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Via electronic mail

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Department of Health Care Services
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Dear Ms. Cisneros:

We are writing on behalf of the Health Consumer Alliance (HCA), a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the National Health Law Program, and the Western Center on Law and Poverty. The HCA's comments are joined by the American Academy of Pediatrics, California; Autism Deserves Equal Coverage; Autism Health Insurance Project; Autism Speaks; California School-Based Health Alliance; Children Now; Children's Defense Fund-California; Children's Partnership; Disability Rights California; Disability Rights Education and Defense Fund; Maternal Child Health Access; and Public Law Center.

Thank you for the opportunity to comment on the draft APL XX-XXX regarding "Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder." We are extremely disappointed, however, that the draft APL includes several provisions that are inconsistent with federal and state law.

Specifically:

- DHCS may not limit services based on school attendance, or limit the kind of services provided in schools to "direct observation."
- DHCS may not arbitrarily reduce medically necessary hours of treatment based on age or "other activities" of the child.
- DHCS may not place a hard cap on services at 40 hours per week and may not use hours spent receiving other services or engaged in other activities to reduce recommended hours of Behavioral Health Treatment (BHT).
- DHCS may not limit payment for services not authorized by a plan to instances of retroactive eligibility.

- DHCS should not allow plans to authorize treatment for less than 180 days, except in limited cases, and should not require monthly reporting of beneficiary progress.
- DHCS must ensure that enrollees with other health coverage are protected from excess cost-sharing.
- DHCS should not use an overly broad definition of custodial care.
- DHCS may not limit the location of service provision to "conventional" settings.
- DHCS's comprehensive diagnostic evaluation (CDE) requirements are too onerous and should be revised or eliminated; treatment must be authorized in the interim while awaiting a CDE
- DHCS should clarify what qualifies as an "existing relationship" with a provider.
- DHCS should ensure that plans respond to continuity of care requests within three days to eliminate any potential service gaps.
- DHCS should not to limit continuity of care to fee-for-service providers.
- DHCS may not limit provisional diagnoses to those under age 3.

DHCS must immediately amend these provisions, as described in more detail below, to ensure that the APL sets forth a policy that complies with federal and state Medicaid and Mental Health Parity rules. In addition, we recommend that DHCS make improvements to the continuity of care rules set forth in this letter, and make the recommended wording change to insure clarity.

We do appreciate that this draft APL includes several important protections that will help children in Medi-Cal access critically needed BHT services to correct and ameliorate the symptoms and behaviors associated with ASD for thousands of children with ASD. In particular:

- We commend DHCS for requiring Medi-Cal managed care plans (MCPs) to automatically implement continuity of care for beneficiaries whose care is moving from a Regional Center to an MCP to ensure a smooth transition. Draft APL at 3.
- We appreciate that DHCS is instructing MCPs to perform an Outbound Call Campaign to inform transitioning beneficiaries of their automatic continuity of care rights. Draft APL at 4-5. For calls that are not answered immediately, we recommend subsequent calls occur during different times and that a message is left informing beneficiaries of their continuity of care rights.
- We are glad that DHCS has instructed MCPs to comply with existing requirements relating to coordination of care with Regional Centers and Local Educational Agencies, and recommend that DHCS also specifically refer to the requirements set forth in APL 14-017.
- We thank DHCS for specifying that all BHT provider types may provide services, including qualified autism service providers, qualified autism service professionals, and qualified autism service paraprofessionals as defined in the APL and H&S Code section 1374.73(c). Described in more detail below, DHCS should also specify that all of these provider types are eligible to be considered for COC.

- We appreciate that the MCPs are required to report data to DHCS and request it include the number of individuals at each stage of the process as well as the time it takes to move from one part of the process to the next—*i.e.*, time from request to CDE appointment, time from CDE appointment to CDE completion, time from request to assessment, and time from request to service utilization. We ask DHCS share this data with stakeholders on a monthly basis and include a breakdown by plan and county.

It is imperative that current Regional Center consumers continue to receive BHT services in a manner that meets their needs, regardless of whether the service is received through Regional Center or MCP. These provisions of the APL will go a long way to ensuring continuity and access.

Below are our detailed comments.

- **DHCS may not limit services based on school attendance, or limit the kind of services provided in schools to “direct observation.”**

DHCS appears to propose that MCPs can reduce the number of hours offered to school-age children while they are in school. As DHCS has previously recognized, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate of the federal Medicaid Act requires states to offer a broad array of services to children under 21 that is “designed to ensure that eligible 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.”¹ In California, DHCS has delegated responsibility for meeting EPSDT requirements for child enrollees to its contracted MCPs.² Thus, the MCPs have primary responsibility for ensuring that enrollees under 21 have access to the full “range of medically necessary services that is expanded to include [all] necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions.”³ DHCS may not presume that school attendance somehow replaces medically necessary BHT.

