New York City Independent Budget Office Fiscal Brief

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Bearing the Cost of Early Intervention Services:

Recent Changes Not Likely to Shift Much Spending From City & State to Private Insurers

Summary

When federal legislators created the Early Intervention program to provide services to young children with disabilities, they intended that private insurers would pick up a significant portion of the cost. Yet much of the cost of providing assistance has been borne by the city and state. In 2010, New York City and State shouldered about 67 percent of the $482.3 million spent on providing Early Intervention services to nearly 60,800 children age 3 or younger in the city.

The city and state have sought to increase reimbursements from Medicaid, for which the federal government typically pays half, and especially from private insurers. Any costs not picked up by Medicaid or private insurance are covered by the city and state—$115.9 million for the city and $111.4 million for the state in 2010. Total city and state costs, including the state and local share of Medicaid, were $321.6 million in 2010.

Recent legislation in Albany, including changes in the budget adopted last month and set to go into effect in April 2013, have been aimed at improving the ability of the city and state to get reimbursements for Early Intervention services. IBO has examined claims data from 2002 through 2010 and considered the likelihood these legislative efforts will reduce the program's reliance on city funds. Among our findings:

- As efforts to claim reimbursements have grown, the city and state share of Early Intervention costs has fallen from about 80 percent in 2002 to just below 67 percent in 2010.
- The share of Early Intervention costs covered by private insurance reimbursements is still small, having grown from 0.1 percent in 2002 ($356,000) to 2.0 percent in 2010 ($9.6 million).
- Although few Medicaid claims were denied in 2009 and 2010 because of restrictions on plan benefits, more than 36 percent of all private insurance denials were due to insurer imposed restrictions.

Increased reimbursements by Medicaid and private insurance have occurred thanks to both external policy changes and improved claiming practices. There appears to be some room for improvement, in terms of speeding up processing times for claims submitted to Medicaid and private insurance and reducing technical errors. However, given the large percentage of claims denied due to private insurer restrictions on plan benefits, which the recent changes in Albany have barely addressed, there is a limit to how much more the city can do to improve reimbursements solely through process improvements.

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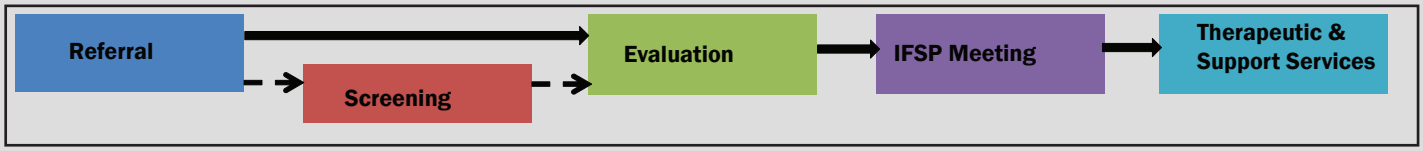
Background

The Early Intervention (EI) program provides therapeutic and support services to young children with disabilities or developmental delays and their families. It was created by Congress in October 1986 through an amendment to the Individuals with Disabilities Education Act, established in New York State in July 1993, and is administered locally by the Department of Health and Mental Hygiene (DOHMH). In 2010, New York City's total program cost, including administration and costs covered by third-party payers, was $507 million or 30 percent of DOHMH's budget.[1]

The primary impetus behind the program was an emerging consensus that the earlier children with disabilities receive therapeutic services, the greater the developmental and educational gains. There was also an expectation that reaching children at a young age would result in lower special education costs than if services were delayed until school age. EI was established as an entitlement program available at no cost to eligible children and their families.[2] Eligible children must be 3 years old or younger and have a diagnosed disability or delay in one of five areas of development: physical, cognitive, communication, social-emotional, and adaptive.

New York State has one of the largest EI programs in the country, serving 4.2 percent of children age 3 or younger in 2009, compared with 2.7 percent nationwide.[3] The percentage served is even higher in New York City at 4.4 percent.[4] In 2010, 60,767 New York City children used some type of Early Intervention services, and 36,657 of these used general services, meaning they had an approved Individualized Family Service Plan (IFSP). For a child with an IFSP who entered the program in 2008, the mean cost of providing services was $27,357 for an entire course of treatment, which could range from a few months to over three years. The median cost of a full course of treatment was $16,178.

Since the majority of costs are paid by the state and local governments, both the city and state have over time proposed a number of initiatives intended to trim spending without fundamentally altering program eligibility. Most recently, Governor Cuomo's Executive Budget for state fiscal year 2012–2013 contained a proposal to profoundly restructure the way EI is administered and funded. While the more controversial elements of this proposal were not adopted, the state is planning to transfer some of the administrative responsibility for the program from local districts to the state starting in April 2013. This is expected



The Pathway to Early Intervention Services

A child's entry into EI begins with a referral to one of DOHMH's borough-level offices. Under state law a number of different persons and entities—including health care providers, day care programs, and social service agencies—are required to refer all children suspected of having a developmental delay to DOHMH. A family may also self-refer into the program. After referral, a child is assigned an initial service coordinator and scheduled for either an in-depth multidisciplinary evaluation or a briefer screening test designed to determine whether full evaluation is necessary.

