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Department of Health Care Services



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DATE:

All Plan Letter XX-XXX

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT
COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM
DISORDER

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about requirements pertaining to the provision of Behavioral Health Treatment (BHT) services to Medi-Cal beneficiaries under 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

BACKGROUND:

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 ASD¹. Currently, the Centers for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.

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 (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to provide coverage to individuals eligible for the EPSDT benefit for any Medicaid covered service listed in section 1905(a) of the Act 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

¹ See Diagnostic and Statistical Manual (DSM) V.

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 Act regardless of whether or not they have been approved under a State Plan Amendment.

All children must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. All children enrolled in 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. Ultimately, the goal of EPSDT is to ensure children receive the health care they need, when they need it.

In response to the CMS guidance and in accordance with 42 CFR 440.130(c), the Department of Health Care Services (DHCS) issued guidance (APL 14-011) on September 15, 2014 to include BHT services as a covered Medi-Cal benefit for beneficiaries 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 ASD to the extent required by the federal government. BHT services, such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services, prevent or minimize the adverse effects of ASD, and promote, to the maximum extent practicable, the functioning of a beneficiary with ASD.

Beneficiaries receiving BHT services at the Regional Centers prior to September 15, 2014 continued to receive BHT services there until such time a transition plan was developed by DHCS and the Department of Developmental Services (DDS). Beginning on February 1, 2016, the provision of BHT services will transition from the Regional Centers to the MCPs over a six-month period according to the number of beneficiaries in the MCP's county.

PROGRAM DESCRIPTION AND PURPOSE:

BHT means evidence-based interventions, professional services and treatment programs that prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a beneficiary. BHT is the design, implementation, and evaluation of environmental modification 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. 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 services based on reliable evidence and are not experimental. BHT services are designed to treat ASD, and 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.

POLICY:

In accordance with existing contracts, MCPs are responsible for the provision of EPSDT services for members under 21 years of age. MCPs shall: (1) inform members that EPSDT services are available for beneficiaries under 21 years of age, (2) provide comprehensive screening and prevention services 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, lead toxicity screening, at designated intervals or as may become necessary if circumstances suggest variations from normal development), and (3) provide diagnosis and based upon recommendation of a licensed physician and surgeon or a licensed psychologist treatment for ASD including all medically necessary services, including but not limited to, BHT services.

The provision of EPSDT services for MCPs' beneficiaries under 21 years of age that includes medically necessary evidence-based BHT services that prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a beneficiary, will become the MCPs' responsibility effective on the beneficiary's transition date. MCPs shall ensure that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the MCP's contracts.

CONTINUITY OF CARE:

For new beneficiaries receiving BHT services who did not receive services from a Regional Center prior to September 15, 2014, continuity of care follows requirements as set forth in APL 15-019.

For beneficiaries transitioning from a Regional Center, MCPs must implement an automatic continuity of care request for them. This means that beneficiaries do not have to request continuity of care; instead the MCP must initiate it. DHCS and DDS will provide MCPs with confirmation on the list of beneficiaries for whom responsibility for BHT services will transition from the Regional Centers to the MCPs. If data are not available, MCPs will identify service needs and current providers when contacting beneficiaries by phone during the call campaign prior to the transition. Additionally, DHCS will provide the MCPs with beneficiary-specific utilization, diagnosis and assessment data at least 45 days prior to the transition. This file will include information about services currently accessed by beneficiaries and the providers offering them. DHCS expects MCPs to use DHCS-supplied utilization data to determine the beneficiary's service needs and enter into continuity of care agreements. MCPs must make a good faith effort to proactively contact the provider(s) to begin the continuity of care process. If data are not available, MCPs will identify service needs and current providers when contacting beneficiaries by phone during the call campaign prior to the transition. If a continuity of care agreement cannot be reached, the MCP must establish a warm handoff to the new BHT provider and ensure that no gaps in services occur until such time that the MCP approves a new assessment.

