



KERN HEALTH SYSTEMS

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| KERN HEALTH SYSTEMS | | | | |
| POLICY AND PROCEDURES | | | | |
| SUBJECT: Behavioral Health Therapy and Behavioral Intervention Services | | | POLICY #: 3.72-P | |
| DEPARTMENT: Health Services - Utilization Management | | | | |
| Effective Date: | Review/Revised Date: | DMHC | | PAC |
| 2018 | 04/23/2018 | DHCS | | QI/UM COMMITTEE |
| | | BOD | | FINANCE COMMITTEE |

[Signature]
Chief Executive Officer

Date 4/23/18

[Signature]
Chief Medical Officer

Date 4/20/18

[Signature]
Administrative Director of Health Services

Date 4/19/18

POLICY:

Kern Health Systems (KHS) will develop and implement procedures for the identification and provision of medically necessary Behavioral Health Treatment (BHT) and Behavioral Intervention Services (BHT/BIS) to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Upon renewals for the 1915(c) Home and Community-Based Services Waiver and 1915(i) Home and Community-Based Services State Plan Amendment (SPA), The Centers for Medicare and Medicaid Services (CMS) asserted that under the EPSDT benefit, KHS will cover medically necessary BHT/BIS for all members under 21 years of age.

BHT/BIS are defined as professional services and treatment programs, including but not limited to Applied Behavioral Analysis (ABA) and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with or without the diagnosis of Autism Spectrum Disorder.

The Centers for Medicare and Medicaid Services (CMS) guidance clarified that all children must receive EPSDT screenings designed to identify health and developmental issues 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.

DEFINITIONS:

BHT/BIS 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/BIS teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT/BIS are based on reliable evidence and are not experimental. BHT/BIS 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.

The Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT/BIS pursuant to Section 1905(a) (4) (B) of the Social Security Act (SSA) for 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 individuals 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 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 (SPA).

1.0 PROCEDURES:

In accordance with existing Medi-Cal contracts and federal EPSDT requirements, KHS is responsible for the provision of EPSDT services for members under 21 years of age (see APL 18-007 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the Age of 21 for additional information).

KHS will:

- 1) Inform members that EPSDT services are available for members under 21 years of age.
- 2) Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, 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
 - screening services to identify developmental issues as early as possible.
- 3) Provide access to medically necessary diagnostic and treatment services, including but not limited to, BHT/BIS based upon a recommendation of a licensed physician and surgeon or a licensed psychologist.

The provision of EPSDT services for members under 21 years of age, which includes medically necessary, evidence-based BHT/BIS that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of KHS effective on the date of the member's transition from the Regional Center (RC), or for new members, upon KHS enrollment. KHS will ensure that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in KHS's DHCS contract.

2.0 CRITERIA FOR BHT/BIS SERVICES

In order to be eligible for BHT/BIS, a Medi-Cal beneficiary must meet all of the following coverage criteria: 1) Be under 21 years of age.

- 1) Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT/BIS are medically necessary.
- 2) Be medically stable.
- 3) 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).

KHS is responsible for coordinating the provision of services with the other entities to ensure that KHS and the other entities are not providing duplicative services

3.0 COVERED SERVICES AND LIMITATIONS

Medi-Cal covered BHT/BIS services must be:

- 1) Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
- 2) Delivered in accordance with the member's KHS-approved behavioral treatment plan.
- 3) Provided by California State Plan approved providers as defined in SPA 14-026.9
- 4) Provided and supervised according to a KHS-approved behavioral treatment plan developed by a BHT/BIS provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

BHT/BIS are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and that has been developed by a BHT/BIS Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT/BIS Provider. The behavioral treatment plan may be modified if medically necessary. BHT/BIS may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

The following services do not meet medical necessity criteria or qualify as Medi-Cal covered BHT/BIS for reimbursement:

- 1) Services rendered when continued clinical benefit is not expected.
- 2) Provision or coordination of 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/BIS, custodial care:
 - Is provided primarily for maintaining the member's or anyone else's safety.
 - 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.
- 7) Services that are not evidence-based behavioral intervention practices.

4.0 BEHAVIORAL TREATMENT PLAN

BHT/BIS must be provided, observed and directed under an approved behavioral treatment plan.

