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FINANCING HEALTH CARE SERVICES AT MOUNT SINAI ADOLESCENT HEALTH CENTER: OVERVIEW OF FINDINGS FROM 2010

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INTRODUCTION

The Mount Sinai Adolescent Health Center (MSAHC) provides confidential, comprehensive medical, mental health, sexual and reproductive health, and health education services to adolescents and young adults ages 10–24 in the New York City metro area. MSAHC offers a comprehensive, interdisciplinary and integrated model of care. The largest center of its kind in the United States, the MSAHC provides health care services to over 10,000 patients per year. Services are provided onsite at the Center, as well as at three school–based health centers.

Patient care at MSAHC is financed through a complex network of private and public health insurance programs, grants from the government and private foundations, and contributions from individual donors. MSAHC is unique in that no patient is turned away, regardless of their ability to pay.

In this first of four annual **Health Policy Update** reports, the financing of patient care at MSAHC is examined for the calendar year 2010. The report begins with an overview of the health insurance status of adolescents and young adults in the United States. It then describes the health care financing options for adolescents and young adults in New York State generally and at MSAHC specifically. Next, a profile of MSAHC patients aged 10–24 is presented, with specific attention paid to how services were categorized, billed, and paid for generally and among specific subgroups of patients. The report continues with a discussion of the implications of the patient data presented in the context of recent changes that national health care reform, The Patient Protection and Affordable Care Act (PPACA, now referred to as ACA), has already implemented, as well as additional impending changes that will take effect over the next four years. This monumental legislation will likely have substantial impact on adolescent and young adult health insurance coverage and access in the United States. MSAHC will be playing a key leadership role in this transition and future annual **Health Policy Update** reports will monitor how these changes impact its client profile, use of available financial support, as well as the manner in which MSAHC maintains its commitment to the provision of adolescent and young adult–centered physical and mental health services. Finally, a set of recommendations for future directions in financing is presented, as well as proposed plans for future analyses of the financial data.

BACKGROUND

Health Insurance Status of Adolescents and Young Adults in the United States

Though the vast majority of adolescents and young adults are insured either privately (through their parent's employer–based or individual coverage) or publicly (through Medicaid or the Children's Health Insurance Program (CHIP)), a significant minority of adolescents and young adults are uninsured or experience periods during the year when they have no insurance coverage. In addition, many young people are underinsured for a variety of services, specifically mental health and other prevention and wellness services.

Data from the 2002 National Health Interview Survey show that among adolescents ages 10–18, 65% are covered through private insurance, 22% are covered through public insurance, 1% is covered through a combination of public and private insurance, and 12% are uninsured.[a] Adolescents are more likely to be without health insurance if they are older (15–18 vs. 10–14), living in poverty, have a parent with a high school education or less, and/or live in the Southern or Western parts of the U.S.[1] Additionally, data from the 2006 National Health Interview Survey indicate that while just 6% of adolescents ages 10–17 were uninsured for a full year before the survey, 20% of young adults 18–24 were uninsured during the same time period. An additional 7% of 10–17 year olds and 20% of 18–24 year olds were uninsured for part of the year before the survey. [2]

There are also large racial and ethnic disparities in insurance coverage. African American and Hispanic adolescents are more likely than their white peers to lack insurance, to have spent the previous full year uninsured, to lack a usual source of care, to have delayed care in the past year, and to have an unmet need for dental care and prescription drugs.[3]

The availability of health insurance for adolescents has changed dramatically during the last few decades. While there has been a decline in the availability of private health insurance, public insurance coverage has grown. In the mid–1980s, Congress enacted a series of Medicaid expansions mandating states to raise income eligibility thresholds to the federal poverty level for children and adolescents. In 1997, Congress established the State Children's Health Insurance Program (SCHIP, now referred to as CHIP since its reauthorization in 2009) which provides federal funding for states to extend coverage to children and adolescents from low income families.[4] Once adolescents enroll in Medicaid or CHIP, their access to particular benefits may vary, depending on the state in which they live and the types of state programs for which they may be eligible.[5]

[a] **It is important to note that the most recent available national statistics on insurance coverage among adolescents is 7-10 years old and research using more recent data is greatly needed.**

Medicaid provides a comprehensive set of services, including screenings and treatment, check–ups, physician and hospital visits, as well as vision and dental care. Under Medicaid, states are required to cover children to certain minimum levels (children 6–18 in families with incomes at or below 100% of the poverty level), but can expand coverage beyond this minimum income threshold at their discretion.[6] Within CHIP, states are allowed to set premiums and cost sharing on a sliding scale based on income and can provide a more limited set of benefits than Medicaid.[7]

Uninsured Adolescents and Young Adults

Although rates of uninsurance among adolescents are relatively low, it is important to note that the health problems caused by lack of insurance are very large in scope. Adolescents who lack health insurance have worse access to needed health services than those who have insurance. Adolescents who are uninsured often receive care later in the development of a health problem or not at all. As a result, they are at higher risk for hospitalizations and missed diagnosis of serious and even life–threatening conditions. Adolescents without insurance coverage are more likely to fail to get needed medical care, more likely to delay needed medical care, and more likely to fail to get needed prescription drugs because of cost than adolescents with public or private insurance.[8] They are also more likely to have no usual source of care and no physician visit in the past year.

