) is usually also treated separately.

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The following are some of the findings:

- Most third party payers treat licensed consulting psychologists in the same manner as physicians (enrolled or independent providers of services) for purposes of reimbursement. This has come about because of a combination of licensure of consulting psychologists, laws and regulations regarding insurance, facilities, and benefits, and perceptions about skills and educational level.

- Third party payers will pay for the services of an extremely wide range of occupations when they are performed in licensed facilities. They rarely pay for independent solo practice other than physicians and licensed consulting psychologists.

- Facility licensing by state government sets minimum standards and determines many of the kinds of professionals that must or can be used. Insurance law and third party payment policies or regulations determine which facilities can be covered for reimbursement.

- Coverage for outpatient mental health treatment is less clear because there is no state regulation of mental health or psychiatric clinics. Claims are submitted by the physician or licensed consulting psychologist, not the clinic, for the services of the staff including social workers. Clinics have found policies vary so greatly that they usually check each patient's insurance company to see how the policy pays for treatment with a particular diagnosis and which professional staff can be used.

- Third party payments for chemical dependency are generally easier to describe and delineate because most coverage is for treatment in licensed facilities, and the coverage is clearly defined in state insurance law.

- Out of the home residential treatment for children under the cost of care programs is financially most complex and confusing for counties which serve as intermediary. The system works simply and easily for the family, the professional, and the provider agency.

- When reimbursements are made for social services other than those performed in residential treatment facilities, they are usually made by governmental programs.

Many of the social services programs have been reorganized under the Community Social Services Act and program and are now operated, funded, or reimbursed at the county level. The counties are likely to develop a variety of different policies and patterns regarding reimbursement of mental health, chemical dependency and social services.

. Generally, third party reimbursement for mental health and chemical dependency is built on health insurance, and follows the medical model. Third party payers generally reimburse licensed facilities and do not review which personnel are being used in treatment. In private practice or unlicensed facilities, they reimburse for the usual and customary charges of the doctor (physician or licensed consulting psychologist) which includes supportive and ancillary services. However, third party payers vary greatly as to which supportive or ancillary staff charges are allowable in the doctor's claim, particularly treatment by a social worker or psychiatric nurse.

THIRD PARTY PAYMENTS
FOR
MENTAL HEALTH, CHEMICAL DEPENDENCY AND SOCIAL SERVICES
AND
THEIR RELATIONSHIPS TO OCCUPATIONAL REGULATION

Prepared for the
Human Services Occupational Advisory Council
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Manpower Division
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Researcher
Blue Carstenson
March 1980

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THIRD PARTY PAYMENTS FOR MENTAL HEALTH, CHEMICAL DEPENDENCY AND SOCIAL SERVICES AND THEIR RELATIONSHIPS TO OCCUPATIONAL REGULATION

I. INTRODUCTION

A. Purpose of the Study

One of the reasons that groups seek occupational regulation is to obtain third party reimbursement for services rendered. Thus, third party reimbursement has been a factor in some of the applications for regulation in the mental health, chemical dependency and social services areas. In recognition of this fact, this study has been undertaken in order to give the Human Services Occupations Advisory Council and its subcommittees, and the Minnesota Department of Health a framework of information for regulatory decision-making in the mental health, chemical dependency and social services areas. It may also be useful to the Department of public welfare, the insurance industry, providers, consumer groups, and professionals in these areas.

This study describes some of the basic systems of third party payments for mental health, chemical dependency and social services (MH/CD/SS); explores the coverage provided and the standards and policies affecting major service providers and occupational groups; and shows how these systems relate to occupational regulation.

It was not possible in the time allotted for the study to cover all third party payment systems, all providers of services, or all occupational groups in the areas of mental health, chemical dependency, and social services in Minnesota. Therefore, studies of the full implications for occupational licensing remain a future task.

B. History and Development of Third Party Payments

Third party reimbursement for mental health treatment is a relatively recent phenomenon. In England and in colonial America, the family was primarily responsible for either providing for or financing the

care of the mentally ill and the impoversihed. If there were no family resources, the mentally ill and the impoverished went to the city or county almshouse, the county poorhouse, or the county poor farm.[1]

In 1751, at the urging of Ben Franklin, Pennsylvania became the first state to help establish a hospital for the "sick poor and for the reception and care of lunaticks." Virginia and other states followed suit. Dorothea Dix and other reformers finally persuaded New York State to develop a state mental hospital program in the 1850's; however, New York state did not assume full financial responsibility for mental hospitals and welfare programs until 1890. Since then other states have gradually followed New York in assuming financial and operating responsibilities for the care and treatment of the mentally ill through state systems of mental hospitals.[2]

Medical Assistance (Medicaid Assistance, Title XIX) and Medicare introduced the first major third party payments for mental illness in the mid 1960s. According to a national study by Brunsgaard,[3] reimbursement for care provided in state mental hospitals increased by 215% between 1964 and 1968, with Medicaid and Medicare accounting for nearly all of the increase. During that time, the use of general hospitals and nursing homes for the treatment of mental illness[4] also increased because of Medicaid and Medicare policies. Similarly, community-based treatment for mental illness has continued to

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[1] James E.J. Brunsgaard, Financing Mental Health Care, A Survey of Reimbursement Policies, Procedures, and Sources in the Department of Mental Hygiene in the United States.

A Major Report to the Health Care Administration Department, George Washington University, June 1969.

[2] Ibid, pages 5-8

[3] Ibid, page 55

[4] Dorothy P. Rice, Ruth Knee, and Mararet Conwell,"Financing the Care of the Mentally Ill Under Medicare and Medicaid," American Journal of Public Health, Dec. 1970, Vol. 60, No. 12, pages 2237-8

expand partly because of the increasing use of third party reimbursements. Other reasons for this expansion include earlier detection and treatment, pressures for deinstitutionalization, the use of tranquilizers and other medications, and an increase in the number and types of community-based treatment resources.

Prior to the 1970s, mental health and chemical dependency treatments often were not included in the coverage of third party payments. During the past seven years, however, Minnesota legislators and employers have made many changes which have altered this picture. Most private and public third party payer systems now reimburse treatment of mental illness and chemical dependency on the same basis used to reimburse for physical health treatment. Among these public systems are government programs such as Medical Assistance, Medicare, Community Social Services Program (Title XX, Chemical Dependency, Mental Health, etc.), child welfare cost of care programs, and other governmental programs.

The number, types and coverage of private third party payment programs have continued to increase, including group and individual insurance, fraternal insurance, Blue Cross/Blue Shield, HMOs, and self-insured programs. In 1973, the Minnesota legislature prohibited exclusion of payment for treatment of mental illness on any health insurance policies.

The policies of these third party payment systems differ as to which providers and professional groups they will reimburse for what services, for how long, and under what conditions. Some of the larger private third party payers have as many as a hundred different policies which have been negotiated or offered. This paper outlines these systems and shows generally how they function in relation to the various providers and occupational groups.

C. Methodology

A complete description of the methodology of this study along with a list of persons interviewed, is in the appendix. Briefly, the methodology involved studying the law, making a literature search, and interviewing

nearly 100 persons for information. Those interviewed included staff representatives of governmental and private third party payers, provider agencies, and regulatory agencies, and individual professionals in the field. Drafts of the study were circulated to some of these persons for comment. Although the third party payers, providers, and professionals did not always agree about what is actually happening regarding payment for mental health and chemical dependency, there are many generalizations that can be drawn from their comments about the present systems.

The persons and agencies assisting in the study are listed in the Appendix which is a separate document. The Appendix also includes: descriptions of some of the key rules, lists of licensed facilities, information about the Community Social Services Act, information from Blue Cross/Blue Shield, and other supportive documents.

II. SUMMARY DESCRIPTION AND FINDINGS

A. Description of the Third Party Payment Systems

1. The Major Programs

The third party payment systems for mental health, chemical dependency and social services (MH/CD/SS) are "a patchwork quilt" of various overlapping public and private programs and systems.

Some of the major third party payment systems are: Medical Assistance, Medicare, Blue Cross/Blue Shield and other private insurance companies, self-insured company health programs, Child Care, Cost-of-Care Programs, Community Social Services, Veterans Administration programs, and the Catastrophic Health Expense Protection Program (CHEPP). State income maintenance and Social Security programs can sometimes be used to reimburse residential treatment programs for living expenses (for emotionally handicapped children, for example).

Another major payer of mental health, chemical dependency and social services are the Community Social Services Programs administered by county government. The Community Social Services Act of 1979 combined many of the state MH/CD/SS programs and funds as of January 1980. Included are the state chemical dependency, community mental health, detoxification, mental retardation and day care program funds, plus the Federal Title XX Social Services funds. These combined funds are now allocated to the county boards of commissioners for mental health, chemical dependency, mental retardation, and other social services programs. County boards can elect either to provide the services directly, or to contract for them, or to reimburse providers for these services.

2. The Pyramid of Liability

Third party payment programs may be viewed as a pyramid which consists of various layers of protective programs (see Chart I). When one layer of programs fails to protect or pay because the benefit levels have been exhausted or do not cover the particular services needed, the next lower level of the pyramid may then assume primary liability for providing the service. For example, if private insurance benefits are exhausted, then family resources are used. Beyond that, CHEPP may be of help. If these resources fail, then Community Social Services may take over to provide payments or services, followed by Medical Assistance, and so on.

3. Some Reasons for Variations

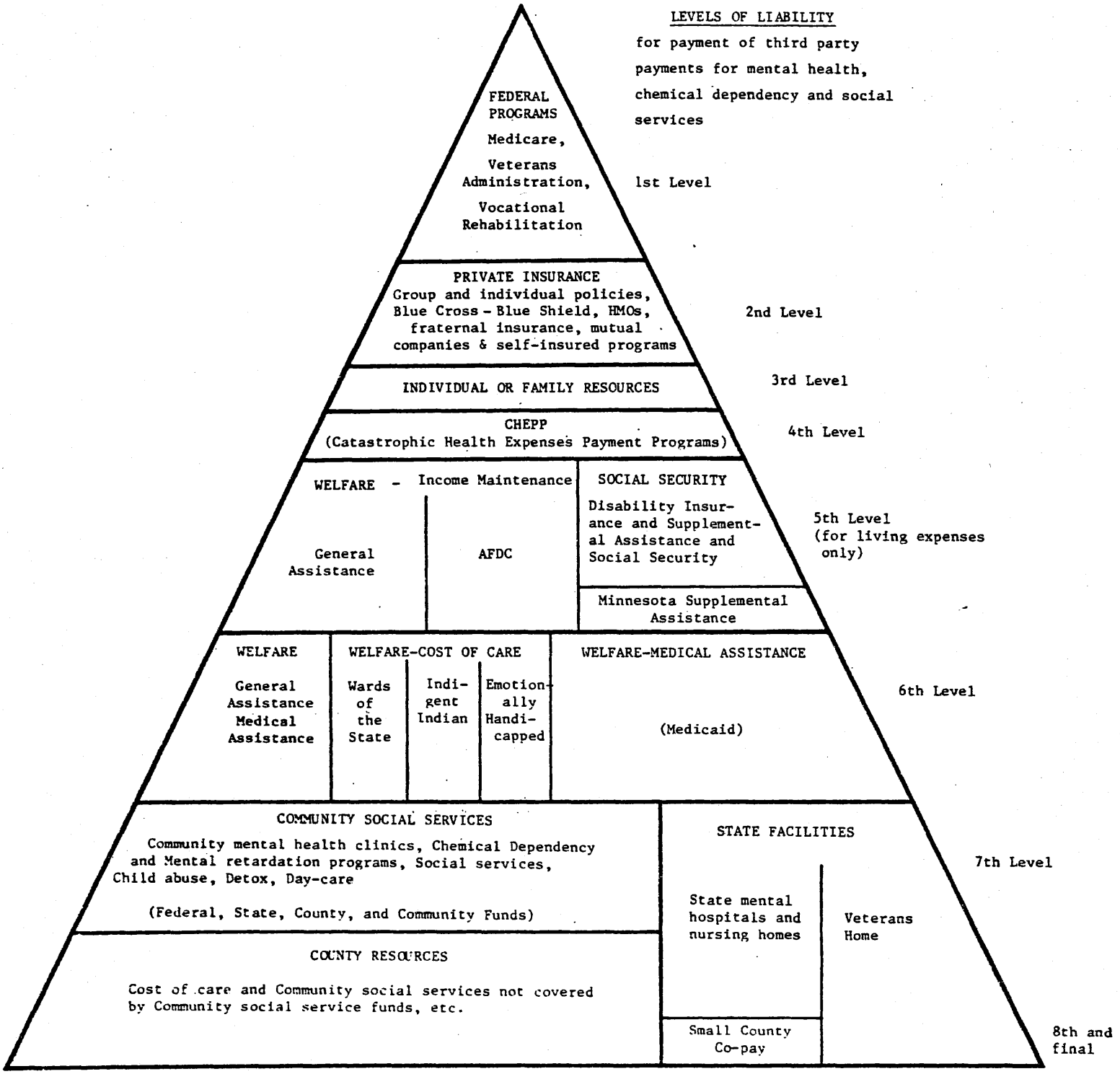
Variations in policies result from the demands of the market place, collective bargaining, legislative actions, responses to particular needs and desires and other factors. Minnesota Statute 62 A requires that individual and group policies establish a minimum amount of treatment for chemical dependency. The state also requires that if an insurance policy provides for inpatient care for mental illness, it must also provide outpatient care for mental illness. Beyond these minimum levels of care required by law, individual policies vary greatly as to the number of days or visits, deductables, copayments, limits and eligible providers.

