REHABILITATIVE SERVICES: REIMBURSEMENT FOR DRUG MEDI-CAL PROGRAM

Section 1: Reimbursement for Substance Use Disorder Treatment Services

This segment of the State Plan describes the reimbursement methodology for Substance Use Disorder Treatment Services covered under the rehabilitation benefit and rendered by qualified providers as described in Section 13.d.5 of Supplement 3 to Attachment 3.1 A to this State Plan. Qualified providers are DMC certified providers that must be licensed, registered, enrolled, and/or approved in accordance with all applicable state laws and regulations; abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and sign a provider agreement with a county or the Department of Health Care Services. During the period beginning October 1, 2020 and ending September 30, 2025, MAT for OUD services are exclusively covered and reimbursed under the 1905(a)(29) benefit.

A. DEFINITIONS

"Allowable cost" is reasonable and allowable cost, determined based on year-end cost reports and in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Publication 15-1), 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR Part 200 as implemented by HHS at 45 CFR Part 75, and Medicaid non-institutional reimbursement policies.

"Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies" means the percentage change in the Index for State and Local Purchases contained in the National Deflators Fiscal Year Averages workbook published by the Department of Finance to the following website: https://www.dof.ca.gov/Forecasting/Economics/Indicators/Inflation/

"Legal Entity" means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing Substance Use Disorder Treatment Services under contract with the county alcohol and drug department or agency or with DHCS.

"Medication for Addiction Treatment for Opioid Use Disorder (MAT for OUD)" has the same meaning as the term is defined in 13.d.5 of Attachment 3.1-A to this State Plan.

"Narcotic Treatment Program (NTP) Level of Care" include Daily Dosing services and Individual and Group Counseling services and has the same meaning as defined in 13.d.5 of Attachment 3.1 A to this State Plan.

"Non-Narcotic Treatment Program (non-NTP) Levels of Care" include Outpatient Treatment Level of Care, Intensive Outpatient Treatment Level of Care, and Perinatal Residential Substance Use Disorder Treatment Level of Care as defined in 13.d.5 of Attachment 3.1 A to this State Plan.

"Peer Support Services" means peer support services as defined in 13.d.5 of Attachment 3.1 A to this State Plan.

"Provider of Services" means any private or public agency that provides direct substance use disorder services and is certified by the State as meeting applicable standards for participation in the DMC Program, as defined in the Drug Medi-Cal Certification Standards for Substance Use Disorder Clinics.

"Published charges" are usual and customary charges prevalent in the alcohol and drug treatment services sector that are used to bill the general public, insurers, and other non- Title XIX payers. (42 CFR § 447.271, and § 405.503(a)).

"Statewide maximum allowance" (SMA) is established for each type of non-NTP service, for a unit of service.

"Substance Use Disorder Treatment Services" are substance use disorder treatment services, except for Peer Support Services, as described under Section 13.d.5 in Supplement 3 to Attachment 3.1 A to this State plan. Substance Use Disorder Treatment Services includes all services, except for Peer Support Services, provided in the Narcotic Treatment Program Level of Care and Non-Narcotic Treatment Program Levels of Care.

"Unit of Service" (UOS) means a face-to-face or telehealth contact on a calendar day (for non-NTP services). Only one unit of each non-NTP service per day is covered by Medi-Cal except when additional face-to-face contact may be covered for Medication Assisted Treatment for Opioid Use Disorder and/or unplanned crisis intervention. To count as a unit of service, the subsequent contacts shall not duplicate the services provided on the first contact, and the contact shall be clearly documented in the beneficiary's patient record. For NTP services, "Unit of Service" means each calendar day a client receives services, including take-home dosing.

B. ALLOWABLE LEVELS OF CARE, SERVICES AND UNITS

Allowable services and units of service are as follows:

Non-NTP Levels of Care	**Units**
Intensive Outpatient Treatment	One face-to-face contact per calendar day to provide one or more Substance Use Disorder Treatment Service, except for crisis intervention and MAT for OUD. One additional face-to-face or telehealth contact per calendar day for crisis intervention services and one additional face-to-face or telehealth contact per calendar day for MAT for OUD.
Outpatient Drug Free Treatment	One face-to-face or telehealth contact per calendar day to provide one or more Substance Use Disorder Treatment Service, except for crisis intervention and MAT for OUD. One additional face-to-face or telehealth contact per calendar day for crisis intervention services and one additional face-to-face contact per calendar day for MAT for

	OUD.
Perinatal Residential Substance Use Disorder Treatment	24-hour structured environment per day (excluding room and board)

Narcotic Treatment Program Level of Care (consist of two components)	**Units**
a) Daily Dosing	Daily bundled service which includes the following components: 1. Core: Intake assessment, treatment planning, physical evaluation, drug screening, and supervision. 2. Laboratory Work: Tuberculin and syphilis tests, monthly drug screening, and monthly pregnancy tests of female methadone patients. 3. Dosing: Ingredients and labor cost for administering MAT for OUD and Disulfiram daily doses to patients.
b) Counseling Individual and/or Group	A patient must receive a minimum of fifty (50) minutes of face-to-face counseling sessions with a therapist or counselor up to a maximum of 200 minutes per calendar month, although additional services may be provided and reimbursed on medical necessity.

Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care	**Units**
Peer Support Services	15 Minutes

C. REIMBURSEMENT METHODOLOGY

1. The reimbursement methodology for county and non-county operated providers of non-NTP Levels of Care and Peer Support Services is the lowest of the following:

   a. The provider's usual and customary charge to the general public for providing the same or similar level of care or service;
   b. The provider's allowable costs of providing the level of care or service;
   c. The SMA, established in Section D.1.a below; or.
   d. The SMA established in Section D.1.a below for State Fiscal Year (SFY) 2009-10

adjusted for the cumulative growth in the California Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies, as reported by the Department of Finance.

2. The reimbursement methodology for non-county operated NTP providers of the NTP Level of Care is the lowest of:

   a. The provider's usual and customary charge to the general public for the same or similar level of care,
   b. The uniform statewide daily reimbursement rate (USDR) established in Section D.1.b below, or.
   c. The USDR established in Section D.1.b below for State Fiscal Year (SFY) 2009-10 adjusted for the cumulative growth in the California Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies, as reported by the Department of Finance

3. Reimbursement for county-operated NTP providers of the NTP Level of Care is at the lowest of:

   a. The provider's usual and customary charge to the general public for providing the same or similar level of care;
   b. The provider's allowable costs of providing the level of care as described in Section D below;
   c. The USDR established in Section D.1.b below, or.
   d. The USDR established in Section D.1.b below for State Fiscal Year (SFY) 2009-10 adjusted for the cumulative growth in the California Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies, as reported by the Department of Finance.

D. COST DETERMINATION PROTOCOL FOR NON-NTP LEVELS OF CARE, PEER SUPPORT SERVICES, AND COUNTY-OPERATED PROVIDERS OF THE NTP LEVEL OF CARE

The following steps will be taken to determine the reasonable and allowable Medicaid costs for providing Peer Support Services, Substance Use Disorder Treatment Services in Non-NTP Levels of Care, and Substance Use Disorder Treatment Services in the NTP Level of Care.

1. Interim Payments

Interim payments for non-NTP Levels of Care and Peer Support Services provided to Medi-Cal beneficiaries are reimbursed up to the SMA. Interim payments for the NTP Level of Care daily dosing service, individual counseling service, and group counseling service provided to Medi-Cal beneficiaries are reimbursed up to the USDR.

a. SMA METHODOLOGY FOR THE NON-NTP LEVEL OF CARE AND PEER SUPPORT SERVICES

"SMAs" are based on the statewide median cost of each level of care or service, as

described in Section C above, as reported in the most recent interim settled cost reports submitted by providers. Until providers have submitted cost reports for Peer Support Services and the State has completed the interim settlement of those cost reports, SMAs for Peer Support Services are the statewide median rate based upon rates submitted by counties. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The SMAs are updated annually with the rate effective July 1 of each State fiscal year. SMAs are effective as of July 1, 2021 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx.

b. UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGY FOR THE NARCOTIC TREATMENT PROGRAMS LEVEL OF CARE

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is calculated by the State annually based on the average daily estimated cost of providing dosing and ingredients, core and laboratory work services as described in Section C. The daily estimated cost does not include room and board and is determined based on the annual estimated cost per patient and a 365-day year, using the most recent and accurate data available. The USDR is paid to county operated and non-county operated NTP providers each day a dose is administered to a beneficiary. NTPs may contract with other entities to perform some work services, such as laboratory work. NTPs pay those outside entities for that work. Those outside entities may not submit claims to the state for reimbursement of work services for which they were paid by the NTP. Outside entities may continue to claim for reimbursement for those services if they are not provided as part of NTP. The State will periodically monitor the services provided by the NTP for which the USDR was paid to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the USDR.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The USDR rates are effective as of July 1, 2021 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx.

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the median cost, as reported in the most recently submitted cost reports, for individual counseling and group counseling provided in the Outpatient Level of Care as described under Section D.1.a above. The USDR for NTP Individual and Group Counseling are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx.

2. Cost Determination Protocol

The reasonable and allowable cost of providing Substance Use Disorder Treatment Services in each non-NTP Level of Care, Peer Support Services, and the NTP Level of Care will be determined in the CMS-reviewed cost report pursuant to the following methodology. Total allowable costs include direct and indirect costs that are determined

in accordance with CMS Provider Reimbursement Manual (CMS Pub 15-1), 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR Part 200 as implemented by HHS at 45 CFR Part 75, and CMS Medicaid non-institutional reimbursement policies.

Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such as professional service contracts, that can be directly charged in providing the specific non-NTP Levels of Care, the NTP Level of Care, and Peer Support Services. Direct practitioners include individuals who are qualified to provide DMC Medi-Cal Services as defined in Section 13.d.5 of Supplement 3 to Attachment 3.1-A.

Indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its net direct costs or allocated indirect costs based upon the allocation process in the Legal Entities approved cost allocation plan. If the Legal Entity does not have a plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with the CMS Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75. When the legal entity does not have a cost allocation plan, the CMS-reviewed State-developed cost report determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report also allocates indirect costs to each NTP Level of Care and Non-NTP Level of Care based upon each level of care's percentage of direct costs. The CMS-reviewed State-Developed cost report allocates allowable indirect costs allocated to each level of care to Peer Support Services and Substance Use Disorder Treatment Services provided within the Level of Care based upon staff hours.

For the Perinatal Residential Substance Use Disorder Treatment Level of Care, total allowable costs include direct and indirect costs that are determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Direct practitioners include individuals who are qualified to provide DMC Medi-Cal Services as defined in Section 13.d.5 of Supplement 3 to Attachment 3.1-A.

Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. In accordance with 2 CFR § 200.416, when there is not an approved indirect cost rate, the CMS-reviewed State-developed cost report determines indirect costs as the difference between total costs and direct costs and allocates indirect costs to each Substance Use Disorder Treatment Level of Care based upon each level of care's percentage of direct costs. As stated in Title 2, CFR, § 200.56 "indirect costs means those costs incurred for a common or joint purpose benefitting more than one cost

objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved." Specifically and in accordance with 2 CFR § 200.416 and 2 CFR part 200, App. VII., ¶ A.1, indirect costs that are directly attributable to the provision of medical services but would generally be incurred at the same level if the medical service did not occur will not be allowable. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. In accordance with Title 2 CFR § 200.405, costs incurred that benefit multiple purposes and would be incurred at the same level if the medical services did not occur are not allowed (e.g., room and board, allocated cost from other related organizations).

The total allowable cost for providing the specific Non-NTP Level of Care, NTP Level of Care, or Peer Support Services by each Legal Entity is further reduced by any third parties payments received for the service provided. This netted amount is apportioned to the Medi-Cal program using a basis that must be in compliance with the CMS Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

The Legal Entity specific non-NTP Level of Care or NTP Level of Care service unit rate is calculated by dividing the Medi-Cal allowable cost for providing the specific non-NTP Level of Care or NTP Level of Care service by the total number of UOS for the specific non-NTP or NTP service for the applicable State fiscal year.

3. Apportioning Costs to Medicaid (Medi-Cal)

Total allowable direct and indirect costs allocated to Non-NTP Levels of Care, the NTP Level of Care, and Peer Support Services are apportioned to the Medi-Cal program based upon units of service. For each level of care and peer support services, the provider reports on the CMS-reviewed State-developed cost report, the total units of service it provided to all individuals. Units of service are measured in the increments defined in Section C. The total allowable direct and indirect costs allocated to a particular Non-NTP Level of Care, NTP Level of Care, or to Peer Support Services is divided by the total units of service reported for the same level of care or service to determine the cost per unit.

For each Non-NTP Level of Care, NTP Level of Care, and Peer Support Service, the provider reports on the CMS-reviewed State-developed cost report the total units of service provided to Medi-Cal beneficiaries. The cost per unit calculated for each level of care or service is multiplied by the total units for that level of care or service provided to Medi-Cal beneficiaries to apportion costs to the Medi-Cal program.

The total allowable cost for providing the level of care or service is further reduced by any third parties' payments received for the level of care or service provided to Medi-Cal beneficiaries.

4. Cost Report Submission

Each Legal Entity that receives reimbursement for Non-NTP Levels of Care or Peer Support Services is required to file a CMS reviewed State-developed cost report by November 1 following the end of each State fiscal year. Each county Legal Entity that receives reimbursement for the NTP Level of Care is required to file a CMS reviewed State-developed cost report by November 1 following the end of each State fiscal year. An extension to submit the cost report may be granted by the State.

5. Interim Settlement

The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the CMS-reviewed State-developed cost report for the reporting period. Total reimbursable costs are specified under Section B.1 for Non-NTP Levels of Care, Peer Support Services and the NTP Level of Care provided by county operated providers, and Section B.2 for the NTP Level of Care provided by non-county operated providers. If the total reimbursable costs are greater than the total interim payments, the State will pay the provider the difference. If the total interim payments are greater than the total reimbursable costs, the State will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR § 433.316.

6. Final Settlement Process

The State will perform financial compliance audit to determine data reported in the provider's State-developed cost report represents the allowable cost of providing non-NTP or NTP services in accordance with the CMS Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75; and the statistical data used to determine the unit of service rate reconcile with the State's record. If the total audited reimbursable cost based on the methodology as described under Section B(1) is less than the total interim payment and the interim settlement payments, the State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR § 433.316. If the total reimbursable cost is greater than the total interim and interim settlement payments, the State will pay the provider the difference.

