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

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**DATE:** March 2, 2018

ALL PLAN LETTER 18-006
SUPERSEDES ALL PLAN LETTER 15-025

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT COVERAGE FOR MEMBERS UNDER THE AGE OF 21

**PURPOSE:**
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about the provision of medically necessary Behavioral Health Treatment (BHT) services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.[1] This APL supersedes APL 15-025.

**BACKGROUND:**
BHT is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior.[2] BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are based on reliable evidence and are not experimental. BHT services include a variety of behavioral interventions that have been identified as evidenced-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant to Section 1905(a)(4)(B) of the Social Security Act (SSA) for EPSDT.[3, 4] Section 1905(r) of the SSA defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic and treatment services for low-income individuals under 21 years of age. States are required

[1] See Title 42 of the United States Code (USC), Section 1396d(a)(4)(B). 42 USC is available at: http://uscode.house.gov/browse/prelim@title42&edition=prelim
[2] See California Government Code (GOV), Section 95021, at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=95021.
[3] The CMS Informational Bulletin dated July 7, 2014, is available at: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf.
[4] Section 1905 of the SSA is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

to provide any Medicaid covered service listed in Section 1905(a) of the SSA that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to ensure that children receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. When medically necessary, states may not impose limits on EPSDT services and must cover services listed in Section 1905(a) of the SSA regardless of whether or not they have been approved under a State Plan Amendment (SPA).

CMS guidance clarified that all children must receive EPSDT screenings designed to identify health and developmental issues as early as possible. All children enrolled in Medicaid (Medi-Cal) must be screened at regular intervals in accordance with recommendations for preventive pediatric health care developed by the American Academy of Pediatrics "Bright Futures" guidelines. When a screening examination indicates the need for further evaluation of a child's health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay.

On September 30, 2014, in response to CMS guidance and in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c), the Department of Health Care Services (DHCS) included BHT services as a Medi-Cal covered benefit for members under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist, after a diagnosis of Autism Spectrum Disorder (ASD).[5, 6] In 2016, over the course of several months, DHCS completed the transition of BHT services for members with an ASD diagnosis from the Department of Developmental Services (DDS) Regional Centers (RCs) to the MCPs.

Upon renewals for the 1915(c) Home and Community-Based Services Waiver and 1915(i) Home and Community-Based Services SPAs, CMS asserted that under the EPSDT benefit, Medi-Cal must cover medically necessary BHT services for all members under 21 years of age.[7] Accordingly, effective July 1, 2018, MCPs are

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[5] 42 CFR 440.130(c) defines "preventive services" as "services recommended by a physician or other licensed practitioner of the healing arts within the scope of authorized practice under state law to— (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency". 42 CFR, Part 440, is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=5a4149f390cdecf30c385d48cb76202d&mc=true&node=pt42.4.440&rgn=div5

[6] ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called ASD in the Diagnostic and Statistical Manual (DSM) V.

[7] Home and Community-Based Services 1915(c) Waiver and 1915(i) SPAs are available at: http://www.dds.ca.gov/waiver/index.cfm

responsible for providing medically necessary BHT services for all members that meet the eligibility criteria for services as stated in 1905(r) of the SSA and outlined in this APL, even without a diagnosis of ASD, based upon medical necessity as determined by a licensed physician and surgeon or a licensed psychologist.

On July 1, 2018, DHCS will transition the provision of medically necessary BHT services for eligible members under 21 years of age without an ASD diagnosis from the RCs to the MCPs. Members receiving BHT services through DDS prior to July 1, 2018, will continue to receive the RC-coordinated BHT services at the RCs until the transition date. Beginning on July 1, 2018, the authorization and payment of BHT services will transition from the RCs to the MCPs.

**POLICY:**
In accordance with existing Medi-Cal contracts and federal EPSDT requirements, MCPs are responsible for the provision of EPSDT services for members under 21 years of age (see APL 18-007,[8] *Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21* for additional information). MCPs must:

1) Inform members that EPSDT services are available for members under 21 years of age.
2) Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, in accordance with the most current Bright Futures periodicity schedule, including, but not limited to:
   - a health and developmental history
   - a comprehensive unclothed physical examination
   - appropriate immunizations
   - lab tests and lead toxicity screening
   - screening services to identify developmental issues as early as possible.
3) Provide access to medically necessary diagnostic and treatment services, including but not limited to, BHT services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist.

