Alignment (or Lack Thereof) of Public and Private Payer Policies & Impact on the Front-Line Provision of Services

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Acknowledgement and Disclaimer

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Recap: OPIP's Webinar Series

Part 1: What, Why, and How to **Educate** about Adolescent Well-Care Visits

- Three webinars

Part 2: From **Recommendations to Implementation**: Implementing & Documenting AWV in Alignment with CCO Incentive Metrics

- Five webinars
- ***Today's webinar*** is the last in the series

Part 3: Going to Them – Leveraging Partnerships with **School Based Health Centers** (SBHCs)

- Two webinars

After today, 8 of 10 will have been presented
All are recorded and on the Transformation Center website

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OPIP's Ten Part Webinar Series

Part 2: From **Recommendations to Implementation**: Implementing **& Documenting** AWV in Alignment with CCO Incentive Metrics

1. Structure & Composition of adolescent well-care visits (Held June 2nd)
2. Privacy and Confidentiality (Held June 30th)
3. Depression Screening and Follow-Up for Adolescents (Held July 7th)
4. Substance Abuse Screening, Brief Intervention, Referral and Treatment for Adolescents (Held July 27th)
5. Alignment of Public and Private Payer Policies and Impact on the Front-Line Provision of Services (Today)

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I am from a CCO, Why Do Private Payor Policies Matter in My Efforts to Increase Adolescent Well-Care Visits Rates?

- The majority of practices that serve publicly ensured adolescents serve both publicly and privately insured patients
- Practices are not allowed to differentially bill
  - For example: Not allow to bill for publicly insured but not privately insured
- Practices don't implement standardized systems and processes by the type of insurance policy their patients have
- In OPIP's work with dozens practices on this topic area, some of the **barriers and disincentives** to the work that has been spotlighted in the webinar series has been due to lack of alignment with private payor policies or reimbursement
  - Given a large portion of your work to transform care is related to the front-line, we felt the context would be helpful to inform your efforts
  - During open time for questions/discussion we would love to hear about community-based approaches to the issues raised

Goals For Today's Webinar

- **In this SHORTER webinar, we will highlight examples of where private and public payor policies create disincentives and incentives to improved adolescent well-visits, and share applied examples of how each has played out in practices:**

1. **Blinding of Explanation of Benefits (EOBs)**
2. **Coverage for adolescent preventive care aligned with Bright Futures**
    a) Number of well-visits
    b) Periodicity of well-visits
    c) Kinds of well-visits
    d) Use of -25 and -33 modifiers and impact on reimbursement
3. **Auto-Assignment to Billing Provider of Preventive Care**
4. **Incentives to the Assigned PCP for Enhanced Access and Increase in Claims Tied to CCO Incentive Metrics**

- **Allow time for participants to share on community-level approaches they have used to ensure alignment of policies**

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Blinding of EOBs- The Issue

Note: See our June 30th webinar on Privacy & Confidentiality for more information on this topic

The Issue:

- Documentation and billing (e.g. CPT codes) completed for a service that is provided has the potential to reveal details about the care adolescent's receive, even if they thought they were receiving confidential care
- A 2015 survey of health care providers in Oregon found the following:
  - 32% reported redirecting care to another provider or setting
  - 38% reported avoiding coding and/or billing for services
  - 41% reported a financial impact on their health center/practice because they cannot or do not bill a clients insurance (private or OHP)

Current Solutions:

- Medicaid EOBs are now blinded
- HB 2758 requires commercial health insurance companies to allow any member the right to request (via standardized form) that PHI (including EOB) be sent directly to them instead of the person paying for insurance
  - Does not suppress or blind, only redirects
  - Does not apply to online patient portals etc.

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Blinding of EOBs- Practice Example

- An adolescent with private insurance goes to a primary care practice for treatment of a sexually transmitted infection
- This adolescent had no awareness of HB 2758, or the standardized form to redirect EOBs. Neither did the primary care office
- The practice hands the teen information that outlines the office policies around confidential care that he can consent for without his parents- including what he is coming in for today
- The provider treats the patient, and assures him that the practice will not contact his parents about this visit
- The parent of this adolescent then receives an EOB showing the CPT code provided for that visit, revealing not only that the adolescent sought care without parent approval, but also that they received it, and that it related to a STI

The result is that the parent and the adolescent are both upset and may now be distrusting of the health care provider

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Coverage for Adolescent Well Care
Number of Visits

The Issue:

- Though the Affordable Care Act led to important changes in the provision of well-visits overall, there remains wide variation in policies in coverage for well-visits. Some plans have moved to covering an unlimited number (*recognizing that almost no children use the previous maximum*), while some private plans only allow one well visit per year. Most have a cap on the number provided
- This is very difficult for practices to effectively track, and they are not allowed to bill different payors in different ways
- The resulting scenario limits community level collaboration, and even potentially raises confidentiality concerns due to denied claims
  - If an adolescent accesses a well-visit on their own at a SBHC for instance, they may be denied a claim for a well-visit they go to at their pe
    - the denial of which would alert the person paying for the health insurance that something occurred without their knowing
    - This is a barrier for SBHCs and PCPs in the community to work together to provide these services to their community