¹ Letter from Sarah C. Brooks, Cal. Dep’t of Health Care Servs., to All Medi-Cal Managed Care Health Plans 1 (Dec. 14, 2014) [hereinafter APL 14-017], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf>.

² CAL. DEP’T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR TWO-PLAN COUNTIES, Ex. A, Att. 10 § 5 (2014) [hereinafter TWO-PLAN CONTRACT], <http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf>; CAL. DEP’T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR GEOGRAPHIC MANAGED CARE, Ex. A, Att. 10 § 5 (2014) [hereinafter GMC CONTRACT], <http://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf>; CAL. DEP’T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COUNTY ORGANIZED HEALTH SYSTEMS, Ex. A, Att. 10 § 4 (2014) [hereinafter COHS CONTRACT], <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.

³ APL 14-017 (quoting 42 U.S.C. 1396d(r)(5)).

School attendance is not a valid medical necessity criterion on which a reduction of hours can be based.⁴ EPSDT requires the state to ensure the provision of all medically necessary services to correct or ameliorate any physical or behavioral conditions, and to “prevent disease, disability, and other health conditions or their progression; [p]rolong life; and “[p]romote physical and mental health and efficiency.”⁵ And DHCS has confirmed that MCPs may not reduce services based on the premise that they will be provided by the school, absent proof that a school is in fact providing medically necessary BHT in accordance with professional standards with qualified health care providers consistent with EPSDT.⁶ Under EPSDT neither the state nor its contracted plans are permitted to limit medically necessary care based on a child’s school attendance.⁷ Rather, the state and the plan are directed to coordinate with a child’s school to ensure that the child receives all medically necessary care.

The EPSDT mandate also does not permit DHCS to limit the *type* of medically necessary Medicaid reimbursed services provided in school. If BHT services other than “direct observation” are medically necessary for Medi-Cal enrollees under 21 in school, they must be provided. California regulations set out a detailed list of nine criteria to be used in determining when services including BHT are medically necessary under EPSDT.⁸ When services meet these criteria, MCPs must ensure that the child receives them.⁹ BHT services in school-based settings may be medically necessary for many children with ASD. Unlike some other conditions and treatments, treatment location and setting is frequently an integral part of BHT treatment.¹⁰ Treatment in a school or community setting may be medically necessary as a central part of the treatment plan to ensure treatment goals are met, especially generalization of skills and behaviors across environments; provision of services in schools may also be necessary to meet medically

⁴ See 42 U.S.C. § 1396b(c) (“Nothing in this subchapter shall be construed as prohibiting or restricting. . . payment under subsection (a) of this section for medical assistance for covered services furnished to a child with a disability because such services are included in the child’s individualized education program established pursuant to part B of the Individuals with Disabilities Education Act.”); see also, e.g., *Detsel by Detsel v. Sullivan*, 895 F.2d 58, 66 (2d Cir. 1990) (state may not “preclude a claimant who resides at home from receiving Medicaid reimbursement for [services] rendered during those few hours of each day when her normal life activities take her outside her home to attend school”).

⁵ See APL 14-017 (quoting 42 C.F.R. 440.130(c) and 42 U.S.C. 1396d(r)(5)); see also CAL. WELF. & INST. CODE § 14132(v); CAL. CODE REGS. tit. 22, § 51340(e).

⁶ APL 14-017 (“Where another entity—such as a local education agency (LEA), Regional Center, or local governmental health program—has overlapping responsibility for providing services to an individual under the age of 21, MCPs must assess what level of medically necessary services the individual requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services.”).

⁷ See CMS, Dear State Medicaid Director 13 (Dec. 15, 2014), <http://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>.

⁸ CAL. CODE REGS. tit. 22, § 51340(e)(3).

⁹ TWO-PLAN CONTRACT, at Ex. A, Att. 10 § 5; GMC CONTRACT, at Ex. A, Att. 10 § 5; COHS CONTRACT, at Ex. A, Att. 10 § 4.

