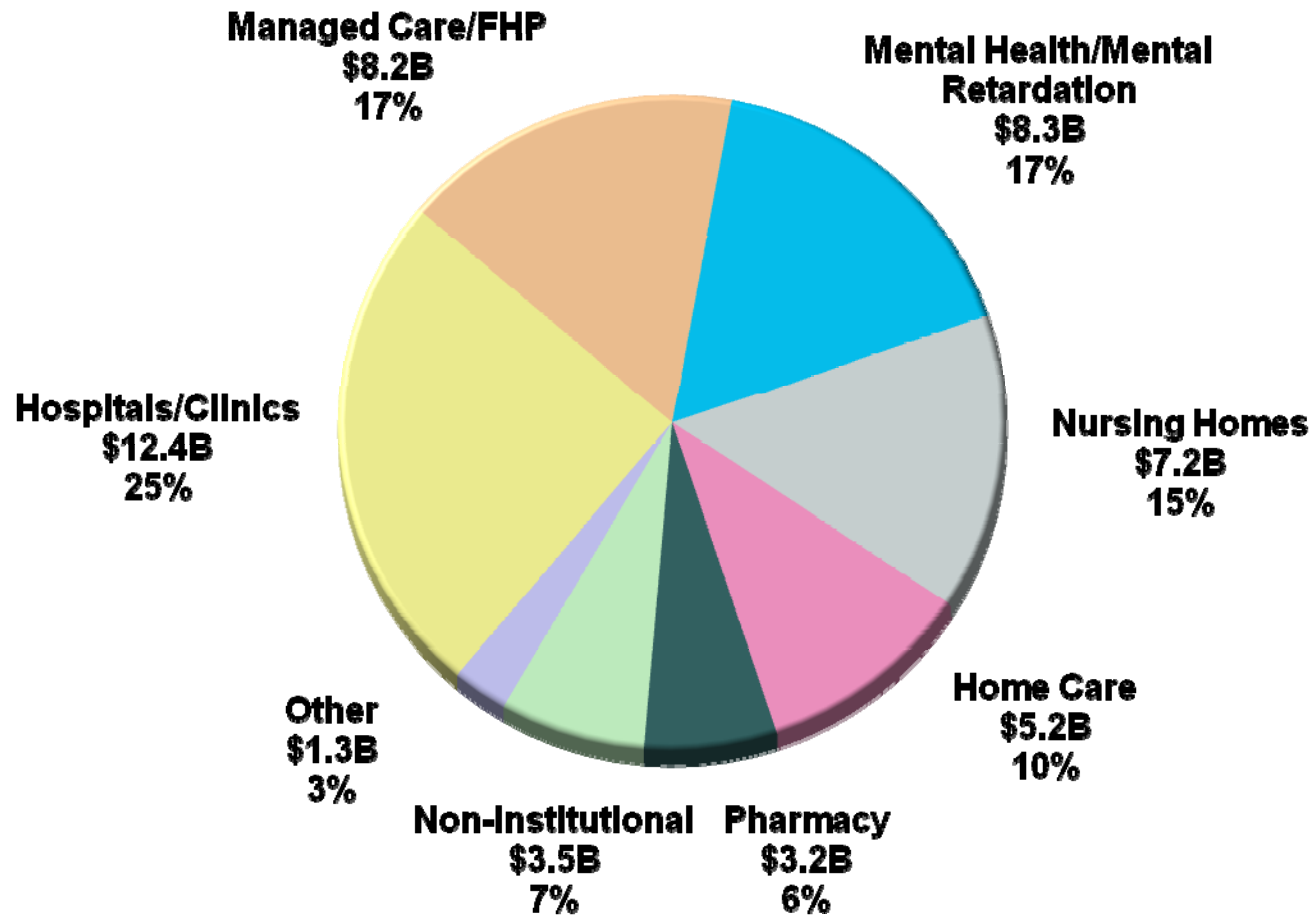


*The Impact of Insurance on
Behavioral Health
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New York, NY:
The New York Perspective*

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NYS MEDICAID

2009-2010 All Funds Spending By Program \$49.2 Billion



Medicaid Special Needs Populations

Only 20 Percent of All Enrollees, but Accounts for 75% of all Expenditures in Calendar Year 2007

	Total Medicaid Expenditures in Billions	Enrollees	Pct. Total Expend.	Pct. Total Enrollees	Avg. Costs per Enrollee
Total MA Population incl. Non-Utilizers	\$41.4	5,104,843	100%	100%	\$8,108
Non-Special Population ¹⁾	\$10.3	4,075,222	25%	80%	\$2,528
Special Need Populations ²⁾	\$31.1	1,029,621	75%	20%	\$30,195

1)Includes non-utilizers

2)High Need populations are HIV, MR/DD, Mental Health, Chemical Dependence, LTC and Chronic Care.

