CALIFORNIA DEPARTMENT OF
Mental Health

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November 8, 2002

DMH INFORMATION NOTICE NO.: 02-08

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: CHANGES IN MEDI-CAL REQUIREMENTS FOR THERAPEUTIC BEHAVIORAL SERVICES

The Department of Mental Health (DMH) is issuing this notice to inform mental health plans (MHPs) and interested stakeholders of DMH's intent to change the requirements for delivery of and reimbursement for therapeutic behavioral services (TBS) through the Medi-Cal program. DMH will be requiring MHPs to establish MHP payment authorization systems for TBS, providing additional guidance for determining and documenting the need for TBS, and describing TBS-related issues that are still under consideration. DMH intends that the new requirements detailed in this letter apply to TBS delivered on or after January 1, 2003. The changes will be implemented via an amendment to the DMH/MHP contracts. DMH, in consultation with the Department of Health Services (DHS), will continue to review the issues and may include some of the requirements in regulations at Title 9, California Code of Regulations (CCR), Division 1, Chapter 11, at a later date. These changes are intended to ensure more consistent implementation of TBS statewide with the overall goal of improving quality and accountability for these Medi-Cal specialty mental health services.

Basic Principles

The basic principles for the delivery of TBS as described in DMH Letter No. 99-03 dated July 23, 1999, remain unchanged; however, there are changes in specific procedural requirements, particularly related to on-going review of the services. Changes will be noted in this notice under the relevant heading. DMH is not changing the reporting and informing requirements of DMH Letter No. 01-03 dated August 8, 2001; DMH Letter No. 01-07 dated November 16, 2001; and DMH Information Notice No. 00-03 dated

June 23, 2000. MHPs must also continue to follow the general requirements for the management of Medi-Cal specialty mental health services as described in state and federal laws and regulations and the DMH/MHP contracts.

TBS is an intensive one-to-one, short-term outpatient treatment intervention for children and youth with serious emotional problems or mental illness who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care. Medi-Cal coverage of TBS is required by Emily Q. v. Bontá, (C.D.Cal., 2001, CV 98-4181 AHM (AIJx)). The Judgment and Permanent Injunction in the case was entered May 11, 2001.

TBS is intended to be a short-term intervention provided in the course of a child or youth's overall mental health treatment. The interventions are provided to address an immediate and specific need (behaviors or symptoms) in the child or youth's life that place the child or youth at risk of placement at a higher level of residential care or to enable a transition from any of those levels to a lower level of residential care. TBS should not be provided once the behaviors or symptoms TBS was intended to address have been resolved or reduced to an acceptable level and no additional behaviors or symptoms that place the child or youth at risk have been identified. TBS must be therapeutic in nature. TBS may not be provided as non-therapeutic safety monitoring or other types of attendant care. Caution must be taken, even with medically necessary TBS, to ensure that counter-productive dependency is not fostered.

Authorization Requirements

Previously, MHPs have not been required to have a formal authorization system for any non-hospital services. Title 9, CCR, Section 1830.215, established the criteria for an MHP payment authorization system, but does not require the MHP to establish the system for any particular services. Many MHPs use MHP payment authorization functions for specialty mental health services delivered by their individual and group providers, but allow organizational providers to make treatment decisions without formal authorization from the MHP. On October 1, 2002, DMH issued DMH Information Notice No. 02-06, which established MHP payment authorization requirements for day treatment intensive and day rehabilitation to begin January 1, 2003.

Effective January 1, 2003, the DMH/MHP contract will require MHPs to establish or use their existing MHP payment authorization systems for TBS. MHPs must require providers, including MHP staff, to request initial and on-going MHP payment authorization as described below. MHPs will not be permitted to delegate the authorization function to providers. In the event that the MHP is the TBS provider, the MHP will be required to assure that the authorization process does not include staff

involved in providing TBS. MHPs will need to require providers to submit MHP payment authorization requests prior to the end of the specified hours or days in the current authorization period and will need to make timely decisions on these requests to ensure there is no break in medically necessary services to the beneficiary.

MHPs should note the decisions of the MHP payment authorization process are subject to the notice of action (NOA) requirements of Title 9, CCR, Section 1850.210, and, when required by Title 9, CCR, Section 1850.215, the continuation of services pending a fair hearing decision. When applicable, the NOA must advise the beneficiary of the right to request continuation of previously authorized services pending the outcome of a Medi-Cal fair hearing if the request for hearing is timely.