If an evaluator determines that a child is eligible for EI services, the next step is the development of an Individualized Family Service Plan. The IFSP is developed during a meeting between the child's parents or caregivers, the evaluator, the initial service coordinator, and a representative of DOHMH. The IFSP codifies the specific services to which a child is entitled, including frequency and expected duration. Each child with an IFSP receives ongoing service coordination and may also be eligible for assistive technology, respite (which provides temporary relief to caregivers), transportation, and various general services. General, or therapeutic, services make up the bulk of services provided. Specifically, most children utilize one or more of the following: occupational therapy, physical therapy, special instruction, speech or language therapy, and family services. Other available, but less frequently utilized, general services include audiology, nutrition, psychological services, social work, and vision services. Once an IFSP is approved, the child is assigned to a specific service provider or providers by DOHMH, and may begin receiving services.

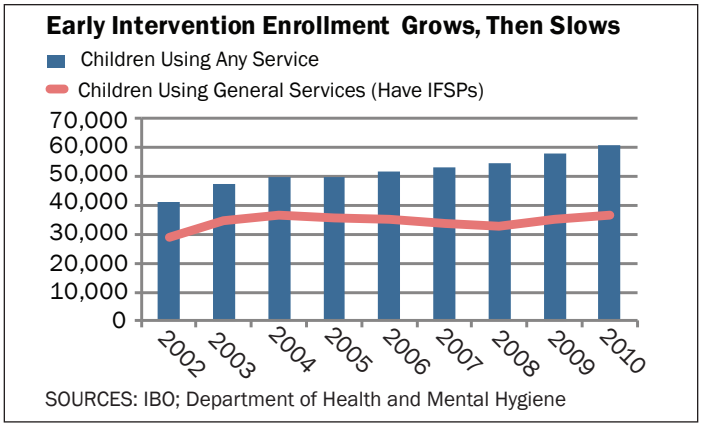
to lower overall administrative costs and may also affect third-party reimbursement rates, but should have little impact on service provision or direct program costs.

Given the share of the health department's budget devoted to the Early Intervention program and recent efforts to curtail city and state spending in this area, IBO has taken a close look at spending and funding trends in the program over time. This report utilizes nine years worth of claims data provided by DOHMH to examine to what extent the reimbursement of EI service costs by Medicaid and private insurance has increased since 2002, and how this was achieved. It also explores the opportunities and obstacles that remain to further increasing Medicaid and private insurance reimbursements and decreasing the program's reliance on city funds.

Early Intervention Services and Funding

During the period from 2002 through 2010, overall spending on EI services increased by 30.2 percent, but slowed significantly in the latter half of this period as enrollment growth also slowed. The funding structure outlined in federal and state law emphasizes the responsibility of public and private insurance carriers for these costs, but this has not always squared with actual program funding. In 2002, direct city and state funding (not including these jurisdictions' required contributions to Medicaid) covered the majority of the costs; however, the funding burden began to shift more towards Medicaid and private insurers throughout the course of the decade.

Spending Slows. From 2002 through 2010, the overall cost—in nominal dollars—of the EI program increased from $370 million to $482 million. Adjusted for inflation, all of the spending growth occurred in the early years of this period; real spending increased by 1.7 percent from 2002 through 2006, but fell by 5.7 percent from 2006 through 2010. These spending trends are closely related to changes in program enrollment. The number of children using EI services rose from 40,992 to 60,767 from 2002 through 2010, a nearly 50 percent increase, but growth slowed in the second half of the period. More significant was the slower growth in the enrollment of children using general services, those with approved IFSPs, since this subgroup is responsible for 98 percent of service costs. Enrollment of children with service plans increased by 21.6 percent from 2002 through 2006, but grew by only 4.5 percent from 2006 through 2010. The available data provide no explanation for this slowdown in the growth of



IFSPs. For their part, DOHMH maintains that they authorize all eligible children for appropriate services.

Increased Third-Party Reimbursements Had Modest Impact on Total City Costs. As initially envisioned by lawmakers, the cost of providing EI services was intended to fall primarily on public and private insurance. In the 1986 statute, the federal government is designated as the "payer of last resort" and it is specified that appropriated funds not be used to pay "for services which would have been [otherwise] paid for from another public or private source."[5] New York State law details the funding mechanism more explicitly: families are required to provide and municipalities are required to collect all documentation necessary to determine a child's insurance status and to seek payment from third-party payers. Wherever applicable, municipalities are required to first seek reimbursement from private insurers, then from Medicaid, for EI services. Only once third-party sources have been exhausted are remaining service costs divided between the city and the state.[6] The city and the state originally split these costs equally, but starting in April 2009 the city's share increased to 51 percent.

In practice, direct city and state funds have until recently covered the majority of costs for the city's EI program. In 2002, the city and state bore direct responsibility for 59.3 percent of EI service costs, or approximately $110 million each. Another 40.6 percent of the costs were paid by Medicaid, and less than 0.1 percent of costs were paid by private insurance. By 2010 a significant shift in the funding burden had occurred. While total service costs—again in nominal terms—increased by $112 million from 2002 through 2010, direct city and state costs grew by only a combined $8 million. Much of the increased cost was instead borne by Medicaid. From 2002 through 2010, Medicaid payments for EI increased by $95 million, which is 85 percent of the rise in service costs. Private insurance

payments grew by $9 million, 8 percent of increased service costs. As a result, the share of EI service costs covered directly by the city and state had dropped to 47.1 percent by 2010.

