State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

October 24, 2022

THIS LETTER SENT VIA EMAIL

Mr. James G. Scott, Director
Division of Program Operations
Medicaid and CHIP Operations Group
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 0300
Kansas City, MO 64106-2898

STATE PLAN AMENDMENT 22-0043: ADDITION OF QUALIFYING COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES IN THE STATE PLAN

Dear Mr. Scott:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 22-0043 for your review and approval.

SPA 22-0043 proposes to add qualifying community-based mobile crisis intervention services, as authorized by section 9813 of the American Rescue Plan Act of 2021, codified as Title 42 of the United States Code (U.S.C.), section 1396w-6, to the Medicaid State Plan as a Rehabilitative Mental Health Service, Substance Use Disorder (SUD) Treatment Service, and Expanded SUD Treatment Service. The qualifying community-based mobile crisis intervention services will be available 24 hours a day, 7 days a week, 365 days a year, and will include the following service components:

- Crisis assessment
- Mobile crisis response
- Crisis planning
- Facilitation of a warm handoff
- Referrals to ongoing supports
- Follow up check-ins

Qualifying community-based mobile crisis intervention services are an integral part of California's broader effort to strengthen the continuum of community-based care for Medi-Cal beneficiaries who are living with mental health and/or substance use disorder conditions. The new qualifying community-based mobile crisis intervention services are designed to provide relief to beneficiaries experiencing a behavioral health crisis,

including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the individual is experiencing the behavioral health crisis, including at the individual's home, school or workplace, on the street, or where an individual socializes. In accordance with Title 42 of the U.S.C., section 1396w-6(b)(1)(A) and CMS State Health Official Letter #21-008, the new qualifying community-based mobile crisis intervention services will not be provided to beneficiaries in a hospital or other facility setting.

Included in this submission are the following:

- Supplement 3 to Attachment 3.1-A, pages 6t-6w (new)
- Supplement 3 to Attachment 3.1-B, pages 4t-4w (new)
- Attachment 4.19-B, pages 23-25.11 (redline and clean)
- Attachment 4.19-B, pages 38-41w (redline and clean)

In compliance with the American Recovery and Reinvestment Act of 2009 (42 U.S.C. section 1396a(a)(73)), DHCS routinely notifies Indian Health Programs and Urban Indian Organizations of SPAs that have a direct impact on the programs and organizations. DHCS released the Tribal Notice on August 23, 2022, and held a webinar on August 31, 2022.

DHCS anticipates the federal budget impact for Federal Fiscal Year (FFY) 2022-2023 to be $61,474,000 and $92,211,000 for FFY 2023-2024.

If you have any questions or need additional information, please contact Ivan Bhardwaj, Acting Medi-Cal Behavioral Health Division Chief, at (916) 842-8598 or by email at Ivan.Bhardwaj@dhcs.ca.gov.

Sincerely,

[redacted]

Jacey Cooper
State Medicaid Director
Chief Deputy Director
Health Care Programs

Enclosures

cc: See Next Page

cc: Tyler Sadwith
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0043

2. STATE: CA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Section 9813 of the American Rescue Plan Act of 2021
42 CFR 440.130 and 42 CFR Part 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022-2023 $ 61474000
b. FFY 2023-2024 $ 92211000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 3 to Attachment 3.1-A, page 6t-6w
Supplement 3 to Attachment 3.1-B, page 4t-4w
Attachment 4.19-B, pages 23, 25.1, 25.3, 25.6, 25.9, 25.10, and 25.11
Attachment 4.19-B, pages 38-41w

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, pages 23, 25.1, 25.3, 25.6, 25.9, 25.10, and 25.11
Attachment 4.19-B, pages 38-41u

9. SUBJECT OF AMENDMENT
To add qualifying community-based mobile crisis intervention services, as authorized by section 9813 of the American Rescue Plan Act of 2021, to the Medicaid State Plan as a Rehabilitative Mental Health Service, Substance Use Disorder (SUD) Treatment Service, and Expanded SUD Treatment Service.

