The Matrix of Inclusion:
Expanding Access to Care

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Medicaid and Psychology Trainees: Essential Components of Access to Mental and Behavioral Health Care

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March 8, 2020
What is Medicaid?
What does Medicaid expansion mean?

Source: Kaiser Family Foundation, February 19, 2020
How do psychologists interact with the Medicaid program?

- Psychologists are eligible to treat Medicaid patients in all US States.
- Psychological Services are essential to treating behavioral health conditions, through both psychotherapy and integrated care services.
- Psychologists are well qualified to serve this population given their robust and rigorous training.

Image: https://labblog.uofmhealth.org/industry-dx/benefits-for-mind-body-and-work-ability-seen-medicaid-expansion
Psychology training programs are vital, but costly
- Grants are not always reliable or sustainable
- Medicaid reimbursement for supervised trainee services serves multiple purposes:
  - Serving low income and needy populations
  - Increasing the sustainability of training programs through consistent reimbursement
  - Often increases multicultural diversity of staff (due to shifts in psychology trainee populations in recent years)
APA data shows that psychologists STAY where they train
- Both physical location (e.g. in state) and type of setting (e.g. serving same sorts of populations)

- Workforce retention is one of our most valuable advocacy tools
- State regulators and legislators want to know that people they train will stay in state, and our data shows they do
Current State of Medicaid Reimbursement for Supervised Trainee Services

- 25 states + DC allow for Medicaid reimbursement for trainee services (have added 15 states since 2015)

- Reimbursement looks different in every state:
  - Setting Specific (e.g. restricted to certain sites)
  - Limited in Scope (e.g. only certain services)
  - Capped fees (e.g. 50% of supervisor rate)
  - Accreditation specific (e.g. some states limit reimbursement to accredited internship sites)
But why can’t trainees bill Medicare & commercial insurance, too?

• Medicare views psychology trainee billing as double dipping
• Very few states allow psychology trainee billing with commercial insurance (MN and IL)

Since Medicaid is a state and federal partnership, it requires a state by state approach.

In addition to state characteristic differences (size, population, expansion status/funding abilities), the players involved in Medicaid advocacy change depending on where you are:

- State Medicaid Agency
- Managed Care Organization proliferation
- State Psychological Association
- APA Education and Practice Directorates
What does APA state level advocacy for trainee Medicaid reimbursement look like?

- Identify challenges to securing Medicaid reimbursement for trainees
  - Regulatory, Legislative, Managed Care, other political issues

- Determine key players

- Draw on expertise of local/state advocates (members of SPTA, training program leadership, FACs) to determine best strategy

- Implement state-specific strategy
Examples of Medicaid Advocacy in Action

- Alaska
- Arkansas
- Georgia
- Kentucky
- New Mexico
- Nevada
- New Jersey
- Texas
- Pilot Projects: DC, DE, PA, WA, LA
Medicaid increases Access to Care

- Medicaid reimbursement means greater access to essential services
- Expanding reimbursement means MORE providers in the pool to provide services to Medicaid populations
- Expansion of Medicaid has increased provision of mental and behavioral health services across the board, and made available more opportunities for psychologists to participate
- Medicaid is a great way to build or expand a practice, and helps serve people who might not otherwise receive much needed services.
Questions?

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Medicaid Pilot Projects and Psychologist Reimbursement

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Legal & Regulatory Affairs, APA Practice

Mar 8, 2020  Practice Leadership Conference, Washington DC
Pilot Projects:

Goals

- Use trainees to fill unmet needs for underserved Medicaid populations
  
  Main focus: integrated care services by interns

- Build a pipeline of psychologists trained to provide integrated care to Medicaid populations

- Demonstration project: value of these interventions by trainees; developing outcomes and best practices

- Make training programs more viable -- thru reimbursement for trainees’ services
Pilot Projects: Stakeholders

- APA and SPTA
- APA accredited internship program(s)
- Service delivery site(s) (ideally already integrated with training program)
- State Medicaid agency
- One or more Medicaid Managed Care Organizations (MMCOs)
Pilot Project concept

States may be reluctant to make statewide changes

Pilot Project provide:
- Demonstration project to show value of psychological trainees’ services
- in that state’s Medicaid population & regulatory/payor environment
- In narrow, controlled environment
- With high level of oversight by interested & reputable stakeholders

The plan: successful Pilot Project outcomes → statewide implementation of changes
Current Pilot Projects

Working with four SPTAs: WA, DE, PA and LA

PA: training/service sites would be Children’s Hospital of Philadelphia and Philadelphia College of Osteopathic Medicine

