# Table of Contents

**State/Territory Name: California**

**State Plan Amendment (SPA) #: 18-011**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

May 24, 2018

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-011, which was submitted to the Centers for Medicare and Medicaid Services (CMS) on March 19, 2018. This SPA makes a technical change to remove the comprehensive diagnostic evaluation (CDE) requirement for children diagnosed with autism spectrum disorder (ASD) to receive Behavioral Health Treatment (BHT) services under the preventive services benefit of the Medicaid state plan. Removing the CDE requirement allows BHT services provided under preventive services to align with BHT services provided under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children without an ASD diagnosis.

The effective date of this SPA is March 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Limitations on Attachment 3.1-A, pages 18b-18c
- Limitations on Attachment 3.1-B, pages 18b-18c

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

/s/

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Rene Mollow, California Department of Health Care Services (DHCS)
Cynthia Smiley, DHCS
Jim Elliott, DHCS
Nathaniel Emery, DHCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: **18-011**

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SSA 1905(a)(13), 42 CFR 440.130

7. FEDERAL BUDGET IMPACT:
a. FY 2018 $0
b. FY 2019 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Limitations on Attachment 3.1-A, Page 18b
Limitations on Attachment 3.1-B, Page 18b
Limitations on Attachment 3.1-A, Page 18c
Limitations on Attachment 3.1-B, Page 18c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Limitations on Attachment 3.1-A, Page 18b
Limitations on Attachment 3.1-B, Page 18b
Limitations on Attachment 3.1-A, Page 18c
Limitations on Attachment 3.1-B, Page 18c

10. SUBJECT OF AMENDMENT:
Behavioral Health Treatment

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
**Mari Cantwell**

14. TITLE:
**Chief Deputy Director**
**Health Care Programs**
**State Medicaid Director**

15. DATE SUBMITTED:
March 19, 2018

16. RETURN TO:

**Department of Health Care Services**
**Attn: State Plan Coordinator**
**1501 Capitol Avenue, MS 4506**
**P.O. Box 997417**
**Sacramento, CA 95899-7417**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
March 19, 2018

18. DATE APPROVED:
May 24, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
March 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Hye Sun Lee

22. TITLE: Acting Associate Regional Administrator, Division of Medicaid & Children's Health Operations

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN CHART

| | TYPE OF SERVICE | PROGRAM DESCRIPTION** | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS* |
|---|---|---|---|
| 13c | Preventive services (cont.)<br><br>Behavioral Health Treatment (BHT) | Covered as medically necessary services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of Autism Spectrum Disorder (ASD). In accordance with 42 CFR 440.130(c), Behavioral Health Treatment (BHT) services, such as Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention services, prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a beneficiary. Services that treat or address ASD under this state plan are available only for the following beneficiaries: infants, children and adolescents under 21 years of age. Services that treat or address ASD will be provided to all children who meet the medical necessity criteria for receipt of the service(s).<br><br>Services include:<br>• Behavioral-Analytic Assessment and development of behavioral treatment plan; and<br>• BHT intervention services are identified in the BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1.<br><br>BHT intervention services are interventions designed to treat ASD, including a variety of behavioral interventions identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings. | BHT intervention services are provided under a prior authorized behavioral treatment plan that has measurable goals over a specific timeline for the specific patient being treated and is developed by a qualified autism service provider. The behavioral treatment plan shall be reviewed no less than once every six months by a qualified autism service provider. Services identified in the behavioral treatment plan may be modified and must be prior authorized.<br><br>Additional service authorization must be received to continue the service. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.<br><br>Services must be provided, observed and directed under an approved behavioral treatment plan developed by a qualified autism service provider, as described in the BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1.<br><br>The behavioral health treatment plan is not used for purposes of providing or coordinating respite, day care, or educational services. No reimbursement is available for respite, day care or educational services. No reimbursement is available to a parent or caregiver of an individual receiving BHT for costs associated with their participation under the treatment plan.<br><br>BHT services may be provided by one of the following:<br><br>Qualified Autism Service Provider (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1) |

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

STATE PLAN CHART

| | TYPE OF SERVICE | PROGRAM DESCRIPTION** | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS* |
|---|---|---|---|
| 13c | Preventive services (cont.)<br><br>BHT (cont.) | | Qualified Autism Service Professional (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1)<br><br>Qualified Autism Service Paraprofessional (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1) |

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

STATE PLAN CHART

| | TYPE OF SERVICE | PROGRAM DESCRIPTION** | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS* |
|---|---|---|---|
| 13c | Preventive services (cont.)<br><br>Behavioral Health Treatment (BHT) | Covered as medically necessary services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of Autism Spectrum Disorder (ASD). In accordance with 42 CFR 440.130(c), Behavioral Health Treatment (BHT) services, such as Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention services, prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a beneficiary. Services that treat or address ASD under this state plan are available only for the following beneficiaries: infants, children and adolescents under 21 years of age. Services that treat or address ASD will be provided to all children who meet the medical necessity criteria for receipt of the service(s).<br><br>Services include:<br>• Behavioral-Analytic Assessment and development of behavioral treatment plan; and<br>• BHT intervention services are identified in the BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1.<br><br>BHT intervention services are interventions designed to treat ASD, including a variety of behavioral interventions identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings. | BHT intervention services are provided under a prior authorized behavioral treatment plan that has measurable goals over a specific timeline for the specific patient being treated and is developed by a qualified autism service provider. The behavioral treatment plan shall be reviewed no less than once every six months by a qualified autism service provider. Services identified in the behavioral treatment plan may be modified and must be prior authorized.<br><br>Additional service authorization must be received to continue the service. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.<br><br>Services must be provided, observed and directed under an approved behavioral treatment plan developed by a qualified autism service provider, as described in the BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1.<br><br>The behavioral health treatment plan is not used for purposes of providing or coordinating respite, day care, or educational services. No reimbursement is available for respite, day care or educational services. No reimbursement is available to a parent or caregiver of an individual receiving BHT for costs associated with their participation under the treatment plan.<br><br>BHT services may be provided by one of the following:<br><br>Qualified Autism Service Provider (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1) |

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

STATE PLAN CHART

| | TYPE OF SERVICE | PROGRAM DESCRIPTION** | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS* |
|---|---|---|---|
| 13c | Preventive services (cont.)<br><br>BHT (cont.) | | Qualified Autism Service Professional (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1)<br><br>Qualified Autism Service Paraprofessional (see BHT Services Chart in Supplement 6 to Attachment 3.1-A Page 1) |

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services