STATE HEALTH POLICY

State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

The success of the ABCD Initiative provides lessons for states and other entities wishing to improve the quality of health care while controlling costs and improving efficiency. Identifying and implementing key processes to improve state policies affecting screening in primary care are the focus of this brief. ABCD states changed state statutes, state regulations, contracts, provider manuals, Web sites, and other documents that define state policies designed to improve the delivery of child development services. They also changed eligibility and claims processing systems to implement the policies described in the documents, conducted quality improvement projects designed to assess performance and foster change, and helped providers better understand new and existing policies through workshops, letters to providers and other means. These states made changes not only to Medicaid policies, but also to those governing related programs, such as early intervention and maternal and child health programs.

NATIONAL ACADEMY *for* STATE HEALTH POLICY

Briefing

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Findings from the ABCD Screening Academy: State Policy Improvements that Support Effective Identification of Children At-Risk for Developmental Delay

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In July 2007, recognizing the opportunity to improve the delivery of developmental services—and make a lifelong difference to children at-risk for developmental delay—teams from 19 states, Puerto Rico and the District of Columbia came together to form the Assuring Better Child Health and Development (ABCD) Screening Academy. (See text box on last page for more information on the ABCD program.) The 21 Screening Academy members[1] worked intensively for a 14-month period to identify and implement the policy and practice improvements necessary to move the use of standardized screening tools as part of well-child care from a 'best practice' to a 'standard of practice.' The National Academy for State Health Policy (NASHP), through a grant from the Commonwealth Fund, supported and monitored their efforts.

Although the period of intense support has ended—and members have already made significant progress toward policy and practice improvement—their work continues. Members' accomplishments offer useful examples to others working to improve the delivery of developmental services. This brief reports on the policy improvements made by Screening Academy members during the 14 month period—and those that are still in progress.

Table 1: Policy Improvements among ABCD Screening Academy Participants

	Coverage (Benefits and Eligibility)	Reimbursement	Program Performance
Alabama	C	C	P
Alaska	P		C P
Arkansas	C P	C P	
California	P		
Colorado			P
Connecticut	C	C	P
Delaware	P		P
District of Columbia	C	C P	P
Kansas	C	C	
Maryland	C P	C	P
Michigan	C	C	
Minnesota	C P	C P	
Montana	C	C	
New Jersey			P
New Mexico	P	C	P
Ohio	C	C	
Oklahoma	C	C	P
Oregon	C P	C P	P
Puerto Rico	C	C	
Virginia	C	C	C P
Wisconsin		P	P

KEY:	State has completed at least one policy improvement	State has at least one policy improvement in process	States with completed policy improvements pursuing additional policy improvements

Overview of Results

Screening Academy members worked with multiple stakeholders, from both the private and public sectors, to identify, shape, implement, and inform stakeholders of policy improvements designed to support primary care providers' use of a validated developmental screening tool as part of well-child care. Collectively, Screening Academy members[2] clarified existing policies and established new policies; changed claims processing systems, provider handbooks and MCO contracts; and conducted workshops and other activities to inform providers of the new policies. (This latter strategy and others that states used to support practice change are highlighted in the third briefing in this series entitled, *State Strategies to Support Practice Change to Improve Identification of Children At-Risk for or with Developmental Delays: Findings from the ABCD Screening Academy*).

By July 2008 (the end of the 14-month period of intense support), all 21 Screening Academy members reported significant progress toward policy improvement. Among these members, five completed all planned policy improvements,

twelve completed at least one improvement *and* were in the process of completing others, and four had not yet completed any improvements but were in the process of doing so (Table 1). These policy improvements can be categorized into three groups:

1. *Program coverage*, defined as policies that govern what services the program will cover for which people (benefits and eligibility). Eighteen members had made (or were pursuing) improvements in this area.
2. *Reimbursement*, defined as policies that govern how much the program will pay for a qualified service. Fifteen members had made (or were pursuing) improvements in this area.
3. *Program performance*, defined as policies that govern how services will be delivered, including policies intended to assess and improve service delivery. Twelve members had made (or were pursuing) improvements in this area.

Improving Coverage (Benefits and Eligibility)

Eighteen ABCD Screening Academy members worked to improve coverage policies—fourteen members had completed at least one improvement by July 2008. These are the policies that govern which services are covered by a program (benefits) and which people are covered by a program (eligibility).

What services are covered

Seventeen members worked to improve Medicaid's coverage of services by adding developmental screening with a validated screening tool to their benefit package or clarifying that the service was already covered. (Reimbursement policies that define the conditions under which screening is covered and the amount the Medicaid agency will pay for that service are discussed in the reimbursement section of this paper.)