The city and state's total EI costs, however, also include the amount they contribute towards Medicaid and this has grown as overall Medicaid spending on EI has increased. In 2002, total Medicaid spending on EI services was $150 million, towards which the city and state together contributed half the funds, or $75 million. Due to a temporary increase in federal Medicaid payments in 2009 and 2010, city and state contributions to Medicaid grew more slowly than the overall total, increasing to only $94 million out of $245 million by 2010. Including these additional Medicaid contributions, the combined city and state share of EI costs has fallen over time, from 79.6 percent in 2002 to 66.7 percent in 2010. This decrease is partly due to the enhanced federal Medicaid matching rate, but not entirely. If this had not been in effect in 2010, the city and state would have been responsible for 72.6 percent of EI service costs—less dramatic, but still a decline from 2002 levels. Paying for EI services through Medicaid rather than direct support is a better deal for the city and state regardless of the matching rate since the federal government typically provides half of the funding.

Factors Driving Increased Insurance Reimbursements

A combination of policy changes, insurance enrollment trends, and increased reimbursement rates for enrolled children explain increased Medicaid and private insurance payments for EI services. The importance of each of these factors, however, has varied between these two funding sources. For Medicaid, policy changes at the state level and the city's better acceptance rates for submitted claims have played a crucial role in boosting total reimbursements, while for private insurance much of the improvement has been due to better documentation of insurance coverage status and increased submission of claims. For both Medicaid and private insurance, submission success rates—the share of submitted claims

The Total Cost of Early Intervention Services Increases, But the Share Paid by the City and State Declines

Dollars in thousands

Fiscal Year of Service	Total Cost of EI Services	Medicaid		Direct Support		Private Insurance	Total City & State Costs
		Federal	City & State	City	State		
2002	$370,486	$75,204	$75,204	$109,861	$109,861	$356	**$294,926**
2003	447,018	NA	NA	NA	NA	520	**NA**
2004	450,554	NA	NA	NA	NA	622	**NA**
2005	440,435	90,398	90,398	129,452	129,452	735	**$349,302**
2006	445,715	103,860	103,860	117,695	117,695	2,605	**$339,251**
2007	415,201	99,252	99,252	106,746	106,746	3,204	**$312,745**
2008	405,490	99,487	99,487	101,225	101,225	4,067	**$301,937**
2009	452,555	129,621	97,018	109,622	108,419	7,875	**$315,058**
2010	482,283	151,094	94,228	115,942	111,395	9,624	**$321,566**

Percents

Fiscal Year of Service	Total Cost of EI Services	Medicaid		Direct Support		Private Insurance	Total City & State Share
		Federal	City & State	City	State		
2002	$370,486	20.3%	20.3%	29.7%	29.7%	0.1%	**79.6%**
2003	447,018	NA	NA	NA	NA	0.1%	**NA**
2004	450,554	NA	NA	NA	NA	0.1%	**NA**
2005	440,435	20.5%	20.5%	29.4%	29.4%	0.2%	**79.3%**
2006	445,715	23.3%	23.3%	26.4%	26.4%	0.6%	**76.1%**
2007	415,201	23.9%	23.9%	25.7%	25.7%	0.8%	**75.3%**
2008	405,490	24.5%	24.5%	25.0%	25.0%	1.0%	**74.5%**
2009	452,555	28.6%	21.4%	24.2%	24.0%	1.7%	**69.6%**
2010	482,283	31.3%	19.5%	24.0%	23.1%	2.0%	**66.7%**

SOURCES: IBO; Department of Health and Mental Hygiene

NOTES: Medicaid reimbursement data not available for 2003-2004. Direct city and state funds are IBO estimates.

paid in full or in part—have varied by service type, with the largest relative gains seen for evaluation, screening, and speech therapy.

The Reimbursement Process. Explaining the changes in Medicaid and private insurance reimbursement requires an understanding of the overall claiming process. In New York City, the third-party reimbursement process is managed by a fiscal agent, an independent entity under contract to provide fiscal management and insurance claiming services. As of calendar year 2008, seven other counties in the state utilized a fiscal agent for some aspect of EI administration, but New York City is the only jurisdiction where the entire claiming process is managed externally. Since September 2008 the city's fiscal agent has been Covansys; prior to this it was First Health. While DOHMH's contract with Covansys does allow for incentive based payments, these options have not been exercised and the fiscal agent is instead paid a fixed fee regardless of claiming volume or success.

The city's reimbursement process works as follows. DOHMH contracts out EI service provision to a number of agencies (currently around 100) from a list approved by the state's Department of Health (DOH). These agencies provide services to eligible children and then bill DOHMH, via Covansys, based on a state-set rate schedule. The fiscal agent pays providers with DOHMH funds and then seeks reimbursement from third-party payers—Medicaid and private insurance for enrolled children. The fiscal agent gives third-party payers 120 days to respond to a claim and then bills the state DOH for 49 percent of nonreimbursed costs. (The remaining nonreimbursed costs are absorbed by the city.) In the case of children enrolled in Medicaid, the state DOH requires Covansys to make at least three attempts to obtain reimbursement from Medicaid before billing the state's EI program. The state health department also requires all EI providers to register with Medicaid and to authorize New York City to receive their Medicaid payments in order to facilitate claiming.

