DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

December 20, 2021

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

Dear Ms. Cooper:

Enclosed is an approved copy of California State Plan Amendment (SPA) 21-0058, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on October 15, 2021. SPA 21-0058 adds Drug Medi-Cal Organized Delivery Services (DMC-ODS) expanded substance use disorder (SUD) treatment services to the Medicaid State Plan. Many of these services were previously authorized under Section 1115 authority. The Expanded SUD treatment services covered under SPA 21-0058 are provided subject to the terms of California's approved Section 1915(b) waiver for California Advancing and Innovating Medi-Cal (CalAIM). The 1915(b) waiver enables the State to limit Expanded SUD treatment services to the DMC-ODS counties that contract with the State to provide expanded SUD treatment services. In addition, California's approved Section 1115 Demonstration Waiver for CalAIM provides the expenditure authority necessary for Expanded SUD treatment services delivered to DMC-ODS beneficiaries receiving short-term SUD treatment in institutions for mental diseases. The services authorized by SPA 21-0058 include: the services outlined in SPA 20-0006-A (the services available in Drug Medi-Cal – or DMC - State Plan counties), care coordination, family therapy, recovery services, observation, and MAT to treat SUDs other than opioid use disorder (OUD). Furthermore, SPA 21-0058 includes the following levels of care: all levels of care included in SPA 20-0006-A, partial hospitalization, residential treatment (other than perinatal residential), and withdrawal management.

Per the state's approved request, the Peer Support Services portion of SPA 21-0058 will have an effective date of July 1, 2022 to coincide with the establishment of the state's peer specialist certification program, which will become effective July 1, 2022. This change in the effective date is specific to the implementation of Peer Support Services portion of SPA 21-0058 and the effective date for the implementation of all other DMC-ODS Expanded SUD treatment services contained in SPA 21-0058 will remain January 1, 2022.

This SPA also establishes the payment methodology for all expanded substance use disorder services and drugs in the state plan to satisfy the non-risk prepaid inpatient health plan (PIHP) upper payment limit (UPL) requirements for Section 1915(b) waiver services. Furthermore, this SPA updates the Medication-Assisted Treatment (MAT) for OUD state plan reimbursement page to reflect reimbursement for all MAT for OUD services from January 1, 2022 onward. For unbundled physician administered drugs (PAD) for the treatment of Opioid Use Disorder and Alcohol Use Disorder, this SPA also states the reimbursement methodology for Non-Regional counties will be the provider's invoice cost or reflect the same approved methodology on the existing Pharmacy

State Plan pages. For Regional counties, the PAD reimbursement for county-operated providers will be the provider's invoice cost or reflect the same approved methodology on the existing Pharmacy State Plan pages and, for non-county operated providers, the reimbursement will be the same as the approved methodology on the existing Pharmacy State Plan pages.

The effective date of this SPA is January 1, 2022 unless otherwise noted. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Supplement 3 to Attachment 3.1-A, pages 6f - 6s
- Supplement 3 to Attachment 3.1-B, pages 4f - 4s
- Limitations on Attachment 3.1-A, page 20a2
- Limitations on Attachment 3.1-B, page 20a2
- Attachment 4.19-A, pages 45.4 – 45.6
- Attachment 4.19-B, pages 41e- 41u

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

Sincerely,

James G. Scott, Director,
Division of Program Operations

Enclosure

cc: Dr. Kelly Pfeifer, Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Tyler Sadwith, DHCS
Jacob Lam, DHCS
Shaina Zurlin, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 1 — 0 0 58

2. STATE: California

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2022

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
42 CFR 440.130 and 42 CFR Part 447

7. FEDERAL BUDGET IMPACT
a. FFY ~~21/22~~ $ 0
b. FFY ~~22/23~~ $ ~~8,000 (in thousands)~~ $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 3 to Attachment 3.1-A, page 6f-~~6r~~ 6s
Supplement ~~2~~ 3 to Attachment 3.1-B, page 4f-4s
Limitations on Attachment 3.1-A, page 20a2
Limitations on Attachment 3.1-B, page 20a2
Attachment 4.19-A, pages ~~41g-r~~ 45.4 - 45.6
Attachment 4.19-B, pages ~~41a-b~~ 41e-41u

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~None~~ Attachment 4.19-B, pages 41e, 41f and 41u

