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**DATE:** December 3, 2015

ALL PLAN LETTER 15-025  
(SUPERSEDES ALL PLAN LETTER 14-011)

**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 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<sup>1</sup>. Currently, the Centers for Disease Control and Prevention 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 (SSA) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the SSA defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic and treatment services for low-income infants, children and adolescents under 21 years of age. States are required 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

<sup>1</sup> See Diagnostic and Statistical Manual (DSM) V.

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.

All children must receive EPSDT screenings designed to identify health and developmental issues, including ASD, 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.

In response to the CMS guidance and in accordance with Title 42 Code of Federal Regulations Section 440.130(c), the Department of Health Care Services (DHCS) issued interim guidance on September 15, 2014 in APL 14-011 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.<sup>2</sup> BHT services, such as Applied Behavior Analysis (ABA) and other evidence-based interventions, professional services, and treatment programs, 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 through Department of Developmental Services Regional Centers prior to September 15, 2014 continue to receive the Regional Center-coordinated BHT services at the centers, until the transition begins. Beginning on February 1, 2016, the authorization and payment of BHT services will transition from the Regional Centers to the MCPs over an estimated six-month period according to the number of beneficiaries in the MCP's county or counties.

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. 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 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.

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<sup>2</sup> APLs are available at: <http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx>.

**POLICY:**

In accordance with existing Medi-Cal contracts, MCPs are responsible for the provision of EPSDT services for beneficiaries under 21 years of age (see APL 14-017<sup>3</sup> for additional information). To conform to the federal EPSDT requirements, MCPs must: (1) inform beneficiaries that EPSDT services are available for beneficiaries under 21 years of age; (2) provide access to 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 and lead toxicity screening, at designated intervals or as necessary if circumstances suggest variations from normal development; and (3) provide access to comprehensive diagnostic evaluation based upon a recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services, including but not limited to, BHT services.

The provision of EPSDT services for beneficiaries under 21 years of age, which 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 responsibility of MCPs effective on the beneficiary's transition date from the Regional Center or upon MCP enrollment for beneficiaries with ASD that do not meet Regional Center criteria. MCPs must ensure that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the contract.

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.

**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 requirements are set forth in APL 15-019.

For beneficiaries under 21 years of age with a diagnosis of ASD transitioning from a Regional Center, MCPs must automatically generate a continuity of care request. Beneficiaries will not have to independently request continuity of care from the MCP; instead the MCP must initiate the continuity of care process prior to the beneficiary's transition to the MCP for BHT services. DHCS will provide MCPs with a list of beneficiaries for whom the responsibility for BHT services will transition from the Regional Centers to the MCPs. DHCS will also provide MCPs with beneficiary-specific

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<sup>3</sup> DHCS All Plan Letter 14-017 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf>

utilization data at least 45 days prior to a beneficiary transitioning. This utilization data file will include information about services recently accessed by beneficiaries and the rendering providers. MCPs will be required to utilize the data and treatment information provided to them by DHCS, the Regional Center 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(s) to begin the continuity of care process.

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

1. 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 Regional Center to the MCP, or the date of the beneficiary's initial enrollment in the MCP if enrollment occurred on, or after, September 15, 2014;
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 appropriate 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 CMS approved provider; and
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, as long as it is allowable under federal and state privacy laws and regulations.

BHT services will not be discontinued 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 Regional Center provider under continuity of care or a new in-network MCP provider. MCPs must ensure continuity of care even if a comprehensive diagnostic evaluation has not yet been completed for a transitioning beneficiary.

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

**OTHER HEALTH COVERAGE:**

MCPs may utilize their existing processes for determining coordination of benefits for payment of co-pays and deductibles when beneficiaries have commercial Other Health Coverage (OHC) in accordance with the OHC Program Terms and Conditions of the

contract. OHC is to be verified on the Medi-Cal Eligibility Data Systems (MEDS) and/or Automated Eligibility Verification System as an active code. For these beneficiaries in non-county organized health system counties may voluntarily choose to disenroll from the MCP into FFS, if the beneficiary has OHC noted on their MEDS file as comprehensive coverage and reported by a trusted source to DHCS.