Policy Changes. Underlying policy changes, some external to the city, have helped drive increased third-party reimbursements for Early Intervention. The first was a change in Medicaid's reimbursement policies. Starting in 2003, Medicaid began reimbursing the city for the cost of EI evaluations and screening tests, which had previously not been covered. This state-level policy change, working in conjunction with an uptick in referrals, is an important reason why Medicaid reimbursements have increased since 2002. During this period DOHMH was also undergoing an internal push to improve its Medicaid and private insurance claiming practices. DOHMH became more aggressive in its collection of insurance documentation, and its fiscal agent began submitting more claims for reimbursement, and for a wider range of services. Falling denial rates also suggest that the quality of submitted claims improved.

Another significant policy change was the implementation of a county cap on Medicaid expenditures. Prior to calendar year 2006, New York City paid a fixed share of the costs associated with providing Medicaid services to its residents. State-level legislation then capped most of the city's Medicaid costs at calendar year 2005 levels, plus a yearly inflation adjustment of about 3 percent. All costs above the cap amount are now picked up by the state and federal governments.

One impetus for this change was that local governments, which are responsible for enrolling residents in Medicaid and even in certain cases (like EI) authorizing Medicaid services for beneficiaries, previously faced a strong disincentive to do so. The county cap, however, has effectively severed the link between counties' Medicaid payments and their residents' Medicaid utilization. In terms of EI, this policy has allowed the city to increase the number and value of claims it submits to Medicaid without providing additional matching funds. The state government, however, is now responsible for covering a larger share of Medicaid costs than was the case pre-2006 and as such faces a greater incentive to keep costs down. Until recently, this incentive was tempered by federal stimulus funds that increased the federal contribution to Medicaid from October 2008 through June 2011.

Insurance Enrollment Trends. During the period in our analysis, the percentage of EI participants with Medicaid coverage alone has remained fairly steady at between 53.6 percent and 57.1 percent. In contrast, the percentage with just private insurance coverage has increased from a low of 18.7 percent of new participants in 2003 to 31.2 percent in 2010, while the percentage with both types of insurance has increased from 4.2 percent to 11.6 percent over the same period.[7]

These increases in private insurance enrollment may partially explain improved reimbursements. Notably though, EI's enrollment trends have little in common with underlying insurance patterns. The general trend in New

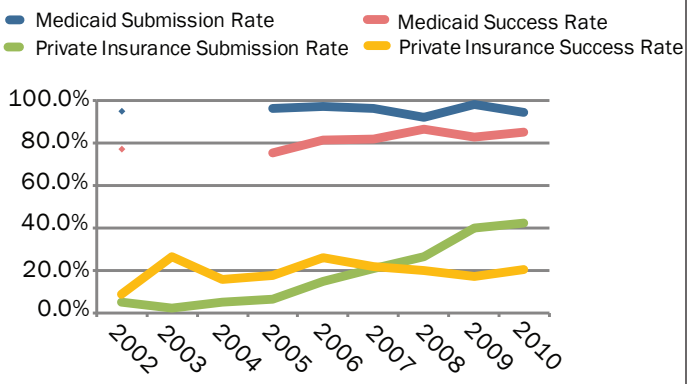
York City during this period has been a decline in the percentage of uninsured children that has been driven entirely by an increase in public insurance rates. Overall, private insurance rates have actually declined.[8] Therefore, much of the increase in private insurance coverage within EI is likely due to better information collection on the part of DOHMH more than changes in access to insurance.

Increased Reimbursement Rates for Enrolled Children. For children with Medicaid coverage who entered EI in 2002 or earlier, Medicaid reimbursed the city for 69.6 percent of their total service costs on average. For children entering the program in 2010, Medicaid reimbursed an average of 84.1 percent of total costs. Private insurance covers a comparatively small share of the costs associated with its enrollees, but there has been some improvement in this area as well. On average, private insurers reimbursed the city for just 0.3 percent of total service costs for those children with private insurance coverage who entered EI in 2002 or earlier. For children entering the program in 2010, however, private insurance companies reimbursed an average of 5.1 percent of total costs.

In the case of Medicaid, improvements in claiming success—the share of claims that are paid in whole or in part—have been the key factor in driving up reimbursement rates. From 2002 through 2010, the fiscal agent has consistently submitted between 92.4 and 98.3 percent of service claims generated by Medicaid-enrolled children for reimbursement. Since Medicaid does not cover all services—respite and assistive technology devices are never reimbursed—this submission rate has likely reached its peak. In contrast to the flat submission rate, the success rate of Medicaid claims has improved gradually from 77.3 percent of claims at least partially paid in 2002 to 85.3 percent in 2010.