¹⁰ See BEHAVIORAL ANALYST CERTIFICATION BOARD, APPLIED BEHAVIOR ANALYSIS TREATMENT OF AUTISM SPECTRUM DISORDER: PRACTICE GUIDELINES FOR HEALTHCARE FUNDERS AND MANAGERS 17 (2015), http://bacb.com/wp-content/uploads/2015/07/ABA_Guidelines_for_ASD.pdf (discussing clinical importance of delivery of ABA services across a range of community settings of significance to the individual, including schools).

necessary treatment hour requirements.¹¹ Providing services in natural settings in which the child functions, such as schools, is also required under the integration mandate of the Americans with Disabilities Act (ADA).¹² Prohibiting school-based BHT treatment and limiting services on a school site to observation violates both EPSDT and the ADA.

- **DHCS may not arbitrarily reduce medically necessary hours of treatment based on age or “other activities” of the child.**

It is axiomatic that the numbers of service hours for direct therapy and supervision must be set based on individualized determinations of medical necessity including such factors as the nature and severity of symptoms and deficits and necessary procedures to address those deficits.¹³ Just as DHCS may not allow MCPs to reduce the number or treatment hours provided to a child based on school attendance, it also may not allow MCPs to consider any other extraneous factors unrelated to the intensity of hours medically necessary for treatment, such as age, or “other activities.” We are not aware of any other condition subject to such limitations on access to medically necessary treatment, which suggests that DHCS has improperly singled out individuals with ASD for discriminatory limitations on treatment based on their diagnosis.¹⁴ This provision plainly violates the Medicaid Act and should be stricken.

- **DHCS may not place a hard cap on services at 40 hours per week and may not use hours spent receiving other services or engaged in other activities to reduce recommended hours of Behavioral Health Treatment (BHT).**

Even if the APL is revised to insure that treatment hours are determined solely by medical necessity, the APL remains fundamentally flawed by capping BHT treatment at 40 hours per week for all services combined including direct treatment and necessary supervision. The EPSDT mandate does not permit states to set “hard caps” on services for children which do not allow children to receive additional services when they are medically necessary.¹⁵ Indeed, the draft APL itself concedes that “States may not impose limits on EPSDT services.” Draft APL at 2. Thus DHCS’s proposed limit on the number of service hours per week a child may receive is unlawful under EPSDT and

¹¹ *Id.*

¹² *Olmstead v. L.C.*, 527 U.S. 581 (1999). Literature supports that individuals with ASD have difficulty generalizing skills across settings. Therefore it is important that individuals receive the intensive ABA treatment across settings to ensure generalization. See, e.g. Eikeseth *et al.*, *Outcome for Children with Autism Who Began Intensive Behavioral Treatment Between Ages 4 and 7: A Comparison Controlled Study*, 31 BEHAVIOR MODIFICATION 264 (2007).

¹³ See CENTERS FOR MEDICARE & MEDICAID SERVICES, EPSDT - A GUIDE FOR STATES: COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS 23-24 (2014) (services must be provided whenever they are “determined to be medically necessary for an individual child”); see also 42 C.F.R. § 440.230(b).

¹⁴ 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. § 440.230(c).

¹⁵ See CENTERS FOR MEDICARE & MEDICAID SERVICES, *supra* note 13 at 23 (“Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements.”), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf; see also 42 C.F.R. §§ 440.230(c), (d); HCFA Dear State Medicaid Director (May 26, 1993); *Mitchell v. Johnston*, 701 F.2d 337, 351 (5th Cir. 1983).

must be eliminated to ensure that children receive all of the services necessary to treat their ASD.

Treatment plans providing for 40 hours a week in direct treatment alone, not including necessary supervision hours, are typically necessary for many children with ASD.¹⁶ Moreover, while 40 hours per week of direct service may be sufficient to correct or ameliorate symptoms associated with ASD for a majority of children, hours above that may be medically necessary for any number of children for some period of time based on individualized determinations of medical necessity.¹⁷ Children whose symptoms are severe are especially likely to need more than 40 hours of services per week. Additional direct service hours or supervision may also be necessary during periods of transition, where new programs or protocols are initiated or new challenging behaviors or other impediments to progress arise.¹⁸ Older children with particularly challenging behaviors—such as extreme wandering or violence toward self or others—sometimes require a two-to-one provider-to-patient ratio, necessitating additional hours. To comply with EPSDT’s mandate that all medically necessary care must be covered, DHCS and its MCPs must authorize more than 40 hours of services per week when medically necessary. The proposed APL’s hard cap on services violates EPSDT and must be eliminated.¹⁹

- **DHCS may not limit payment for services not authorized by a plan to instances of retroactive eligibility.**

DHCS proposes in this APL that “BHT services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.” Draft APL at 6. This rule completely undermines the role of continuing benefits in three ways.