Each of the private plans for protection against health care costs has been developed separately, in response to the needs and desires of purchasers. And each of the governmental programs has been developed separately to meet particular needs and to respond to the interests of particular groups.

Sometimes governmental programs and statutes are developed to change the financial burdens of care between different third party payers and various levels of government. Requiring third party payers to include mental health and chemical dependency treatments in their benefits not only increases the amount of treatment in community facilities but also may have the effect of

CHART 1

THE PYRAMID OF FINANCIAL LIABILITY FOR THIRD PARTY PAYMENTS
FOR MENTAL HEALTH AND SOCIAL SERVICES IN MINNESOTA



reducing the amount of care provided by the state hospitals.

4. The Impact of Medicare and Medical Assistance

The development of Medicare and Medical Assistance (or Medicaid) in the 1960s led to major changes in third party payments for mental health and social services. Initially, Medicare and Medical Assistance did not provide reimbursement to state hospitals but did provide reimbursement for nursing home and general hospital care. As a result, many patients were sent or transferred to nursing homes and general hospitals. Older people, even those with a primary mental illness diagnosis, were sent to nursing homes both because Medicare, Medical Assistance and other third party payers would reimburse that care and because less stigma is attached to nursing home care.

Even though these third party payers now reimburse state hospitals for treatment (but not for continuing maintenance), many patients have been "de-institutionalized" to nursing homes and many other mentally ill persons are now being treated in nursing homes and hospitals. According to Minnesota Department of Welfare's 1979 Residential Care Study, more mentally ill patients (some 12,900 persons) are now being cared for in nursing homes than in any other type of facility. This group of people with a primary diagnosis of mental illness constitutes about 20% of the total nursing home population in the state (see Section V.B.).

Relatively few mental health professionals work in nursing homes. Training and special mental health treatment in nursing homes has not kept pace with the increasing percentage of the patients with this diagnosis. Many nursing staff members and physicians serving nursing homes have limited training in this area.

Because of their size, Medicare and Medical Assistance programs have had an impact on the policies of private insurance companies and other third party payers. They have, over time, tended to set the general standards of what is reimbursable. Other third

party payers closely monitor Medicare and Medical Assistance policy making.

B. Problems in Generalizing About Third Party Payment Systems and Practices

Public and private third party payers of health and social services have not tended to think of themselves as a separate group. Instead, they have seen themselves as private providers of health insurance or public or private providers of a program or services in each of the areas. Different levels of government have responded to demands for services over time by creating different programs.

Last year a major step was taken toward coordinated planning. The state Legislature through the Community Social Services Act, made county boards of commissioners responsible for planning, operating, contracting and evaluating all community mental health, chemical dependency, and social services. What with the possibility of 87 different county Community Social Service plans and the existence of different state regulations for different facilities, the number of variations in programs and services that will or will not be paid for is now even greater.

The private sector has diversified in the types, kinds and numbers of third party payers and policies it offers. Competition has stimulated differences as third party payers have attempted to meet the interests and demands of the market, including the specific demands of employers and of collective bargaining agreements. State insurance law and regulations have placed minimum standards on many insurance policies, but programs such as HMOs and self-insurance programs do not fall within the jurisdiction of insurance regulation.

The result is a wide range of practices and policies governing what third party payers pay for and a great deal of confusion about the types of professionals or credentials needed to obtain third party payments. The patterns of practice regarding payment of occupational groups are not easily recognizable nor are they clear cut. Generalizations, therefore, almost always require qualifications and statements of exceptions. This seems duplicative and confusing, but it is necessary in order to show how third party payments systems work.

It is difficult to generalize because of the confusion in processing claims from different types of facilities. In general, most third party payers indicate that it is relatively easier to handle claims from hospitals, nursing homes and physicians because procedures are already established for doing so. They experience some difficulty with processing claims from the newer chemical dependency licensed facilities. Because of exceptions and unclear policies, many more problems are experienced in dealing with psychiatric clinics, outpatient mental health and chemical dependency programs, and other programs involving some of the newer mental health occupations.

C. How Third Party Payers Organize and Divide Services and the Types of Services they Cover

1. The Focus of Private and Public Third Party Payment Programs

Private insurance programs generally try to provide for mental health and chemical dependency by reimbursing for intensive primary psychiatric treatment, chemical dependency treatment programs, and admissions and discharge social services at hospitals and nursing homes. Governmental programs, United Way agencies, and other private efforts provide other social services and educational programs. Governmental programs also provide financial and program assistance to the poor, the handicapped and special groups. Long term maintenance and custodial care tends to be the responsibility of Medical Assistance, state mental hospitals or nursing homes, or other public programs.

2. Third Party Payments and Social Services

Payment for many of the social services programs, as well as many of the mental health programs and centers, is now coming from the combined funding created by the Community Social Services Act. This includes Title XX Social Services funds and state mental health and chemical dependency funds. The Cost-Of-Care Programs for child welfare also provide significant funding for social services.

3. Types of Professional Services Covered by Third Party Payments

Third party payers separate claims for "mental health" treatment from claims for "chemical dependency" treatment. In most cases, this is required by law.

Taken as a whole, third party payers for mental health and chemical dependency treatments and social services pay for an extremely broad range of services provided by a broad range of professionals.

D. Standards and Policies Used by Third Party Payers to Direct and Control Payments to Providers

1. The Role of the "Doctor" in third party payments

Many of the third party payment systems for MH/CD/SS are health care or health insurance systems. These systems are built upon the "medical" or "hospital" model. The "medical model" or "hospital model" are terms used to describe a form of organization in which a "medical doctor" or his/her designee is responsible for all decisions related to admissions, diagnosis, treatment and evaluation of the health care of the patient.

In the areas of mental health and chemical dependency treatment, most third party payers treat licensed consulting psychologists (most of whom are Ph.D.'s) in the same way as they do physicians. Third party payers rely on physicians and licensed consulting psychologists to provide leadership and quality assurance for other professional staff including social workers, nurses and chemical dependency counselors. In the mental health field, the term "doctor" has expanded so that reimbursement can be made for licensed consulting psychologists for a number of tasks formerly allotted to physicians.

2. Responsibility of the "Doctor" for Quality Control in Licensed Facilities

Public and private third party payers rely heavily upon licensure as a measure of quality. In turn, these payers and the facility licensing programs rely heavily upon "doctors" to provide leader-

ship and quality control. In mental health, where the "doctor" is the physician or licensed consulting psychologist, third party payers rely on the "doctor" to approve admissions, to prepare diagnoses, treatment plans and evaluations and to insure appropriate usage of the services of a facility.

Some insurance policies pay only for the direct mental health treatment services of the physician. Most third party payers treat chemical dependency, psychiatric, and detoxification units in hospitals in the same manner as other hospital units or wards for purposes of third party payments. Again, they rely on medical supervision for hospital cost and quality control programs.

3. Third Party Payers and Chemical Dependency and Mental Health Coverage in Facilities

Mental health care has usually been covered when the service is provided by: 1) a state mental hospital, 2) a psychiatric unit in a general hospital, and/or 3) licensed physicians or consulting psychologists and their staffs. Significant differences are found among third party payers for coverage in non-profit or private mental health or psychiatric clinics.

Chemical dependency treatment is usually "covered" by third party payer policies when services are provided: (1) in licensed primary care inpatient and outpatient treatment centers; (2) in chemical dependency units in general hospitals; (3) in state mental hospitals; and (4) by individual psychiatrists, other physicians or licensed consulting psychologists. Third party payers are required by law to handle claims from all licensed, free standing, primary treatment facilities for chemical dependency in the same manner as they do hospital claims for treatment. If these primary treatment centers are free standing (not hospital affiliated) the third party payers again rely upon the physician or licensed consulting psychologist for quality control through diagnosis, treatment plan and evaluation. Private and public third party payers express concern about the length of treatment for chemical dependency. Many of the major

programs have limited the lengths of stay they will reimburse in hospital or treatment facilities. A number of the third party payers are not opposed to paying the free standing facilities because their average daily cost is about half that of the average hospital chemical dependency facility.[1] Mental health, chemical dependency, and social and behavioral problems among children are often treated in group residential facilities. Charges for these services are usually paid by the county which is then reimbursed by a variety of third party payers.

4. Third Party Payment for Outpatient, Ambulatory or Clinic Care

The third party payers differ greatly on payment of ambulatory care, except that they always pay the medical doctor, and they usually pay the licensed consulting psychologist.

Most third party payers seriously review diagnosis and treatment in mental health and chemical dependency claims. Over time, facilities and practitioners in independent practice develop a reputation for credibility that helps or hurts the acceptance of their claims for payment.

Sometimes third party payers will accept billings from physicians or licensed consulting psychologists for services provided by social workers, psychiatric nurses or chemical dependency counselors working under their supervision. Then again, sometimes payers will not accept these billings. The policies are not universal. Many differences are observed in the policies regarding payment of other professional staff. Often special documentation is required. As a result of these complexities, most clinics require a staff person to check each case with poten-

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[1]The Cost of Resident Care, 1979, Minnesota Department of Public Welfare

tial third party payers before treatment is actually begun.

Providers indicate that diagnosis may be altered to better fit third party payment reimbursement categories. According to many service providers, the selection of therapists for patients in private or non-profit clinics is too often made on the basis of what occupational credentials the therapist has rather than on the basis of which therapist on their staff is best able or fitted to work with the client.

The problems arising from the lack of facility licensing for psychiatric clinics are troublesome for the clinics and for some occupational groups. This appears to be one of the factors encouraging these groups to seek occupational licensing.

E. Third Party Payers: Standards and Policies that Affect Occupational Groups

1. Physicians and Licensed Consulting Psychologists

Third party payers generally treat licensed physicians and licensed consulting psychologists as comparable under the medical model. Both are perceived by third party payers as being competent to admit, diagnose, use correct medical terminology, prepare a treatment plan, treat and evaluate a patient. While claims departments may react more favorably to a mental health claim coming from a psychiatrist, they will accept any licensed physician's signature, regardless of specialty, if the diagnosis and treatment plans seem appropriate. Most third party payers also accept "licensed consulting psychologists" regardless of their specialty if the diagnoses and treatment plans seem appropriate.

Most third party payers allow licensed consulting psychologists to file claims for work performed or supervised in private practice, in clinics, hospitals, CD and MI facilities and as consultants in the same way physicians do, except that they do not prescribe medications or perform psycho-surgery (not a common proceedure).

Third party payers give several reasons for this practice:
(1) state policies provide for licensed consulting psychologists to perform some of the functions of physicians (admitting,

diagnoses, etc.) in many state facilities, programs and state licensed facilities;

(2) licensed consulting psychologists (except those "grandfathered") hold earned doctorates;

(3) licensed consulting psychologists have passed the higher of the two levels of licensing examinations; and

(4) licensed consulting psychologists who are practicing in clinical settings have the competencies to prepare acceptable written diagnosis, treatment plans, and evaluations for third party payers.

Third party payers count heavily upon these diagnoses, treatment plans and evaluations to help them determine the differences among: active treatment, which is covered; custodial care, which is not covered; and care with little effective treatment, which may or may not be covered.

The major third party payers give "enrolled providers" such as licensed facilities, physicians, and consulting psychologists their own provider numbers to place on claims to speed payment. A provider number automatically indicates in the third party payment system that the provider has met the standards as a qualified provider of services.

2. Other Occupational Groups

Most third party payers treat all other providers of mental health and social services as "non-enrolled" and pay for their services as a part of the claims of enrolled (or qualified) providers, i.e., licensed facilities, physicians and consulting psychologists. To get reimbursement, these "non-enrolled" professionals (social workers, RNs, CD Counselors, etc.) must be under the direction or supervision (or work at the direction) of a licensed physician or consulting psychologist in a licensed facility or in private practice. (See table 1.)

Under Medical Assistance the maximum reimbursement rate for these unenrolled professionals is about half that of enrolled providers (a maximum of $22.50 compared with $45.00). Similarly the usual

TABLE 1

OCCUPATIONS
PAID BY THIRD PARTY PAYERS

OCCUPATIONAL GROUPS	As Individual Provider	Supervised by Licensed Provider	As part of Licensed Agency	As part of Licensed Hospital or Nursing Home
Psychiatrists, M.D. (Lic.)	A	A	A	A
Physicians, M.D. (Lic.)	A	A	A	A
Psychologists (Lic.) Consulting	M	M	M	A
Psychologists (Lic.) Other	No	S	M	A
Psychologists,(Not Lic.)	No	No	S	A
Social Workers, MSW	S	S	S	A
Social Workers	No	No	S	S
Registered Nurses, Psychiatric	No	S	S	A
Registered Nurses	No	S	S	A
Psychiatric Technicians	No	No	No	A
Chemical Dependency Counselors	No	No	M	A
Pastoral Counselors	No	No	S	A
Ministers and Chaplains	No	No	M	M
Detox Technicians	No	No	S	A
Psychotherapists	No	S	M	A
Social Gerontologists (Adult Day Care)	No	No	S	S
Educational Psychologists	No	No	M	-
School Guidance Counselors	No	No	-	-
Vocational Guidance and Employment Counselors	No	No	S	S
Rehabilitation Counselors	No	No	S	S
Occupational Therapists	No	S	S	A
Physical Therapists	No	S	S	A
Recreation Therapists	No	No	S	A
Art Therapists	No	No	No	A
Music Therapists	No	No	No	A
Human Service Generalists	No	S	S	S
Marriage & Family Counselors	No	No	S	A
Licensed Practical Nurses	No	S	M	A
Group Home Workers or Parents	M	No	S	-
Foster Home Parents	M	-	-	-
Acupuncturists	No	No	No	S
Other Healers	No	No	No	A

Key:

A - Nearly always M - Most of the time S - Sometimes No - No evidence of payment found

and customary rate for these other professionals is about half or less than half of licensed physicians or consulting psychologists. However, the rates for MSW social workers, psychiatric nurses, chemical dependency counselors, licensed psychologists, pastoral counselors and other mental health workers vary greatly.

