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The Office of Program Development and Analysis (OPDA) has the responsibility for planning and policy development within the National Institute on Drug Abuse (NIDA). As part of this function, OPDA issues a series of reports to the drug abuse field concerning legislation, trends in program development and activities related to health services financing. The material in this report was researched and written by Birch and Davis Associates, Inc., 1112 Spring Street, Silver Spring, Maryland 20910, under Contract No. 271-78-1305.

SELF-SUFFICIENCY THROUGH THIRD PARTY REIMBURSEMENTS: A Study of Six Drug Treatment Programs

Just a few years ago, third party reimbursement was a totally new phenomenon for drug abuse treatment programs. At that time, Federal funds were becoming less available and programs were compelled to seek alternate sources of funding to meet higher matching requirements and increased costs of operation. Consequently, NIDA engaged in a variety of efforts to train and assist projects to maximize their third party resources.

One of the more interesting findings of last year's National Drug Abuse Treatment Utilization Survey (NDATUS) was the magnitude and relative importance of third party funding. With total funding reported at $510 million, $71 million (or 14 percent) derived from third party sources. Clearly, there is an increasing number of drug treatment programs tapping third party sources, and a considerable number of these are becoming quite successful at it.

The study reported herein examines the experience and key characteristics of six projects identified as largely self-sufficient. It is hoped that the findings will be of general interest to the field and that certain applications can be made of relevant strategies to assure continued stable funding for community drug abuse treatment services.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service • Alcohol, Drug Abuse, and Mental Health Administration

INTRODUCTION

At the beginning of the community-based drug treatment program, NIDA provided financial support for development and operations. NIDA anticipated that, over a eight year period, programs would begin to earn income from other sources, primarily from third parties, state and local governments, and clients, thereby slowly replacing NIDA grant funds. Through this financial diversification, treatment programs were to become "financially self-sufficient", that is, they were to rely more heavily on non-NIDA funds.

NIDA itself supported a number of iniatives to help grantees reach the goal of self-sufficiency. For example, it sponsored a series of third party and financial management seminars, produced a two-year Report Series on third party reimbursements, provided extensive technical assistance to programs, and Single State Agencies (SSA), and developed a manual for SSAs on third party reimbursement strategies.

Nonetheless, in 1976, a NIDA-funded study indicated that the majority of NIDA grantee programs would probably not attain 100 percent self-sufficiency and, at best, that programs could expect to attain only about 30 percent alternate funding.* Partly in response to this study, NIDA began to fund programs according to a "maintenance" strategy under which programs would continue to receive 60 percent grant or contract support.

Despite this finding and a change in funding strategy, NIDA remained vitally interested in helping programs procure additional funds. Last year, the National Drug Abuse Treatment Utilization Survey (NDATUS) revealed that about 60 programs across the country were relying exclusively or primarily on third party and client fee funds. Thus, the purpose of this study was to investigate six of these rather unique treatment programs to learn:

- What types of programs they are
- Where and how they obtain funding

*Utilization of Third-Party Payments for the Financing of Drug Abuse Treatment, DHEW Publication No. (ADM) 77-440, 1977

- If NIDA-funded programs can employ similar methods to increase financial self-sufficiency

A detailed protocol was developed to guide the site visit. The protocol was organized to obtain comparable information about program history, operations, and financial management, and also about each of the five factors that impact a program's ability to collect third party reimbursements: provider certification, client eligibility, benefit coverage, reimbursement rates, and billing efficiency.

Site selection criteria were developed to identify six programs from a variety of states, providing a range of drug treatment services, generating monies from numerous third party payment programs, and operating with at least 75 percent financial self-sufficiency (i.e. non-NIDA funds). Following an initial telephone survey of about 30 programs, six were selected:

- GATEWAY Rehabilitation Center, located in Aliquippa, Pennsylvania, outside Pittsburgh, has a bed capacity of 85 and provides 28-day residential rehabilitation services to about 900 drug and alcohol abusers per year. It has been in operation since 1972 and now requires an annual operating budget of just over $1,000,000. The program receives funds from a variety of sources, including Pennsylvania Governor's Council on Drug and Alcohol Abuse Programs (SSA), Bureau of Vocational Rehabilitation, private insurance companies, and patient fees.

- JEFF-GRAND Medical Group, Inc., with treatment facilities in Los Angeles and San Diego and a management office in Santa Ana, provides 21-day outpatient detoxification services. In addition, the Los Angeles center provides primary medical care and optometry and dental services to all clients and methadone maintenance services for pregnant addicts. The program has been in existence since 1976 and currently treats about 300 clients in Los Angeles and 150 clients in San Diego. Its annual budget is over $500,000 and it receives most of its income from Medi-Cal.

- Methadone Maintenance Health Program, Corp. (MMHP), in Harlem provides long-term outpatient methadone maintenance treatment. The program has been in operation since 1973 and currently treats about

300 clients. The program's annual budget is about $250,000, and most of the income is from Medicaid.

