



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



GAVIN NEWSOM
GOVERNOR

September 30, 2020

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 20-0006: DRUG MEDI-CAL MODIFICATIONS

Dear Mr. Scott:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 20-0006 for your review and approval. This SPA proposes to modify substance use disorder (SUD) services in the Drug Medi-Cal (DMC) Treatment Program. DHCS seeks an effective date of July 1, 2020, for this SPA.

SPA 20-0006 will 1) allow reimbursement for individual services delivered via telehealth if the provider has obtained consent from all participants, in accordance with California Business & Professions Code Section 2290.5, and takes the necessary security precautions, in compliance with HIPAA and 42 CFR Part 2; 2) define Medication Assisted Treatment (MAT) as all Food and Drug Administration (FDA) approved drugs and biological products to treat opioid use disorders (OUD) to MAT services and add MAT as a service component of all SUD service modalities; 3) remove levoalphacetylmethadol (LAAM) as a specifically identified reimbursable Narcotic Treatment Program (NTP) medication, as it has been discontinued by the manufacturer; 4) remove the prior authorization requirement to receive additional Outpatient Drug Free (ODF) services; 5) appropriately define naltrexone as a service component of all SUD service modalities, rather than a separate SUD service modality, included under MAT and; 6) make technical changes to the provider qualification requirements.

The enclosed SPA revises or adds language to the provisions set forth in the following pages:

- Supplement 3 to Attachment 3.1-A, pages 3-6a
- Supplement 3 to Attachment 3.1-B, pages 1-4a

Mr. James G. Scott
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Pages continued:

- 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

In compliance with the American Recovery and Reinvestment Act of 2009, 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 May 27, 2020, and held a webinar on May 29, 2020.

DHCS anticipates that the total federal cost associated with these changes would be \$111,770 for the fourth quarter of Federal Fiscal year (FFY) 2019-2020 and \$447,080 for FFY 2020-2021.

If you have any questions or need additional information, please contact Marlies Perez, Acting Chief, Medi-Cal Behavioral Health Division, at 916-345-7589 or by email at Marlies.Perez@dhcs.ca.gov.

Sincerely,



Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

Enclosures

cc: Kelly Pfeifer, MD
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**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 0 — 0 0 06

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

a. FFY 2020 \$ 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
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 38-41g

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*)

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

10. SUBJECT OF AMENDMENT

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

OTHER, AS SPECIFIED

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL

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

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

REIMBURSEMENT FOR DRUG MEDI-CAL SERVICES

A. DEFINITIONS

“Drug Medi-Cal services” are substance use disorder treatment services as described under Supplement 3 to Attachment 3.1 A to this State plan.

“Non-Narcotic Treatment Program (non-NTP) service modalities” include Outpatient Drug Free Treatment, Intensive Outpatient Treatment, and Perinatal Residential Substance Use Disorder Treatment.

“Narcotic Treatment Program (NTP) service modality” includes Daily Dosing services and Individual and Group Counseling services.

“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.

“Allowable cost” is reasonable and allowable cost, determined based on year-end cost reports and Medicare cost reimbursement principles as described at 42 CFR Part 413, the Medicare Provider Reimbursement Manual (Centers for Medicare and Medicaid Services, Publication 15-1), OMB A-87 and Medicaid non-institutional reimbursement principles.

“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.

“Legal Entity” means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing Drug Medi-Cal services under contract with the county alcohol and drug department or agency or with DHCS.

“Unit of Service” (UOS) means a face-to-face 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 unplanned crisis intervention. To count as a unit of service, the second contact 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.

“Regional Counties” means those counties listed in Section H of this segment to this State plan.

“Non-Regional Counties” means those counties listed in Section I of this segment to this State plan. Non-Regional Counties provide Drug Medi-Cal services through Legal Entity providers.

“Service Component” means a service provided within an individual service modality. Service components include intake, individual counseling, group counseling, patient education, medication services, medication assisted treatment, collateral services, crisis intervention services, and treatment planning and discharge services.

