Behavioral Health Treatment (BHT)
Frequently Asked Questions

Q: What are Behavioral Health Treatment (BHT) services?
A: BHT services are evidence-based treatments that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder (ASD). BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of a targeted behavior. BHT services are based on reliable evidence and are not experimental. Examples of BHT services include behavioral interventions, cognitive behavioral intervention package, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training package, pivotal response training, schedules, scripting, self-management, social skills package, and story-based intervention.

Q: What is ASD?
A: ASD refers to a pattern of behaviors involving three central features: impairments in socialization, verbal and nonverbal communication and restricting and stereotyped actions that can vary widely in terms of symptom expression, and degree of impairment and developmental onset through the individual's life span.

Q: How is ASD diagnosed?
A: If you suspect you or your child may have ASD, you should make an appointment with your child's Primary Care Physician (PCP). The PCP will submit a referral for further assessment and provide you with next steps.

Q: Why are BHT services changing?
A: On July 7, 2014, the federal government required Medicaid to cover BHT for children with ASD as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This became effective on September 15, 2014 for all Medi-Cal Managed Care Health Plans (MCPs). This means the State is required to offer BHT services through MCPs rather than the Regional Centers (RCs).

Q: Who is eligible for BHT services?
A: Children and adolescents under 21 years of age diagnosed with ASD may be eligible to receive BHT services.

Q: Who can prescribe BHT?
A: BHT services must be recommended by a licensed physician and surgeon or licensed psychologist.

Q: What is a Qualified Autism Service (QAS) provider?

A: As defined in Health & Safety Code Section §1374.73, A QAS provider is either a person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified or a person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Q: Who can provide BHT services?

A: As defined in Health & Safety Code Section §1374.73, treatment services must be provided by a QAS provider, professional, or paraprofessional. The professional and paraprofessional must be supervised and employed by the QAS provider.

Q: What BHT services are covered?

A: Covered services may include, but are not limited to: ABA, OT, ST, behavioral interventions, and parental training.

Q: Are there BHT service exclusions?

A: Individuals do not qualify for BHT services if they are 21 or older, not medically stable and need 24-hour medical or nursing services, have intellectual disabilities and need procedures and/or monitoring in a hospital or intermediate care facility for person with intellectual disabilities (ICF/ID).

Q: How will beneficiaries transition from regional centers (RCs)?

A: The transition will occur in 6 phases starting on February 1, 2016. Counties with less than 100 beneficiaries will transition all at once (see Table 1 below).

Table 1: Counties Transitioning at Once				
Alpine	Amador	Butte	Calaveras	Colusa
Del Norte	El Dorado	Glenn	Humboldt	Inyo
Kings	Lake	Lassen	Madera	Marin
Mariposa	Mendocino	Merced	Modoc	Mono
Monterey	Napa	Nevada	Placer	Plumas
San Benito	San Francisco	San Mateo	Santa Cruz	Shasta
Sierra	Solano	Sonoma	Stanislaus	Sutter
Tehama	Trinity	Tulare	Tuolumne	Yolo
Yuba				

A 6-month transition period will occur for all counties with 100 or more beneficiaries (see Table 2 below).

Table 2: Counties Transitioning Over 6-Months			
Alameda	Contra Costa	Fresno	Imperial
Kern	Orange	Riverside	Sacramento
San Bernardino	San Diego	San Joaquin	San Luis Obispo
Santa Barbara	Santa Clara	Ventura	

For beneficiaries residing in the counties shown in Table 2 above, the transition from RC to MCP will occur based on the beneficiary's birth month, as shown below.

Month of Transition	**Birth Months**
February	January and February
March	March and April
April	May and June
May	July and August
June	September and October
July	November and December

Los Angeles County will use a 6-month transition period according to RC locations:

Month	**Regional Center**
February	South Central Los Angeles Regional Center
March	Frank D. Lanterman Regional Center
April	Harbor Regional Center Westside Regional Center
May	San Gabriel Regional Center Pomona Regional Center
June	Eastern Los Angeles Regional Center
July	North Los Angeles Regional Center

Q: Will beneficiaries receive notification?

A: MCPs will notify managed care beneficiaries twice; 60 and 30-days prior to the transition of BHT services. Fee-for-Service beneficiaries will be notified 30-days prior to the transition of BHT services to State Plan services in February 2016.

