To:	Jennifer Tracey, Senior Director, Growth & Sustainability, HealthySteps
From:	Sharon Woda Randi E. Seigel Marisa McGrenera
Date:	August 16, 2023
Subject:	Billing California Medi-Cal for Dyadic Therapy Benefit

I. Background

Providers of dyadic therapy services have raised concerns regarding their ability to bill California Medi-Cal for Medi-Cal-covered dyadic therapy services provided to Medi-Cal-enrolled children and families ("Medi-Cal beneficiaries") if and when dyadic services may not be reimbursed by other third-party payors. If the provider chooses to provide dyadic services to children and their families who are uninsured or whose third-party payors do not cover the services ("non-Medi-Cal children and families"), the providers may choose to provide the services at a rate less than that which is paid by Medi-Cal for these services. The HealthySteps National Office ("HealthySteps") seeks to ensure that its provider sites in California understand how to bill for dyadic services provided to Medi-Cal-eligible children and their families and to address these provider concerns about delivering these services to non-Medi-Cal children and families for which reimbursement may not be available.

Specifically, HealthySteps has requested that Manatt set forth federal rules governing providers that bill Medicaid for medically necessary dyadic services, and address any California-specific, including provider-specific, requirements related to providing or billing for dyadic care services, and consider whether there are any federal or state laws that would prohibit the provision of dyadic therapy services to non-Medi-Cal children and families at a rate less than the rate paid by Medi-Cal. Manatt then applied these rules to specific scenarios requested by HealthySteps.

II. Limitations

This Memorandum was prepared for HealthySteps, and the legal analysis provided in this Memorandum is specific to the facts described in this Memorandum and may not be relied upon by any third party. Furthermore, this Memorandum is not intended to provide billing advice or guidance to any specific provider and does not take into account the fact that providers may have their own policies and procedures that may prohibit this practice.

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III. Short Answer

In short, we have not identified any law or regulation that prohibits providers from on the one hand billing Medi-Cal for covered dyadic therapy services provided to Medi-Cal beneficiaries and on the other hand not billing, or billing at a rate below the Medi-Cal rate, for dyadic therapy services provided to non-Medi-Cal children and families.

IV. Medi-Cal Coverage of Dyadic Services

Effective January 1, 2023, dyadic services and dyadic caregiver services were added as Medi-Cal covered benefits.[1] The Dyadic Services benefit "is a family- and caregiver-focused model to address developmental and behavioral health conditions of children."[2] Dyadic services, preventive behavioral health services for individuals ages 0-20 years old and/or their caregivers, include (i) Dyadic Behavioral Health ("DBH") Well-Child Services, (ii) Dyadic Comprehensive Community Support Services, (iii) Dyadic Psychoeducational Services, and (iv) Dyadic Family Training and Counseling for Child Development.[3] Dyadic Caregiver Services include certain assessment, screening, counseling, and brief intervention services provided to caregivers.[4]

Members under age 21 and their parents/caregivers are eligible for DBH services that are medically necessary, delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule,[5] and in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") requirements per 42 U.S.C. § 1396d(r).[6]

Dyadic services may be provided by licensed clinical social workers, licensed professional clinical counselors, licensed marriage and family therapists, licensed psychologists, psychiatric physician assistants, psychiatric nurse practitioners, and psychiatrists. Additionally, associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers, and psychology assistants may render services under a supervising clinician. Screening conducted by appropriately trained nonclinical staff, such as community health workers, is allowed so long as such screening is not separately billed.[7]

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[1] DHCS, *Dyadic Services Added as Medi-Cal Benefits and Psychotherapy Updates* (November 1, 2022).
[2] Cal. Welf. and Inst. Code § 14132.755(b).
[3] All Plan Letter ("APL") 22-029.
[4] DHCS, *Dyadic Services Added as Medi-Cal Benefits and Psychotherapy Updates* (November 1, 2022); *Non-Specialty Mental Health Services: Psychiatric and Psychological Services* (November 2022).
[5] Bright Futures/American Academy of Pediatrics Periodicity Schedule (2023).
[6] APL 22-029.
[7] *Id.*

Medi-Cal covers dyadic services provided at a provider's office, a beneficiary's home, outpatient hospitals, community mental health centers, comprehensive rehab facilities, state or local public health clinics, and rural health clinics,[8] as well as at facilities or clinics offering physical and behavioral health services, including federally qualified health centers ("FQHCs").[9] Psychological and psychiatric services meet the criteria for an FQHC reimbursable "visit," which includes DBH Well-Child Services. Other ongoing dyadic services provided by an FQHC are also reimbursable by Medi-Cal.[10] There are no service location limitations for dyadic services.[11] If dyadic services are not reimbursable under the definition of an FQHC visit, FQHC providers may be reimbursed at the Fee-for-Service rate available for dyadic services as outlined in the Non-Specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.[12]