B. REIMBURSEMENT METHODOLOGY – NON-REGIONAL COUNTIES

1. The reimbursement methodology for county and non-county operated providers of non-NTP 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 services;
 - b. The provider’s allowable costs of providing these services;
 - c. For Legal Entities not directly contracted with DHCS, until June 30, 2014, the SMA, established in Section E.1.a below, is reduced by the portion related to the “County administrative” component, and effective July 1, 2014, the full SMA will apply. For Legal Entities directly contracted with DHCS, the SMA, established in Section E.1.a below, applies.
2. The reimbursement methodology 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 services, or
 - b. Through June 30, 2014, the uniform statewide daily reimbursement rate (USDR) established in Section E.1.b below, is reduced by the amount related to “County administrative” component. Effective July 1, 2014, except for NTP daily dosing service, the USDR will apply.
3. Reimbursement for county-operated NTP providers of NTP services in Non-Regional Counties is at the lowest of:
 - a. The provider’s usual and customary charge to the general public for providing the same or similar services;
 - b. The provider’s allowable costs of providing these services as described in Section E below; or
 - c. The USDR established in Section E.1.b below, less the amount related to “County administrative” component. Effective July 1, 2014, except for NTP-daily dosing services, USDR will apply.

C. ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGIES – NON-REGIONAL COUNTIES

1. Effective with the California State Fiscal Year (SFY) 2009-10 rate development process, the rates established by the methodologies in Sections E.1.a and E.1.b, below shall be modified as follows.

For SFY 2009-10, effective from July 1, 2009 through June 30, 2010, the SFY 2009-10 SMA and USDR rates, for non-NTP and NTP services, developed using the normal rate-setting methodologies as set forth in Sections E.1.a and E.1.b, below will be reduced by 10 percent.

2. For SFY 2010-11 and subsequent fiscal years, the reimbursement rates for Drug Medical Services shall be the lower of the following:
 - a. The rates developed through the normal rate-setting methodologies as set forth in Sections E.1.a and E.1.b, below or,
 - b. The S FY 2009-10 rates 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. ALLOWABLE SERVICES AND UNITS OF SERVICE – ALL COUNTIES

Allowable services and units of service are as follows:

Services	Unit of Service
Intensive Outpatient Treatment	One face-to-face or telehealth contact per calendar day to provide one or more service components, except for crisis intervention and Medication Assisted Treatment. One additional face-to-face or telehealth contact per calendar day for crisis intervention services.
Outpatient Drug Free Treatment	One face-to-face or telehealth contact per calendar day, except for crisis intervention and Medication Assisted Treatment provided as a component of Outpatient Drug Free. One additional face-to-face or telehealth contact per calendar day for crisis intervention services.
Perinatal Residential Substance Use Disorder Services	24-hour structured environment per day (excluding room and board)

Medication Assisted Treatment	One face-to-face or telehealth contact per calendar day to monitor and/or administer medication used in Medication Assisted Treatment.
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Narcotic Treatment Programs (consist of two components):

- | | |
|-----------------|---|
| a) Daily Dosing | Daily bundled service which includes the following components: <ol style="list-style-type: none"> 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 patients. 3. Dosing: Ingredients and labor cost for administering medication used in medication assisted treatment. |
|-----------------|---|

b) Counseling Individual and/or Group	10 minutes
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E. COST DETERMINATION PROTOCOL FOR NON-NTP AND COUNTY-OPERATED NTP PROVIDERS – NON-REGIONAL COUNTIES

The following steps will be taken to determine the reasonable and allowable Medicaid costs for providing non-NTP and NTP services.

1. Interim Payments

Interim payments for non-NTP and NTP services provided to Medi-Cal beneficiaries are reimbursed up to the SMA/USDR for the current year.

a. SMA METHODOLOGY FOR NON-NTP SERVICES

“SMAs” are based on the statewide median cost of each type of service as reported in the most recent interim settled cost reports submitted by providers. The SMAs are updated annually with the rate effective July 1 of each State fiscal year.

b. UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGY FOR
DMC NARCOTIC TREATMENT PROGRAMS

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in Section D. The daily cost is determined based on the annual cost per patient and a 365-day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators.

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under Section E.1.a above.

2. Cost Determination Protocol

The reasonable and allowable cost of providing each non-NTP service and NTP service 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 Medicare cost reimbursement principles in 42 CFR 413, OMB Circular A-87 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 in providing the specific non-NTP and NTP service. 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 OMB Circular A-87, Medicare cost reimbursement principles (42 CFR 413 and Medicare Provider Reimbursement Manual Parts 1 and 2), and Medicaid non-institutional reimbursement policy.

