PROVIDER *Update*

CalViva HEALTH | health net

REGULATORY | SEPTEMBER 8, 2023 | UPDATE 23-951m | 4 PAGES

Follow These Guidelines for BHT for Medi-Cal Members Under Age 21

The Plan and its delegated PPGs are responsible for meeting all members' BHT needs across environments

Effective May 4, 2023, the Department of Health Care Services (DHCS) issued guidance to Medi-Cal managed care health plans 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 All Plan Letter (APL) 19-010, *Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21*, or any superseding APL, and in accordance with mental health parity requirements.[1]

What are the Plan and its delegated entities' responsibilities for BHT for members under age 21?[1]

Health Net*, on behalf of CalViva Health, and delegated participating physician groups (PPGs) have primary responsibility for ensuring that all of a member's needs for medically necessary BHT services are met across environments, including on-site at school or during virtual school sessions.

For members under age 21 and consistent with APL 19-010 or any superseding APL, the Plan and its delegated PPGs 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, the Plan and its delegated PPGs 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. 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.

Criteria for BHT services for members under age 21[1]

The Plan and its delegated PPGs must use current clinical criteria and guidelines when determining what BHT services are medically necessary. If the Plan and its

THIS UPDATE APPLIES TO:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers
- Community Support (CS) Providers
- Enhanced Care Management (ECM) Providers

PROVIDER SERVICES

888-893-1569
www.healthnet.com

PROVIDER PORTAL

provider.healthnetcalifornia.com

delegated PPGs use commercially available tools, such as InterQual® Criteria, they must ensure appropriate independent review of members' medical needs for BHT services in accordance with EPSDT requirements and medically accepted standards of care.

When considering a member's need for BHT services, the Plan and its delegated PPGs must ensure the member:

1. Has a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary;
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.

Behavioral treatment plan[1]

BHT services must be provided, observed and directed under a Plan- or delegated PPGs-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 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 approved behavioral treatment plan must be provided by qualified providers in accordance with California's Medicaid State Plan. In cases where the approved behavioral treatment plan includes BHT services provided during school hours, the Plan or delegated PPG must ensure effective coordination with the Local Educational Agency (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. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary. The Plan and its delegated PPGs 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.

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

- 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.
- Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
- Identify measurable long-, intermediate- and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant and based upon clinical observation.
- Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
- 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).
- Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
- 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.

- Include care coordination that involves the guardian, school, state disability programs and other programs and institutions, as applicable.
- 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, the Plan and its delegated PPGs 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.
- Deliver BHT services in a home or community-based setting, including clinics. BHT intervention services provided in schools, 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 needs for BHT services in each setting.
- Include an exit plan/criterion. However, only a determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services.

Coordination of care[1]

The Plan and its delegated entities have primary responsibility for ensuring that EPSDT members receive all medically necessary BHT services. The Plan and its delegated entities must establish data and information sharing agreements as necessary to coordinate the provision of services with other entities that may have overlapped responsibility for the provision of BHT services, including but not limited to Regional Centers (RCs), LEAs and county mental health plans. When another entity has overlapping responsibility to provide BHT services to the member, the Plan and its delegated entity must:

- Assess the member's medical needs for BHT services across community settings, according to the EPSDT standard.
- Determine what BHT services (if any) are actively being provided by other entities.
- Coordinate the provision of all services including durable medical equipment and medication with the other entities to ensure that the Plan, delegated entities and other entities are not providing duplicative services; and
- Ensure that all 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 Plan and/or delegated PPG 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 same type of service [e.g., applied behavior analysis (ABA)], addresses the same deficits and is directed to equivalent goals.

The Plan and its delegated PPGs have the primary responsibility for providing all medically necessary BHT services. When services provided by an LEA or RC do not fulfill all the member's medical needs for BHT services, the Plan or delegated PPG must authorize any remaining medically necessary services. The Plan and its delegated PPGs 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.

Furthermore, the Plan and its delegated PPGs must not assume that BHT services included in a member's Individualized Family Service Plan (IFSP), Individualized Education Program (IEP) or Individualized Health and Support Plan (IHSP) are actively being provided by the LEA. The Plan or delegated PPG 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 (e.g., during a PHE).

If a member's IEP team concludes that Plan- or delegated PPG-approved BHT services are necessary to the member's education, the IEP team must determine that the approved BHT services must be included in the member's IEP. The Plan and its delegated PPGs must keep in mind that services in a member's IEP must not be reduced or discontinued without formal amendment of the IEP. If the Plan- or delegated PPG-contracted provider determines that BHT services included in a member's IEP are no longer medically necessary, the Plan and its delegated PPGs are not authorized to use Medi-Cal funding to provide such services.

However, the Plan and its subcontractors are solely financially responsible for providing, or coordinating with the LEA to provide, any BHT services included in a member's IEP until the IEP is amended. In addition, the Plan and its delegated PPGs must coordinate with the LEA to ensure that BHT services determined to be no longer medically necessary are removed from the IEP as Plan- or delegated PPG-provided services upon amendment of the IEP.

The Plan and its delegated PPGs are encouraged to attempt to obtain written agreement from the LEA to timely take over the provision of any Plan- or delegated PPG-approved BHT services included in the IEP upon a determination that the services are no longer medically necessary.

As an alternative, the Plan or delegated PPG 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 APL 23-010, to provide any medically necessary BHT services included in a member's IEP.

The Plan or delegated PPG may reimburse the LEA for the school-based provider's services only to the extent the services continue to meet the 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.

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 Plan and its delegated PPGs are required to ensure members have access to and support medication adherence for the carved-out prescription drug benefit.

The Plan and its delegated PPGs are the primary providers 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 Plan or delegated PPG is responsible for covering any gap in medically necessary services for the member.

The Plan and its delegated PPGs 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, the Plan and its delegated PPGs must cover medically necessary BHT services that were being provided by the LEA when school was in session. For more information on the coordination of care requirements for BHT services, refer to APL 19-010 or any superseding APL.

Continuity of care[1]

The Plan and its delegated PPGs 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 22-032*, Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care*, or any superseding APL.

The Plan and its delegated PPGs are not contractually responsible for educationally necessary BHT services covered by an LEA and provided pursuant to a member's IFSP, IEP or IHSP. However, if medically necessary, the Plan and its delegated PPG must provide supplementary BHT services and must provide BHT services to address any gap in service caused when the LEA discontinues the provision of BHT services (e.g., during a PHE).

Timely access standards[1]

The Plan and its delegated PPGs must provide BHT services in accordance with timely access standards, pursuant to WIC Section 14197 and the Plan contracts.

Additional information

Relevant sections of the provider operations manuals have been revised to reflect the information contained in this update as applicable. Provider operations manuals are available electronically in the Provider Library on the provider portal at provider.healthnetcalifornia.com > *Provider Library* under Quick Links, or go directly providerlibrary.healthnetcalifornia.com.

[1] Information taken or derived from APL 23-010, *Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21*. www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.