V. Legal and Regulatory Framework

A. Federal Rules Governing Billing Medicaid for Medically Necessary Dyadic Therapy Services

In December 2014, the Centers for Medicare & Medicaid Services ("CMS") issued a State Medicaid Director letter regarding "Medicaid Payment for Services provided without Charge (Free Care)" ("2014 SMD Letter") to clarify that Medicaid payments are allowed for any covered services for Medicaid-eligible beneficiaries when delivered by Medicaid-qualified providers.[13] The CMS letter further provides that "Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large."[14]

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[8] Center for the Study of Social Policy & Manatt, *Pediatrics Supporting Parents Technical Assistance Analysis of New Medi-Cal Family Therapy Guidance and Dyadic Integrated Care Models Currently Implemented in California (Dyadic Care Crosswalk)* (September 27, 2020).
[9] CA Health & Wellness, *Provider Update* (March 27, 2023); APL 22-029.
[10] *Medi-Cal Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Manual* (p. 5-6) (December 2020); CA Health & Wellness, *Provider Update* (March 27, 2023).
[11] APL 22-029.
[12] *Id.*; *Non-Specialty Mental Health Services: Psychiatric and Psychological Services* (November 2022).
[13] December 15, 2014; available at smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf (December 15, 2014).
[14] *Id.* Furthermore, in this letter, CMS expressly stated that it was withdrawing its prior guidance on free care expressed in the School-Based Administrative Claiming Guide and other CMS guidance.

Accordingly, and in compliance with this guidance, CMS permits HealthySteps providers to bill Medi-Cal for dyadic services regardless of whether the providers receive reimbursement for the same service provided to non-Medi-Cal children and families. We next turn to assess whether there are other federal laws or California laws that may prohibit this practice; as discussed below we did not identify any such laws.

B. Federal Fraud and Abuse Laws

Notwithstanding the above, we also considered whether the practice of billing non-Medi-Cal children and families at a rate below the Medi-Cal rate could run afoul of any of the federal fraud and abuse laws. In short, this practice would not.

We first considered whether the Beneficiary Inducement Provision ("BIP") of the Civil Monetary Penalties Law ("CMPL")[15] is implicated. The BIP, with certain exceptions, prohibits providers from knowingly offering to Medicare and Medicaid beneficiaries anything of value that would influence their choice of providers. Here, the providers are not providing anything of value to Medicaid (and other federal program) beneficiaries; instead, they are providing Medicaid beneficiaries with Medi-Cal-covered services. The BIP does not concern the provision of anything of value (including free services) to non-federal program beneficiaries. Thus, the CMPL is not implicated by the proposed practice.[16]

We then considered whether the proposed billing practice could violate the federal law that prohibits, among other things, federal health care-enrolled providers from charging Medicaid substantially in excess of its usual charges to other payors or persons unless there is good cause ("Substantially in Excess Prohibition").[17] As a general matter, a provider's "charges to Medicare [and Medicaid] should be comparable [to] (and not 'substantially in excess' of) charges to private payors."[18] The Office of Inspector General ("OIG") has attempted on numerous occasions to provide definitive guidance on the Substantially in Excess Prohibition but never finalized definitions for "substantially in excess" or "usual charges."

The OIG has authority to exclude providers from federal health care programs for violating the Substantially in Excess Prohibition; however, to our knowledge, there has been virtually no enforcement of this prohibition. The OIG has previously stated that it would not use

[15] Practices that violate the BIP may also violate the federal Anti-Kickback Statute ("AKS").
[16] Because the proposed billing practice does not implicate the BIP here, it also does not implicate the AKS.
[17] 42 U.S.C. § 1320a-7(b)(6)(A).
[18] Health Care Programs: Fraud and Abuse; Revised OIG Civil Money Penalties Resulting From Public Law 104-191, 65 FR 24400-01.

this authority to exclude or attempt to exclude any provider that provides discounts or free services to uninsured or underinsured patients but has not fully addressed whether this would apply to insured patients.[19]

In certain OIG opinions, the OIG noted that this prohibition was "not a blanket prohibition on discounts to private pay customers" and that "a provider need not even worry about . . . [this law] unless it [was] discounting close to half of its non-Medicare/Medicaid business."[20]

The Substantially in Excess Prohibition is not likely to be implicated here because the provider is not billing Medi-Cal based on its charges and Medi-Cal is not taking into account the provider's charges in setting the Medi-Cal rate. Furthermore, this prohibition is highly unlikely to be implicated given CMS's express statement that a provider may bill Medi-Cal irrespective of whether it would bill other insurers or patients for the same service.