The MHP payment authorization requirements in this notice replace the MHPs' obligations under DMH Letter No. 99-03, page 6, to review the TBS component of a beneficiary's client plan monthly. The MHP payment authorization process provides for ongoing clinical review of TBS by the provider and the formal review of the provider's decisions by the MHP payment authorization function.

Authorization

- MHPs must require providers to request MHP payment authorization for TBS in advance of the delivery of the services included in the authorization request.

- MHPs must approve or deny the MHP payment authorization request in advance of service delivery for the first authorization and subsequent reauthorizations of TBS.

- Both the initial authorization and subsequent reauthorization decisions must be made by a licensed practitioner of the healing arts (LPHA) as required by Title 9, CCR, Section 1830.215.

- MHPs are encouraged to make authorization decisions within three working days of MHP payment authorization request whenever possible; however, authorization decisions to approve or deny the initial authorization or subsequent reauthorizations for TBS must be completed by the MHP within 14 calendar days.

- If the request for MHP payment authorization is denied, modified, deferred, reduced or terminated, an NOA must be provided to the beneficiary.

- MHPs retain the authority to set additional standards necessary to manage their programs, including but not limited to establishing maximum hours for individual TBS service components (e.g., assessment, client plan development, and collateral services). MHPs may not, however, establish standards that would prevent the

delivery of medically necessary TBS.

Initial Authorization

The initial MHP payment authorization may not exceed 30 days or 60 hours, whichever is less. The initial authorization will cover the provider conducting an initial TBS assessment, which must identify at least one symptom or behavior TBS will address; developing an initial TBS client plan, which must identify at least one TBS intervention; and providing the initial delivery of direct one-to-one TBS.

Reauthorization

- MHP reauthorizations for TBS may not exceed 60 days or 120 hours whichever is less.

- When the provider received an initial authorization for 30 days or 60 hours, the provider's first request for reauthorization must include a TBS client plan that meets the criteria specified in the "TBS Client Plans" section of this notice.

- When the provider's initial request for MHP payment authorization includes a completed TBS assessment and TBS client plan, the MHP may authorize TBS services consistent with the limits of this section, i.e., an initial MHP payment authorization request that covers direct one-to-one TBS that are fully supported by an assessment and TBS client plan may be approved for 60 days or 120 hours, whichever is less.

- Reauthorizations must be based upon clear documentation of the following and any additional information from the TBS provider required by the MHP:

    - The child or youth's progress towards the specific goals and timeframes of the TBS client plan. A strategy to decrease the intensity of services and/or to initiate the transition plan and/or terminate services when TBS has been effective for the child or youth in making progress towards specified measurable outcomes identified in the TBS plan or the child or youth has reached a plateau in benefit effectiveness.

    - If applicable, the child or youth's lack of progress towards the specific goals and timeframes of the TBS client plan and changes needed to address the issue. If the TBS being provided to the child or youth has not been effective and the child or youth is not making progress as expected towards identified goals, the alternatives considered and the reason that only the approval of the requested additional hours/days for TBS instead of or in addition to the

alternatives will be effective.

- The review and updating of the TBS client plan as necessary to address any significant changes in the child or youth's environment (e.g., a change in residence).

- The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

- To facilitate any requests for reauthorization that may be necessary, the MHP and the provider should consider establishing a date certain for initiating reauthorization requests at the time each MHP payment authorization request is approved.

- When the MHP approves a fourth MHP payment authorization request for a beneficiary, the MHP is required to provide a summary of the TBS services provided, justification for the additional authorization and a termination plan with clearly established timelines and benchmarks, including a planned date for termination of TBS, in writing to the Mental Health Director for the MHP of the beneficiary and to the DMH Deputy Director, Systems of Care, within five working days of the authorization decision.

Implementation of Authorization Requirements
MHPs will be required to implement these MHP payment authorization requirements effective January 1, 2003, for beneficiaries whose initial referral for TBS occurs on or after January 1st. For beneficiaries who were receiving direct one-to-one TBS or who had been referred to a provider that would provide both the initial assessment of the need for TBS and direct one-to-one TBS prior to January 1, 2003, the MHPs must complete the reauthorization for on-going TBS by March 1, 2003.

TBS Documentation
All documentation (assessments, client plans, progress notes) in client charts must be consistent with the DMH/MHP contract, Exhibit A, Attachment 1, Appendix C; DMH Letter No. 99-03, Section VI, "Client Plan and Documentation Requirements;" and the requirements identified in Title 9, CCR, Division 1, Chapter 11. This notice does not establish new requirements for content of TBS documentation, but provides additional guidelines and clarifications to the TBS-specific requirements of DMH Letter No. 99-03.