Until the recent passage of the ACA, the transition into young adulthood (ages 18–24 and above) often resulted in changes in family and legal status. Many young people lost eligibility under their parents' private insurance coverage, while simultaneously losing eligibility for public insurance programs.[9] Young adults in the workforce are less likely to have employer–sponsored coverage, as they are more likely to be employed in low–wage positions and in settings with few employees (and thus are less likely to be working in settings in which federally mandated employer requirements for health insurance coverage exist) and few insurance benefits.[10] Public and private insurance coverage both decline steeply when comparing adolescents to young adults in their early twenties. Young adults ages 19–24 are the most likely to be uninsured out of all age groups.[11]

Given this previously established health insurance profile, and as noted, the high proportion of the uninsured represented by young adults , policy makers designing ACA prioritized opportunities (even before the full roll out of health care reform in 2014) for enrolling young adults up to age 26 as part of their parents' private health insurance benefit packages. While this policy action does not support low income young adults (those who will be eligible up to 133% of the Federal Poverty Level (FPL) for Medicaid coverage in 2014, as well as for other young people who will be eligible to enroll in state and regional exchanges), it is an important initial step in closing a substantial insurance coverage gap.

Health Insurance Options and Special Health Coverage Programs for Adolescents and Young Adults in New York and at MSAHC

In addition to private insurance and traditional **Medicaid** fee–for service and managed care plans, New York offers access to health insurance through several targeted programs. **Child Health Plus A** is part of the Medicaid program and follows many of the same rules as traditional Medicaid. However, Child Health Plus A, which covers children under 19, has more generous income guidelines than traditional Medicaid and covers more medical services than adult Medicaid. **Child Health Plus B** is New York's CHIP program, covering many children under 19 who are not eligible for Child Health Plus A, but whose families do not have private health insurance. Child Health Plus B is also available to youth who are not eligible for Child Health Plus A due to their immigration status. **Family Health Plus** is a health insurance option for young adults ages 19 and over. The program covers many services for low–income adults who do not have health insurance, but who are not eligible for Medicaid.

There may be special circumstances or specific conditions for which adolescents and young adult MSAHC patients are eligible for other public health coverage. They may be covered under the **Family Planning Benefit Program** if they are in need of family planning services and are uninsured or do not want to use their Medicaid, Child Health Plus A/B, or private insurance due to confidentiality concerns. Pregnant adolescents and young adults may be covered under the **Prenatal Care Assistance Program** if they are otherwise uninsured, low–income, and do not qualify for other public coverage. The **AIDS Drug Assistance Program (ADAP)** provides FDA–approved HIV/AIDS treatment drugs to low–income patients. The **Healthy Women Program** provided free breast and cervical cancer screening services to female patients, but as of mid–2010 is no longer available to MSAHC patients. These types of coverage, with the exception of the Healthy Women Program, are accepted forms of payment at MSAHC.

Table 1 presents a summary of the variety of health insurance streams which help to sustain the MSAHC model. It is anticipated that many of these different types of programs may undergo significant changes if the ACA is fully implemented as planned. The anticipated transition will require careful monitoring to assure that the same types of benefits and conditions for health care delivery are maintained, enhanced, and further improved over time. As described above and summarized below, the diverse funding streams represent a complex financing landscape that requires ongoing close monitoring, careful negotiations between MSAHC and the funding source, as well as staff to assure that as many clients as possible are screened for their potential eligibility. It also requires precious time and expertise to assure that those adolescents and young people eligible for specific programs are in fact enrolled.

Table 1: Federal and New York State Insurance Programs Reimbursing for Health Coverage Delivered to MSAHC Patients		
Program Name	**Eligibility**	**Services**
Medicaid		
Traditional Medicaid/Medicaid Managed Care	**Up to 100% FPL (up to 150% FPL for parents)**	**Primary and specialty care, prescription drugs, hospitalizations, dental and vision care, and other services**
Child Health Plus A	**<19 years old, up to 185% FPL**	**Similar to traditional Medicaid**
Family Planning Benefit Program (FPBP)	**Males and females of childbearing age, up to 200% FPL**	**Most FDA-approved birth control methods, screening for sexually transmitted infections and HIV, pregnancy testing and counseling, and other family planning-related services.**
Prenatal Care Assistance Program	**Pregnant women, up to 200% FPL**	**Prenatal care, labor and delivery, postpartum care up to two months**
Child Health Plus B	**<19 years old, 186-250% FPL**	**Similar to traditional Medicaid; must be delivered through managed care plans**
Family Health Plus	**Adults age 19+, up to 100-150% FPL**	**Primary and specialty care, prescription drugs, hospitalizations, and other services**
AIDS Drug Assistance Program (ADAP)	**HIV positive, up to 435% FPL**	**Medications for the treatment of HIV/AIDS**
Healthy Women Program	**MSAHC patients until mid-2010 *only***	**Breast and cervical cancer screening**

Sources: New York State Department of Health and Mount Sinai Adolescent Health Center