First, benefits must continue pending appeal. Medi-Cal beneficiaries have an absolute right to appeal any termination or reduction of “non-acute continuing services,” which include EPSDT services.²⁰ While such an appeal is pending, beneficiaries have the right to continue receiving services at the current service level through the date through which services were requested by the treating physician, the date a hearing decision is rendered, or the date on which the hearing appeal is withdrawn or closed, whichever is earliest.²¹ Thus, DHCS and its plans must absolutely ensure payment for services, even

¹⁶ See BEHAVIORAL ANALYST CERTIFICATION BOARD, *supra* note 10 at 14, 25; *id.* at 34 (noting that the standard of care requires 2 hours of supervision for every 10 hours of treatment).

¹⁷ See *id.* at 25.

¹⁸ *Id.* at 34.

¹⁹ A hard cap on services also violates the prohibition on quantitative treatment limitations in the Mental Health Parity Addiction & Equity Act. See 42 U.S.C. §§ 1396u-2(b)(8), 1396u-7(b)(6); see also 80 Fed. Reg. 19481-19452 (April 10, 2015) (proposed rule implementing mental health parity requirements to Medicaid Managed Care plans), <http://www.gpo.gov/fdsys/pkg/FR-2015-04-10/pdf/2015-08135.pdf>.

²⁰ CAL. CODE REGS. tit. 22, § 51003(c)(1); see also *id.* § 51014.1; 42 C.F.R. § 438.420.

²¹ CAL. CODE REGS. tit. 22, § 51014.2(d).

if they are provided without prior authorization, when they qualify as continuing services provided while an appeal is pending.

Second, an MCP may occasionally wrongly fail to authorize a request for medically necessary services, necessitating a Medi-Cal beneficiary to pay for services out-of-pocket while appealing the plan's denial. If the MCP's denial is overturned, the plan or the state is liable to reimburse the beneficiary for the cost of care. DHCS must amend the wording in this section to clarify that BHT services provided without prior authorization during the pendency of an appeal disputing a plan's denial, reduction, termination or modification of a request for medically necessary care may be considered for payment or reimbursement.²²

Third, the prior authorization requirement is particularly confusing in the context of the transition of BHT from Regional Centers to MCPs. We have always understood that DHCS did not intend to require transitioning enrollees to obtain a new prior authorization from their MCP when they had an *existing authorization* from the Regional Center at the time of the transition. But the language in the APL suggests instead that transitioning enrollees can only obtain continuing BHT services from their MCP if the MCP first approves the services, by suggesting that services not authorized by an MCP are not eligible for payment. Draft APL at 6; *see also id.* at 4 (during the transition, "BHT services must continue until MCPs have established a behavioral treatment plan"). DHCS must not allow MCPs to require re-authorization of Regional Center-authorized treatment during the transition.

We appreciate that "DHCS expects MCPs to use DHCS-supplied utilization data to determine the beneficiary's service needs and enter into continuity of care agreements." Draft APL at 3. However, DHCS must ensure that MCPs do not require transitioning enrollees to undergo a new evaluation, assessment, or authorization before their current treatment plan expires, even if the MCP and enrollee's existing providers are unable to reach a COC agreement, unless the enrollee requests a new assessment. Any handoff to an in-network BHT provider must not disrupt the current treatment plan for transitioning enrollees and DHCS must ensure that MCPs do not reassess these enrollees until their current treatment plan expires or when the enrollee or treating provider requests a new assessment. The current treatment plan should be implemented until a new treatment plan is developed and approved. DHCS may not require enrollees to undergo a new Comprehensive Diagnostic Evaluation (CDE) due to a transition in payer or provider and MCPs may only initiate change in treatment if the treating provider recommends it as clinically appropriate. Similarly, beneficiaries who change MCPs or IPAs within the same MCP should not be required to undergo a new evaluation or assessment as this would disrupt the current treatment plan. We urge DHCS to clarify that MCPs must comply with rules concerning benefits paid pending appeal, services eligible for retroactive reimbursement, and may not require

²² *See Conlan v. Bonta*, 102 Cal. App. 4th 745, 763 (2002), *as modified on denial of reh'g* (Oct. 29, 2002); *see also* APL 07-002.

transitioning enrollees to undergo a new assessment, evaluation, prior authorization or CDE before receiving services pursuant to an existing treatment plan.