An MCP shall offer continuity of care with an out-of-network provider to beneficiaries for up to 12 months in accordance with existing contract requirements and APL 15-019 if all of the following circumstances exist:

- The beneficiary has an existing relationship with a qualified autism service provider. An existing relationship means a beneficiary has seen an out-of-network provider at least one time during the six months prior to responsibility of BHT services being transitioned from the RC to the MCP, or the date of the beneficiary's initial enrollment in the MCP if enrollment occurred on, or after, September 15, 2014;
- The provider is willing to accept payment from the MCP based on the current Medi-Cal fee schedule;
- The MCP does not have any documented quality of care concerns that would cause it to exclude the provider from its network;
- The provider is a California State Plan approved provider as defined in Health & Safety Code section 1374.73; and
- The provider supplies the MCP with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

BHT services will not be discontinued during a continuity of care evaluation. MCPs shall ensure continuity of care with an out-of-network provider even if a comprehensive diagnostic evaluation has not been completed. Pursuant to Health & Safety Code section 1373.96, BHT services must continue until MCPs have established a behavioral treatment plan.

Outbound Call Campaign

To inform beneficiaries who are transitioning from the Regional Center of their automatic continuity of care rights, DHCS is instructing MCPs to perform an Outbound Call Campaign to transitioning beneficiaries from the Regional Centers using the following criteria:

1. Call campaign effective start date of December 1, 2015 on a rolling basis over a period of 6 months based on the MCP's transition schedule.
2. Calls shall be made to beneficiaries between the 30 and 60 day notices. For example, call attempts should begin between December and January to reach beneficiaries transitioning in February.
3. The number of call attempts is defined as follows:
 - a. 5 call attempts after the 60-day notices are mailed.
 - b. MCPs can follow up between the transition date and 30 day notice period if the beneficiary has not been reached.

- c. If the beneficiary initiates the contact with the plan, the call would count as contact made as long as the plan addresses the points below.
4. Calls shall be made using the MCP's own script as long as the following points are addressed:
 - a. Inform the beneficiary of the transition
 - b. Inform the beneficiary of the continuity of care process
 - c. Encourage the beneficiary to sign the consent form which will allow their treatment information to be shared with the plan
5. Do not call beneficiaries who have explicitly requested not to be called.
6. DHCS will provide instructions for the reporting requirements and the reporting template separate from this APL.

CRITERIA FOR BHT SERVICES:

In order to be eligible for BHT services, a Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:

1. Be under 21 years of age;
2. Have a diagnosis of ASD based upon a comprehensive diagnostic evaluation (CDE)²
 - a. For individuals under 3 years of age, a rule out or provisional diagnosis is acceptable to receive BHT services.
3. Have a recommendation from a licensed physician or a licensed psychologist that evidence-based BHT services are medically necessary;
4. Be medically stable; and
5. 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).

For individuals diagnosed with ASD, under the age of 3 with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, the plan must ensure appropriate referrals are made to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services, respectively.

² A Comprehensive Diagnostic Evaluation performed by a licensed physician or licensed psychologist with training and direct experience assessing children with developmental disabilities (developmental or neuro-psychologist preferred):

- Comprehensive unclothed medical examination (by the primary care physician/pediatrician as required by EPSDT);
- A parent/guardian interview;
- Direct play observation;
- Review of relevant medical, psychological, and/or school records;
- Cognitive/developmental assessment;
- Measure of adaptive functioning;
- language assessment (by a speech language pathologist),
- sensory evaluation (by and occupational therapist); and,
- If indicated, neurological and/or genetic assessment to rule out biological issues (by a developmental pediatrician, pediatric neurologist and/or geneticist).