10. 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:
Please note: The Governor's Office does not wish to review the State Plan Amendment.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Jacey Cooper

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
October 24, 2022

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

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

"Psychiatric inpatient hospital professional services" means services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services to not include routine hospital services or hospital-based ancillary services.

"Rehabilitative Mental Health Services" means any of the following: mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, community-based mobile crisis intervention services, crisis stabilization, adult residential treatment services, crisis residential treatment services, psychiatric health facility services, and peer support services, provided to individuals who meet medical necessity criteria as defined in Supplement 3 to Attachment 3.1-A of the State plan; and services provided in a treatment foster home.

"Relative value statistic" means a statistic that has been developed from dissimilar elements that acts as a common basis for the purpose of allocating a pool of costs.

"Schedule of Maximum Rates (SMR)" means a schedule of maximum rates per unit of service, as defined in Section G of this Segment, which will be paid for each type of service.

"SD/MC hospital" means a hospital as defined in Attachment 3.19-A, Pages 38-40 of the State Plan. A SD/MCC hospital may be a UC hospital, may be owned and operated by a county government, or may be owned and operated by a private entity.

"State Owned and Operated Provider" means a provider that is owned and operated by the Regents of the University of California.

"Targeted Case Management" has the meaning defined in supplement 1 to attachment 3.1-A, pages 8-17 of the State Plan.

"Services Provided in a Treatment Foster Home" means a bundle of rehabilitative mental health services provided to children and youth up to 21 years of age who have been placed in a Residential Treatment Foster Home and who meet medical necessity criteria for those services as established by the State. The bundle of

When cost report data is not available for a rehabilitative mental health service or targeted case management, the State will set the interim rate at the SMIR calculated for the service as described in Section G of this segment.

2. Cost Report Submission
   Each county owned and operated provider and private organizational provider that receives reimbursement for rehabilitative mental health and targeted case management services pursuant to this section is required to file a CMS-approved State-developed cost report by December 31st following the close of the State Fiscal Year (i.e., June 30th). Each county owned and operated provider must certify that it's cost report is based on actual, total expenditures as necessary for claiming Federal Financial Participation pursuant to all applicable requirements of state and federal law including Sections 430.30 and 433.51 of Title 42 Code of Federal Regulations.

3. Cost Determination
   The reasonable and allowable cost of providing rehabilitative mental health and targeted case management services for each county owned and operated provider and private organizational provider will be determined in the CMS-approved State-developed cost report pursuant to the following methodology.

   - Total allowable costs include direct and indirect costs that are determined in accordance with the reimbursement principles in Part 413 of Title 42 of the Code of Federal Regulations (C.F.R.), Title 2, C.F.R. Part 200 as implemented by the United States Department of Health and Human Services at Title 45, C.F.R. Part 75 and CMS Medicaid non-institutional reimbursement policy.
   - 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 rehabilitative mental health and targeted case management services.
   - Indirect costs may be determined by applying the cognizant agency specific approved indirect cost rate to its net direct costs, allocating indirect costs based upon the allocation process in the agency's approved cost allocation plan, or allocating indirect costs based upon direct program costs.
   - Indirect costs allocated pursuant to an approved cost allocation plan will be reduced by any unallowable amount based on CMS' Medicaid non-institutional reimbursement policy.

For the following subset of rehabilitative mental health services – Adult Residential Treatment Services, Crisis Residential Treatment Services, services provided in a treatment foster home and Psychiatric Health Facility Services – allowable costs are determined in accordance with the reimbursement principles in title 42 CFR 413, Title 2, C.F.R. Part 200 as implemented by the United States Department of Health and Human Services at Title 45, C.F.R. Part 75 and CMS Medicaid non-institutional reimbursement policy. Allowable direct costs will be limited to the costs

related to direct practitioners, medical equipment, medical supplies and overhead costs determine using one of the following methods:

- The provider may allocate overhead costs based upon an approved indirect cost rate.
- When there is not an approved indirect cost rate, the provider may allocate those overhead costs that are "directly attributable" to the professional component of providing the medical services using a CMS approved allocation methodology.
- Overhead costs that are not directly attributable to the provision of medical services but would benefit multiple purposes and generally be incurred at the same level if the medical service did not occur, will not be allowable (e.g., room and board, allocated cost from other related organizations).