The provision of EPSDT services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of MCPs effective on the date of the member's transition from the RC or, for new members, upon MCP enrollment. MCPs must ensure

[8] DHCS All Plan Letters are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the MCP contract.

**CRITERIA FOR BHT SERVICES:**
In order to be eligible for BHT services, a Medi-Cal member must meet all of the following coverage criteria:

1) Be under 21 years of age.
2) Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
3) Be medically stable.
4) Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

MCPs are responsible for coordinating the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services.

**COVERED SERVICES:**
Medi-Cal covered BHT services must be:

1) Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
2) Delivered in accordance with the member's MCP-approved behavioral treatment plan.
3) Provided by California State Plan approved providers as defined in SPA 14-026.[9]
4) Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

BHT services are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and that has been developed by a BHT Service Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider. The behavioral treatment plan may be modified if medically necessary. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

[9] California SPAs are available at:
http://www.dhcs.ca.gov/formsandpubs/laws/Pages/ApprovedSPA.aspx

The following services do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:

1) Services rendered when continued clinical benefit is not expected.
2) Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
3) Treatment whose sole purpose is vocationally- or recreationally-based.
4) Custodial care. For purposes of BHT services, custodial care:
   - Is provided primarily for maintaining the member's or anyone else's safety.
   - Could be provided by persons without professional skills or training.
5) Services, supplies or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas and camps.
6) Services rendered by a parent, legal guardian or legally responsible person.
7) Services that are not evidence-based behavioral intervention practices.

**BEHAVIORAL TREATMENT PLAN:**
BHT services must be provided, observed and directed under an approved behavioral treatment plan.

The approved behavioral treatment plan must meet the following criteria:

1) Be developed by a BHT Service Provider for the specific member being treated.
2) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
3) Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
4) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
5) Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
6) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
7) Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).

8) Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
9) Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.
10) Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11) Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12) Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community.
13) Include an exit plan/criteria.

**CONTINUITY OF CARE:**
Continuity of care requirements for new members who did not receive BHT services from an RC prior to July 1, 2018, are set forth in APL 18-008*, Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care*.

Members under 21 years of age transitioning from an RC to an MCP will not have to independently request continuity of care from the MCP. Instead, the MCP must automatically initiate the continuity of care process prior to the member's transition to the MCP for BHT services. At least 45 days prior to the transition date, DHCS will provide MCPs with a list of members for whom the responsibility for BHT services will transition from RCs to MCPs, as well as member-specific utilization data. The utilization data file will include information about services and rendering providers recently accessed by members. MCPs will be required to utilize the data and treatment information provided by DHCS, the RC, or the rendering provider to determine BHT service needs and associated rendering providers. This information should be used to determine if the current BHT provider is in the MCP's network and if a continuity of care arrangement is necessary. MCPs must make a good faith effort to proactively contact the provider to begin the continuity of care process.

An MCP must offer members continued access to an out-of-network provider of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:

1) The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider at least one time during the six months prior to either the transition of services from the RC to the MCP or the date of the member's initial enrollment in the MCP if enrollment occurred on or after July 1, 2018.
2) The provider and the MCP can agree to a rate, with the minimum rate offered by the MCP being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.
3) The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the MCP's network.
4) The provider is a California State Plan approved provider.
5) The provider supplies the MCP with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

Additionally, if a member has an existing relationship, as defined above, with an in-network BHT service provider, the MCP must assign the member to that provider to continue BHT services.

BHT services should not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by the MCP, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network MCP provider.

If a continuity of care agreement cannot be reached with the RC provider by the date of transition to the MCP, the MCP must appropriately transition the member to a new, in-network BHT service provider and ensure that neither a gap nor a change in services occurs until such time as the MCP approves a new assessment and behavioral treatment plan from an in-network BHT service provider.

**OUTBOUND CALL CAMPAIGN:**
To inform members who are transitioning from RCs of their automatic continuity of care rights, MCPs must conduct an Outbound Call Campaign, as described below.

MCPs must:

1) Call the member (or his/her parent/guardian) after 60-day member informing notices are mailed and prior to the date of transition.
2) Make five call attempts to reach the member (or his/her parent/guardian).
3) Inform the member of the transition and the continuity of care process.
4) Not call members who have explicitly requested not to be called.

**REPORTING AND MONITORING:**
MCPs must report metrics to DHCS related to the requirements outlined in this APL in a manner determined by DHCS.

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 applicable APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

For questions regarding this APL, contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services