Under federal Early Periodic Screening Diagnosis and Treatment (EPSDT) law each Medicaid agency establishes a schedule for EPSDT screens. These schedules define when a visit should occur and what procedures it should include. The American Academy of Pediatrics recommends that pediatric primary care providers administer a standardized, general developmental screen at the 9-, 18-, and 30 month visits.

Early Periodic Screening Diagnosis and Treatment is Medicaid's comprehensive and preventive child health program. It is designed to ensure that a child's health and developmental needs are identified and addressed early. It includes both well-child visits (referred to as EPSDT screens) and follow-up services. Many states use state-specific names for the EPSDT benefit.

Many payers do not currently cover the 30 month visit. (The AAP recommends that providers administer the screen at the 24 month visit when a payer does not cover the 30 month visit.) Even still, seven ABCD Screening Academy members added the 30 month visit to their EPSDT periodicity schedules—California, Connecticut, Kansas, Maryland, Michigan, Oregon, and Puerto Rico—while Maryland allows a 30-month "interperiodic" visit if the screen is not completed at the 24 month visit. They further specified that the visit include administration of a developmental screening tool—and provided a list of recommended standardized screening tools.

Screening Academy members used multiple strategies to communicate these policies to providers and families, including revising EPSDT manuals, periodicity schedules, communicating with providers and creating websites. For example,

- Kansas is developing on-line training for providers on the anticipated content of EPSDT services, including the expectation that providers will use a developmental screening tool.
- The Oregon Department of Human Services developed a website dedicated to informing providers and other stakeholders of the policy improvements and other products they produced as part of their ABCD effort (http://www.oregon.gov/DHS/ph/ch/abcd.shtml). Maryland used their website to announce updates to provider manuals reflecting the recommendations of the 2006 AAP Policy statement (http://www.dhmh.state.md.us/epsdt/healthykids/manual/table_contents.htm).
- The Minnesota Department of Human Services (DHS) is working to establish coverage for maternal depression screening during a pediatric visit for all Minnesota Medicaid enrollees. To date, DHS has drafted a written provider update to notify providers

of billing guidelines for maternal depression screening for Medicaid beneficiaries who receive services through fee-for-service. They plan to issue the update in the near future. DHS is also currently in discussions with their contracted MCOs that DHS hopes will lead to MCO adoption of the fee-for-service billing guidelines.

- Based on the Bright Futures guidelines, Michigan incorporated new developmental screening guidelines in the EPSDT policy. This was done in collaboration with the Michigan Chapter of the AAP. A letter listing the changes was distributed to all Medicaid providers who care for children.
- The District of Columbia and Virginia are working to add the requirement into managed care contracts that providers use standardized screening tools as part of well-child care.
- Oklahoma clarified information on Developmental Surveillance and Screening on the state's Frequently Asked Questions (FAQ) page. See http://www.ohca.state.ok.us/providers.aspx?id=586&menu=74&parts=7569_8197_7573 for details.

Who is covered

One state, Alaska, is working to change the policies that govern which children are eligible to receive services from their early intervention program. These changes are meant to make it more likely that children identified as needing developmental services qualify to receive those services from the early intervention program. (The Early Intervention Program for Infants and Toddlers with Disabilities was authorized by Congress under Part C of the Individuals with Disabilities Education Act (IDEA); the program is often referred to as "Part C.")[3]

Alaska is revising its Part C eligibility criteria to begin covering children who have a 25 percent or greater delay in an area, instead of those that have a 50 percent or greater delay. The state believes the change in Part C eligibility will be especially beneficial for children referred as the result of developmental screening with validated tools which tend, in Alaska's experience, to identify those with less severe delays. Strong partnerships between the Medicaid and early intervention agencies have been crucial to this progress.

Reimbursement

Reimbursement policies include both the amount paid for a service and the requirements that providers must meet in order to receive payment. For example, both establishing a policy to pay $25 for a developmental screen and modifying EPSDT policies to only pay for certain EPSDT screening visits when a developmental screen is administered as part of the visit are considered reimbursement policies.

Sixteen ABCD Screening Academy members worked to improve reimbursement policy—all 16 had completed at least one policy improvement by July 2008 (Table 1).

- All 16 established, modified, or clarified the conditions under which they would pay CPT code 96110 (developmental testing: limited).[4]
- Six (Arkansas, District of Columbia, Maryland, Ohio, Oklahoma and Virginia) established, modified, or clarified the conditions for CPT code 96111 (developmental testing: extended).[5]
- Ohio increased the amount it pays for CPT codes 96110 and 96111; Maryland increased the amount it pays for CPT code 96111.

