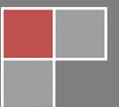




Pediatric Council Guidebook

A Guide for AAP Chapters in Cultivating
Effective Pediatric Councils with Payers

The American Academy of Pediatrics



American Academy of Pediatrics

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PEDIATRIC COUNCIL Guidebook

A Guide for AAP Chapters in Cultivating Effective Pediatric Councils with Payers

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THE PEDIATRIC COUNCIL GUIDEBOOK
AND DISCLAIMER**

The following guidelines and limitations should be strictly adhered to by those participating in Pediatric Councils:

- (1) There should be no exchange of payment information, which includes fees, price or cost data by individual pediatricians or other health care providers. Sharing of fee schedules and other fee or cost information by competitors in this context is strictly prohibited by antitrust laws.
- (2) Pediatric Councils must not be used to negotiate with purchasers of health care services on any term or condition of payment or to otherwise attempt in any manner to put pressure on any purchaser by implying or threatening a boycott of any plan that does not follow the chapter's recommendations.
- (3) Each health care provider must make independent decisions based on his or her own individual circumstances regarding what fees to charge, what capitation rates to accept, with what third-party payers to contract, and the other terms and conditions of these contracts.
- (4) This notice and the Pediatric Council Guidebook are not intended as a substitute for legal advice. Each AAP chapter and the physicians who participate in the pediatric councils should consult with a qualified health care attorney about the limits placed on their conduct by the antitrust laws in the use of information obtained via the pediatric council, pediatric council e-mail list, and this Guidebook. Use of pediatric councils by the AAP chapters or individual health care providers in any manner to limit competition or restrain trade is strictly prohibited by state and federal antitrust laws and is subject to severe penalties.

Pediatric Council Guidebook

Overview

Concern about appropriate payment continues to face pediatricians. Insurance carriers, managed care organizations (MCOs), employers and other purchasers of health care (collectively referred to as payers) looking at ways to reduce expenditures, are not fully aware of the impact of plan design on pediatric services, particularly on access to appropriate, quality care and payment. Several American Academy of Pediatrics (AAP) Chapters, looking at ways to address member concerns about managed care, have developed pediatric councils.

Pediatric councils serve as a forum for pediatricians to discuss with payers concerns about covered services, plan policies and administrative procedures, which impact access, quality, efficiency of treatment and payment. Chapters have reported that these councils facilitate communication and lay the groundwork for successful problem solving with individual payers.

The AAP supports the development and use of pediatric councils by AAP Chapters for appropriate purposes and within the safety-zone parameters established by the Federal Trade Commission and Department of Justice for provider's collective provision of non-fee and fee-related information to purchasers of healthcare services (the "DOJ/FTC Guidelines"). This Guidebook is based on the experiences of those AAP chapters with pediatric councils and is intended to share information on starting and maintaining pediatric councils within the DOJ/FTC Guidelines. Sections include:

- Developing a Pediatric Council
- Identifying and Prioritizing Issues
- Coordinating Pediatric Council Meetings
- Maintaining the Relationship and Cultivating Synergy within your Pediatric Council
- Antitrust Concerns
- Building on Success: Perspectives from Chapter Pediatric Councils
- Resources for Chapter Pediatric Councils

The Academy remains deeply committed to addressing payment issues. If you have questions about specific payment issues or would like consultation on payment advocacy, please contact Academy staff.

For private payer issues, including information on the AAP Private Payer Advocacy, please contact:

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Developing a Pediatric Council

AAP Chapter Pediatric Council Guidebook

Why Start a Pediatric Council?

To assure access to comprehensive and quality pediatric services, appropriate payment from public and private payers is necessary. The myriad of payers and managed care plans that pediatricians must deal with can be confusing and frustrating. Payers may have different covered services and reimbursement levels. It is often difficult and time consuming for an individual pediatrician to repeatedly address pediatric concerns with the payer.

Several American Academy of Pediatrics (AAP) Chapters have developed pediatric councils to foster enhanced communication with payers. Pediatric councils serve as a forum to identify issues, discuss the impact of managed care policies and practices on the provision of pediatric care, and share ideas for resolution of issues between pediatricians and payers. These meetings do not focus on fee schedules and payment rates, but address aspects of managed care that affect payment such as covered services, plan policies, coding policies, and administrative procedures.

Pediatric councils are an effective strategy in the process of advocating for access to services, quality of care and appropriate payment. Chapters have reported this collaborative process has enhanced communication with carriers and managed care organizations, identified key contacts, educated and informed carriers of pediatric practice and delivery, and assisted in resolving issues with carrier policies and practices.

As a chapter considers implementing a pediatric council or seeking ways to enhance its pediatric council, the chapter may benefit from the experience of other AAP Chapters. This guide is intended to identify steps chapters may consider in implementing and maintaining a pediatric council. The recommendations are based on the experiences of those chapters that have already developed pediatric councils.

Goals

Each chapter may have specific areas of concern regarding managed care issues and may develop its own specific goals. Generally, goals may involve covered services, plan policies and administrative practices, coding, and quality, just to name a few.

Uniform Benefits Coverage: Often health plans have different covered benefits for their subscribers, leading to inequitable care for patients, e.g., covering some, but not all of the AAP-recommended pediatric services or other guidelines for health supervision visits, or not allowing pediatricians to code for after-hours office visits if they have ‘scheduled’ office hours in the evenings or on weekends. Thus a major goal would be to make patient benefits as uniform as possible so that all patients are given access to optimal care.

Consistent Coding: Payers also rarely recognize all of the codes in the current CPT manual (professional edition) or they may have ‘rules’ regarding which ICD-9-CM codes can be used by primary care pediatricians. Thus another goal could be to educate all the payers to recognize the full range of current CPT and ICD codes applicable to good pediatric care. Use of these codes by the members of the pediatric councils indicates a level of understanding that carrier medical directors will appreciate.

Quality and Cost Effective Care: It is important that the carrier medical directors understand that the chapter desires to work with them to provide the highest quality care in the most cost-effective manner for their subscribers, e.g., seeing patients in the physician’s office after hours improves continuity of care and is less expensive than referring them to emergency departments. Quality and cost effectiveness are important to all payers and discussions should focus on those concepts to facilitate understanding and develop a common ground from which to work.

Key Participants

Members of chapter leadership need to carefully consider who will be involved with the pediatric council. Obviously, payers need to be included and it is recommended that there be representation by the medical director. The medical director is involved with plan decisions regarding coverage and policy as opposed to provider representatives who functions as liaison between the carrier and providers and generally do not have as broad scope of decision making authority.

The following lists key players in a Pediatric council. Each chapter may include other representation as deemed appropriate, but the following categories are the key members of a Pediatric council.

