State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: December 26, 2019

ALL PLAN LETTER 19-018

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: PROPOSITION 56 DIRECTED PAYMENTS FOR ADVERSE CHILDHOOD EXPERIENCES SCREENING SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized Adverse Childhood Experiences (ACEs) screening services for adults (through 64 years of age) and children.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and other tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the California Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill (AB) 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4620-101-3305 appropriates Proposition 56 funding to support clinically appropriate trauma screenings for children and adults with full-scope Medi-Cal coverage as well as Provider training for trauma screenings, which DHCS is implementing in the form of a directed payment arrangement.[2] On June 30, 2019, DHCS requested approval from the federal Centers for Medicare & Medicaid Services (CMS) for this directed payment arrangement in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c)(2).[3] Subject to future budgetary authorization and appropriation by the California Legislature and the necessary federal approvals of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual

[1] This APL does not apply to Prepaid Ambulatory Health Plans or Rady Children's Hospital.
[2] AB 74 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB74.
[3] Part 438 of the CFR can be accessed at: https://www.ecfr.gov/cgi-bin/text-idx?SID=c131f365759360ca3555585f2b6a1b6e&mc=true&node=pt42.4.438&rgn=div5.

basis for the duration of the program. The requirements of this APL may change if required for CMS approvals applicable to this directed payment arrangement.

AB 340 (Arambula, Chapter 700, Statutes of 2017)[4] required DHCS, in consultation with the California Department of Social Services and others, to convene an advisory working group to update, amend, or develop, if appropriate, tools and protocols for screening children for trauma as defined within the Early and Periodic Screening, Diagnostic, and Treatment benefit. The workgroup reported its findings and recommendations to DHCS and the legislative budget subcommittees on health and human services for consideration.[5]

An ACEs screening evaluates children and adults for trauma that occurred during the first 18 years of life. The ACEs questionnaire[6] for adults (ages 18 years and older) and Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (ages 0 to 19 years) are both forms of ACEs screening.[7] Both the ACEs questionnaire and the PEARLS tool are acceptable for use for Members aged 18 or 19 years. The ACEs screening portion (Part 1) of the PEARLS tool is also valid for use to conduct ACEs screenings among adults ages 20 years and older. If an alternative version of the ACEs questionnaire for adults is used, it must contain questions on the 10 original categories of ACEs to qualify.[8]

DHCS will provide and/or authorize ACEs-oriented trauma-informed care training for Providers and their ancillary office staff. DHCS must approve or authorize any other trauma-informed care training that is not provided by DHCS. The training will be available in person, including regional convenings, and online. The training will include general training about trauma-informed care, as well as specific training on use of the ACEs questionnaire and PEARLS tool. It will also include training on ACEs Screening Clinical Algorithms to help Providers assess patient risk of toxic stress physiology and how to incorporate ACEs screening results into clinical care and follow-up plans. More information about training is available on https://www.acesaware.org/.

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[4] AB 340 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB340.
[5] The advisory workgroup's findings and recommendations are available at: https://www.dhcs.ca.gov/provgovpart/Documents/AB340Recommendations.pdf.
[6] The ACEs questionnaire was derived from the 1998 ACE study, which can be found at: https://www.ajpmonline.org/article/S0749-3797(98)00017-8/pdf.
[7] The ACEs questionnaire and the PEARLS tool are available at the following link: https://www.acesaware.org/screen/screening-for-adverse-childhood-experiences/.
[8] The 10 original ACE categories are: abuse—physical, emotional, and sexual; neglect—physical and emotional; and household dysfunction—parental incarceration, mental illness, substance dependence, separation or divorce, and intimate partner violence.

DHCS will establish a website for Providers to self-attest to their one-time completion of the state-sponsored trauma-informed care training. DHCS will maintain a list of Providers who have self-attested to their completion of the training. MCPs will have access to the list. Beginning July 1, 2020, Network Providers must attest to completing certified ACEs training on the DHCS website to continue receiving directed payments.