Fourteen of the members that improved reimbursement policies changed Medicaid's policies for beneficiaries who receive services through fee-for-service. In addition, Ohio anticipates that its contracted MCOs will adopt its fee-for-service payment amounts and Providence Health Plan (a major private payer in Oregon) has already adopted Oregon's Medicaid reimbursement policies.

Examples of the changes to reimbursement policies made by Screening Academy members include the following.

- Alabama's CHIP program changed its policy so that instead of reimbursing providers only for developmental screens that result in an abnormal diagnosis they now reimburse providers for conducting the procedure as part of a well-child visit regardless of diagnosis. The program pays providers for administering up to four standardized screening instruments during the first four years of a child's life. Providers bill for the procedure using CPT Code 96110.

- Alabama's Medicaid and SCHIP programs have implemented a policy that allows Independent Nurse Practitioners enrolled as EPSDT providers to use the 96110 code to bill for conducting developmental screening with a standardized screening tool. Medicaid will pay for up to two screens per child at the rate of $8 per procedure (80 percent of the $10 maximum rate physicians may be paid).
- Connecticut and Oklahoma Medicaid revised their policies to allow reimbursement for developmental screening (procedure code 96110) on the same day as a routine office visit or well-care/EPSDT visit. Oklahoma Medicaid pays $9.30 in addition to the reimbursement for the well child visit. If a provider uses more than one screening tool at a single visit, e.g. Ages and Stages Questionnaire and the Modified Checklist for Autism in Toddlers (MCHAT), they can submit for reimbursement for two instances of 96110 in addition to the CPT code for the well child visit.
- The District of Columbia's standard payment for an EPSDT visit is a 'bundled' payment for all procedures provided during the visit. As a result of its ABCD work the District's Medicaid agency has begun paying an additional amount above the standard rate to providers who conduct a developmental screen with a standardized instrument during the visit. This reimbursement policy encourages providers to screen children during an EPSDT visit and supports performance measurement by incentivizing providers to report that they have done so. Similarly, Kansas Medicaid revised policy to allow an EPSDT visit to be bundled or unbundled as long as they are consistent with age visits specified in the AAP algorithm.
- Maryland's Medicaid program began paying for up to two 'units' of CPT 96110 on the same date of service to allow providers to administer both (1) a general developmental screening test and (2) an autism or social/emotional screening test in the same visit.
- Michigan increased allowable billing for 96110 for a single beneficiary to three per provider per beneficiary per day.
- As of July 2008, Ohio's Medicaid program increased the amount it pays through its fee-for-service system for the 96110 and 96111 CPT codes to $10.32 and $51.01 from $8.49 and $42.51, respectively.
- In the Oregon Health Plan prioritized list of services (1115 waiver), policies allow for reimbursement of CPT code 96110 "in addition to other CPT codes, such as evaluation and management (E & M) codes or preventive visit codes." The 96110 CPT code can be paired with any well-child or treatment visit codes for reimbursement (http://www.oregon.gov/OHPPR/HSC/docs/Jan09Plist.pdf).

Improving Program Performance

Thirteen ABCD Screening Academy members worked to improve policies that govern program performance—two completed at least one improvement by July 2008 (Table 1). These actions range from conducting Medicaid managed care quality improvement activities to changing referral processes to facilitate exchange of information between primary care providers and Part C providers.

Managed Care Strategies

Federal law requires that states have a written strategy for assessing the quality of care delivered by managed care organizations. Five ABCD Screening Academy members built on these requirements to improve program performance by increasing standardized screening. For example, the Medicaid agencies in the District of Columbia and Virginia are both negotiating with their Managed Care Organizations (MCOs) to incorporate the reimbursement policies they established for fee-for-service into their managed care contracts. Additionally:

- Connecticut is scheduled to begin several pilot PCCM sites in the next year and is considering incorporating developmental screening into quality measures used for evaluating services delivered in those pediatric practices.
- New Jersey Medicaid has begun discussions with their Health Maintenance Organizations (HMOs) to require HMO-contracted providers to use validated developmental screening tools during specified EPSDT visits. An EPSDT workgroup, which is a

collaborative workgroup consisting of staff from all five Medicaid HMOs and various state departments continues to meet quarterly.

- Wisconsin project staff provided the MCOs with information on the importance of developmental screening based on the AAP policy statement and how using a tool in addition to clinical judgment is more effective than relying soley on clinical judgment. As a result, some Medicaid-contracted MCOs are providing reimbursement for developmental screening.