- Pediatrician: Ideally, this should be a small group (about 3-5). The intent is to have a small number so as not to give the impression of overwhelming or intimidating the payer representatives. The composition of the pediatrician group should include members of chapter leadership who have had experience working with payers and who have a commitment to addressing concerns on an ongoing basis.
- Carrier medical directors that are operating within the chapter's service area
- A representative from the State Department of Insurance or Department of Managed Care. This individual can clarify regulations governing health plans, as well as assure there will be no anti-trust violations.
- A representative from the State Department of Health. This representative should be invited because the topics discussed will be health issues of concern to the care of children. Additionally, many states have MCO's that share in State Children Health Insurance Programs (SCHIP) and Medicaid managed care, so they have a vested interested in any decisions.
- A representative from the State or Local Medical Society
- Depending on the issues discussed at each meeting, guests may be invited to present information as unbiased experts regarding that topic
- Some chapters suggest including the following as needed:
 - Employers or business groups representing employers (particularly self-insured)
 - Financial officers of the health plans as they are involved in decisions on payment
 - Pediatric specialists (especially if the topic is related to that specialty)
 - Medical directors of IPAs, PHOs, or ACOs

What pediatric councils are saying:

When asked “how do you determine the “right mix’ for your chapter pediatric council” responses included:

- We issued an open invitation to chapter members after explaining our goals of correcting unintended consequences of payer policies and looking for ‘win win’ opportunities*
- We first got volunteers that wanted to be a part of it and then those that lead the group sought out specific pediatricians*
- By level of interest; Was careful not to have too many docs from a single practice; Recruited people from large and small practices*
- We have 2 representatives on the sub committee and have opened the meeting to any board member. Usually we get 2-3 other members attending either in person or via teleconference*

<http://www.aap.org/en-us/about-the-aap/aap-facts/Pages/AAP-Facts.aspx#AAPStrategicPlanAgendaforChildren>

Additionally, AAP Chapters may have developed their own strategic plan and priorities that may serve as the basis for the chapter pediatric council advocacy to private payers.

Identify areas of concern by the payers

To keep the payers engaged, the topics discussed need to resonate with their interests. Payers' interests are generally keyed to:

- **Cost Effectiveness:** What are ways to provide services more efficiently that will decrease costs to the payer?
- **Quality of care:** Payers are interested in evidence based and evidence informed practice and ways to implement best practices that will enhance quality as well as help the payer to meet certain accreditation requirements such as NCQA HEDIS measures.
- **Market Share:** Payers are in a competitive environment and are concerned about public perception and being family/consumer friendly.

Survey the payers in your community on their concerns and review their annual reports or media reports on health care projects and activities the carriers and employers are implementing.

3. Immunizations: recommended vaccines; time and costs association with vaccines and immunization administration
4. Requirements for lead screening
5. Bright Futures recommended preventive care services and the need for benefits coverage
6. Counseling for obesity and nutrition
7. Quality of care, pay for performance
8. Developmental screening recommendations and need for coverage and payment
9. Need for screening for cholesterol, anemia
10. School health requirements
11. Administrative simplification; using standardized health forms for prior approval
12. Medical Home for children

Of course, other topics may be discussed based on the concerns and priorities of the chapter and members.

To assist AAP Chapters and members in discussions with payers, presentations and talking points are being collected and are now available on the AAP Member Center, private payer advocacy page under the link *AAP Chapter Pediatric Council Payer Discussion Resources on Pediatric Issues* at:

<http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private/AAP-Chapter-Pediatric-Council-Shared-Resources.aspx>

These resources can provide the framework for consistent messaging to payers on pediatric issues. Topics include obesity, mental health, immunizations and vaccines, and preventive care. Additional topics will be added as provided by other Chapter pediatric councils.

Agenda Components

Purpose: Once the issues have been identified and a decision is made on which topics to address, the agenda should be finalized. For each meeting, begin with a review of the purpose of the pediatric committee including any particular goals the Chapter hopes to achieve through the pediatric council. This will enable the meeting participants to remain focused on the purpose of the pediatric council.

Ground Rules: Another agenda item should be a review of any ground rules for discussing issues. Payers need to be reassured that the pediatric councils are not ‘gripe sessions’ or solely concerned with payment. Chapter pediatric councils are encouraged to prohibit any discussion of fees at the meeting and require attendees to abide by the stipulation of not discussing fees. This minimizes any antitrust concerns as well as reiterates the focus on access and quality. If fee-related information is presented to the payers and discussed at the pediatric council meetings, the utmost care should be taken to assure that the method by which the information is collected and presented satisfies the DOJ/FTC Guidelines discussed in the section on Antitrust.

Discussion Topics: The majority of time on the agenda should be spent on the one or two topics that are presented to inform and educate the meeting participants. Chapters may

consider including a brief paragraph describing the issue as background information so the participants may prepare in advance what to discuss. (An example is included at that end of this section).

Distributing the Agenda: Ideally, the agenda should be sent out well in advance of the meeting and should include any data to support the issues to be discussed. The meeting participants should have time to review the agenda. One chapter pediatric council reports that a 'pre-agenda' is sent to the payers and if any are uncomfortable discussing a particular topic, their concerns are discussed privately and if necessary, parameters for discussion of the particular topic are developed.

Recap/Summary: Include time to review and clarify follow up activities and the responsibility party. Identify due dates for activities to be completed. Prior to adjourning, identify the time and date for the next scheduled meeting.

To assist AAP Chapters in encouraging payer participation in the pediatric council, the AAP has developed an invitation letter to health plans on pediatric councils. The letter may be sent to payers and can be accessed on the AAP Member Center, private payer advocacy page at: <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/Letter-to-Health-Plans-about-Pediatric-Councils.pdf>

Below is a copy of the AAP letter to health plans. Also, below is an example of an agenda from the Rhode Island Chapter pediatric council.

American Academy of Pediatrics

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November 1, 2011

Dear Medical Director:

The American Academy of Pediatrics (AAP) has a private payer advocacy initiative to engage health plan carriers in a collaborative dialogue on pediatric issues at both the national level and, through AAP chapters, the local level. Academy chapters are independently chartered, organized groups of pediatricians and other health care professionals working to achieve AAP goals in their communities. This arrangement provides chapters with autonomy to address the needs and interests of members in their region.

An effective component of the AAP private payer advocacy initiative is the exchange of ideas and information on pediatric issues by AAP chapter pediatric councils. Several AAP chapters have developed pediatric councils which meet regularly with health insurance plans to discuss pediatric issues related to access, quality and coverage. Pediatric councils have the potential to facilitate better working relationships between pediatricians and health insurance plans and to improve quality of care for children. Ideally, changes may lead to more appropriate coverage for pediatric services, as well as smoothly and efficiently run pediatric practices and health plan claims adjudication.

The intent of pediatric councils is to identify, inform and educate on issues impacting the delivery of pediatric services and to enhance quality of care. A pediatric council is not a forum for joint contract negotiation, individual contract discussion or other fee-related concerns. Moreover, pediatric councils are not forums to discuss, allude to, or even imply any sort of collective action on the part of pediatricians.

The AAP chapter within your service area would like to include representatives from your health plan in the pediatric council meetings. The chapter will provide specific information regarding issues and meeting times. These meetings will provide an excellent opportunity to address health care issues of the children you have insured and to build on your existing relationships with pediatricians in this region.

