

## Tips for Coordinated Care Organizations (CCOs)

### Minding the Gap: Identifying Children Not Being Screened According to Claims Data and Addressing Root Causes

*Developed by the Oregon Pediatric Improvement Partnership (OPIP) with support from the Oregon Health Authority Transformation Center*

**Webinar (August 9, 2018) available here:**

<https://www.oregon.gov/oha/HPA/DSI-TC/Pages/Dev-Screen-Tech-Assist.aspx>

**Purpose and tips included:** This high-level tip sheet is intended for coordinated care organizations (CCOs) who want to improve their developmental screening rates (based on 96110 claims), and are interested in exploring potential root causes and opportunities for improvement. The tip sheet is based on learnings OPIP and Ms. Reuland, OPIP's director with previous extensive experience with developmental screening, has gathered working within Oregon, with numerous practices, health systems, and states across the country. This tip sheet does not address the most obvious reason children have not received developmental screening, which is that the primary care practice where the child receives care does not conduct screening. Given this has been a primary focus of CCOs, and because there are numerous materials, trainings, and resources focused on supporting practices to implement developmental screening, we have not included a focus on this root cause. Instead, this document highlights **nine additional root causes** that can be explored to target improvement efforts.

#### *Addressing root causes related to the denominator (children who should have been screened)*

##### **#1: Child did not attend a well-visit at which developmental screening would have been conducted, and therefore was not screened**

- The denominator for the incentive metric is children who are continuously enrolled, not children who have had a well-visit at which screening is conducted.
- Well-visit rates significantly decline between ages 2 and 3, which is when the developmental screening recommended at the 30-month visit is supposed to occur. This is partially because immunizations (and the adherence requirements tied to immunizations) are often completed by 18-24 months.
- For these reasons, it is valuable to examine the developmental screening rates by whether the child had a well-visit.
  - Examine the findings by the age of the child (under 1, 1-2 years old and 2-3 years old). Most likely, the developmental screening rate will decrease with age, and will be correlated with whether the child had a well-visit. Therefore, a targeted approach to increase developmental screening rates is outreach and engagement strategies to enhance well-visit rates, particularly for the children between 2 and 3 years old.
  - Examine other factors for the group of children who did not access a well-visit including:
    - 1) Zip code in which the child resides
    - 2) Race, ethnicity or language
    - 3) Practice they are attributed to

- Then, use this information to consider targeting or tailoring outreach to address specific factors for these groups to enhance access to recommended well-child care.
- Sometimes circumstances arise that impact the timing of children accessing care (e.g. they obtain insurance, switch practices etc.). In these cases, they may access care at a visit at which screening is not recommended. This can create a scenario where the child does not receive a screening, and does not access care again during the measurement period. One way practices have addressed this issue is to implement a developmental screening tool for all new patients ages 7 months to 3 years old who come in for a visit to establish care, regardless of reason for visit.

### **#2: Child cycled off and on insurance, was screened, but is not included in the denominator because he/she did not meet the continuous enrollment requirement**

- The denominator for the metric is children who are continuously enrolled for 12 months, allowing for a one-month gap in insurance. In some areas and for some high performing practices, this can cause over half of the population they serve (and thus have screened) to be removed from the denominator.
- Examine screens (96110 claims) comparing the denominators of **all children vs. children who meet the continuous enrollment requirement**. Note the number of children who had screens that were not included in the denominator when the continuous enrollment requirement is applied.
  - It can be helpful to look at these findings by specific zip codes, and by practices to where children are attributed. This analysis can help to identify regions where big practices (to which a significant number of children may be attributed) are screening, but where enrollment churn is impacting the numerator for their developmental screening measure given the continuous enrollment requirement. If this is a large number of children, it can be an effective strategy even though it increases the denominator (children), because it increases the numerator (children screened) in a way that increases the overall rates. This can help guide and inform family-centered strategies to ensure eligible children maintain their insurance.