RESULTS

Profile of MSAHC Adolescent Health Center Patient Visits

The following section presents a demographic profile of MSAHC patients and the financial streams that support the provision of their care in the year 2010. The data presented were collected via MSAHC's HCAP insurance screening, CERNER registration, and EAGLE billing data systems and analyzed using Stata 11 data analysis and statistical software. It was particularly important to analyze how the profile of patients' reliance on difference sources of insurance and other government funding streams change when disaggregated by demographic subgroups and visit details. These analyses will be repeated in subsequent years and will help ascertain how the diverse sources of funding on which MSAHC depends to maintain its integrated service delivery model is further maximized, how diverse funding streams shift over time, and how the streams are impacted by the unfolding of health care reform. Through this external monitoring, this effort will help to further elucidate what the barriers as well as facilitators are for the delivery of adolescent and young adult–centered services.

Demographic Profile

There were 9,307 unique youth aged 10 to 24 served during the time period Jan 1, 2010 to Dec 31, 2010. These youth made 47,734 visits. The majority of patients served during the period were female (79%) (See **Table 2**). Most were Hispanic (43%) or African American (36%). A wide range of age groups were represented, with the majority of patients aged 16–18 (40%) or 19–21 (36%) at their first visit in 2010. Forty–four percent (44%) of youth seen were new patients during their first visit of the year.

Table 2. Patient Information at First Visit of 2010 (N=9,307)		
	n	%
Gender		
Female	7,396	79
Male	1,911	21
Race/Ethnicity		
African American	3,307	36
Hispanic	4,022	43
White	317	3
Other	473	5
Unknown	1,188	13
Age		
10–12	263	3
13–15	1,340	14
16–18	3,737	40
19–21	3,385	36
22–24	582	6
Patient Status		
New Patient	4,155	44
Returning Patient	5,152	55

Source: MSAHC patient enrollment data

Visit Information

Among the 47,734 unique visits made to MSAHC, 64% were to the Medical Department (Primary Care), 18% were to the Mental Health Department, 4% were to Project Impact,[b] and 14% were to a school-based health center (See **Table 3**). Among thirteen possible visit types, about half (51%) were medical office visits, 13% were for health education, and 11% were for individual therapy. Billable and non-billable services are defined by whether the specific service is covered through existing diverse funding streams. Non-billable services are not covered through any public or private insurance programs. It is noteworthy that while nearly a quarter of visits (approximately 22%) fell into the category of non-billable, they represent important complementary services that enable MSAHC to provide a more comprehensive set of services that respond to the myriad of client needs which surface in the provision of youth-centric services.

[b] Since 1990, Project Impact (Improving Access to Care and Treatment), the HIV treatment and prevention program for HIV infected and at risk adolescents, has provided medical, mental health and health education services to over 135 HIV infected and thousands of at risk youth integrated into the primary care program at the MSAHC. MSAHC is home to one of New York City's largest adolescent HIV/AIDS Mental Health Programs.

Table 3. MSAHC Visit Information by Billable and Non-Billable Services Rendered—2010 (N=47,734)		
	n	%
Visit Department		
Medical/Primary Care	30,340	64
Mental Health	8,771	18
Project Impact	1,721	4
School-based health center	6,902	14
Visit Type Billable		
Medical Office Visit	24,482	51
Health Education	6,014	13
Mental Health Assessment/Testing	645	1
Individual Therapy	5,420	11
Family Therapy	626	1
Group Therapy	216	<1
Visit Type Non-Billable		
Non-Billable Health Education	2,122	5
Non-Billable Social Work	2,025	4
Non-Billable Nutrition	637	1
Non-Billable Provider Rendered Visit	3,014	6
Non-Billable Lab Work	475	1
Non-Billable Group Visit	2,022	4
Non-Billable PPD Read	21	<1

Source: MSAHC patient enrollment data

Among 37,403 *billable* visits in 2010 (see **Table 4**), 65% were for medical office visits, 16% were for health education, 17% were for family, individual or group therapy, and 2% were for mental health assessment/testing.

Table 4. MSAHC Billable Visits by Type—2010 (N=37,403)		
	n	%
Medical Office Visit	24,482	65
Health Education	6,014	16
Family/Group/Individual Therapy	6,262	17
Mental Health Assessment/Testing	645	2

Source: MSAHC patient enrollment data

Billing Information

In order to analyze billing information, while acknowledging that a patient's insurance status could change once or even several times throughout the year, we chose to assess insurance status at a single point in time: the patient's first visit of calendar year 2010, *regardless of whether they were a new or returning patient.*[c] Among billable first visits of the year (n=8,204), the majority (64%) were classified as "self-pay" meaning the patient either did not have insurance or did not use insurance for the visit[d] (see **Table 5**). Almost one-third (31%) of visits were classified as Medicaid, including Medicaid Fee-For-Service, Medicaid Managed Care, Family Planning Benefit Program, and Prenatal Care Assistance Program. Three percent (3%) of visits were covered by private insurance. The remaining billing categories (Child Health Plus A, Child Health Plus B, Family Health Plus, ADAP, Healthy Women Program, and CYP) each accounted for 1% of visits or less.