10. SUBJECT OF AMENDMENT
State Plan Amendment (SPA) 21-0058 adds Drug Medi-Cal Organized Delivery Services (DMC-ODS) expanded substance use disorder treatment services to the Medicaid State Plan. SPA 21-0058 also proposes to add peer support services as a DMC-ODS expanded substance disorder service and includes peer support specialists as a distinct provider type.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
Jacey Cooper — Digitally signed by Jacey Cooper Date: 2021.10.15 12:05:08 -07'00'

13. TYPED NAME
Jacey Cooper

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
October 15, 2021

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
October 15, 2021

18. DATE APPROVED
December 20, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2022

20. SIGNATURE OF REGIONAL OFFICIAL
Digitally signed by James G. Scott -S Date: 2021.12.20 19:32:55 -06'00'

21. TYPED NAME
James G. Scott

22. TITLE
Director, Division of Program Operations

23. REMARKS
For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.
Box 7: CMS pen and ink change with state concurrence on 12/1/21.
Box 8: CMS pen and ink page changes with state concurrence on 12/17/21.

Instructions on Back

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATION ON SERVICES

13.d.6 Expanded Substance Use Disorder Treatment Services

Expanded Substance Use Disorder (SUD) treatment services are provided in accordance with the Code of Federal Regulations (CFR) 440.130(d) to restore the beneficiary to their best possible functional level. All expanded SUD treatment services must be recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practice. Expanded SUD treatment services are provided by Drug Medi-Cal (DMC) certified providers and are based on medical necessity.

COVERED EXPANDED SUD TREATMENT SERVICES

“Assessment” consists of activities to evaluate or monitor the status of a beneficiary’s behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards. Assessment may be initial and periodic, and may include contact with family members or other collaterals if the purpose of the collateral’s participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the “Other laboratory and X-ray services” benefit of the California Medicaid State Plan).
- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary’s needs, planned interventions and to address and monitor a beneficiary’s progress and restoration of a beneficiary to their best possible functional level.

"Care Coordination" consists of activities to provide coordination of SUD care, mental health care, and primary care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and includes one or more of the following components:

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports.

"Family Therapy" is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

"Group Counseling" consists of contacts with multiple beneficiaries at the same time. Group Counseling shall focus on the needs of the participants.

"Individual Counseling" consists of contacts with a beneficiary. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

"Medical Psychotherapy" is a counseling service to treat SUDs other than OUD conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.

"Medication Services" includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders as defined below.

“Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Opioid Use Disorders (OUD)” includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29) and described in Supplement 7 to Attachment 3.1-A.

“Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders” includes all FDA-approved drugs and services to treat AUD and other non-opioid SUDs. MAT for AUD and non-opioid SUDs may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the “Levels of Care” section. This service includes:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group counseling as defined above)
- Family Therapy (as defined above)
- Medication Services (as defined above)
- Patient Education (as defined below)
- Recovery Services (as defined below)
- SUD Crisis Intervention Services (as defined below)
- Withdrawal Management Services (as defined below)
- Prescribing and monitoring of MAT for AUD and Other Non-Opioid Substance Use Disorders, which consists of prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT services for AUD and Other Non-Opioid Substance Use Disorders

“Patient Education” is education for the beneficiary on addiction, treatment, recovery and associated health risks.

“Peer Support Services” are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the

beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

Peer support services are based on an approved plan of care and can be delivered as a standalone service. Peer support services include the following service components:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

  **Peer Support Services will be implemented and have an effective date of July 1, 2022.*

"Recovery Services" are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries. Beneficiaries may

receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services.

Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Recovery Services can be delivered as a standalone service, or as a service delivered as part of the levels of care listed below. Recovery Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group counseling as defined above)
- Family Therapy (as defined above)
- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.
- Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.

"SUD Crisis Intervention Services" consists of contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation, and be provided in the least intensive level of care that is medically necessary to treat their condition.