- Seeking Medicaid reimbursement of HBAI (formerly H&B) codes for integrated care
Current Pilot Projects cont’d

- WA: training/service sites: two main integrated care training sites in state: Columbia Valley Community Health (CVCH) in rural Central Washington and HealthPoint in Seattle area

- Seeking to eliminate reimbursement work around: trainees get temporarily licensed as LMHC Associate
  
  Downsides: Expensive and time consuming for training site and trainees; trainees regulated by counselor’s board; limits pool of applicants

- CVHC is most rural population of any Pilot Project and HealthPoint has very diverse urban population, e.g., Russian, SE Asian, E African
Current Pilot Projects cont’d

**DE:** Training/service site would be Christiana Care near Wilmington – one of the state’s largest hospital systems, with trainees in a variety of settings, e.g., ob-gyn and cardiology

**LA:** Training/service sites would be Louisiana State University and Tulane sites in New Orleans
  - One Pilot Project that’s predominantly traditional MH care.
  - Aligns with City’s focus on trauma
  - Delay due to political chaos w MMCOs and 1-year contracts
Pilot Project Challenges

- Getting all of stakeholders interested & participating in one state
- Getting the attention of busy state agencies
- Labor intensive for APA staff and sometimes also state participants
- Each state is very different
Medicaid Reimbursement Rates

- Request by one SPTA inspired us to research reimbursement rates for key CPT codes in all 50 states

- We know that: 1) Low reimbursement is one of main reasons psychologists don’t want to participate in Medicaid; and

- 2) There’s direct correlation between access and reimbursement rates

- So this information will help us target states to advocate for higher reimbursement → greater access for underserved Medicaid patients

- Our new Senior Dir. For Health Care Finance, Dr Stephen Gillaspy, will be going into more detail in his plenary session at 4:45 this afternoon in Constitution BCDE. The following is a sneak peek of some key points
## Sample Psychotherapy Rates

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<tr>
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<td>$72.39</td>
<td>$103.14</td>
<td>$83.65</td>
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- Lowest: $26 (PA), $38 (MI), $52 (PA), $13 (PA), $3.47 (CA)
- 2nd: $167 (NJ), $113 (NJ), $169 (WI)
- Average: $108.75, $72.39, $103.14, $83.65, $23.70
- Getting new CPT codes (testing in 2019 and HBAI in 2020) paid -- and paid correctly--in various Medicaid programs

- Fact sheet on HBAI codes that SPTAs can use w their Medicaid agencies and MMCOs (and that we can use in Pilot Projects)

- State profiles
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The Matrix of Inclusion: Expanding Access to Care

Interface With Insurance Companies
How I got into this

- 1987 American Biodyne – Nicholas Cummings
- 1988 Sent to Florida as Area Director
- Capitated contract with Humana – over 2 million “covered lives”
Overview

- Private Health Insurance – What and Why
- Health Insurance Literacy
- Basics of Private Health Insurance
- Getting Reimbursed – The Claims Process
- Communicating and Maintaining Relationships with Insurance Companies
WHY? Risk Protection

- Types of Risk
  - Personal – loss of income due to death, illness, disability, unemployment
  - Property – loss or damage due to fire, flood, theft, accidents, natural disaster
  - Liability – negligence or events that result in injury to others

- Ways to handle risk
  - Risk Avoidance
  - Risk Reduction
  - Risk Assumption
  - Risk Transfer – to a third party, i.e., INSURANCE
A Contract That Transfers Risk – A health insurance policy is a written contract between a policy holder and an insurance company. The policy spells out what is and is not covered, how much the policy holder pays (the premium) per month for the specified coverage.
Health Insurance Literacy (HIL)

Definition: The degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about insurance plans, select the best plan for their financial and health circumstances, and use the plan once enrolled. (Quincy, 2012, p. 7)

HIL Can Be Seen as Intersection of Financial Literacy and Health Literacy
Health Insurance Literacy

- Low health insurance literacy is ubiquitous
  - All income levels
  - All education levels
  - Even those who have had insurance all of their lives

- Cost sharing terms are the least understood: A 2013 survey revealed that only 14% of respondents accurately understood basic cost sharing terms like deductible, copay, coinsurance, and out-of-pocket maximum

Most People Overestimate Their Knowledge of Health Insurance

Three out of four people felt confident they know how to use health insurance; but...
...only One out of five could accurately calculate out-of-pocket costs for a routine doctor’s visit.