Improving Referral Processes

Effective linkages between primary care, Part C providers and other community referral resources are crucial to improving program performance and spreading the use of developmental screening. All Screening Academy members worked to improve referral processes among members of these three groups, however seven are working to implement policies to improve communication between primary care and Part C providers. For example,

- The District of Columbia, Maryland and Virginia developed universal consent forms for both primary care and Part C providers in an effort to improve linkages between the two systems and plan to promote the use of these forms statewide.
- Alaska, Oklahoma, Oregon and Wisconsin have developed uniform referral/consent forms to ease communication between primary care and Part C providers. Oregon's form, for example, includes medical diagnosis, reason for referral, and parent consent that satisfies confidentiality laws for health care (HIPAA)[6] and education (FERPA)[7]—the form is currently being piloted by three large practices. All three teams hope to spread the use of the forms statewide.
- Alabama requires Part C providers to give feedback to primary care providers about the services provided by Part C to the child (after the child is found eligible for services). The ABCD team continues to work on improving the communication and referral processes between these two systems.
- Wisconsin requires Part C and Part B (Early Childhood Special Education) providers to inform the referring physician of the status of the child's eligibility for specialized services using a "Fax Back" portion on the Referral Form.

Streamlining Eligibility for Part C

One state, Alabama, is working to improve performance by streamlining the eligibility process for Part C. The state's Part C program serves children with a 25 percent delay in one or more developmental domains or who have a specified diagnosis. Alabama believes that most of the children identified through administration of a validated screening tool will meet those criteria. Therefore, state Part C program administrators are considering determining that children who are referred to Part C by a physician are eligible for the Part C program—if, in the physician's clinical judgment, as informed by administration of a validated developmental screening tool, the child will meet the eligibility requirements.

Putting the Pieces Together: Oregon's Approach to Policy Improvement

ABCD Screening Academy members either created a public/private partnership or built upon an existing partnership. Members' experiences confirm that the active involvement of stakeholders is critical to identifying, developing, and implementing state policies that improve the identification of children at-risk for developmental delays by incorporating use of a validated, objective developmental screening tool into regular well-child care. Oregon's approach exemplifies this experience.

The support of their private partners enabled Oregon to complete policy improvements: The Oregon ABCD team completed two major policy improvements in Medicaid:

- In April 2008, the Oregon Health Services Commission published the *Prioritized List of Health Services Practice Guidelines Prevention Tables*[8] (Oregon's EPSDT periodicity schedule) which clarified that providers may use CPT code 96110 to bill for developmental screening as part of any preventive care visit (and that Medicaid would pay for the service when provided to a qualified child),

- The Medicaid agency also changed its policies to begin requiring contracted MCOs to increase preventive health services and is offering them incentives for doing so.

The private partners engaged in multiple efforts to inform pediatric primary care providers about improvements in Medicaid billing policies: The Oregon Pediatric Society (OPS) and Oregon Academy of Family Physicians publicized the billing clarifications in their newsletters. Additionally, the Office of Family Health (Title V Program) created a website dedicated to informing providers of these policy clarifications. Finally, members of the ABCD team presented information describing the billing policies to medical directors and quality improvement staff from Medicaid-contracted MCOs. The ABCD Project published the evidence base and criteria for selecting tools for developmental screening and surveillance and is mailing to all OPS members in the state.

The private/public partnership fostered change in commercial coverage: Providers were initially hesitant to use the 96110 code, citing worry over denied claims and the trouble over setting up separate billing practices for developmental screening—one for Medicaid and another for commercially insured patients. The ABCD team partnered with the Oregon Pediatric Society, led by an ABCD physician champion, to address these concerns. This group met with private payers to explain the evidence base for developmental screening and encourage them to 'match' Medicaid payment policies by starting to pay for developmental screenings using the 96110 code. Around the same time, a medical group practice in Eugene, Oregon wrote letters to all private payers in the state asking them to unbundle the screening and preventive visits and begin paying the 96110 code to cover the cost to practices of implementing parent-completed screens. One major payer, Providence Health Plan, immediately changed its policy and is reprocessing past denied claims to reimburse practices in line with this new policy. Aligning private payer policy with the revised Medicaid policy remains a priority item for sustaining the work of the Oregon ABCD initiative.

The private partners are providing resources to support practice improvement in response to policy improvement: The Northwest Early Childhood Institute[9], and the Oregon Pediatric Society is partnering with CareOregon, Medicaid's largest MCO, to prepare a quality improvement curriculum by adapting the Tennessee "START"[10] program to Oregon's practice environment. The START program is an educational program offered by the the Tennessee Chapter of the American Academy of Pediatrics to help pediatric care providers - including pediatricians, family physicians, nurse practitioners, nurses, and others - learn skills and strategies to implement routine developmental and behavioral screening using standardized screening tools as part of their health care procedures. Oregon START and the ABCD Project are collaborating to assure training and technical assistance be expanded and sustained statewide for all providers of preventive child health.