- PHOENIX Community Services Center, located in the Watts section of Los Angeles, provides 21-day outpatient detoxification and methadone maintenance services to approximately 300 clients. The program had only been in operation six months at the time of the study and was projecting an annual budget of $540,000. Its primary source of income is Medi-Cal, supplemented by private fees.

- ROBINWOOD Clinic, Ltd., in Detroit, is an outpatient drug-free program serving approximately 230 drug and alcohol patients. It has been in operation for 4 years. Its annual budget is about $340,000, and it generates income from Blue Cross/Blue Shield of Michigan, other insurance companies, and private fees.

- VITAM Center, Inc., started in 1970, in Norwalk, Connecticut, provides long-term residential care for drug-abusing adolescents. Its current caseload is about 90, although an expanded capacity to 105 is now under construction. VITAM is the only program of the six that receives NIDA funds (now 22 percent of the total budget) and supplements these funds with patient fees, private insurance, Department of Children and Youth reimbursements, Food Stamp and Child Nutrition Program funds, and appropriations from local school districts.

All information reported by the six respondent programs has been taken more or less at face value. No effort was made to validate information with state-level or other programs in the states visited and, so, this report reflects only the perspectives of the respondents.

1. ALL PROGRAMS WERE ESTABLISHED IN ENVIRONMENTS WITH DEFINITE THIRD PARTY REIMBURSEMENT OPPORTUNITIES

It has been fairly well established that drug treatment programs are seriously limited in their pursuit of third party reimbursements by external constraints, that is, by the characteristics of the major third party payors themselves. Fundamentally, third party payors, both

public (e.g. Medicaid) and private (e.g. Blue Cross/Blue Shield) are in existence to cover the cost of traditional medical care provided by traditional medical providers. Many drug treatment programs have difficulty accommodating this traditional framework.

- Most payors require that medical services be provided along the lines of a "medical model". This means that services must be provided by a physician, or in some cases, by nursing or other personnel under the direct supervision of a physician. Some more liberal plans will pay for services provided by psychologists, medical social workers, or other staff. For a variety of reasons, drug treatment programs may not have such a staff:

  - The relatively high cost of these professionals

  - In some areas, the scarcity of such professionals

  - Differing theories about the efficacy of drug treatment provided by a medical model staff

- Many payors simply do not have provisions under which drug treatment programs can qualify as providers. If no drug treatment criteria exist, centers may be forced to comply with requirements designed to qualify other types of providers such as outpatient hospital clinics, skilled nursing homes, or physician offices. If payors do have specific criteria for drug treatment programs, they may be very difficult for many programs to meet.

- Most private insurance is tied to employer groups or to individuals who are steadily self-employed. In most states, public health insurance programs cover specific categories of indigent people, e.g. the disabled, the aged, and dependent children and their families. Many drug treatment clients are not employed,* nor do they easily meet the welfare eligibility criteria in many states. In fact, it has been estimated that only about 30 percent of the clients in NIDA programs are employed.

*In fact, a recent CODAP report indicated that 66 percent of drug abuse clients had no insurance coverage.

- Further, many insurance and Medicaid plans simply do not include the full range of drug treatment or related services. For example, an insurance plan may cover only one or two of the services provided by the drug treatment center (e.g. physician examinations and laboratory tests, but not maintenance or counseling). Or, even more limiting, the payor may exclude all services related to a drug-dependence diagnosis.

- Finally, even if all other conditions are favorable, the reimbursement rate may not cover the cost of providing the service and, consequently, the center will not be able to attain financial self-sufficiency. Many clients are too poor to pay the difference and Medicaid prohibits programs from collecting additional reimbursement from clients.

Thus, not surprisingly, the self-sufficient programs studied existed in environments which did not impose all of these constraints.

(1) Each of The Six Programs Had At Least One Compatible Third Party Payment Source

The primary reason that the six programs are financially self-sufficient is that they have a significant third party source to tap. These sources were not necessarily easy to tap (as discussed in the following sections) but they did exist. Five of the six programs have either liberal Medicaid or strong private insurance coverage that specifically covers substance abuse. The sixth program draws upon special state payment sources.

- New York and California are both well-known for their liberal Medicaid plans. Both states make specific provision for the inclusion of drug abuse treatment programs. Both states have specific schedules of drug treatment and related services for which reimbursement can be made. JEFF-GRAND, PHOENIX and MMHP have modeled their programs on state protocols, and provide mainly the services allowed by Medicaid. Finally, client eligibility requirements are quite broad, enabling virtually all of the centers'

clients to enroll and maintain eligibility during the course of treatment.