On January 17, 2019, DHCS issued APL 19-001, "Medi-Cal Managed Care Health Plan Guidance on Network Provider Status," which describes how DHCS evaluates Network Provider status and establishes requirements that must be satisfied in order for Network Providers to be eligible for directed payments.[9]

POLICY:
Subject to obtaining the necessary federal approvals, DHCS is requiring MCPs, either directly or through their delegated entities and Subcontractors, to comply with a minimum fee schedule of $29.00 for each qualifying ACEs screening service (as defined below) by a Network Provider with dates of service on or after January 1, 2020, in accordance with the CMS-approved preprint, which will be made available on the DHCS Directed Payments Program website upon CMS approval.[10] Network Providers must receive at least the amounts specified in the table below from the MCP, or the MCP's delegated entities and Subcontractors, for each qualifying ACEs screening service.

A qualifying ACEs screening service is one provided by a Network Provider through the use of either the PEARLS tool or a qualifying ACEs questionnaire to a Member enrolled in the MCP who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). To qualify, the ACEs questionnaire must include questions on the 10 original categories of ACEs.[11] Providers may utilize either an ACEs questionnaire or the PEARLS tool for Members 18 or 19 years of age; the ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adults ages 20 years and older. MCPs are responsible for ensuring that qualifying ACEs screening services are reported to DHCS in encounter data in accordance with APL 14-019, "Encounter Data Submission Requirements," using Healthcare Common Procedure Coding System (HCPCS) codes G9919 or G9920. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided, and that HCPCS codes G9919 and G9920

[9] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[10] DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.
[11] The 10 original ACE categories are: abuse—physical, emotional, and sexual; neglect—physical and emotional; and household dysfunction—parental incarceration, mental illness, substance dependence, separation or divorce, and intimate partner violence.

are not reported for non-qualifying ACEs screening services or for any other services. Providers must calculate the score for the billing codes using the questions on the 10 original categories of ACEs.

HCPCS Code	Description	Directed Payment	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

Providers may screen Members utilizing a qualifying ACEs questionnaire or PEARLS tool as often as deemed appropriate and medically necessary. However, each MCP is only required to make the $29.00 required minimum payment to a particular Network Provider once per year per Member screened by that Provider, for a child Member assessed using the PEARLS tool, and once per lifetime per Member screened by that Provider, for an adult Member (through age 64) assessed using a qualifying ACEs questionnaire.

To be eligible for the directed payment, the Network Provider must meet the following criteria:

1. The Network Provider must utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;
2. The Network Provider must bill using one of the HCPCS codes in the table above based on the screening score from the PEARLS tool or ACEs questionnaire used; and
3. The Network Provider that rendered the screening must be on DHCS' list of Providers that have completed the state-sponsored trauma-informed care training. The training requirement will be waived for dates of service prior to July 1, 2020. However, commencing July 1, 2020, Network Providers must have taken a certified training and self-attested to completing the training to receive the directed payment for ACEs screenings.

Providers must document all of the following: the tool that was used; that the completed screen was reviewed; the results of the screen; the interpretation of results; what was discussed with the Member and/or family; and any appropriate actions taken. This documentation must remain in the Member's medical record and be available upon request.

Data Reporting

Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after January 1, 2020. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include the Health Care Plan code, HCPCS code, service month, payor (i.e. MCP, delegated entity, or Subcontractor), and the Network Provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports must be submitted in a consumable file format (i.e. Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager.

Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, MCPs must submit an attestation to DHCS stating that no updated information is available. If updated information is available for the quarterly report, MCPs must submit the updated quarterly report in the appropriate file format and include an attestation that the MCP considers the report complete.

MCPs must submit encounter data for HCPCS codes G9919 and G9920, as required by DHCS.

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim[12] or accepted encounter for a qualifying ACEs screening service, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying ACEs screening services received by the MCP more than one year after the date of service. These timing requirements may be waived only through an agreement in writing

[12] A "clean claim" is defined in 42 CFR 447.45(b). 42 CFR Part 447 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=605e8561a83bfced0a6ea61f9d7b4e20&mc=true&node=pt42.4.447&rgn=div5.

between the MCP (or the MCP's delegated entities or Subcontractors) and the Network Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Network Providers. This communication must, at a minimum, include a description of the minimum requirements for a qualifying screening, how payments will be processed, how to file a grievance, and how to determine who the payor will be.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement will be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint, which will be made available on the DHCS Directed Payments Program website upon CMS approval. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and Subcontractors.

Subject to future budgetary authorization and appropriation by the California Legislature and CMS approval of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis in future years. Please note that the requirements of this APL may change if required for CMS approvals applicable to this directed payment arrangement or as required in future budgetary authorization and appropriation by the California Legislature.

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division