4. Allocating Costs to Services
   Allowable direct and indirect costs will be allocated to each type of rehabilitative mental health services and targeted case management services using one or more of the following three methods:

   - Direct assignment: Providers with the ability to determine costs at the service level may directly assign allowable direct and indirect costs.
   - Time study: Providers may allocate allowable direct and indirect costs among services based upon the results of a CMS-approved time-study.
   - Relative value: Providers that render multiple types of service may allocate allowable direct and indirect costs among services based upon relative value statistics.

5. Apportioning Costs to Medicaid (Medi-Cal)
   Total allowable direct and indirect costs allocated to a type of service will be apportioned to the Medi-Cal program based upon units of service. For each type of rehabilitative mental health and targeted case management service, the provider will report on the CMS-approved State-developed cost report, the total units of service it provided to all individuals. Units of service will be measured in increments of time as defined in Section H below. The total direct and indirect costs allocated to a particular type of rehabilitative mental health service or to targeted case management will be divided by the total units of service reported for the same type of service to determine the cost per unit of service.

   For each type of rehabilitative mental health and targeted case management service, the provider will report the total units of service provided to Medi-Cal

certified reconciled state-developed cost report is submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS-approved state-developed cost report are reasonable, allowable and in accordance with State and Federal rules and regulations, including Medicare principles of reimbursement issued by CMS and CMS' Medicaid non-institutional reimbursement policy. The audit will also determine that the provider's CMS-approved state-developed cost report represents the actual cost of providing rehabilitative mental health and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 C.F.R.), Title 2, C.F.R. Part 200 as implemented by the United States Department of Health and Human Services at Title 45, C.F.R. Part 75, CMS' Medicaid non-institutional reimbursement policy, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and Federal regulatory authorities. 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 costs are greater than the total interim payments, the state will pay the provider the difference.

D. REIMBURSEMENT METHODOLOGY AND PROCEDURES – COUNTY OWNED AND OPERATED HOSPITAL-BASED OUTPATIENT PROVIDERS AND PRIVATE HOSPITAL-BASED OUTPATIENT PROVIDERS

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements for rehabilitative mental health and targeted case management services provided by county owned and operated hospital-based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers.

1. Interim Payments

Interim payments to county owned and operated hospital-based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers are intended to approximate the Medicaid (Medi-Cal) costs incurred by the provider for services rendered to Medi- Cal beneficiaries. Interim payments for rehabilitative mental health and targeted case management services provided by county owned and operated hospital- based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers will be based upon interim rates that are established by the State on an annual basis. The State will follow the process described below to calculate an interim rate for each

schedules for the services provided for the reporting period. The State will pay the provider an additional amount if the total reimbursable cost is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

2. Final Settlement

The State will complete its audit of the interim settled CMS 2552 hospital cost report and supplemental schedules within three years of the date the certified reconciled CMS 2552 hospital 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 CMS 2552 hospital 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 CMS. The audit will also determine that the provider's CMS 2552 hospital cost report and supplemental schedules represent the actual cost of providing rehabilitative mental health and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 C.F.R.), Title 2, C.F.R. Part 200 as implemented by the United States Department of Health and Human Services at Title 45, C.F.R. Part 75, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will pay the provider an additional amount if the total reimbursable cost is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

E. REIMBURSEMENT METHODOLOGY AND PROCEDURES – PSYCHIATRIC HOSPITAL PROFESSIONAL SERVICES PROVIDED IN SD/MC HOSPITALS

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements for psychiatric hospital professional services provided in SD/MC hospitals.