DHCS coordinates with many of the commercial carriers in California to identify coverage and update MEDS. If a beneficiary feels that his/her coverage is not accurately identified, the beneficiary can update his/her information.<sup>4</sup>

**OUTBOUND CALL CAMPAIGN:**

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

1. Outbound Call Campaign effective start date is December 1, 2015 on a rolling basis over a period of six months based on the MCP's transition schedule;
2. Calls must be made to beneficiaries (or their guardians/parents) after the 60 day notices are mailed and prior to the transition. 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. Five call attempts after the 60 day notices are mailed and prior to the beneficiary transition date;
  - b. MCPs can follow up between the transition date and 30 day notice period if the beneficiary has not been reached; and
  - c. If the beneficiary initiates contact with the MCP, the call would count as contact made as long as the MCP addresses the points found in (4) below.
4. Calls may be made using the MCP's own script as long as the following points are addressed:
  - a. Inform the beneficiary of the BHT transition to the MCP from the Regional Center;
  - b. Inform the beneficiary of the continuity of care process; and
  - c. Encourage the beneficiary to sign the consent form which will allow his/her treatment information to be shared with the MCP.
5. Do not call beneficiaries who have explicitly requested not to be called; and
6. DHCS will provide instructions for the reporting requirements and the reporting template to MCPs at a later date.

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<sup>4</sup> See this website: [http://www.dhcs.ca.gov/services/Pages/TPLRD\\_OCU\\_cont.aspx](http://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx).

**CRITERIA FOR BHT SERVICES:**

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

1. Be under 21 years of age;
2. Have a diagnosis of ASD based upon completion of a comprehensive diagnostic evaluation (CDE);<sup>5</sup> For individuals under three years of age, a rule out or provisional diagnosis is acceptable to receive BHT services.
3. Have a recommendation from a licensed physician and surgeon 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 who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, the MCP 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. 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 as defined by Welfare and Institutions Code Section 14132(v).
2. Delivered in accordance with the beneficiary's MCP approved behavioral treatment plan.

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<sup>5</sup> 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) consists of the following:

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

Services must be provided and supervised under an MCP-approved behavioral treatment plan developed by a contracted (or other form of agreement between the MCP and provider) and MCP-credentialed “qualified autism service provider,” as defined by H&S Code Section 1374.73(c)(3).

Treatment services may be administered by one of the following California State Plan CMS approved providers:

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; and/or
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 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 must be reviewed, revised and/or modified no less than once every six months by a qualified autism 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 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 Project.<sup>6</sup>

The behavioral treatment plan must:

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 and 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;

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<sup>6</sup> Randolph, MA, National Autism Center. (2015), “Findings and Conclusions: National Standards Project, Phase 2.”: <http://www.nationalautismcenter.org>.

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 in treating ASD, tailored to the beneficiary;
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 beneficiary's progress is measured and reported, transition plan, crisis plan and 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. Consider the beneficiary'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 service that is provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community; and
13. Include an 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. For purposes of BHT services, custodial care:
  - a. Is provided primarily for maintaining the beneficiary'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, legal guardian or legally responsible person; and
7. Services that are not evidence-based practices used in the treatment of ASD.



**REIMBURSEMENT:**

DHCS will pay a monthly supplemental payment 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 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, cost of capital and risk.

Subject to federal approval and the terms of the 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 to the associated time period of service.

**REPORTING AND MONITORING:**

MCPs must report to DHCS, at a minimum, the number of beneficiaries transitioning from the Regional Centers, authorized hours by provider type, BHT services provided, grievances and appeals and the number of beneficiaries reached for the Outbound Call Campaign. DHCS will issue a reporting template with instructions to MCPs at a later date.

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