"Withdrawal Management Services" are provided to beneficiaries when medically necessary for maximum reduction of the SUD symptoms and restoration of the beneficiary to their best possible functional level. Withdrawal Management Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined above)
- MAT for AUD and non-opioid SUDs (as defined above)
- Peer Support Services (as defined above)
- Observation, which is the process of monitoring the beneficiary's course of withdrawal. Observation is conducted at the frequency

required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

PROVIDER QUALIFICATIONS

Provider Entities

Expanded SUD Treatment Services are provided by DMC certified providers. DMC certified providers providing Expanded SUD Treatment Services must: 1) be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations; 2) abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and 3) sign a provider agreement with a county.

PRACTITIONER QUALIFICATIONS

	Expanded SUD Treatment Services											
	Assessment *	Care Coordination **	Crisis Intervention	Family Therapy	Counseling (Individual and Group)	Medical Psychotherapy	Medication Services	Patient Education	Peer Support Services	Observation	Recovery Services	Prescribing and Monitoring of MAT for AUD and Other Non-Opioid Substance Use Disorders
Practitioner Qualifications	C, L*	C, L	C, L	L	C, L	M	L	C, L	P	C, L	C, L	L***

C = Counselors

An Alcohol or other drug (AOD) counselor that is either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA).

L = Licensed Practitioner of the Healing Arts
A Licensed Practitioner of the Healing Arts (LPHA) include any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioner working under the supervision of a licensed clinician.

M = Medical director of a Narcotic Treatment Program
The medical director of a Narcotic Treatment Program is a licensed physician in the State of California.

P = Peer Support Specialist
A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet ongoing education requirements. Peer Support Specialists provides

services under the direction of a Behavioral Health Professional.

Notes

*The physical examination shall be conducted by an LPHA in accordance within their scope of practice and licensure. An SUD diagnosis may only be made by an LPHA.

** Certified counselors may assist with some aspects of this service, however, a licensed provider is responsible for supervising this service component.

All personnel performing observations must complete training in withdrawal management.

***May be provided by an LPHA within their scope of practice.

EXPANDED SUD TREATMENT LEVELS OF CARE

1. Outpatient Treatment Services (also known as Outpatient Drug Free or ODF services) (ASAM Level 1) are provided to beneficiaries when medically necessary.

   Outpatient Services include the following service components:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
   - MAT for AUD and other non-opioid SUDs (as defined above)
   - Patient Education (as defined above)
   - Recovery Services (as defined above)
   - SUD Crisis Intervention Services (as defined above)

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2. Intensive Outpatient Treatment Services (ASAM Level 2.1) are provided to beneficiaries when medically necessary in a structured programming environment.

   Intensive Outpatient Services include the following services:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
   - MAT for AUD and other non-opioid substance use disorders (as defined above)
   - Patient Education (as defined above)
   - Recovery Services (as defined above)
   - SUD Crisis Intervention Services (as defined above)

3. Partial Hospitalization Services (ASAM Level 2.5) are delivered to beneficiaries when medically necessary in a clinically intensive programming environment.

   Partial Hospitalization Services include the following services:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
   - MAT for AUD and other non-opioid SUDs (as defined above)
   - Patient Education (as defined above)
   - Recovery Services (as defined above)
   - SUD Crisis Intervention Services (as defined above)

4. Residential Treatment Services are delivered to beneficiaries when medically necessary in a, short-term treatment program corresponding to at least one of the following levels:

   - Level 3.1 - Clinically Managed Low-Intensity residential Services
   - Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
   - Level 3.5 - Clinically Managed High Intensity Residential Services
   - Level 3.7 - Medically Monitored Intensive Inpatient Services
   - Level 4.0 - Medically Managed Intensive Inpatient Services

   Residential Treatment Services include the following services:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)

- MAT for AUD and other non-opioid SUDs (as defined above)
- Patient Education (as defined above)
- Recovery Services (as defined above)
- SUD Crisis Intervention Services (as defined above)

5. Narcotic Treatment Program is an outpatient program that provides FDA-drugs approved to treat SUDs when ordered by a physician as medically necessary. NTPs are required to offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone and disulfiram. NTPs shall offer adequate counseling services to each beneficiary as clinically necessary.