There are several exceptions to these general rules:

(1) Medical Assistance treats "licensed psychologists" the same as "licensed consulting psychologists," extending them the same rates, authorities and enrollment privileges for Medicaid reimbursement.

(2) Control Data's master insurance policy with Equitable and Lincoln National Life policies both provide that a social worker with a master degree can be paid for independent practice.

(3) For purposes of reimbursement social workers are treated as professionals "qualified" to make assessments, diagnoses and treatment plans in primary treatment child care facilities (which are licensed under DPW Rule 5) and in all of the cost of care programs. The licensed physician or consulting psychologist is used in the Rule 5 facilities programs to periodically re-evaluate each child.

Most third party payers volunteered that they would not be interested in providing third party reimbursement for MSW social workers, psychiatric nurses or chemical dependency counselors for independent practice even if they were "licensed." They did not want to give them the same authority for supervision, diagnosis and development of treatment plans as they do licensed physicians and consulting psychologists.

Some of the reasons given were: (a) increased costs, (b) insufficient training (MA vs. PhD), (c) not sufficiently skilled in making diagnosis, treatment plans or evaluation using medical insurance terminology, and (d) the possible impact upon the entire structure of the delivery system.

Third party payers are willing to pay for social worker, chemical dependency counselors and RN services when they are supervised by an MD or licensed consulting psychologist. It is apparent that both the payers and public want the services and feel that the services are valuable.

Third party payers have developed confidence in physicians and in licensed consulting psychologists for their ability to assure quality control in the area of mental health and chemical dependency through proper diagnosis, treatment, planning and evaluation. Third party payers indicate that they do not have the same levels of confidence in the skills and abilities of social workers, chemical dependency counselors, psychiatric nurses and other mental health professionals to adequately develop diagnoses, treatment plans and evaluations, and to provide the controls they want in independent practice.

III. A DESCRIPTION OF MAJOR TYPES OF THIRD PARTY PAYERS FOR MENTAL HEALTH/CHEMICAL DEPENDENCY/SOCIAL SERVICES AND SOME OF THEIR POLICIES AND PATTERNS OF REIMBURSEMENT REGARDING DIFFERENT OCCUPATIONAL GROUPS

A. Medicare

Medicare is a major third party payer for hospital care but does not provide major reimbursement for mental health, chemical dependency or social services. Medicare has two carriers operating in Minnesota: Travelers Insurance Company which operates the program in the metro area and in southeastern Minneosta, and Blue Cross/Blue Shield which operates the program in the rest of the state. Medicare provides health insurance for persons on Social Security, which includes persons over age 65 and their survivors and the permanently physically disabled under 65.

Medicare reimburses for most mental health and chemical dependency treatments when they are provided by staff in a general hospital or a nursing home or by a physician or a licensed consulting psychologist. The services of other mental health or chemical dependency professionals are usually only covered when 1) the professionals are working in hospitals or nursing homes, 2) they are working under the direction of a physician or a licensed consulting psychologist, and 3) the services are billed as part of the facility's physician's or licensed consulting psychologist's services.

The Blue Cross/Blue Shield Medicare program reports that over the past year (7/1/78 to 6/30/79) mental illness constituted only 1.2% (or about 2,500 cases) of hospital admissions under Medicare. The major diagnostic groups included mental disorders (.3%), depression .3%), schizophrenia (.2%), psychosis (.3%), and neurosis (.1%). Most cases of mental illness among older people appear to be treated either at doctors' offices, nursing homes, state hospitals and social agencies rather than in general hospitals.

B. Medical Assistance

Medical Assistance or "medicaid" is probably the largest third party payer for mental health, chemical dependency and social services. Half of the nearly $1 billion Minnesota Public Welfare budget (for fiscal year 1980) is allocated for health care, and the biggest share of that is Medical Assistance. Welfare and medical assistance payment plans often set the standards for other third party payment systems or plans in Minnesota. Federal dollars, policies and guidelines largely help direct state policy, but there are major differences between states in benefits provided.

About a quarter of a billion dollars of Medical Assistance was paid for nursing home care in Minnesota in 1979. In fiscal year 1977, over 12,900 of the patients in nursing homes had a primary diagnosis of mental illness, according to the 1979 Department of Public Welfare Residential Care Study. Most mental health care in nursing homes is being provided by social workers and under the supervision of MDs. In addition, state mental hospitals receive a substantial amount of Medical Assistance payments for the treatment of mentally ill, chemically dependent and mentally retarded citizens. Medical Assistance also pays for mental health and chemical dependency treatments and social services for a significant number of group residential care patients, general hospital patients, and outpatients.

During 1977 the Department of Welfare recorded more than 4,800 mental health and chemical dependency admissions which accounted for 14.2% of their total hospital admissions. Chemical dependency admissions accounted for 4.6% and other mental health admissions accounted for 9.6%.[1]

In 1977, the last year for which Medical Assistance statistics[2] are available from DPW, Medical Assistance paid out

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[1] Minnesota Department of Health, Minn. Hospital Rate Review System's report "Top 47 Medical Diagnoses for Calendar 1977".

[2] Medical Assistance Division, Income Maintenance Bureau, Department of Public Welfare.

over $2.7 million for outpatient individual psychotherapy services. Half of this amount, $1.35 million, was claimed by social workers and other non-enrolled providers supervised by enrolled licensed providers in a wide variety of settings. An equal amount went to physicians, enrolled licensed consulting psychologists, and enrolled licensed psychologists. Medical Assistance reimbursement for outpatient service allows a maximum of $22.50 per hour for usual and customary charges of non-enrolled providers (social workers, psychiatric nurses, etc). This is half the rate for enrolled providers (licensed MDs and consulting psychologists). THE Amount paid for psychiatrists is considerably below what psychiatrists earn in other settings. In many facilities, Medical Assistance patients are regularly assigned to social workers rather than to the psychiatrists on staff, according to the directors of several clinics.

C. General Assistance Medical Assistance (GAMA)

The Public Welfare General Assistance programs spent nearly $500,000 in FY 1979 for ambulatory mental health and psychological services. Additional funds covered inpatient mental health, chemical dependency treatment and social services for persons on General Assistance. The GAMA policies for reimbursement follow Medical Assistance policies.

D. Community Social Services Act (CSSA)

The Minnesota Community Social Services Act of 1979 provides for a major restructuring of social services and mental health programs involving over $200 million in federal, state and local program funds. The major effect is to create a single, common county community services fund by shifting mental health, chemical dependency, detoxification, day care and mental retardation program funds from the state to the county and pooling these funds with Title XX Social Services funds and county social services funds. The new county programs will operate under a comprehensive community social service plan as of 1981.

County boards of commissioners (or a human service or welfare board) will develop the plan with community participation and operate, fund and/or reimburse for the services which are a part of the plan. Some services in some counties will be operated on a third party payment reimbursement for services basis.

The fund will be used to finance a broad range of social services including: mental health, chemical dependency, detox, mental retardation, child protection, child and adult protective services, counseling, halfway houses, family services, outreach and referral services, special transportation, neighborhood services, senior citizen programs, social services for welfare clients, treatment for emotionally handicapped children, and other special services. The fund will provide services for all ages and incomes but will emphasize services for low income individuals and families.

Mental health, chemical dependency outpatient, halfway house and detoxification programs operated by community mental health boards spent $34.7 million in FY 1979, about half of which was provided by the state. These funds are now going to the county boards who will fund mental health programs in their counties at the same level as in present community mental health boards or clinics.

The CSSA law will probably make many changes in what services are funded, the nature of some services, and the way services are reimbursed or paid for. The State hospital system, the Medical Assistance income maintenance programs, and most cost of care programs will not be directly changed by the new law. The county boards will decide on fund allocations, policy matters, program direction, program evaluation, and the policies regarding contracts and third party reimbursements. The state will retain responsibility for facility and program licensing, technical assistance, and evaluation of the overall planning.

E. Private Insurance Carriers

Insurance companies are regulated by the insurance commissioner of the Minnesota Department of Commerce. Chapter 62 A.149 of the Minnesota Statutes states that all group or individual insurance policies shall provide reimbursement for treatment of alcoholism, chemical dependency or drug addiction on the same basis as coverage for other treatment benefits when that treatment is rendered in a licensed hospital or a licensed (Rule 35) residential treatment program (upon the diagnosis or recommendation of a physician), or a licensed non-residential treatment program (Rule 43). Lists of the Rule 35 and 43 facilities are in the appendix.

Minnesota Statutes, Chapter 62A. 152 provides that all group policies shall provide coverage for at least 90% of the first $600 of the cost of the usual and customary charges in a year for mental or nervous disorder consultation, diagnosis and treatment on an outpatient basis. These must be furnished by a hospital, community mental health center or mental health clinic "approved or licensed" by the Commissioner of Public Welfare or by licensed consulting psychologists. The Department of Welfare does not license or approve mental health or psychiatric clinics.

Treatment for mental illness provided by hospitals, nursing homes, other licensed health care facilities and physicians is not specifically required in insurance law, but was provided by all of the insurance companies studied. With few exceptions, insurance companies require that all types of psychiatric clinics submit bills for treatment under the signature of individual licensed doctors or consulting psychologists rather than bills from the clinic or outpatient facility in general. In contrast, insurance companies will accept bills from a licensed chemical dependency outpatient facility (as a clinic or facility) although they want the doctor's or consulting psychologist's involvement. These bills usually do not come in under the doctor's provider number.

Policies vary greatly as to the benefits they offer and the types of providers they permit. The reimbursement actually provided by an insurance company can be more liberal than its written policy if, in the judgement of the claims department, it is in the best interest of

the patient and the insurance company. Reimbursement policy for group health insurance policies are generally more liberal than under individual policies.

Policies offered by the various companies differ greatly as to the types of professional treatment for which payment is allowed. Companies and policies will always pay for mental health and chemical dependency services of physicians and usually for anyone who is working directly under their supervision. Most private insurance companies appear to reimburse for licensed consulting psychologists in the same manner, although representatives of some companies say they do not pay licensed consulting psychologists for independent practice. Only two companies reimburse social workers (MSW) as independent practitioners (Control Data's Equitable master policy and Lincoln National Life).

Insurance companies vary as to what they mean by "working directly under the supervision of a doctor". Some require the person to be in the same room as the doctor while others require only a periodic review. Some require that the doctor see the patient, while others do not. Most want the doctor to prepare 1) the diagnosis, 2) treatment plan, and 3) periodic reviews or evaluations. The counseling, therapy, the assessment, or intake may be done by the social worker, psychiatric nurse or other mental health professional working under supervision.

Since the variations in requirements of insurance companies are so great, most clinics find that they must call the insurance companies after the patient's first visit to find out: 1) if the treatments can be covered, and 2) what qualifications, licensure or certification are required to qualify for reimbursement. The most common policy is for the insurance company to pay for services provided by psychiatrists, other physicians, consulting psychologists, and other mental health professionals who work under their supervision (including social workers, licensed psychologists, psychiatric nurses, and chemical dependency counselors). The diagnosis, treatment plan and evaluation and signature for the bill must be done by the doctor or consulting psychologist.

F. Blue Cross/Blue Shield

Blue Cross/Blue Shield of Minnesota (BC/BSM) with over 1 million subscribers is the largest private third party payment system. BC/BSM is a nonprofit health service organization regulated under Mn. Statute 62C, it is the Federal Medicare carrier for part of; the state, it has an HMO, and it offers a wide range of policies; to groups and individuals.

As a group insurance, BC/BSM offers mental health, chemical dependency, and social services through licensed and approved health care facilities, such as hospitals, Rule 35 and 43 CD facilities, Rule 28 mental health programs, and nursing homes. Reimbursement is made for physicians and licensed consulting psychologists, and a number of other mental health professionals, including nurses, social workers, psychiatric technicians, OTs, RTs, chaplains, and others as long as they are part of an approved and acceptable treatment plan.[1]

BC/BSM standard business policies provided 10,277 hospital reimbursement cases for mental illness and chemical dependency in 1978 or about 7.6% of their hospitalizations. One third of this amount [2] was for chemical dependency.

As provided under Chapter 62A.149, BC/BSM pays for up to 73 days of residential chemical dependency treatment in Rule 35 facilities or hospitals, and for outpatient treatment up to 130 hours under "basic" benefits, plus additional coverage under Major Medical. Ambulatory mental health treatment coverage includes 90% of the first $600 at outpatient hospital clinics and at DPW Rule 28 mental health centers, or by a physician or licensed consulting psychologist (Chapter 62A.152). Treatment by all mental health care professionals in Rule 28 mental health centers or clinics is covered, but only physicians or licensed consulting psychologists are eligible for reimbursement in other types of settings according to BC/BSM.

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[1] Letters from Margo Dickenson Research Analyst, Blue Cross/Blue Shield of Mn. 2/27/80 (see appendix).

[2] Report to the Health Department Hospital Rate Review Section by Mickal Steinmetz, Health Economics, Provider Relations, BC/BSM 10/17/78.

BC/BSM states correct billing for mental health treatment must include the name and/or specialty of the professional actually present with the patient during treatment. Mental health facilities and professionals providing this care report many differences, interpretations, and problems in this area.

