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

Medicaid and CHIP Operations Group

December 20, 2021

Jacey Cooper
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 94899-7413

Re: California State Plan Amendment (SPA) 20-0006-A

Dear Ms. Cooper:

Enclosed is an approved copy of California State Plan Amendment (SPA) 20-0006-A, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2020 as SPA 20-0006, which was split into two separate SPAs per CMS request. California SPA 20-0006-A makes updates to the substance use disorder treatment services provided under the rehabilitation services benefit. The SPA adds peer support services, modifies SUD crisis intervention services, and revises the provider qualifications.

This SPA also updates the reimbursement to match the substance use disorder service changes in the coverage section and adds a methodology for non-methadone drugs, including reimbursement for services covered under the mandatory Medication-Assisted Treatment (MAT) for Opioid Use Disorders (OUD) benefit.

Per the state's request, the Peer Support Services portion of SPA 20-0006-A will have an effective date of July 1, 2022 to coincide with the establishment of the state's peer specialist certification program, which will become effective July 1, 2022. This effective date is specific to the implementation of the Peer Support Services portion of SPA 20-0006-A only; the effective date for all other SUD treatment services contained in SPA 20-0006-A will be July 1, 2020.

The effective date of this SPA is July 1, 2020 unless otherwise noted. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Limitations on Attachment 3.1-A, pages 20 and 20a
- Limitations on Attachment 3.1-B, pages 20 and 20a
- Supplement 3 to Attachment 3.1-A, pages 3, 4, 5, 6, 6a, 6b, 6c and 6d
- Supplement 3 to Attachment 3.1-B, pages 1, 2, 3, 4, 4a, 4b, 4c and 4d
- Attachment 4.19-B, pages 38, 39, 40, 41, 41a, 41b, 41c, 41d, 41e and 41f

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

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2021.12.20 19:28:34 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosure

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

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: 20 — 0006-A

2. STATE: California

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

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

4. PROPOSED EFFECTIVE DATE: July 1, 2020

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.130 and 42 CFR Part 447

7. FEDERAL BUDGET IMPACT See Box 23
a. FFY ~~2020~~ (7/1/20-9/30/20) $112 (in thousands)
b. FFY 2021 $ 448 (in thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 3 to Attachment 3.1-A, pages 3-6a ~~d~~
Supplement 3 to Attachment 3.1-B, pages 1-4a ~~d~~
Limitations on Attachment 3.1-A, pages 20-20a 1
Limitations on Attachment 3.1-B, pages 20-20a 1
Attachment 4.19-B, pages 38-~~41g~~ 41f

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* See Box 23
Supplement 3 to Attachment 3.1-A, pages 3-6a*
Supplement 3 to Attachment 3.1-B, pages 1-4a*
Limitations on Attachment 3.1-A, pages 20-20a*
Limitations on Attachment 3.1-B, pages 20-20a*
Attachment 4.19-B, pages 38-41f
*Delete Supp. 3 to Att. 3.1-A p.3a & 4a; Supp. 3 to Att. 3.1-B p. 1a & 2a; Lim. to Att. 3.1-A, p. 20a1 and Lim. to Att. 3.1-B, p. 20a1 as obsolete.

10. SUBJECT OF AMENDMENT See Box 23

~~Counseling via telehealth and telephone, FDA approved drugs to treat opioid use disorder, add Medication Assisted Treatment, remove LAAM, remove Early and Periodic Screening, Diagnosis, and Treatment services prior authorization, accurately define Naltrexone as a component of service, and technical changes to Provider Qualifications.~~

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Jacey Cooper

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
September 30, 2020

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
September 30, 2020

18. DATE APPROVED
December 20, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2021.12.20 19:29:09 -06'00'

21. TYPED NAME
James G. Scott

22. TITLE
Director, Division of Program Operations

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment. Box 1: Per CA's RAI response, pen-ink update to renumber SPA as part "A."
Box 7: CMS pen ink clarification to FFY20 per 12/15/21 email with CA. Box 8-CMS pen & ink correction per 12/16/21 email with CA. Box 8 & 9: Corrected page numbering. Per CA email on 12/17/21, CA confirmed specific pages to be deleted as obsolete under 20-0006-A. Box 10-CMS pen & ink update of SPA description made on 12/16/21: Adds peer support services, modifies SUD crisis intervention services, and revises the provider qualifications. Updates reimbursement section and adds methodology for non-methadone drugs, including reimbursement for services covered under the mandatory Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD) benefit.

Instructions on Back

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.4 Rehabilitative mental health services (continued)	See Supplement 3 to Attachment 3.1-A for program coverage and eligibility details.	Services are based on medical necessity.
13.d.5 Substance Use Disorder Treatment Services	Substance use disorder treatment services include:	
	Narcotic treatment program (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.
	Outpatient Treatment Services (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.

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

(Note: This chart is an overview only.)

TYPE OF SERVICE***	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Intensive Outpatient Treatment Services (see Supplement 3 to Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.
	Perinatal Residential Substance Use Disorder Treatment (see Supplemental 3 to Attachment 3.1-A for program coverage and details)	Prior authorization is not required. The cost of room and board are not reimbursable DMC services.