Q: What if a managed care beneficiary didn't transition during their birth month and the above schedule says they should have transitioned?

A: Beneficiaries who didn't transition during their birth month should call their MCP. They will receive notification and transition the following month.

Q: Do I need to provide permission to share Protected Health Information (PHI)?

A: Yes, your RC and/or RC provider needs a signed consent form to share your treatment and PHI. Treatment and PHI will only be shared with MCPs and BHT

providers. The consent form is valid for one year and you may choose to cancel consent to share treatment and PHI at any time. If you cancel the consent to share information, this could impact the MCP's authorization of your BHT treatment plan.

Q: Where can a copy of the PHI consent form be found?
A: Copies of the consent form have been provided to the RCs and MCPs. You may request it from them or print a copy from the DHCS website.

Q: How does Continuity of Care (COC) work?
A: If BHT services have been received outside of the MCP's BHT network within the past 6 months, the MCP will reach out to the current BHT provider and attempt to enter into a COC agreement for up to 12 months. COC means your current BHT services will not be changed if your BHT provider and MCP enter into an agreement. If you think you should have received COC but did not, please contact your MCP for assistance.

Q: Who should be contacted if I need to continue services?
A: You should contact your MCP. They will reach out to the RC BHT provider and attempt to enter into a COC agreement.

Q: What if I can't stay with my same provider? Will my services change?
A: No. Your services will not change until your QAS provider has completed an updated behavior treatment assessment or your treatment needs change. This will take place approximately six months after the last assessment, even if it occurred when you received services from the RC.

Q: Will beneficiaries be able to keep their current provider?
A: MCPs will contact the current RC BHT provider and attempt to enter into a COC agreement. Plans are required to offer COC with the RC provider and beneficiaries may still be able to see the same BHT provider when:

1) The MCP is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
2) The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates;
3) The provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues;
4) The provider is a State Plan approved provider; and
5) The provider provides to the MCP all relevant treatment information as long as it is allowable under federal and State privacy laws and regulations

Or, the MCP will contact the beneficiary to identify a new provider(s) and will arrange for a warm hand off. Beneficiaries' current services will not change at least until they have a new assessment, even if they change providers.

Q: Will beneficiaries have the option to change providers?

A: Yes. Beneficiaries have the option to change providers at any time by contacting his or her MCP member services center.

Q: What rights do beneficiaries have if they don't agree with a denial or change in BHT services?

A: If a beneficiary does not agree with a denial or change of services, he or she may:

1) Call and file a grievance and/or appeal with the MCP;
2) Request a State Hearing; *or*
3) Request an Independent Medical Review (IMR) unless they are in the following COHS counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

An IMR ***cannot*** be filed after a State Hearing has been completed.

Q: If a beneficiary is not currently enrolled into a Medi-Cal MCP, how can they access BHT services?

A: Beneficiaries who are not enrolled into a MCP will receive BHT services through the RCs.

Q: How can BHT providers verify beneficiary eligibility?

A: A beneficiary's eligibility information may be obtained through the Automated Eligibility Verification System (AEVS). Providers must verify beneficiary eligibility and obtain authorization from the MCP ***before*** BHT services are provided.

Q: Who should beneficiaries call for additional assistance?

A: Beneficiaries should contact their current Medi-Cal MCP first. They may also contact the Medi-Cal Managed Care Office of the Ombudsman at 1-888-452-8609 or by email MMCDOmbudsmanOffice@dhcs.ca.gov. An ombudsman is available between the hours of 8:00am and 5:00pm, Monday through Friday.

Q: Who can BHT providers contact for additional assistance?

A: Providers should contact the MCP directly. MCP information may be obtained through the Automated Eligibility Verification System (AEVS). The MCP has a resource team to assist providers with contracting, credentialing, referral/prior authorization training, billing, and claims status and information. FFS beneficiaries should contact ABAinfo@DHCS.CA.gov.

Q: How do beneficiaries request to enroll into a Medi-Cal MCP?

A: Beneficiaries who wish to enroll into a MCP may contact Health Care Options (HCO) at 1-800-430-4263, except for beneficiaries in COHS counties. HCO representatives are available between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. In COHS counties, you will be enrolled in the MCP in your county. For questions, please contact your local COHS plan.