We also, however, considered whether a broad reading of the Substantially in Excess Prohibition could apply and concluded that even if it did, the proposed billing practice poses a low risk of violating such provision. If the number of dyadic services delivered by the Medi-Cal-enrolled provider to non-Medi-Cal children and families, excluding those who are uninsured (for whom the prohibition does not apply), is significantly lower than half of the number of services provided to the total Medi-Cal-enrolled provider's patients, then based on the OIG guidance, providing discounted rates or providing services for free to non-Medi-Cal children and families presents very little risk to the provider.

C. California-Specific Requirements Related to Providing or Billing for Dyadic Services

Medi-Cal requirements governing the provision and coverage of dyadic services do not address the proposed billing practice – there is no requirement that a provider bill non-Medi-Cal children and families as a condition to billing Medi-Cal. Thus, there is no reason to believe that the 2014 SMD Letter discussed above does not apply.

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[19] *See, e.g.,* Proposed Rule Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53939 (Sept. 15, 2003); https://oig.hhs.gov/authorities/docs/frsienprm.pdf; OIG Letter, issued April 20, 2000, available at https://oig.hhs.gov/documents/other-guidance/917/amldiscount.htm; OIG Letter, issued April 26, 2020, available at https://oig.hhs.gov/documents/other-guidance/916/lab.htm.

[20] *See* https://oig.hhs.gov/documents/other-guidance/917/amldiscount.htm.

We also assessed whether any other California law or regulation would prohibit the provision of services for free or at reduced cost to insured persons (e.g., insured non-Medi-Cal children and families). Specifically, we evaluated whether California (i) requires providers to bill insured persons for services not covered by their insurance plan, (ii) requires providers to collect copayments or coinsurance from insured persons, or (iii) prohibits providers from discounting fees for insured persons. We did not identify any California law or regulation that requires or prohibits, respectively, the foregoing conduct.

California has multiple statutes designed to prohibit false claims or attempts to defraud Medi-Cal or other insurers.[21] California prohibits providers from submitting to insurers false claims or information that results in the provider obtaining higher reimbursement than that to which he or she is entitled.[22] However, these statutes are inapplicable to the proposed billing practice because, as proposed, these providers are not submitting a claim to any insurer (other than Medi-Cal for covered services) because the services are not covered by insurers. Thus, there is no claim to insurers that could be false.

We also considered whether the proposed billing practice could violate California law prohibiting unfair competition, which prohibits unfair business practices.[23] The Attorney General considered whether a dual pricing structure itself constitutes an act of unfair competition. The Attorney General stated in the opinion provided that a discount alone, permissibly given to certain individuals in justifiably different functional classifications, does not constitute unfair competition.[24] Thus, it appears that California would permit not charging under- or uninsured

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[21] *See* Cal. Welf. & Inst. Code § 14014 (providing that a person who "willfully and knowingly counsels or encourages any individual to make false statements or otherwise causes false statements to be made on an application, in order to receive health care services to which the applicant is not entitled, shall be liable to the Medi-Cal program for damages incurred for the cost of services rendered to the applicant"); Cal. Penal Code § 550(a)(7) (prohibiting the aiding or abetting of knowingly submitting false or fraudulent claims). *See also* Cal. Penal Code § 532 (prohibiting knowingly defrauding another of money); Cal. Bus. & Prof. Code § 810 (providing that a health care professional who knowingly presents or makes false claims shall lose their license); and Cal. Bus. & Prof. Code § 1680 (unprofessional conduct includes obtaining any fee by fraud or misrepresentation).
[22] Cal. Welf. & Inst. Code § 14107 (prohibiting a person (i) with intent to defraud, from presenting for allowance or payment any false or fraudulent claim for furnishing services or merchandise; (ii) from knowingly submitting false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing services or merchandise; (iii) from knowingly submitting false information for the purpose of obtaining authorization for furnishing services or merchandise; and (iv) from knowingly and willfully executing, or attempting to execute, a scheme to defraud the Medi-Cal program).
[23] Cal. Office of Attorney General, Official Report No. 81-304 (October 16, 1981); Cal. Bus. & Prof. Code § 17200 (California law defines "unfair competition" as including "unlawful, unfair or fraudulent business practice and unfair, deceptive, untrue, or misleading advertising.").
[24] Cal. Office of Attorney General, Official Report No. 81-304 (October 16, 1981), n.9; Cal. Bus. & Prof. Code § 17042; *Moran v. Prime Healthcare Mgt., Inc.*, 208 Cal. Rptr. 3d 303 (Cal. App. 4th Dist. 2016).

children and families while billing Medi-Cal for these services as they are in justifiably different functional classifications (patients with coverage versus patients without coverage).