Note: Enrollees include persons enrolled at anytime in Calendar Year 2007

Source: DOH/OHIP Datamart

Overlap Between Special Need Populations: Mental Health - Calendar Year 2007

	Number of Persons	Percent
Total Number of Persons using Mental Health Services	472,098	100%
Overlapping Conditions		
Long Term Care (Institutional & Non-Institutional)	84,381	18%
Chronic Care*	108,328	23%
MR/DD	41,185	9%
Chemical Dependence	62,743	13%
HIV	17,235	4%

** Defined by the following 10 conditions; Acute Cerebrovascular Disease (CVD), Acute Myocardial Infarction, Asthma, Congestive Heart Failure (CHF), Chronic Renal Failure, Chronic Obstructive Pulmonary Disease (COPD), Coronary Atherosclerosis, Diabetes, Hypertension and Sickle Cell Anemia*
 Source: DOH/OHIP Datamart

Coordinating the Care of High-Cost, Medically Complicated Beneficiaries

- The Chronic Illness Demonstration Program (CIDP) will run for three years at seven sites at a cost of \$30M (including FFP).
- Each project is required to have an integrated network of providers to assure facilitated access to medical, mental health and substance abuse services for participants and collaboration with community-based social services.
- CIDP uses a predictive algorithm to identify patients at high risk (est. 70%) for medical, substance abuse, or psychiatric hospitalizations in the next 12 months.

Coordinating the Care of High-Cost, Medically Complicated Beneficiaries (cont.)

- These patients have largely uninterrupted Medicaid eligibility, but limited engagement in primary care.
 - ✓ Per patient average cost in the prior 12 months was \$37,500.
 - ✓ Average cost in the next 12 months is expected to be \$46,000 without intervention.
- Shared risk and savings will be introduced in the second and third years of the project.

Federal and State Health Reform Goals Are the Same

- Expand coverage & access
- Enhance quality
- Control costs

Reform Objectives

- **Develop** a new payment system to pay more for higher cost services and less for lower cost services
- **Ensure** better payment homogeneity for similar/comparable services across ambulatory care settings
- **Invest** in ambulatory care to provide more adequate reimbursement
- **Improve** clarity and transparency of payment structure and methodology
- **Update** payments frequently to recognize medical advances and changes in cost of service delivery
- **Encourage** migration of services from inpatient to ambulatory/primary care settings
- **Support** evidenced-based, state-of-the-art healthcare.

Reform Payment Methodologies

- Straightforward and transparent
- Based on costs of serving Medicaid patients
- Incentivize efficiency and rewards quality
- Recognize complexity/severity of illness
- Position NY for federal payment reforms

Reform Payment Levels

- **The 2008-09 Budget Began Reform**
 - Reduces inpatient rates, including inpatient detox
 - \$178 million invested in hospital clinics, ambulatory surgery and ER
 - Additional investments in D&TCs and physicians
 - Enhancements for weekend/evening hours, and diabetes/asthma educators
- **The 2009-10 Budget Builds on these Reforms**
 - Further reduces inpatient rates
 - Increases investment in hospital and community clinic rates
 - ✓ Medicaid will cover approximately 90% of average hospital clinic costs
 - ✓ Medicaid will cover approximately 90% of average D&TC costs
 - Increases investment in physician fees
 - Enhances payments for providers that meet medical home standards

Clinic Certification Reform Needed in New York State

- Over the years clinic certification had become irrational in New York.
- Licensure, certification and Medicaid payment rests with several different agencies and had not been well coordinated.
- Some certifications had been frozen -- some rates frozen.
- Providers cope by figuring out how to get the kind of certification with the highest reimbursement while trying to provide the right service.

Certification Reform Policy

Adopted February 2008

- Clinic certification reform and Medicaid reform share the important goal of providing the right service to the right person in the right setting at the right price.
- Certification Reform Policy:
 - Ensures that the appropriate agency has lead authority for surveillance;
 - That applicable rules are clear to providers;
 - That certification rules do not impede coordinated care for patients with multiple co-morbidities, and that;
 - Mental health services are integrated into the primary care delivery system.

APG's Methodological Advantages

- Recognized and tested payment system
- Enables prospective pricing for Ambulatory Care
- Grouping and payment logic similar to DRGs
- Uses standard HIPAA-compliant code sets (HCPCS and ICD-9 codes)
- Uses current HIPAA compliant claim formats
- Greater clarity and transparency of payment structure and methodology
- Features more frequent payment updates to:
 - Better acknowledge the impact of medical advances, and
 - Accommodate changes in service delivery patterns.
- Four year transition using “blend” to allow time to adjust to new payment methodology

APG's Clinical Strengths

- Superior to “Threshold Visit” and outdated PAS rates
- Payment varies based on service intensity
- Payment homogeneity for comparable services across ambulatory care settings
 - relative payment “weights” do not vary by setting,
 - base rates do vary to recognize differing cost structures between settings
- Emphasizes diagnosis and procedures over service volume

How Mental Hygiene Providers can prepare:

- Use the DOH website to learn more about APGs
<http://www.nyshealth.gov/healthcare/medicaid/rates/apg>
- Improve coding on claims according to ICD-10 and HCPCS codes to ensure appropriate reimbursement through APGs
- Talk with your billing departments and billing/practice management vendors about APG implementation
- Prepare to use new rate codes on claims upon APG implementation
- Test and check claims with eMedNY once testing capacity is available