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March 22, 2019

Jennifer Kent, Director
Department of Health Care Services
1501 Capitol Ave., MS 0000
P. O. Box 997413
Sacramento, CA 95899-7413

Via Email: DHCS_PMMB@dhcs.ca.gov

RE: Comments re Proposition 56 Trauma Screenings and Developmental Screenings

Dear Jennifer:

I am writing on behalf of the National Health Law Program (NHeLP) concerning the Proposition 56 Developmental and Trauma Screening proposals, as part of the Governor's proposed 2019-20 Budget. NHeLP protects and advances the health rights of low-income and underserved individuals. We appreciate the opportunity to comment on these important new proposals. Screening children and youth under age 21, as required by the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) entitlement, is critical for children and youth, and greater attention on complying with these requirements is needed by DHCS and the plans. In addition, the one-time use of a trauma screen for adults on Medi-Cal is a welcome addition.

1. Developmental Screenings for Children ages 0 to 30 months.

Despite the fact that developmental screenings are already required for all children in accordance with the state's EPSDT mandate, and that Medi-Cal managed care plans are currently obligated by contract to ensure these screening services are provided for Medi-Cal eligible children within this age range, we recognize that the low Medi-Cal reimbursement rates may make it less likely to occur. In fact, screening rates in California are well below average when compared to other states, as highlighted in the recent State Auditor's report on preventive services for children on Medi-Cal.[1] Furthermore, while early childhood screenings are

essential, all screenings required at developmental periods, as well as inter-periodically as necessary, should be done for all children on Medi-Cal, not only at these 3 periods during early developmental stages. Nevertheless, we support the Administration's focus on EPSDT and it's efforts to improve screening rates for very young children by increasing the rates providers are paid for the screenings and establishing a CPT code which can be used to track results.

We make the following specific recommendations to the developmental screening proposal:

- **Expand the screening proposal target population** to include financial incentives for developmental, including behavioral health, screenings at other periodicity schedule periods from age 3-20.
- **Improve the quality and reliability of encounter data** collection and reporting by managed care plans. Paying more to plans/providers to incentivize screening does not ensure data is being accurately reported from providers to the plans and to DHCS.
- **Verify that the rate increases go directly to the providers** and not only to the plans as capitation increases.
- **Require the use of a statewide (or state approved) standardized screening tool.** The proposal appears to allow the plans or providers to utilize any tool as long as it meets AAP and CMS established criteria. Tools should be validated, as well as consistent statewide so results can be comparable from plan to plan and region to region. The state should be required to approve any deviations from the prescribed tool.
- **Screenings should be allowed at all periodicity schedules (through age 20) without prior authorization.** Requiring TARs or TAR overrides may create barriers to completing screens.
- **DHCS should increase monitoring of plans' compliance with EPSDT (and contract) screening obligations** by ensuring plans informing and outreach materials to members specifically address this requirement and through specific targeted audits. Additional oversight should also include plans' compliance with all EPSDT contractual obligations.
- **DHCS should collect developmental screening results.** While not a part of this proposal, screenings are a pathway to identify when children and youth need additional follow-up diagnostic and treatment services. DHCS has no way to determine whether such services are being provided, when determined necessary as a result of a screening, because the results and outcomes from the screenings are not tracked. This is a critical omission.

[1] https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf

2. Trauma Screening for Children and Adults.

The proposal to establish additional funding for Medi-Cal providers to conduct a new (and separate) trauma screen for children and youth is a critical addition, and consistent with the state's EPSDT obligations. We strongly support this proposal to require providers to conduct such a screenings annually, as well as more frequently as necessary, and we support the development of a CPT code to track it's use statewide. The addition of a one-time trauma screen for adults on Medi-Cal is also a welcome benefit.

We make the following specific recommendations to the trauma screening proposal:

- **Amend plan contracts to ensure trauma screenings are required to be conducted annually.** Trauma screening should be part of the required screenings under EPSDT, and therefore should be annually required as are other screenings (e.g. behavioral), as well as at more frequent intervals when medically necessary. To require this screening only be conducted every three years is insufficient to address trauma that may occur or manifest from experiencing ACEs at any point during childhood or youth.
- **Expand the Approved Screening Tools to be consistent with the AB 340 Trauma Screening Workgroup recommendations.** The AB 340 Workgroup recommended that Medi-Cal providers be given three options for screening pediatric patients for exposure to trauma: 1) The Bay Area Research Consortium (BARC) assessment tool which focuses on trauma items only; 2) The Whole Child Assessment (WCA) tool which adds trauma items to other required elements of the Staying Healthy Assessment; and 3) An alternative tool to screen for trauma that meets minimum requirements and is approved by DHCS**.**
- **Combine the trauma screening tool (BARC, or other approved trauma-only screening tool) with the annual developmental screening tool (Staying Healthy Assessment (SHA)).** In order to ensure trauma screenings are conducted by primary care providers as part of the required annual screen of members, a single combined screening tool that is validated should be developed and tracked. Therefore, the BARC should be combined with the SHA to reduce the paperwork burden. Augmented funding for providers should continue.
- **DHCS should conduct a study to determine whether the funding allocated for the child/youth screening is adequate** to ensure it occurs as required. It is unclear how the amount of $29 per screen was determined to be adequate and more study is needed during implementation.
- **Trauma screening results should be tracked and DHCS should publish the screening rate results.** While not a part of this proposal, DHCS acknowledges that trauma and ACEs have a significant impact on mortality, health and wellbeing. DHCS must require plans to identify and track when children and youth need additional follow-up diagnostic and treatment services as a result of trauma screens. DHCS has no way to determine whether such services are being provided, when determined necessary as

a result of a screening, because the results and outcomes from the screenings are not being tracked. This is a critical next step.

- **The tool for adults trauma screenings should be consistent and approved by DHCS in advance**. Unlike with the trauma screening tool for children and youth, allowing the plans or providers to utilize a screening tool of their choice is a mistake. A lengthy process was undertaken by the AB 340 Workgroup convened by DHCS to determine the appropriate and consistent tool to be used for such screenings. Allowing multiple alternative tools means there will be no ability to track results of the screenings at a later date.
- **Additional funding is needed for provider training and education** on the use and implementation of the tool. Given this is a new screening obligation on Medi-Cal providers, there needs to be education and training on the appropriate use of the tool. The curriculum for the training should be developed by those entities who designed and are familiar with the BARC tool.

Thank you for the opportunity to comment on the proposal. Please feel free to contact me at lewis@healthlaw.org or (310) 736-1653 if you have any questions.

Sincerely,

Kim Lewis,
Managing Attorney