DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: November 22, 2023

ALL PLAN LETTER 23-010 *(REVISED)*
SUPERSEDES ALL PLAN LETTER 19-014

TO: ALL MEDI-CAL MANAGED CARE 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 for Members under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, as outlined in APL *23-005* or any superseding APL, and in accordance with mental health parity requirements. This APL clarifies that the MCP has primary responsibility for ensuring that all of a Member's needs for Medically Necessary BHT services *covered under Medicaid,* are met across environments, including on-site at school or during virtual school sessions. For example, if educational BHT services provided to a Member by school-based Providers have been discontinued during the COVID-19 Public Health Emergency (PHE), the MCP must ensure that Medically Necessary BHT services are provided. The MCP is responsible for coordinating with other entities and covering *gaps in Medically Necessary BHT services covered under Medicaid for the Member. The Department of Health Care Services (DHCS) recognizes there are specific services that are carved out of the MCP contract and are the responsibility of other entities such as those under the Department of Education (schools), or County Mental Health Plans (MHP), or California Children's Services for non-Whole Child Model counties. This APL does not change or override the obligations for which those entities are responsible.* Revised text is found in *italics.*

BACKGROUND:

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance on coverage of BHT services pursuant to federal law.[1] Federal law requires the EPSDT benefit to include a comprehensive array of preventive, diagnostic and treatment services for low-income individuals under 21 years of age, which

[1] The CMS Informational Bulletin dated July 7, 2014, is available at: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf

encompasses BHT services.[2, 3] In accordance with federal EPSDT requirements, Medi-Cal provides coverage for all Medically Necessary BHT services for eligible beneficiaries under 21 years of age. This includes children diagnosed with autism spectrum disorder (ASD) and children for whom a licensed physician, surgeon, or psychologist determines that BHT services for the treatment of ASD are Medically Necessary, regardless of diagnosis.[4, 5]

On March 30, 2016, CMS issued a final rule (CMS-2333-F) that applied certain requirements from the Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. 110-343, enacted on October 3, 2008) to services covered by MCPs. The general parity requirement contained in 42 CFR Section 438.910(b) prohibits treatment limitations for mental health benefits from being more restrictive than the predominant treatment limitations applied to medical or surgical benefits.[6] In accordance with federal law, mental health parity also applies to BHT services.

BHT services for the treatment of ASD are described in California's Medicaid State Plan, Limitations on Attachment 3.1-A, 13c – Preventive Services, BHT, and Attachment 3.1-A, Supplement 6.[7] BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without a diagnosis of ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training,

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[2] See Title 42 of the United States Code (USC), Section 1396d(r). The USC is searchable by code and Section at: https://uscode.house.gov/.
[3] See Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c). CFR is searchable at: https://www.ecfr.gov/cgi-bin/ECFR?page=browse.
[4] 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, childhood disintegrative disorder, pervasive developmental disorder not otherwise specified and Asperger syndrome. These conditions are called ASD in the Diagnostic and Statistical Manual V. (American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013).
[5] For additional information on EPSDT requirements, including the definition of "Medically Necessary," see APL *23-005*: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[6] For additional information on mental health parity, see APL 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services, or any superseding APL.
[7] California's Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx.

modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

POLICY:
For Members under the age of 21, and consistent with APL *23-005* or any superseding APL, MCPs are required to provide and cover, or arrange, as appropriate, all Medically Necessary EPSDT services, including BHT services, when they are covered under Medicaid, regardless of whether California's Medicaid State Plan covers such services for adults. Additionally, MCPs must comply with mental health parity requirements when providing BHT services consistent with APL 22-006 or any superseding APL.

For the EPSDT population, state and federal law define a service as "Medically Necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions.[8, 9] A BHT service need not cure a condition in order to be covered. Services that are considered to maintain or improve the Member's current health condition must be covered to "correct or ameliorate" a Member's condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. MCPs must cover all services that maintain the Member's health status, prevent a Member's condition from worsening, or that prevent the development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Therefore, MCPs must cover BHT services *covered under Medicaid* regardless of whether California's Medicaid State Plan covers such services for adults, when the BHT services have an ameliorative, maintenance purpose.