State/Territory: California

Section 2: Reimbursement for Expanded Substance Use Disorder Treatment Levels of Care

This segment of the State Plan describes the reimbursement methodology for Expanded Substance Use Disorder Treatment Services covered under the rehabilitation benefit and rendered by qualified providers as described in Section 13.d.6 of Supplement 3 to Attachment 3.1 A to this State Plan. Qualified providers are DMC certified providers that must be licensed, registered, enrolled, and/or approved in accordance with all applicable state laws and regulations; abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and sign a provider agreement with a county. During the period beginning October 1, 2020 and ending September 30, 2025, MAT for OUD services are exclusively covered and reimbursed under the 1905(a)(29) benefit.

A. **DEFINITIONS**

"Allowable cost" is reasonable and allowable cost, determined based on year-end cost reports and Medicare cost reimbursement principles in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

"Expanded Substance Use Disorder Treatment Services" are expanded substance use disorder treatment services as described under section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State plan

"Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care" include Recovery Services, Peer Support Services, Care Coordination Services, Medication for Addiction Treatment (MAT) for Opioid Use Disorder (OUD) and MAT for Alcohol Use Disorder (AUD) as those services are described under section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State plan.

"Expanded Substance Use Disorder Levels of Care", as described under Section 13.d.6 of Supplement 3 to Attachment 3.1-A of this state plan, includes Non-Narcotic Treatment Program Levels of Care and Narcotic Treatment Program Level of Care.

"Intensive Outpatient Treatment Level of Care" has the same meaning as defined in section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State Plan.

"Legal Entity" means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing Expanded Substance Use Disorder Treatment Services under contract with the county alcohol and drug department or agency or with DHCS.

"Medication for Addiction Treatment for Alcohol Use Disorder and Other Non-Opioid Use Disorders (MAT for AUD)" includes services to treat alcohol use disorder (AUD) and other non-opioid substance use disorders (SUD) involving FDA-approved medications to treat AUD and non-opioid SUDs. MAT for AUD does not include the FDA approved medication.

"Medication for Addiction Treatment for Alcohol Use Disorder and Other Non-Opioid Use Disorders (MAT for AUD) Medications" include all FDA approved medications to treat alcohol use disorders and other non-opioid use disorders.

"Medication for Addiction Treatment for Opioid Use Disorders (MAT for OUD)" includes services to treat Opioid Use Disorder (OUD) involving FDA-approved medications to treat OUD. MAT for AUD does not include the FDA approved medication.

"Medication for Addiction Treatment for Opioid Use Disorder (MAT for OUD) Medications" include all forms of drugs approved to treat opioid use disorder under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed to treat opioid use disorder under section 351 of the Public Health Services Act (42 U.S.C. 262).

"Narcotic Treatment Program (NTP) Level of Care" is a subset of Expanded Substance Use Disorder Levels of Care and includes Daily Dosing services as described in Section C below and Individual and Group Counseling services as described under section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State plan.

"Non-Narcotic Treatment Program (non-NTP) Levels of Care" is a subset of Expanded Substance Use Disorder Levels of Care and includes Outpatient Treatment Services Level of Care, Intensive Outpatient Treatment Level of Care, Partial Hospitalization Level of Care, Residential Treatment Level of Care, and Withdrawal Management Level of Care as described under section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State plan.

"Non-Regional Counties" means those counties listed in Section H of this segment to this State plan.

"Outpatient Treatment Services Level of Care" has the same meaning as defined in section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State Plan.

"Partial Hospitalization Level of Care" has the same meaning as defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State Plan.

"Provider of Services" means any private or public agency that provides Expanded Substance Use Disorder Treatment Services and is certified by the State as meeting applicable standards for participation in the DMC Program, as defined in the Drug Medi-Cal Certification Standards for Substance Use Disorder Clinics.

"Published Charges" are usual and customary charges prevalent in the alcohol and drug treatment services sector that are used to bill the general public, insurers, and other non-Title XIX payers. (42 CFR §§ 447.271 and 405.503(a)).

"Regional Counties" means those counties listed in Section G of this segment to this State plan.

"Residential Treatment Level of Care" has the same meaning as defined in Section 13.d of Supplement 3 to attachment 3.1-A to this State Plan.

"Statewide Maximum Allowance" (SMA) is an interim rate established for each type of non-NTP Level of Care and Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care per unit.

"Withdrawal Management Level of Care" has the same meaning as defined in section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State plan.