For the non-NTP Perinatal Residential Substance Use Disorder Services, allowable costs are determined in accordance with Medicare cost reimbursement principles in 42 CFR 413, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy. 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. When there is not an approved indirect cost rate, the provider may allocate those overhead costs that are directly attributable to the provision of the medical services using a CMS reviewed cost allocation methodology. 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. For those 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 or NTP 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 OMB A-87 and Medicare cost reimbursement principles, 42 CFR 413. The amount that is apportioned to the Medi-Cal program is further reduced by any provisions specified in the Legal Entity's contractual agreement in providing the non-

NTP or NTP service to arrive to the Medi-Cal allowable cost for providing the specific non-NTP or NTP service.

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

3. Cost Report Submission

Each Legal Entity that receives reimbursement for non-NTP or county operated NTP services is required to file a CMS reviewed cost report by the November 1 following the end of each State fiscal year. An extension to submit the cost report may be granted by the State for good cause.

4. Interim Settlement

No later than eighteen months after the close of the State fiscal year, DHCS will complete the interim settlement pursuant to Section E.3. 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 services and county operated NTP 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.

5. Final Settlement Process

The State will complete the final settlement process within three years from the date of the interim settlement. 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 services in accordance with Medicare cost reimbursement principles (42 CFR 413), OMB A-87, and Medicaid non-institutional reimbursement principles; 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.

F. REIMBURSEMENT METHODOLOGY – REGIONAL COUNTIES

1. The reimbursement methodology for non-NTP services provided by county operated providers is equal to the allowable costs incurred by the county to provide the Drug Medi-Cal services.
2. The reimbursement methodology for non-NTP services provided by non-county operated providers is equal to the prevailing charges for the same or similar services in the county where the provider is located. If prevailing charges are not available, the State would 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 non-county operated NTP providers of NTP services is the lowest of:
 - a. The provider's usual and customary charge to the general public for the same or similar services, or
 - b. The uniform statewide daily reimbursement rate (USDR) established in Section E.1.b above.
4. Reimbursement for county-operated NTP providers is at the lowest of:
 - a. The provider's usual and customary charge to the general public for providing the same or similar services;
 - b. The provider's allowable costs of providing these services as described in Section E above; or
 - c. The USDR established in Section E.1.b above.

G. COST DETERMINATION PROTOCOL FOR NON-NTP AND NTP COUNTY LEGAL ENTITIES – REGIONAL COUNTIES

The following steps will be taken to determine the reasonable and allowable Medicaid costs for providing Drug Medi-Cal non-NTP and NTP services provided by county-operated providers.

1. Interim Payments

Interim payments for all Drug Medi-Cal services provided to Medi-Cal beneficiaries are reimbursed at the lower of the billed amount or the SMA, per E.1.a, or USDR, per E.1.b, as applicable for services rendered by a county Legal Entity.

2. Cost Determination Protocol – County Legal Entity

The reasonable and allowable cost for a county Legal Entity to provide each non-NTP and NTP service will be determined in the State-developed Regional County cost report pursuant to the following methodology. Total allowable costs include direct and indirect costs that are determined in accordance with Medicare cost reimbursement principles in 42 CFR 413, OMB

Circular A-87, 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 provide the specific non-NTP and NTP service. 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 costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87, Medicare cost reimbursement principles (42 CFR 413 and Medicare Provider Reimbursement Manual Parts 1 and 2), and Medicaid non-institutional reimbursement policy.

For the non-NTP Perinatal Residential Substance Use Disorder Services, allowable costs are determined in accordance with Medicare cost reimbursement principles in 42 CFR 413, OMB Circular A-87, and CMS Medicaid non-institutional reimbursement policy. Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Indirect costs may be determined by either applying the cognizant agency approved indirect cost rate to its total direct costs, or allocated indirect costs based upon the allocation process in the provider's approved cost allocation plan. When there is not an approved indirect cost rate, the provider may allocate those overhead costs that are directly attributable to the provision of the medical services using a CMS reviewed cost allocation methodology. 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. For those 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 or NTP services by each county 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 OMB A-87 and Medicare cost reimbursement principles, 42 CFR 413. The amount that is apportioned to the Medi-Cal program is further reduced by any provisions specified in the Legal Entity's contractual agreement in providing the non-NTP or NTP service to arrive to the Medi-Cal allowable cost for providing the specific non-NTP or NTP service.

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

3. 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.

4. Interim Settlement

No later than eighteen months after the close of the State fiscal year, DHCS will complete the interim settlement of the Regional County State-developed cost report. 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 G.2 for all Drug Medi-Cal services. 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.