DMH will issue sample forms for documenting assessments, client plans and progress notes that MHPs may use, if they meet the MHP's needs. More information on these forms will be provided in the next few weeks. In the future, DMH will be considering suggestions from some stakeholders that the State establish required or approved forms for these functions. MHPs and other stakeholders will be consulted before any action is taken in this area.

TBS Assessment

Assessment activities are both initial and on-going components of all specialty mental health treatment. Initial and on-going assessments of the need for TBS may be accomplished as a part of the overall assessment of a child or youth's mental health needs or through a separate assessment specifically targeted to determining whether TBS is needed. Consistent with DMH Letter No. 99-03, Section III, "Criteria for Medi-Cal Reimbursement for Therapeutic Behavioral Service", an assessment for specialty mental health services, either focused on TBS or with TBS consideration as a component, must be comprehensive enough to identify that the child or youth meets medical necessity criteria, is a full-scope Medi-Cal beneficiary under 21 years of age, and is a member of the certified class; that there is a need for specialty mental health services in addition to TBS; and that the child or youth has specific behaviors and/or symptoms that require TBS. Assessments must:

- Identify the child or youth's *specific* behaviors and/or symptoms that jeopardize continuation of the current residential placement or the *specific* behaviors and/or symptoms that are expected to interfere when a child or youth is transitioning to a lower level of residential placement.

- Describe the critical nature of the situation, the severity of the child or youth's behaviors and/or symptoms, what other less intensive services have been tried and/or considered, and why these less intensive services are not or would not be appropriate.

- Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement or to successfully transition to a lower level of residential placement and can be expected to provide a level of intervention necessary to stabilize the child or youth in the existing residential placement or to address behaviors and/or symptoms that jeopardize the child or youth's transition to a lower level of care.

- Identify what changes in behavior and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated.

- Identify skills and adaptive behaviors that the child or youth is using now to manage the problem behavior and/or is using in other circumstances that could replace the specified problem behaviors and/or symptoms.

Concrete identification of behaviors and interventions in the assessment process is the key component necessary to developing an effective TBS client plan.

TBS Client Plans

A TBS client plan may be a separate client plan for the delivery of TBS or a component of a more comprehensive client plan. The TBS client plan is intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the child or youth as identified by the assessment process. TBS client plans must include:

- Clearly specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.

- A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan.

- A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes.

- A specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results.

- A transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving client plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.

- As necessary, a plan for transition to adult services when the beneficiary turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

- If the beneficiary is between 18 and 21 years of age, notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

A clear and specific TBS client plan is a key component in ensuring effective delivery of TBS.

TBS Client Plan Addendum
A client plan addendum or other mechanism should be used to document the following situations:

- There have been significant changes in the child or youth's environment since the initial development of the TBS client plan.

- The TBS provided to the child or youth has not been effective and the child or youth is not making progress as expected towards identified goals. In this situation, there must be documented evidence in the chart and any additional information from the provider indicating that they have considered alternatives, and only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective.

TBS Progress Notes
Progress notes should clearly and specifically document the occurrence of the specific behaviors and/or symptoms that threaten the stability of the residential placement or prevent transition to a lower level of residential placement, the delivery of the significant

interventions identified in the TBS client plan, and the progress being made in stabilizing the behaviors and/or symptoms by changing or eliminating maladaptive behaviors and increasing adaptive behaviors. Documentation continues to be required once each day that TBS is delivered. Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time. The time of service may be noted by contact/shift.

Minimum Qualifications for Providers
TBS providers must meet the organizational provider qualifications already established in Title 9, CCR, Section 1810.435, and in the DMH/MHP contract, Exhibit A, Attachment 1, Section K, as implemented by each MHP. In addition, both individuals who assess beneficiaries to determine the need for TBS and individuals who provide direct TBS interventions must meet the requirements of the Judgment and Permanent Injunction in Emily Q. v. Bontá, which requires that TBS provides have training in behavior analysis with an emphasis on positive behavioral interventions. DMH has worked with the California Institute of Mental Health (CIMH) to develop a training series on the principles of functional behavioral analysis and positive behavioral interventions as they relate to

TBS. The training for TBS assessors is currently underway. Training for individuals who provide direct TBS interventions is being developed. Additional information on options for meeting the training requirements will be provided by DMH in the near future.