1. Interim Payments

Interim payments for psychiatric hospital professional services provided in SD/MC hospitals are intended to approximate the Medicaid (Medi-Cal) costs incurred by the SD/MC hospital for the services rendered to Medi-Cal beneficiaries. Interim payments for psychiatric hospital professional services provided in SD/MC hospitals will be based upon interim rates that are established by the State on an annual basis. The State will follow the process described below to calculate an interim rate for psychiatric hospital professional services provided in each SD/MC hospital.

schedules represent the actual cost of providing rehabilitative and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Title 2, C.F.R. Part 200 as implemented by the United States Department of Health and Human Services at Title 45, C.F.R. Part 75, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will pay the provider an additional amount if the total reimbursable costs is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

F. REIMBURSEMENT METHODOLOGY AND PROCEDURES – INDIVIDUAL AND GROUP PROVIDERS AND OTHER QUALIFIED PROVIDERS
Individual and group providers and other eligible providers that render rehabilitative mental health services and/or targeted case management services will be reimbursed based upon the SMIR.

G. SCHEDULE OF MAXIMUM RATES
The State originally calculated the Schedule of Maximum Interim Rates (SMIR) for targeted case management services and rehabilitative mental health services, except crisis stabilization, crisis residential treatment, adult residential treatment, peer support services, and community-based mobile crisis intervention services using data from state fiscal year 1998-99 cost reports. These rates are updated on an annual basis and published in an information notice that is posted to the single state agency's website. The following describes the methodology the State used to calculate the original SMIR and the methodology the state will use to annually update those rates.

1. Extract from each provider’s cost report the reported gross costs for each type of service and reported units of service for each type of service. Gross costs do not include county administrative and utilization review costs.
2. Divide gross costs by units of service for each type of service.
3. Remove from the data set those providers that have a cost per unit that is one standard deviation above the mean.
4. After completing step 3, remove those providers that have a cost per day in the top ten percent of the remaining providers.
5. From the remaining providers, calculate the sum of gross costs reported for each type of service.
6. From the remaining providers, calculate the sum of the units of service reported for each type of service.
7. Divide the sum of gross costs determined in step 5 by the sum of the units of service as determined in step 6 to calculate the statewide average cost per unit for each type of service.

8. The statewide average cost per unit calculated in step 7 will be increased on an annual basis, effective the first day of each state fiscal year, using the change in the home health agency market basket index.

The State calculates that the SMIR for peer support services will be equal to the interim rate set for targeted case management services. The statewide average cost per unit for peer support services will be increased on an annual basis, effective the first day of each state fiscal year, using the change in the home health agency market basket index. The annually updated cost per unit for peer support services will be published in an annual information notice that is posted to the single state agency's website.

The SMIR for Community-Based Mobile Crisis Intervention Services is equal to the SMIR for crisis intervention services multiplied by six hours.

The State originally calculated the SMIR for crisis stabilization using a cost survey of fourteen county programs that provided services for up to 24 hours in an emergency room setting. The statewide average cost per unit for crisis stabilization services will be increased on an annual basis, effective the first day of each fiscal year, using the change in the home health agency market basket index. The annually updated cost per unit for crisis stabilization services will be published in an annual information notice that is posted to the single state agency's website.

The State originally calculated the SMIR for crisis residential treatment and adult residential treatment services based on a cost survey from approximately sixty facilities. The survey distinguished between the cost of treatment from the cost for room and board, which is excluded from the SMIR for crisis residential treatment and adult residential treatment. The statewide average cost per unit for crisis residential treatment and adult residential treatment will be increased on an annual basis, effective the first day of each fiscal year, using the change in the home health agency market basket index. The annually updated cost per unit for crisis residential treatment and adult residential treatment will be published in an annual information notice that is posted to the single state agency's website.

The SMIR for services provided in a treatment foster home will initially be set at $87.40 per day and the State will annually increase this SMIR based upon the change in the home health agency market basket index. The $87.40 daily rate is based upon the existing rate the State pays providers for a similar service called intensive treatment foster care. The treatment component of these rates are based upon an hourly rate of $23 for an in-home support counselor multiplied by the number of hours the in-home support counselor is likely to provide treatment to the child. The most intensive level of treatment expects the in-home support counselor to provide 114 hours of treatment per month, which is 3.8 hours per day. The hourly rate of $23 multiplied by 3.8 hours per day of treatment equals the daily rate of $87.40.