5. Final Settlement Process

The State will complete the final settlement process within three years from the date of the interim 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 non-NTP or NTP services in accordance with Medicare cost reimbursement principles (42 CFR 413), OMB A-87, Medicaid non-institutional reimbursement principles, 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.

H. REGIONAL COUNTIES

1. Humboldt
2. Lassen
3. Mendocino
4. Modoc
5. Shasta
6. Siskiyou
7. Solano

I. NON REGIONAL COUNTIES

- | | | |
|------------|--------------|-----------------|
| 1. Alameda | 4. Butte | 7. Contra Costa |
| 2. Alpine | 5. Calaveras | 8. Del Norte |
| 3. Amador | 6. Colusa | 9. El Dorado |

- 10. Fresno
- 11. Glenn
- 12. Imperial
- 13. Inyo
- 14. Kern
- 15. Kings
- 16. Lake
- 17. Los Angeles
- 18. Madera
- 19. Marin
- 20. Mariposa
- 21. Merced
- 22. Mono
- 23. Monterey

- 24. Napa
- 25. Nevada
- 26. Orange
- 27. Placer
- 28. Plumas
- 29. Riverside
- 30. Sacramento
- 31. San Benito
- 32. San Bernardino
- 33. San Diego
- 34. San Francisco
- 35. San Joaquin
- 36. San Luis Obispo
- 37. San Mateo

- 38. Santa Barbara
- 39. Santa Clara
- 40. Santa Cruz
- 41. Sierra
- 42. Sonoma
- 43. Stanislaus
- 44. Sutter-Yuba
- 45. Tehama
- 46. Trinity
- 47. Tulare
- 48. Tuolumne
- 49. Ventura
- 50. Yolo

State Plan Chart

Limitations on Attachment 3.1-A

(Note: This chart is an overview only.)

PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*

PROGRAM COVERAGE**

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 and in accordance with a client plan signed by a licensed mental health professional.
13.d.5 Substance Abuse Treatment Services	Substance abuse treatment services include: Narcotic treatment program (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Abuse Treatment Services)	Beneficiaries must meet medical necessity criteria. Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*

PROGRAM COVERAGE**

TYPE OF SERVICE***

<p>13.d.5 Substance Use Disorder Treatment Services (continued)</p>	<p>Outpatient Drug Free Treatment Services (see Supplement 3 To Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)</p>	<p>Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.</p>
<p>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)</p>	<p>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)</p>	<p>Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.</p>
<p>Perinatal Residential Substance Use Disorder Services (see Supplemental 3 to Attachment 3.1-A for program coverage and details)</p>	<p>Perinatal Residential Substance Use Disorder Services (see Supplemental 3 to Attachment 3.1-A for program coverage and details)</p>	<p>Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims. The cost of room and board are not reimbursable DMC services.</p>
<p>Substance Use Disorder Treatment Services provided to Pregnant and Postpartum Women (see Supplemental 3 to Attachment 3.1-A for program coverage and details)</p>	<p>Substance Use Disorder Treatment Services provided to Pregnant and Postpartum Women (see Supplemental 3 to Attachment 3.1-A for program coverage and details)</p>	<p>Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.</p>

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

***Outpatient services are pursuant to 42 CFR 440.130.

State/Territory: California

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

LIMITATION ON SERVICES

13.d.5 Substance Use Disorder Treatment Services

Substance use disorder treatment services are provided to stabilize and rehabilitate Medi-Cal beneficiaries who have been recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practices, to receive treatment for a substance-related disorder. Substance use disorder treatment services are provided by DMC certified substance use disorder treatment facilities or DMC certified perinatal residential substance use disorder programs and are based on medical necessity. Medically necessary rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements, excluding crisis services for which a client plan is not required. Services include:

- Intensive Outpatient Treatment; these services are pursuant to 42 CFR 440.130
- Narcotic Treatment Program
- Outpatient Drug Free Treatment
- Perinatal Residential Substance Use Disorder Services

The intake assessment and treatment plan are standard for all DMC treatment modalities (see SUD Services Chart for service definitions).

Intensive Outpatient Treatment counseling services are provided to patients a minimum of three hours per day, three days a week, and are available to all patients for whom it has been determined by a physician to be medically necessary.