Source: American Institute of Research Health Insurance Literacy Survey, 2013 www.air.org
A survey conducted by the Health Reform Policy Center in 2014 found that

- Health insurance literacy, although universally low, is highest for white, non-Hispanic adults,
- Low income adults have low health insurance literacy and there are significant racial and ethnic differences within income levels,
- Health insurance literacy is particularly low among the uninsured, however there are significant racial and ethnic differences among the uninsured, as well.

Racial and Ethnic Differences in Health Insurance Literacy

Understanding of Key Health Insurance Terms

And, it’s Not Getting Any Better!

A very recent survey conducted in October 2019 found that the situation may actually be getting worse:

- More than one in four people reported that not understanding their health insurance had led them to avoid treatment.

- Very low awareness of the 10 essential benefits covered by ACA – more than half (54%) said their insurance covered none of these benefits, including hospitalization and mental health care.

- This is compared to a similar survey in 2018 where 28% were unaware that their insurance was required to cover these essential benefits.

- 21% knew the dates for open enrollment in 2015; only 11% knew the dates in 2019.

- Fewer than one-third were able to correctly define the following three terms: premium, deductible, copay.

Why is this happening?

- The survey authors speculate that health coverage and insurance has been a major political issue since the passage of the ACA and all that attention has come with a lot of misinformation and distortion of the facts.

- Cost of healthcare has increased and insurance companies are shifting more and more of the costs to the consumer in the form of higher deductibles, higher copays, higher coinsurance – according to the Kaiser Foundation, the average annual deductible has more than doubled over the past 5 years.

In summary, lack of health insurance literacy and low numeracy matters because it has a significant impact on how effectively people use health care services, whether or not they seek care when they need it, and whether or not they understand what they will have to pay when they do access care.

Our role?

We have a responsibility to assess and build health insurance literacy in the people we serve. We need to ask questions and provide information in a form consumers can understand.
Know the Types of Private Insurance

- Typically employer sponsored, typically for profit
- Types
  - Indemnity – fee-for-service
  - HMOs
  - Managed care (PPOs, POS, EPOs)
- Other options
  - HDHPs, HSAs, HRA, FSAs, Co-Ops, AHPs
Know the Language

Cost sharing terms (Financial Terms)
- Premium
- Deductible
- Copay
- Coinsurance
- Out-of-Pocket Maximum

Non-financial terms
- Covered benefit
- Exclusion
- Network/non-network provider
- Preauthorization and utilization review
- EOB
- Coordination of benefits (Primary/Secondary)
The Claims Process

1. Policyholder goes to Provider
2. Evaluation performed, diagnosis determined
3. Codes assigned (ICD-11 & CPT)
4. Claim sent to insurance company
Receiving Payment

- Insurance company reviews claim – a process called adjudication – complicated with many layers
- Decision to pay all, some, or none of the claim sent back to provider in the form of a report – the Explanation of Benefits (EOB)
- EOB reviewed and entered in provider’s system – does patient have another insurance? Send claim for remaining amount to second payer
- Bill patient for deductible, copay, coinsurance
Be consistent

- Set a standard fee for each CPT code you use and stick to it
- Charge that fee for all insurance companies *regardless of the rate stipulated in your contract with them*
- If you adjust your fees in any way (e.g., provide a discount to uninsured or those choosing not to use insurance, have a sliding fee scale), make sure you have this information in writing. If client is choosing **not** to use insurance, make sure they sign an “Opt-Out” contract, this is especially important if client has Medicare or a Medicare replacement policy (Medicare Advantage)
So, is it worth it?

**Advantages**
- Access to a larger pool of potential patients
- Improved cash flow
- More control over finances
- Improved opportunity to provide services to those who cannot afford to pay out-of-pocket

**Disadvantages**
- Loss of control/autonomy of your practice – oversight and review from insurance companies
- Increased record keeping time
- Extra administrative layers
- Discrimination against those without insurance
- Difficulties dealing with a bureaucratic system
Establish good channels of communication and keep them open

- Know what you’re talking about
- Establish good relationships with the people you need to deal with in the payer organization
- It may make sense to hire or designate a specific person in your practice to handle relations with insurance companies
- Stay on top of the changes – read newsletters, watch webinars, visit websites
- Be mindful of re-credentialing deadlines and processes
If, after weighing all the factors involved in “interfacing” with insurance companies, you decide to pursue third party billing, you can prepare for it by making sure you have the eligibility/credentialing information you require, carefully assessing your practice to determine what changes you may need to make to become an approved provider, and having a system in place for accurate and timely claim filing and billing. You’ll need to have a process in place for monitoring and reconciling payments, maintaining records, and ensuring confidentiality.

*With all of this in place, third party payment can prove to be a great source of long-term financial stability and sustainability!*