H. ALLOWABLE SERVICES (ALSO USED IN THE COST REPORT)
Allowable Rehabilitative Mental Health and Targeted Case Management Services and units of service are as follows:

Service	Units of Service
Mental Health Services	One Minute Increments
Medication Support Services	One Minute Increments
Day Treatment Intensive	Half-Day or Full-Day
Day Rehabilitation	Half-Day or Full-Day
Crisis Intervention	One Minute Increments
Crisis Stabilization	One-Hour Blocks
Adult Residential Treatment Services	Day (Excluding room and board)
Crisis Residential Treatment Services	Day (Excluding room and board)
Psychiatric Health Facility Services	Day (Excluding room and board)
Targeted Case Management	One Minute Increments
Services provided in a treatment home	Day (Excluding room and board)
Peer Support Services	15 Minute Increments
Community-Based Mobile Crisis Intervention Services	Encounter

REHABILITATIVE SERVICES: REIMBURSEMENT FOR DRUG MEDI-CAL PROGRAM

Section 1: Reimbursement for Substance Use Disorder Treatment Services

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

A. DEFINITIONS

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

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

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

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

"Community-Based Mobile Crisis Intervention Service" is a Substance Use Disorder Treatment Service as defined in Supplement 3 to Attachment 3.1-A of this State plan.

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

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

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

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

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

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

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

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

B. ALLOWABLE LEVELS OF CARE, SERVICES AND UNITS

Allowable services and units of service are as follows:

Non-NTP Levels of Care	Units
Intensive Outpatient Treatment	One face-to-face contact per calendar day to provide one or more Substance Use Disorder Treatment Service, except for crisis intervention and MAT for OUD. One additional face-to-face or telehealth contact per calendar day for crisis intervention services and one additional face-to- face or telehealth contact per calendar day for MAT for OUD.
Outpatient Drug Free Treatment	One face-to-face or telehealth contact per calendar day to provide one or more Substance Use Disorder Treatment Service, except for crisis intervention and MAT for OUD. One additional face-to-face or telehealth contact per calendar day for crisis intervention services and one additional face-to-face contact per calendar day for MAT for OUD.
Perinatal Residential Substance Use Disorder Treatment	24-hour structured environment per day (excluding room and board)

Narcotic Treatment Program Level of Care (consist of two components)	Units
a) Daily Dosing	Daily bundled service which includes the following components: 1. Core: Intake assessment, treatment planning, physical evaluation, drug screening, and supervision. 2. Laboratory Work: Tuberculin and syphilis tests, monthly drug screening, and monthly pregnancy tests of female methadone patients. 3. Dosing: Ingredients and labor cost for administering MAT for OUD and Disulfiram daily doses to patients.

b) Counseling Individual and/or Group	A patient must receive a minimum of fifty (50) minutes of face-to-face counseling sessions with a therapist or counselor up to a maximum of 200 minutes per calendar month, although additional services may be provided and reimbursed on medical necessity.
Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care	**Units**
Peer Support Services	15 Minutes
Community-Based Mobile Crisis Intervention Services	Encounter

C. REIMBURSEMENT METHODOLOGY

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

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

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

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

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

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

4. Reimbursement for Community-Based Mobile Crisis Intervention Services is the provider's allowable cost of providing the service as described in Section D.2 and D.3 below.

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

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

1. Interim Payments

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

a. SMA METHODOLOGY FOR THE NON-NTP LEVEL OF CARE, COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES AND PEER SUPPORT SERVICES

"SMAs" are based on the statewide median cost of each level of care or service, as described in Section C above, as reported in the most recent interim settled cost reports submitted by providers. Until providers have submitted cost reports for Peer

Support Services and Community-Based Mobile Crisis Intervention Services and the State has completed the interim settlement of those cost reports, SMAs for Peer Support Services and Community-Based Mobile Crisis Intervention Services are the statewide median rate based upon rates submitted by counties. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The SMAs are

updated annually with the rate effective July 1 of each State fiscal year. SMAs are effective as of July 1, 2021 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx.

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

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

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

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the median cost, as reported in the most recently submitted cost reports, for individual counseling and group counseling provided in the Outpatient Level of Care as described under Section D.1.a above. The USDR for NTP Individual and Group Counseling are effective as of January 1, 2022 and

are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx.