Sincerely,

/S/

Errol R. Alden, MD, FAAP
Executive Director
American Academy of Pediatrics

ERA/lt

Sample Chapter Pediatric Council Agenda

**RI American Academy of Pediatrics
Pediatric Council Meeting Agenda
March 22, 2007**

6:00 pm – 8:00 pm
Collis Conference Room
1st Floor Hasbro Children's Hospital
Sandwich dinner provided

The Pediatric Council is a committee of the Rhode Island Chapter of the American Academy of Pediatrics with representatives from state government and insurance carriers as invited guests. The aim of the Pediatric Council is to serve as a forum to promote access for children to medically appropriate services. Some of us around the table are competitors. As such, we need to be mindful that discussion of economic issues, such as rate of reimbursement or any agreement among competitors related to business issues, should be avoided. Each participant should make his/her own business decisions regarding any issue that may be discussed at a Council meeting. The unique opportunity presented by the Pediatric Council to have a dialogue concerning issues relating to children and their healthcare needs is important for all who share the goal of advancing the cause of children. Our ability to do this is dependent on everyone's good will.

Each meeting will consist of agenda set by the RI AAP of two or three items that are important to RI's children and their access to care. We ask that each participant come to the meeting prepared to discuss each agenda item to the best of his/her professional ability so that we may strive towards a resolution, or at least an understanding, that maximizes the potential for children. Many issues will not have easy solutions. It is our goal at these meetings to work collaboratively towards a solution, to exchange ideas in an effort to resolve each issue. If issue resolution is not possible in just one meeting, our discussions will aim towards an understanding of the issue in an effort to create movement toward a solution.

Thank you for agreeing to participate in this landmark committee.

Agenda items –

1. 6:00 – 6:10 Review of Minutes
2. 6:10 – 6:25 Gardisil reimbursements
3. 6:25 – 6:40 Vaccine counseling codes
4. 6:40 – 7:10 Meeting follow-ups
 - a. December 2006: Minute Clinic/Retail Based Clinics (RBCs)
 - b. September 2006: Recognizing modifiers
 - c. September 2006: Annual exams
 - d. June 2006: Developmental Screening
4. 7:10 – 8:00 June 2006: Access to pediatric mental health services

Future meetings -

Thursday June 7, 2007

Thursday September 20, 2007
Thursday December 6, 2007

2. Gardasil –

A question from our non-Vaccines For Children (VFC) colleagues, family physicians and internists -

Now that Gardasil is a VFC provided vaccine, how does this affect the insurance company reimbursements for Gardasil that is administered in a non-VFC office?

ie: the 17-year old girl who now sees an internist for medical care who is vaccinated with the Gardasil at her well child appointment. Although RI VFC covers Gardasil for girls to age 18, this internist is a nonVFC practice, and so purchased the Gardasil for her patients. Does the physician submit the CPT code for the administration and biologic of this vaccine for full reimbursement by patient's insurer? Or is this vaccine cost not covered by insurers and the patient instead needs to receive her Gardasil elsewhere? And where is that "elsewhere?"

3. Vaccine counseling codes –

Each one of these immunization administration codes includes:

-Administrative staff services such as making the appointment, preparing the patient chart, billing for the service and filing the chart

-Clinical staff services such as greeting the patient, taking routine vital signs, obtaining a vaccine history on past reactions and contraindications, presenting a Vaccine Information Sheet (VIS) and answering routine vaccine questions, preparing and administering the vaccine with chart documentation and observing for any immediate reaction.

The American Academy of Pediatrics and the Centers for Disease Control and Prevention certainly encourages the physician to counsel patients/family members about the risks and benefits of all vaccines to include discussions of previous vaccine reactions, the impact of any new illness and possible contraindications to the vaccine. These discussions of varying time take place during visits with the physician.

The Academy developed the pediatric-specific codes in an effort to get the Centers for Medicare and Medicaid Services to recognize the physician work involved in administering vaccines in the pediatric population.

90465: immunization administration <8 years of age (percutaneous, intradermal, subcutaneous or intramuscular injections) when the physician counsels the patient/family, first injection, per day – 2007 Medicare \$19.42

90466: each additional injection, per day – 2007 Medicare \$10.37

90467: immunization administration <8 years of age (intranasal or oral) when the physician counsels the patient/family, first administration – 2007 Medicare \$12.66

90468: each additional administration, per day – 2007 Medicare \$9.62

90471: immunization administration (percutaneous, intradermal, subcutaneous or intramuscular injections), one vaccine – 2007 Medicare \$19.42

90472: each additional vaccine – 2007 Medicare \$10.37

90473: immunization administration by intranasal or oral route, one vaccine –
2007 Medicare \$13.04

90474: each additional vaccine – 2007 Medicare \$8.87

4a. Retail Based Clinics –

Providence Journal Bulletin editorial from February 27, 2007 and Dr. Yul Ejnes' letter to the editor March 4, 2007.

4b. Recognizing modifiers –

4c. Annual Exams –

4d. Developmental Screening –

5. Access to pediatric mental health services in Rhode Island

Guest – Dr. Gillian Elliott Pearis

President, Rhode Island Council for Child and Adolescent Psychiatry

The RI Chapter of the American Academy of Child and Adolescent Psychiatry

Guest – Dr. Gerald Tarnoff, child psychiatry

Pre Meeting with Pediatricians

Prior to the actual meeting, it is strongly encouraged that the pediatrician members of the pediatric council meet or hold a conference call to determine each member's role and decide on a means of presenting the information.

Roles

Pediatricians: The key element for an effective meeting is for each pediatrician to know, understand and carry out the assigned role in order to articulate the issue clearly and concisely. Determine the role of each of the pediatric members. Assign each physician that part of the issue that he or she will be responsible to research and present. For example, one pediatrician may be assigned the topic on OSHA regulations regarding injections and another may be assigned the topic on requirements for providing vaccine information to parents.

Council Chair: It is essential that there be an identified pediatrician leader within the pediatric council to maintain focus on the agreed-upon goals and roles and to be able to lead the pediatric council meetings. Skills required of the pediatrician leader include the ability to organize and facilitate meetings and to moderate discussions and in particular steer discussion from potentially antitrust behavior. As the moderator, the Chair will prepare an introduction, introduce the attendees, direct the meeting, and summarize at the end.

Presentation format

Chapters with pediatric councils report that the most effective means of presenting the topics is to stay focused on the purpose to educate and inform to build consensus for resolution. Have hard data to support the position on an issue. To maintain compliance with HIPPA privacy regulations, data should be reported in the aggregate and not identify any individual. When meeting with a group of payers, the data should not target a particular payer. If the issue only relates to a particular payer, it is best to have a private meeting with the payer as opposed to singling out one payer in a group meeting.