BC/BSM does not recognize "extra territorial jurisdiction" of state legislatures to write laws governing insurance policies written out of state for residents of that state. BC/BSM would not recognize social workers as eligible providers, even if they were licensed.

G. Fraternal Insurance

Fraternal companies are licensed to sell insurance under the supervision of the Minnesota State Insurance Commissioner. These are insurance companies which have been developed by membership groups, church-related groups, fraternal orders or other organizations. They usually start with life insurance policies and then expand to other types of insurance. The Lutheran Brotherhood is the largest of these fraternal companies in Minnesota.

A number of these companies have health insurance policies, most of which are designed primarily to insure the person for a set amount of money for each day in the hospital. Others have more extensive benefits. The policies usually will pay a fixed amount for a limited number of days in general or mental hospitals. These insurance plans are governed by Chapter 63 which has fewer mandatory requirements regarding mental health than does Chapter 62A which regulates other commerical health insurance policies.

H. Self Insured Companies

A number of companies, such as General Mills, feel that they make better use of the funds they spend on health insurance for their employees if they self-insure their employees rather than using a private carrier or Blue Cross. General Mills, for example, spends more on health benefits for employees than they spend on wheat. Many of these companies use a benefits administrative company to handle claims management and to authorize payments by the company directly to service providers. In general, it appears that these plans offer basically the same benefits as most general private carriers with group health insurance including mental health and chemical dependency coverage.

There is a dispute as to whether the Federal ERRISA Law provisions regarding fringe benefits puts the self-insured company plans under the jurisdiction of state insurance law. The plans covered in this study had as good or better mental health and chemical dependency provisions than that law requires. Others may or may not be as extensive.

I. Health Maintenance Organizations (HMOs)

In 1980, ten health maintenance organizations, covering over a quarter of a million persons, were operating in Minnesota with the approval by the state Department of Health. Some HMOs, such as the Group Health Association of the Twin Cities, provide mental health services directly. The Nicollet-Eitel HMO (Minneapolis) provides the services through a mental health clinic which is affiliated with Nicollet-Eitel Hospital. Physician Health Plan (Minneapolis) and SHARE (St. Paul) contract with the Metropolitan Psychiatric Clinic for outpatient psychiatric services and evaluations. The clinic provides services and also acts as a screen to authorize services by other providers.

Several HMOs are working to expand and improve their mental health services because they feel these services are weak. The HMOs now report using psychiatrists, licensed consulting psychologists, social workers, psychiatric nurses and chemical dependency

counselors. All HMOs contacted indicated that they provide mental health and chemical dependency services at hospitals and at licensed primary care treatment facilities with the HMO's prior approval.

HMOs seemed to emphasize inpatient mental health and chemical dependency treatment, and the amount of care offered varied greatly among HMOs.

In 1978, HMOs in Minnesota reported that 17% of all HMO hospital care days were for mental health and chemical dependency while only about 4% of the outpatient contacts were for mental health and chemical dependency. The percentage of hospital days devoted to mental health and chemical dependency treatment varied from seven to 26% among the different HMOs (See Table 2).

These figures represented only .17 outpatient mental health and chemical dependency contacts per 1000 enrollees per year. The outpatient contacts for mental health and chemical dependency ranged from 3% to 10% of all patient contacts for health care. Group Health Association figures for outpatient services in the metropolitan area were not available, but Group Health indicated that their situation probably was the same as that of the other HMOs and that they were in the process of trying to improve the situation.

J. Champus

Champus is a U.S. Defense Department program which provides medical care for dependents of persons in military service. Champus pays for the services of physicians and licensed consulting psychologists but does not pay for social workers or psychiatric nurses unless they are a part of the doctor's bill.

The program pays for residential care for mental health and chemical dependency in accredited hospitals and in licensed inpatient facilities providing primary treatment.

TABLE 2

PERCENT OF ALL OUTPATIENT CONTACTS AND HOSPITALIZATIONS WHICH WERE FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY TREATMENT IN HMOs IN MINNESOTA IN 1978

Health Maintenance Organizations	% of all outpatient contacts which were for mental health or C.D. treatment	% of all hospital days which were for mental health or C.D. treatment
Medical Center (St. Louis Park)	4%	6%
Physical Health Plan (Minneapolis)	4%	14%
S.H.A.R.E. (St. Paul)	5%	11%
H.M.O., MN (Twin Cities)	N.A.	26%
H.M.O., MN, (NE MN)	N.A.	7%
Group Health (N.E. MN)	3%	7%
Group Health (Twin Cities)	3%	25%
Nicollet Eitel (Mpls)	10%	23%
Ramsey Health Plan (St. Paul)	3%	1.7%
County Health Center (Two Harbors)	4%	15%
Sub Totals		
Twin Cities	3%	23%
N.E. Minnesota	4%	9%
TOTALS Minnesota	4%	17%

Source: HMOs Statistical Report 1978
HMO Section
Health Systems Division
MN Dept. of Health

K. Veterans Administration (V.A.)

The Veterans Administration provides a small amount of third party reimbursements for mental health, chemical dependency, and social services. The Veterans Administration contracts for nursing home care and for some other types of medical care when the individual is located too far from Veterans Administration facilities. The largest share of V.A.'s contracted services goes to nursing home care. However, good V.A. nursing homes are available in Minnesota, so most of the veterans who need long term care and who have behavior problems are housed in Veterans Administration facilities or Minnesota Veterans Homes. When veterans are placed in nursing homes, Veterans Administration social workers provide social services and supervision. "The V.A. hospital provides most MH/CD services."

The Veterans Administration will pay for a limited amount of services from physicians which may include mental health and chemical dependency treatments. The V.A. does not pay for consulting psychologists, social workers or other personnel unless their services are provided as an integral part of the physician's treatment program, are supervised by a physician, and are billed as a part of the physician's bill.

L. Third Party Reimbursement for the Care and Treatment of Emotionally Handicapped Children

The Department of Welfare under State Statute (62A. 151) provides for reimbursement to county welfare boards for the "cost of care" of emotionally handicapped children. Recipients are children who are placed out of the home in: (a) group residential facility (Rule 5), (b) a group home (Rule 8), or (c) a foster home. Chapter 62A.151 provides that all group insurance policies or plans shall include payment of benefits for the treatment of emotionally handicapped children in residential treatment facilities licensed by the Department of Public Welfare on the same basis as they pay for inpatient hospital care.

In FY 1978, total federal, state, county, insurance, and family expenditures for residential treatment for emotionally disturbed children under this program totaled over $14.3 million. In addition, there were other "Cost Of Care" programs totaling over $21 million that covered out-of-the-home care and treatment of children (some of whom were emotionally handicapped or in need of mental health or chemical dependency treatment). (See Table 3) While the grand total exceeds $35 million, it is estimated that between $20 million and $25 million in Cost-Of-Care program funds involve mental health or chemical dependency problems.

The proportion of the cost borne by the counties has been increasing dramatically (see Chart 2) but, in 1979, the legislature took several steps to help relieve the counties from this increasing financial burden. In FY 1978, the counties paid two thirds of the Cost-Of-Care for emotionally handicapped children, while the federal government paid 21%, the state paid 7% and private insurance or the families paid 5% (see Chart 3). The family may either subrogate the child's insurance to the county or pay the facility and bill the insurance company themselves. Children are referred to Rule 5 or Rule 8 facilities by the welfare department, the courts, law enforcement officers, the family, social agencies, or even by the teenagers themselves.

Some of the Rule 5 facilities include Arlington House, Gerard Schools, St. Cloud Childrens Home, Lakeview School, MN. Sheriff's Ranch, Booth-Brown, Bar-None Ranch, St. Joseph's Home for Children and Woodland Hills. Rule 8 facilities include Park Avenue Group Home, Welcome Community Home, St. Paul Group Homes, the Aitkin Courage House, and the Morrison County Adolescent Group Home. (See appendix for a summary of Rules 5 and 8 and complete listings of the facilities licensed under these rules).

The Cost-Of-Care in Rule 5 facilities is usually quite high ($40 to $60 a day for many months). Families may pay the bill directly or subrogate their insurance rights to the county and have the county collect from the insurance company. Most families exhaust insurance

TABLE 3

THIRD PARTY REIMBURSEMENTS FOR RESIDENTIAL CHILD CARE IN MINNESOTA-1978*

The cost of residential care for Minnesota children placed out of the home by County Welfare Departments. (Note: Rules 5 and 8, facilities and foster care are nearly always reimbursed on a third party payment basis.)

PROGRAM CATEGORIES	Total Costs	Federal Share (Title XX or AFDC)	State Share	County Share	Family & Private Ins. Share
Emotional Handicapped Welfare Placements					
Emotionally Handicapped Children Placed in Rule 5 & 8 Facilities Charged to Welfare Accounts 5135 & 5136	$ 8,895,844	-	11.4%	87.5%	7.9%
Emotionally Handicapped Children Placed in Rule 5 & 8 Facilities Charged to Title XX, Social Services	5,465,085	54%	-	46%	-
Sub Total for Emotionally Handicapped Children	14,360,929	20.6%	7.1%	67.4%	4.9%
Other Child Welfare Placements Made (1)					
Wards of the State	2,336.620	0	34.1%	66.8%	.1%
Wards of the County	10,332,491	0	0	100%	0
Juvenile Offenders under Title XX Social Services	1,074,505	54%	0	46%	0
Indian Program (Indigent Indian 5165 & 5166) (2)	1,503,223	0	56.7%	43.3%	0
Foster Care (AFDC)	5,842,595	56% (3)	26% (3)	20%	0
Sub Total for Other Child Placements	21,009,434				
GRAND TOTAL	$35,450,363				

(1) Children are placed in Rule 5 or 8 facilities or foster care for a variety of reasons but one of the most common is because of mental illness or chemical dependency problems of the child or family. These figures do not include state hospital placements or correction institutions.

(2) Includes some adults

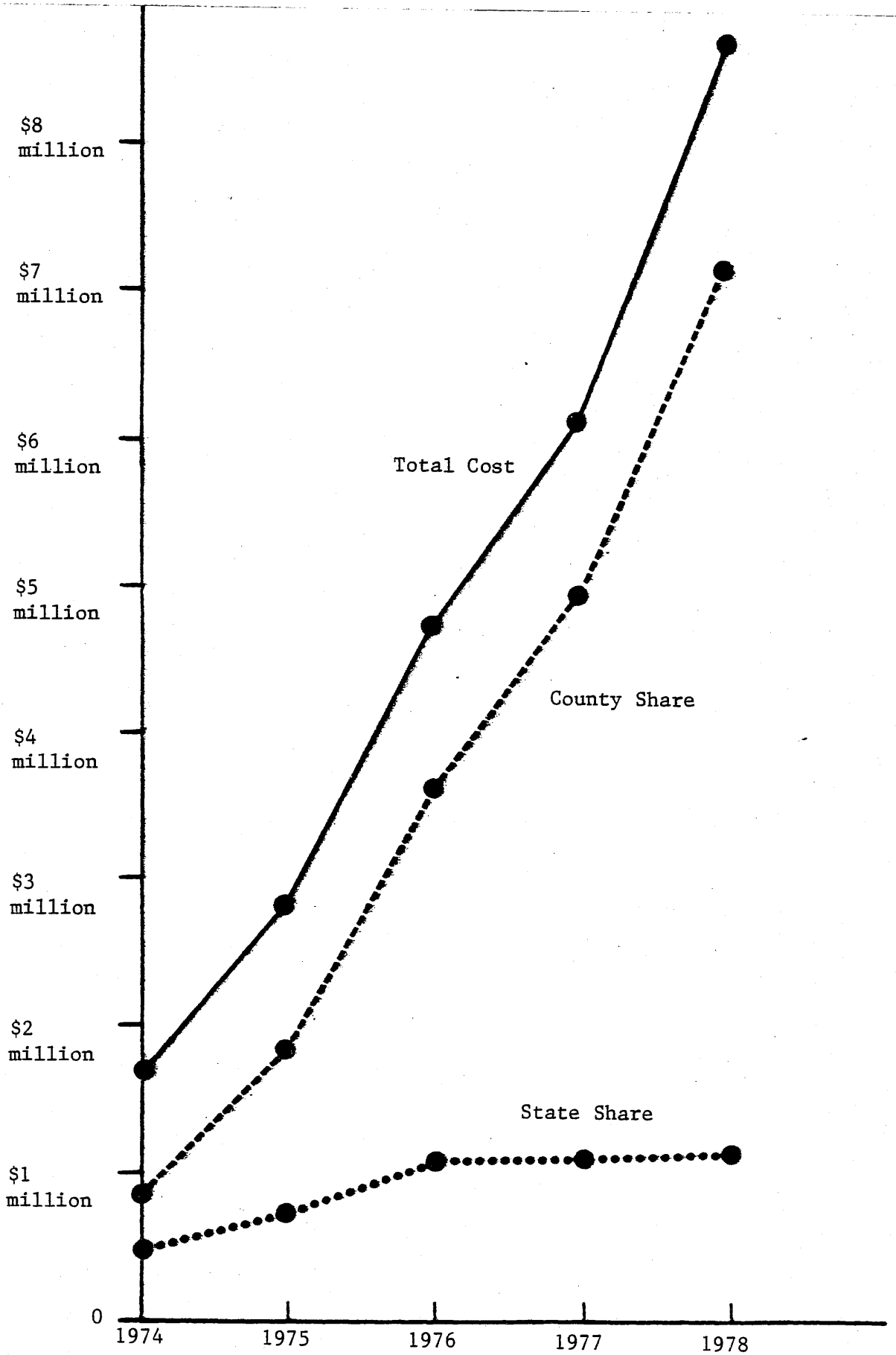
(3) Estimates as the rates changed during the year