The approved behavioral treatment plan must meet the following criteria:

- 1) Be developed by a BHT/BIS Provider for the specific member being treated.
- 2) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT/BIS.
- 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) 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/BIS with demonstrated clinical efficacy tailored to the member.
- 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 member's progress is measured and reported, transition plan, crisis plan, and each individual BHT/BIS provider 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 member'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/BIS in a home or community-based setting, including clinics. Any portion of medically necessary BHT/BIS that are provided in school must be clinically indicated as well as proportioned to the total BHT/BIS received at home and community.
- 13) Include an exit plan/criteria.

5.0 CONTINUITY OF CARE

Continuity of care requirements for new members who did not receive BHT/BIS from an RC prior to July 1, 2018, are set forth in APL 18-008, Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care.

Members under 21 years of age transitioning from an RC to KHS will not have to independently request continuity of care from KHS. Instead, KHS will automatically initiate the continuity of care process prior to the member's transition to KHS for BHT/BIS.

At least 45 days prior to the transition date, DHCS will provide KHS with a list of members for whom the responsibility for BHT/BIS will transition from the RC to KHS, as well as member-specific utilization data. The utilization data file will include information about services and rendering providers recently accessed by members. KHS will be required to utilize the data and treatment information provided by DHCS, the RC, or the rendering provider to determine BHT/BIS needs and associated rendering providers. This information should be used to determine if the current BHT/BIS provider is in KHS's network and if a continuity of care arrangement is necessary. KHS will make a good faith effort to proactively contact the provider to begin the continuity of care process.

KHS will offer members continued access to an out-of-network provider of BHT/BIS (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:

- 1) The member has an existing relationship with a qualified provider of BHT/BIS. An existing relationship means the member has seen the provider at least one time during the six months prior to either the transition of services from the RC to KHS or the date of the member's initial enrollment with KHS if enrollment occurred on or after July 1, 2018.
- 2) The provider and KHS can agree to a rate, with the minimum rate offered by KHS being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT/BIS.
- 3) The provider does not have any documented quality of care concerns that would cause him/her to be excluded from KHS's network.
- 4) The provider is a California State Plan approved provider.
- 5) The provider supplies KHS with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

Additionally, if a member has an existing relationship, as defined above, with an in-network BHT/BIS provider, KHS will assign the member to that provider to continue BHT services.

BHT/BIS should not be discontinued or changed during the continuity of care period until a new

behavioral treatment plan has been completed and approved by KHS, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network KHS provider.

If a continuity of care agreement cannot be reached with the RC provider by the date of transition to KHS, then KHS will appropriately transition the member to a new, in-network BHT/BIS provider and ensure that neither a gap nor a change in services occurs until such time as KHS approves a new assessment and behavioral treatment plan from an in-network BHT/BIS provider.

6.0 OUTBOUND CALL CAMPAIGN

To inform members who are transitioning from RCs of their automatic continuity of care rights, KHS will conduct an Outbound Call Campaign, as described below. KHS will must:

- 1) Call the member (or his/her parent/guardian) after 60-day member informing notices are mailed and prior to the date of transition.
- 2) Make five call attempts to reach the member (or his/her parent/guardian).
- 3) Inform the member of the transition and the continuity of care process.
- 4) Not call members who have explicitly requested not to be called.

7.0 REPORTING AND MONITORING

KHS will report metrics to DHCS related to the requirements outlined in this APL in a manner determined by DHCS.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including applicable APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