Medical necessity decisions are individualized. Therefore, MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity. The determination of whether a service is Medically Necessary for an individual Member must be made on a case-by-case basis, taking into account the particular needs of the Member.

MCPs must comply with mental health parity requirements when providing BHT services. Treatment limitations for BHT services may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Additionally, mental health parity requirements stipulate that MCPs must disclose utilization management criteria.

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[8] See 42 USC Section 1396d(r); See also: EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, JUNE 2014 at pp. 23-24, available at: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.
[9] See Welfare and Institutions Code (WIC) Section 14059.5(b)(1). State law is searchable at: https://leginfo.legislature.ca.gov/.

I. CRITERIA FOR BHT SERVICES FOR MEMBERS UNDER THE AGE OF 21

MCPs must use current clinical criteria and guidelines when determining what BHT services are Medically Necessary. MCPs that use commercially available tools, such as InterQual® Criteria, must ensure appropriate independent review of Members' medical needs for BHT services in accordance with EPSDT requirements and medically accepted standards of care.

For example, case-base-case reviews are likely warranted to ensure that care is not inappropriately denied or otherwise restricted or limited. MCPs must not limit BHT services on the basis of school attendance or other categorical exclusions. Blanket limitations or restrictions on benefits and services, such as caps on number of hours, are prohibited. MCPs must disclose the specific criteria on which any denial of authorization is based. While MCPs may use tools to understand criteria and standards of practice, any service denials or limitations must be based on medical necessity and case-by-case review of the Member's health care needs and condition.

When considering a Member's need for BHT services *under Medicaid*, the MCP must ensure the Member:

1) Has a recommendation from a licensed physician, surgeon, or psychologist that evidence-based BHT services are Medically Necessary *and covered under Medicaid;*
2) Is medically stable; and
3) Does not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

II. COVERED SERVICES

BHT services must be:

1) Medically Necessary *and covered under Medicaid;*
2) Provided and supervised in accordance with an MCP-approved behavioral treatment plan that is developed by a BHT service Provider who meets the requirements in California's Medicaid State Plan; and,
3) Provided by a *Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional* who meets the requirements contained in California's Medicaid State Plan.[10]

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[10] See California's Medicaid State Plan, Limitations on Attachment 3.1-A,13c - Preventive Services, BHT, and Attachment 3.1-A, Supplement 6.

Medi-Cal does not cover the following as BHT services under the EPSDT benefit:

1) Services rendered when continued clinical benefit is not expected, unless the services are determined to be Medically Necessary.
2) Provision or coordination of respite, day care, *recreational services*, educational services, or reimbursement of a parent, legal guardian, or legally responsible person (hereinafter, "Guardian") for costs associated with participation under the behavioral treatment plan.
3) Treatment where the sole purpose is vocationally- or recreationally-based.
4) Custodial care. For purposes of BHT services, custodial care:
    a. Is provided primarily to maintain the Member's or anyone else's safety; and,
    b. 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 or legal custodian.
7) Services that are not evidence-based behavioral intervention practices.

MCPs are not contractually responsible for educationally necessary BHT services covered by a Local Educational Agency (LEA) and provided pursuant to a Member's Individualized Family Service Plan (IFSP), Individualized Education Program (IEP), or Individualized Health and Support Plan (IHSP). However, if Medically Necessary and *covered under Medicaid*, the MCP must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g., during a PHE).[11] *Lastly, if medically necessary BHT services are otherwise still needed, but the need is not documented in an IEP or IFSP/IHSP, then the MCP may coordinate any needed BHT services in a school-linked setting.*

III. BEHAVIORAL TREATMENT PLAN

BHT services must be provided, observed, and directed under an MCP-approved behavioral treatment plan. The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific Member being treated. The behavioral treatment plan must identify the Medically Necessary services *covered by Medicaid* to be provided in each community setting in which treatment is medically indicated, including on-site at school or during remote school sessions. Medically Necessary BHT services provided under the MCP-approved behavioral treatment plan must be provided by qualified Providers in accordance with California's Medicaid State Plan. In cases where the MCP-approved behavioral treatment plan includes BHT services provided