- ROBINWOOD (Detroit) and GATEWAY (Pittsburgh) are both located in the center of highly industrialized and highly unionized areas. Recognizing the high cost (both economic and personal) of substance abuse among workers, union and industry leaders have encouraged the inclusion of substance abuse benefits in union contracts. Thus, in these areas, Blue Cross/ Blue Shield plans contain comprehensive substance abuse and outpatient psychiatric riders which pay for most of the services provided by the two programs. Concomitantly, most of the clients served by the two centers are steady employees or dependents of employed persons. In part, this is because union workers dominate the catchment area. But more important, both programs market agressively to this clientele.

- VITAM is situated in a relatively affluent area and obtained its early financial support from this affluent population (fees and contributions) and from its NIDA grant. Because it is a children's program, VITAM is eligible for reimbursement from the Department of Children and Youth. Also, because it operates a school, it is entitled to funding from local school districts. Finally, it collects some support from Food Stamp and Child Nutrition Programs, from parents, and from private insurance companies.

It seems clear that without these major third party opportunities, the six treatment programs would not exist as they do today. Of course, considerable hard work and individual iniative were required to realize income from these payors; unfortunately, even with hard work and iniative, many programs may not have access to these payors.

(2) <u>These Opportunities Do Not Exist Uniformly For All Treatment Programs</u>

As was discussed on pages 4 and 5, these favorable conditions do not exist in all states or localities. Moreover, even in the states occupied by the six programs, the third party

opportunities are not available to all centers. For example:

- MMHP is a private program licensed by the State and City to provide methadone maintenance services; this license is required as a condition of Title XIX reimbursement. MMHP recieved its license in 1973 and, according to the program Director, was the last of the 24 private programs in the City to be licensed. Since 1973, 13 of the 24 private programs have closed and, to his knowledge, no other private programs have been licensed. During this period, the number of public programs has grown and there are now about 100 public methadone and detoxification programs in the City. Moreover, all clinics (both private and public) are now limited to a capacity of 300. Apparently, the City is attempting to make drug abuse treatment a public service and, therefore, the conditions are not favorable for the development of a private methadone maintenance center in New York City.

- In California, Medicaid reimbursement is also tied to a State license and, according to the two programs surveyed, these licenses are difficult to obtain. PHOENIX and JEFF-GRAND both report that licensure is based, in part, on a time consuming and difficult protocol. Until this protocol has been approved and a license issued, no Title XIX reimbursement is available. Furthermore, submission of the protocol requires that a program have a facility, a staff, and a program plan. Thus, a program must be either pre-existing or have access to financial support for initial development. JEFF-GRAND was initiated with the personal funds of the Board of Directors and stockholders. Other funding sources used for development might include NIDA grants or contracts, state funds, or contributions. Obviously, such funds are not easy to obtain. Even if a program can generate up-front monies, JEFF-GRAND and PHOENIX report that the number of licenses issued seems to be limited. Apparently, a program needs community backing and strong political support to obtain a license and begin collecting Medi-Cal funds.

- GATEWAY and ROBINWOOD had to become accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) before they could collect from Blue Cross/Blue Shield. Both now are accredited as alcohol facilities and this status enables them to collect reimbursement for drug and alcohol patients under substance abuse provisions.

  - ROBINWOOD reports that it was time consuming and costly to achieve accreditation; each subsequent survey will cost between $600 and $2,000 depending on the length of the survey and the number of surveyors.*

  - GATEWAY received only one-year conditional accreditation for each of the past three years. This fall the program must secure the more strenuous two-year accreditation to retain its Blue Cross entitlement.

    In addition, ROBINWOOD collects reimbursement under Blue Cross/Blue Shield of Michigan's outpatient psychiatric center (OPC) rider and must meet specific BCBSM requirements. Currently, there is a moratorium on the award of new OPC contracts. It seems that more and more insurance companies are requiring JCAH accreditation as a condition of reimbursement. JCAH criteria evaluate a program's staffing, procedures, medical records, and other dimensions. NIDA is now focusing technical assistance resources on helping programs receive accreditation but even with this assistance, many programs may have difficulty becoming providers.

- VITAM is the most idiosyncratic program of the the six studied. It draws most of its funds from sources that do not generally support drug abuse treatment:

  - Reimbursement from the Department of Children and Youth (equalling $826 per month per

*Programs are required to pay professional fees and expenses of the JCAH surveyors.

child) is limited to programs that serve adolescents or children and serving this sub-population often presents additional responsibilities and costs. Many drug treatment programs do not or cannot serve this clientele.

- Reimbursement from local school districts (equalling $530 per month per child) is available only to licensed schools. VITAM obtained a license as a "school for children with social, emotional, and learning disorder problems" but only after three years of negotiation.

- Reimbursement for meals is limited to residential and day-treatment programs that have kitchens.*

Few programs have the unique combination of characteristics that enable VITAM to collect reimbursement from such diverse funding sources.

This brief report can only comment on the constraints imposed by the payors tapped by the six programs; recall, however, that the very existence of these barriers connotes the existence of a viable payor. Programs in other areas may face a more serious barrier where no major payor exists at all.