Finally, we identified no other California law or regulation that restricts the delivery of free care or charity care for uninsured or commercially insured patients.

VI. Application to Specific Scenarios

Scenario 1: A hospital-based FQHC clinic setting also has a small percentage of commercially insured patients or patients with Medicaid + a secondary insurance provider. Clinicians will offer behavioral health services as part of well-child care. For patients with Medicaid, clinicians would bill example codes 90846, 90847, H2015, H2027, H1011, and T2027. They will use Z-codes as the primary billable ICD-10 code, which Medi-Cal will reimburse. These codes are only reimbursable with Z-code diagnoses from Medi-Cal. For commercially insured patients, clinicians would conduct the same type of clinical assessment and intervention; however, there is not the same CPT or H-code pairing with a Z-code ICD-10 that is a billable service recognized by commercial payors. Therefore, clinicians assume that if they submit the same combination of codes (e.g., 90846 + Z65.9 or H10111 + Z13.39) to the commercial payors, then the claim will be denied. Since the provider does not want the patient to be left with having to pay the bill out of pocket (that was associated with routine standard of practice at the clinic), then the provider thinks they would be left with either the patient having to pay the bill or the practice writing off their charges.

There is a consensus among clinicians in the field that doing the above (charging Medi-Cal for their members and writing off charges (or not billing altogether) to the commercial payors who will not reimburse the same coding combination) would constitute insurance fraud.

Response: Pursuant to the CMS-issued 2014 SMD Letter, the hospital-based FQHC clinic may bill Medi-Cal for dyadic services for behavioral health as part of well-child care visits so long as the services are billed pursuant to the Medi-Cal dyadic services billing requirements and are delivered to Medi-Cal beneficiaries. The Substantially in Excess Prohibition is unlikely to be implicated, and we identified no California law or regulation that suggests that the practice of not billing patients for non-covered services would constitute insurance fraud.

Scenario 2: The second example is for the same clinic described above. However, this time the behavioral clinician identifies that the patient would benefit from a stand-alone follow-up visit with the behavioral clinician (following the team-based well-child visit). The clinic is wondering whether it could provide this follow-up visit to the member with commercial

insurance in a way that would not cause the patient to have to pay the bill. For patients with Medi-Cal, the clinician has a process for authorizing the patient to receive the service by checking their insurance eligibility. Once verified, they schedule the patient for the service. Again, the service would consist of providing a behavioral health service in the context of pediatric primary care and would be billed using the Medi-Cal-approved dyadic services code, such as a combination of 90847 + Z65.9 or H1011 + Z13.39. The patient with commercial insurance might be authorized to receive behavioral health services by their payor; however, the payor does not have a "family therapy benefit to charge with a billable diagnosis of Z65.9." Thus, if billed, the payor would deny the claim and the patient would have to pay or the clinic would have to write off the charge. In this case, is it legal to not bill the service since it is not a benefit covered by the payor? Or alternatively, can the clinic write off the uncovered charges? The clinic wants to be able to offer the necessary services equally to both commercially insured and uninsured or Medi-Cal-insured patients (free of charge to the patient) in spite of the fact that their coverages are different.

Response: Pursuant to the CMS-issued 2014 SMD Letter, the hospital-based FQHC may bill Medi-Cal for dyadic services for behavioral health as part of well-child care visits so long as the services are billed pursuant to the Medi-Cal dyadic services billing requirements and are delivered to Medi-Cal beneficiaries. The Substantially in Excess Prohibition is unlikely to be implicated, and we identified no California law or regulation that suggests that the practice of not billing patients for non-covered services would constitute insurance fraud. We would defer to the hospital-based FQHC's financial policies and procedures regarding whether the patient should not be billed or the charge should simply be written off; there may be other factors the hospital-based FQHC may want to consider (that are outside the scope of this memo) that are relevant to the approach (e.g., whether the free services may qualify as charity care or qualify as bad debt).