### ***Addressing root causes related to the numerator (children who were continuously enrolled, had a visit, but did not have a 96110 claim submitted)***

#### **#3: Practice is screening, but not submitting the claim (96110)**

- OPIP has worked with a number of practices who are screening, but not submitting the 96110 claim. Practices who continue to avoid submitting claims often note concerns about:
  - 1) co-pays for families,
  - 2) lack of coverage for privately insured children; and
  - 3) previous experience with denials of claims.

These concerns are likely remnants of outdated experiences, as OPIP does **not** hear feedback related to denial of claims among the practices currently submitting claims. This may have been an issue with some payers before the passage of the Affordable Care Act (which ensured coverage of Bright Futures' recommended services across payer types), and before the CCO incentive metric increased pressure for coverage.

- Please see this overview that explains key modifiers to use when submitting a 96110 claim to address and avoid these potential issues (OPIP document): <http://www.oregon-pip.org/focus/DevScreening.html>. Many practices have observed that if they use two modifiers with the 96110 claim, the barriers are addressed:
  - 1) Modifier -25 to indicate the service was part of a well-visit, and
  - 2) Modifier -33 to indicate the service is a Bright Futures recommended service to be provided in the context of the well-visit.
- Some practices receive bundled payments for well-visits. In these circumstances, practices often have not built workflows related to submitting specific claims for specific services provided in the context of the well-visit (such as developmental screening). OPIP has trained these practices on the importance of submitting the individual 96110 claim on top of the well-visit claim, and the value of the -25 modifier in these settings.
- Practices cannot differentially bill for patients with different insurance types. As such, for practices that see a large number of pediatric patients who are uninsured, submitting a claim may be a barrier. Given Oregon's rate of insured children, this should be an issue for a very small number of practices. That said, for these practices, an approach that can be explored is to submit the 96110 claim with a \$0.00 charge. If this approach is used, it important to ensure that data systems and/or centralized data warehouses that these practices submit claims to maintain zero-billed claims. OPIP has worked in settings where claims associated with no cost were removed from data submitted or reported to external entities.

#### **#4: Practice is screening, but they experience barriers to documentation in the electronic medical record (EMR)**

- Some practices are conducting developmental screening and entering the information into their electronic medical record, but the 96110 claim is not being submitted.
  - Key requirements for submission of the 96110 claim are that the tool needs to be administered and interpreted, and the results be communicated to the parent.
  - In some EMRs there are specific flow sheets or check boxes related to each part of the developmental screening tool, and to communication about the screening tool that must be completed for the 96110 claim to be triggered.
    - OPIP has found that sometimes providers are not trained on the specific parts of the flowsheet that need to be completed for the 96110 claim to be submitted.
  - In other EMRs there is no systematic or fixed field that triggers the submission of the 96110 claim. In this situation, individual staff and providers are required to submit the claim, which can lead to 96110 claims not being submitted.
- There are methods for practices and health systems to enhance and modify the templates in their EMRs to enhance documentation of the developmental screen results, follow-up steps, and to trigger the 96110 claim to be submitted. Examples of EMR templates that have improved documentation and consistent use of the 96110 claim will be shared in a separate tip sheet.

*Context for Tips #5 and #6: Given the denominator for the metric is continuously enrolled children, it is normal for practice-level rates of developmental screening to be less than 100%; however, if practice-level developmental screening rates are below 50-60% it is often because of the following issues.*

#### **#5: Practice is conducting developmental screening, but not at every visit in which it is recommended**

- Bright Futures recommendations call for developmental screening to be implemented at the following well-visits: 9-month, 18-month and 30-month. Examination of the practice's developmental screening rates disaggregated by the three specific age groups (under 1, 1-2, and 2-3) can illuminate this issue.
  - Some adaptations practices implement that lower developmental screening rates are:
    - To screen at the 12-month (1 year) well-visit instead of the 9-month visit. This can negatively impact the screening rate for the first age-specific component of the metric that assesses whether children who turned one in the measurement period were screened before their first birthday.
    - To only conduct autism screening (often using the MCHAT) at the 18-month visit instead of doing both autism AND developmental screening. Similarly, this protocol will negatively impact screening rates for the 1-2 age group.
  - It is critical when following up with practices to ask specific questions about the periodicity of developmental screening, including which specific visits they are administering a standardized screening tool at.