COVERED SERVICES:

Medi-Cal covered BHT services must be:

1. Medically necessary as defined by Welfare & Institutions Code Section 14132(v).
2. Prior authorized by the MCP or its designee; and
3. Delivered in accordance with the beneficiary's MCP approved behavioral treatment plan.
4. MCPs will comply with current contract requirements relating to coordination of care with Regional Centers and SELPA for Regional Center services and supports and/or special education services and Local Education Agencies to ensure the delivery of medically necessary BHT services.

Services must be provided and supervised under an MCP approved behavioral treatment plan developed by a contracted and MCP- credentialed "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3). Treatment services may be administered by one of the following:

1. A qualified autism service provider as defined by H&S Code section 1374.73(c)(3).
2. A qualified autism service professional as defined by H&S Code section 1374.73(c)(4) who is supervised and employed by the qualified autism services provider.
3. A qualified autism service paraprofessional as defined by H&S Code section 1374.73(c)(5) who is supervised and employed by a qualified autism service provider.

BHT services are provided under a prior authorized behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider. The behavioral treatment plan shall be reviewed, revised and/or modified no less than once every six months by a qualified autism service provider and prior authorized by the MCP for a time period not to exceed 180 days. Additional service authorization must be received to continue the service(s). BHT services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.

Beneficiary progress shall be reported monthly to MCP' designees using a MCP determined standardized reporting format in accordance with the beneficiary's behavioral treatment plan to reflect the beneficiary's progress and response to BHT services. The behavioral treatment plan may be modified early if necessary. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or are no longer medically necessary.

BHT services must be provided, observed and directed under an approved behavioral treatment plan. The 14 BHT services that have been identified as evidence-based are described in Phase 2 of the National Standards Project³.

³ National Autism Center. (2015). *Findings and conclusions: National standards project, Phase 2*. Randolph, MA: Author www.nationalautismcenter.org

The behavioral treatment plan shall:

1. Be developed by a qualified autism service provider for the specific beneficiary being treated;
2. Include a description of patient information, reason for referral, brief background information (demographics, living situation, home/school/work information), clinical interview, review of recent assessment/reports, assessment procedures and results, focused or comprehensive ABA requirements;
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. Each goal must 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 in treating ASD, tailored to the beneficiary;
9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent or guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the beneficiary's progress is measured and reported, transition plan, crisis plan, and identifies the individual providers responsible for delivering the services;
10. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable;
11. The beneficiary's age, school attendance requirements, and other daily activities must be considered when determining the number of hours of direct service and supervision, up to a total of 40 hours each week;
12. BHT services must be delivered in a home or community-based settings, including clinics, and are limited to direct observation in schools.
13. Include exit plan/criteria.

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. Providing or coordinating 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

- a. for purposes of BHT services, custodial care:
 - i. is provided primarily for maintaining the recipient's or anyone else's safety; and
 - ii. 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:
 - a. resorts;
 - b. spas; and
 - c. camps.
6. Services rendered by a parent, legal guardian, or legally responsible person.
7. Services that are not evidence-based practices used in the treatment of ASD.

REIMBURSEMENT:

A monthly supplemental payment will be paid to MCPs for each reported Medi-Cal beneficiary in that given month who received BHT services in accordance with the requirements outlined in this APL and the applicable provisions of the MCP contract. This monthly supplemental payment includes funding for all associated BHT components including the CDE, assessment and prescribed BHT services, and an adjustment for administration and underwriting gain.

Subject to federal approval and the terms of the MCP contract, the monthly supplemental payment will be retroactively applied to BHT services provided by MCPs to Medi-Cal beneficiaries effective September 15, 2014. Any future rate adjustments for BHT services will be applied retroactively to the associated time period of service.

DELEGATION OVERSIGHT:

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements, as well as DHCS guidance, including APLs.

REPORTING AND MONITORING:

MCPs shall report to DHCS, at a minimum, utilization of BHT services, number of beneficiaries transitioning from the Regional Centers, and percent of beneficiaries reached for the outbound call campaign in a manner specified by DHCS. DHCS will issue a reporting template with instructions separate from this APL to MCPs.

For questions about this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

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