Table 5. MSAHC Payment Source Among Billable First Visits in 2010 (N=8,204)

	n	%
Self-Pay	5,269	64
Medicaid	2,575	31
Private Insurance	258	3
Family Health Plus	58	1
Child Health Plus A	15	<1
Child Health Plus B	17	<1
ADAP	9	<1
Healthy Women	3	<1

Source: MSAHC patient financial data

Table 6 shows payer categories among billable first visits of 2010 (n=8,204) by selected characteristics of patients and visits (*Note: all following comparisons were found to be statistically significant (p<.01)).*In bivariate analysis, male patients were more likely than female clients to be classified as self-pay (68% vs. 63%) and less likely to be covered by Medicaid (28% vs. 32%). White patients were substantially more likely to be classified as self-pay (84%) than African American (65%) and Hispanic (60%) patients. Payer category varied only slightly by age. New patients were more likely to be self-pay (69%) than returning patients (60%). Payer information also varied by the characteristics of the visit. Visits to the AHC Medical Department or to a school-based health center were more likely to be classified as self-pay (65% and 63%, respectively), while visits to

[c] **Future analyses could delve deeper into how patterns of use vary over time for both new and returning visits and settings, including the use of school-based health centers.**

[d] **MSAHC covers the cost of "self-pay" visits using internal funds provided by various private foundations and individual donors.**

the AHC Mental Health Department and Project Impact were less likely to be classified as self–pay (53% and 60%, respectively) and more likely to be covered by Medicaid or private insurance. It is important to note that the Medicaid category includes several types of Medicaid, including the Prenatal Care Assistance Program (PCAP) which is only open to females. According to data from HCAP (see **Figure 1** and **Table 7** of this report), 476 patients were successfully enrolled into PCAP in 2010, representing 18% of all Medicaid patients. This largely explains the larger proportion of female Medicaid patients at MSAHC, as well as the greater overall use of health services by females.

Table 6. MSAHC Payment Profile Among Billable First Visits by Selected Characteristics and Types of Insurance Source (N=8,204)																
	Self-Pay		Medicaid		Private Insurance		Family Health Plus		Child Health Plus A		Child Health Plus B		ADAP		Healthy Women	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Gender																
Female	4,111	63	2,099	32	206	3	48	1	10	<1	9	<1	3	<1	3	<1
Male	1,158	68	476	28	52	3	10	1	5	<1	8	<1	6	<1	0	<1
Race/Ethnicity																
African American	1,867	65	891	31	90	3	19	1	3	<1	2	<1	6	<1	2	<1
Hispanic	2,150	60	1,267	36	97	3	29	1	10	<1	9	<1	1	<1	0	0
White	246	84	23	8	22	8	1	<1	0	0	0	0	1	<1	0	0
Other	291	68	122	29	9	2	2	<1	1	<1	1	<1	1	<1	0	0
Unknown	715	69	272	26	40	4	7	1	1	<1	5	<1	0	<1	1	<1
Age																
10-12	122	61	66	33	9	5	0	0	2	1	0	0	0	0	0	0
13-15	741	65	341	30	45	4	2	<1	8	1	8	1	0	0	0	0
16-18	2,079	63	1,078	33	103	3	6	<1	3	<1	8	<1	0	0	1	<1
19-21	1,990	65	925	30	83	3	41	1	2	<1	1	<1	4	<1	2	<1
22-24	337	63	165	31	18	3	9	2	0	0	0	0	5	1	0	0
Patient Status																
New Patient	2,478	69	938	26	111	3	27	1	9	<1	10	<1	1	<1	0	0
Returning Patient	2,791	60	1,637	35	147	3	31	1	6	<1	7	<1	8	<1	3	<1

Note: All results are statistically significant (p<0.01)
Source: MSAHC patient enrollment and financial data

Table 6 (continued). MSAHC Payment Profile Among Billable First Visits of 2010 by Selected Characteristics and Type of Insurance Source (N=8,204)																
	Self-Pay		Medicaid		Private Insurance		Family Health Plus		Child Health Plus A		Child Health Plus B		ADAP		Healthy Women	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Visit Department																
AHC Medical	4,243	65	1,992	31	215	3	55	1	10	<1	6	<1	5	<1	3	<1
AHC Mental Health	163	53	106	34	31	10	2	1	3	1	3	1	1	<1	0	0
AHC Project Impact	31	59	18	35	0	0	0	0	0	0	0	0	3	6	0	0
School-based health center	832	63	459	35	12	1	1	<1	2	<1	8	1	0	0	0	0
Visit Type																
Medical Office Visit	4,155	64	2,022	31	194	3	45	1	12	<1	14	<1	5	<1	3	<1
Health Education	780	64	405	33	32	3	10	1	0	0	0	0	0	0	0	0
Family/Group /Individual Therapy	146	53	106	39	13	5	2	1	2	1	2	1	4	1	0	0
Mental Health Assessment/ Testing	72	54	41	31	18	13	1	1	1	1	1	1	0	0	0	0

Note: All results are statistically significant (p<0.01)
Source: MSAHC patient enrollment and financial data