Trends differ for private insurance, where increased reimbursement rates have been driven mainly by higher claim submission rates. The percentage of service claims generated by children with private insurance coverage that are submitted for reimbursement has increased dramatically from 5.2 percent of claims in 2002 to 42.2 percent in 2010. There is probably room for further improvement, but this submission rate will never be as high as that for Medicaid absent regulatory changes. Like Medicaid, private insurance never reimburses for respite and assistive technology devices. But unlike Medicaid, private insurance also does not reimburse for service coordination or transportation, and individual carriers or

Claim Submission and Success Rates Differ for Children With Medicaid Versus Private Insurance



SOURCES: IBO; Department of Health and Mental Hygiene
NOTES: Medicaid reimbursement data not available for 2003-2004.
The submission rate is the percentage of claims submitted to Medicaid or private insurance for children who have that coverage.
The success rate is the percentage of submitted claims paid in full or in part.

plans may not cover specific general services. The success rate for private insurance claims has also improved, from 8.7 percent in 2002 to 20.6 percent in 2010. However, it has been stuck at around 20 percent since 2007, below the peak of 26.6 percent in 2003.

Reimbursement Results Have Improved for Most Service Types. From 2002 through 2010, reimbursement rates have improved to varying extents for all widely used services except for special instruction. Across all service types, the mean reimbursement gap—that is, the share of a service's unit cost that is covered by neither Medicaid nor private insurance—decreased from 58.9 percent of unit costs in 2002 to 46.7 percent of unit costs in 2010. During the same period, the mean reimbursement gap for all general services shrank from 55.6 percent to 46.5 percent of unit costs.

Evaluation/screening and speech therapy have undergone the most dramatic improvements in reimbursement rates. The mean reimbursement gap for evaluation and screening has declined from 99.9 percent of unit costs in 2002 to just 41.2 percent in 2010. Most of this change can be traced to the state's decision to begin covering these services through Medicaid in 2003. For speech and language therapy, the mean reimbursement gap was 63.3 percent of unit costs in 2002, higher than the mean for all general services, but by 2010 had shrunk to 43.2 percent. These improvements have been especially helpful in boosting overall reimbursements because these two services have been respectively the third and fourth fastest growing services in dollar terms. In both cases, the dollar

The Mean Reimbursement Gap Varies by Service Type

Dollars in thousands

Service Category Or Type	Reimbursement Gap		Total Costs	
	2002	2010	2002	2010
Any Service	0.589	0.467	$370,486	$482,283
Evaluation/ Screening	0.999	0.412	15,972	25,365
Service Coordination	0.565	0.502	34,155	41,944
Transportation	0.709	0.640	32,823	8,889
Any General Service	0.556	0.465	284,886	403,385
Family Services	0.544	0.444	4,540	39,934
Occupational Therapy	0.552	0.422	48,891	52,253
Physical Therapy	0.519	0.413	50,454	55,724
Special Instruction	0.532	0.534	102,967	151,871
Speech/Language	0.633	0.432	71,085	96,430

SOURCES: IBO; Department of Health and Mental Hygiene

NOTES: A value of 1.000 indicates no third-party reimbursement. Assistive technology devices and respite are not shown because there is no reimbursement for these services.

growth has been driven primarily by increases in utilization rather than in unit costs.

In contrast, reimbursement rates for special instruction failed to increase from 2002 through 2010. Special instruction includes: "the design of learning environments and activities," "curriculum planning," "providing families… with information, skills, and support," and "working with the child to enhance… development."[9] While special instruction is provided in various forms to children with a range of developmental issues, one notable subcategory is applied behavioral analysis, a time intensive and therefore costly treatment for autism. Due in part to the fact that applied behavioral analysis has recently become more widely used and is seldom covered by insurance, reimbursement rates for special instruction have stagnated over time. The mean reimbursement gap for special instruction has been flat at around 53 percent since 2002. Special instruction has been the highest growth EI service in dollar terms, driven by increases in the mean unit cost and number of units of service per child, so the stubbornly high reimbursement gap has had implications for the city's bottom line.

The Claiming Process: Improvements Made, Roadblocks Remain

Improvements and increased efficiencies in the claiming process have been instrumental in allowing the fiscal agent to submit more and better quality claims for reimbursement. IBO analysis of EI claiming data suggest that thus far, improvements have been concentrated around Medicaid rather than private insurance claims. Perhaps one reason for this is that relatively few private insurance claims are denied due to fiscal agent errors; most denials are due to either insurer-imposed restrictions on plan benefits or no response from the insurer. In contrast, a smaller percentage of Medicaid claims lack responses and almost none are denied due to restrictions on plan benefits. A comparatively larger share of Medicaid denials are due to timing issues or technical errors, suggesting there is room for additional process improvements by the fiscal agent.

Claim Processing Times. Overall claim processing times have improved since 2002 for Medicaid, but worsened for private insurance. In 2002, the average amount of time between service and claim submission was 76 days for private insurance, considerably shorter than the average of 124 days for Medicaid. By 2010, however, average submission times had decreased to 71 days for Medicaid and increased to 83 days for private insurance. These numbers may understate actual submission times for 2010, as some 2010 claims may still have been outstanding when IBO received these data. Nevertheless, the general trends discussed above hold in other years as well. Covansys could potentially decrease claim submission times for private insurance by streamlining and removing any inefficiencies or unnecessary steps from their submission process. One reason this may not have yet occurred is that Medicaid claims are more frequently denied due to missed filing deadlines and so have become the first priority. Process streamlining is also more challenging in the case of private insurance as insurers utilize many different sets of requirements for claiming.