The public/private partnership supports ongoing policy improvement even after the end of the period of intensive support: Although the period of intense support ended in July 2008, Oregon's ABCD team continues to pursue policy improvements by Medicaid and other organizations. For example, based on the experience of other ABCD states, Oregon policymakers are now considering policies to implement maternal depression screening in pediatric care. The ABCD Project will develop strategies to implement maternal depression screening and referral processes and policies for implementation in preventive child health visits. In addition, the Quality Improvement Committee of the Oregon Pediatric Society is working with the Oregon chapter of the AAP to assure the training and implementation of the Oregon START program satisfies the recertification requirements for pediatricians for quality improvement practice.

Endnotes

1 Three states withdrew over the course of the ABCD Screening Academy because they determined that they would not be able to achieve their goals for this project due to staff turnover, changes in leadership and changing policy priorities. These states (Maine, New York, and Rhode Island) are not counted among the 21 members identified here as participating in the Screening Academy and their experience is not included in this briefing.

2 In this brief, Screening Academy states, the District of Columbia, and Puerto Rico are referred to as 'members.'

3 Please visit http://www.ed.gov/programs/osepeip/index.html for more information.

4 The use of developmental screening instruments of a limited nature (e.g., Developmental Screening Test II, Early Language Milestone Screen, PEDS, Ages and Stages, and Vanderbilt ADHD rating scales) is reported using CPT code 96110 (developmental testing; limited). American Academy of Pediatrics. Developmental Screening/Testing: Coding Fact Sheet for Primary Care Pediatricians. Retrieved 13 November 2008. http://www.medicalhomeinfo.org/tools/Coding/Developmental%20Screening-Testing%20Coding%20Fact%20Sheet.doc.

5 Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report

Extended developmental testing using standardized instruments (e. g., Bayley Scales of Infant Development, Woodcock-Johnson Tests of Cognitive Abilities (Third Edition) and Clinical Evaluation of Language Fundamentals (Fourth Edition)) are reported using CPT code 96111.

American Academy of Pediatrics. Developmental Screening/Testing: Coding Fact Sheet for Primary Care Pediatricians. Retrieved 13 November 2008. http://www.medicalhomeinfo.org/tools/Coding/Developmental%20Screening-Testing%20Coding%20Fact%20Sheet.doc

6 The Health Insurance Portability and Accountability Act (HIPAA) provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. For more information visit http://www.hhs.gov/ocr/privacy/index.html.

7 The Family Education Rights and Privacy Act is a Federal law that protects the privacy of student education records. For more information visit http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html.

8 For details please visit http://www.oregon.gov/DHS/ph/ch/docs/OHPReimbursement.doc.

9 A non-profit organization dedicated to promoting social, emotional and mental development in early childhood through education, training, and research

10 Please visit http://www.tnaap.org/developmental/developmental.asp for more information.

About the ABCD Program and this Series:

Since 2000, the National Academy for State Health Policy (NASHP) has administered the Assuring Better Child Health and Development (ABCD) program. During this time NASHP has administered three projects.

From 2000-2003 and 2003-2006 NASHP administered two 3-year, multi-state learning collaboratives to develop and test Medicaid-based models for improving the delivery of early child development services to low-income children and their families by strengthening primary health care services and systems. A total of eight states participated in the collaboratives.

Based on the work of these pioneer states NASHP formed the ABCD Screening Academy. Nineteen states, Puerto Rico and the District of Columbia participated in the Screening Academy. They worked, with the support of NASHP, to improve identification of children with or at risk for or with developmental delays. Participants developed and implemented (or are implementing) policy improvements designed to promote, support, and spread the use of a standardized developmental screening tool as part of regular well-child care. Screening Academy participants also supported selected primary care practices' efforts to incorporate standardized developmental screening tools into regular well child care—and continue to work to spread those improvements to other practices within their state.

This series of State Health Policy Briefs summarize the findings from the ABCD Screening Academy participants toward policy and practice level improvements and the results of these interactive processes as reported to NASHP in August 2008 by participating states. Each will also focus on the promising role of partnerships—broad stakeholder engagement—in initiating and sustaining a spread strategy to improve preventive care and developmental services for young children in primary care settings.

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It is important to note that the views presented here are those of the authors. Any errors or omissions are also those of the authors.

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