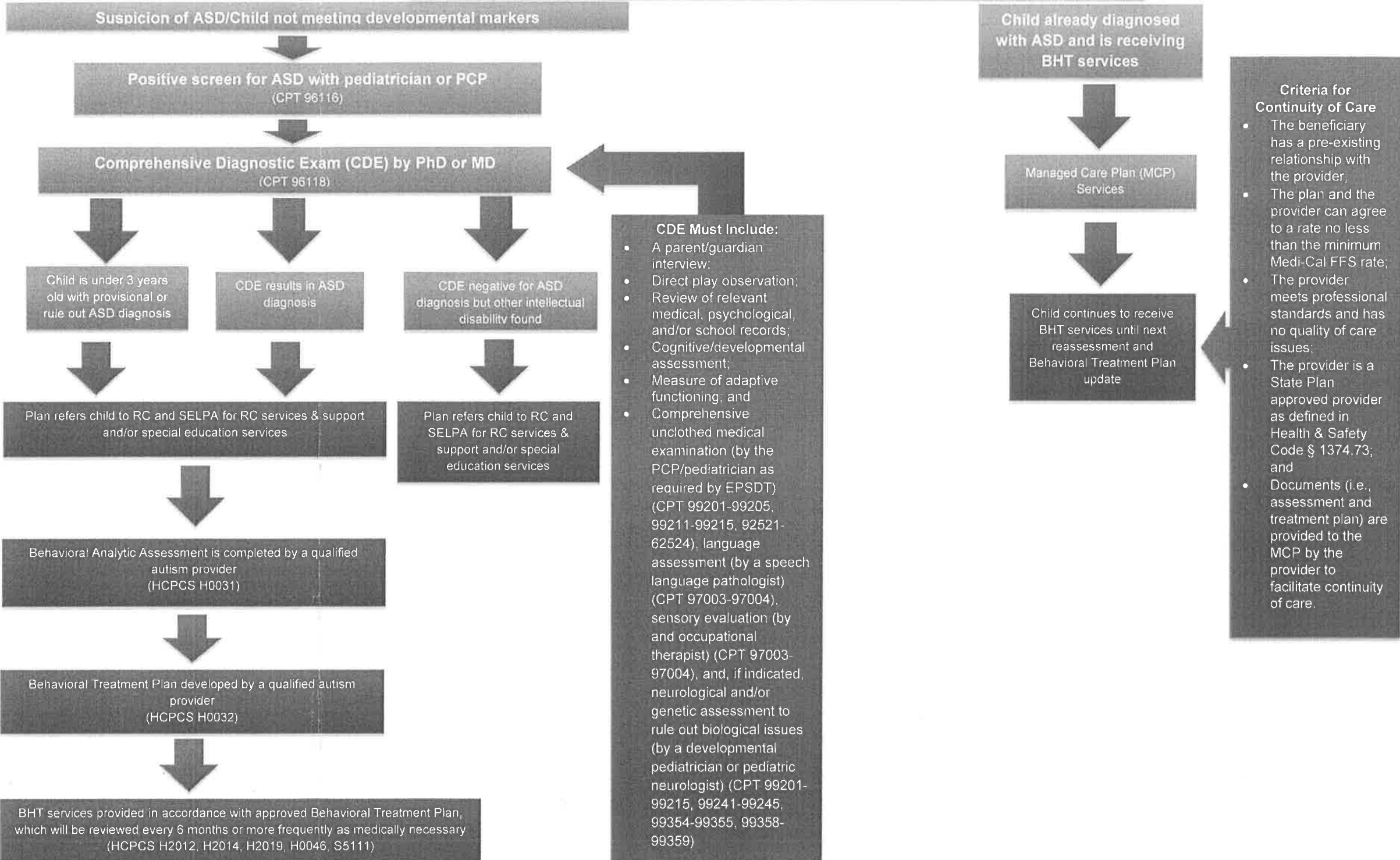
ATTACHMENTS:

- Attachment A: *ASD Screening, Diagnosis and Treatment Protocol*

Revision 04/2018: Revisions provided by Administrative Director of Health Services. Policy created in accordance with APL 18-006. **Revision 01/2018:** Revisions provided by Administrative Director of Health Services. Policy created in accordance with APL 14-011.

20xx DHS Contract A-x(x)
20xx DHS Contract A-x(x)

Autism Spectrum Disorder (ASD) Screening, Diagnosis and Treatment Protocol



CDE Must Include:

- A parent/guardian interview;
- Direct play observation;
- Review of relevant medical, psychological, and/or school records;
- Cognitive/developmental assessment;
- Measure of adaptive functioning; and
- Comprehensive unclothed medical examination (by the PCP/pediatrician as required by EPSDT) (CPT 99201-99205, 99211-99215, 92521-62524), language assessment (by a speech language pathologist) (CPT 97003-97004), sensory evaluation (by and occupational therapist) (CPT 97003-97004), and, if indicated, neurological and/or genetic assessment to rule out biological issues (by a developmental pediatrician or pediatric neurologist) (CPT 99201-99215, 99241-99245, 99354-99355, 99358-99359)

Criteria for Continuity of Care

- The beneficiary has a pre-existing relationship with the provider;
- The plan and the provider can agree to a rate no less than the minimum Medi-Cal FFS rate;
- The provider meets professional standards and has no quality of care issues;
- The provider is a State Plan approved provider as defined in Health & Safety Code § 1374.73; and
- Documents (i.e., assessment and treatment plan) are provided to the MCP by the provider to facilitate continuity of care.