The components of Intensive Outpatient Treatment are:

- Intake
- Individual Counseling
- Group Counseling
- Patient Education
- Medication Services
- Medication Assisted Treatment
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

State/Territory: California

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

Narcotic Treatment Program: This outpatient program uses methadone, all drugs 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), when ordered by a physician as medically necessary to treat opioid use disorders. Narcotic Treatment Programs may also use oral Naltrexone to treat alcohol dependence, as long as the patient is not using methadone or buprenorphine. A patient must receive a minimum of fifty minutes of face-to-face, or telehealth counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

The components of the Narcotic Treatment Program are:

- Intake
- Individual Counseling
- Group Counseling
- Patient Education
- Medical Psychotherapy
- Medication Services
- Medication Assisted Treatment
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

Outpatient Drug Free (ODF) Treatment Services to stabilize and rehabilitate patients who have a substance use disorder diagnosis are covered under DMC when prescribed by a physician as medically necessary.

The components of Outpatient Drug Free Treatment Services are:

- Intake
- Individual Counseling
- Group Counseling
- Patient Education
- Medication Services
- Medication Assisted Treatment
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

Individual counseling is provided only for the purposes of intake, crisis intervention, collateral services, and treatment and discharge planning. Each ODF participant is to receive at least two group face-to-face, or telehealth counseling sessions every 30 days focused on short-term personal, family, job/school and other problems and their relationship to substance use. Reimbursable group sessions may last up to 90 minutes.

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 diagnoses. These services include women-specific treatment and recovery services. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services are provided in a 24-hour structured environment and covered under the Drug Medi-Cal program when medically necessary. Individual and/or Group Counseling must be provided a minimum of two sessions per 30 day period. Medically necessary rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements. The cost of room and board are not reimbursable under the Medi-Cal program.

The components of Perinatal Residential Substance Use Disorder Treatment are:

- Intake, once per admission
- Individual Counseling
- Group Counseling
- Medication Assisted Treatment
- Patient Education, varies according to the needs of the beneficiary
- Collateral Services, as needed
- Crisis Intervention Services, as needed
- Treatment Planning, occurs upon admission and every 90 days thereafter
- Discharge Services, once per admission

Services shall include:

- Provision of or arrangement for transportation to and from medically necessary treatment.
- Safeguarding Medication: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

State/Territory: California

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

Provider Qualifications

Substance use disorder services are provided at qualified and DMC certified substance use disorder treatment facilities and DMC certified perinatal residential substance use disorder programs that agree to abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services, and that sign a provider agreement with a county or the State.

Counseling services defined in California Code of Regulations, Title 9, Chapter 8, shall be provided by a qualified substance use disorder treatment professional functioning within the scope of their practice.

The following substance use disorder treatment professionals may provide substance use disorder treatment services in any DMC certified program:

- A registrant of a certifying organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA) and the registrant is enrolled in a counseling certification program and complete counseling certification requirements within the time allowed as required in California Code of Regulations, Title 9, Chapter 8;
- An Alcohol and other drug (AOD) counselor that is certified by an organization that is recognized by the Department of Health Care Services and accredited with the NCCA and the AOD counselor meets all the qualifications contained in California Code of Regulations, Title 9, Chapter 8;
- An intern registered with the California Board of Psychology or the California Board of Behavioral Sciences; and
- A Licensed Practitioner of the Healing Arts (LPHA) including; Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), and Licensed Marriage and Family Therapists (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

State/Territory: California

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

Assurances

The State assures that substance use disorder treatment services shall be available to children and youth found to be eligible under the provisions of Social Security Act section 1905(r)(5).

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 provider qualifications for DMC benefits are the same across all the service modalities. See chart on page 6a of Supplement 3 to Attachment 3.1-A.

Service Component Definitions

Medication Assisted Treatment includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders. Additionally, Medication Assisted Treatment includes oral Naltrexone for the treatment of alcohol use disorders and injectable Naltrexone for the treatment of alcohol or opioid use disorders. Medication assisted Treatment shall be provided in conjunction with counseling or behavioral therapy and in accordance with an individualized treatment plan.

Other service component definitions may be found in the SUD Services Chart on page 6a.