We ran a multivariate logistic regression model predicting the odds of being self-pay (vs. not) in the subsample of patients ages 10 to 24 at their *first* 2010 visit (see **Table 7**). Females were still significantly less likely than males to be self-pay (OR= 0.88, 95% CI= 0.78–0.99), and African American, Hispanic, and patients of other or unknown race were less likely than white patients to be self-pay. New patients were more likely to be self-pay than returning patients (OR= 1.49, 95% CI=1.35–1.66). This finding may reflect MSAHC's ability to screen and link clients to health insurance programs for which they are eligible. Older patients (19–21 year olds) were more likely to be self-pay than 10–12 year olds. In multivariate analysis, when compared to medical office visits, health education visits were not significantly associated with self-pay status (OR= 0.93, 95% CI=0.82–1.06), but family/group/individual therapy (OR= 0.52, 95% CI=0.41–0.66) and mental health assessment/testing (OR= 0.50, 95% CI=0.36–0.71) had a reduced odds of being self-pay than medical office visits.

Table 7. Logistic Regression Analysis on the Associations between MSAHC Patient and Visit Characteristics and Self-Pay Status at First Visit of 2010 (N=8,173)

	Odds Ratio (95% CI)
Gender	
Female	0.88 (0.78, 0.99)*
Male	1.00
Race/Ethnicity	
African American	0.37 (0.27, 0.51)*
Hispanic	0.31 (0.23, 0.42)*
White	1.00
Other	0.44 (0.32, 0.60)*
Age	
10–12	1.00
13–15	1.29 (0.94, 1.77)
16–18	1.27 (0.94, 1.72)
19–21	1.43 (1.05, 1.94)*
22–24	1.38 (0.97, 1.96)
Patient Status	
New Patient	1.50 (1.36, 1.66)*
Returning Patient	1.00
Visit Type	
Medical Office Visit	1.00
Health Education	0.93 (0.82, 1.06)
Family/Group/Individual Therapy	0.52 (0.41, 0.66)*
Mental Health Assessment/Testing	0.50 (0.36, 0.71)*

*Note: *Signifies statistically significant (p<0.01)*
Source: MSAHC patient enrollment and financial data

Health Insurance Screening Information

In 2010, 2184 unique patients were processed through the HCAP insurance screening system. **Figure 1** presents a flowchart summarizing the results of the HCAP data analysis. Among all patients processed through the system, 11% (n=245) had unknown eligibility, 11% (n=246) were not eligible for the program they were being screened for, 34% (n=743) were already insured, and 44% (n=950) were screened for a specific program.

Among those screened for a specific program (n=950), 55% (n=519) were screened for the Prenatal Care Assistance Program (PCAP), 24% (n=229) were screened for the Family Planning Benefit Program (FPBP), 17% (n=160) were screened for traditional Medicaid, 2% (n=21) were screened for Child Health Plus A (CHP A), 1% (n=10) were screened for Child Health Plus B, and 1% (n=11) were screened for Family Health Plus (FHP).

Figure 1. HCAP Screening Flowchart (N=2,184)