Coordination Between TBS and Other Services

Based on the needs of the child or youth, TBS may and should be provided in various home and community settings. DMH encourages maintaining a system of seamless integrated services for all children and youth receiving specialty mental health services. TBS may only be provided to children and youth who are also receiving other specialty mental health services; therefore, there is a potential for the child or youth to be receiving TBS at the same time and location that the child or youth is participating in other programs. The potential for overlap presents both a risk and an opportunity. There is an opportunity to provide a blended array of complementary services to a child or youth as long as the purpose, roles and responsibilities of each program and provider remain distinct enough to provide a clear audit trail. All specialty mental health services, including TBS, must be identified as the appropriate intervention necessary to support the beneficiary's efforts in attaining the objectives necessary to achieving the goals of their client plan(s).

The following information should be considered in situations where there is a risk of confusion about program functions and provider roles:

- The role of the staff providing TBS is to implement the TBS client plan by providing the interventions addressing the specific problem behaviors and/or symptoms TBS is intended to resolve.

- TBS is provided face-to-face by one provider to the one child or youth for whom the services are authorized.

- TBS involves proactive interventions, not general supervision.

- TBS must be provided in a manner that decreases the need for TBS and should not foster dependency.

- TBS staff providing TBS to a child or youth may not provide services to another child or youth during the time period authorized for TBS.

- Transporting a child or youth is not a reimbursable TBS activity. Accompanying a child or youth who is being transported may be reimbursable, depending on the specific circumstances.

- TBS is not intended to supplant the child or youth's other mental health services provided by other mental health staff. For example, TBS staff activities are not

reimbursable as TBS, if the TBS staff “fills in” in the absence of a case manager to work with the child or youth on aspects of their mental health that are not the behaviors and/or symptoms TBS is expected to address. TBS must be clearly differentiated from other mental health services as stabilizing a situation in which a child or youth is at risk of placement in an RCL 12 to 14 group home or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.

- Direct TBS providers delivering TBS in group homes may not be counted in the group home staffing ratio. The TBS provider's function must be clearly differentiated. When the child or youth is a resident of the group home, the child or youth continues to be considered part of the group home census.

- Direct TBS providers delivering TBS at day treatment intensive or day rehabilitation sites may not be counted in the day treatment intensive or day rehabilitation staffing ratio. The TBS provider's function must be clearly differentiated. If the child or youth is receiving day treatment intensive or day rehabilitation as part of the child or youth's client plan, that child or youth would continue to be counted as an attendee in the day program. For example, if 24 clients are in a day treatment intensive program, three qualified staff are required to fulfill the staff-to-client ratio (1:8). If one of those 24 clients is also receiving TBS services during some or all of the day treatment intensive hours, the TBS staff may <u>not</u> be included in the day treatment intensive staff-to-client (1:8) ratio. There must be a total of four staff present during the time TBS is being delivered—one for TBS and three for day treatment intensive.

- It is expected that the direct TBS provider would have contact with the child or youth's parents/caregivers. The TBS provider would be delivering "collateral TBS" when working with the caregiver towards the goals of the child or youth's TBS client plan. Direct TBS providers providing collateral service activities as part of TBS must ensure that the collateral contact meets the requirements of Title 9, CCR, Sections 1810.206 and 1840.314. The contact must be with individuals identified as significant in the child or youth's life and be directly related to the needs, goals and interventions of the child or youth as identified on the TBS client plan.

- Staff providing TBS are not authorized to provide seclusion. Staff providing TBS will follow requirements regarding restraint that are applicable to the setting.

<u>Distinction between TBS and Other One-To-One Services</u>

One-to-one services available in other settings or through other service delivery systems may focus on some of the same problem behaviors and or use some of the same interventions as TBS. At times, TBS is requested or authorized for use in the same settings or to achieve similar goals. In those cases, distinctions must be made as to the purpose of the service to prevent overlap of services, duplicate billing and confusion for

both the beneficiary and the beneficiary's support system. Below are specific distinguishing characteristics among one-to-one services, particularly those that may be provided in group or foster homes and schools.

- The role of caregivers and staff providing TBS are different. Caregivers such as foster parents or group home staff are responsible for the daily care and supervision of the child or youth. The staff providing TBS are responsible for providing mental health interventions to address the behaviors and/or symptoms identified by the TBS client plan.

    - Example:
      It would be the role of the caregiver to assist the child or youth with improving hygiene or learning appropriate table manners. It would be the role of the TBS staff to assist the child or youth with learning to identify early signs of distress that result in behaviors and/or symptoms that interfere with the ability to maintain the daily hygiene or lead to a high level of agitation during meals and place the child or youth at risk of placement at a higher level of care.

