DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: June 13, 2023

ALL PLAN LETTER 23-017
SUPERSEDES ALL PLAN LETTER 19-018

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

SUBJECT: 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, initially funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized Adverse Childhood Experiences (ACE) 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 4260-101-3305,[2] Senate Bill 74 (Mitchell, Chapter 6, Statutes of 2020), Section 2, Item 4260-101-3305, and AB 128 (Ting, Chapter 21, Statutes of 2021), Section 2, Item 4260-101-3305 appropriated Proposition 56 funds to support clinically appropriate trauma screenings for children and adults 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 (42 CFR), Part 438.6(c),[3] as well as Provider training for trauma screenings.

AB 340 (Arambula, Chapter 700, Statutes of 2017) required DHCS, in consultation with the California Department of Social Services and others, to convene an advisory

[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
[3] Part 438 of the CFR can be accessed at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438

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.[4]

The Budget Act of 2021 authorized continued funding for the ACE screening payments past 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 the supplemental payments for trauma screenings to the state General Fund. In accordance with the State Plan Amendment (SPA) 21-0045,[5] effective July 1, 2022, the ACEs program will become a benefit, and it will no longer be funded by Proposition 56. The ACEs Aware program must continue to be utilized to provide informational resources for ACE screening services.

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 arrangement is authorized pursuant to 42 CFR section 438.6(c)(2)(ii) as a minimum fee schedule for Network Providers that provide a particular service under contract using State Plan approved rates in accordance with 42 CFR section 438.6(c)(1)(iii)(A).

Allowed ACE Screening Tools

An ACE screening evaluates children and adults for trauma that occurred during the first 18 years of life and helps primary care clinicians assess risk for toxic stress and guide effective responses.

For Children and Adolescents: The Pediatric ACEs and Related Life-Events Screener (PEARLS) is used to screen children and adolescents ages 0-19 for ACEs.[6] Three versions of the tool are available, based on age and reporter:

- PEARLS child tool, for ages 0-11, to be completed by a parent/caregiver;
- PEARLS adolescent, for ages 12-19, to be completed by a parent/caregiver; and

[4] AB 340 (2017) Trauma Screening Workgroup Recommendations are available at: https://www.dhcs.ca.gov/provgovpart/Documents/AB340Recommendations.pdf.
[5] SPA 21-0045: Eliminates Sunset Date for Supplemental Payments for Developmental Screenings and Trauma Screenings, is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-21-0045-Pending.pdf
[6] The ACE questionnaire and the PEARLS tool are available at the following link: https://www.acesaware.org/screen/screening-for-adverse-childhood-experiences/

- PEARLS for adolescent self-report tool, for ages 12-19, to be completed by the adolescent

For Adults: The ACE questionnaire may be used for adults (ages 18 years and older).[7] Both the ACE questionnaire and the PEARLS tool are acceptable for use for Members aged 18 or 19 years. The ACE screening portion (Part 1) of the PEARLS tool is also valid for use to conduct ACE screenings among adults ages 20 years and older. If an alternative version of the ACE questionnaire for adults is used, it must contain questions on the 10 original categories of ACE to qualify.[8]

The tools are available in multiple languages and in de-identified and identified formats.[9]

ACEs Aware Trainings

DHCS will provide and/or authorize ACE-oriented trauma-informed care training for Providers and their ancillary office staff.

The "Becoming ACEs Aware in California" Core Training is a free, two-hour training for which clinicians and clinical team members will receive 2.0 Continuing Medical Education and/or 2.0 Maintenance of Certification credits upon completion. The training provides information about ACEs Aware, toxic stress, screening, risk assessment, and evidence-based care to effectively intervene on toxic stress. The training also includes information on the ACE screening workflows, risk assessment and treatment algorithms, and ACE-associated health conditions to help clinicians assess whether a patient is at low, intermediate, or high risk for having a toxic stress physiology. More information about training is available at https://www.acesaware.org/learn-about-screening/training/.

ACEs Aware Certification

[7] The ACE questionnaire was derived from the 1998 ACE study, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study", is available at: https://www.ajpmonline.org/article/S0749-3797(98)00017-8/pdf.
[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.
[9] DHCS Data De-Identification Guidelines can be found at: https://www.dhcs.ca.gov/dataandstats/Pages/PublicReportingGuidelines.aspx

Medi-Cal Providers must self-attest to completing certified ACE training to receive directed payments for screening. DHCS established a website for Providers to self-attest to their one-time completion of a core ACEs Aware training.[10]

DHCS maintains a list of Providers who have self-attested to their completion of the training. MCPs will have access to the list by emailing DHCS at questions@ACEsAware.org. For dates of services beginning on or after July 1, 2020, Network Providers must attest to completing certified ACE training on the DHCS website to continue receiving directed payments.