- **DHCS may not allow plans to discontinue treatment if “goals are not met.”**

DHCS must continue to provide BHT services as long as they are medically necessary, without regard to whether a child with ASD has met a particular treatment goal.²³ While we share DHCS’s objective in working to help Medi-Cal enrollees with ASD to meet their treatment goals, it will not be possible for all children to meet all goals all the time. This is particularly true when circumstances beyond the child’s or provider’s control intervene during the course of treatment—for example, when the child becomes ill with a virus, or the child’s family moves, or the child’s beloved pet passes away. A wide variety of external factors may intervene during the course of treatment to make it impossible for children to meet all of the goals set forth at the beginning of treatment. In addition, temporary plateaus or even regression are not uncommon in ABA therapy and in the event of a more sustained lack of progress, MCPs must first consider revisions to the treatment plan, procedures or treating personnel—not discontinuance of therapy. EPSDT does not permit DHCS to punish children in those circumstances by taking away their medically necessary care. Rather, DHCS and its MCPs have an obligation to adjust treatment and treatment goals when necessary in order ensure that children have access to care necessary to “correct or ameliorate” the symptoms associated with their ASD.²⁴

Similarly, treatment may not be discontinued when children meet their treatment goals if new medically necessary goals are identified during the course of treatment. Continued treatment may also be medically necessary to maintain skills and functioning and prevent regression, and this care must be covered pursuant to EPSDT.²⁵

- **DHCS should not allow plans to authorize treatment for less than 180 days, except in limited cases, and should not require monthly reporting of beneficiary progress.**

In the covered services section, MCPs are permitted to require prior authorization more frequently than 180 days. Draft APL at 6. This is inconsistent with the standard of care for BHT. BHT is an intensive treatment that makes incremental progress and the standard treatment plan lasts 6 months in order to track meaningful progress. Shorter authorization periods have the effect of severely constricting access to medically necessary BHT, and for that reason, both the DMHC and CDI have prohibited health plans and insurers from using medically inappropriate short authorization periods for

²³ See, e.g., CENTERS FOR MEDICARE & MEDICAID SERVICES, *supra* note 13 at 10 (“A service need not cure a condition in order to be covered under EPSDT.”).

²⁴ 42 U.S.C. § 1396d(r)(5).

²⁵ See, e.g., *A.M.T. v. Gargano*, 781 F. Supp. 2d 798, 807 (S.D. Ind. 2011); 42 C.F.R. § 440.130(c); CENTERS FOR MEDICARE & MEDICAID SERVICES, *supra* note 13 at 10 (“Services are covered when they prevent a condition from worsening or prevent development of additional health problems.”).

BHT. We strongly urge DHCS to revise this section to require MCPs to authorize treatment for a minimum of 180 days, unless a shorter time authorization period is mutually agreed by the provider and health plan for a specific patient due to patient-specific circumstances, rather than allowing them to authorize treatment for much shorter periods.

Similarly, we are concerned that DHCS proposes in the APL to require providers to make monthly reports to MCPs on enrollees' progress under the treatment plan. We appreciate that providers and MCPs should communicate regularly about enrollees' progress in treatment, and that they must have some degree of flexibility to adapt the course of treatment when needed. But we are deeply concerned that mandatory monthly reporting will only be used as a tool by MCPs to reduce or terminate needed services under the guise of discontinuing care when treatment goals are either achieved or missed.

If DHCS is adamant that MCPs report on enrollees' progress under the treatment plan, those reports should follow the same time frame as treatment authorization (not less than 180 days unless a shorter timeframe is agreed upon by the provider and MCP) and the standards for the report should be developed by DHCS with stakeholder review. Monthly reporting, with formats that vary according to MCP, will place a significant burden on an already strained provider networks, restricting providers' availability to actually provide medically necessary care.

California's prior authorization and utilization management procedures may not delay delivery of needed treatment services and must be consistent with the "preventive thrust" of EPSDT.²⁶ Imposing such discriminatory procedures on access to ASD treatment also contravenes the provisions on non-quantitative treatment limitations contained in the Mental Health Parity and Addiction Equity Act.²⁷ These onerous administrative requirements further discriminate against Medicaid eligible children by significantly inhibiting their access to care in comparison to children fortunate enough to have private insurance, and do not face these hurdles.

- **DHCS must ensure that enrollees with other health coverage are protected from excess cost-sharing.**

We are concerned that COC section does not address the needs of enrollees with other health coverage (OHC). Many Regional Center consumers currently receive BHT through their OHC and rely on the Regional Center to pay their cost-sharing. In the Regional Center system when a child has another source of coverage for BHT, she is

²⁶ See CENTERS FOR MEDICARE & MEDICAID SERVICES, *supra* note 13 at 46.