Avoid any discussion of fees and sounding self-serving. However, concepts related to payment are appropriate to discuss. For example, presenting the impact of a carrier's policy on pediatric practice and payment is appropriate. Frame the discussion around the impact on the following three areas:

- 1) Cost effectiveness: Be prepared to demonstrate to payers how a proposed change will decrease expenditures in a given time period and/or be more efficient
- 2) Health plan market share and the perception of being family friendly: Since families are becoming more involved in selecting health plans, they are likely to evaluate plans on how the children will be covered for services
- 3) Quality of care: Payers are concerned about evidence-based practice and plan accreditation status through the Joint Commission on Accreditation of Health Care

Organizations (JCAHCO) and the National Committee on Quality Assurance (NCQA).

If appropriate, bring in outside speakers as unbiased experts to present information, i.e. a pharmaceutical representative to discuss combination vaccines and someone to discuss HEDIS requirements.

Meeting Structure

Notices

Invitation letters stating the purpose of the pediatric council should be sent to the carrier Medical Directors inviting them to participate. The letter should reassure the invitees that fees and payment will not be discussed at the meeting. A follow up phone call with a personal invitation may be considered particularly if there has not been any prior contact with the Medical Director.

Agendas should be sent out at least two weeks prior to the meeting in order to allow adequate time for the participants to review the issues. For subsequent meetings, a copy of the previous meeting minutes or summary should be included with the agenda.

Structure

The meeting should be tightly monitored by the pediatric council chair to ensure that:

- ground rules are adhered to,
- fees or payment are not discussed,
- reimbursement issues are discussed within DOJ/FTC Guidelines and
- the meeting remains focused on education and information and does not become a “gripe session”.

The intent is to foster open communication with the payers and to lay the groundwork for follow up discussions privately with the individual payers at a later time for problem resolution. Generally, allow 1 ½ to 3 hours for each pediatric council meeting.

The tone of the meeting should be collaborative. Pediatric members are advised to stress a willingness to work *with* the payer on the issue with a key resolve to advocate for pediatrics and pediatricians. Establish a means to follow up on the issue with the payer by identifying key contacts within each health plan who can assist in resolving the issue, conducting a one-on-one meeting with the payer after the pediatric council meeting, and identifying timeframes within which to complete activities.

Seating arrangements need to be considered so that the payers are not directly across the pediatricians as they would be in a contract negotiation or adversary hearing. Pediatricians should be interspersed among the payer representatives to enhance the collaborative tone.

Meeting Frequency

To sustain ongoing communication and build momentum, the pediatric council should meet at the very least three to four times a year, or more often if appropriate. Too much time between meetings (such as six months or a year) will inhibit networking and relationship building. Chapters with pediatric councils report meeting as a council on average of two to four times per year and having additional follow up meetings with individual payers as needed.

What pediatric councils are saying:

When asked “what do you consider to be key elements to run a successful pediatric council meeting”, responses included:

- *Sticking to agenda and having a plan, covering broad topics and not getting bogged down in details*
- *Having a formal agenda, firm but friendly tone, new items each meeting*
- *1)Attendance 2) A strict and tight agenda sent out before the meeting 3) Meeting stays on track and on target with little outside extemporaneous conversations that distract from the meeting. 4) The meeting "results" in something positive and workable*
- *Finding topics that can be "win win" opportunities, e.g. presenting chapter MOC programs so insurers can incorporate them into their pay for performance plans*
- *Good communication and rapport with the medical directors*
- *Presentation of data; discussion-oriented; discuss topics that health plans request information on*
- *Attendance by all members. Send agenda out in advance; follow agenda. Make meetings short (three hours).*
- *Constantly introduce new topics to keep MCOs a little off-guard.*

Advocacy through Education Pediatrics 101

Several AAP Chapters meet with payers to present a pediatric perspective on a payer issue. The Alabama Chapter includes a standing agenda item at each meeting called Pediatrics 101 which focuses on a particular pediatric topic. The remainder of the meeting addresses current issues. The intent of Pediatrics 101 is to inform payers of an issue or service from a pediatric perspective. As part of its strategic plan, the Alabama Chapter pediatric council outlines a full year of Pediatrics 101 topics in order to have a long range plan for the pediatric council. This keeps payers engaged in seeking to learn more about the pediatric perspective and establishes the chapter as a key resource to the payers.

Pediatrics 101 presentations and resources and talking points from AAP chapters are available on the AAP Member Center, private payer advocacy page under the link ***AAP Chapter Pediatric Council Payer Discussion Resources on Pediatric Issues*** at:

<http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private/AAP-Chapter-Pediatric-Council-Shared-Resources.aspx>

with the carriers to meet their concerns regarding prior approval for Synagis, by developing a standard prior approval form. This tactic met the payer's concerns on documenting the medical necessity for this expensive vaccine, while streamlining the process for pediatricians.

Do not discount the value of meaningful dialogue with payers. Several chapter pediatric councils report that enhanced payer relationships are a frequently cited benefit. Included among improved payer relations are:

- Identifying key contacts
- Develop a process for problem resolution
- Develop the chapter and members as resources to payers on pediatric issues
- Provide a pediatric perspective to payer policies and processes
- Collaborative opportunities on payer and community initiatives impacting pediatric

Regular Contacts and Meetings: It is important to meet as frequently as possible and as necessary. Too much time between meetings will inhibit networking and relationship building. Most pediatric councils (58%) report meeting 3-4 times per year and about a third of the pediatric councils report meeting 1-2 times per year. Again, the meetings may be as a group or individually with a payer.

Establish Key Contacts: In addition to the medical director, identify key contacts within each payer. Over time, as the relationship grows, these contacts will be helpful to individual pediatric practices as references for problem resolution for specific problems between the physician and payer. For example, the chapter may want to know the best person to work with on claims processing issues, or plan member communications.

Addressing Regional Issues

Some chapters may be in a state that is geographically dispersed or has regional issues with particular regional health plans. In order to address regional issues that may not encompass the entire state, chapters may consider having regional pediatric councils within the state or developing a mechanism with the statewide pediatric council to address regional issues.

Chapters may also consider coordinating pediatric council activities within their District to address common issues with a regional payer. For example, the Connecticut, New York and New Jersey AAP Chapter have dealt with issues related to the same carrier that covers the tri-state region. In a coordinated effort with the AAP Connecticut Chapter, the three New York AAP Chapters and the New Jersey AAP Chapter, the AAP persuaded Emblem Health to enhance its otoacoustic emissions (OAE) policy to cover OAE as a screening tool by pediatricians .

One concern voiced by chapter pediatric councils is the degree of impact or influence local medical directors of large, national carriers may have on carrier policy. While some organizations may adopt a centralized decision making approach, it is important to remember that successful organizations are responsive to market conditions. Each state or region is a different market with differing resources, communities and issues. Further, each state has their own laws and regulations that payers must adhere to in order to operate in that state. Pediatric councils that can leverage local market issues and state laws can be successful in dealing with local medical directors in a centralized organization.

In New York, state law requires that benefits coverage is to begin effective the date the vaccine recommendations are approved by ACIP (for HPV for males this was October 25, 2011). As a result, the AAP New York Chapter pediatric councils were successful in engaging carriers, including the national carrier UnitedHealthcare (UHC) to begin benefits coverage and payment retroactive to the date the revised HPV recommendations for males were approved on October 25, 2011. By using state law, the NY Chapters were able to overcome UHC's standard national policy to provide benefits coverage within 60 days of published recommendations

Chapters may also consider engaging other specialty societies or the state medical society to coordinate advocacy efforts. For example, the Texas Pediatric Society reports working through the Texas Medical Society in addressing issues with payers. This approach harnesses the resources of both organizations and increases the number of physicians being represented within the state.