Another factor in claim processing times is the length of time between claim submission and the initial response from the insurer. Although the fiscal agent has little control over the length of these adjudication lags, they too have increased in the case of private insurance. From 2002 through 2010, the average adjudication lag increased slightly from 31 days to 32 days for private insurance claims and shrank from 27 days to 17 days for Medicaid claims.[10]

Denial of Private Insurance Claims. Data on 2009 and 2010 services show that 36.2 percent of all private insurance denials were due to insurer-imposed restrictions on plan benefits, including: the use of an out-of-network provider, service not covered, or therapy deemed not medically necessary; surpassing a cap on visits or benefits;

or a failure to secure preauthorization or a primary care physician referral. Fifteen percent of fully denied claims (those where no payment is remitted) and 41.9 percent of partially denied claims were specifically coded as due to the use of an out-of-network provider. Most of these types of restrictions do not technically violate New York State insurance law, which during the period in question specified only that private insurers reimburse the cost of EI services if they are otherwise covered under a policy and excluded these payments from counting against lifetime or annual benefit limits. Nevertheless, the frequency with which insurers utilize plan restrictions to justify EI claim denials effectively serves to circumvent the original legislative intent—namely that private insurance companies cover a significant portion of the EI costs associated with their enrollees.

In 2009 and 2010, another 19.9 percent of all denials were coded as "no response, explanation of benefits, or remittance advice from insurer." In the case of fully denied private insurance claims, this was the most common denial reason, followed by child not covered at time of service, out-of-network provider, and not a covered service. Some of these claims may still be pending, and as such, will eventually be paid. Just under half, however, are for service dates in 2009, rendering reimbursement unlikely. A failure to respond to a claim could be due to a processing error on the part of either the fiscal agent or the insurer. It could also be due to an insurer's unwillingness to pay claims or engage with local governments when it comes to EI services.

Most Private Insurance Claim Denials Are Due to Insurer-Imposed Restrictions or Lack of Response
2009 and 2010

Denial Reasons	% of All Denials	% of Full Denials	% of Partial Denials
Out-of-Network Provider	20.1%	15.0%	41.9%
No Response From Insurer	19.9%	24.5%	0.0%
Other Denial	19.0%	11.0%	53.3%
Child Not Covered At Time of Service	13.8%	17.0%	0.1%
Not a Covered Service	12.2%	14.6%	2.0%
Unresolved Technical Errors	9.0%	10.7%	1.8%
Visit Limit Reached/ Benefits Exhausted	2.2%	2.5%	0.7%
Exceeds Insurer's Filing-Time Limit	2.1%	2.6%	0.0%
Preauthorization Required & Not Obtained	1.4%	1.7%	0.1%
No Primary Care Physician Referral	0.2%	0.3%	0.0%
Not Medically Necessary	0.04%	0.05%	0.0%
Memo: Total Number of Denied Claims	1,898,876	1,540,121	358,755
Memo: Percent of All Claims	99.3%	80.5%	18.8%

SOURCES: IBO; Department of Health and Mental Hygiene
NOTES: Denial codes are only available for service dates from 9/1/2008-6/30/2010. Data are complete through 3/31/2011; some claims for 2010 services may have been outstanding at this time. Other denial could include the following: deductible/coinsurance/copayment amount (EI absorbs these costs), duplicate claims, payment should be covered by another payer, etc.

Finally, only 11.2 percent of all denials were due to technical errors or missed filing deadlines that can be linked to fiscal agent claiming practices. Moreover, while there were a similar percentage of technical errors both years, the percentage of claims that exceeded time limits decreased from 2009 to 2010, suggesting some delays were due to the transition to a new fiscal agent in September 2008. Since only a minority of denials is due to fiscal agent errors, the city's ability to increase reimbursements through process improvements alone is therefore limited.

Denial of Medicaid Claims. In many regards trends are quite different for Medicaid, where only 0.02 percent of denials are due to restrictions on plan benefits (use of an out-of-network provider or a service that is not covered). For fully denied Medicaid claims, the most common denial reasons in 2009 and 2010 were instead other denial, child not covered at time of service, no response from Medicaid, unresolved technical errors, and exceeds Medicaid's filing-time limit. All partially denied claims were coded as "other denial" and most were for transportation, for which Medicaid has reimbursed only a portion of costs since 2007.

Due to the large number of unspecified, "other" denials, it is difficult to draw conclusions about which party bears more responsibility for Medicaid denials. More tellingly, 15.3 percent of denials can be linked to technical errors and missed filing deadlines on the part of the fiscal agent. This is a slightly higher percentage of denials than is the case for private insurance claims, despite faster turnaround times and a more uniform submission process for Medicaid. For both types of claims, technical errors account for roughly 9 percent of denials, but missed filing deadlines account for 6.8 percent of Medicaid denials and only 2.1 percent of private insurance denials.