2. Cost Determination Protocol

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

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

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

For the Perinatal Residential Substance Use Disorder Treatment Level of Care,

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

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

Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. In accordance with 2 CFR § 200.416, when there is not an approved indirect cost rate, the CMS-reviewed State-developed cost report determines indirect costs as the difference between total costs and direct costs and allocates indirect costs to each Substance Use Disorder Treatment Level of Care based upon each level of care's percentage of direct costs. As stated in Title 2, CFR, § 200.56 "indirect costs means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved." Specifically and in accordance with 2 CFR § 200.416 and 2 CFR part 200, App. VII., ¶ A.1, indirect costs that are directly attributable to the provision of medical services but would generally be incurred at the same level if the medical service did not occur will not be allowable. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. In accordance with Title 2 CFR § 200.405, costs incurred that benefit multiple purposes and would be incurred at the same level if the medical services did not occur are not allowed (e.g., room and board, allocated cost from other related organizations).

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

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

3. Apportioning Costs to Medicaid (Medi-Cal)

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

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

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

4. Cost Report Submission

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

5. Interim Settlement

The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the CMS-reviewed State-developed cost report for the reporting period. Total reimbursable costs are specified under Section C.1 for Non-NTP Levels of Care, and Peer Support Services, under C.3 for the NTP Level of Care provided by county operated providers, under Section C.2 for the NTP Level of Care provided by non-county operated providers, and under Section C.4 for Community-Based Mobile Crisis Intervention Services. If the total reimbursable costs are greater than the total interim payments, the State will pay the provider the difference. If the total interim payments are greater than the total reimbursable costs, the State will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR § 433.316.

6. Final Settlement Process

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

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 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).

"Community-Based Mobile Crisis Intervention Service" is a Rehabilitative Substance Use Disorder Service as defined in Supplement 3 to Attachment 3.1-A of this State plan.
"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 known as Outpatient Drug Free or ODF)	15-Minutes

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

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

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

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

Services and Drugs	Units
Recovery Service	15 Minutes
Peer Support Service	15 Minutes
Care Coordination Service	15 Minutes
MAT for AUD	15 Minutes
MAT for AUD Medication	Dose
MAT for OUD	15 Minutes
MAT for OUD Medication	Dose
Community-Based Mobile Crisis Intervention Services	Encounter

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
Community-Based Mobile Crisis Intervention Services	Encounter

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

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

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

3. Apportioning Costs to Medicaid (Medi-Cal)

Total allowable direct and indirect costs allocated to an Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care are apportioned to the Medi-Cal program

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

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

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

4. Cost Report Submission

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

5. Interim Settlement

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

6. Final Settlement Process

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

E. REIMBURSEMENT METHODOLOGY – REGIONAL COUNTIES

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

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

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

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

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

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

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

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

1. Interim Payments

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

January 1, 2022 and are published at:
https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal- Rates.aspx.

2. Cost Determination Protocol – County Legal Entity

The reasonable and allowable cost for a county Legal Entity to provide each Expanded Substance Use Disorder Treatment Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care will be determined in the State-developed Regional County cost report pursuant to the following methodology. The cost pools include Outpatient Treatment Services, Intensive Outpatient Treatment, Narcotic Treatment Programs, Partial Hospitalization, Residential Treatment, Withdrawal Management, Peer Support Services, Care Coordination Services, MAT for OUD, and MAT for AUD. Total allowable costs include direct and indirect costs that are determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

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

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

For the Residential Treatment level of care, allowable costs are determined in accordance with Medicare cost reimbursement principles accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75. Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. In accordance with 2 CFR § 200.416, when there is not an approved indirect cost rate, the provider may allocate

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

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

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

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

3. Apportioning Costs to Medicaid (Medi-Cal)

Total allowable direct and indirect costs allocated to an Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care are apportioned to the Medi-Cal program based upon units of service. For each Substance Use Disorder Level of Care and Expanded

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

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

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

4. Cost Report Submission

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

5. Interim Settlement

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

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

6. Final Settlement

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.