²⁷ See CENTERS FOR MEDICARE & MEDICAID SERVICES, Proposed Rule regarding Application of Mental Health Parity Requirements on Coverage, 80 Fed. Reg 19418, <http://www.gpo.gov/fdsys/pkg/FR-2015-04-10/pdf/2015-08135.pdf> at p. 19419 (MCOs must comply with MHPAEA); p. 19430 (states applying non-quantitative treatment limitations such as prior authorization requirements to EPSDT services must insure that they are applied consistent with the intent of the MHPAEA).

encouraged, similar to Medi-Cal, to seek BHT from her OHC before seeking services through the Regional Center. But unlike Medi-Cal currently, the Regional Center will then pay the difference between the cost-sharing the child would owe if she saw a Regional Center provider, and any cost-sharing that her OHC requires—even if that provider is not contracted with the Regional Center.²⁸

DHCS, however, has instructed stakeholders that it will only protect MCP enrollees from excess cost-sharing if they receive care from an OHC provider who also accepts their MCP. Under this misguided policy, when the responsibility for a child's services moves from the Regional Centers to Medi-Cal early next year, hundreds of families with OHC will be presented with the Hobson's choice of paying OHC cost-sharing for their child's behavioral health treatment or delaying critical treatment while they try to find a new provider who will accept both their OHC and their Medi-Cal managed care plan—if any such provider is available. We urge DHCS to direct MCPs to work to ensure COC with OHC providers who do not participate in Medi-Cal managed care to the greatest extent possible. DHCS should work with MCPs and OHC providers to ensure a warm-handoff of treatment in cases where the providers and plans cannot reach an agreement over payment. However, regardless of what agreements the MCPs reach on payment with out-of-network BHT providers, DHCS is responsible for covering the cost-sharing required by the OHC of the families of these Medi-Cal beneficiaries as a condition of their accessing BHT services from the OHC.²⁹

- **DHCS must not use an overly broad definition of custodial care.**

We are concerned that criterion (4) of the medical necessity criteria, which prohibits authorization of BHT for custodial care, may be construed to deny access to medically necessary services. Draft APL at 7-8. Where a child's treatment plan includes therapies aimed at developing, maintaining, or restoring skills related to ADLs or safe behavior, those services must be provided, consistent with EPSDT.³⁰

- **DHCS may not limit the location of service provision to "conventional" settings.**

Medical necessity criterion (5) improperly limits the community-based settings in which treatment may be provided to those deemed "conventional." Draft APL at 8. The EPSDT and *Olmstead* mandates require the state to ensure that children receive treatment in the least restrictive, clinically appropriate setting.³¹ Whether a particular community-based setting is deemed "non-conventional" is not part of a medical necessity determination. In fact, many children with ASD do participate in summer camps, and

²⁸ See CAL. WELF. & INST. CODE § 4659.1.

²⁹ 42 U.S.C. § 1396a(a)(25)(C); see also 42 C.F.R. § 447.20(a).

³⁰ 42 U.S.C. 1396d(r)(5); see also 42 C.F.R. 440.130(c).

³¹ See 42 U.S.C. § 1396d(r); *Olmstead v. L.C.*, 527 U.S. 581 (1999); see also CAL. GOV. CODE § 11135; BEHAVIORAL ANALYST CERTIFICATION BOARD, *supra* note 10 at 17 (discussing clinical importance of delivery of ABA services across a range of community settings of significance to the individual).

may require BHT services in that setting as prescribed by their treating provider and documented in their treatment plan. MCPs must not be allowed to deny services to children in those instances simply because the services will be provided at a camp. At a minimum, we ask DHCS clarify camps, e.g. sleep-away camps vs. day camps. Often day camps for children with ASD are in the child's community and the camps help integrate the child into his/her own community through trips to the mall, park, grocery store, etc, even though the camp has a particular home base.

- **DHCS's comprehensive diagnostic evaluation (CDE) requirements are too onerous and should be revised or eliminated; treatment must be authorized in the interim while awaiting a CDE.**

We have serious concerns with the new criteria for CDEs. The draft APL adds restrictive criteria for CDEs that do NOT adhere to the current standard of care for children with ASD as reflected in the National Standards Project Phase 2 (NSP2) best practice guidelines. The NSP2 includes the following components of a CDE: (1) Parent or caregiver interview; (2) Review of relevant medical, psychological, and/or school records; (3) Cognitive/developmental assessment; (4) Direct play observation; (5) Measurement of adaptive functioning; and (6) Comprehensive medical examination.³² The additional criteria not in NSP2 but included in draft APL are: (1) language assessment (by a speech language pathologist); (2) sensory evaluation (by an occupational therapist); and (3) if indicated, neurological and/or genetic assessment to rule out biological issues (by a developmental pediatrician, pediatric neurologist and/or geneticist). Draft APL at 5. These additional requirements conflict with the EPSDT requirements of the Medicaid Act, which require services to be provided when the need for them is revealed by a screen, which includes any encounter with a licensed practitioner.³³ Moreover, these additions are not based on any established clinical evidence or best practices for treating children with suspected ASD.