2. PERSISTENCE IS ALSO REQUIRED TO ACHIEVE FINANCIAL SELF-SUFFICIENCY

In addition to favorable third party reimbursement opportunities, the hard work and diligence of the six programs directors and their staffs were equally responsible for the programs' financial success. In no case was reaching financial self-sufficiency easy and, in fact, maintaining this status presents a continuing challenge.

(1) All Six Programs Experienced Periods of Financial Uncertainty And Adjustments to Attain Self-Sufficiency

*Food Stamps are available only for residents. Child Nutrition Program reimbursements are available for all meals served to residents and day-treatment patients.

None of the six programs had thrid party reimbursements at their inception. All programs went through periods of financial uncertainty and each of the programs developed unique and creative mechanisms for coping with third party and other requirements.

ROBINWOOD was originally set up as a private corporation and most of its clinicians were compensated fifty percent of all fees charged. Under this mechanism, staff shared the risk of "no-shows" and down-time and ROBINWOOD's cash requirements were held to a minimum. In anticipation that Blue Cross/Blue Shield of Michigan reimbursement would soon be made only for services provided by salaried staff, ROBINWOOD changed its compensation policy; this resulted in dissatisfaction and most of the original staff resigned. Although ROBINWOOD recovered, this was a period of chaos and strained public relations. In addition, ROBINWOOD initially intended that about one-fourth of its clients could be indigent and charged reduced rates. BCBSM objected to this plan, arguing that under such a policy BSBSM would be subsidizing the care of non-insured clients. If ROBINWOOD continued to charge on a sliding-fee scale, BCBSM was prepared to pay only an "average" charge, computed on the basis of all charges, even the reduced ones. Obviously, without an alternative funding source, (e.g. a grant) ROBINWOOD would be unable to break-even (i.e. attain 100 percent self-sufficiency) and, therefore, reluctantly altered its admission policy. Now, ROBINWOOD accepts only clients whose insurance or personal resources will cover the full cost of care.

GATEWAY began serving clients in 1972 with the expectation that a contract with Blue Cross of Western Pennsylvania (BCWP) was imminent. For a variety of reasons, the contract did not materialize until late 1975 and this placed GATEWAY in a precarious financial position. This situation was exacerbated by a number of other factors:

- GATEWAY lacked a firm financial and admissions policy and admitted clients without making any arrangements for payment. Moreover, the per diem charges were less than the real cost of care.

- The program was saddled with a large facility and expensive mortgage.

- The program experienced a public relations image problem within the professional community from which referrals were made and, thus, referrals and utilization declined.

As a result, GATEWAY's Board of Directors engaged a consulting firm which recommended some dramatic changes. A new Executive Director, Controller, and other staff were hired and more stringent financial and admission policies were adopted. With the income from BCWP and the new iniatives, GATEWAY expects to break even this year.

VITAM also experienced serious financial difficulties that were resolved only after a major reorganization and restaffing. Even with a large NIDA grant during the early years, internal management problems created a sizable financial deficit:

- VITAM secured a very costly mortgage which was poorly negotiated and, thus, incurred a substantial burden.

- The program became involved in a construction program with substantial cost overruns.

- VITAM did not make arrangements for payment prior to a client's admission into the program.

- The program was unaware of, and therefore did not collect from, a number of important third party sources.

In 1976, the Board of Directors became concerned about VITAM's financial viability and directed a number of sweeping changes, including recruitment of a new Executive Director and Controller,

reorganization and strengthening of the organizational structure, and tightening of the financial management policies.

When the idea for JEFF-GRAND was originally conceived, 21-day outpatient detoxification was not a covered service under Medi-Cal. The Director worked closely with the State in establishing criteria for coverage of this service. Effective July, 1977, routine narcotic detoxification was available on an inpatient basis only to patients with serious medical complications. During the time the Director was working with Medi-Cal, she also was initiating JEFF-GRAND and it took about a year to obtain provider status. Thus, prior to the first collections, the program incurred development costs for procuring and renovating a facility, hiring and training a staff, and developing a program plan, all requirements for obtaining a license. After being refused state and local funding, the Board and stockholders made significant investments in and loans to the corporation to support it during the development year. Without these private funds, the program would not exist. And, indeed, the program was instrumental in creating the very third party mechanism which now supports it.

The Director and Founder of PHOENIX spent over a year developing the program and securing financial arrangements. His original objective was to establish a program that treated not only drug abuse problems but also the larger medical problems experienced by many addicts. He approached several physicians with a proposal to establish such a clinic but none had adequate capital. He then established a relationship with the Los Angeles Counseling and Guidance Center (LACGS), a private non-profit psychiatric clinic in the City. LACGS assisted the Director during the program development year by paying his expenses (but not his salary). He has finally obtained a license and is collecting Medi-Cal reimbursements but states that this process was arduous. One of the most difficult requirements was demonstrating community support for the type and location of the program. Considerable lobbying and political negotiating was involved.