State/Territory: California

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

LIMITATION ON SERVICES

13.d.7 Community-Based Mobile Crisis Intervention Services

Community-based mobile crisis intervention services are covered as a Rehabilitative Mental Health Service, Substance Use Disorder (SUD) Treatment Service, and Expanded SUD Treatment Service.

Community-based mobile crisis intervention services ("mobile crisis services") provide rapid response, individual assessment and community-based stabilization to Medi-Cal beneficiaries who are experiencing a mental health and/or SUD ("behavioral health") crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed, and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis, but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restoring the beneficiary to the highest possible functional level.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the individual is experiencing the behavioral health crisis. Locations may include, but are not limited to, the individual's home, school or workplace, on the street, or where an individual socializes. Mobile crisis services cannot be provided in hospitals or other facility settings. Mobile crisis services must be available to beneficiaries experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

Service Components

Mobile crisis teams must be able to perform all mobile crisis service components. Service components include:

- **Crisis assessment** to evaluate the current status and environment of the beneficiary experiencing the behavioral health crisis with the goal of mitigating any immediate risk of danger, determining a short-term strategy for restoring stability, and identifying appropriate follow-up care.
- **Mobile crisis response** consisting of an expedited on-site intervention with a beneficiary experiencing a behavioral health crisis with the goal of stabilizing the individual within a community setting and de-escalating the crisis.
- **Crisis planning** to develop a plan to avert future crises, including identifying conditions and factors that contribute to a crisis, reviewing alternative ways of responding to such conditions and factors, and identifying steps that the beneficiary can take to avert or address a crisis.
- **Facilitation of a warm handoff** if the beneficiary requires urgent treatment in an alternative setting. The mobile crisis team must identify an appropriate facility or provider, and provide or arrange for transportation, as needed.
- **Referrals to ongoing supports** by identifying and connecting a beneficiary to ongoing behavioral health treatment, community-based supports, social services, and/or other supports that could mitigate the risk of future crises. This may include identifying appropriate services, making referrals or appointments, and otherwise assisting a beneficiary to secure ongoing support.
- **Follow up check-ins** to continue resolution of the crisis, provide further crisis planning, check on the status of referrals, and provide further referrals to ongoing supports.

Mobile Crisis Team Requirements and Provider Qualifications

Mobile crisis services are provided by a Mobile Crisis Team consisting of multidisciplinary behavioral health professionals. All members of the Mobile Crisis Team must meet the State's training requirements.

Mobile crisis teams must include at least two behavioral health professionals as listed in Table 1 below, including at least one provider who is qualified to provide a crisis assessment within their authorized scope of practice under California law.

Table 1. Qualified Mobile Crisis Team Members by Delivery System

Rehabilitative Mental Health Treatment Providers*	SUD Treatment Providers**	Expanded SUD Treatment Providers**	Other Provider Types***
• Physician • Psychologist • Waivered Psychologist • Licensed Clinical Social Worker • Waivered/Registered Clinical Social Worker • Licensed Professional Clinical Counselor • Waivered/Registered Professional Clinical Counselor • Marriage and Family Therapist • Waivered/Registered Marriage and Family Therapist • Registered Nurse • Certified Nurse Specialist • Licensed Vocational Nurse • Psychiatric Technician • Mental Health Rehabilitation Specialist • Physician Assistant	• Licensed Practitioner of the Healing Arts (LPHA) as defined in the "Provider Qualifications" subsection of the "SUD Treatment Services" section of this supplement. • AOD Counselor • Peer Support Specialist	• LPHA as defined in the "Practitioner Qualifications" subsection of the "Expanded SUD Treatment Services" section of this supplement. • AOD Counselor • Peer Support Specialist	• Community Health Workers as defined in the Community Health Worker Services preventive services benefit. • Emergency Medical Technicians. Emergency Medical Technicians must be certified in accordable with applicable State of California certification requirements. • Advanced Emergency Medical Technicians. Advanced Emergency Medical Technicians must be certified in accordable with applicable State of California certification requirements. • Paramedics. Paramedics must be licensed in accordance with applicable State of

Rehabilitative Mental Health Treatment Providers*	SUD Treatment Providers**	Expanded SUD Treatment Providers**	Other Provider Types***
• Nurse Practitioner • Pharmacist • Occupational Therapist • Other Qualified Provider • Peer Support Specialist			California licensure requirements. • Community Paramedics. Community paramedics must be licensed, certified, and accredited in accordance with applicable State of California licensure requirements.