#### **#6: Practice reports screening, but significant variation exists among providers within the practice**

- Some practices report screening according to the Bright Futures recommended periodicity, but discover only some of the providers were consistent in this screening periodicity. This can occur in group-level practices where individual autonomy is highly valued and supported, or in practices where individual providers are co-located and share office space, but clinical support staff (like medical assistants) are not shared.
- When following up with these types of clinical settings, it is critical to ask specific questions about the periodicity of developmental screening for each primary care provider who sees a significant number of children, including the specific visits at which they are administering a standardized screening tool.

#### **#7: Practice says they are screening, but they are actually doing developmental milestones**

- Bright Futures has a set of toolkits meant to help a practice implement the recommendations. One component of these toolkits is a set of pre-visit questionnaires and visit-based tools: <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Early-Childhood-Tools.aspx>.
- Sometimes practices report doing Bright Futures-aligned screening because they are using these tools, however these tools are Bright Futures-aligned developmental surveillance. Practices cannot submit a 96110 claim for standardized developmental surveillance.

#### **#8: Practice serves populations with low literacy levels**

- The most commonly used screening tools are completed by the parent, and if not assisted, require the ability to read at the following levels:
  - 1) Ages and Stages Questionnaire: 4<sup>th</sup>-6<sup>th</sup> grade reading level
  - 2) Parents Evaluation of Developmental Status: 4<sup>th</sup>-5<sup>th</sup> grade reading level
- This may be a reason that children whose parents have low literacy rates are not screened. While the overall rate is likely to be low (and therefore not significantly impacting a CCO-

level rate), it may be an important and high number of families in specific practices or in specific regions. Examining rates by clinics that serve a population with potentially low literacy rates may be a valuable way to identify if this is a significant barrier. Innovative and family-centered strategies can be explored to support families in completing the tools, such as using trained staff in the office, trained community health workers, or partnering with home visiting services to assist in completing the tools for applicable children.

#### **#9: Practice serves a comparatively more diverse population (race, ethnicity, language)**

- The most commonly used screening tools are available only in specific languages:
  - 1) Ages and Stages Questionnaire (in Oregon, most practices use this tool): English, Spanish, Arabic, French, and Vietnamese.
  - 2) Parents Evaluation of Developmental Status: English and Spanish, *with separate licensing in*: Albanian, Amharic, Arabic, Armenian, Bengali, Bulgarian, Burmese, Cambodian, Chinese (Traditional and Simplified characters), Danish, Dutch, Dzongkha, Farsi, Filipino Tagalog, French, Galician, German, Greek, Gujarati, Haitian-Creole, Hebrew, Hindi, Hmong, Icelandic, Indonesian, Karen, Korean, Laotian, Malay, Nepali, Polish, Portuguese and Cape Verdean, Punjabi, Quechua, Russian, Serbian (Cyrillic and Latin), Samoan, Somali, Sotho, Swahili, Tagalog, Taiwanese, Tamil, Thai, Turkish, Urdu, Vietnamese, Visayan, Yoruba and Zulu.
- This may be a reason that children whose parents speak a language that the tool is not available in are not screened. While the overall rate is likely to be low (and therefore not significantly impacting a CCO-level rate), it may be an important and high number of families in specific practices.
- Examining rates by the following may be a valuable way to identify if this is an issue impacting a significant number of children within a specific region, or for a specific practice:
  - 1) the language the parent chose to have information provided in when they enrolled in Medicaid;
  - 2) children whose parents requested translation; and/or
  - 3) variables related to race and ethnicity.

Innovative and family-centered strategies can be explored to support families in completing the tools, such as using trained staff in the office, trained community health workers, or partnering with home visiting services to assist in completing the tools for applicable children.