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

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DATE: December 26, 2019

ALL PLAN LETTER 19-016

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

SUBJECT: PROPOSITION 56 DIRECTED PAYMENTS FOR DEVELOPMENTAL 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 developmental screening services for children.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and 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 4260-101-3305 appropriates Proposition 56 funding to support clinically appropriate developmental screenings for children with full-scope Medi-Cal coverage, 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 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.

[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

Developmental Surveillance and Developmental Screening

The MCP contract[4] and the Medi-Cal Provider Manual[5] require MCPs to adhere to the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits.[6] Furthermore, AB 1004 (McCarty, Chapter 387, Statutes of 2019) requires MCPs to ensure that developmental screening services provided for Members as part of the Early and Periodic Screening, Diagnostic, and Treatment benefit comply with the AAP/Bright Futures periodicity schedule and guidelines.[7]

The AAP/Bright Futures periodicity schedule requires developmental surveillance to occur during every periodic pediatric health visit. Developmental surveillance is defined as a flexible, longitudinal, and continuous process that includes eliciting and attending to parents' concerns, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings. Developmental screening is indicated as medically necessary whenever a problem is identified during developmental surveillance. The AAP/Bright Futures guidelines also require developmental screening using standardized developmental screening tools during the periodic pediatric health visits that occur at 9 months, 18 months and 30 months. The 30-month developmental screening may be performed at the 24-month periodic health visit.

Developmental screening identifies areas in which a child's development differs from same-age norms. Because development is dynamic in nature, and because surveillance and screening have limitations, periodic screening with a validated instrument should occur so that a problem not detected by surveillance or a single screening can be detected by subsequent screening. Repeated and regular screening is necessary to ensure timely identification of problems and early intervention, especially in later-developing skills such as language.[8]

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[4] Medi-Cal Managed Care Plan Boilerplate contracts can be accessed at the following link: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[5] Medi-Cal Provider Manuals can be accessed at: http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=developmental+screening
[6] The AAP/Bright Futures periodicity schedule can be accessed at: https://brightfutures.aap.org/Pages/default.aspx
[7] AB 1004 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1004
[8] Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening can be accessed at the following link: https://pediatrics.aappublications.org/content/118/1/405.full

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 make directed payments to eligible Network Providers of $59.90 for each qualifying developmental screening service (as defined below) 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] These directed payments must be in addition to whatever other payments the Network Providers would normally receive from the MCP, or the MCP's delegated entities and Subcontractors, as Network Providers.

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). MCPs are responsible for ensuring that qualifying developmental screening services are reported to DHCS in encounter data in accordance with APL 14-019, "Encounter Data Submission Requirements," using Current Procedural Terminology (CPT) code 96110 without the modifier KX.[11] The KX modifier is used to document screening for Autism Spectrum Disorder (ASD). ASD screening is different from general developmental screening, and while both types of screening are AAP/Bright Futures recommendations, only general developmental screenings are eligible for a directed payment. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided, and that CPT code 96110 without the modifier KX is not reported for non-qualifying developmental screening services or for any other services.

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[9] APLs can be found 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] CPT code 96110 with modifier KX should be used to indicate completion of ASD screening at age 18 months and 24 months in accordance with the AAP/Bright Futures recommendations.

CPT Code	Description	Directed Payment
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument	$59.90

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.[12] 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.

[12] 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.

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.

Developmental screening is considered preventive care and, therefore, is not subject to any prior authorization requirements. MCPs must include oversight in their utilization management processes, as appropriate.

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 Health Care Plan code, CPT code, service month, payer (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 shall 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 continue to submit encounter data for CPT code 96110 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 or accepted encounter for a qualifying developmental 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 developmental 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 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 payer 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 shall 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.

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.

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.

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