*Source: Minn. Children,, The Cost of Care Out Of The Home, prepared by the Minn. Social Services Assn. 1979

CHART 2

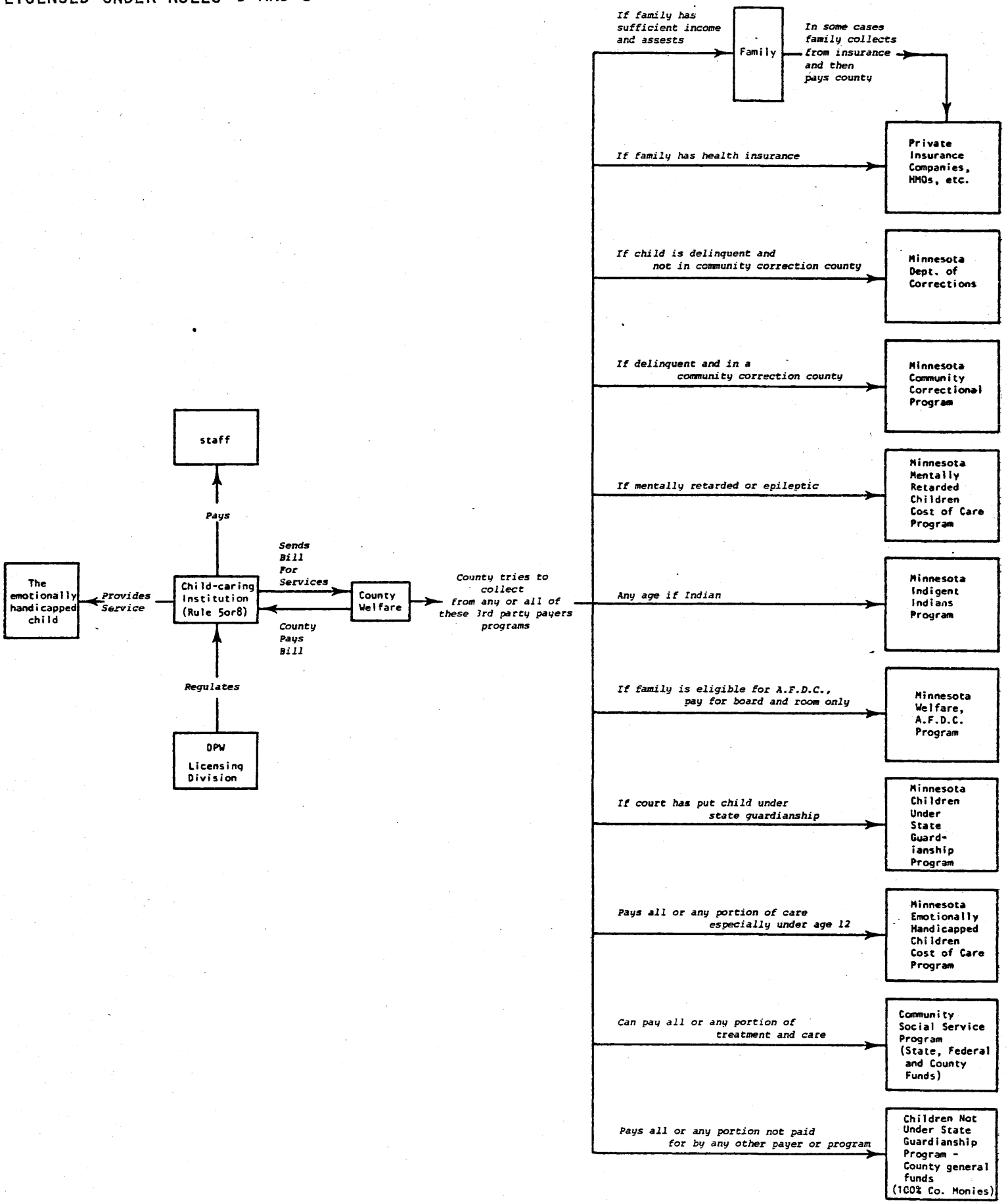
REIMBURSEMENT FOR COST OF CARE OF EMOTIONALLY HANDICAPPED CHILDREN PLACED OUT OF THE HOME

DPW ACCOUNT NUMBERS 5135, 5136



Source: Mn. Social Services Assn., "Minnesota's Children: A Growing Concern, A Study of the Cost of Care of Children in out of the Home Placement."

THIRD PARTY PAYMENT SYSTEM FOR EMOTIONALLY HANDICAPPED CHILDREN BEING TREATED IN A CHILD-CARING FACILITY LICENSED UNDER RULES 5 AND 8



benefits or have no insurance. Many children go through county welfare departments and/or the courts, in which case welfare guarantees payment when family resource and insurance benefits have been exahusted. This happens quite frequently.

The evaluation is usually done by a social worker at the social services unit in the county welfare department; however, it may also be done by the courts, a psychiatrist, a physician, a licensed consulting psychologist or a mental health clinic.

The county government acts as the payee and tries to collect from other third party payers. There are at least ten different types of third party payers from whom the county can try to collect funds to cover all or part of the costs, but unpaid portions will be paid by the county. Because many of these funds are fixed state appropriations and counties draw upon them for other projects and services, the percentage of matching funds provided by the state and the amount of dollars actually available vary and are uncertain. Qualification requirements for some of the programs are complex. Changes in the percent match and uncertainty about amounts of money still remaining in various funds make this what county welfare directors call "the great shell game" of welfare, a game which can have great financial significance for the county.

The following is a description of the third party payment systems which may be tapped by the county to help pay for Cost-Of-Care treatment for children:

1. If the child has private insurance which has been subrogated to the county and the child is placed in a Rule 5 facility, the county can bill the insurance company for the amount provided by the family insurance policy covering the child.
2. The county can bill the parents for the portion not covered by private insurance, on a sliding fee schedule. This may involve child support payments.
3. If the family is eligible for AFDC the county can bill AFDC for the Cost-Of-Care but not for treatment of the child. This

is often done in foster home placements. It will mean that the county will be picking up only a very small portion of the cost of care (20% in 1981).

4. The county may elect to pay for the treatment and the board and room for the cost of care and treatment under the Community Social Services Program. Community Social Services Act funds (which include all Title XX, mental health, CD and child care funds) will pay for any or all of the costs of care and treatment for handicapped children. Some counties may be able to charge these payments against the minimum amounts required by law for mental health care. As an average across the state, the CSSA fund in 1980 will be composed of roughly 20% state funds, 25% federal funds, and 55% county funds. The exact amount in each county is determined by complex formulas and by levels of county expenditures. Whether a county will elect to use CSSA funds will depend on that county's particular situation.

5. The county may forward the remaining unpaid portions of cost of care for emotionally handicapped children to DPW for reimbursement under the "Cost-Of-Care Programs or accounts 5135 and 5136.

   In 1978 the state paid 70% of the cost for children under age 12 who were in voluntary child care facilities licensed under Rule 5, and 1.96% for children age 12 through 17 in Rule 5 licensed facilities. The state did not pay for services in Rule 5 Group Homes in 1978. In 1979 the legislature increased this fund, allowing the counties an opportunity to choose more of these types of care to this account.

6. If the child is also a juvenile offender in a non-community corrections county, the county can bill the commissioner of corrections for 50% of the eligible county expenditures. The county may also be reimbursed under Title XX, usually for the treatment portion.

7. If the county is under the Community Corrections Act and the child is a delinquent, the county can bill the Community Corrections Fund for the remaining portion of the bill if there are any state funds left for the county.

8. If the child is under state guardianship and is in a DPW licensed home or facility, a county can bill the state for 50% of the cost. Recoveries can be deducted from the county share.

9. If the child (or the adult) is an "indigent Indian" and is emotionally handicapped, a county can bill the indigent Indian account and receive up to 56.7% in FY 1978 from the state.

10. If the child is also retarded or epileptic and in a licensed facility, the counties could bill the state for 60% of the costs in 1978.

11. If the county cannot find any category to match state or federal funds for the emotionally handicapped child, the bill can simply be placed in the general account 5135 (children not under state guardianship) where the county pays 100% and does not have to do any further paper work. If the child is emotionally handicapped enough to be mentally ill, then the child can be placed in a state mental hospital where the county pays $10 a month.

M. Mental Retardation Programs

Mentally retarded persons receive health, mental health and chemical dependency care through private insurance company payments under their insurance policies, but do not generally receive insurance payments for care or treatment of "mental retardation." There are several exceptions. Some insurance companies pay for the original diagnosis by a physician.

Under certain limited conditions, private insurance companies are required by law to pay for some (of mental retardation) residential care in intermediate care facilities for the mentally retarded. A mentally retarded person, who (a) is covered by a health insurance policy, (b) is also eligible for medical assistance under Title XX, and (c) is also approved by a physician as needing intermediate care in an ICF-MR (Intermediate Care Facility for Mentally Retarded), may receive the care for which the insurance company pays. The ICS-MR bills the state DPW and DPW bills the insurance company. The parents or guardians are required to sign a form subrogating their insurance payments to the state.

Some insurance companies see "mental retardation" as a condition but not as a disease. They pay for treatment, not for care. However, they indicate they will usually pay for any physician's bill that comes in for mental retardation cases. Insurance companies generally do not reimburse for the "cost of care" of mentally retarded children except for straight medical care from a physician or hospital.

Being licensed under Rule 34 by DPW does not provide an institution with credentials needed to automatically bill third party payers for other-than-normal health care costs that are not related to retardation and which are often provided by another health provider such as an MD and hospital.

IV. MENTAL HEALTH/CHEMICAL DEPENDENCY/SOCIAL SERVICES PROVIDERS: THE KINDS OF STAFF THEY EMPLOY, AND THE THIRD PARTY REIMBURSEMENT THEY RECEIVE

Different types of agencies and facilities shape the functions and the scope of freedom of action of the various occupational groups they employ. Third party payers increasingly affect the type of occupational groups that agencies and facilities employ by their decisions to either pay or not to pay for their employees. This exploratory study described the major types of agencies and facilities which receive third party payments for mental health, chemical dependency, and social services. Representative facilities were contacted and discussions held with persons in charge of third party payments in the facility in order to identify the types of staff employed and what their third payment experience has been. The major types of facilities studied were: (See Table 4.)

A. General hospitals with mental health and chemical dependency programs
B. State mental hospitals
C. Nursing homes, board and care, and board and lodging homes serving the mentally ill
D. Chemical dependency treatment centers
E. Community mental health programs
F. Private psychiatric clinics
G. Halfway houses
H. Community residential treatment facilities for the mentally ill
I. Group residential facilities, group homes, and foster homes
J. Private practice
K. Detoxification units
L. Employee assistance programs

Third party payers are concerned about the increasing mental health/chemical dependency treatment costs in all of the different types of facilities. They often request additional supportive documentation, evaluations prior to making the initial payments, and when treatment goes over three weeks or a month. They indicate they are not always satisfied with these reports. MH/CD professionals at many different types of facilities sometimes find it difficult to supply the information as fully and as completely as is

TABLE 4

THE NUMBER OF RESIDENTS AND AVERAGE COST IN MINNESOTA

LICENSED RESIDENTIAL FACILITIES FOR MENTAL HEALTH

TYPE OF FACILITY	NUMBER OF FACILITIES	AVERAGE DAILY POPULATION	AVERAGE COSTS PER DAY	PAGE SOURCE OF FIGURES
State hospitals	9	3,035		
Total MI/CD/MR			$ 52	2.4
Mentally ill		1,542		
Chemically dependent		571		
State nursing homes	2	732	$ 34	4.5
Community based residential programs (Rule 36) 1978	15(2)	384	$ 15	16.88
Cost of care programs for emotionally disturbed children (Rule 5) 1978	31	1,183(3)	$40-$65	17.
Residential CD treatment (Rule 35) Total	70	2,171(3)		
Hospital based			$ 100	18
Primary treatment			$ 51	
Halfway house			$ 20	18
Psychiatric units in general hospitals		441	$ 110	88.90
Nursing homes, patients with primary diagnosis of mental illness		12,900	$ 28	88.90
Board and care homes		2,300	$ 17	88.90
Board and Lodging		1,112	$ 14	88.90
Adult foster care		750	$ 14	88.90

(1) Source: Residential Care Study, Executive Study, Minnesota Department of Health March 1979 (the figures are for 1977 unless acted).

(2) This number has dropped to 7 as of January, 1980

(3) According to DPW licensing division the figure is for total beds rather than average daily population.

needed. Some of the reasons they give for their actions include: 1) concerns about confidentiality of psychiatric records at insurance companies 2) possible psychological harm to the patient from being labeled, 3) the inadequate or general nature of the medical diagnostic terms used, and 4) differences in treatment philosophies, methods, and terminologies.

A. General Hospitals with Mental Health and Chemical Dependency Treatment Programs

The phenomenon of third party payments is changing the locations where mental illness is treated. The number of MH/CD beds in general hospitals is now equal to those in state mental hospitals. In 1960 there were 15,000 beds in state hospitals and very few MH/CD beds in general hospitals. A major reason for the change is that third party payers are paying the cost of MH/CD patients in general hospitals because private insurance policies now provide MH/CD treatment in the same manner as treatment for other illnesses.