Also, the AAP, through the Private Payer Advocacy Advisory Committee (PPAAC) has established contacts with the largest national private carriers: Aetna, CIGNA, Humana, HealthNet and Wellpoint and will meet or conference call with the carriers to discuss pediatric issues. AAP Chapter pediatric councils are encouraged to inform PPAAC of issues with the national carriers to address with the payers.

A common thread shared by established chapter pediatric councils that have developed longstanding relationships with payers is to maintain a long term view with the understanding that it takes time for change to be implemented by most payers. Chapter pediatric councils identified key elements in fostering relationships with payers to remain collegial in discussions and emphasize the importance of presenting a problem solving approach in discussion with payers as opposed to confrontational tactics. As one chapter pediatric council chairperson observed, the key is to “know how and when to use the stick when the carrot doesn't work without wrecking the relationship.”

What pediatric councils are saying:

When asked what actions or processes have you implemented to engage payers and members to “come to the table” to attend and participate in meetings, responses included:

Keeping payers engaged:

- Constant contact and relationship building that is non-confrontational
- Approached it as a mutually beneficial meeting
- Make council actions relevant to their concerns.
- Relatively frequent email contact.
- Allow attendance via telephone.
- Personal invitations

Keeping Chapter members engaged:

- Updates showing council value soliciting issues. half of member of council are non-board members
- Newsletter articles asking for input on issues
- Annual meetings - 3 per year where we "display" and will hold a mini town hall next year
- Schedule the meeting to coincide with a chapter meeting
- Meetings are adjacent to our board meetings
- Delegate tasks to various members to keep them actively participating
- Allow attendance via telephone.

“Providers who collectively threaten to or actually refuse to deal with a purchaser because they object to the purchaser’s administrative, clinical, or other terms governing the provision of services run a substantial antitrust risk.”

Given the high stakes, physicians should always consult with competent legal counsel before embarking on potentially risky activity.

Statements of Antitrust Enforcement Policy in Health Care from the DOJ / FTC joint antitrust guidelines include 9 statements providing antitrust guidelines. Five of the nine statements deal specifically with physician conduct:

- Statement 4: Providers' Collective Provision Of Non-Fee-Related Information To Purchasers Of Health Care Services
- Statement 5 Providers' Collective Provision Of Fee-Related Information To Purchasers Of Health Care Services
- Statement 6 Provider Participation In Exchanges Of Price And Cost Information
- Statement 8 Physician Network Joint Ventures
- Statement 9 Multiprovider Networks

The entire set of statements can be accessed at:

<http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm>

Statement 4 of the DOJ/FTC Guidelines discusses the collective provision of *non-fee-related* information to payers. Statement 5 of the DOJ/FTC Guidelines discusses the collective provision of *fee-related* information. Statement 6 discusses provider participation in exchange of price and cost information. Statements 8 and 9 were revised in 2009 to address physician and multi-provider networks respectively. It is essential that every AAP Chapter and the physician participants of pediatric councils understand and follow the guidelines in these statements.

These statements describe “safety zones.” Conduct falling within these safety zones will not be challenged under antitrust laws by the DOJ and FTC, “absent extraordinary circumstances.” Please note that “safety zones” are not exclusive categories. They do not define the limits of what is permissible under antitrust law. They simply indicate and clarify a few factors that are easily identifiable and give the DOJ/FTC (referred to in the documents as “the Agencies”) “confidence that arrangements falling within them are unlikely to raise substantial competitive concerns.”

Generally, discussion topics at existing pediatric council meetings have focused on covered benefits, administrative procedures, and plan policies. AAP chapters should avoid discussing specific payment levels or any collective action at pediatric council meetings or elsewhere.

This does not mean, however, that chapters cannot provide fee-related information to plans when necessary. Chapters may provide both fee- and non-fee-related information to payers if they satisfy the conditions outlined in Statements 4, 5, and 6 of the DOJ/FTC Guidelines.

Non—Fee-Related Information – Competing physicians may wish to collectively provide non-fee-related information, such as outcomes data, suggested practice parameters, or discussions of scientific or clinical issues, to payers in an effort, for example, to influence their coverage decisions or contract terms. The DOJ/FTC guidelines state that, absent extraordinary circumstances, such collective provision of non-fee-related information will not raise any significant antitrust concerns. Of course, a threatened or implied physician boycott of any plan that does not follow the physicians’ joint recommendations on non-fee-related issues would be unlawful. Thus, an important distinction is made between collectively providing information and coercing a payer.

Fee-Related Information and Price and Cost Surveys – The guidelines are more restrictive regarding physicians’ collective provision of fee-related information to payers or physicians’ participation in surveys about price and cost information. However, absent extraordinary circumstances, such information may be collected and provided to payers without being challenged as unlawful provided that the following three conditions are satisfied:

- 1. The survey of fee-related information or costs is managed by a third-party, such as a payer, governmental agency, trade association, academic institution, or health care consultant.*
- 2. While current fee-related information may be surveyed and furnished to purchasers, any information that is shared with the physicians must be more than 3 months old.*
- 3. If information is provided to the physicians, there must be at least five physicians providing data, no physician’s data may represent more than 25% of any statistic, and any information disseminated must be sufficiently aggregated so that recipients will not be able to match the information with any individual physicians.*

The above safeguards are designed to ensure that the collection and exchange of fee-related information is not used by competing physicians to coordinate their prices or to facilitate anticompetitive behavior.

In addition, whenever sharing any information about covered benefits, administrative procedures or plan policies, it is important to consider whether the information could be used by pediatricians or managed care plans to inhibit competition, and whether pediatricians, in providing such information, are coercing payers to implement the provider’s joint recommendations. Any such action must be strictly avoided.

The Sherman Act

The federal antitrust statute most relevant to physicians is Section 1 of the Sherman Act,

which generally prohibits “contracts, combinations, and conspiracies” in restraint of trade. To be in violation of Section 1 of the Sherman Act, two elements must be present:

- (1) there must be an agreement between two or more separate economic entities (known as concerted action) and
- (2) the parties’ conduct must unreasonably restrain trade.

Concerted Action — Concerted action requires an agreement between two or more separate economic entities. Thus, an individual physician or a single entity such as a fully integrated group practice that acts independently cannot engage in concerted action. For this reason, the unilateral actions of a large, fully integrated group practice in setting fees or a payer in setting reimbursement rates or determining which physicians to include in its provider network generally are immune from challenge under Section 1 of the Sherman Act. In determining whether there has been concerted action, courts are willing to infer agreement among parties from circumstantial evidence, even where there is no evidence of an explicit agreement. Therefore, competing pediatricians should avoid discussing with each other such issues as their charges for various procedures, payers with whom they plan to contract, the types of services they plan to provide, locations at which they plan to provide services, and any business plans of a competitively sensitive nature.