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Number of Well Visits
Practice Example

- An adolescent with private insurance goes to an SBHC concerned about Depression symptoms, and the SBHC staff offers them a confidential well visit
- The adolescent decides to go ahead with the well visit. The SBHC collected insurance information and billed their insurance company for a well visit
- The following month the mother of the adolescent schedules a well visit with their usual PCP in response to a reminder letter indicating the teen is due for a well visit
- After the well visit the PCP bills insurance, and the claim is denied, as only one per year is covered, and the teen had a qualifying well visit the month prior at the SBHC.

The result is that the parent and the PCP are both upset and the scenario works against collaboration between the PCP and SBHC. The adolescent may feel that their confidentiality was breached.

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Coverage for Adolescent Well Care- *Periodicity of Well Visits*

The Issue:

- Further complicating the NUMBER of well-visits is plan level variation in the PERIODICITY of well-visits
- For example, some plans cap the number of visits allowed in a calendar year, others between a certain age range, while others only allow a visit after a certain number of months have passed from the last
- This is very difficult for practices to effectively track. Even if they could track the differences, they are not allowed to differentially bill

The result of this scenario is the same as the previous example- denied claims impeding collaboration and trust

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Coverage for Adolescent Well Care- *Kinds of Well-Visits*

The Issue:

- The NCQA HEDIS Specifications for adolescent well care include many types of visits that would **not meet the intent of the OHA CCO Incentive Metrics**, including sports physicals and other visit types
- Some private payors may count different visit types as a well visit that would NOT count for a Medicaid plan
- Combined with issues related to differences in the number and periodicity of visits covered, this really can complicate the scenario further
- This is very difficult for practices to effectively track, and allows for understandably confusing and differing interpretations across public and private payors, especially as practices try to address elements relating to **CCO Incentive Metrics**

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Kinds of Well Visits
Practice Example

- An adolescent with private insurance needs a sports physical and decides to visit their SBHC to get one rather than their usual source of care, given the convenience of location etc.
- The adolescent has their sports physical (NOT an Adolescent Well Visit)
- After the encounter, the SBHC bills insurance for the sports physical, and receives payment for the visit
- The following month the mother of the adolescent schedules a well visit with their usual PCP in response to a reminder letter indicating the teen is due for a well visit
- After the well visit the PCP bills insurance, and the claim is denied, as only one per year is covered, and the teen had a qualifying well visit (for this plan the sports physical counts) the month prior at the SBHC

The result is that the parent and the PCP are both upset and the scenario works against collaboration between the PCP and SBHC

Coverage for Adolescent Well Care- *Common Modifiers*

The Issue:

- The 25 modifier is a CPT code indicating significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service
- The 33 modifier is a CPT code indicating the service is preventive, and should be covered without cost sharing as per the ACA. This includes USPTF A and B recommendations, as well as Bright Futures recommendations
- Use of these modifiers are important for services for adolescents, where a number of preventive screenings and evaluations are recommended, and some payors have been slow to implement requirements of the ACA.
- That said, some sites have had reimbursement trouble:
  - Some plans require the use of these modifiers to get reimbursed without cost sharing for some of the screenings
  - Other plans deny claims with these modifiers attached as the service is defined as part of a bundled well visit

The result is a catch-22 for practices, as they are unable to bill payors differently. It may also impact provider billing practices, and consequently incentive metrics

Auto-Assignment to Billing Provider

The Issue:

- Some plans require patients to be assigned to a provider for primary care, and auto-assign patients to a an eligible provider they see if they have not accessed care within a certain period of time (e.g. three years)
- This is particularly an issue for this population. Nationally, only 46% of adolescents on Medicaid received a well visit in the past year- which represents the population with the LOWEST utilization compared to any other age group (from the WHO)
- As you can imagine, this usually happens outside the awareness or understanding of the patient
- The result is that patients are assigned to providers unknowingly, and in some plans, this means that they can only access primary care at their assigned provider

Auto-assignment to Billing Provider Practice Example

- An adolescent with private insurance goes to an SBHC in order to ask about getting birth control, and the SBHC staff offers her a confidential well visit. Though she has insurance through her parents, she been generally healthy and has not accessed the healthcare system in 4 years.
- The adolescent decides to go ahead with the well visit. The SBHC collected insurance information and billed their insurance company for a well visit. As a result, the SBHC she visited was assigned as her primary care provider.
- The following month the mother of the adolescent schedules a well visit with the adolescents PCP in response to a reminder letter indicating the teen is well overdue for a well visit.
- After the well visit the PCP bills insurance, and the claim is denied, as the service was not provided by the assigned PCP, which is now the SBHC.