   Narcotic Treatment Program Services include the following services:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medical Psychotherapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
   - MAT for AUD and other non-opioid substance use disorders (as defined above)
   - Patient Education (as defined above)
   - Recovery Services (as defined above)
   - SUD Crisis Intervention Services (as defined above)

6. Withdrawal Management Services are provided to beneficiaries experiencing withdrawal in the following outpatient and residential settings:
   - Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)
   - Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting)
   - Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)

- Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits)
- Level 4-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability)

Withdrawal Management Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
- MAT for AUD and other non-opioid SUDs (as defined above)
- Observation (as defined above)
- Recovery Services (as defined above)

Assurances

The State assures that all medically necessary services coverable under 1905(a) of the Social Security Act are provided to Medicaid eligible individuals under age 21 in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, described in Social Security Act sections 1902(a)(43), 1905(a)(4)(B) and 1905(r). The State assures that substance use disorder treatment services shall be available to children and youth, as necessary to correct or ameliorate a substance use disorder or condition, as required under the provisions of Social Security Act section 1905(r)(5), regardless of their county of residence.

The State assures that the Single State Agency shall not delegate to any other State Agency the authority and responsibilities described in 42 CFR section 431.10(e).

Expanded SUD treatment services are provided subject to the terms of the State's approved Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CalAIM) or subsequent waiver program, including any approved waiver of statewideness, comparability and/or freedom-of-choice that enables the State to limit Expanded SUD treatment services to the Drug Medi-Cal Organized Delivery System to counties that contract with the State to provide expanded SUD treatment services, except in the case of individuals under age 21 in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and the requirements of the provisions of Social Security Act sections cited above, including 1905(r)(5).

The State assures that all Medicaid program requirements that have not been waived in the Section 1915(b) Waiver Proposal for CalAIM or subsequent waiver program shall be adhered to, including all EPSDT Medicaid requirements.

The state assures that Residential Treatment Services are not covered when provided in facilities that are Institutions for Mental Diseases unless expressly authorized under the State's approved Section 1115 Demonstration Waiver or as otherwise consistent with federal law.

The state assures that all services involving family members or other collateral contacts are for the direct benefit of the beneficiary.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.6 Expanded Substance Use Disorder Treatment Services	Expanded Substance Use Disorder Treatment Services are provided within the following levels of care (see Supplement 3 to Attachment 3.1-A for additional details):	Prior authorization is required for select Expanded Substance Use Disorder Treatment Services (as indicated below):
	1. Outpatient Treatment Services	Prior authorization is not required.
	2. Intensive Outpatient Treatment Services	Prior authorization is not required.
	3. Partial Hospitalization Services	Prior authorization is not required.
	4. Residential Treatment Services	Prior authorization is required.
	5. Narcotic Treatment Program	Prior authorization is not required.
	6. Withdrawal Management Services	Prior authorization is not required.

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

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

LIMITATION ON SERVICES

13.d.6 Expanded Substance Use Disorder Treatment Services

Expanded Substance Use Disorder (SUD) treatment services are provided in accordance with the Code of Federal Regulations (CFR) 440.130(d) to restore the beneficiary to their best possible functional level. All expanded SUD treatment services must be recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practice. Expanded SUD treatment services are provided by Drug Medi-Cal (DMC) certified providers and are based on medical necessity.

COVERED EXPANDED SUD TREATMENT SERVICES

“Assessment” consists of activities to evaluate or monitor the status of a beneficiary’s behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards. Assessment may be initial and periodic, and may include contact with family members or other collaterals if the purpose of the collateral’s participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the “Other laboratory and X-ray services” benefit of the California Medicaid State Plan).
- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary’s needs, planned interventions and to address and monitor a beneficiary’s progress and restoration of a beneficiary to their best possible functional level.

"Care Coordination" consists of activities to provide coordination of SUD care, mental health care, and primary care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and includes one or more of the following components:

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports.

"Family Therapy" is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

"Group Counseling" consists of contacts with multiple beneficiaries at the same time. Group Counseling shall focus on the needs of the participants.

"Individual Counseling" consists of contacts with a beneficiary. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

"Medical Psychotherapy" is a counseling service to treat SUDs other than OUD conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.

"Medication Services" includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders as defined below.

“Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Opioid Use Disorders (OUD)” includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29) and described in Supplement 7 to Attachment 3.1-B.

“Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders” includes all FDA-approved drugs and services to treat AUD and other non-opioid SUDs. MAT for AUD and non-opioid SUDs may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the “Levels of Care” section. This service includes:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group counseling as defined above)
- Family Therapy (as defined above)
- Medication Services (as defined above)
- Patient Education (as defined below)
- Recovery Services (as defined below)
- SUD Crisis Intervention Services (as defined below)
- Withdrawal Management Services (as defined below)
- Prescribing and monitoring of MAT for AUD and Other Non-Opioid Substance Use Disorders, which consists of prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT services for AUD and Other Non-Opioid Substance Use Disorders

“Patient Education” is education for the beneficiary on addiction, treatment, recovery and associated health risks.

“Peer Support Services” are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the

beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

Peer support services are based on an approved plan of care and can be delivered as a standalone service. Peer support services include the following service components:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

**Peer Support Services will be implemented and have an effective date of July 1, 2022.*

"Recovery Services" are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries. Beneficiaries may

receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services.

Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Recovery Services can be delivered as a standalone service, or as a service delivered as part of the levels of care listed below. Recovery Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group counseling as defined above)
- Family Therapy (as defined above)
- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.
- Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.

"SUD Crisis Intervention Services" consists of contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation, and be provided in the least intensive level of care that is medically necessary to treat their condition.

"Withdrawal Management Services" are provided to beneficiaries when medically necessary for maximum reduction of the SUD symptoms and restoration of the beneficiary to their best possible functional level. Withdrawal Management Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined above)
- MAT for AUD and non-opioid SUDs (as defined above)
- Peer Support Services (as defined above)
- Observation, which is the process of monitoring the beneficiary's course of withdrawal. Observation is conducted at the frequency

required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

PROVIDER QUALIFICATIONS

Provider Entities

Expanded SUD Treatment Services are provided by DMC certified providers. DMC certified providers providing Expanded SUD Treatment Services must: 1) be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations; 2) abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and 3) sign a provider agreement with a county.

PRACTITIONER QUALIFICATIONS

	Expanded SUD Treatment Services											
	Assessment *	Care Coordination **	Crisis Intervention	Family Therapy	Counseling (Individual and Group)	Medical Psychotherapy	Medication Services	Patient Education	Peer Support Services	Observation	Recovery Services	Prescribing and Monitoring of MAT for AUD and Other Non-Opioid Substance Use Disorders
Practitioner Qualifications	C, L*	C, L	C, L	L	C, L	M	L	C, L	P	C, L	C, L	L***

C = Counselors

An Alcohol or other drug (AOD) counselor that is either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA).

L = Licensed Practitioner of the Healing Arts
A Licensed Practitioner of the Healing Arts (LPHA) include any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioner working under the supervision of a licensed clinician.

M = Medical director of a Narcotic Treatment Program
The medical director of a Narcotic Treatment Program is a licensed physician in the State of California.

P = Peer Support Specialist
A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet ongoing education requirements. Peer Support Specialists provides

services under the direction of a Behavioral Health Professional.

Notes

*The physical examination shall be conducted by an LPHA in accordance within their scope of practice and licensure. An SUD diagnosis may only be made by an LPHA.
** Certified counselors may assist with some aspects of this service, however, a licensed provider is responsible for supervising this service component.
All personnel performing observations must complete training in withdrawal management.

***May be provided by an LPHA within their scope of practice.

EXPANDED SUD TREATMENT LEVELS OF CARE

1. Outpatient Treatment Services (also known as Outpatient Drug Free or ODF services) (ASAM Level 1) are provided to beneficiaries when medically necessary.

   Outpatient Services include the following service components:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
   - MAT for AUD and other non-opioid SUDs (as defined above)
   - Patient Education (as defined above)
   - Recovery Services (as defined above)
   - SUD Crisis Intervention Services (as defined above)

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2. Intensive Outpatient Treatment Services (ASAM Level 2.1) are provided to beneficiaries when medically necessary in a structured programming environment.

   Intensive Outpatient Services include the following services:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
   - MAT for AUD and other non-opioid substance use disorders (as defined above)
   - Patient Education (as defined above)
   - Recovery Services (as defined above)
   - SUD Crisis Intervention Services (as defined above)

3. Partial Hospitalization Services (ASAM Level 2.5) are delivered to beneficiaries when medically necessary in a clinically intensive programming environment.

