blue california
Promise Health Plan

Network Provider Update

To: Medi-Cal Network Providers June 26, 2020

From: Patricia Molawi *Patricia Mowlavi*
Chief Financial Officer
Blue Shield of California Promise Health Plan

Subject: California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) Supplemental Payment Notification

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We are writing to let you know that Blue Shield of California Promise Health Plan (Blue Shield Promise) is currently making supplemental payments in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56).

Specifically, within the next several weeks, if you meet qualifying requirements, you may receive a supplemental payment and details regarding services rendered that are eligible under one or more of the following All Plan Letters (APLs):

- APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
- APL 19-015: Proposition 56 Directed Payments for Physician Services
- APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services; See Appendix B of this letter for additional specific requirements
- APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services; See Appendix C of this letter for additional specific requirements
- APL 20-013: Proposition 56 Directed Payments for Family Planning Services

See Appendix A of this letter for a summary of our processes for managing payments, questions and inquiries, and disputes related to these Proposition 56 payments. We have also provided a summary on our News and Announcements page on the Blue Shield Promise website.

Please note that the California Department of Health Care Services (DHCS) has indicated that the Proposition 56 supplemental payment program will continue through July 1, 2021.

We will send you any additional updated Proposition 56 information as it becomes available.

Should you have any questions about Proposition 56 supplemental payments, please contact us by email at Prop56inquiries@BlueShieldca.com or call (800) 468-9935 from 8 a.m. to 5 p.m., Monday through Friday.

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Appendix A: Proposition 56 Additional Requirements and Information

See specific approved APLs for a full detailed listing of the requirements.

A.1: Typical Payment Process Summary

All eligible payments are calculated based on the specific APL criteria. These payments are validated based on the receipt of a qualifying clean FFS claim or encounter from the provider or the providers IPA. The payments are made direct to the FFS provider or the servicing providers IPA and based on the date of qualifying service. The payments are processed every 90 days from receipt of a clean claim or encounter and as applicable to the approved APL. The payments made are accompanied with a detailed cover letter describing the payments, who to contact with any questions, and how to file an appeal and grievance. The accompanying payment cover letters you will receive contain detailed backup describing how the payments were calculated. In the case of payments made to IPAs, the backup details provided with the cover letter will contain detailed information on which providers the IPA is to make the payments.

A.2: Provider Questions and Inquiries

Providers can communicate questions and inquiries regarding Proposition 56 supplemental payments to Blue Shield Promise by email at Prop56inquiries@BlueShieldca.com or call (800) 468-9935. Please provide missing claim or encounter records, including the date of service, billing NPI, CPT codes, and patient information, when you contact Blue Shield Promise.

A.3: Provider Disputes Policy and Procedure

Providers may submit a formal, written dispute regarding the processing or non-payment of directed payments required by Proposition 56 to the Provider Dispute and Resolution Department at:

Blue Shield of California Promise Health Plan
Attn: Provider Dispute Resolution Department
P.O. Box 3829
Montebello, CA 90640

Upon receipt of the written dispute specifying the issue of concern, the dispute will be entered into the provider dispute database. An acknowledgement letter will be sent to the provider within fifteen (15) working days of receiving the written dispute, and a resolution letter will be sent within forty-five (45) working days.

All provider disputes must be submitted in writing within one hundred eighty (180) days from the last date of action on the issue. If a provider attempts to file a provider dispute via telephone, Blue Shield Promise staff will instruct the provider to submit the provider dispute to Blue Shield Promise in writing. Information about how to file a dispute can be found at Blue Shield Promise's website at Blueshieldca.com/promise. You will find the information in the section titled *Policies, Guidelines, Standards and Forms*. All provider disputes are forwarded to the appropriate department for processing.

APPENDIX B: Additional Details Regarding Payments for All Plan Letter 19-016

Proposition 56 Directed Payments for Developmental Screening Services

In accordance with All Plan Letter (APL) 19-016 published by the Department of Health Care Services, Blue Shield of California Promise Health Plan is including these additional details to help providers understand how they may qualify for supplemental payments funded by Proposition 56 for developmental screening services. For more information, please view the full text of the letter at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-016.pdf.

Requirements for a qualifying screening

A qualifying developmental screening service is one provided by a Network Provider, in accordance with the AAP/Bright Futures periodicity schedule and through use of a standardized tool that meets the criteria specified below, 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).

- Developmental screenings must be provided in accordance with the AAP/Bright Futures periodicity schedule and guidelines at 9 months, 18 months, and 30 months of age and when medically necessary based on developmental surveillance. For purposes of directed payments, a routine screening will be considered to have been done in accordance with AAP guidelines and eligible for payment if done on or before the first birthday, after the first birthday and before or on the second birthday, or after the second birthday and on or before the third birthday. Screenings done when medically necessary, in addition to the routine screenings, are also eligible for directed payments.

A qualifying developmental screening service must be performed using a standardized tool that meets all of the following CMS criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

The CMS Technical Specifications and Resource Manual includes a list of standardized tools that are cited by AAP/Bright Futures and meet the above criteria.* The list is updated regularly as new tools meeting the CMS criteria are developed.

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; discussion 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.

The provider must document completion of the developmental screening with CPT code 96110 without the modifier KX. Additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX. See referenced located

*A link to the CMS 2019 Technical Specifications and Resource Manual can be found at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html. Please note that the list of standardized tools begins on page 79.

APPENDIX C: Additional Details Regarding Payments for All Plan Letter 19-018

Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services

In accordance with All Plan Letter (APL) 19-018 published by the Department of Health Care Services, Blue Shield of California Promise Health Plan is including these additional details to help providers understand how they may qualify for supplemental payments funded by Proposition 56 for adverse childhood experiences (ACEs) screening services. For more information, please view the the letter at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-018.pdf

Requirements for a qualifying screening

A qualifying ACEs screening service is one provided by a Network Provider through the use of either the PEARLS (Pediatric ACEs and Related Life-events Screener) 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.
- 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.
- Providers must calculate the score for the billing codes using the questions on the 10 original categories of ACEs.

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 (2) HCPCS codes G9919, G9920 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. Please visit https://www.acesaware.org/ for more information about the ACEs Aware Inititiave and details about provider training opportunities.

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.

Frequency of payments for screenings

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.