OREGON TPEC Transforming Pediatrics and Early Childhood

OPIP

Learnings Related to Coverage Barriers of Early and Periodic Screening, Diagnostic and Treatment (ESPDT) Services in Primary Care Settings For Claims Aligned with the Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services CCO Incentive Metric

Background: The Oregon Pediatric Improvement Partnership (OPIP) is dedicated to building health and improving outcomes for children and youth in Oregon. A key area of focus within OPIP is on improving social-emotional health care services for young children . This includes a number of community-based improvement efforts that informed and guided OPIP's development of incentive metrics for Coordinated Care Organizations (CCOs) focused on social-emotional services, including the System-Level Social-Emotional Health metric and newly adopted Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services metric that starts in 2025. Through the ground-level improvement work with primary care practices and assessing their health plan contracts, particularly in Transforming Pediatrics for Early Childhood , we identified a number of barriers specific to coverage of evidence-based EPSDT social-emotional services, within Coordinated Care Organizations, when provided in a primary care setting. The purpose of this memo and the requested meeting with Oregon Health Authority's (OHA) EPSDT team is to share these key barriers, recommended solutions, and inform the Oregon Health Authority's efforts to ensure provision and coverage of EPSDT services.

Context on Related EPSDT Recommendations and Evidence-Based Services in Primary Care Setting:
The figure below provides a high-level summary of several screenings (the "S" in EPSDT) including in Bright Futures recommendations in the first five years of life to assess a child's development and well-being. When screenings identify children, there are evidence-based diagnostic tests and treatments. This includes including brief interventions, (the D" and "T) provided by primary care staff with applicable expertise, such as integrated behavioral health clinicians or primary care providers with enhanced skills (e.g., STAT assessment as a follow-up to autism screening).

Image 1. American Academy of Pediatrics and Bright Futures™ Periodicity Schedule

	INFANCY								EARLY CHILDHOOD							
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																
Maternal Depression Screening[11]				•	•	•	•									
Developmental Screening[12]								•			•		•			
Autism Spectrum Disorder Screening[13]											•	•				
Developmental Surveillance		•	•	•	•	•	•		•	•		•		•	•	•
Behavioral/Social/Emotional Screening[14]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
  - **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
    (Anchored to the **American Academy of Pediatrics and Bright Futures™ Periodicity Schedule, Above is a highlight of relevant "S" for APM recommendations)**
    - **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
      - **Treatment:** Control, correct or reduce health problems found.

Barriers to Coverage of Evidence-Based Services in Primary Care:

Within OPIP's community-based improvement efforts, OPIP has conducted extensive interviews with practices to understand barriers to coverage of services from CCOs (and their related health plan partners). As OHA works to ensure coverage of ESPDT, it will be important to also clarify coverage and address barriers to coverage with private payors because practices cannot bill for services differentially based insurance type. Per the Affordable Care Act, private payors must cover EPSDT services, and therefore OPIP recommends OHA include communication efforts on these barriers with private payors as well.

Barrier #1: Payors Do Not Provide Payment for Specific Screenings Aligned with the EPSDT Schedule. OPIP recommends that OHA examine whether claims for the following screens were ever denied, particularly at visits in which multiple screens are recommended *(e.g., at the 18-month well-child visit, where three screens are recommended: developmental, autism , and social-emotional screening is recommended*), and ensure future coverage of these screening codes.

1) Social-Emotional (CPT: 96127)
2) Developmental Screening (CPT: 96110)
3) Autism Screening (CPT: 96110)
4) Perinatal Depression Screening: Post Natal (CPT: 96161)

Barrier #2: Payors Require a Formal Diagnostic Assessment to be Billed Before Covering Treatment Services

- Some payors require a diagnostic assessment to be performed and billed before treatments services can be billed and covered. For example: Psychiatric Diagnostic Evaluation (90791) Mental health assessment, by non-physician (H0031).
- Within primary care, given their context and role, evidence-based strategies often allow them to make a diagnosis based on screening tools and clinical observation. Therefore, treatment could be provided **without** needing an additional Psychiatric Diagnostic.
- The requirement for a diagnostic assessment to occur before treatment services can be covered creates an additional visit and process that often is not family centered.
- Perhaps these policies were created based on an assumption that children receiving treatment services would all be referred to an external organization that does not have the clinical history with the patient and would require a new diagnostic assessment. As integrated behavioral health services within primary care becomes more readily available, evidence-based supports provided in a process and setting that may be more appropriate for young children and their families should be covered.

Barrier #3: Lack of Coverage for Diagnostic and/or Treatment Services in a Primary Care Setting

Numerous clinics shared significant barriers to coverage of treatment services, particularly those deemed "behavioral health" as they had clearly been "carved out" by the health plan (including

within CCOs) to be eligible to be reimbursed by behavioral providers only within the CCO/Heath Plan. Below is a list of common claims that have been reported to be denied in the past when billed by applicable behavioral health staff located within primary care submitted the claim (in accordance with OHA posted fee rates). (Barrier #4 describes an additional payment barrier related to these claims codes.)

- Psychiatric Diagnostic Evaluation *(90791)*
- Mental Health Assessment, by non-physician *(H0031)*
- Individual Psychotherapy *(90832-90838)*
- Family Psychotherapy *(90846, 90847)*
- Group Psychotherapy *(90849, 90853)*
- Multi-Family Group Training Session *(96202-3)*
- Health Behavior Assessment *(96156)*
- Health Behavior Intervention *(96158, 96159, 96164, 96165, 96167, 96168, 96170,96171)*
- Preventive Medicine Counseling *(99401-99404, 99411-99412)*

Barrier 4: Lack of Coverage for Treatment Services in Primary Care Settings When Claims Codes Are Paired with Z or R Diagnosis Codes

- Even when treatment codes are covered in primary care (see Barrier #3), they are sometimes not covered when paired with Z or R diagnosis codes, which are often the most clinically appropriate diagnoses for young children.
- Of the practices who report receiving coverage for treatment services described in #3, a number report that the payment coverage was only for when the claim was paired with F diagnosis codes, representing a diagnosed mental health disorder. For young children needing social-emotional intervention and treatment services, they likely will not carry a mental health diagnosis yet but should receive appropriate treatment interventions to prevent or delays diagnosis.
- As is outlined in OHA's Oregon Early Childhood Diagnostic Crosswalk**,** many evidence-based, applicable diagnostic codes for young children are Z and R codes. Lack of coverage prevents practices from providing and young children from receiving appropriate treatment services.

Lastly, while out of the scope of the EPSDT-related coverage of required services, it is important to note that many primary care practices shared that they do not receive payment aligned with the OHA posted fee rates for issue focused-interventions. This is particularly true when billed by staff who have a Licensed Clinic Social Worker (LCSW) degree, even though they have the appropriate skill set to provide evidence-based interventions to this young population for these services. Paying a lower rate for LCSW creates a barrier to sustaining this workforce in primary care. Therefore, we recommend payment parity with integrated behavioral health providers.