MMHP was created as a private physician clinic, during a time when any physician could apply for a license to open a methadone clinic. As such, it had relatively little difficulty initially becoming licensed and collecting Medicaid reimbursements. Many such programs were started around this time and, not unexpectedly, allegations of fraud developed. From these problems there developed an atmosphere of suspicion about the financial integrity and quality of care in private methadone maintenance programs; some of this mistrust was deserved and some was probably not. Nonetheless, when State and City programs were given a rate increase (from $4.00 to $8.00 per day), the private programs were maintained at the $4.00 rate. In response, a consortium of private programs sponsored a suit on behalf of one private physician. The judge ruled in favor of the private practitioner but, prior to the final disposition of the case, the appealing physician was indicted for Medicaid fraud. The rate was not increased and MMHP continued to provide services for $4.00 per day. (The rate for City programs has since been increased again, now to $9.00). The relatively low rate has resulted in a number of problems for the program. First, MMHP is not able to pay competitive wages and so staff turnover is high. In addition, the low rate prevents the program from adding several services that the Director feels are crucial to effective drug treatment.

(2) Maintaining a High Level of Third Party Income Requires Continued, Careful Management

These programs have completed the most difficult step in becoming financially self-sufficient, that is, they have developed workable relationships with the third party payors and with clients. However, once these relationships are established, careful management is required to maintain them. Most management attention is now focused on managing scarce resources. Although three of the six programs are for-profit corporations, none of the six showed large "profits" and all are operating near (some slightly above and some below) the break-even point. The reimbursement rate, whether negotiated or fixed, may not exactly equal true cost

and always assumes high levels of efficiency, frugality, and utilization. Obviously, if the reimbursement rate does not cover the cost of care, a program that relies solely on such reimbursement cannot subsist. Therefore, the role of the manager is to (1) understand and monitor the costs of providing services, (2) compare costs to revenue periodically, and (3) take steps to assure that revenue covers costs. This can be done by

- Increasing the revenue
- Decreasing the costs

The six programs carry out these management responsibilities in some interesting ways. For example:

- Contingency Planning for Different Levels of Utilization and Different Reimbursement Rates: GATEWAY prepares a dozen annual budgets, each based on different assumptions about the level of utilization and on possible rates to be negotiated. By comparing these conditional budgets to their actual monthly utilization and cost experience, GATEWAY is better able to keep costs in line.

- Strict Expenditure Controls: Frugality is the watchword at VITAM. Among the techniques employed are the following:

  - The linens used in the residential program have been donated by the local hospital. VITAM only pays a nominal fee for laundry services.

  - A formal purchase order system is used and all purchase discounts are taken.

  - The Controller evaluates competitive bids for all major purchases or services.

  - After eight months of negotiation, the excise taxes ($100 per month) were removed from the telephone bill.

  - The long distance telephone bill is analyzed monthly and all calls over $1.00 are accounted for.

- Financial Diversification: Several of the programs are taking aggressive steps to broaden their financial bases, rather than relying on a single, vulnerable source. For instance:

  - JEFF-GRAND is creating a non-profit corporation and MMHP will apply for non-profit status in 1979, both to become eligible for federal grant funds.
  - VITAM is building additional residential capacity and expects that the income from the added beds will offset the loss of NIDA grant funds.
  - Both GATEWAY and VITAM have established professionally managed, ongoing fund raising campaigns to support program expansion and provide reserves for security.

- Program Diversification: Three of the programs believe that the cost of providing drug abuse treatment can be partially offset by providing other, more easily reimbursed, services. Two--ROBINWOOD and GATEWAY--also serve alcohol clients* and find, generally, that the alcohol clientele tend to have better private insurance coverage or personal resources. The third program, JEFF-GRAND, generates sizeable program income by providing primary medical services, most of which are reimbursed by Medi-Cal.

- Rate Negotiation: As noted earlier, MMHP currently suffers under a low reimbursement rate ($4.00). The program has been engaged in rate negotiations with the State for over a year and, based on its operating budget for the coming fiscal year ($450,000), has recently obtained State approval for a $7.39 rate. This rate must now be reviewed and approved by City officials before coming into effect. Actually, all six of the study programs are now in some phase of rate negotiation with one or more payors; they report that such negotiation is one of the most arduous and continuing tasks of third party management.

*Funding considerations are not the only reason for this programmatic mix.

These programs will face continuing challenges and, no doubt, develop additional innovative mangement techniques to parlay maximum reimbursement from the various third party payors. They view these efforts not as a special, one-time iniative but, rather, they see these tasks as the essence of drug treatment program management and, frankly, are surprised that treatment programs can survive at all without engaging in some or all of these strategies.