*Prior authorization is not required for emergency services.
**Coverage. is limited to medically necessary services.
***Outpatient services are pursuant to 42 CFR 440.130.

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.4 Rehabilitative mental health services (continued)	See Supplement 3 to Attachment 3.1-A for program coverage and eligibility details.	Services are based on medical necessity.
13.d.5 Substance Use Disorder Treatment Services	Substance use disorder treatment services include:	
	Narcotic treatment program (see Supplement 2 To Attachment 3.1-B for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.
	Outpatient Treatment Services (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.

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

(Note: This chart is an overview only.)

TYPE OF SERVICE***	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Intensive Outpatient Treatment Services (see Supplement 2 to Attachment 3.1-B for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required.
	Perinatal Residential Substance Use Disorder Treatment (see Supplemental 2 to Attachment 3.1-B for program coverage and details)	Prior authorization is not required. The cost of room and board are not reimbursable DMC services.

*Prior authorization is not required for emergency services.
**Coverage. is limited to medically necessary services.
***Outpatient services are pursuant to 42 CFR 440.130.

LIMITATION ON SERVICES

13.d.5 Substance Use Disorder Treatment Services

Substance use disorder (SUD) treatment services are provided in accordance with the Code of Federal Regulations (CFR) 440.130(d) to restore the beneficiary to their best possible functional level. All SUD treatment services must be recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practice. SUD treatment services are based on medical necessity.

Services that involve the participation of a non-Medicaid eligible are for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service. These services are marked with an *.

COVERED SUD TREATMENT SERVICES

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

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or

order laboratory testing (laboratory testing is covered under the "Other laboratory and X-ray services" benefit of the California Medicaid State Plan).

- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.

"Group Counseling" means a contact with multiple beneficiaries at the same time. Group counseling shall focus on the needs of the participants. Group counseling shall be provided to a group that includes at least 2 and no more than 12 participants.

"Individual Counseling" means a contact with a beneficiary. Individual counseling also includes a contact between a beneficiary, substance use disorder treatment professional, and one or more collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals. Individual counseling also includes preparing the beneficiary to live in the community, and providing linkages to treatment and services available in the community.

"Medical Psychotherapy" means a type of counseling service to treat SUDs other than Opioid Use Disorders (OUD) conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.

"Medication Services" means the prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT to treat Opioid Use Disorders as defined below.

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

"*Peer Support Services" are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self

sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

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

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

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

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

PROVIDER QUALIFICATIONS

Provider Entities

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

	SUD Treatment Services						
	Assessment*	Counseling (Individual and Group)	Medical Psychotherapy	Medication Services	Patient Education	Peer Support Services	SUD Crisis Intervention
Practitioner Qualifications	C, L*	C, L	M	L	C, L	P	C, L

C = Counselors
An Alcohol or other drug (AOD) counselor that is 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA).

L = Licensed Practitioner of the Healing Arts
A Licensed Practitioner of the Healing Arts (LPHA) include any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional

Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioner working under the supervision of a licensed clinician.

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

P = Peer Support Specialist
A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet ongoing education requirements. Peer Support Specialists provides services under the direction of a Behavioral Health Professional.

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

SUBSTANCE USE DISORDER TREATMENT LEVELS OF CARE

1. Intensive Outpatient Treatment Services are provided to beneficiaries when medically necessary in a structured programming environment.

   Intensive Outpatient Treatment includes the following service components:
   - Assessment (as defined above)
   - Individual Counseling (as defined above)
   - Group Counseling (as defined above)
   - Patient Education (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
   - SUD Crisis Intervention Services (as defined above)

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

The components of the Narcotic Treatment Program are:

- Assessment (as defined above)
- Individual Counseling (as defined above)
- Group Counseling (as defined above)
- Patient Education (as defined above)
- Medical Psychotherapy (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
- SUD Crisis Intervention Services (as defined above)

3. Outpatient Treatment Services (also known as Outpatient Drug Free or ODF) are provided to beneficiaries as medically necessary.

   Outpatient Services include the following components:

   - Assessment (as defined above)
   - Individual Counseling (as defined above)
   - Group Counseling (as defined above)
   - Patient Education (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
   - SUD Crisis Intervention Services (as defined above)

4. Perinatal Residential Substance Use Disorder Treatment is a non-institutional, non- medical, residential program which provides rehabilitation services to pregnant and postpartum women with a substance use disorder diagnosis. Each beneficiary shall live on the premises and shall be supported in their efforts to restore and apply interpersonal and independent living skills and access community support systems. Perinatal Residential Substance Use Disorder Treatment programs shall provide a range of activities and services for pregnant and postpartum beneficiaries. Supervision shall be available day and night, seven days a week. Medically necessary rehabilitative services are provided in accordance with individualized beneficiary needs. The cost of room and board is not reimbursable under the Medi-Cal program. Facilities shall store and safeguard all residents'

medications, and facility staff members may assist with resident's self-administration of medication.

