Clinic Reform: The Clinical Model

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Changes are more than fiscal: Opportunity for clinical transformation

- Evidence that change is needed
  - Modal number of outpatient visits is 1
    - (Next highest frequency is 4)
  - People wait too long or fail to get access to clinic services
    - Almost 1/3 of hospital discharges wait > 1 months for a clinic visit
  - Too many people with SMI are stuck in non-clinic services (ACT; CDT)
Clinic Reform: Opportunities for clinical transformation

Driving frame for clinic reform:
- What do clinics need to do better in order to promote recovery
- How can reimbursement reform assist clinicians and clinics with tools that will add dimensions of flexibility and broaden the spectrum of services available in clinics
Clinic Reform

- Meet the client where he/she is
  - Flexibility to tailor services
    - Outreach
    - Crisis
    - Home visits
  - Flexibility for complex care
    - Multiple service per day reimbursed for certain services
    - Complex Care Management
  - Opportunities for integrated physical/mental health care
    - Health and wellness services
    - Consultation Services
    - Integrated Dual Diagnosis Screening and treatment
Elements of Reimbursement System

- **Services Billed using Ambulatory Patient Groups (APGs)**
  - based on CPT/HCPC Codes

- **Non Face-to-Face:** Bill for non face-to-face time spent coordinating care for complex patients
  - Time spent must be medically necessary and documented in the consumer’s chart

- **Multiple Same Day Services:**
  - Reduce the need for consumers to make multiple trips
  - Minimize missed appointments
  - Some limits will be established

- **Physician Billing:** For some services the physician component will be billed using the physician fee schedule
Elements of Reimbursement System

- Payment adjustments for:
  - Visits in a language other than English
  - Visits delivered outside of normal business hours
  - Visits provided in off-site non-licensed locations
    - Restricted to services for children up to and including age 18 and for homebound adults
    - Outreach and engagement will always be done offsite
  - Medicaid/Medicare cross-over clients will be reimbursed the same as Medicaid fee-for-service clients
APGs Replace “Threshold Visit”

- Uses CPT codes to consolidate related procedures
- Establishes procedure weights based on factors affecting resource use
  - service duration, location, practitioner qualifications
- OMH procedure weights will be based on the *minimum qualifications* for staff to be permitted under OMH regulations to deliver a particular procedure;
  - Doctors
  - Psychologists
  - Nurse Practitioners/Physicians’ Assistants
  - LCSWs/LMSWs/RNs/psychoanalysts/other licensed counselors
  - Peers/family advocates/approved others
- Payments for a visit is the service weights (added together and discounted as appropriate) times a base rate
Guiding principle:
How do we promote recovery?

- What works
  - Flexibility/Mobility
  - Groups
  - Integrated health and mental health services
  - Integrated substance abuse and mental health services
Clinic Reform: Synergies

- Strategies that will work together to boost transformation
  - Clinic Reform
  - Clinic Licensing:
    - Standards of Care
    - Adoption of “tracer methodology”
    - Focus on what clinics do and the outcomes they achieve---transformed services will be recognized
  - Care Monitoring Initiative:
    - Focuses on outreach, mobility, and engagement of patients at risk of falling out of care
  - Integrated Dual Diagnosis Treatment:
    - Encourages the treatment of substance abuse and mental illness at one site, by the same team
  - ACT Transformation:
    - Focuses on moving patients out of ACT services into more integrated community settings, such as clinic based services
Conclusion

- Clinic Reform: Model for transformed services that will
  - Enhance recovery and health in those who receive our services
  - Allow and promote a healthy “bottom line” for doing the right things