3. IN CONTRAST TO A POPULAR VIEW, THE SIX STUDY PROGRAMS HAD SURPRISINGLY FEW COMPLAINTS ABOUT THIRD PARTY PAYORS

Considering the resistance that many treatment programs voice to seeking third party reimbursements, the six programs directors expressed few complaints. The majority of complaints focused on initiating third party mechanisms as discussed above. Other complaints centered predictably on the administrative aspects of third party collections, such as:

- Billing Lag: Almost all of the payment sources are more sluggish than desirable, creating annoying and, in some cases, serious cash flow problems. Although several payors reportedly process invoices within two weeks, payment lags of 60 days are more common. Also, several programs noted that public payment programs (e.g. Medicaid, State Department of Children and Youth) get more and more dilatory as the end of the fiscal year approaches; payments as late as six months were not unheard of.

- Changes in Procedure: Several of the programs complained that the third party payors frequently change billing forms and instructions, making it difficult for the bills to be submitted accurately and on time. For example, two of the programs had experienced frequent changes in the set of diagnostic codes (e.g. ICDA) that were to be used for billing.

- Tracking Elibigility: Almost all of the programs found that considerable work is required to monitor continuing eligibility of the clients.

- Determining Benefits: Several programs have had trouble determining precisely which type and what

amount of services are covered by the payors. For example, if the patient has exhausted part of his/her benefits with a prior provider, the treatment program must determine the extent of remaining benefits; in some cases, this cannot be determined until a claim is rejected because benefits have been exhausted.

Three additional topics of concern to many drug programs were explored with these six:

- Staffing: In general, respondents felt that third party requirements did not unduly influence program staffing decisions, and only two would change their staff composition dramatically if third party requirements were more flexible.

  - JEFF-GRAND cannot receive reimbursement for psychotherapy unless counselors hold PhD or MD degrees. JEFF-GRAND does not believe that these professionals are the most successful in treating their population and does not employ them. If staff requirements for psychotherapy were less restrictive, they would hire additional counselors, probably nurses. Limited nurse counseling is now reimbursed only as a small part of methadone maintenance treatment.

  - MMHP had only three bachelor level counselors. With the anticipated higher rates from Medicaid, MMHP will be able to expand its staff to include a part-time psychiatrist and psychologist, a full-time social worker and vocational/educational counselor.

  Staffs of the other four programs combined professionals and paraprofessionals depending on their treatment philosophy. These four expressed no desire to change their staff complexion, except for the possibility of adding vocational rehabilitation and training staff.

- Services: In general, the programs felt that the third party sources covered a sufficient range of services and duration of treatment so that individual treatment plans could be based on clinical

judgements rather than on payor treatment regimens. In California, JEFF-GRAND participated in designing the 21-day detoxification program which is now the standard treatment protocol for detoxification throughout the State. PHOENIX believes that the 21-day detoxification period is too short and is working with Medi-Cal to lengthen the allowable detoxification period. The other four programs also have considerable flexibility, for example:

- ROBINWOOD provides a full range of psychotheraputic services including family therapy, group and individual therapy, and marathons. They also provide a didactic lecture series for clients and their families on the psychology of substance abuse. These lectures are reimbursed under the existing BCBSM Substance Abuse Riders.

- In additon to a complete residential program, VITAM operates a special school for its adolescent residents; local school districts pay VITAM $596 per month per child for education and transportation.

- Within the existing per diem rates, GATEWAY is able to offer 28-day residential rehabilitation services which affords staff ample time to interact with each client on an individual and group basis.

Programs expressed interest in adding vocational services and expanding aftercare which are rarely covered as a direct service by health insurance payors.

- Confidentially: Finally, many programs believe that clients are reluctant to use third party sources for fear that their families or employer will find out or disapprove. The six study programs have encountered virtually no difficulty. Confidentiality can be easily maintained although most of the programs felt it is clinically wise to involve families, and often employers, in the treatment process.

- Nationwide, confidentiality regulations prohibit programs from contacting the parents of adolescent clients without written, informed consent; unless the parents are involved, services are usually not reimbursed. Only two of the programs serve minors and each strongly encourages family involvement, both to enhance treatment and to ensure payment.

- The two programs which rely chiefly on employer sponsored insurance (i.e., GATEWAY and ROBINWOOD) often encourage clients to inform and involve their employers in the treatment, especially when their continued employment is in jeopardy. Also, they work with Employee Assistance Programs (EAP) to keep employers informed of clients' progress.

Of course, it cannot be concluded that this harmonious situation can exist among all payors and drug treatment providers, or that the popular view is not well-founded. Neither, however, is this popular view a foregone conclusion and treatment programs should perhaps enter into third party relationships with less foreboding.