Providers are encouraged to join the ACEs Aware Clinician Directory, which is a subset of Providers who have attested to completing a certified Core ACEs Aware training. Clinicians who would like to opt-in to the ACEs Aware Clinician Directory or update their data may resubmit the ACEs Provider Training Attestation form.

Provider Requirements

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 for Network Providers to be eligible for directed payments.[11]

ACE screenings provided on or after January 1, 2020, may be provided in any clinical setting in which billing occurs through Medi-Cal Fee-For-Service or to a Network Provider of an MCP.

ACE Screening Implementation

Strategies for successfully implementing ACE screening and response include the following:

- Promoting availability of ACE screening and payment to eligible Providers;
- Educating Members about ACE screening and toxic stress;
- Establishing policies and procedures to incorporate ACE screening results into Member risk stratification (per California Advancing and Innovating Medi-Cal (CalAIM) Population Health Management and Enhanced Care Management requirements);

[10] The attestation website is available at: https://www.medi-cal.ca.gov/TSTA/TSTAattest.aspx
[11] See APL 19-001, or any superseding APL, for more information. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

- Establishing consistent protocols for ACE screening, referrals and follow-up processes, and a pathway to incorporate ACE screening results into MCP care management systems;
- Establishing quality metrics to measure and monitor ACE screenings and Member outcomes; and
- Standardized approaches to facilitate claims payment, data aggregation, and population health level analysis for reporting and evaluation purposes.

The requirements of this APL may change, if required, to ensure federal authority for this directed payment arrangement or to comport with future State legislation.

POLICY:
For dates of service on or after January 1, 2020, MCPs must comply with a minimum fee schedule of $29.00 for each qualifying ACE screening service (as defined below) provided by an eligible Network Provider. For calendar year 2020, the requirement is imposed in accordance with the existing CMS-approved preprint, which is available on the DHCS Directed Payments Program website.[12] Eligible Network Providers must receive at least the amounts specified in the table below from the MCP, or the MCP's Subcontractors for each qualifying ACE screening service.

A qualifying ACE screening service is one provided by a Network Provider through the use of either the PEARLS tool or a qualifying ACE 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 ACE questionnaire must include questions on the 10 original categories of ACE. Providers may utilize either an ACE questionnaire or the PEARLS tool for Members 18 or 19 years of age; the ACE screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACE screenings among adults ages 20 years and older. MCPs must ensure that qualifying ACE screening services are reported to DHCS in encounter data in accordance with the MCP Contract and with APL 14-019, "Encounter Data Submission Requirements," using Healthcare Common Procedure Coding System (HCPCS) codes G9919 or G9920. MCPs must ensure that the encounter data reported to DHCS is appropriate for the services being provided, and that HCPCS codes G9919 and G9920 are not reported for non-qualifying ACE screening services or for any other services. Providers must calculate the Member's ACE screening score for the billing codes using the questions on the 10 original categories of ACE.

[12] DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

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 using a qualifying ACE 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 ACE questionnaire.

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

1. The Network Provider must use either the PEARLS tool or a qualifying ACE 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 ACE questionnaire used; and
3. The Network Provider that rendered the screening must be on DHCS' list of Providers that have completed a certified Core ACEs Aware 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 ACE screenings.

If the billing Provider submitting the claim is an institution (i.e., a clinic), in order for the billing Provider to receive payment for the ACE screening the rendering Provider must have completed a certified Core ACEs Aware training. When clinics and other Provider

groups submit a claim for a qualified ACE screening, these institutional Providers are responsible for ensuring that the rendering Provider has completed and attested to completing a certified ACEs training.[13] Inclusion of the rendering Provider's National Provider Identifier on a claim in which the billing Provider is an institution (i.e., clinic) allows the MCP to verify that the rendering Provider has completed the ACEs training.

For each ACEs screening, the MCP must require Providers to document 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 by the Member and/or Member's parent(s)/guardian(s) in compliance with all relevant state and federal privacy requirements.

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 Payments Program website, which is hereby incorporated herein by reference.[14]

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 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

[13] For more information, see the ACEs Screening Program available at: https://secure.medi-cal.ca.gov/TSTA/TSTAattest.aspx

[14] DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

service.[15] The Contract specifies the requirements pertaining to timely payment in Exhibit A, Attachment 8, Provision 5.[16]

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 an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, the MCP is not required to make payments for claims or submitted encounter submitted one year following the date of service. These timing requirements may be waived only 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.[17] 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

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[15] A "clean claim" is defined in 42 CFR section 447.45(b). Additionally, MCP boilerplate 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.
[16] 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.
[17] See the MCP Contract at Exhibit E, Attachment 2, Program Terms and Conditions.

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 will 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 upon CMS approval.[18] 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 policies and procedures (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.[19] These requirements must be communicated by each MCP to all applicable 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 CAP and subsequent sanctions.

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[18] DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx

[19] 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.

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