Medicaid does not necessarily employ stricter filing deadlines than private insurance, so this discrepancy is somewhat surprising. Medicaid requires that the first

Few Medicaid Claim Denials Are Due to Restrictions on Plan Benefits

2009 and 2010

Denial Reasons	% of All Denials	% of Full Denials	% of Partial Denials
Other Denial	44.8%	32.1%	100.0%
Child Not Covered At Time of Service	27.0%	33.2%	0.0%
No Response From Medicaid	12.9%	15.9%	0.0%
Unresolved Technical Errors	8.5%	10.4%	0.0%
Exceeds Medicaid's Filing-Time Limit	6.8%	8.4%	0.0%
Out-of-Network Provider	0.02%	0.02%	0.0%
Not a Covered Service	0.01%	0.01%	0.0%
Memo: Total Number Of Denied Claims	1,480,704	1,203,719	276,985
Memo: Percent of All Claims	21.9%	17.8%	4.1%

SOURCES: IBO; Department of Health and Mental Hygiene

NOTES: Denial codes are only available for service dates from 9/1/2008-6/30/2010. Data are complete through 3/31/2011; some claims for 2010 services may have been outstanding at this time. Other denial could include the following: deductible/coinsurance/copayment amount (EI absorbs these costs), duplicate claims, payment should be covered by another payer, etc.

claim of an EI participant be submitted within 90 days of the service date, but according to DOHMH this deadline can be extended up to two years with justification. Filing deadlines for private insurance vary by carrier, but may be up to one year after the date of service. Nevertheless, the greater likelihood of a Medicaid denial due to timing issues may explain the seeming prioritization of Medicaid submissions. It is also worth noting that the percentage of Medicaid claims that exceeded time limits decreased from 2009 to 2010 after the fiscal agent switch was complete.

Lastly, compared with private insurance claims, a smaller percentage of Medicaid denials are coded as "no response, explanation of benefits, or remittance advice from insurer." Overall, 12.9 percent of Medicaid denials are due to a failure to respond, but 58 percent of these are from 2010 and may still be pending. Looking only at 2009 service dates, 11.3 percent of Medicaid denials are coded as "no response."

Recent Legislation and the Outlook for Reducing City Costs

Recently enacted state legislation has the potential to improve private insurance reimbursements for Early Intervention services in the coming years. Throughout the service period analyzed in this report, New York law required private insurers to reimburse the cost of EI services if they are otherwise covered under a policy and excluded these payments from counting against benefit caps. Legislation introduced in the Assembly last session, as originally written, would have required private insurers to reimburse municipalities for EI services at approved costs and would have strictly limited the reasons for which claims can be denied. A weakened version of the legislation, which eventually passed and was signed by Governor Cuomo in August 2011, requires only that insurers provide municipalities with information on the extent of benefits for EI services available under a policy, and that parents provide municipalities with a written referral from their child's physician to facilitate claiming.[12]

Another new bill passed by the state Legislature and signed by Governor Cuomo in November 2011 mandates private insurance coverage for autism screening, diagnosis, and treatment including applied behavioral analysis, with benefits capped at $45,000 per year.[13] Similar legislation has already been enacted in 28 other states, most recently California, despite concerns about its potential impact on premiums. This new mandate will go into effect on November 1, 2012 in New York. Given the frequency with which private insurers deny EI claims for other covered services, it is unclear whether the new mandate will result in higher private insurance reimbursements for autism treatments provided through EI.

More recently, Governor Cuomo's Executive Budget for state fiscal year 2012-2013 contained a series of proposals to more profoundly transform EI's fiscal structure. As originally written, this legislation would have transferred much of the financial risk for the program from local districts to service providers. This would likely have resulted in significant savings for the city and state, though would have left providers and/or insurers worse off.

The state Legislature rejected these more controversial changes to the program's fiscal structure, but did enact another of the Governor's proposals to relieve DOHMH and other local districts of their responsibility to contract directly with EI providers and to submit claims to third-party payers.[14] Effective April 1, 2013, all fiscal transactions will instead be handled through a central fiscal agent, or agents, under contract with the state DOH. After a service is provided, providers will utilize the state's fiscal agent and data system to submit claims for

reimbursement to Medicaid or private insurance where applicable, followed by their municipality. The state DOH will continue to reimburse local districts for roughly half of their costs and, with approval of the state Division of the Budget, will also have discretion to increase these reimbursements above 50 percent. This new, centralized system will likely reduce DOHMH's administrative responsibilities and costs, but will not necessarily affect the overall level of third-party reimbursements.

At the federal level, private insurance reimbursements could be impacted by the essential health benefits package required under the Affordable Care Act. The Department of Health and Human Services has instructed each state to define a benchmark plan—in terms of types and amounts of services offered—that insurers must emulate in order to participate in insurance exchanges starting in 2014. It remains to be seen how comprehensive the New York plan will be and whether it results in enhanced, or even diminished, private insurance coverage for EI services.

Over the past decade, DOHMH has significantly increased its third-party reimbursements and decreased its reliance on direct city and state funding for the Early Intervention program. While city and state contributions towards EI participants' Medicaid costs have increased, a cap on county costs has shifted much of this burden from the city to the state. Temporary federal stimulus funds also mitigated the impact of rising Medicaid costs on the city and state in 2009 and 2010.