General hospitals have found that developing treatment facilities for mental illness and chemical dependency is easy and advantegous. Many hospitals have surplus beds which they can readily and inexpensively convert to chemical dependency and mental health treatment beds. Patients are more likely to use general hospitals because: 1) third party payments are readily available from governmental and private insurance programs; 2) doctors like to continue to be involved in the treatment and can do so when the patient is in the doctor's hospital; 3) treatment is becomming more effective, and medication permits treatment in less secure facilities; 4) patients and families like it because of nearness to home, there is less stigma, and they can afford it through insurance plans; 5) the ease of obtaining third party reimbursement from a general hospital makes it possible to attract and keep good mental health personnel; and 6) medical, pharmacy and laboratory back up services are readily available.

To encourage use and attract licensed consulting psychologists, some hospitals are giving licensed consulting psychologists "hospital privileges" similar to those given to physicians, including the privilege of admitting patients. These psychologists then may bill the insurance company or other third party payer separately as physicians. Their costs are not included in the hospital beds. If they do, their costs would not be included in the hospital rate.

With this rapid growth of hospitalization in general hospitals for mental health and chemical dependency, third party payers are raising questions more frequently about cases, especially when they go beyond the three or four week limit set by some third party payers for regular chemical dependency or mental health treatment. Some third party payers are comparing the average daily costs of general hospitals, free standing primary treatment residential care, and outpatient care (see Table 5).

Hospitals report little difficulty with the third party payers regarding selection or use of professionals and supportive staff in the treatment of the mentally ill and chemically dependent patient. They are well established licensed providers of services with built in review and auditing systems. All admissions, diagnoses, treatment plans, and evaluations are made by physicians or licensed consulting psychologists working under the medical supervision of physicians. As a result, general hospitals generally use a broader range of staff than residential CD primary care facilities. These may include psychiatrists, other physicians, psychologists at all levels, social workers, psychiatric nurses, nurse practitioners, registered nurses, licensed practical nurses, psychiatric technicians, human service specialists, attendents, nurses aides, chemical dependency counselors, pastoral counselors, chaplains, and occupational, recreational, dance, art, and music therapists.

B. State Mental Hospitals

State hospitals still provide a large part of the residential care for mentally ill and chemically dependent patients, especially the longer term, more difficult to treat patients. A large portion are short term. They also house and care for many of the patients who have either exhausted private insurance benefits or are receiving maintenance care and treatment. The number of patients with mental health diagnoses has steadily declined. Chemical dependency patient loads are up slightly, but the number of patients treated and released has increased.

TABLE 5

AVERAGE DAILY COSTS FOR MENTAL HEALTH/CHEMICAL DEPENDENCY FACILITIES IN MINNESOTA

TYPE OF FACILITY	MENTAL HEALTH AND/OR CHEMICAL DEPENDENCY
General hospital (Mental health and CD units)	$ 110
State hospital	$ 52
Primary treatment chemical dependency facility (Rule 43 facility)	$ 51
Cost of residential care facilities for children (Rule 5)	$40-65
Non-residential facility (outpatient)	$ 28

Source: Residential Care Study, Executive Study 1979 Minnesota Department of Public Welfare.

Third party payment systems can and do pay for many of the short term active treatment cases. State law requires that mental illness be treated in the same manner as other illness and state hospitals are aggresively seeking third party payments. To increase the amount of third party payments, the state has employed a third party payment specialist in each state hospital to pursue payments from both the public and the private sector with considerable results. Third party payers tend to look at state hospital treatment and evaluation reports very carefully to insure that they are paying only for actively treated patients, not for maintenance.

State hospitals use a wide variety of professionals in their treatment (See Table 6).

TABLE 6

TYPES AND NUMBERS OF PROFESSIONAL STAFF IN STATE HOSPITALS AND COMMUNITY MENTAL HEALTH PROGRAMS 1979

	NUMBERS OF FULL TIME STAFF OR EQUIVALENT	
types	Community Mental Health Programs	State Hospitals
All physicians	N.A.	70
Psychiatrists	37	N.A.
Psychologists	133	69
Social Workers	231	116
Nurses	49	293
CD Counselors	113	N.A.
Others	184	N.A.
Total	749	N.A.

Source: 1980 Mental Health Plan, Department of Public Welfare (pages 10 and 13).

C. Nursing Home, Board and Care, and Board and Lodging Homes serving the Mentally Ill

Nursing homes licensed under Health Department Rule 44 provide residential care and treatment for nearly 13,000 patients, the largest single group of the mentally ill in residential care in the state. This is larger than the populations in state hospitals on any given day. The following figures were taken from the March 1979 Minnesota Department of Public Welfare Residential Care Study (See Table 7.)

TABLE 7

TREATMENT OF MENTAL ILLNESS IN NURSING HOMES

Total nursing home residents with a primary diagnosis of mental illness	12,900	
Patients over the age of 65	11,610	90%
Patients under the age 65	1,290	10%
Average cost per day in a nursing home(note: more than half of all nursing home costs are paid by Medical Assistance)	$ 27.50	
Estimated cost per day for mentally ill persons in nursing homes in Minnesota	$ 354,750	

Nursing homes account for 72% of all the residential community based mental health facilities.

Persons receiving board and care, (licensed) or board and lodging (licensed)	3,412
Average cost per day (more than half paid by SSI)	$ 17.00

Nursing homes are certified and licensed by the Minnesota Department of Health. Costs are regulated under Rule 49 of the Department of Public

Welfare. Major care is provided by physicians, social workers (without MSW), registered nurses (without psychiatric credentials), licensed practical nurses, occupational therapists, physical therapists, and consulting psychologists. Medical Assistance reimburses for care provided under the medical model.

Nationally, data extracted from tables in the 1977 National Nursing Home Survey, conducted by the National Center for Health Statistics of HEW shows:

Table 8

NURSING HOMES, BOARD AND CARE, AND BOARD AND LODGING HOMES SERVING THE MENTALLY ILL

Primary diagnosis of nursing home patients:	
Mental Illness	20% ... of these 1/3 are senile
Alcoholism	.5%
Types of services to nursing home patients:	
Social Work	7%
Psychological/Psychiatric	1.4%
Reality therapy	7%

Professionals servicing nursing homes include:

12,000 social workers (baccalaureate or masters level)

5,800 psychologists, psychiatrists, psychiatric nurses and others

Medical Assistance and other third party payers follow the medical model in which the focus is not on health training credentials.

D. Chemical Dependency Treatment Centers (DPW Rules 35 and 43)

The Licensing Division of DPW indicates that there are about seventy licensed residential facilities under Rule 35 (see appendix for partial list). Seven are units in state mental hospitals. Several are connected with general hospitals such as Abbott-Northwestern. There are at least eight larger free-standing, primary treatment facilities such as Hazelden, Parkview, and Twin Town. The rest are mostly halfway houses such as Dayton House, Freedom House, House of Hope, and New Expectations. Treatment at general hospitals runs about $100 a day and the free standing primary treatment facilities about $50 a day (DPW 1979 Residential Care Study). DPW lists 45 outpatient facilities which are being licensed under Rule 43 including St. Marys, Hazelden, Twin Town, Chanhassen, Glenmore, First Step, and several mental health, psychiatric, and family counseling clinics.

Minnesota Statute 62A. 149 requires coverage for chemical dependency in all group and individual insurance policies in all licensed residential facilities (Rule 35) and outpatient facilities (Rule 43 in the Appendix). Blue Cross/Blue Shield also provides this coverage. Medical Assistance only pays for hospital care and some outpatient coverage. The Fraternal policies are reported to have low levels of benefits.

Provider facilities report that Blue Cross pays claims promptly, as do most, but not all of the major carriers and self-insured plans. Medical Assistance has a 30 day limit on payment for chemical dependency treatment programs. Others have different limits. Many of the fraternal plans do not have good benefits in this area. Several carriers are challenging the Legislature's right to require non-resident insurance companies to have this same protection for Minnesota residents.

The insurance companies have generally recognized a Rule 35 license as acceptable credentials for all personnel employed by these facilities. This includes chemical dependency counselors, medical doctors, psychiatrists, psychologists, social workers, psychiatric nurses, registered nurses, pastoral counselors, and others. Many of the staff in these facilities were former patients.

E. Community Mental Health Programs

Last year community mental health boards in Minnesota spent over $17 million in the operation of community mental health outpatient clinic services under the provisions of Chapter 245.61 and DPW Rule 28, with the state directly funding $7 million in grant and aid funds. In addition, in 1979 they spent over $5.7 million on outpatient chemical dependency services of which 35% was state grant in aid funds. Outpatient CD facilities are licensed under DPW Rule 43. Community mental health boards also funded, contracted, or reimbursed for the services of CD halfway houses ($4,845,513 with 25% coming from state monies) detox facilities ($6.2 million with 63% state monies) and outpatient services for the mentally retarded ($2.5 million with 45% state monies).[1]

The Community Social Services Act now gives the community mental health and chemical dependency program funds, along with Title XX Social Services and other funds, to the county boards of commissioners which will either provide or contract for services. The level of funding for the program areas of mental health, chemical dependency, and mental retardation cannot be reduced during the first two years. The state also has additional funding for special mental health projects.

Because of these changes, the Department of Public Welfare is now working on revising DPW Rule 28 which set standards for approval of mental health boards and their clinics and programs. The state does not license any psychiatric or mental health outpatient services or clinics. Under Rule 43, DPW will continue to license chemical dependency clinics and outpatient services.

Under Rule 28, "community mental health clinics" are required to have:

1) a licensed physician with an approved residency program in psychiatry,
2) a licensed consulting psychologist,
3) either a clinical MSW social worker or a psychiatric nurse (reigstered nurse with a master's degree), and
4) other staff which may include chemical dependency counselors, "other professionals, paraprofessionals, and disciplines." In the new draft rules these additional staff positions will be subject to the review and approval of the Commissioner. The 1979 DPW Mental Health Plan re-

[1] Source: Minnesota Department of Public Welfare, Mental Health Bureau

ported that 30% of the employees of community mental health programs were social workers with a MSW. A number of the CMHC directors are social workers with MSW's. Many different occupational groups are represented among mental health personnel.

Some of the community mental health clinics report that some third party payers are reimbursing their clinics as "providers of services." Most community mental health centers and programs report that third party payers do not recognize their programs as state approved "providers of services." Third party payers require that CMHC claims for reimbursement be submitted with the signatures of individual providers of service (licensed physicians or consulting psychologists). Chapter 62A.152, Subd.2, in the insurance statutes calls for group policies to reimburse 40% of the costs, up to $600, for "mental or nervous disorder consultation, diagnosis, and treatment services" ...furnished by (1) hospital, (2) "community mental health center or mental health clinic approved or licensed by the commissioner of public welfare," or (3) a licensed consulting psychologist.

Community mental health boards collected only $531,992 from private insurance in 1979 for the treatment of mental illness and chemical dependency. About 70% was for the treatment of mental illness, 18% was for outpatient CD treatment, 8% for detox services, and 6% for halfway houses.

F. Private Psychiatric Clinic

Many psychiatrists and licensed consulting psychologists in Minnesota choose to affiliate with or to organize psychiatric clinics because of the economic advantage, as well as the benefits of working as a leader or member of a psychiatric team. In Minnesota, such psychiatric clinics or counseling centers are not regulated by the state. Psychiatric clinics are headed by psychiatrists or licensed consulting psychologists and may have several of each on the staff. Almost all have social workers on the staff, and many have licensed or unlicensed psychologists, psychiatric nurses, chemical dependency counselors, and other professionals. Some may have specialists, such as social workers or psychologists, who are skilled as family and marriage counselors. Most have a bookkeeper,

secretary, or other staff members who specialize in reimbursement by third party payers. Providing a wider range of skilled and credentialed personnel enables the psychiatric clinic to meet the particular needs of its clients. It also fulfills the requirements of various third party payers for particular credentials to ensure payment for services rendered.

A number of clinics reported that following the initial intake interview and initial assessment and diagnosis, their clinic third party payment "specialist" contacts the client's insurance company or government agency claims office. The task is to determine: 1) whether the diagnosis and treatment are covered by the client's insurance policy, 2) what credentials the therapists or their supervisor must have in order to quality for reimbursement, and 3) how the claim form and bill should be prepared and which signatures are needed. Claims are usually filled with the signature of either a psychiatrist or the licensed consulting psychologist. The case is then assigned to a treatment team or therapist who meets the requirements of the third party payer.

Many psychiatric clinic personnel interviewed reported concerns about the wisdom of assignment of patients by third party payment requirements, rather than by the clinic staff's judgement of which therapists might be best suited to help treat the individual. Specific concerns were for example, the insurance policy may call for treatment only by a physician, although the case might better be treated by a social worker, a chemical dependency counselor, or a psychologist, depending upon their skills and specialties.

Most clinics lose money when psychiatrists see Medical Assistance patients and probably make money when these patients are seen by a licensed consulting psychologist with a master's degree. This is because all licensed physicians and licensed psychologists, as enrolled providers, are paid up to $45 per hour for usual and customary charges. All other staff services can be billed to Medical Assistance for up to $22.50 per hour for usual and customary charges as unenrolled providers. Some private insurers have no ceiling on usual and customary charges for psychiatrists and consulting psychologists. Others have co-payments and maximums. Some

insurance companies have accepted all the hours of therapy performed by teams of a psychiatrist, a consulting psychologist, and a social worker at the psychiatrist's higher rate if the bill came in over his name for so many hours of psychotherapy. Others pay only for the actual time of the psychiatrist, although he may need to use a psychologist, a social worker, or a chemical dependency counselor to help on the case. Every policy must be individually checked as its provisions for reimbursement may be different. Since social workers, nurses, and licensed or unlicensed psychologists are usually on salary, efficient use of staff to meet third party requirements can be important to the clinic. If a patient has several equally serious problems, such as psychiatric disorders, chemical dependency, and marital problems, the insurance policy benefits often determine which is written up as the major diagnosis.

