California Association of Health Plans

1415 L STREET
SUITE 850
SACRAMENTO, CA 95814

916.552.2910 P
916.443.1037 F
CALHEALTHPLANS.ORG

March 22, 2019

Sarah Brooks
Deputy Director, Health Care Programs
Department of Health Care Services

VIA ELECTRONIC MAIL:
Sarah.Brooks@dhcs.ca.gov

Re: Developmental and Trauma Screenings proposals

The California Association of Health Plans (CAHP) represents 46 public and private health care service plans that collectively provide coverage to over 26 million Californians. We appreciate the opportunity to provide input into the proposals in the Governor's budget relating to directed payments for developmental screenings, and trauma screenings.

GENERAL COMMENT ON PROGRAM DESIGN

CAHP would like to first express our support and appreciation for the development of these proposals. We are pleased that the State has allocated specific revenue to encourage more frequent provision of critical services for the Medi-Cal population. We hope that there will be continued investment in programs of this nature and look forward to participating in these Proposals this year.

One overarching comment from our member plans is that most of the measures under these proposals appear to be encounter-based rather than outcomes-based. We hope that these proposals, or future programs, will incentivize more targeted outcomes and perhaps address specific populations or conditions. Without future steps, data received during this first phase, as well as from other similar legislative and regulatory efforts, will not always lead to improved outcomes.

PROVIDER MONITORING/OVERSIGHT

For both the developmental and trauma screening proposals, DHCS states that managed care plans (MCPs) will conduct oversight "*during Facility Site Reviews when MCP nurses go onsite to provider offices and review medical records to determine if appropriate services such as screenings have occurred.*" Additional guidance is requested to inform plans as they work to develop utilization management/oversight processes relating to the trauma screenings.

In developing the FSR process for the Proposals, we hope that DHCS will strategically consider of all of the current and potential future regulatory and legislative survey mandates on MCPs and streamline them to be as efficient as possible. We provide the following recommendations on updating the FSR medical record review (MRR) tool to document providers' completion of each screening:

Developmental Screening

- Update the existing Pediatric C.4 criteria ("Developmental Screening- Pediatric C.4" [pg 72]) to reference critical screenings and/or include the website(s). See suggested revised criteria below:

Developmental Screening (currently Peds C.4)	~~Developmental surveillance at each visit and screening for developmental disorders at the 9th, 18th and 30th month visits. Children identified with potential delays require further assessment and/or referral. (Ref: AAP and CHDP periodicity schedules)~~ *Developmental screenings are conducted at each visit in accordance to the American Academy of Pediatrics recommended universal screening toolkit and periodicity table. These screenings are documented in the medical record and include outcomes such as scores, analysis, referrals and necessary follow-up.*

- DHCS should reinforce and reintroduce with plans and CHDP providers that this criteria is linked to the AAP screenings.

Trauma Screening

- Because Trauma Screening is called out as a separate screening, add new criteria to the Pediatric and Adult sections of the MRR tool.

Trauma Screening (Peds)	*Trauma screenings are conducted during the Initial Health Assessment and at least annually thereafter, utilizing the Bay Area Research Consortium (BARC) (other DHCS approved screening tool). (also include in the criteria what the reviewer should look for as far as the MD next steps to address what came out from the screening – referral, contact authorities or agency, etc.)*
Trauma Screening *(Adults)*	*Trauma screenings are conducted during the Initial Health Assessment and upon the practitioner discretion thereafter, utilizing the Bay Area Research Consortium (BARC) (other DHCS approved screening tool). (also include in the criteria what the reviewer should look for as far as the MD next steps to address what came out from the screening – referral, contact authorities or agency, etc.)*

- The current developmental screenings are typically documented in the medical record by "checking the box" with some comments. Since this screening will be eligible for Prop 56 incentive payment, we would suggest that DHCS provides clear expectation of what needs to be documented in the medical record and include that expectation in the criteria.
- DHCS and the plans are currently working together to revise Policy Letter (PL) 14-004 and both the FSR and MRR tools. This Prop 56 effort presents a good opportunity to add these incentive-eligible screenings to the criteria. DHCS and the plans will have their biannual

Interrater Reliability training in Fall 2019, when the plan nurse reviewers could learn about how to monitor for these new criteria.

BARC and ACEs TOOLS

- The proposal states: *For children, the Bay Area Research Consortium (BARC) tool will be utilized. There are two versions of this tool based on age - one for children, ages 1 – 12, and one for teens, ages 13 – 19. For adults, the Adverse Childhood Experiences (ACEs) assessment or a similar tool can be utilized.*
    - Plans recommend that incentive payments under both screenings proposals be contingent on providers not only administering the screening tools/assessments, but also developing and documenting an appropriate follow-up care plan for positive screenings.
- From a monitoring perspective, it is important that criteria and guidelines are specific and measurable.
- If a provider uses another tool besides BARC, will they be eligible for the Prop 56 payment?
- DHCS already mandates a number of required screening tools for various populations and situations. Use of the BARC tool would generally be new for many providers and will likely have overlap with other screenings that are already required for Medi-Cal beneficiaries by DHCS. We recommend that effort be taken to consider how to reconcile these screenings and reduce duplication of questions that result in beneficiary and provider fatigue. In addition, DHCS should consider allowing greater flexibility of which tool to use for these screenings so that providers can capitalize on improved efficiency where efforts are already in place.
- For adults, some plans expressed concern that the original ACEs questionnaire was validated and tested on a largely Caucasian, college educated population. Thus, the applicability to the Medi-Cal population is suspect. DHCS may want to consider the updated ACEs from the work from Center for Youth Wellness (https://centerforyouthwellness.org/about-us/).
- The BARC tool is noted on the AAP website as "not a validated tool". There is some reservation with implementing a tool that has not been fully validated as safe and effective.
- Physical disabilities and prior medical conditions are not addressed in the BARC tool. This makes completing a Health Risk Assessment tool, a developmental screening tool and a trauma screening tool a significant and time-consuming effort on parents/teens.
- Will the tools be made available in threshold languages? Are plans expected to translate the tool?