[11] IFSP and IEP services are educational services provided pursuant to the Individuals with Disabilities Education Act, 20 USC 1400 et seq. (See definition at 20 USC Section 1401).

during school hours, the MCP must ensure effective coordination with the LEA, as necessary. The Provider of BHT services must review, revise, and/or modify no less than once every six months the behavioral treatment plan. If services are no longer Medically Necessary under the EPSDT medical necessity standard, then the behavioral treatment plan must be modified or discontinued.[12] Decreasing the amount and duration of services is prohibited if the therapies are Medically Necessary. MCPs must permit the Member's Guardian(s) to be involved in the development, revision, and modification of the behavioral health treatment plan, in order to promote Guardian participation in treatment.[13]

The approved behavioral treatment plan must also meet the following criteria:

1) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
2) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
3) Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
4) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
5) Include the Member's current level of need (baseline, expected behaviors the Guardian will 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, or modified (include explanation).
6) Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the Member.
7) Clearly identify the service type, number of hours of direct service(s), observation and direction, 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 Provider who is responsible for delivering services.

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[12] See 42 USC 1396d(r); WIC Section 14059.5(b)(1); and EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, JUNE 2014.
[13] MCPs must accommodate legal requirements regarding parental participation that apply generally to providers of BHT services*, but they cannot require participation by parents/guardians.*

8) Include care coordination that involves the Guardian, school, state disability programs, and other programs and institutions, as applicable.
9) 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. However, MCPs must not reduce the number of Medically Necessary BHT hours that a Member is determined to need by the hours the Member spends at school or participating in other activities.
10) Deliver BHT services in a home or community-based setting, including clinics. BHT intervention services provided in schools, in the home, or other community settings, must be clinically indicated, Medically Necessary and delivered in the most appropriate setting for the direct benefit of the Member. BHT service hours delivered across settings, including during school, must be proportionate to the Member's medical need for BHT services in each setting.
11) Include an exit plan/criteria. However, only a determination that services are no longer Medically Necessary under the EPSDT standard can be used to reduce or eliminate services.[14]

IV. COORDINATION OF CARE

MCPs have primary responsibility for ensuring that EPSDT members receive all Medically Necessary BHT services *covered under Medicaid*. MCPs must establish data and information sharing agreements as necessary to coordinate the provision of services with other entities that may have overlapping responsibility for the provision of BHT services, including but not limited to Regional Centers (RCs), LEAs, and County *MHPs*. When another entity has overlapping responsibility to provide BHT services to the Member, the MCP must:

1) Assess the medical needs of the Member for BHT services across community settings, according to the EPSDT standard;
2) Determine what BHT services (if any) are actively being provided by other entities;
3) Coordinate the provision of all services including Durable Medical Equipment and medication with the other entities to ensure that the MCP and the other entities are not providing duplicative services; and
4) Ensure that all of the Member's medical needs for BHT services are being met in a timely manner, regardless of payer, and based on the individual needs of the Member.

Medically Necessary BHT must not be considered duplicative when the MCP has overlapping responsibility with another entity for the provision of BHT services unless the service provided by the other entity is currently being provided, is the

[14] See 42 USC 1396d(r); WIC Section 14059.5(b)(1) and EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, JUNE 2014.

same type of service (e.g., ABA), addresses the same deficits, and is directed to equivalent goals.

MCPs have the primary responsibility to provide all Medically Necessary BHT services *covered under Medicaid*. When services provided by a LEA or RC do not fulfill all of the Member's medical need for BHT services, the MCP must authorize any remaining Medically Necessary services *covered under Medicaid*. MCPs must not rely on LEA programs to be the primary Provider of Medically Necessary BHT services on-site at school or during remote school sessions. Further, MCPs must not assume that BHT services included in a Member's IEP/IHSP/IFSP are actively being provided by the LEA. The MCP is responsible for determining whether such services continue to be provided by the LEA, and must provide any Medically Necessary BHT services that have been discontinued by the LEA, for example during a PHE.