Some clinic staff indicated their concern about the lack of confidentiality in the way the patient's medical and psychiatric records are kept by insurance companies and self-insured companies. They are concerned that unauthorized clerks or personnel officials may have access to information which could be damaging to their patients. They indicate that because of this concern they may choose less severe diagnosis terms, make the records less complete, or code the diagnosis to protect the patient.

Third party payers indicate that some mental health diagnosis and treatment plans and evaluations are vague and seem incomplete or "soft." These concerns are another reason why third party payers rely upon the quality control of the physician and the licensed consulting psychologist. Despite all of these concerns and difficulties, the number of clinics and the volume of third party payments is increasing, and claims processing seems to be easier than might be expected.

A number of private nonprofit mental health, individual and family therapy, and family service agencies are also seeking to get third party reimbursement by following the practices of the psychiatric clinic. These agencies are increasing by arranging for psychiatric supervision by psychiatrists or licensed consulting psychologists which then may enable them to receive third party payments.

The study found many problems and confusion about unclear policies and practices in reimbursement for psychiatric services in mental health and psychiatric clinics. In the interviews, many of the persons connected with psychiatric or mental health clinics indicated strong support for occupational regulation (usually "licensing") of mental health personnel as a means of resolving problems related to third party reimbursement.

G. Halfway Houses

Treatment for chemical dependency at halfway houses licensed under Rule 43, is covered by insurance law provisions which require health insurance policies to pay for the treatment. Often the individual's health insurance benefits for chemical dependency treatments have been exhausted by the time he or she has reached the halfway house following treatment in a primary treatment facility or a state hospital. The community mental health boards reported that only .6% of the total costs of their halfway houses for chemical dependency were paid for by private insurance. In 1979 Title XX social services paid for more than $1.26 million or over one quarter of the cost of CD halfway houses run by the community mental health boards, according to DPW. Mental health residential treatment in halfway houses is not covered by third party payers in the private sector just as it is not covered in Rule 36 facilities. However, both chemical dependency and mental health treatment halfway houses tap many governmental programs for financial support and treatment, including General Assistance, GAMA, Social Security, SSI, MSA, and Community Social Services. At the present time, private insurance programs pay very little of the halfway house costs in Minnesota. Governmental third party payment programs, grant in aid programs and county funds pay for most of these services.

H. Community Residential Treatment Facilities for the Mentally Ill (DPW Rule 36)

The DPW Residential Care Study showed fifteen community-based residential care facilities licensed by DPW under Rule 36 for mentally ill adults in 1978, with a population of 384, and a foster home adult population of about 750. Most of these persons receive Social Security and SSI. Eight of these facilities have terminated their leases. Under current funding

patterns and third party reimbursement policies, these facilities report difficulty in remaining open.

I. Group Residential Facilities, Group Homes, and Foster Homes used in Treatment and Care of Children Placed Out of the Home

Three kinds of facilities or homes are used to provide help for emotionally handicapped or disturbed children: group residential treatment facilities, group homes, and foster care homes.

Group residential treatment facilities are licensed under DPW Rule 5 (see Appendix for Summary). This type of facility has ten or more (usually over fifty) children who need intensive treatment for serious emotional problems. There is a high staff/patient ratio, with MSW social workers taking primary responsibility for treatment with a consulting psychologist and a psychiatrist available Social Services, medical services and education are provided at the facility. Because of these types of facilities, the child population in the state hospitals has dropped dramatically.

Providers are paid on a third party reimbursement plan over a considerable period of time. Some clients are fully private pay, or fully insurance pay. The courts and the county welfare departments send many children to these facilities. Admissions, diagnosis, and initial treatment plans are set by social workers (MSW) and reviewed by a team which includes a physician, psychiatrist, or consulting psychologist. A social worker, a judge, a family, a doctor, or others may be involved in requesting admission. The facilities under this rule are covered by insurance policies, AFDC, community social services and/or cost of care funds (see Chapter III).

A Rule 8 facility, a group home, is a smaller facility for ten or fewer children who are less emotionally disturbed or handicapped. The services are provided in the community. (See appendix for summary.) Care is funded by a variety of third party services. (See cost of care in the previous chapter.)

Foster care homes are licensed by the county welfare departments, and placement is made by the county welfare social services staff. Many of these children have serious emotional handicaps and problems. The home care is paid for with state and county funds, including AFDC, Medical Assistance, and other welfare programs on a third party payment basis.

J. Private Practice

Physicians established the model of private practice and insurance which tends to set the standards for third party payments. Most third party payers have accepted a licensed consulting psychologist or physician as "provider of service" for reimbursement for mental health and chemical dependency treatment. There are some private insurance individual policies that limit payment to M.D. s.

Private physician care or medical care insurance has established that most other health personnel are ancillary to the M.D. and are to be paid as a part of the doctor's fees. Similarily, most third party payers view social workers, psychiatric nurses and chemical dependency counselors as support staff to the doctor to be paid through the doctor's fee. A number of psychiatric nurses, social workers, and psychologists work in private practice offices under the direct supervision of a psychiatrist or a licensed consulting psychologist, and a number of private insurance companies are reimbursing these persons under the psychiatrist's provider number. The requirements and documentation needed for reimbursement vary greatly. A large number of private insurance companies will not pay for treatment provided by social workers, psychiatric nurses, or other personnel even if they are supervised by psychiatrists in private practice settings.

Social workers and psychiatric nurses with master's degrees in solo private practice report that, with few exceptions, they do not get third party reimbursement for their work. One exception is Control Data's Employees Health Insurance Program which does reimburse social workers with a master's degree for private practice.

K. Detoxification Units

Detoxification units are for the acutely ill chemically dependent and persons with drug or alcohol problems who need protective care. Detoxification units are regulated by DPW which provides substantial funding for these facilities ($4.3 million in 1979). Rule 32 covering detoxification services is felt by DPW to be obsolete and is currently being revised. Detox facilities are of three types: 1) those connected with a hospital, 2) those connected with chemical dependency treatment programs (such as Hazelden), and 3) those that are free standing. They are staffed by RN s (usually psychiatric nurses), licensed practical nurses, and detox technicians trained according to DPW's specifications. The state paid 64% of the cost of detoxification facilities run by the community mental health boards in FY 1974, according to DPW. Acute detoxification care usually has a 72 hour limit. Because the patients are under the influence of chemicals, they are often unable to assist with any claim preparation, and many have lost both their employment and their health insurance. As a result, private insurance paid for less than 6% of the cost of these detox facilities, or a total of $40,777, for the entire state in 1979. Some private insurance companies indicate that they usually will pay for detox if the facility is connected with a hospital or a licensed or primary CD treatment facility and if the detoxification is a part of the treatment. But they will not pay for simply "drying out the alcoholic" or letting the drug user "come down from a trip." Blue Cross/Blue Shield states they will reimburse for detox services when they are a part of a treatment program connected with licensed inpatient chemical dependency facilities.

In 1980, the detoxification program was shifted to the counties under the community social services program so that money for detox facilities will be coming from counties. Many of the smaller counties will not want to maintain their own facilities but may contract or reimburse detox centers for the county's use of the facility. It is anticipated that many of the detox technicians will, over time, become certified and registered chemical dependency counselors.

L. Employee Assistance Programs

Employee assistance programs, which provide some direct services, make referrals for services, and sometimes act as third party payers, are rapidly expanding services. Most employee assistance programs have been established by employers such as General Mills, Control Data, the State of Minnesota, 3M, Medtronics, and the city of Minneapolis. Some are contract services, such as the Minnesota Growth Exchange of St. Cloud which was established by the community Mental Health program. The cost of employee assistance programs is paid for by the employer.

When employees have a personal, family, psychological, or chemical dependency problem that is troubling them and that may affect their work, the program is available to them to help find out what is wrong and where they can get help.

Employee assistance program services include: 1) assistance in locating appropriate social, medical, mental health, and other resources in the community for employees needing help; 2) limited amounts of counseling; 3) assistance in mediating between individual employees, providers of service, insurance carriers, community and governmental programs, and the company; 4) support, encouragement, and assurance to the employee who is seeking help; 5) assistance to employees who have family problems which are affecting their work; 6) assistance in explaining company insurance programs and benefits so that the employee can use them to get help; and 7) some additional resources.

All of the employee assistance programs include initial counseling, assessment, and referral, and most can help in crisis intervention. Programs vary as to the nature and amount of counseling services. Some are developing significant in-house counseling services for long term counseling. Some have considerable influence with third party payers to insure coverage under their company insurance policy. Some have their own special assistance fund such as Medtronics, which pays for emergency assistance and other services, such as marriage encounter therapy weekend sessions which is not covered by their company insurance policy.

Employee assistance counselors become very aware of the short comings and or problems with third party payment systems. Some of these counselors are able to affect company policy about the kinds of health insurance and other benefits the company buys. As these programs become better accepted in companies, benefit managers may increasingly turn to these persons to help shape the private insurance policies they purchase. This in turn will help shape third party reimbursement policies.

V. THE IMPACT OF THIRD PARTY PAYMENTS UPON EACH OF THE DIFFERENT OCCUPATIONAL GROUPS

The impact of third party payments on the various occupational groups is, at first glance, obscure, confusing, and, at times, almost contradictory because third party payment systems vary greatly and are administered through a wide range of service providers. Third party payers, service providers, and professionals disagreed about what was happening. The study involved interviewing a number of professionals working in the field as well as service providers and third party payers, and trying to resolve many of the disagreements on what was perceived. A few differences could not be completely resolved.

Some definite reimbursement patterns affecting different occupations were found. There is little doubt that third party payments, along with governmental programs, affect the income of different professionals more than do direct payments by individuals. Facility licensing and occupational regulation affect the levels and types of third party payments as established by law, regulation, and third party payment policies. It became clear that, rather than licensure by itself, it was a combination of factors that dramatically increased the fee a licensed consulting psychologist can command. These factors were: 1) the licensing of psychologists, 2) changes in state insurance law, 3) changes in facility licensing regulations, and 4) changes in third party payments.

The following mental health and chemical dependency occupations and the impact on them of third party payment policies will be discussed in this chapter.

A. Psychiatrists & other physicians
B. Psychologists
C. Social Workers
D. Chemical Dependency Counselors or Practitioners
E. Psychiatric or Mental Health Nurses
F. Nurses: RNs, LPNs, Nurses Aids
G. Marriage & Family Counselors
H. Rehabilitation Counselors
I. Vocational Guidance & Employment Counselors
J. Physical, Occupational, Recreational, & Art Therapists
K. Mental Health or Psychiatric Technicians
L. Group Home Parents and Workers
M. Halfway House Personnel
N. Detoxification Technician
O. Board and Care Staff
P. Ombudsmen and Patient Care Advocates
Q. Adult Day Care Staff or Gerontologists
R. Foster Parents
S. Human Service Technicians
T. Correctional Workers

A. Psychiatrists and Other Physicians

Most third party payment systems in MH/CD/SS are based upon the medical model. The psychiatrist or physician has very little trouble getting paid by third party payers providing that adequate documentation is submitted with the billing. Psychiatrists and other physicians are generally granted their own provider numbers by each of the major third party payers to speed processing. In private practice, doctors submit their bills including their fees and the fees for nursing staff, other supportive staff (including social workers and psychiatric nurses under the doctor's supervision), and the cost of office operation. For the bigger third party payers, such as Medical Assistance and Blue Cross/Blue Shield, each physician is given a provider number. In private clinics, all insurance claims and bills go out over the physician's signature and provider number. In hospitals, physicians, including psychiatrists, submit their billings to third party payers separately from the hospital bill. (See Table 9.)

There are many third party payers that will not accept facility billings such as those from mental health clinics and treatment programs but will pay for these services if bills for them come in from doctors for their services and for the services of the facility staff who are working under their supervision. Many facilities find less trouble if they submit bills for their work with a covering bill from a physician or consulting psychologist. Third party payers rely heavily upon physician's medical supervision of staff, payment of their diagnoses, treatment plans, and evaluations for evaluating claims.

B. Psychologists

"Licensed consulting psychologists" are generally accepted by third party payers as equivalent to "licensed physicians" or "psychiatrists" for reimbursement purposes. Some private insurance companies issue individual policies that do not pay for services unless provided by a physician. The "licensed consulting psychologists" may get their own provider numbers from many of the major third party payers such as Blue Cross/Blue Shield and Medicaid, and bill directly regardless of practice setting. Many of the MH/CD/SS facility regulations require the approval or supervision

Table 9

OCCUPATIONS

PAID BY THIRD PARTY PAYERS

OCCUPATIONAL GROUPS	As Individual Provider	Supervised by Licensed Provider	As part of Licensed Agency	As part of Licensed Hospital or Nursing Home
Psychiatrists, M.D. (Lic.)	A	A	A	A
Physicians, M.D. (Lic.)	A	A	A	A
Psychologists (Lic.) Consulting	M	M	M	A
Psychologists (Lic.) Other	No	S	M	A
Psychologists,(Not Lic.)	No	No	S	A
Social Workers, MSW	S	S	S	A
Social Workers	No	No	S	S
Registered Nurses, Psychiatric	No	S	S	A
Registered Nurses	No	S	S	A
Psychiatric Technicians	No	No	No	A
Chemical Dependency Counselors	No	No	M	A
Pastoral Counselors	No	No	S	A
Ministers and Chaplains	No	No	M	M
Detox Technicians	No	No	S	A
Psychotherapists,	No	S	M	A
Social Gerontologists (Adult Day Care)	No	No	S	S
Educational Psychologists	No	No	M	-
School Guidance Counselors	No	No	-	-
Vocational Guidance and Employment Counselors	No	No	S	S
Rehabilitation Counselors	No	No	S	S
Occupational Therapists	No	S	S	A
Physical Therapists	No	S	S	A
Recreation Therapists	No	No	S	A
Art Therapists	No	No	No	A
Music Therapists	No	No	No	A
Human Service Generalists	No	S	S	S
Marriage & Family Counselors	No	No	S	A
Licensed Practical Nurses	No	S	M	A
Group Home Workers or Parents	M	No	S	-
Foster Home Parents	M	-	-	-
Acupuncturists	No	No	No	S
Other Healers	No	No	No	A

Key:

A - Nearly always M - Most of the time S - Sometimes No - No evidence of payment found

of either an M.D. or a licensed consulting psychologist. Some hospitals have given "privileges" (including the right to admit patients) to "licensed consulting psychologists." Under these circumstances, physical examinations, physical medical needs, and writing prescriptions are still the responsibility of physicians.