   Partial Hospitalization Services include the following services:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
   - MAT for AUD and other non-opioid SUDs (as defined above)
   - Patient Education (as defined above)
   - Recovery Services (as defined above)
   - SUD Crisis Intervention Services (as defined above)

4. Residential Treatment Services are delivered to beneficiaries when medically necessary in a, short-term treatment program corresponding to at least one of the following levels:
   - Level 3.1 - Clinically Managed Low-Intensity residential Services
   - Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
   - Level 3.5 - Clinically Managed High Intensity Residential Services
   - Level 3.7 - Medically Monitored Intensive Inpatient Services
   - Level 4.0 - Medically Managed Intensive Inpatient Services

   Residential Treatment Services include the following services:
   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)

- MAT for AUD and other non-opioid SUDs (as defined above)
- Patient Education (as defined above)
- Recovery Services (as defined above)
- SUD Crisis Intervention Services (as defined above)

5. Narcotic Treatment Program is an outpatient program that provides FDA-drugs approved to treat SUDs when ordered by a physician as medically necessary. NTPs are required to offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone and disulfiram. NTPs shall offer adequate counseling services to each beneficiary as clinically necessary.

   Narcotic Treatment Program Services include the following services:

   - Assessment (as defined above)
   - Care Coordination (as defined above)
   - Counseling (individual and group as defined above)
   - Family Therapy (as defined above)
   - Medical Psychotherapy (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
   - MAT for AUD and other non-opioid substance use disorders (as defined above)
   - Patient Education (as defined above)
   - Recovery Services (as defined above)
   - SUD Crisis Intervention Services (as defined above)

6. Withdrawal Management Services are provided to beneficiaries experiencing withdrawal in the following outpatient and residential settings:

   - Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)
   - Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting)
   - Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)

- Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits)
- Level 4-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability)

Withdrawal Management Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
- MAT for AUD and other non-opioid SUDs (as defined above)
- Observation (as defined above)
- Recovery Services (as defined above)

Assurances

The State assures that all medically necessary services coverable under 1905(a) of the Social Security Act are provided to Medicaid eligible individuals under age 21 in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, described in Social Security Act sections 1902(a)(43), 1905(a)(4)(B) and 1905(r). The State assures that substance use disorder treatment services shall be available to children and youth, as necessary to correct or ameliorate a substance use disorder or condition, as required under the provisions of Social Security Act section 1905(r)(5), regardless of their county of residence.

The State assures that the Single State Agency shall not delegate to any other State Agency the authority and responsibilities described in 42 CFR section 431.10(e).

Expanded SUD treatment services are provided subject to the terms of the State's approved Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CalAIM) or subsequent waiver program, including any approved waiver of statewideness, comparability and/or freedom-of-choice that enables the State to limit Expanded SUD treatment services to the Drug Medi-Cal Organized Delivery System to counties that contract with the State to provide expanded SUD treatment services, except in the case of individuals under age 21 in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and the requirements of the provisions of Social Security Act sections cited above, including 1905(r)(5).

The State assures that all Medicaid program requirements that have not been waived in the Section 1915(b) Waiver Proposal for CalAIM or subsequent waiver program shall be adhered to, including all EPSDT Medicaid requirements.

The state assures that Residential Treatment Services are not covered when provided in facilities that are Institutions for Mental Diseases unless expressly authorized under the State's approved Section 1115 Demonstration Waiver or as otherwise consistent with federal law.

The state assures that all services involving family members or other collateral contacts are for the direct benefit of the beneficiary.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.6 Expanded Substance Use Disorder Treatment Services	Expanded Substance Use Disorder Treatment Services are provided within the following levels of care (see Supplement 3 to Attachment 3.1-B for additional details):	Prior authorization is required for select Expanded Substance Use Disorder Treatment Services (as indicated below):
	1. Outpatient Treatment Services	Prior authorization is not required.
	2. Intensive Outpatient Treatment Services	Prior authorization is not required.
	3. Partial Hospitalization Services	Prior authorization is not required.
	4. Residential Treatment Services	Prior authorization is required.
	5. Narcotic Treatment Program	Prior authorization is not required.
	6. Withdrawal Management Services	Prior authorization is not required.

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

State/Territory: California

REIMBURSEMENT OF INPATIENT WITHDRAWAL MANAGEMENT SERVICES

A. DEFINITIONS

"Inpatient Withdrawal Management Services" means Level 3.7 and Level 4.0 Withdrawal Management as defined in section 13.d.6 of Supplement 3 to Attachment 3.1-A of this State Plan when provided in an acute care hospital.