Unreasonable Restraint of Trade In interpreting Section 1 of the Sherman Act, the courts have long held that only acts or arrangements that unreasonably restrain competition violate the Act. Certain types of conduct are considered to be so inherently anti-competitive that they are per se illegal. These include the following: (1) price-fixing arrangements (an agreement or understanding among competitors to raise prices, charge a particular fee, or adhere to a pricing formula or specified price levels); (2) group boycotts (an agreement among competitors to refuse to deal with another competitor, a supplier, or a customer to suppress competition); and (3) market allocation agreements (agreements among competitors as to the type of service they will provide or the geographic area in which they will work).

Most physician conduct, however, will be subject to the “rule of reason” analysis in which the court or enforcement agency will focus on the effect that the challenged conduct has on competition. Under a rule of reason analysis, all of the facts and circumstances surrounding the challenged conduct are examined to determine whether, on balance, the pro-competitive aspects of the conduct outweigh its anticompetitive effects. As a rule of thumb, agreements involving some integration of productive assets capable of increasing efficiency and benefiting consumers should be subject to the rule of reason. Evidence of pooling of substantial capital and/or sharing of financial risk usually is sufficient proof of integration to allow use of a rule of reason analysis.

Monopoly Power

Section 2 of the Sherman Act regulates monopoly power. Whereas, physicians often believe that payers are violating the antitrust law through monopolization of the market, payers may incorrectly perceive pediatric councils to be inherently antitrust. However, two elements must be present for monopolization to occur: (1) possession of monopoly power in the relevant market (usually reflected by a 70% or greater share of the relevant market),

and (2) the purpose or intent to exercise that power. Thus, the offense of monopolization is very difficult to prove. The development of monopoly power as a consequence of a superior product, business acumen, or simply good luck is not sufficient to establish an antitrust violation. The entity with monopoly power must have had the intent to monopolize which, as a practical matter, requires evidence that the entity achieved or maintained its monopoly power through competitively inappropriate means, such as unreasonably excluding competitors through predatory pricing (that is, pricing services so low that all rivals and potential rivals are driven out of the market), refusing to deal with competitors, or denying access to an essential facility

What pediatric councils are saying:

When asked “what is the pediatric council chairperson’s mechanism to ensure that discussions did not enter prohibited territory (i.e., antitrust) and to keep discussions focused on resolving the issue” responses included:

- No discussion of dollar amounts, limiting speaking time of speakers, beginning most meetings with reminder of our goals and style
- Yearly formal update and reminder at every meeting. If it goes in that direction, and usually only does with new members, it is stopped
- The Council has used a lawyer to help with any issues concerning antitrust issues
- Printed a notice on the agenda and discussed before any topic that could potential encroach on those issues

Additional Resources

It is advisable to consider inviting a representative from the State Department of Insurance or the Attorney General’s office to the chapter pediatric council meetings. Doing so may help chapters clarify state insurance rules and may even be helpful in ensuring that conversations remain within appropriate boundaries.

Should AAP chapters may have further questions about what can and cannot be discussed at pediatric council meetings and it is advised that they seek the advice of competent legal counsel.

Also, as outlined in DOJ/FTC Guidelines, chapters that are considering providing fee- or non-fee-related information to a health plan and are unsure about the legality of their conduct under antitrust laws can take advantage of the Department of Justice’s expedited business review procedure (58 Fed. Reg 6132 (1993)) or the Federal Trade Commission’s advisory opinion procedure (16 C.F.R. 1.1-1.4 (1993)).

For an overview of the FTC Guidance From Staff of the Bureau of Competition’s Health Care Division on Requesting and Obtaining an Advisory Opinion visit:

<http://www.ftc.gov/bc/healthcare/industryguide/adv-opinionguidance.pdf>

To learn more about the FTC advisory opinion review procedure, visit:
<http://www.ftc.gov/bc/speech2.htm>

FTC advisory opinions on previously submitted health care-related requests can be found online at:
<http://www.ftc.gov/bc/advisory.htm>

To learn more about the DOJ expedited business review procedure, visit:
<http://www.justice.gov/atr/public/busreview/index.html>

DOJ letters on previously submitted business review requests can be found online at:
<http://www.justice.gov/atr/public/busreview/letters.html>

- Seek out ways to gather and generate questions for the payers that will be a win-win for both sides. You will get cooperation from payers when they see benefit from solving their/our problems

Lessons learned by the chapter pediatric council to share with other pediatric councils

- Be ready to pose anything you ask for in terms of cost/benefit or good HEDIS scores
- Be patient. It has taken us four years to get coverage for fluoride varnish universal by all Medicaid MCOs. We just now this month achieved this victory
- Identifying real issues as opposed to individual practice's "speed bumps"
- Carrier medical directors may not have decision making authority on payment so either get them to advocate internally or bring the financial decision makers from the health plans to the meetings
- The payment issues are common to Family Medicine, and teaming up with them through Minnesota Medical Association is an effective way to deal with common payment issues, effectiveness in numbers
- There is a fine line between being too confrontational and being wimpy
- Keep control of the meeting--some will go on and on when speaking
- Getting Pediatricians to educate themselves on the business of running a practice
- Never single out a MCO for being an outlier. Have private conversations if necessary
- Essential to meet regularly to maintain relationships with health plans
- Recognize good performance by reps of plans--let local business media know when you do
- Very important to have the state department of insurance at the table
- Work with your chapter's practice management committee or practice managers--they know more details of payment problems than physicians do
- Communicating with other Councils and national AAP to be sure we are sharing consistent messages and asking for the same things

Promoting your chapter council's activities and keep the chapter and members informed

Mechanisms used by chapters to report on pediatric council activities include:

- Reports and/or meeting minutes submitted to chapter leadership
- Articles submitted for the chapter newsletter
- Updates posted to the chapter website
- Chapter leadership participates on the Council and discusses accomplishments and challenges at the District level
- Report at the District breakfasts
- Chapter President and Executive Director have spoken about progress of the pediatric council, including a slide presentation used at chapter meetings
- Emails to chapter members and postings to chapter listserves

Chapter Pediatric Councils report gains with carriers

Recently reported activities from Chapter Pediatric Councils

Arizona Chapter pediatric council reports success in increasing vaccine payments

NY Chapter pediatric council engages carriers on urgent care centers

Pennsylvania Chapter reports successes in payment for Bright Futures recommendations

Arizona Chapter addressing obesity coverage with carriers

California pediatric council successful in securing appropriate vaccine payments with Anthem Blue Cross

Pennsylvania Chapter pediatric council successfully advocates for appropriate payment for H1N1 immunization administration to Highmark BCBS

Connecticut Chapter pediatric council & practices successfully overturn carrier's policy on rapid strep and throat cultures ConnectiCare

Emblem Health revises OAE policy in response to AAP & NY Chapter's objections

Alabama Chapter pediatric council secures coverage for developmental screening

NY Chapters use state law to get payers to retroactively pay for HPV for males vaccine

Oklahoma Chapter pediatric council successful in increasing vaccine payments

NY 1 Chapter successful in securing increased payment for vaccines

To assist AAP Chapters and members in discussions with payers, presentations and talking points are being collected and are now available on the AAP Member Center, private payer advocacy page under the link ***AAP Chapter Pediatric Council Payer Discussion Resources on Pediatric Issues*** at:

<http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private/AAP-Chapter-Pediatric-Council-Shared-Resources.aspx>

These resources can provide the framework for consistent messaging to payers on pediatric issues. Topics include obesity, mental health, immunizations and vaccines, and preventive care. Additional topics will be added as provided by other Chapter pediatric councils.