SUD Services Chart

Service Component	Individual Counseling										Group Counseling	Transportation Services
	Face-to-face or telehealth ⁴ contact between a beneficiary and a therapist or counselor.	Intake ³	Patient Education	Collateral Services	Crisis Intervention Services	Treatment Planning [*]	Discharge Services [*]	Medical Psychotherapy	Medication Assisted Treatment	Medication Services		
Provider Type	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²
Intensive Outpatient Treatment	X		X	X	X	X	X	X	X	X	X	X
Narcotic Treatment Program	X		X	X	X	X	X	X	X	X	X	X
Outpatient Drug Free Treatment	X		X	X	X	X	X	X	X	X	X	X
Perinatal Residential Substance Use Disorder Services	Δ		Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ	X	X

¹ Licensed providers must meet the following qualifications: MD, PA, NP, RN, Psy, D, LCSW, MFT or Intern registered by Board of Psychology or Behavioral Science Board and supervised by a mental health professional.
² Certified providers must meet the following qualifications: Counselors or registrants certified by an organization who will have 155 hours of formal Education; 160 hours of supervised AOD training; 2,080 hours of work experience in AOD counseling; obtain at least 70% score on a written or oral examination approved by the certifying organization and complete 40 hours of continuing education every two years in order to retain certification.
³ The process of admitting a beneficiary into a Substance Use Disorder Treatment Program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; the assessment of treatment needs to provide medically necessary services; and assistance with accessing community and human services networks. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
⁴ Telehealth is defined as specified in Section 2290.5 of the Business and Professions Code. Counseling services may only be conducted via telehealth if the provider has obtained consent from all participants, in accordance with Cal. Business & Professions Code Section 2290.5, and takes the necessary security precautions, in compliance with HIPAA and 42 CFR Part 2.
^{*} Certified personnel may assist with some aspects of this service, however, a licensed provider is responsible for this service component.
 PNO - Perinatal Outpatient SUD Services
 S - Safeguarding Medication; assistance with resident's self-administration of medication.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

LIMITATION ON SERVICES

13.d.5 Substance Use Disorder Treatment Services

Substance use disorder treatment services are provided to stabilize and rehabilitate Medi-Cal beneficiaries who have been recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practices, to receive treatment for a substance-related disorder. Substance use disorder treatment services are provided by DMC certified substance use disorder treatment facilities or DMC certified perinatal residential substance use disorder programs and are based on medical necessity. Medically necessary rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements, excluding crisis services for which a client plan is not required. Services include:

- Intensive Outpatient Treatment; these services are pursuant to 42 CFR 440.130
- Narcotic Treatment Program
- Outpatient Drug Free Treatment
- Perinatal Residential Substance Use Disorder Services

The treatment modalities (see SUD Services Chart for service definitions).

Intensive Outpatient Treatment counseling services are provided to patients a minimum of three hours per day, three days a week, and are available to all patients for whom it has been determined by a physician to be medically necessary.

The components of Intensive Outpatient Treatment are:

- Intake
- Individual Counseling
- Group Counseling
- Patient Education
- Medication Services
- Medication Assisted Treatment
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

State/Territory: California

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

Narcotic Treatment Program: This outpatient program uses methadone, all drugs 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), when ordered by a physician as medically necessary to treat opioid use disorders. Narcotic Treatment Programs may also use oral Naltrexone to treat alcohol dependence, as long as the patient is not using methadone or buprenorphine. A patient must receive a minimum of fifty minutes of face-to-face, or telehealth counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

The components of the Narcotic Treatment Program are:

- Intake
- Individual Counseling
- Group Counseling
- Patient Education
- Medical Psychotherapy
- Medication Services
- Medication Assisted Treatment
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

Outpatient Drug Free (ODF) Treatment Services to stabilize and rehabilitate patients who have a substance use disorder diagnosis are covered under DMC when prescribed by a physician as medically necessary.

The components of Outpatient Drug Free Treatment Services are:

- Intake
- Individual Counseling
- Group Counseling
- Patient Education
- Medication Services
- Medication Assisted Treatment
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

Individual counseling is provided only for the purposes of intake, crisis intervention, collateral services, and treatment and discharge planning. Each ODF participant is to receive at least two group face-to-face or telehealth counseling sessions every 30 days focused on short-term personal, family, job/school and other problems and their relationship to substance use. Reimbursable group sessions may last up to 90 minutes.

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. These services include women-specific treatment and recovery services. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services are provided in a 24-hour structured environment and covered under the Drug Medi-Cal program when medically necessary. Individual and/or Group Counseling must be provided a minimum of two sessions per 30 day period. Medically necessary rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements. The cost of room and board are not reimbursable under the Medi-Cal program.