If a Member's IEP team concludes that MCP-approved BHT services are necessary to the Member's education, the IEP team must determine that MCP-approved BHT services must be included in the Member's IEP.[15, 16] MCPs are reminded that services in a Member's IEP must not be reduced or discontinued without formal amendment of the IEP.[17, 18] If the MCP-contracted Provider determines that BHT services included in a member's IEP are no longer Medically Necessary, the MCPs are not authorized to use Medi-Cal funding to provide such services.[19] However, the MCP is solely financially responsible for providing, or coordinating with the LEA to provide, any BHT services included in a Member's IEP until such time that the IEP is amended. In addition, MCPs must coordinate with the LEA to ensure that BHT services that are determined to be no longer Medically Necessary are removed from the IEP as MCP-provided services upon amendment of the IEP.

The MCP is encouraged to attempt to obtain written agreement from the LEA to timely take over the provision of any MCP-approved BHT services included in the IEP upon a determination that the services are no longer Medically Necessary. As an alternative, the MCP may coordinate with the LEA to contract directly with a school-based BHT services practitioner, if the practitioner is enrolled in Medi-Cal and otherwise qualified as required by this APL, to provide any Medically Necessary BHT services included in a Member's IEP. The MCP may reimburse the LEA for the school-based Provider's services only to the extent the services continue to meet the

[15] See 20 USC Section 1414.
[16] See Education Code (EC) Section 56345.
[17] See 20 USC Section 1415; Section 7586.
[18] See EC Section 56380; and Government Code Section 7586.
[19] See MCP Contract. MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. See also: 42 CFR 438.210; WIC 14059.5; 34 CFR 300.154(d), (h).

EPSDT standard of medical necessity. Contracting with a school-based practitioner in these circumstances minimizes disruption of educational IEP services in the event the services are determined no longer Medically Necessary.[20]

While BHT does not specifically include prescription drug therapy, children with ABA are likely to have prescription drug therapy as part of their treatment regimen. The MCPs is required to ensure Members have access to and support medication adherence for the carved-out prescription drug benefit.

The MCP is the primary Provider of Medically Necessary BHT services for Members eligible for EPSDT. Whenever Members are unable to receive BHT services from school-based Providers or other entities with overlapping responsibility for the provision of BHT services, the MCP is responsible for covering gaps in Medically Necessary services *covered under Medicaid* for the Member.[21] MCPs are required to provide case management and coordination of care to ensure that Members can access Medically Necessary BHT services. For example, when school is not in session, MCPs must cover Medically Necessary BHT services that were being provided by the LEA when school was in session.

For more information on MCP coordination of care requirements for BHT services, please refer to APL *23-005* or any superseding APL.

V. CONTINUITY OF CARE

MCPs must offer Members continued access to out-of-network Providers of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL *23-022*: Continuity of Care for Medi-Cal *Beneficiaries* Who *Newly Enroll* in Medi-Cal Managed Care *from Medi-Cal Fee-For-Service, on or After January 1, 2023*, or any superseding APL.

VI. TIMELY ACCESS STANDARDS

[20] US Department of Education, Final Rule (FR). Assistance to States for the Education of Children With Disabilities, 78 FR 10525 (2013), at 10531: "We remind public agencies [educational agencies] that they may not reduce or delay providing the services in a child's IEP solely because the State's public benefits or insurance program determined that the services required in the child's IEP are not Medically Necessary or not covered under the public benefits or insurance program. If the services are not Medically Necessary under Medicaid, a public agency would not receive reimbursement for them. But the public agency is not relieved of its responsibility under Part B to ensure that all required services in the IEP are provided at no cost to the parents, even if that means using Part B funds or sources of support other than the child's or parent's public benefits or insurance in order to ensure that the child receives all required services at no cost to the parents."
[21] Instances where schools or other entities may not be able to provide BHT services include, but are not limited to, PHEs.

MCPs must provide BHT services in accordance with timely access standards, pursuant to WIC Section 14197 and the MCP contracts.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD Contract Manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are further responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[22] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL *23-012*, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

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[22] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.