4. THE SIX PROGRAMS HAVE SEVERAL STRENGTHS IN COMMON WHICH ENABLE THEM TO BE FINANCIALLY SELF-SUFFICIENT

Although the programs are highly unique, they do share a number of strengths. These have been alluded to throughout the report but are summarized below:

(1) Above All, Each Of These Programs Makes Financial Self-Sufficiency A Major Program Goal

These programs operate as businesses--they have to be self-sufficient or they close. This fact alone is a powerful incentive for maximizing third party collections and it shapes every aspect of these programs. The study programs share three overriding management policies which support the goal of financial self-sufficiency:

- Most Clients are Personally Responsible for the Cost of Care: In all programs except MMHP, the client's personal financial

liability is made clear prior to admission. Even if a third party source is involved, the client remains responsible and his liability is relieved only after the third party actually pays. The programs are not merciless about collections. They work with each client to identify potential third party coverage for the client and if no payment coverage is available, clients can arrange a time payment plan. Five of the six programs will negotiate reduced fees or waive payment under special circumstances. And only one program refuses to serve clients who cannot pay the full fee.

- Treatment Staff are not Insulated from the Financial Aspects of the Program: Treatment staff are made aware of the necessity of collecting adequate reimbursement (i.e. without reimbursements, they cannot be paid), are urged to believe in the value of their own services, and each staff member is expected to fulfill a specific role in the financial management process, even if only to complete an encounter form and medical record. ROBINWOOD, the only program that collects a substantial amount of money from clients, makes timely payment a therapeutic issue.

- Administrative and Financial Management Tasks are Given a High Priority: All six programs are headed by well-trained, experienced professional managers who have a clear understanding of the clinical aspects of the program but whose major concern is for the viability and integrity of the organization. For the most part, the managers demonstrate obvious leadership skills, and enjoy uniform respect from their staffs. They use budgets, reports, or other management tools, appear to set priorities, to be goal oriented, and to delegate responsibility well. Finally, all are exceptionally committed to their programs. This strong business orientation, however, does not subjugate the main concern of these programs which is to deliver substance abuse

services. As one of the program director's stated "If you provide quality care, the money will come."

(2) All Programs Maintained A Highly Visible Profile In The Community

These programs do not operate in a vacuum but continually "sell themselves" to the communities they serve, which gives them more leverage in obtaining financial support. They use a variety of techniques to stay in the public eye. For example:

- Marketing: ROBINWOOD has established an active Central Diagnostic and Referral Unit (CDR). The CDR supervisor works with industry to set up Employee Assistance Programs (EAP). These EAPs become a major referral source for ROBINWOOD and, thereafter, the CDR helps clients keep or regain their jobs.

- Public Relations: VITAM employes a part-time professional public relations coordinator who carries out a number of publicity activities, including

  - A quarterly newsletter
  - A "Vitam-O-Gram" to announce occasional events
  - A brochure entitled "Ways of Giving to Vitam"
  - Periodic press conference and press releases to local news media
  - Conferences and seminars
  - Published articles in local journals and newspapers.

- Fund Raising: GATEWAY has developed an elaborate fund raising manual which outlines dollar goals, sets time limits and assigns responsibilities. The year-long fund drive will

solicit industry, unions, banks, former patients, prominent members of the community, staff, board, and foundations in an attempt to raise money to repay a sizeable mortgage arrearage. VITAM has a continuing fund raising program through which they expect to raise about $100,000 every year, to be used for capital improvements.

- Political and Community Involvement: Two of the programs--JEFF-GRAND and MMHP--attribute a large measure of their financial success to their extensive lobbying at state and local levels. As mentioned earlier, JEFF-GRAND was influential in changing Medi-Cal detoxification reimbursement from in-to outpatient. MMHP--plagued by the poor reputation of private programs in New York City--has had to work constantly with State and City officials to gain credibility and to establish a more equitable reimbursement rate. GATEWAY and VITAM both credit part of their financial self-sufficiency to the dedication and stature of their board members. Both boards are very active in program policy and are comprised of political, industrial, and community leaders.

(3) Billing Systems Support the Objectives of Financial Self-Sufficiency

In keeping with the goal of financial self-sufficiency, the six programs have each established comprehensive and deliberate systems for billing. Although the source of payment and billing requirements vary substantially, each system performs the following functions:

- Intake and financial evaluation
- Continuous monitoring of third party eligibility and financial status
- Routine identification of billable services (e.g. encounter forms, daily activity logs)
- Efficient and timely billing, at least monthly

- Persistent follow up on delinquent accounts

Despite these billing systems, all programs continue to experience some bad debts. Because these programs rely almost solely on client fees and private insurance, this problem is very serious and is handled in a variety of ways:

- PHOENIX, JEFF-GRAND, and MMHP suffer similar problems in bad debts from the Medicaid programs. These occur primarily as a result of lapsed eligibility or if a client leaves treatment before the program has secured his/her Medicaid card number. PHOENIX and MMHP, both having relatively long treatment periods, photocopy the Medicaid card each month so the information will be available for billing. PHOENIX also has a substantial number of direct pay clients and these are detoxified and discharged from the program if accounts become delinquent.