B. ALLOWABLE EXPANDED SUBSTANCE USE DISORDER TREATMENT LEVELS OF CARE AND UNITS OF SERVICE – REGIONAL AND NON-REGIONAL COUNTIES

1. Allowable Expanded Substance Use Disorder Levels of Care and units of service are as follows:

Non-NTP Levels of Care	Unit of Service (UOS)
Intensive Treatment Outpatient Services	15-Minutes
Outpatient Treatment Services (also	15-Minutes

known as Outpatient Drug Free or ODF)

Residential Treatment	24-hour structured environment per day (excluding room and board)
Partial Hospitalization	Daily
Withdrawal Management ASAM Levels 1 and 2	Daily
Withdrawal Management ASAM Level 3.2, 3.7, and 4.0	24-hour structured environment per day (excluding room and board)

Narcotic Treatment Program Level of Care (consist of two components):

a) Daily Dosing	Daily bundled service which includes the following components: A. Core: Assessment, medication services, treatment planning, physical evaluation, drug screening, and supervision. B. Laboratory Work: Tuberculin and syphilis tests, monthly drug screening, and monthly pregnancy tests of female-methadone patients. C. Dosing: Ingredients and labor cost for Medication for Addiction Treatment (MAT) for Alcohol Use Disorder (AUD) and MAT for Opioid Use Disorder (OUD).
b) Counseling Individual and/or Group	10-Minutes

2. The following Expanded Substance Use Disorder Treatment Services are reimbursed separately from the Level of Care payment when provided in a Non-NTP Level of Care or outside of any Expanded Substance Use Disorder Treatment Level of Care:

Services and Drugs	Units
Recovery Service	15 Minutes
Peer Support Service	15 Minutes
Care Coordination Service	15 Minutes
MAT for AUD	15 Minutes
MAT for AUD Medication	Dose
MAT for OUD	15 Minutes
MAT for OUD Medication	Dose

3. The following Expanded Substance Use Disorder Treatment Services are reimbursed separately from the Level of Care payment when provided in a NTP Level of Care:

Service	Units
Recovery Service	15 Minutes
Peer Support Service	15 Minutes
Care Coordination Service	15 Minutes

C. **REIMBURSEMENT METHODOLOGY – NON-REGIONAL COUNTIES**

1. The reimbursement methodology for Non-NTP Levels of Care and Expanded Substance Use Disorder Treatment Services Provided Outside a Level of Care rendered by county operated providers is equal to the provider's allowable cost of providing the level of care or service pursuant to Section D below.

2. The reimbursement methodology for Non-NTP Levels of Care and Expanded Substance Use Disorder Treatment Services Provided Outside a Level of Care rendered by non-County operated providers is equal to the lowest of:
   a. The provider's usual and customary charge to the general public for the same or similar level of care, or
   b. The provider's allowable cost of providing the level of care or service.

3. The reimbursement methodology for NTP levels of care for non-county operated NTP providers is the lowest of:

   a. The provider's usual and customary charge to the general public for the same or similar level of care, or
   b. The uniform statewide daily reimbursement rate (USDR) established in Section D.1.b below.

4. The reimbursement methodology for NTP Levels of Care for county-operated providers is the lowest of:

   a. The provider's usual and customary charge to the general public for providing the same level of care;
   b. The provider's allowable cost of providing the level of care as described in Section D below; or
   c. The USDR established in Section D.1.b below.

5. The reimbursement methodology for unbundled prescribed physician administered drugs and biologicals used for the treatment of opioid use disorders and alcohol use disorders is the provider's invoice cost or the methodology described in

Supplement 2 to Attachment 4.19-B, Page 10.

D. **COST DETERMINATION PROTOCOL FOR COUNTY OPERATED PROVIDERS THAT PROVIDE EXPANDED SUBSTANCE USE DISORDER LEVELS OF CARE, NON-COUNTY OPERATED PROVIDERS THAT PROVIDE NON-NTP LEVELS OF CARE, AND ALL PROVIDERS THAT PROVIDE EXPANDED SUBSTANCE USE DISORDER TREATMENT SERVICES REIMBURSED OUTSIDE A LEVEL OF CARE – NON-REGIONAL COUNTIES**

The following steps will be taken to determine the reasonable and allowable Medicaid costs for county operated providers that provide Expanded Substance Use Disorder Levels of Care, non-county operated providers that provide non-NTP Levels of Care, and all providers that provide Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care.

1. Interim Payments

Interim payments for all providers that provide non-NTP Levels of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care to Medi-Cal beneficiaries are made up to the SMA described below. Interim payments for all providers that provide the NTP Level of Care are made up to the USDR described below.

a. SMA METHODOLOGY FOR ALL PROVIDERS OF NON-NTP LEVELS OF CARE AND EXPANDED SUBSTANCE USE DISORDER TREATMENT SERVICES REIMBURSED OUTSIDE A LEVEL OF CARE

SMA rates are established by counties and submitted to the State on an annual basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. SMA rates for Expanded Substance Use Disorder Levels of Care and Expanded Substance Use Disorder Treatment Services Provided Outside a Level of Care are effective as of January 1, 2022 and are published at (please note SMA rates are labeled County Interim Rates):
https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

b. UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGY FOR ALL PROVIDERS OF THE NTP LEVEL OF CARE