When interviewed, most third party payers expressed general confidence in the quality assurance provided by licensed consulting psychologists. This confidence was based on payers perceptions about the meaning of such licensure. The accuracy of these perceptions is not necessarily borne out in practice or within the statutes and rules regulating psychologists. The commonly held perception is that all licensed consulting psychologists (1) hold an earned doctorate; (2) are authorized by the state (DPW Rule) to diagnose, treat, and supervise in a licensed CD facility; (3) have the clinical ability to diagnose and write treatment plans using appropriate medical terminology; and (4) can effectively provide psychotherapy and CD consultation.

In reality, a "consulting psychologist" may be licensed for any of several areas of competence (such as industrial or clinical areas). The license does not indicate the areas of competency. Not all "consulting psychologists" have diagnostic and clinical skills. Verification of the clinical competencies can be obtained from the Board of Examiners of Psychologists or elswhere. Licensed consulting psychologists are required to hold an earned doctorate in psychology, have two years supervised experience after formal training is completed, and pass the psychology licensing exam; however, some psychologists with master's degrees and considerable experience were "grandfathered" in as licensed consulting psychologists.

Medical Assistance reimburses licensed psychologists in the same way as licensed consultant psychologists, giving them a provider number as an enrolled service provider.

Some licensed consulting psychologists reportedly are following the example of some psychiatrists in not designating or making clear when the particular counseling hour is being conducted by the consulting psychologist or by a supervised social worker, psychiatric nurse, or chemical dependency counselor,

and billing at their "usual and customary" rate.

C. Social Workers

Third party reimbursement is made for social worker services in a wide range of settings. The services of MSW social workers are paid for by third party payers when they are provided in general hospitals, mental hospitals, community mental health clinics, licensed mental health and CD residential programs, licensed CD outpatient facilities, licensed group residential facilities, and in certain other settings. Third party payers reimburse nursing homes and hospitals for both MSW and BA social workers. In each of these situations, the social workers are working in a licensed facility and are under the supervision of an M.D. or a consulting psychologist. In some cases, supervision by the M.D. or consulting psychologists is minimal, but third party payers see the supervision as an essential quality control.

In a few instances, the master's degree social workers function without supervision by M.D. s or consulting psychologists and are paid by third party payers. One example is the nationwide health insurance policy written for Control Data Corporation by Equitable Insurance Company. Under this policy, the services of an MSW are reimbursable even when provided by an MSW in solo private practice.

Another example is residential treatment centers for children, usually directed by MSW social workers, where the primary diagnosis, treatment plan development, and much of the treatment is carried out by MSWs or persons under their supervision. Reimbursement is made by a variety of third party payers including AFDC, private insurance companies, Title XX, cost of care programs, and others. Admission usually occurs either upon the recommendation of an MSW in a county welfare department, by court order, or by the family. Then, within a month or so, a review of cases is accomplished by a team which includes an M.D. and/or a consulting psychologist.

It is hardest to predict when third party payers will pay for the services of social workers on the staff of private mental health clinics which do not receive state funds. Most clinics nearly always check with the carrier or payer to determine, on a case by case bases if the policy reimburses for the services of an MSW. Some policies pay if the clinic is headed by a psychiatrist or consulting psychologist; others require that the psychiatrist, physician, or consulting psychologist diagnoses, prescribes the treatment to be carried out by the MSW, and supervises and performs periodic reviews of the MSW. Some pay only for doctor-provided services, which may not appear to be a very rational system to the client, the social worker, the psychiatrist or the psychologist involved. This is the greatest area of confusion for third party reimbursement.

Medical Assistance treats MSW's the same as psychiatric RN's and chemical dependency counselors, that is, as unenrolled service providers who require supervision and are paid $22.50 per hour or one half the Medical Assistance rate for psychiatrists and licensed psychologists. The National Association of Social Workers has developed an academy certification of advanced social workers which was mentioned in interviews by some social work practitioners. This certification was neither mentioned nor used by the third party payers in any way that could be observed. It did not appear to be used by most of the providers in describing the credentials of their professional mental health staffs.

D. Chemical Dependency Counselors

Chemical dependency counselors are increasingly accepted by third party payers as members of treatment teams in agencies and facilities treating chemical dependency. These agencies include licensed adult residential CD treatment centers, licensed community residential treatment facilities for children, state hospitals, chemical dependency units in general hospitals, community mental health clinics, chemical dependency outpatient facilities, and psychiatric clinics. To comply with state health insurance laws requiring coverage for CD treatment, most third party payers have accepted facility licensing rather than occupational regulation, as the primary method of determining reimbursement policies for chemical

dependency treatment. The treatment team is headed and supervised by a psychiatrist or licensed consulting psychologist with a variety of types of counselors. The third party payers pay the entire facility bill. Third party payers have most problems in reimbursing for CD counselors, MSWs and psychiatric RNs in V.A. licensed facilities, such as private or nonprofit psychiatric clinics. As with social workers, RNs, chemical dependency counselors and other therapists in private practice are rarely paid directly by any third party payment programs.

E. Mental Health or Psychiatric Technician

Third party payers have traditionally paid for the services of registered nurses in licensed facilities where nurses are under the supervision of physicians, or, in the case of mental health and chemical dependency, they are supervised by physicians or licensed consulting psychologists. In unlicensed facilities, such as psychiatric clinics, many third party payers view psychiatric nurses as ancillary to the physician and pay them through the physician's or consulting psychologist's bill. Some want M.D. diagnosis, treatment plan, supervision, and evaluation. Some want to pay for only those visits where the individual is seen by the doctor. Other third party payers allow for a general supervision and team relationship as in some community mental health clinics.

As with social workers and chemical dependency counselors, it is generally necessary to check out each case with the insurance company to know whether the policy will pay for the services of a psychiatric nurse with a master's degree (also called psychiatric nurse practitioner). Cases are then assigned on the basis of the required credentials as well as rate of reimbursement, rather than on the basis of matching the client with the appropriately skilled staff.

Licensure of nurses does not mean they are paid for independent practice. There is one exception. Home health care agencies directed by registered nurses are paid as service providers by many third party payers.

F. Nurses: RNs, LPNs, and Nurses Aides

Nurses are the largest group of providers of direct care for the mentally ill. Nurses provide the primary mental health care and treatment for the largest group of residential mentally ill patients in the state -the mentally ill in nursing homes. Approximately 20% of Minnesota's 12,900 nursing home patients have a primary diagnosis of mental illness. In addition, RNs provide part of the mental health care for mentally ill and chemically dependent persons in general hospitals, mental hospitals, and in CD and mental health residential treatment programs. Registered nurses and/or licensed practical nurses provide program direction for persons in detoxification units. The units are generally reimbursed for care if they are hospital connected or connected directly with CD residential treatment facilities.

Nurses are directly involved in providing care for the mentally ill in a wide variety of settings, for a substantial proportion of the seriously ill population. As is the case with most other health insurance provisions, third party payers indicated that they do not pay the registered nurse, the LPN, or the nurse's aide for independent practice, but that they would pay for their services as a part of a facility's, physician's, or consulting psychologist's bill.

G. Marriage and Family Counselors

Family counselors are not generally paid by third party payers. Persons doing family counseling in some of the residential treatment centers, however, are being included in the allowable costs for third party billings. Marriage counselors or family counselors in private practice are not paid by third party payers unless they are psychiatrists, licensed psychologists, MSWs, CD counselors, or others who qualify, and not unless their diagnoses fit the appropriate psychiatric or CD categories. If these criteria are met, then the third party carrier may be willing to pay under the terms of the policy or program.

H. Rehabilitation Counselors

Disibility insurance and health insurance will generally pay for rehabilitation counselor services in hospitals, rehabilitation centers and certain other health care facilities.

I. Vocational Guidance and Employment Counselors

Third party payment systems rarely pay for vocationally oriented services except in certain individual disability treatment cases.

Vocational guidance counselors are used in rehabilitation centers and elsewhere to provide some services to mentally ill persons. Some third party payers indicated that they have paid for some of these services when they were provided at established rehabilitation centers. The services must be part of well planned and supervised rehabilitation programs for patients who have had a mental illness, or for physically handicapped persons with serious emotional or mental problems. Third party payment for vocational guidance can come from private insurance, Medical Assistance, court settlements, Workmen's Compensation, or other third party payers.

J. Physical, Occupational, Recreational, and Art Therapists

Most third party payers will pay for MH/CD services provided by occupational therapists, physical therapists, recreational therapists, and art therapists if the services are supervised by M.D. s and performed in traditional health care settings such as general or state mental hospitals, nursing homes, and rehabilitation centers. When these occupations' services are provided in non-traditional settings, such as CD treatment centers, third party payers tend to question the bills more carefully, requesting more information on diagnosis, treatment, and evaluation plans. However, if a physician or licensed consulting psychologist supervises and signs for the service and the facility has a license, the bill is usually paid.

K. Mental Health or Psychiatric Technicians

Mental health or psychiatric technicians have traditionally carried out much of the care and treatment of persons with mental illnesses in state hospitals. Some technicians are being held by general hospital psychiatric or CD wards to provide specialized care for persons with mental illness and chemical dependency. In these settings, third party payers pay the licensed institutions for the services of these technicians who work under the supervision of psychiatrists and other mental health professionals.

L. Group Home Parents and Staff Workers

Most health care third party payers will not pay for group home services. Welfare third party payers such as AFDC, General Assistance, SSI, MSA, and Community Social Services programs (Title XX), and cost of care programs (emotionally handicapped, wards of the state, Indigent Indian, and county programs) provide third party payments to group homes licensed under DPW Rule 8. These payments help to provide both care and treatment for children with emotional, psychiatric, chemical dependency, social, behavioral, family, or other problems. The county social service departments and other social, mental health, and chemical dependency agencies or facilities provide social services needed for the child and work with the foster care family in providing care. These services are paid or reimbursed for by the Community Social Service program as of January 1, 1980.

M. Halfway House Workers

Halfway house workers come from a variety of backgrounds, and, in the case of halfway houses for chemical dependency, most of them have been chemically dependent prior to employment. Many of these workers are chemical dependency counselors who hope to become certified and registered.

All licensed halfway house facilities will seek third party reimbursement for the salaries of the workers they employ. CD facilities licensed under DPW Rule 43 are eligible for payment by private health insurance, but many of the clients or patient residents have already exhausted their benefits by the time they get to the halfway house. Licensure of

the facility and the involvement of a physician or consulting psychologist are the keys to the reimbursement policies of some third party payers. Many residents of halfway houses may be eligible for coverage under various governmental programs, including general assistance and community social services.

N. Detoxification Technicians

Detox centers are usually operated by RNs, psychiatric RNs, or LPNs, and detoxification technicians. The detox technician usually has been trained and certified by the Department of Public Welfare. "Detoxification technicians" may be included as a part of the chemical dependency practitioner registration rules now being drafted by the Health Department.

If the detox center is free standing, most third party payers do not pay. They will pay if the detox center is part of a hospital, such as Chanhassen, or a chemical dependency treatment center, such as Hazelden. Insurance companies say they pay in these cases because detox care is part of a health care treatment program for an individual under medical supervision of an M.D. or licensed consulting psychologist. Several insurance company representatives say they pay for treatment, not custodial care, while patients are "drying out."

The Department of Public Welfare currently provides chemical dependency detoxification center funds to community mental health boards. In January 1980, these funds will go to county boards under the Community Social Services Act. Department of Public Welfare officials say the rule under which the program now operates is out-of-date, and is now being revised.

O. Board and Care Staff

Board and care facilities are regulated by the Department of Health and by the Department of Public Welfare. They provide a lower level of long term care and are often used for long-term mentally ill patients. The services of the staff are reimbursed as part of the facility bill.

These reimbursements are made by the state and the federal Medical Assistance program. Mental health and chemical dependency also provided by other programs, and social services may be provided by the county welfare, social services staffs, or Title XX, Community Social Services.

P. Human Service Technicians

Human service technician is a relatively new occupational group operating in various human service agencies. There may or may not be third party payments for their services. None were reported in this study. However, as one third party payer said, "if the facility is licensed by the state, and the doctor orders the services, we probably are paying for it." No such payments were found in the facilities included in the interviews.

EDITOR'S NOTE

The summary and conclusions, normally found at the end of a study, are in the Executive Summary in the front, and in Chapter II.