The components of Perinatal Residential Substance Use Disorder Treatment are:

- Assessment (as defined above)
- Individual Counseling (as defined above)
- Group Counseling (as defined above)
- MAT for OUD (as defined in Supplement 7 to Attachment 3.1-A)
- Patient Education (as defined above)
- SUD Crisis Intervention Services (as defined above)

Assurances

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

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

The State assures that all Medicaid program requirements regarding free choice of providers as defined in 42 CFR 431.51 shall be adhered to.

The State assures that Perinatal Residential Substance Use Disorder Services are not provided in facilities that are Institutions for Mental Diseases.

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

Reserved for Future Use

State/Territory: California

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

LIMITATION ON SERVICES

13.d.5 Substance Use Disorder Treatment Services

Substance use disorder (SUD) treatment services are provided in accordance with the Code of Federal Regulations (CFR) 440.130(d) to restore the beneficiary to their best possible functional level. All SUD treatment services must be recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practice. SUD treatment services are based on medical necessity.

Services that involve the participation of a non-Medicaid eligible are for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service. These services are marked with an *.

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- Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

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

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

PROVIDER QUALIFICATIONS

Provider Entities

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	SUD Treatment Services						
	Assessment*	Counseling (Individual and Group)	Medical Psychotherapy	Medication Services	Patient Education	Peer Support Services	SUD Crisis Intervention
Practitioner Qualifications	C, L*	C, L	M	L	C, L	P	C, L

C = Counselors
An Alcohol or other drug (AOD) counselor that is 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA).

L = Licensed Practitioner of the Healing Arts
A Licensed Practitioner of the Healing Arts (LPHA) include any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional

Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioner working under the supervision of a licensed clinician.

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

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A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet ongoing education requirements. Peer Support Specialists provides services under the direction of a Behavioral Health Professional.

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

SUBSTANCE USE DISORDER TREATMENT LEVELS OF CARE

1. Intensive Outpatient Treatment Services are provided to beneficiaries when medically necessary in a structured programming environment.

   Intensive Outpatient Treatment includes the following service components:
   - Assessment (as defined above)
   - Individual Counseling (as defined above)
   - Group Counseling (as defined above)
   - Patient Education (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
   - SUD Crisis Intervention Services (as defined above)

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

The components of the Narcotic Treatment Program are:

- Assessment (as defined above)
- Individual Counseling (as defined above)
- Group Counseling (as defined above)
- Patient Education (as defined above)
- Medical Psychotherapy (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
- SUD Crisis Intervention Services (as defined above)

3. Outpatient Treatment Services (also known as Outpatient Drug Free or ODF) are provided to beneficiaries as medically necessary.

   Outpatient Services include the following components:

   - Assessment (as defined above)
   - Individual Counseling (as defined above)
   - Group Counseling (as defined above)
   - Patient Education (as defined above)
   - Medication Services (as defined above)
   - MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
   - SUD Crisis Intervention Services (as defined above)

4. Perinatal Residential Substance Use Disorder Treatment is a non-institutional, non- medical, residential program which provides rehabilitation services to pregnant and postpartum women with a substance use disorder diagnosis. Each beneficiary shall live on the premises and shall be supported in their efforts to restore and apply interpersonal and independent living skills and access community support systems. Perinatal Residential Substance Use Disorder Treatment programs shall provide a range of activities and services for pregnant and postpartum beneficiaries. Supervision shall be available day and night, seven days a week. Medically necessary rehabilitative services are provided in accordance with individualized beneficiary needs. The cost of room and board is not reimbursable under the Medi-Cal program. Facilities shall store and safeguard all residents'

medications, and facility staff members may assist with resident's self-administration of medication.

The components of Perinatal Residential Substance Use Disorder Treatment are:

- Assessment (as defined above)
- Individual Counseling (as defined above)
- Group Counseling (as defined above)
- MAT for OUD (as defined in Supplement 7 to Attachment 3.1-B)
- Patient Education (as defined above)
- SUD Crisis Intervention Services (as defined above)

Assurances

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

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

The State assures that all Medicaid program requirements regarding free choice of providers as defined in 42 CFR 431.51 shall be adhered to.

The State assures that Perinatal Residential Substance Use Disorder Services are not provided in facilities that are Institutions for Mental Diseases.

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

Reserved for Future Use

REHABILITATIVE SERVICES: REIMBURSEMENT FOR DRUG MEDI-CAL PROGRAM

Section 1: Reimbursement for Substance Use Disorder Treatment Services

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

A. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

B. ALLOWABLE LEVELS OF CARE, SERVICES AND UNITS

Allowable services and units of service are as follows:

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

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

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

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

C. REIMBURSEMENT METHODOLOGY

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

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

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

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

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

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

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

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

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

1. Interim Payments

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

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

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

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

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

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

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

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

2. Cost Determination Protocol

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

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

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

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

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

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

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

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

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

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

3. Apportioning Costs to Medicaid (Medi-Cal)

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

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

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

4. Cost Report Submission

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

5. Interim Settlement

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

6. Final Settlement Process

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

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