Increased reimbursements by Medicaid and private insurance have occurred thanks to both external policy changes and improved claiming practices. IBO's analysis suggests that there is still some room for improvement, in terms of speeding up processing times for claims submitted to Medicaid and private insurance and reducing technical errors. Given the large percentage of claims denied due to private insurer restrictions on plan benefits, however, there is a limit to how much more the city can do to increase reimbursements solely through process improvements. In spite of the original legislative intent,

New York City versus Other New York State Counties

Due to changes enacted in the most recent New York State budget, third-party claiming for EI services throughout the state will be centralized and conducted via the state health department's fiscal agent starting in April 2013. Whether or not this centralization results in increased third-party reimbursements for New York City depends upon the firm the state selects as fiscal agent, and whether it is able to submit a higher share of successful claims than Covansys does under the current system.

IBO's analysis suggests that the majority of claim denials are for reasons beyond the control of the fiscal agent, but that there is some room for improvement in terms of technical errors and missed filing deadlines. In order to gauge the extent to which such improvement is possible, it would be useful to compare New York City's current Medicaid and private insurance denial rates with those in other New York State counties. Limitations in the available data, however, make any such comparison problematic.

Data from New York State and New York City paint very different pictures of Medicaid denial rates in the city. Data available from the state Department of Health indicate that the city is doing much worse than the rest of the state in terms of Medicaid denials for EI services. According to their most recent report, New York City had a Medicaid denial rate of 27.0 percent in calendar year 2008, higher than the aggregate denial rate of 12.3 percent for the rest of the state and higher than individual denial rates in all but six counties. As is acknowledged within the state DOH's report, there is some reason to distrust the accuracy of their city data given the fiscal agent transition that occurred in 2008. In contrast, city DOHMH-provided claims data show a Medicaid denial rate of 21.5 percent during 2008 and 14.4 percent during 2009, both of which are higher than the rest of the state in 2008, though only slightly so in the latter case.

In terms of private insurance denials, the city is either doing slightly better, or slightly worse than the rest of the state depending on which data are used. Based on data provided in the state report, the private insurance denial rate was 89.1 percent for New York City and 84.1 percent for the rest of the state in calendar year 2008. Claims data from the city DOHMH show a private insurance denial rate of 80.1 percent, slightly below the rest of the state but still much higher than Medicaid denial rates in the city or the rest of the state.

private insurance is currently covering only a very small fraction of the costs of the EI program.

It remains to be seen whether recent state and federal legislation will significantly alter the reimbursement pattern. Two new laws signed by Governor Cuomo in late 2011 have the potential to boost private insurance reimbursements for EI services, but both contain weaker regulations than their sponsors originally intended. A more ambitious plan for restructuring program finances proposed by the Governor in January 2012 was significantly modified by the state Legislature when the state budget was adopted in March. In its current form it is unclear what impact, if any, this legislation will have on third-party reimbursement levels.

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Endnotes

[1]Unless otherwise noted, all references to years refer to city fiscal years.
[2]Federal law allows for family copays set on a sliding scale. (Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. 1400 et seq.) In New York, services have always been provided without any family payments.
[3]New York State Department of Health, *Annual Performance Report for the NYS Early Intervention Program, 2008-2009*, April 2010.
[4]New York State Department of Health, *Early Intervention Municipality Performance Data-New York City*, Jan 2011.
[5]Education of the Handicapped Act Amendments of 1986, 20 U.S.C. 1400 et seq. In New York State, federal funds appropriated through this act all go towards program administration rather than direct service costs.
[6]New York State Public Health Law Article 25, Title 2-A, sections 2540–2559.
[7]The percentage of children with dual Medicaid and private insurance coverage in 2010 is likely inflated, as Medicaid Managed Care plans may initially be coded as commercial insurance in the EI database. For all new children with private insurance, DOHMH cross checks the insurer with a list of Medicaid Managed Care carriers and then corrects the database if needed. That correction process may not be complete for the 2010 data. Even discounting the 2010 numbers, there has been an increase in the percentage of children with dual coverage.
[8]United Hospital Fund, *Health Insurance Coverage in New York, 2008*, June 2010; and United Hospital Fund, *Health Insurance Coverage in New York, 2002-2003*, Oct 2005.
[9]Regulations for the Early Intervention Program, 10 NYCRR subpart 69-4, effective June 2010.
[10]These numbers may understate the true extent of private insurer adjudication lags. IBO limited its analysis to only those claims where the lag between billing and initial adjudication is less than 120 days, at which point the fiscal agent automatically assigns an adjudication date to outstanding claims. However, a much larger share of private insurance claims than Medicaid claims have a recorded adjudication lag of 120 days or more (15 percent versus 2 percent of claims).
[11]New York State Department of Health, *New York State Early Intervention Program Report to the Legislature, January 1, 2008–December 31, 2008*, March 2011.
[12]2011 New York Assembly-Senate Bill A384B, S4013C.
[13]2011 New York Senate-Assembly Bill S5845, A8512.
[14]2012-2013 New York State Budget Bill, Health and Mental Hygiene, A9056D, S6256D.