Department of Health Care Services

Behavioral Health Treatment (BHT) Services

Stakeholder Meeting
Thursday, September 4, 2014
3:00 pm – 5:00 p.m.
1500 Capitol Avenue
Auditorium

Today's Presentation

- Welcome
- Meeting Purpose
  - Welfare & Institutions Code Section 14132.56
  - Health & Safety Code Section 1374.73
- State and Federal Medically Necessary/Medical Necessity Definitions
  - WIC Code
  - CMS Glossary
- Summary of CMS Informational Guidance
  - Early Periodic Screening, Diagnostic and Treatment Services
- Interim Guidance to Medi-Cal Providers and Managed Care Plans
  - Comments Due by September 9, 2014
- Draft State Plan Amendment
  - Comments due no later than September 29, 2014
- Questions and Answers
- Open Forum

www.dhcs.ca.gov/services/medi-cal/Pages/BehavioralHealthTreatment.aspx

Welcome

René Mollow, MSN, RN

Deputy Director, Health Care Benefits & Eligibility

Laurie Weaver, Chief

Benefits Division

Sarah Brooks, Chief of the Program Monitoring and Medical Policy Branch

Medi-Cal Managed Care Division

Meeting Purpose

Per W & I Code* §14132.56 *noticing requirements

❖**DHCS is required to perform the following in development of the benefit**:

- Obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal.
- Seek statutory authority to implement the new benefit in Medi-Cal.
- Seek an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year.
- Consult with stakeholders.

Meeting Purpose

Health & Safety Code Section §1374.73 authority for BHT

(c) For the purposes of this section, the following definitions shall apply:

- (1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Meeting Purpose

In consultation with stakeholders, the Department will develop and define:

- Eligibility criteria
- Provider participation criteria
- Utilization controls, and
- The delivery system for BHT services

Subject to the limitations allowed under federal law

State and Federal Medically Necessary/ Medical Necessity Definitions

State Definition:

- **W&I Code 14059.5**: A service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
-

Federal Definition (CMS Glossary):

- Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and are not mainly for the convenience of you or your doctor.

Summary of CMS Informational Guidance

- On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant 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 and medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

- All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible.

Interim Guidance to Medi-Cal Managed Care Plans

- The purpose of the guidance is to provide MCPs with interim policy guidance for providing BHT services to Medi-Cal children and adolescent beneficiaries 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

- This guidance mirrors the implementation of BHT services for commercial plans in California.

- In accordance with existing contracts, Medi-Cal MCPs are responsible for the provision of EPSDT services and EPSDT Supplemental Services for Members 0 to 21 years of age, including those who have special health care needs.

- Plans are responsible for covering all medically necessary mandatory and supplemental EPSDT services for beneficiaries 0 to 21 years of age, including health education services, vision, dental and hearing services, and various therapies and other long-term services and supports.

Interim Guidance to Medi-Cal Managed Care Plans

- Effective September 15, 2014, this includes medically necessary ABA services for children or adolescents with ASD that meet eligibility criteria for services.

- Future guidance will be issued pertaining to the provision of other BHT services not addressed in this APL.

- MCP beneficiaries 0 to 21 years diagnosed with ASD who are currently receiving BHT services, including ABA services through a Regional Center, will continue to receive these services through the Regional Center until such time that the department and the Department of Developmental Services develop a plan for transition.

- For Medi-Cal beneficiaries receiving ABA services outside of the MCP's network for Medi-Cal services, the MCP shall ensure continuity of care for up to 12 months as long as 1) the provider has no quality of care issues, 2) there is a pre-existing relationship between the provider and beneficiary exists, and the plan and provider can agree to a rate.

Interim Guidance to Medi-Cal Managed Care Plans

- DHCS and the Department of Managed Health Care (DMHC) will coordinate efforts to conduct readiness reviews of MCPs for purposes of ensuring that MCPs are timely providing medical necessary ABA services.

- DHCS and DMHC will engage in a joint decision making process when considering the content of any licensing filing submitted to either department. The departments will work together to issue template language to MCPs, as needed.

- The department will engage in conversations with the MCPs in order to develop capitation rates for the costs associated with the provision of ABA services. Any rate adjustments will be retroactively applied to September 15, 2014.

- To the extent beneficiaries received ABA services from licensed providers between July 7 and up to and including September 14, 2014, and incurred out-of-pocket expenditures for such services, these expenditures shall be submitted to the Fiscal Intermediary for reimbursement of expenditures through the existing *Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)* process.

Draft State Plan Amendment

DHCS made State Plan Amendment (SPA) language available for public comment on August 29th. **Comments are due by September 29th**. SPA language will be formally submitted to the federal Centers for Medicare and Medicaid (CMS) on September 30, 2014.

- DHCS will work with stakeholders to address public comments submitted.

- Medicaid State Plan
  - State's contract with CMS to administer the Medicaid Program
  - Includes mandatory provisions as well as options elected by states (eligibility groups, optional services, etc.)
  - State plan amendments are necessary to make any changes to eligibility, coverage, or reimbursement methodologies.

Draft State Plan Amendment

- Medicaid State Plan Requirements
  - Sufficient to reasonably achieve purpose of service
  - Cannot be reduced based on diagnosis, type of illness or condition
  - Comparability
  - Statewideness

- State's retain authority to:
  - Define the services to be provided
  - Define the eligibility for the services
  - Ensure services are provided by qualified practitioners
  - Describe the reimbursement methodology

CMS will have 90 days to act on the SPA once it is formally submitted. The addition of BHT will only be implemented to the extent that federal financial participation is available and necessary federal approvals are obtained.

Questions and Answers

Open Forum

- ***Continuity of Care***
- ***Co-Occurring Diagnoses***
- ***Network Adequacy***
- ***Provider Rates***
- ***Education of Primary Care Providers***
- ***Consumer Experience***
- ***Open Discussion***

**** Comments will be limited to 2 minutes per topic/per stakeholder***

Next Steps

If you have questions or would like to provide comments related to the SPA or interim guidance to MCPs, contact DHCS at:

Email Address:

ABAinfo@dhcs.ca.gov

Stakeholder Meeting Schedule

October 16, 2014 3:00 p.m. – 5:00 p.m. Department of Health Care Services Auditorium	November 18, 2014 3:00 p.m. – 5:00 p.m. Department of Health Care Services Auditorium
December 19, 2014 3:00 p.m. – 5:00 p.m. Department of Health Care Services Auditorium	January 22, 2015 3:00 p.m. – 5:00 p.m. Department of Health Care Services Auditorium

Behavioral Health Treatment webpage