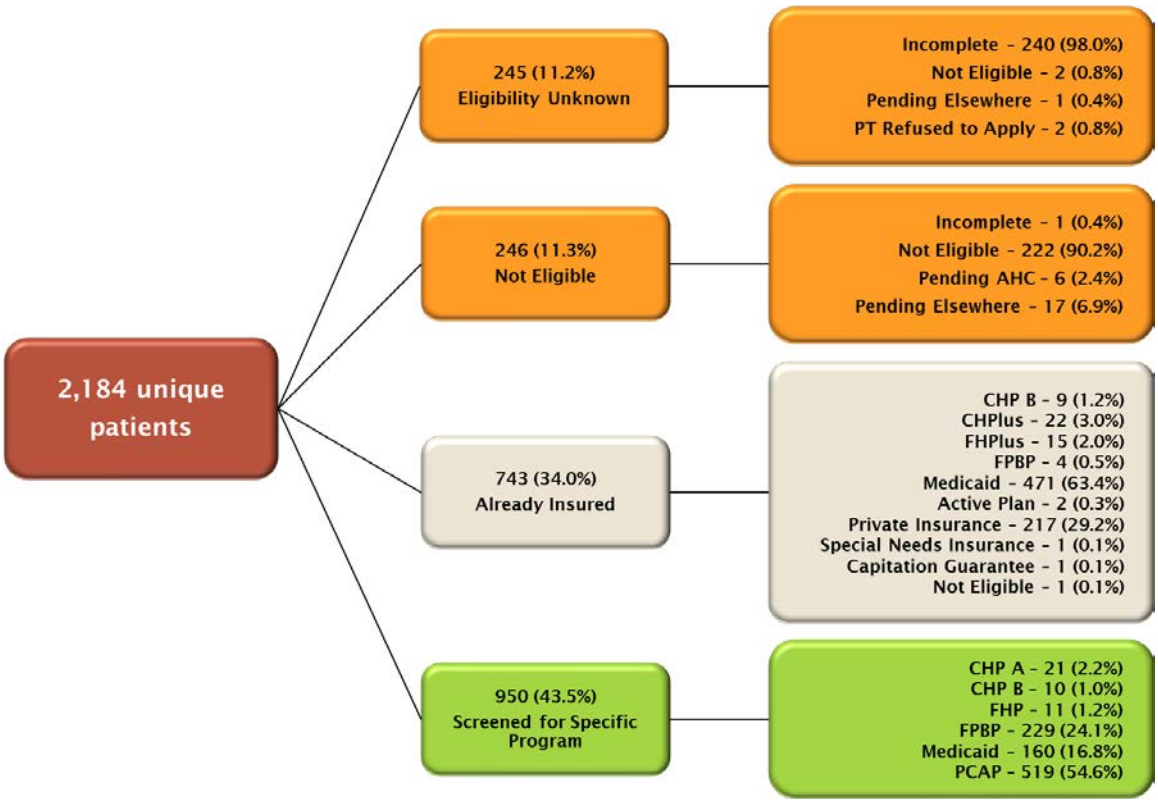

Table 8 shows the number and percentage of applications that were completed among those patients screened for a specific program. More than 85% of those screened for PCAP, Medicaid, and CHP A had a completed application for that program. However, only 14% (n=33) of those screened for FPBP and 9% (n=1) of those screened for FHP had a completed application.

Table 8. Number and Percentage of Applications Completed Among Patients Screened for a Specific Health Insurance Program or Funding Stream	
Program Type	**Applications Completed**
CHP A	18 (85.7%)
CHP B	6 (60.0%)
FHP	1 (9.0%)
FPBP	33 (14.4%)
Medicaid	147 (91.9%)
PCAP	476 (91.7%)

Source: MSAHC patient enrollment and financial data

Payment Information

Accounting for all visits in 2010 (n=47,734), just over a quarter (27%, n=12,875) had a third party payment associated with that visit (not shown). Among billable visit types (n=37,403), medical office visits and mental health assessment/testing (37% and 36%) were more likely to be paid for by a third party than individual/family/group counseling and health education visits (29% and 28%, p<.01) (see **Table 9**).

Table 9. MSAHC Paid Visits by Billable Visit Types (N=37,403)				
	Payment Received for Visit		Payment Not Received	
	n	%	n	%
Medical Office Visit	9,103	37	15,379	63
Health Education	1,702	28	4,312	72
Family/Group/Individual Therapy	1,827	29	4,435	71
Mental Health Assessment/Testing	230	36	415	64

Note: All results are statistically significant (p<0.01)
Source: MSAHC patient enrollment and financial data

DISCUSSION

Implications for Mount Sinai Adolescent Health Center

The data presented in this report clearly indicate that MSAHC is reaching a population in need of its services regardless of their ability to pay. Around two–thirds (64%) of billable first visits in 2010 were classified as self–pay. This was especially true among males, new patients, and older patients, and for medical office and health education visits. Self–pay patients may be uninsured or may have Medicaid or private insurance under their parents' plans, but these patients are unable to access it, or may wish not to use it in order to keep services confidential. Additionally, some MSAHC youth may present as self–pay because they are undocumented immigrants. According to a 2009 MSAHC internal study[12], reasons for self–pay may vary by age. This study found that older youth (ages 18 and older) were more likely to lack insurance whereas younger youth (under 18) were more likely to not wish to use their insurance or have poor education about how to use insurance. Access to services for this population warrants further exploration.

Many of the young people classified as self–pay may be eligible for public health insurance programs such as Child Health Plus A and B and Family Health Plus. MSAHC's HCAP insurance screening system helps to identify these cases, though not every patient is screened as there is only one staff member in the screening office who can assist patients as they proceed through the various components of their visit. The MSAHC evaluation team will explore how the HCAP system can best be optimized in future case studies.

Additionally, adolescents and young adults who classify as self–pay because they wish to keep their family planning services confidential typically qualify for New York's Family Planning Benefit Program (FPBP). One barrier to enrollment in this program may be the obligation of the patient to present a social security number upon enrollment. Many youth do not know their social security number and would not be able to retrieve it without involving a parent, thereby putting their confidentiality at risk. In addition, youth who are undocumented do not have a social security number at all. These barriers may have contributed to only 33 patients in 2010 being successfully screened and enrolled in FPBP.

Social security numbers are not required by some other state family planning programs, such as California's Family Planning, Access, Care and Treatment (PACT) program. In this case, California's strong bipartisan legislative support to waive the social security number requirement during the program's negotiations with the Center for Medicare and Medicaid Services (CMS) was instrumental in not mandating the social security number requirement. Further assessment of this topic, for example, assessing how other state family planning programs are dealing with social security requirements, is needed

and will be a priority for the evaluation team as part of future case studies. How these important issues will be dealt with as the health care system transitions into health care reform will also be explored through an adolescent–consumer lens.

Health Care Reform and the Potential for Improvement in Health Coverage

The ACA will bring about profound changes to the U.S. health care system, with particular benefits for adolescents and young adults.[13] The major changes that already impact youth include the following:

Extended Coverage for Young Adults on Parents' Plans. In **2010**, ACA required that any group health plan or plan in the individual market that provides coverage for dependent children make that coverage available to young adult children up to age 26, even if the young adult no longer lives with his/her parents, is not a dependent on a parent's tax return, or is no longer a student.