The result is that the parent and the PCP are both upset, and the scenario works against collaboration between the PCP and SBHC. The adolescent may feel that their confidentiality was breached.

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Incentives to Assigned Providers

The Issue:

- Many plans offer incentives to primary care providers who meet requirements or benchmarks around quality metrics, including adolescent well-visits
- These metrics are typically calculated including patients that are assigned to a given provider
- In some plans, the assigned provider gets “credit” for the well-visit regardless of WHERE the visit occurred- this encourages collaboration between entities in the same community. Plans that require the visit to occur with the assigned provider create more opportunity for tension between community providers who may overlap

Incentives to Assigned Providers Practice Example

- An adolescent needs a sports physical and decides to visit their SBHC to get one rather than their usual source of care, given the convenience of location etc. Upon scheduling the SBHC informs the teen that they complete sports physicals as part of a well visit only.
- The adolescent has their well visit at the SBHC
- After the encounter, the SBHC bills insurance, and receives payment for the well visit.
- The adolescent's PCP (a pediatrician in the community) receives an incentive for meeting their goal for adolescent well visits, which counted well visits provided to their patients within the SBHC as well
- Ideally, processes exists to establish communication and coordination between these entities

The result is that for plans that build incentives that take a population approach and include care provided at other entities- collaboration within the community is easier to facilitate

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Overview of Key Policies Related Adolescent Well-Visits, Auto-Assignment, and Incentives That May Impact Coordination

Summary for Primary Care Site A

Assignment to Primary Care – If the practice bills and that is the only service billed, are teens auto-assigned

CCO #1

RAE 1: Yes, algorithm based on number and types of visits RAE 2: No RAE 3: No RAE 4: No

CCO #2

Yes, but not to SBHCs

Private Plan 1 (largest)

Private insured are not auto-assigned.

Number of Well-Visits that Can Be Billed – If the SBHC bills a well-visit, is it possible the PCP could then NOT bill?

CCO #1

RAE 1: No limit RAE 2: No limit RAE 3: No Limit RAE 4: Limits tied to Bright Futures recommendations

CCO #2

No Limit

Private Plan 1 (largest)

Policy allows children 5 to 21 to have 18 visits during the time period.

Private Plan 2

Policy allows children to have one well-visit in 365 days.

Incentives to the Assigned PCP for Enhanced Access and Increased in Claims Tied to CCO Incentive Metrics

CCO #1: Yes, generally a proportion of incentive dollars go to the practices. Incentives go to who they assigned to when incentives are paid out. Adolescents also get a direct incentive.

CCO #2:

Yes, incentives to assigned PCP and based on claims. Adolescents also receive incentives.

Private Plan 1 (largest)

Vary widely among practices, and are not tied to incentive metrics

Open Discussion

- ***Questions?***
- ***What are some community- based strategies used to address these issues?***

Downloads

Resources for Download

1. **Slide Deck for this webinar**
   - *September 8_AligningPolicies_Final.pdf*
2. **Consultation form**
   - *Consultation Form_OPIP_AWV.docx*

Questions? Clarifications?

For questions please contact:

- Colleen Reuland (Director of OPIP)
- reulandc@ohsu.edu
- 503-494-0456

Option for CCO-Specific Follow-Up Calls

- Recognize that webinar series has a lot of information
- OHA is supporting OPIP to do individual one-on-one follow-up calls with CCOs to provide consultation, assessment, and expert subject matter technical assistance to address the adolescent well visit within your specific Coordinated Care Organization (CCO)
- Interested CCOs should complete the "**Consultation Form**" to request TA and that will help OPIP determine which team members will be the best match for the CCO specific calls
  - Phone: **503-494-0456**
  - Please complete by **Monday 9/19** and return it to Katie Unger (ungerk@ohsu.edu)

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Eye to Eye: A Youth-Led Approach to Healthcare

Reminder about Opportunity for CCOs and their Practices presented by the OSBHA's Statewide Youth Action Council

Eye-to-Eye training in Bend on September 19. Register https://eyetoeyebend.eventbrite.com

Eye to Eye Training Provided By SYAC

Description: This interactive, youth-led training will focus on improving communication with youth in the context of adolescent well-care visits. The training is intended for CCO staff working to improve their incentive metric rates and for providers and clinic managers who want to provide more accessible care to adolescents.

As a result of this training, previous participants plan to:

- Engage with youth in a meaningful way regarding healthcare messaging
- Get opinions from adolescents coming into the clinic
- Do staff training based on this training
- Keep these learnings in mind when trying to best serve teens
- Learn more about how to involve youth on CACs

Next Webinar

Thursday, September 20th @ 1-2 PM	Capturing Care Provided in School-Based Health Centers (SBHCs) for CCO Incentive Metrics

Thank you!!