Resources for AAP Chapter Pediatric Councils

Pediatric Council Guidebook

AAP Member Center, Private Payer Advocacy page online resources

To assist Chapters and members in addressing private payer issues, the AAP has developed several resources for chapters and members. These resources can be accessed on the AAP Member Center, private payer advocacy page, at <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private-Payer-Advocacy.aspx> including links to Pediatric Council resources.

AAP Endorsed Principles on Benefit Plan Coverage and Payment

The AAP approved a listing of benefit plan coverage and payment principles to serve as an advocacy agenda for discussions with payers. The principles represent existing AAP policy and strategic plan concepts. <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/PaymentPrinciples.pdf>

AAP Letters to Carriers

These letters can be shared with regional payers to coordinate advocacy efforts at the local level. Recent letters can be accessed at:

<http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private-Payer-Advocacy-Letters-to-Carriers.aspx>

Links to Carrier On-line policies

Web site links are provided to the largest national private carrier websites for policies related to clinical guidelines, medical policies, coverage, payment and fee schedules. Knowing carrier's policies can facilitate discussions with payers on the impact to pediatrics and pediatricians.

<http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/LinkstoCarrierOnlinePolicies.doc>

AAP Letter to Health Plans about Pediatric Councils

<http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/Letter-to-Health-Plans-about-Pediatric-Councils.pdf>

Listing of AAP Chapters with Pediatric Councils

This link provides the contact information of Chapter pediatric councils to assist contacts with other pediatric councils: <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private/AAP-Chapter-Private-Payer-Advocacy-Contacts.aspx>

Pediatric Council email listserve

Chapter pediatric council chairs and members are eligible to join the AAP pediatric council email listserv to exchange ideas and strategies on dealing with payer issues. To join the pediatric council listserv, contact AAP private payer advocacy staff at lterranova@aap.org

Payer Discussion Resources on Pediatric Issues

Provides links to powerpoint presentations, talking points and forms developed by AAP Chapter pediatric councils that can be tailored by other pediatric councils for their own discussions with payers. <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private/AAP-Chapter-Pediatric-Council-Shared-Resources.aspx>

Child Health and Medical Home Financing

This powerpoint template is available for AAP leadership, chapters, and/or members to provide information on child health and medical home financing, which can be used for presentations to pediatric council meetings, etc. <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private/Child-Health-and-Medical-Home-Financing.aspx>

AAP Hassle Factor Form

Pediatric Council Guidebook

The Hassle Factor Form was developed by the Academy to provide chapters with a tool they can use to address the problems their members are having with third party payers including managed care organizations. Chapters that have used similar hassle factor forms have found having the data to be useful in beginning a dialogue with the managed care industry.

The AAP Hassle Factor Form and accompanying advocacy materials, including instructions for use, a sample memo to Chapter members, and tips for using the data collected are found on the following pages. These materials may be customized to fit the individual needs of your Chapter or the particular managed care environment in your state.

The Hassle Factor Form and accompanying advocacy materials are also available on the Academy's Member Center, private payer advocacy page at: <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Hassle-Factor-Form-Concerns-with-Payers.aspx>

This Section includes the following:

- *Instructions for Use*
- *Hassle Factor Form*
- *Sample Memo to Chapter Members*
- *Using the Data you Collect*

Hassle Factor Form

Instructions for Chapter

The Academy has developed this form as a tool to assist chapters with payer and managed care problems that arise in their states. AAP members can complete the form on-line and submit it electronically to the AAP. Reports of submitted hassles will be distributed to chapters. A chapter may consider modifying this form for the chapter's own use to better meet the needs of the chapter and the circumstances of managed care in your state. Using the data collected will help you begin a dialogue with payers to address identified problems.

Your chapter may want to contact the state medical society to see if a hassle factor form program is already in place to avoid duplicative efforts. If a hassle factor program is not already in existence, you may choose to coordinate your chapter's program with the state medical society, to bring a single voice to managed care.

Suggestions for using the Hassle Factor Form:

Distribution

Determine how the *Hassle Factor Forms* will be distributed and collected. Members can access the form on the Member Center and periodic reports made available to the chapter. You will find a Sample Memo to Chapter Members in the appendix for use or adaptation to introduce the program to your chapter members.

Appointing a Contact Person

If the chapter decides to collect the data, determine who will collect and aggregate the completed forms (i.e., pediatric council chair or member, or the chapter executive director).

Use by Members

Have chapter members complete a *Hassle Factor Form* for each instance with a specific managed care organization and submit it. The type of problem can be easily checked off on the form, and there is space provided on the next page to give more details. The check-off boxes are designed to facilitate compiling the data. You may want to remind your members that the Hassle Factor Form is for data collection purposes only and they will not receive an individual response to each reported hassle.

Collecting and Aggregating the Data

To facilitate data review, the on-line version of the Hassle Factor Form will allow chapters to access data reported by chapter members. If the chapter decides to use their own Hassle Factor Form to collect data, to help the appointed collection person, you may wish to categorize the different hassles reported whenever possible, to identify emerging trends. Depending upon the volume of returned hassle forms, you may want to do this quarterly or biannually.

Analyzing the Data and Strategic Next Steps

Chapter leadership will have to decide how the aggregated data will be analyzed. The pediatric council will then have to strategically decide which issues to address with payers and how to go about addressing them.

You will find Using the Data You Collect in the appendix that will provide you with suggestions on

how your chapter can get started, including tips for beginning a dialogue with payers.

Should a chapter decide to use their own Hassle Factor Form to collect data, the Academy would appreciate the opportunity to see what kinds of problems you may be addressing with the use of this Hassle Factor Form. Please forward any completed tabulations or Tally Sheets to:

Public Payers:
Dan Walter
Senior Health Policy Analyst
Division of State Government Affairs
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL 60007
email at: dwalter@aap.org

or

Private Payers:
Lou Terranova
Senior Health Policy Analyst
Department of Practice
American Academy of Pediatrics
141 Northwest Point Blvd.
Elk Grove, Village, IL 60007
e-mail at: lterranova@aap.org

American Academy of Pediatrics

HASSLE FACTOR FORM

Access on the Member Center, private payer advocacy page at: <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Hassle-Factor-Form-Concerns-with-Payers.aspx>

HASSLE FACTOR FORM for Private Payers

Please complete each section of this form.