The addition of these arbitrary components of CDEs is especially troubling given that currently, availability of CDEs for BHT services is severely limited. We are aware that wait times for such evaluations exceed nine months in some parts of the state. California agencies have repeatedly recognized that any significant delay or interruption in treatment for children with ASD can permanently impair development and likely cause irreparable harm.³⁴ California children with commercial insurance plans are not subject to delays in treatment while awaiting a diagnostic evaluation and instead are able to access treatment promptly in accordance with American Academy of Pediatrics

³² NAT'L AUTISM CNTR, NATIONAL STANDARDS PROJECT PHASE 2 (2015), <http://www.nationalautismcenter.org/national-standards-project/phase-2/>.

³³ See CENTERS FOR MEDICARE & MEDICAID SERVICES, *supra* note 13 at 5-6.

³⁴ See CAL. DEP'T MANAGED HEALTH CARE, PERVASIVE DEVELOPMENTAL DISORDER AND AUTISM COVERAGE (2012), https://www.autismspeaks.org/sites/default/files/docs/gr/emergency_regs_justification_memo_for_sb_946_dmhc_regs.pdf; CAL. DEP'T INS., NOTICE OF PROPOSED EMERGENCY ACTION PURSUANT TO GOVERNMENT CODE SECTION 11346.1 AND INSURANCE CODE SECTION 1291 (2013) <http://www20.insurance.ca.gov/epubacc/Graphics/186430.PDF>.

Guidelines.³⁵ Indeed, as with the proposed short term authorizations and monthly reporting requirements discussed above, private insurers are not be permitted to impose such requirements. They should not be allowed in Medi-Cal, either.

To avoid delays in excess of the established wait times for services, we recommend that DHCS withdraw the proposed additional CDE and instead require MCPs to provide services that are recommended by a licensed physician or psychologist while a child waits for a CDE, whenever the wait time for such an evaluation exceeds 15 days. Finally, to the extent that children have already completed a diagnostic examination of some kind, they should not be required to undergo a duplicative evaluation before services may commence.

Should DHCS maintain these burdensome and unnecessary components of the CDE, we urge the department to amend the language to allow other qualified health professionals to perform the language assessment and sensory evaluation, which are currently limited to a speech language pathologist and occupational therapist, respectively. Many other licensed professionals are qualified to perform language assessments and sensory evaluations, including psychiatrists, psychologists, developmental pediatricians, and neurologists acting within the scope of their licensure and competency. Limiting the professionals who can perform these tasks will further delay access to treatment.

- **DHCS should clarify what qualifies as an “existing relationship” with a provider.**

The first criterion of when a MCP must enter into a COC agreement is that the beneficiary must have an “existing relationship with a qualified autism service provider.” Draft APL at 4. We suggest that DHCS expand the definition of providers who are eligible to be considered for COC to also include Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals as these providers are critical to the child’s treatment. In addition, DHCS defines existing relationship as “at least one time during the six months prior to responsibility of BHT services being transitioned from the RC to the MCP”. We recommend DHCS define existing relationship as “at least one time during the twelve months”, consistent with COC offered in other contexts.³⁶

- **DHCS should ensure that plans respond to continuity of care requests within three days to eliminate any potential service gaps.**

We request clarification to the MCPs, that in addition to COC requests being automatic, the COC request be replied to within the 3 day standard for situations likely to cause

³⁵ See Chris Plauché Johnson & Scott M. Myers, *Identification and Evaluation of Children with Autism Spectrum Disorders*, 120 PEDIATRICS 1183 (2007), <http://pediatrics.aappublications.org/content/pediatrics/120/5/1183.full.pdf> (recommending that treatment commence as soon as ASD is suspected).