SCOPE/BILLING

- Plans recommend allowing identified non-licensed personnel (e.g. community health advocates or perinatal/family support workers) to provide and bill for screening. Short of being allowed to bill, these personnel could at least be allowed render the screen while overseen by licensed professional, who would then bill accordingly.

PROVIDER TRAINING

- Further clarification is needed regarding who will provide the initial counseling and referrals within the provider office.

- DHCS stated on the stakeholder webinar that health plans will be responsible for training network providers. We understand that providers may not be familiar with some of the screening tools such as the BARC or ACEs tool, and that plans have an important role in disseminating information to our providers. Similar to the state's role in the Health Home Program, having the state develop the trauma training that all plans can use ensures consistency statewide and is more administratively efficient for providers who have limited resources working across different health plans. The training should cover how to administer the assessment what to do with positive results.
- Will guidance be provided to providers? For example: What is the provider expected to do for the caregiver/parent who fills out this survey and becomes disturbed by the potential consequences, or becomes stressed by reporting? Consider also this scenario could occur in a pediatrician office where adults are not normally cared for.
- What resources are available to PCP for positive results on the screen? Referral to Child Protective Services (CPS) could disrupt the doctor/patient relationship. Referral to counseling may not be readily accepted by the child's caregiver and cannot be required by the provider.

PLAN REPORTING / EXISTING PLAN OBLIGATIONS

- Other than encounter data currently reported, plans need to know as soon as possible if any reporting requirements are envisioned with respect to these proposals. For example, would plans be expected to report positive results and referrals?
- Clarification is requested as to whether the proposed developmental screening is to be in addition to the screenings outlined in APL 18-007.

FINANCING / UTILIZATION

- On the stakeholder webinar, DHCS stated the total budgeted Prop 56 amount for each screening initiative ($60 million for developmental screening, $45 million for trauma screening) reflects the department's expectations re: utilization—which is to assume every eligible child and each adult gets screened at the designated frequency. DHCS should clarify that while these are ideal upper limits—which makes sense from a budgeting perspective—this should <u>not</u> be the expectation for actual utilization. The reality of deployment, capturing data, and actual practice change will take time and not result in immediate 100% screening rates.
- While DHCS expects positive screenings would show a referral to services, no budget funding has been allocated to increased services related to positive screenings. Plans would expect to see an increase in utilization across medical and social services delivery systems—behavioral and physical health, county services such as child protective services and associated resources, county specialty mental health, prescription drugs, etc. We are concerned that the current system and network capacity has not been evaluated for the increased demand. We recommend evaluation of the current capacity and additional funding for these services.
- We note great variations in the level of incentive payments for the different CPT codes under these proposals. For example, there is a difference of $30.90 between the Trauma Screening code 96160 ($29) and the Developmental Screening Proposal code 96110 ($59.90). In some

cases, we understand the service may require more time and expertise. We would appreciate more information on the reasons for the variation.

- With regard to the payment levels, DHCS should ensure that the rate is sufficient to compensate the provider for time required to complete assessment. For example, for the trauma screening, if the screening is a 45-minute screening, a provider may not be incentivized by a $29 rate.
- Managed care plans can expect some fraudulent behavior may occur. Plans use standard fraud detection software in claims editing, however, these codes are not currently part of such software. Will an additional burden be placed on plans for the development and deployment of additional fraud detection, or is the state working with the available fraud detection software companies to enhance their queries? MRR cannot be expected to be the validation tool due to cost of RN time and too few FSR RN's to perform these audits.
- With regard to frequency limitations for trauma screenings, it may be difficult to enforce these for populations churning between plans. DHCS should have a process in place to enforce such frequency limitations.
- DHCS stated during the stakeholder webinar that the financing structure for the program is still under development. Plans respectfully ask that the Department start conversations with health plans as soon as possible and keep plans appraised of options under consideration (e.g., supplemental capitation, blended into rates, etc.).

OTHER POLICY CONSIDERATIONS

- There is concern that positive results may lead to patient dismissals from practices, as the medical-legal burden for the provider may pose excessive risks. This may lead to additional access issues for the members and plan.
- One recommendation is to consult the Medical Board regarding the risks involved for providers. For example, could an unintended consequence be increased grievances filed with the Medical Board against providers who use this tool but do not take action?
- There is no question in the proposal regarding to children or teens who are addressing matters related to sexual orientation. Children and teens in California often experience trauma related to sexual orientation, leading to behavioral health issues and homelessness. This may be a gap in the current tool that could be addressed.
- Some plans would also recommend consideration of payments to medical groups in addition to individual providers to account for more integrated models of care. This would incentivize system integration as well as cut down on administrative costs plans must cover to appropriately review and direct payments.

Please contact me should you have any questions or need additional information.

Sincerely,

Wendy Soe
Vice President, State Programs
California Association of Health Plans