*Rehabilitative Mental Health Treatment services are provided by certified mental health organizations or agencies and by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for Rehabilitative Mental Health Services established by the Department of Health Care Services, to the extent authorized under state law.

**SUD and Expanded SUD Treatment services are provided by DMC certified providers that: 1) are 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 or the Department of Health Care Services.

***Other Provider Types are eligible to participate on mobile crisis teams delivering Rehabilitative Mental Health Treatment, SUD Treatment, or Expanded SUD Treatment services as defined above.

Limitations

In accordance with Section 1947(b)(1)(A) of the Social Security Act (Title 42 of the United States Code section 1396w-6(b)(1)(A)), added by Section 9813 of the American Rescue Plan Act, and applicable CMS guidance, mobile crisis services cannot be provided to beneficiaries in a hospital or other facility setting.

State/Territory: California

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

LIMITATION ON SERVICES

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Community-based mobile crisis intervention services are covered as a Rehabilitative Mental Health Service, Substance Use Disorder (SUD) Treatment Service, and Expanded SUD Treatment Service.

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Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the individual is experiencing the behavioral health crisis. Locations may include, but are not limited to, the individual's home, school or workplace, on the street, or where an individual socializes. Mobile crisis services cannot be provided in hospitals or other facility settings. Mobile crisis services must be available to beneficiaries experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

Service Components

Mobile crisis teams must be able to perform all mobile crisis service components. Service components include:

- **Crisis assessment** to evaluate the current status and environment of the beneficiary experiencing the behavioral health crisis with the goal of mitigating any immediate risk of danger, determining a short-term strategy for restoring stability, and identifying appropriate follow-up care.
- **Mobile crisis response** consisting of an expedited on-site intervention with a beneficiary experiencing a behavioral health crisis with the goal of stabilizing the individual within a community setting and de-escalating the crisis.
- **Crisis planning** to develop a plan to avert future crises, including identifying conditions and factors that contribute to a crisis, reviewing alternative ways of responding to such conditions and factors, and identifying steps that the beneficiary can take to avert or address a crisis.
- **Facilitation of a warm handoff** if the beneficiary requires urgent treatment in an alternative setting. The mobile crisis team must identify an appropriate facility or provider, and provide or arrange for transportation, as needed.
- **Referrals to ongoing supports** by identifying and connecting a beneficiary to ongoing behavioral health treatment, community-based supports, social services, and/or other supports that could mitigate the risk of future crises. This may include identifying appropriate services, making referrals or appointments, and otherwise assisting a beneficiary to secure ongoing support.
- **Follow up check-ins** to continue resolution of the crisis, provide further crisis planning, check on the status of referrals, and provide further referrals to ongoing supports.

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Mobile crisis services are provided by a Mobile Crisis Team consisting of multidisciplinary behavioral health professionals. All members of the Mobile Crisis Team must meet the State's training requirements.

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Rehabilitative Mental Health Treatment Providers*	SUD Treatment Providers**	Expanded SUD Treatment Providers**	Other Provider Types***
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*Rehabilitative Mental Health Treatment services are provided by certified mental health organizations or agencies and by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for Rehabilitative Mental Health Services established by the Department of Health Care Services, to the extent authorized under state law.

**SUD and Expanded SUD Treatment services are provided by DMC certified providers that: 1) are 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 or the Department of Health Care Services.

***Other Provider Types are eligible to participate on mobile crisis teams delivering Rehabilitative Mental Health Treatment, SUD Treatment, or Expanded SUD Treatment services as defined above.

Limitations

In accordance with Section 1947(b)(1)(A) of the Social Security Act (Title 42 of the United States Code section 1396w-6(b)(1)(A)), added by Section 9813 of the American Rescue Plan Act, and applicable CMS guidance, mobile crisis services cannot be provided to beneficiaries in a hospital or other facility setting.