³⁶ See Letter from Sarah C. Brooks, Cal. Dep’t of Health Care Servs., to All Medi-Cal Managed Care Health Plans 1 (Aug. 26, 2015), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-019.pdf>.

harm. Interruptions in care due to the transition from RCs to MCPs are likely to cause harm in the form of regression or increased symptoms. The DMHC and HHS Agency already recognized the vulnerable nature of this population in the Emergency Regulations promulgated in September of 2012 regarding BHT services for children in the former Healthy Families Program who are now Medi-Cal beneficiaries. The Emergency Regulations cited likely significant and irreparable harm for any denial or delay of BHT treatment for this population, which would extend to any interruption in care. MCPs should not experience any difficulty meeting the 3 day timeframe since DHCS will be providing COC information in advance of transfer from RCs to MCPs. The APL should also ensure no interruption in care in the instances where an agreement cannot be reached and transition to a new provider is necessary.

- **DHCS should not to limit continuity of care to fee-for-service providers.**

We recognize that the recently proposed updates to the federal Medicaid managed care regulations would require all providers in Medicaid to be enrolled in the state's fee-for-service program in order to be reimbursable under a Medicaid managed care contract.³⁷ But current law does not prohibit a provider who is not enrolled in fee-for-service from receiving reimbursement through an MCP and we see no policy reason for narrowing the number of providers eligible for continuity of care at this time. This narrowing of criteria is inconsistent with DHCS's stated intent to utilize the same providers available to children with private insurance and regional centers and will adversely impact the exact population DHCS is trying to serve through this transition—children with ASD—since many children with ASD in the Regional Center system have OHC with non-Medi-Cal providers and receive BHT through their OHC since the Regional Centers will pay for their co-pays. Eliminating these children's ability to receive COC with their OHC BHT providers will eviscerate the purpose of COC by disrupting long-standing provider relationships even when the provider and plan can agree to work together. Further DHCS has repeatedly informed providers during the stakeholder meetings that to provide BHT they only need to meet the qualifications in the Health and Safety Code, which are being adopted in the SPA.³⁸ More than a year into the benefit implementation, it is inappropriate to require that providers enroll in fee-for-service in order for families to be eligible for COC. We urge DHCS to remove this criterion for COC.

- **DHCS may not limit provisional diagnoses to those under age 3**

We would like to commend DHCS for permitting the use of a provisional diagnosis for a child under age 3. We urge DHCS to ensure MCPs accept a provision diagnosis for anyone transferring from a Regional Center to a MCP regardless of age. If an MCP would like to conduct a CDE to confirm the provisional diagnosis and the treating physician agrees it is clinically appropriate, the MCP must ensure that treatment is not interrupted and COC is provided while the enrollee completes the CDE process.

³⁷ 80 Fed. Reg 31098 at 31190, 31286 (2015).

³⁸ See CAL. HEALTH & SAFETY CODE § 1374.72.

Further, an MCP may not terminate or withdraw authorization of medically necessary BHT treatment even if an ASD diagnosis is not given. EPSDT requires the provision of medically necessary services to treat conditions that is revealed in a screen.³⁹ The Medicaid Act also prohibits discrimination of benefits based on diagnosis.⁴⁰ If the treatment is medically necessary, the MCP must authorize care regardless of diagnosis and DHCS may not permit a MCP to terminate care due to lack of an ASD diagnosis.

- **We recommend that DHCS clarify that services may be recommended by a physician, surgeon, or psychologist.**

The APL's background and policy section states that BHT services are "covered Medical benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist." Draft APL at 2. We recommend changing the end of the sentence to "licensed physician or surgeon or a licensed psychologist" to make clear that a beneficiary does not need a recommendation from both a licensed physician and surgeon. We believe this is a typo as previous guidance states "licensed physician or surgeon." APL 14-011.

Thank you again for the opportunity to comment. If you have any questions or need any further information, please contact Abbi Coursolle at coursolle@healthlaw.org or 310-736-1652, or Linda Nguy at lnguy@wclp.org or 916-282-5117.

Sincerely,



Abbi Coursolle
National Health Law Program



Linda Nguy
Western Center on Law & Poverty

And on behalf of:

American Academy of Pediatrics, California; Autism Deserves Equal Coverage; Autism Health Insurance Project; Autism Speaks; California School-Based Health Alliance; Children Now; Children's Defense Fund-California; Children's Partnership; Disability Rights California; Disability Rights Education and Defense Fund; Maternal Child Health Access; and Public Law Center

CC: Melissa Harris, Deputy Director,
CMCS Disabled and Elderly Health Programs Group
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CMCS Children and Adults Health Programs Group
Marsha Lillie-Blanton, Director,
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³⁹ See CENTERS FOR MEDICARE & MEDICAID SERVICES, *supra* note 13 at 5-6.

⁴⁰ 42 CFR 440.230(c).