DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: June 9, 2023

ALL PLAN LETTER 23-016
SUPERSEDES ALL PLAN LETTER 19-016

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

SUBJECT: 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, initially 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 appropriated Proposition 56 funds 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 in accordance with Title 42 of the Code of Federal Regulations (CFR), Part 438.6(c).[2]

The Budget Act of 2021 authorized continued funding for enhanced payments for developmental screening services beyond the December 31, 2021, sunset date. In addition, beginning July 1, 2022, the Budget Act of 2021 changed the source of the nonfederal share of these payments to the state General Fund.

The Centers for Medicare and Medicaid Services (CMS) has approved this directed payment arrangement for calendar year (CY) 2020. For the CY 2021 rating period and subsequent rating periods for which this APL is in effect, this directed payment

[1] This APL does not apply to Prepaid Ambulatory Health Plans.
[2] State legislation is searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml. Part 438 of the CFR can be accessed at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438

arrangement is a uniform dollar add-on for Network Providers that provide a particular service under contract using State Plan approved rates in accordance with Title 42 CFR, Parts 438.6(c)(1)(iii)(A).

Developmental Surveillance and Developmental Screening

The Contract[3] and the Medi-Cal Provider Manual[4] require MCPs to adhere to the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits.[5] 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.

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

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[3] Boilerplate MCP Contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are also advised to review their specific MCP contracts and amendments executed thereto.

[4] Medi-Cal Provider Manuals can be accessed at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual

[5] The AAP/Bright Futures periodicity schedule can be accessed at: https://brightfutures.aap.org/Pages/default.aspx

ensure timely identification of problems and early intervention, especially in later-developing skills such as language.[6]

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.[7]

POLICY:
For dates of service on or after January 1, 2020, MCPs must comply with a uniform dollar add-on of $59.90 for each qualifying developmental screening service (as defined below) provided by an eligible Network Provider. For calendar years (CY) 2020, 2021, and 2022, the requirement is imposed in accordance with the existing CMS-approved preprint, which is available on the DHCS' Directed Payments Program website.[8] MCPs, either directly or through their Subcontractors, continue to be obligated to comply with the uniform dollar add-on requirement on and after January 1, 2023. Eligible Network Providers must receive at least the amount specified in the table below from the MCP, or the MCP's Subcontractors, for each qualifying developmental screening service.

A qualifying developmental screening service is one provided by an eligible 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.[9] 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 screenings 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,

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[6] 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
[7] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[8] DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.
[9] 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.

and that CPT code 96110 without the modifier KX is not reported for non-qualifying developmental screening services or for any other services.

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.[10] 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; the completed screen was reviewed; the results of the screen; the interpretation of results; discussion

[10] 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.

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 by the Member and/or Member's parent(s)/guardian(s).

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

MCPs must follow the reporting requirements described in the "Prop 56 Directed Payments Expenditures File Technical Guidance" document available on the DHCS Directed Payment - Proposition 56 website, which is hereby incorporated herein by reference.[11]

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL are made in accordance with the timely payment standards in the Contract for clean claims or accepted encounters that are received by the MCP or Subcontractor no later than one year after the date of service.[12] The Contract specifies the requirements pertaining to timely payment in Exhibit A, Attachment 8, Provision 5.[13]

MCPs have an obligation to communicate and provide clear policies and procedures to their Network Providers with respect to the MCP's claims or encounter submission processes, including what constitutes a clean claim or acceptable encounters. If the Network Provider does not still adhere to these articulated policies and procedures, the MCP is not required to make payments for claims or submitted encounters submitted one year following the date of service. These timing requirements may be waived

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[11] DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.
[12] A "clean claim" is defined in Title 42 CFR section 447.45(b). Title 42 CFR Part 447 is available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447. MCPs are also advised to review their specific MCP Contracts and amendments executed thereto.
[13] MCP boilerplate Contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are also advised to review their specific MCP contracts and amendments executed thereto.

through an agreement in writing between the MCP (or the MCP's Subcontractors) and the Network Provider.

MCPs or their Subcontractors must not pay any amount for any services or items, other than Emergency Services, to a Provider that is suspended, excluded, or terminated from the Medi-Cal program.[14] This prohibition must apply to non-emergency services furnished by a Provider at the medical direction or prescribed by a suspended, excluded, or terminated Provider when the Provider knew or had a reason to know of the suspension, exclusion, or termination, or by a suspended, excluded, or terminated Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

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 identify the responsible payor. In addition, MCPs must make available to a Network Provider an itemization of payments made to the Network Provider in accordance with this APL. The itemization must include sufficient information to uniquely identify the qualifying service for which payment was made, be provided upon the Network Provider's request unless the MCP has established a periodic dissemination schedule and be made available in electronic format when feasible.

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 applicable CMS-approved preprints, which will be made available on the DHCS' Directed Payments Program website[15] 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.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required policies and procedures

[14] See the MCP Contract at Exhibit E, Attachment 2, Program Terms and Conditions.
[15] Directed Payment Program website is located at https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx

(P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD Contract Manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are further responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.[16] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a Corrective Action Plan and subsequent sanctions.

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 Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[16] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.