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is calculated by the State on an annually based on the average daily estimated cost of providing dosing and ingredients, core and laboratory work services as described in Section C. The daily estimated cost does not include

room and board and is determined based on the annual estimated cost per patient and a 365-day year, using the most recent and accurate data available. The USDR is paid to county operated and non-county operated NTP providers each day a dose is administered to a beneficiary. NTPs may contract with other entities to perform some work services, such as laboratory work. NTPs pay those outside entities for that work. Those outside entities may not submit claims to the state for reimbursement of work services for which they were paid by the NTP. Outside entities may continue to claim for reimbursement for those services if they are not provided as part of the NTP Level of Care.. The State will periodically monitor the services provided by the NTP for which the USDR was paid to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the USDR.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The USDR rates are effective as of January 1, 2022 and are published at:
https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the median cost, as reported in the most recently submitted cost reports, for individual counseling and group counseling provided in the Outpatient Level of Care as described under Section D.1.a above. The USDR for NTP Individual and Group Counseling are effective as of January 1, 2022 and are published at:
https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

2. Cost Determination Protocol

The reasonable and allowable cost of providing each non-NTP Level of Care, the NTP Level of Care, and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care will be determined in the CMS-reviewed cost report pursuant to the following methodology. Total allowable costs include direct and indirect costs that are determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such as professional service contracts, that can be directly charged in providing the specific non-NTP Level of Care, NTP Level of Care, or Expanded Substance Use Disorder

Treatment Service Reimbursed Outside a Level of Care. Direct practitioners include individuals who are qualified to provide Expanded Substance Use Disorder Treatment Services as defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A.

In accordance with 2 CFR § 200.416, indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its total direct costs or allocated indirect costs based upon the allocation process in the Legal Entity's approved cost allocation plan. If the Legal Entity does not have a plan, the CMS-reviewed State-developed cost report determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report allocates indirect costs to each Expanded Substance Use Disorder Level of care based upon each level of care's percentage of direct costs.

For the Residential Treatment Level of Care, total allowable costs include direct and indirect costs that are determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Direct practitioners include individuals who are qualified to provide Expanded Substance Use Disorder Treatment Services as defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A.

Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. In accordance with 2 CFR § 200.416, when there is not an approved indirect cost rate, the provider may allocate those overhead costs that are not directly attributable to the provision of the medical services using a CMS reviewed cost allocation methodology. The CMS-reviewed cost allocation methodology, as implemented in the state-developed cost report, determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report allocates indirect costs to each Expanded Substance Use Disorder Level of care based upon each level of care's percentage of direct costs. As stated in Title 2, CFR, § 200.56 "indirect costs means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved." Specifically and in accordance with 2 CFR § 200.416 and 2 CFR part 200, App. VII., ¶ A.1, indirect costs that are directly attributable to the provision of medical services but

would generally be incurred at the same level if the medical service did not occur will not be allowable. For those facilities, allowable indirect costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. Costs incurred that "benefit" multiple purposes and would be incurred at the same level if the medical services did not occur are not allowed (e.g., room and board, allocated cost from other related organizations).

The total allowable cost for providing the specific non-NTP Level of Care, NTP Level of Care, or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care by each a Legal Entity is further reduced by any third parties' payments received for the services provided in the non-NTP or NTP Level of Care to Medicaid beneficiaries.

The Legal Entity specific unit rate for each non-NTP Level of Care, NTP Level of Care, or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care is calculated by dividing the Medi-Cal allowable cost for providing the specific non-NTP or NTP Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care by the total number of Units of Service for the specific non-NTP or NTP Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care for the applicable State fiscal year.

3. Apportioning Costs to Medicaid (Medi-Cal)

Total allowable direct and indirect costs allocated to an Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care are apportioned to the Medi-Cal program based upon units of service. For each Expanded Substance Use Disorder Level of Care and Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care, the provider reports on the CMS-reviewed State-developed cost report, the total units of service it provided to all individuals. Units of service are measured in the increments defined in Section C. The total allowable direct and indirect costs allocated to a particular Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care is divided by the total units of service reported for the same level of care or service to determine the cost per unit of service.

For each Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care, the provider reports on the CMS-reviewed State-developed cost report the total units of service provided to Medi-Cal beneficiaries. The cost per unit calculated for each level of care or service is multiplied by the total units of that service provided to Medi-Cal beneficiaries to apportion costs to the Medi-Cal program.

The total allowable cost for providing the specific Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed outside a Level of Care by each a Legal Entity is further reduced by any third parties' payments received for the services provided in the non-NTP or NTP Level of Care to Medicaid beneficiaries.

4. Cost Report Submission

Each Legal Entity that receives reimbursement for non-NTP Level of Care, county operated NTP Level of Care, or Expanded Substance Use Disorder Services Reimbursed Outside a Level of Care is required to file a CMS reviewed cost report by November 1 following the end of each State fiscal year. An extension to submit the cost report may be granted by the State.

5. Interim Settlement

The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the State-developed cost report for the reporting period. Total reimbursable costs are specified under Section B.1 for non-NTP Levels of Care and county operated providers of the NTP Level of Care. If the total reimbursable costs are greater than the total interim payments, the State will pay the provider the difference. If the total interim payments are greater than the total reimbursable costs, the State will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR § 433.316.