"Cost Report" means the CMS 2552 Hospital Cost Report.

B. REIMBURSEMENT METHODOLOGY AND PROCEDURES

A hospital shall be paid its reasonable and allowable Medicaid costs for Inpatient Withdrawal Management Services. The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursement for Inpatient Withdrawal Management Services.

1. Interim Rates
   Each county will negotiate an interim per diem rate with the hospital and submit that rate to DHCS. Each county will negotiate the interim per diem rate based upon the hospital's historical actual cost as determined in the hospital's most recently filed Cost Report. The interim rate approximates, but does not need to equal, actual cost. Interim rates shall be established on an annual basis.

2. Interim Payments
   Interim payments for Inpatient Withdrawal Management Services are based upon interim per diem rates that are negotiated by a county and a hospital on an annual basis as described in section B.1, above.

3. Cost Report Submission
   Each hospital that provides Inpatient Withdrawal Management Services that does not otherwise submit the cost report to the Department of Health Care Services annually must submit a Cost Report and supplemental schedules by November 1st following the close of the State Fiscal Year (i.e., June 30th). An extension to submit the cost report may be granted by the state for good cause.

4. Interim Settlement
   No later than eighteen months after the close of the state fiscal year, the State will complete the interim settlement of each hospital's cost report. The interim settlement will compare interim payments made to each hospital with the amount determined in the Cost Report and supplemental schedules. Final reimbursement

will be limited to the lower of the hospital's reasonable and allowable costs or usual and customary charges for inpatient withdrawal management services. The total allowable cost for providing the specific Inpatient Withdrawal Management Services is further reduced by any third party and patient payments received for the Inpatient Withdrawal Management Services. The State will pay the hospital additional amounts due if the total reimbursement calculated in the cost report is more than the interim payments made to the hospital. Any overpayments are recouped, and the federal share of the overpayments is returned to the federal government in accordance with 42 CFR 433.316.

5. Final Settlement
The State will complete the audit of the interim settled Cost Report and supplemental schedules within three years of the date the Cost Report and supplemental schedules are submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the Cost Report and supplemental schedules are reasonable, allowable, and in accordance with State and Federal rules, regulations, and Medicare principles of reimbursement issued by the Centers for Medicare and Medicaid Services (CMS). The audit will also determine that the hospital's Cost Report and supplemental schedules represent the actual cost of providing inpatient withdrawal management services in accordance with Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations, Part 200 of Title 2, Code of Federal Regulations, Generally Accepted Governmental Auditing Standards, as published by the Comptroller General of the United States and other State and Federal regulatory authorities. Final reimbursement will be limited to the lower of the hospital's reasonable and allowable costs or usual and customary charges for inpatient withdrawal management services. The total allowable cost for providing the specific Inpatient Withdrawal Management Services is further reduced by any third party and patient payments received for the Inpatient Withdrawal Management Services. The State will pay the hospital additional amounts due if the total reimbursement calculated in the cost report is more than the interim payments made to the hospital. Any overpayments are recouped, and the federal share of the overpayments is returned to the federal government in accordance with 42 CFR 433.316.

6. Cost Principles
For the purpose of paragraphs B.4 and B.5, reasonable and allowable costs will be determined using the Cost Report and the cost principles described in 42 CFR 413 and the Provider Reimbursement Manual, CMS Publications 15-1 and 15-2.

7. Apportioning Costs to Medicaid (Medi-Cal)
Total inpatient costs will be determined from the Cost Report and supplemental schedules. Total inpatient hospital costs will be apportioned to the Medi-Cal program using a cost per day for each routine hospital cost center and a cost-to-charge ratio for each ancillary and other hospital cost centers. Intern and resident costs will be included in the total costs determined on the CMS 2552 and apportioned

to the Medi-Cal program. For these Inpatient Withdrawal Management Services, the State does not reimburse these costs separately using a per resident amount methodology.

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)

<u>Narcotic Treatment Program Level of Care (consist of two components)</u>:

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. <u>Cost Report Submission</u>

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. <u>Interim Settlement</u>

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. <u>Final Settlement Process</u>

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.