Pre–existing Condition Exclusions. Beginning in **2010**, private health insurance plans cannot impose pre–existing condition exclusions for children. This will enable families to purchase health insurance for their adolescents who have been excluded due to their health status.

In addition, other future changes have significant implications for health insurance coverage and implications for health care delivery. In the following section, diverse approaches to health care delivery, projected impacts upon the content of the health insurance package, as well as a new commitment to prevention, are briefly described.

Health Insurance Mechanisms

Medicaid Expansion. Beginning in **2014**, creates a new mandatory Medicaid eligibility category for all individuals with income at or below 133% of the Federal Poverty Level. Extends Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to all children up to age 21 who are gaining coverage under Medicaid.

CHIP Program Maintenance. Beginning in **2010**, requires states to maintain current income eligibility levels for CHIP for youth age 18 and younger and over 133% of the Federal Poverty Level through 2019. This means that adolescents that are currently eligible for CHIP, even at higher income levels, will not lose coverage.

State Health Insurance Exchanges. Beginning in **2014**, the ACA requires the creation of state health insurance exchanges where individuals and families without access to employer sponsored coverage or public programs, such as Medicaid, and incomes from 100% up to 400% FPL, will be able to purchase private insurance. Families of adolescents, as well as individual young adults, would be able to purchase individual policies through the exchanges.

Components of Health Insurance Coverage, Content of Care, and Special Populations

Essential Benefits Package. Beginning in **2014, r**equires qualified health plans to include the following essential benefits as part of a comprehensive benefits package: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, laboratory services, prevention and wellness services, chronic disease management, and oral and vision care. Further details of the essential health benefits package will be defined by the Secretary of Health and Human Services (HHS) based on the scope of benefits offered by a typical employer plan. On October 7, 2011, the Institute of Medicine released a report recommending how the Secretary of HHS should determine and update the essential health benefits called for in ACA.

Preventive Care. Beginning in **2010**, eliminates co–pays for services recommended by the United States Preventive Services Task (USPST) Force (http://www.uspreventive servicestaskforce.org), immunizations recommended by the Centers for Disease Control and Prevention (http://www.cdc.gov/vaccines/), and evidence–informed preventive care and screenings provided in Bright Futures (http://brightfutures.aap.org/). In addition, the list of preventive services that will be included under health care reform are being shaped by the recommendations that emerged from the Institute of Medicine report and recommendations on Women's Preventive Care (http://www.iom.edu /Reports/2011/Clinical–Preventive–Services–for–Women–Closing–the–Gaps.aspx). As all the IOM recommendations have been successfully accepted by the federal Secretary of Health and Human Services and will be required as part of health care reform implementation beginning in August, **2012**, it will also shape the type of preventive services made available to MSAHC's female patients without requiring any co–payment. The specifics of how clinics will be reimbursed for these services are currently being developed.

Increasing Access for Vulnerable Populations. Beginning in **2014**, ACA requires states to continue Medicaid coverage for youth who age out of foster care until they reach age 26. Additionally, in **2014**, there is a requirement for states to conduct outreach to, and enrollment in Medicaid and CHIP, several vulnerable populations, including unaccompanied homeless youth, children with special health care needs, pregnant women, racial and ethnic minorities, rural populations, and individuals with HIV/AIDS. The ACA allows legal immigrants who are residing in this country at least five years to purchase coverage through the state health insurance exchanges, but does not address in a positive way the ongoing problem of health care access for undocumented immigrants.

It is still unclear how each of the aforementioned policy changes will affect health care financing and patient care at MSAHC. The ACA will likely result in more patients qualifying for and enrolling in Medicaid and private insurance, and may potentially increase the proportion of MSAHC's income that is generated through these funding streams, although concerns regarding adequate reimbursement levels for serving

Medicaid beneficiaries remains. The law may also create a larger demand for services at MSAHC due to both the increase in coverage among adolescents and young adults and ACA's increased emphasis on preventive care. MSAHC may need to respond to this demand with increased clinical and administrative staff, more resources directed toward preventive services, and training opportunities for staff working with special populations. Additionally, health care reform efforts may not take into account reimbursement for the special confidentiality and other unique health care needs of adolescents and young adults for integrated mental and physical health care, as much of the law integrates adolescents with younger children with respect to financing. For young adults, it will be important to assess what the content of care will comprise of and whether the USPST's array of preventive services will be sufficient. Thus, MSAHC's historical role of championing the comprehensive health care needs of adolescents and young adults will likely need to continue as health care reform is implemented. Even under the best of circumstances, there will likely be challenges in assuring adolescent–focused health care delivery as the system undergoes significant transitions.

The policy component of the MSAHC evaluation will continue to track changes to the patient financial profile resulting from health care reform and its relevance to the MSAHC model through 2014. Given the scope and breadth of the ACA, as well as its political controversy, the impact of the recession upon state coffers, and the upcoming 2012 election, it is not clear at this time what the potential impact of the political context may have upon the full implementation of the ACA.