- GATEWAY attempts to obviate bad debts by collecting the $1,400 total fee prior to or during the 28-day residential stay. When this is not possible, they set up a deferred payment plan and the Controller follows each case individually.

- ROBINWOOD turns seven month old accounts over to a collection agency after all reasonable attempts to obtain payment have been exhausted. They do so in compliance with Section 2.11(n) of the Federal Confidentiality Regulations which define the conditions under which client identities can be revealed to "service organizations". Service organization has been interpreted to include lawyers and collection agencies. These parties, in turn, are fully bound by the confidentiality regulations.

- When parents are responsible for the full cost of treatment at VITAM, the Director explains the fees to the family, evaluates the parents' financial capacity, and establishes

a payment schedule; sometimes reduced fees are negotiated. Periodically, each account is reviewed and parents whose payments are not up to date are brought in for counseling; new arrangements are made when necessary.

Only one of the six programs will terminate treatment if a client refuses to pay. All six expect that their percentage of bad debts will decrease as eligibility screening and monitoring improves and as clients and payors learn that the day of free services is over.

* * * * * * * * *

In summary, the study revealed two major conditions that contribute to financial self-sufficiency--a hospitable environment for third party collections and strong and informed leadership. While these two factors may not be sufficient to bring about financial self-sufficiency in other drug treatment centers, clearly they must be present in all. And, realistically, replicating these conditions is not easy.

Nonetheless, states and programs can learn some important lessons from the experience of these six programs. The following recommendations can provide direction for seeking or providing technical assistance and in developing training programs.

- Workshops and Technical Assistance: NIDA, and many States, have already sponsored many seminars on third party reimbursement and financial management and continue to provide technical assistance in a number of administrative and clinical disciplines. Based on the experience of these six programs, it appears that future training and assistance should focus on:

  - Board Development: Identify and recruit community, business, and political leaders who have influence with third party payors and other sources of funds and who will use their influence to assist programs to attain funding.

- Lobbying: Identify governmental, industry, or union officials who make decisions about third party coverage and then assemble "facts and figures" to support the cost-benefit or need for on-going treatment.

- Marketing: Develop marketing strategies to increase the percentage of clients who are eligible for or enrolled in some type of third party coverage.

- Fund Raising: Develop creative, practical ideas or themes for fund raising and then prepare and implement fund raising plans (e.g. time tables, brochures, letters of solicitation, mailing lists, target amount, etc.).

- Accreditation: Since third parties increasingly require treatment programs to meet accreditation criteria, and since the six programs report such extreme difficulty in becoming providers, NIDA's technical assistance and training efforts should help programs understand the requirements and processes for accreditation and should also help programs develop the procedures and documentation necessary for compliance.

- Rate Setting and Negotiation: First, establish the true costs of services and, second, negotiate with third party payors for adequate reimbursement rates. Even better, develop systems for continuous monitoring of costs and establish mechanisms for automatic, periodic rate renegotiation. This type of assistance may be provided to a single program but might be more effective if provided to a group of programs pursuing a common source.

Many of these technical assistance or training activities can most appropriately be addressed to treatment programs organized along traditional state lines. Others, however, may be more effective if the target audience is defined by different, more relevant criteria. For example, treatment programs may be

grouped according to the existence of large union representation in the service area, to the stage of development in seeking third party reimbursements (e.g. those that already have provider status and need a billing system and those who have not attained provider status yet), or according to the types of services provided (e.g. residential or outpatient). SSAs will play an important coordinating role in helping treatment programs communicate across state lines.

- Pool of Resources: Within the six study programs and, most assuredly, within many other programs throughout the country, there are administrative and financial professionals who have accomplished what the majority of drug treatment programs are still struggling to do. Many of these professionals are in a very advantageous position to help other treatment programs over the hurdles of third party reimbursement. Through studies such as this and other means, SSAs should identify these "field" resources, catalogue their skills and availability, and seek access to these resources. SSAs might consider developing some communication networks that tap into the financially self-sufficient programs on a regular basis. This type of cross-fertilization can provide inspiration, facts, and assistance to NIDA programs.

- Incentives for Third Party Collections: All six program directors were asked for suggestions about how publicly-funded programs could increase their financial self-sufficiency. One uniform response was to increase the incentive for generating these revenues. NIDA's current maintenance strategy guarantees most programs 60 percent funding and states and programs have developed many ways for generating the balance. Regardless of the particular mechanism employed, it seems clear that each treatment center must bear some risk (and have the possibility of some reward) for generating additional program revenues. Based on this limited survey, it is impossible to determine exactly what type of

incentives might work. Therefore, it is recommended that SSAs review the grant and contract award processes to determine (1) the degree of incentive upon individual programs to generate funds and (2) the relationship between these incentives and success in collecting third party reimbursements or client fees, and (3) means by which incentives can be improved.

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