- The role of education staff providing services pursuant to an Individualized Education Plan (IEP) and the role staff providing TBS interventions are different. The education staff are responsible for addressing behaviors that interfere with the child or youth's educational goals or that interfere with the rights of other students to an appropriate learning environment. TBS staff are responsible for providing short-term therapeutic interventions necessary to address the behaviors and/or symptoms identified by the TBS client plan that jeopardize continued placement in their current living arrangement or jeopardize transition to a lower level of residential placement. One-to-one services provided through the education system may be planned as long-term services. TBS must be planned as a short-term service and may not be used solely for the purposes of maintaining a child or youth in a school. In addition, TBS is not reimbursable when TBS staff attend IEP meetings focused on the child or youth's education goals.

    - Example of Education One-to-One:
      The student is displaying oppositional defiant behavior in the classroom to the extent that the teacher is not able to give sufficient attention to other students. The student is learning disabled and needs constant assistance to stay on task and not be disruptive to all the other students. A one-to-one educational aide may be needed with this student in the classroom for these reasons.

    - Example of TBS:
      The student is extremely shy, anxious, withdrawn and phobic and has difficulty leaving home, getting to school, remaining in school and relating to others. The student has been hospitalized in the past for suicidal thoughts and for

panic attacks occurring in school. The student has missed so much school that the student is not benefiting from a special education placement. The student's similar behaviors at home have created a risk of placement in an RCL 12 through 14 group home. The student is receiving individual therapy on a weekly basis. The parents are being seen monthly. An assessment has determined that TBS is needed to enable the student to remain at home, to break the pattern of nonattendance at school by helping the student to become more comfortable with the transition from home to school and to helping the student to remain in the classroom once at school.

- Activities that primarily involve passive observation of behavior would not generally be appropriate TBS strategies. Passive observation may be appropriate in limited circumstances, e.g., to gather information that will increase the likelihood of successfully implementing a reward and consequence plan for specific problem behaviors or to provide the final evaluation when the child or youth is being transitioned from TBS.

    - Example of observation activities that would not be TBS:
      TBS worker follows a child through school day although no behaviors have been identified at school that place the child at risk of a higher level residential placement or would prevent the child's transition to a lower level of residential care.

    - Example of observation activities that would be TBS:
      Information is needed to determine more accurately if there are identifiable antecedents that trigger a child or youth's outbursts in the home or at school that place the child at risk of a higher level residential placement.

- One-to-one training in activities of daily living (ADLs) is different from TBS interventions. ADL training focuses on teaching skills appropriate to the skill and developmental level of a child or youth to enable maximum independence and self-care. TBS interventions are focused on ameliorating problem behaviors that interfere with the child or youth using these skills effectively.

    - Example:
      A youth is at risk of placement in an RCL 14 group home because the youth has problems taking the bus to school, including running away from the bus stop and missing school and getting into in fights on the bus. An ADL instructor might work with the youth to develop the skills necessary to get to the bus stop on time (preparation for the day, directions to get to the bus stop), to find a seat (ask right questions, analyze the environment), and to get off at the appropriate stop (reading the schedule, paying attention to landmarks). The TBS staff might work with the youth to identify what

stressors exist that interfere with timely arrival at the bus stop (inability to get out of bed because of depression, inability to leave the house on time due to angry outbursts), what interferes with the youth's ability to maintain self-control on the bus (inability to deal with peers, acting-out behaviors) and what predisposes the youth to running away from school at the bus stop (exacerbated anxiety about school attendance).

Statewide Maximum Allowance

DMH intends to request that DHS establish a separate Statewide Maximum Allowance (SMA) for TBS. The specifics of the SMA and what will be covered are under development. Information will be provided as it becomes available. The change in the SMA will require that DHS submit a State Plan Amendment to the Centers for Medicare and Medicaid Services and modify Title 22, CCR, Section 51516. DMH intends to provide at least 90 days notice to MHPs before implementing a new SMA.

Conclusion

DMH expects to issue DMH/MHP contract amendments to the MHPs in November 2002, with the amendments effective January 1, 2003. DMH will continue to evaluate the implementation of TBS to ensure that TBS continues to serve its intend purpose. Additional changes may be implemented in the future as determined by DMH. MHPs are encouraged to consult with DMH as needed to resolve any questions or concerns regarding implementation of the changes. Please contact your contract managers in the Technical Assistance and Training Section below for assistance.

DMH Technical Assistance and Training Contract Managers

Bay Area Region	Ruth Walz	(707) 252-3168
Central Region	Anthony Sotelo	(916) 651-6848
Northern Region	Jake Donovan	(916) 651-9867
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Sincerely,

Original Signed by

Wm. DAVID DAWSON
Chief Deputy Director

cc: California Mental Health Planning Council
Chief, Technical Assistance and Training