Furthermore, addressing health insurance alone will not adequately ensure that adolescents and young adults receive complete and appropriate treatment tailored to their needs. The content of the health care being delivered, such as adequate professional capacity, implementation of clinical preventive services, as well as assurances of confidentiality, adequate follow–up care, and non–judgment on the part of the provider, are also key issues. Further monitoring of how ACA impacts these areas will be a priority for future evaluation activities.

RECOMMENDATIONS

Based upon this analysis, a series of recommendations and future directions can be explored:

1. Ascertain whether there is sufficient staffing in place to screen adolescents for the potential health insurance programs for which they qualify. If screening for eligibility is not feasible at the time of the visit due to multiple patients being served at any one time, follow–up screening through phone calls, email, or text messaging may need to be explored. If hiring of new staff to conduct screenings is not feasible, cross–training of other staff to participate in these efforts, given the potential for maximizing reimbursement may need to be considered. Moreover, MSAHC's existing program in which non–patient community members are screened for Medicaid eligibility should perhaps occur during non–clinic hours.

2. MSAHC has been pro–active in identifying a wide number of diverse funding streams to support their health care delivery model. They have also been champions of enabling youth to receive the quality and confidentially of care that they seek. As a result, the majority of clients are being supported through a "self–pay" mechanism, placing a substantial requirement to continue to identify private donors and other fund raising efforts to sustain the program. Building upon previous internal studies and further analyzing and disaggregating the primary reasons why "self–pay" is selected can perhaps be used to develop additional strategies for maximizing available reimbursement streams. For example, some youth receiving care for non–confidential services could likely request access to their family's health insurance information if they were educated about the way to better use the benefits for which their families qualify and which they often pay for. In addition, tailoring education and outreach to self–pay clients by age and other characteristics may result in more success in covering youth through third party payment mechanisms.

3. Given that 22% of all client visits fall into the category of "non–billable" services, including varying percentages of different types of health education, social work, nutrition, lab, and group visits, these visits represent viable data that MSAHC may be able to: a) use in their negotiation efforts with existing funders, b) potentially advocate for expansion (for example, reimbursement for group visits may help to sustain this potentially cost–effective approach for delivering some aspects of adolescent care), and c) support further grant development (for example, Centers for Disease Control and Prevention funding for obesity prevention to enhance MSAHC's role in the delivery of nutrition counseling). This data is also useful as ACA is implemented to

assure that these types of services are included to sustain the program's comprehensive set of services.

4. An important funding stream, given the profile of reproductive health services provided by MSAHC, is New York's Family Planning Benefit Program. Thus far, state regulations require that the patient produce a social security number, proof of age, citizenship, and proof of income in order to be eligible for the program. Future research should explore regulations in other states which have less cumbersome eligibility requirements for their family planning programs. MSAHC can play an important role by pursuing advocacy efforts for changing policies that would benefit young people's access to a significant part of their health care needs—reproductive health services.

5. Health care reform implementation provides a unique potential opportunity for increasing reimbursement for MSAHC, including reaching several distinct groups of youth who currently are not eligible to receive health insurance benefits: young adults up to age 26 who are now eligible to remain as beneficiaries on their parent's insurance plan and in 2014, low income youth and young adults up to 133% of poverty who will be eligible for Medicaid–funded services, and youth and young adults who are eligible for purchasing private insurance through New York's State Health Insurance Exchange. Further opportunities will be shaped by the overall Mount Sinai institution, as they explore what role they will play, including being part of Accountable Care Organizations (ACOs), in which MSAHC, including its school–based health centers, would be in position to become part of integrated systems of care. Within this environment, it will be particularly important to champion the needs of youth for comprehensive care, including access to confidential health care.

Future Potential Analyses

The initial analyses of the MSAHC data for 2010 raises a number of potential further questions, including ascertaining how health insurance coverage eligibility may change over time. Thus, as clients receive care over subsequent visits, their health insurance coverage may also impact the types of funding sources available to MSAHC for future reimbursement. If regulations and eligibility are modified, for example, as in the recent case of the Ryan White Program, changes in program requirements may hamper the eligibility of MSAHC clients who previously were eligible to receive care. Thus, changes over time in the policy context, as well as changes occurring in individual clients' life circumstances, may impact the patterns of insurance coverage and use. This variability will make additional data mining useful to MSAHC. Additionally, deeper analysis into the types of health services (as defined by ICD–9 codes) that are associated with private

and public insurance coverage versus self-pay may provide further context for designing interventions to maximize enrollment in public health insurance programs.

Summary

MSAHC is in an important position to advocate for the rights of youth not only in New York City, but throughout the country. Joining forces with other networks of champions, (such as the American Academy of Pediatrics, the Society for Adolescent Health and Medicine, American Psychological Association, The National Alliance to Advance Adolescent Health, and the National Initiative to Improve Adolescent Health), will be key in assuring a successful, though likely intensive, campaign if long-lasting preferred outcomes are to be achieved in designing a new system of care. Given MSAHC's long and illustrious history of being a major leader in the delivery of care to a large number of adolescents and young adults, their experience and history can play an important role in shaping the future of health care delivery for young people. Future reports will help to monitor how the financial profile of MSAHC adapts over time to new opportunities aimed at this innovative model's sustainability.

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