SECTION A: General Information

Physician Name: First Name: Mid Name: Last Name:

Subspecialty:

AAP Member ID:

Practice City: State:

Practice Chapter:

Practice Type:

Person completing this form: First Name: Mid Name: Last Name: Title:
(If other than the physician identified above)

SECTION B:

Please check all that apply and briefly describe problems on the next section (Section C). If provided examples do not describe your hassle, please check "Other Problem Not Listed," and detail on the next section (Section C).

- Administration Calls not returned
- Claim/appeal lost by organization
- Credentialing delay/problems
- Excessive wait on telephone
- Failure to notify enrollees of denied services or failure to do so in a timely manner
- Grievance procedure problems
- Inaccurate data entry following clean claim
- Insufficient pediatric subspecialists in the network
- Medical records request problem
- Numerous calls for single claim
- Organization missing supporting documents
- Uncustomary request for patient information

Payment Processing Related to specific CPT ICD-9-CM HCPCS Level II code
Specify the code CPT ICD-9-CM HCPCS

- Denial of payment
- Reduction of payment
- Recording of billed services (bundling, downcoding, etc.)
- Payment incorrect as per contract
- Late payment problem(s)
- Failure to follow CPT guidelines
- Non-recognition of modifiers
- Changing units of service

Claims Adjudication Denial of preauthorization (specify whether hospital or other)
 Hospital Other (If 'Other' please specify)

- Excessive delay in processing claims
- Excessive denials of referral
- Excessive emergency room service denial
- Excessive mental health service denial
- Excessive operative report requests
- Excessive prepayment or postpayment review
- Excessive requests for medical necessity review
- Lack of clear communication on EOB, written communications
- Length of stay dispute

Contractual Issues
(based on reviewing your managed care contract) Lab tests cannot be performed at preferred location

- Reimbursement denied due to carve out provisions
- Fee schedule not provided or excessive delay in obtaining it
- Managed care formulary
- Uncompensated for language interpretation

Other problem not listed (Briefly Describe in Section C)

SECTION C:

Name of carrier with whom the hassle is related: (REQUIRED)

Type of Plan:

How Frequently does this occur:

Briefly describe the problem(s) including any actions you have taken (phone call, letter, etc) and any responses

Hassle Factor Form

Sample Memo To Chapter Members on using the Hassle Factor Form

TO: Chapter Members
FROM: (insert name)

Chapter President (or insert office)

RE: AAP *Hassle Factor Form*

Many pediatricians are concerned about difficulties providing quality care to children within a managed care setting. And many of you have asked if the chapter can help. The American Academy of Pediatrics has developed the *Hassle Factor Form*, a monitoring tool, which we can use to document payer issues. The chapter will compile these and use them to address these problems in an appropriate manner with commercial health plans, managed care organizations and Medicaid.

How will this form help? Specific examples strengthen our arguments. We may find that problems only occur in one region of the state or with one type of service. Alternately, we may find that a problem is statewide and pervasive. Either way, having a clearer understanding of the nature of the problem will increase our ability to be effective. **But we need your help to make it work.**

[Note to chapter leaders: the paragraph below describes a sample process. Your chapter may set up a different process.]

1. An electronic form is available on the AAP's Web site, private payer advocacy page at <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Hassle-Factor-Form-Concerns-with-Payers.aspx>
2. Each time you encounter a problem, whether it is a first time or a recurring hassle with a specific managed care organization, please fill out a form and submit the online form the the AAP.
3. The AAP will share the data with the Chapter to compile this information and use it in our advocacy work with managed care organizations, the Medicaid department and other agencies.

If you have questions or would like to become more involved in this effort, please call (*insert name and phone number*).

I hope that you will use this form and that you will encourage your colleagues to use it as well. Speaking with one voice will help us ensure that children receive the quality care they deserve.

Thank you.

Hassle Factor Form

Using the Data You Collect

Once you have collected the *Hassle Factor Forms* and tallied the data, you can use this data to begin a dialogue with the managed care organizations in your state. While there are a number of ways to use the information, the most important goal should be to bring managed care organizations to the discussion table, so that your members' problems may be addressed.

Once you have collected the data, the compiled results can be used in a number of different ways. How your chapter utilizes this information is up to you. Below you will find suggestions of ways to approach payers with the data, or, alternatively, to address some of the problems directly:

Using the Data to Dialogue with Payers

- First, the pediatric council or assigned committee will have to review and analyze the aggregate data to identify existing problems that can be addressed. Distributing a log of the hassle factors experienced by your membership to this committee will give them the knowledge base necessary to begin.
- Once the committee reviews trends and strategically targets those hassles it would like to address first, you may want to distribute a similar log of hassles to your membership. This will show members that the chapter is following through in its effort to address identified problems in the managed care environment.
- Next, you could convene a pediatric council meeting. Regular monthly or quarterly meetings could be held to begin to address the issues reported in your hassle log and identified as strategic targets. The meetings should not be used, however, to negotiate with MCOs or to endeavor to coerce them into accepting the chapter's recommendations on a term or condition of the managed care arrangement.
- You may want to appoint a person who is knowledgeable in managed care to be the chapter's pediatric council's "Managed Care Ombudsman," who could bring unique problems to the attention of MCOs in your state. This "Ombudsman" could be in charge of conducting the regular contacts with representatives of the chapter and managed care, and could additionally be responsible for identifying and addressing more specific problems in the interim between meetings. Pursuing this option would require a chapter member who is knowledgeable in this area and willing to provide the time and energy necessary to taking on this challenge.

Using the Data to Build Membership Interaction and Find Solutions

- Distributing a log of reported hassles to your membership may also help you to find pediatricians who have had similar past problems resolved. You may want to distribute the log of hassles with an accompanying note, asking members who have experienced solutions to any of the published problems to please respond with ideas as to how other members might similarly address their own issues. These "solutions" could then be collected and distributed as appropriate.

Using the Data to Educate Your Membership

- Your chapter may want to offer socioeconomic education sessions for your members. After identifying the priority issues for your chapter members, you may want to have local speakers who are knowledgeable about problem areas talk with members about potential solutions. This will show the pediatricians in your state that the chapter is responsive not only in identifying needs, but in responding directly with practical seminars beneficial to their practices.
- Your chapter may want to address a number of the administrative issues identified by the *Hassle Factor Form* simply by publishing tips and guidelines in chapter publications. A common hassle, such as a referral problem, may have a very simple and clear-cut solution or explanation. Utilizing the resources you already have, you may want to set up a “Hassle Column” or offer consultation and tips through chapter publications. Such a method will require few additional resources, and will show your members that their *Hassle Factor* submissions are not going unheeded.

Using the Data to Guide Public Policy

- The use of the *Hassle Factor Form* may help your chapter focus its legislative efforts. Identifying new problems requires investigation, and there may be legislative solutions already in place in other states to use as a model. A compilation of hassles reported can be an excellent tool when discussing each year’s legislative goals and objectives.

AAP Chapter Pediatric Council Contacts

As of 08/12

Chapter Pediatric Councils meet regularly with health plans to discuss access, quality and coverage issues impacted by health plan coverage and administration policies.

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