6. Final Settlement Process

The State will perform financial compliance audits to determine data reported in the provider's State-developed cost report represents the allowable cost of providing non-NTP or NTP Levels of Care in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75; and the statistical data used to determine the unit of service rate reconcile with the State's record. If the total audited reimbursable cost based on the methodology described under Section B(1) is less than the total interim payment and the interim settlement payments, the State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR § 433.316. If the total reimbursable cost is greater than the total interim and interim settlement payments, the State will pay the provider the difference.

E. REIMBURSEMENT METHODOLOGY – REGIONAL COUNTIES

1. For county-operated providers, the reimbursement methodology for non-NTP Levels of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care is equal to the allowable costs incurred by the county-operated provider as determined Pursuant to Section F below.

2. For non-county-operated providers, the reimbursement methodology for non-NTP Levels of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care is equal to the prevailing charges for the same or similar non-NTP Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care in the county where the provider is located. If prevailing charges are not available, the State will use the best available alternative data, subject to CMS review, that would serve as a reasonable proxy, including the use of trended historical cost data.

3. The reimbursement methodology for the NTP Level of Care provided by non-county operated providers is the lowest of:
    a. The provider's usual and customary charge to the general public for the same or similar level of care, or
    b. The uniform statewide daily reimbursement rate (USDR) established in Section D.1.b above. The uniform statewide daily reimbursement (USDR) rates for the daily dosing service, individual counseling and group counseling are calculated by the State on an annual basis. The USDR rates are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

4. Reimbursement for county-operated providers of the NTP Level of Care is the lowest of:
    a. The provider's usual and customary charge to the general public for providing the same or similar level of care;
    b. The provider's allowable costs of providing the level of care as described in Section F above; or
    c. The USDR established in Section D.1.b above. The uniform statewide daily reimbursement (USDR) rates for the daily dosing service, individual counseling and group counseling are calculated by the State on an annual basis. The USDR rates are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx.

5. The reimbursement methodology for county-operated providers for the payment of prescribed unbundled physician administered drugs and biologicals used for the treatment of opioid use disorders and alcohol use disorders will be reimbursed at the provider's invoice cost or the methodology described in Supplement 2 to Attachment 4.19-B, Page 10.

6. The reimbursement methodology for non-county operated providers for the payment of prescribed unbundled physician administered drugs and biologicals used for the treatment of opioid use disorders and alcohol use disorders will be reimbursed per the methodology described in Supplement 2 to Attachment 4.19-B, Page 10.

F. COST DETERMINATION PROTOCOL FOR EXPANDED SUBSTANCE USE DISORDER TREATMENT LEVELS OF CARE AND EXPANDED SUBSTANCE USE DISORDER TREATMENT SERVICES REIMBURSED OUTSIDE A LEVEL OF CARE PROVIDED BY COUNTY LEGAL ENTITIES – REGIONAL COUNTIES

The following steps will be taken to determine the reasonable and allowable Medicaid costs for Expanded Substance Use Disorder Treatment Levels of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care provided by county-operated providers.

1. Interim Payments

   Interim payments for all Expanded Substance Use Disorder Treatment Levels of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care provided to Medi-Cal beneficiaries are reimbursed at the lower of the billed amount or the SMA, per D.1.a, or USDR, per D.1.b, as applicable for services rendered by a county Legal Entity. The Uniform Statewide Daily Reimbursement (USDR) rates for the daily dosing service, individual counseling and group counseling are calculated by the State on an annual basis. The USDR rates are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

2. Cost Determination Protocol – County Legal Entity

   The reasonable and allowable cost for a county Legal Entity to provide each Expanded Substance Use Disorder Treatment Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care will be determined in the State-developed Regional County cost report pursuant to the following methodology. The cost pools include Outpatient Treatment Services, Intensive Outpatient Treatment, Narcotic Treatment Programs, Partial Hospitalization, Residential Treatment, Withdrawal Management, Peer Support Services, Care Coordination Services, MAT for OUD, and MAT for AUD. Total allowable costs include direct and indirect costs that are determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2

CFR part 200 as implemented by HHS at 45 CFR part 75 .

Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such ~~as~~ professional service contracts, that can be directly charged to provide the specific Expanded Substance Use Disorder Treatment Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care. Direct practitioners include individuals who are qualified to provide Expanded Substance Use Disorder Treatment Services as defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A.

In accordance with 2 CFR § 200.416, indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its net direct costs, or allocated indirect costs based upon the allocation process in the Legal Entity's approved cost allocation plan. If the Legal Entity does not have a cost allocation plan, the CMS-reviewed State-developed cost report determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report allocates indirect costs to each Expanded Substance Use Disorder Level of care based upon each level of care's percentage of direct costs. .

For the Residential Treatment level of care, allowable costs are determined in accordance with Medicare cost reimbursement principles accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75. Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. In accordance with 2 CFR § 200.416, when there is not an approved indirect cost rate, the provider may allocate those overhead costs that are not directly attributable to the provision of the medical services using a CMS reviewed cost allocation methodology. The CMS-reviewed cost allocation methodology, as implemented in the state-developed cost report, determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report allocates indirect costs to each Expanded Substance Use Disorder Level of care based upon each level of care's percentage of direct costs. As stated in Title 2, CFR, § 200.56 "indirect costs means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved." Specifically and in accordance with 2 CFR § 200.416 and 2 CFR part 200, App. VII., ¶ A.1.
Specifically indirect costs that are directly attributable to the provision of medical services but would generally be incurred at the same level if the medical service

did not occur will not be allowable. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. Costs incurred that "benefit" multiple purposes and would be incurred at the same level if the medical services did not occur are not allowed (e.g., room and board, allocated cost from other related organizations).

The total allowable cost for providing the specific Expanded Substance Use Disorder Treatment Levels of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care by each county Legal Entity is further reduced by any third parties payments received for the Expanded Substance Use Disorder Treatment Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care provided. This netted amount is apportioned to the Medi-Cal program using a basis that must be in compliance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

The Legal Entity specific Expanded Substance Use Disorder Treatment Level of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care unit rate is calculated by dividing the Medi-Cal allowable cost for providing the specific Expanded Substance Use Disorder Treatment Level of Care by the total number of UOS, as defined in Section C, for the specific Expanded Substance Use Disorder Treatment Level of Care for the applicable State fiscal year.

3. Apportioning Costs to Medicaid (Medi-Cal)

Total allowable direct and indirect costs allocated to an Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care are apportioned to the Medi-Cal program based upon units of service. For each Substance Use Disorder Level of Care and Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care, the provider reports on the CMS-reviewed State-developed cost report, the total units of service it provided to all individuals. Units of service are measured in the increments defined in Section C. The total allowable direct and indirect costs allocated to a particular Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care is divided by the total units of service reported for the same level of care or service to determine the cost per unit of service.

For each Expanded Substance Use Disorder Level of Care or Expanded Substance

Use Disorder Treatment Service Reimbursed Outside a Level of Care, the provider reports on the CMS-reviewed State-developed cost report the total units of service provided to Medi-Cal beneficiaries. The cost per unit calculated for each level of care or service is multiplied by the total units of that service provided to Medi-Cal beneficiaries to apportion costs to the Medi-Cal program.

The total allowable cost for providing the specific Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed outside a Level of Care by each a Legal Entity is further reduced by any third parties' payments received for the services provided in the non-NTP or NTP Level of Care to Medicaid beneficiaries.

4. Cost Report Submission

Each Regional County is required to file a State-developed, and CMS-reviewed, cost report by November 1 following the close of the State fiscal year.

5. Interim Settlement

The interim settlement will compare interim payments made to each county operated provider with the total reimbursable costs as determined in the Regional County State- developed cost report for the reporting period. Total reimbursable costs for county- operated Legal Entities are specified under Section F.2 for all Expanded Substance Use Disorder Treatment Levels of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care.

If the total reimbursable costs are greater than the total interim payments, the State will pay the county operated provider the difference. If the total interim payments are greater than the total reimbursable costs, the State will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR § 433.316.

6. Final Settlement Process

The State will perform a financial compliance audit to determine if the data reported in the Regional County State-developed cost report represent the allowable cost of providing Expanded Substance Use Disorder Treatment Levels of Care in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75 , and the statistical data used to determine the unit of service rate reconciled with the State's records. If the total

audited reimbursable cost is less than the total interim payment and the interim settlement payments, the State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR § 433.316. If the total reimbursable cost is greater than the total interim and interim settlement payments, the State will pay the provider the difference.

G. **REGIONAL COUNTIES**

Humboldt
Lassen
Mendocino
Modoc
Shasta
Siskiyou
Solano

H. **NON REGIONAL COUNTIES**

Alameda	Napa	San Joaquin
Contra Costa	Nevada	San Luis Obispo
El Dorado	Orange	San Mateo
Fresno	Placer	Santa Barbara
Imperial	Riverside	Santa Clara
Kern	Sacramento	Santa Cruz
Los Angeles	San Benito	Stanislaus
Marin	San Bernardino	Tulare
Merced	San Diego	Ventura
Monterey	San Francisco	Yolo

REIMBURSEMENT FOR 1905(a)(29) MEDICATION ASSISTED TREATMENT FOR OPIOID USE DISORDERS

1. Payment for a) unbundled and bundled services; and b) bundled services and prescribed drugs and biologicals administered by a provider for the treatment of opioid use disorders are reimbursed per the Drug Medi-Cal Program methodologies described in Attachment 4.19-B, starting on page 38.

2. Payment for unbundled prescribed drugs and biologicals used for the treatment of opioid use disorders are reimbursed per the methodology described in Supplement 2 to Attachment 4.19-B, Pages 1-10 for drugs that are dispensed or administered.

3. For Regional Counties and Non-Regional Counties, payment for unbundled prescribed physician administered drugs and biologicals used for the treatment of opioid use disorders are reimbursed per the methodology described in Attachment 4.19-B, Page 41i, 41j, 41o, and 41p.