The components of Perinatal Residential Substance Use Disorder Treatment are:

- Intake, once per admission
- Individual Counseling
- Group Counseling
- Medication Assisted Treatment
- Patient Education, varies according to the needs of the beneficiary
- Collateral Services, as needed
- Crisis Intervention Services, as needed
- Treatment Planning, occurs upon admission and every 90 days thereafter
- Discharge Services, once per admission

Services shall include:

- Provision of or arrangement for transportation to and from medically necessary treatment.
- Safeguarding Medication: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

State/Territory: California

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

Provider Qualifications

Substance use disorder services are provided at qualified and DMC certified substance use disorder treatment facilities, and DMC certified perinatal residential substance use disorder programs that agree to abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services, and that sign a provider agreement with a county or the State.

Counseling services defined in California Code of Regulations, Title 9, Chapter 8, shall be provided by a qualified substance use disorder treatment professional functioning within the scope of their practice.

The following substance use disorder treatment professionals may provide substance use disorder treatment services in any DMC certified program:

- A registrant of a certifying organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA) and the registrant is enrolled in a counseling certification program and complete counseling certification requirements within the time allowed as required in California Code of Regulations, Title 9, Chapter 8;
- An Alcohol and other drug (AOD) counselor that is certified by an organization that is recognized by the Department of Health Care Services and accredited with the NCCA and the AOD counselor meets all the qualifications contained in California Code of Regulations, Title 9, Chapter 8;
- An intern registered with the California Board of Psychology or the California Board of Behavioral Sciences; and
- A Licensed Practitioner of the Healing Arts (LPHA) including; Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), and Licensed Marriage and Family Therapists (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

Assurances

The State assures that substance use disorder treatment services shall be available to children and youth found to be eligible under the provisions of Social Security Act section 1905(r)(5).

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 provider qualifications for DMC benefits are the same across all the service modalities. See chart on page 4a of Supplement 3 to Attachment 3.1-B.

Service Component Definitions

Medication Assisted Treatment includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders. Additionally, Medication Assisted Treatment includes oral Naltrexone for the treatment of alcohol use disorders and injectable Naltrexone for the treatment of alcohol or opioid use disorders. Medication assisted Treatment shall be provided in conjunction with counseling or behavioral therapy and in accordance with an individualized treatment plan.

Other service component definitions may be found in the SUD Services Chart on page 4a.

SUD Services Chart

Service Component	Individual Counseling										Group Counseling	Transportation Services	
	Face-to-face or telehealth ⁴ contacts between a beneficiary and a therapist or counselor.	Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. Approval of a treatment plan by a physician licensed in the State of California. 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	Intake ³ Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder which includes exploration of relevant mental, emotional, psychological and behavioral problems that may be contributing to the substance use disorder. This may also include health questionnaires.	Patient Education A learning experience using a combination of methods such as teaching, counseling, and behavior modification techniques which influence patients' knowledge and health and contributing to the illness behavior.	Collateral Services Sessions with therapists or counselors and significant persons in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.	Crisis Intervention Services Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.	Treatment Planning ¹ The provider shall prepare an individualized written treatment plan, based on information obtained in intake and assessment process. The treatment plan includes: problems to be addressed; goals to be reached which address each problem; action steps which will be taken by the provider and/or beneficiary to accomplish identified goals; target dates for accomplishment of action steps and goals; and a description of services, including the type of counseling to be provided and the frequency thereof. The treatment plan may also include medical direction.	Discharge Services* The process to prepare a person for the post treatment return or reentry into the community and the linkage of the individual to essential community treatment, housing and human services.	Medical Psychotherapy Type of counseling service consisting of face-to-face or telehealth discussion conducted by the medical director of the Narcotic Treatment Program on a one-to-one basis with the patient.	Medication Assisted Treatment The use of medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262), counseling, and behavioral therapy to treat opioid use disorders and oral naltrexone to treat alcohol use disorders.			Medication Services The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.
Provider Type	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	C ²
Intensive Outpatient Treatment	X		X	X		X	X	X		X		X	
Narcotic Treatment Program	X		X	X		X	X	X		X		X	
Outpatient Drug Free Treatment	X		X	X		X	X	X		X		X	
Perinatal Residential Substance Use Disorder Services	Δ		Δ	Δ		Δ	Δ	Δ		Δ		Δ	X

¹ Licensed providers must meet the following qualifications: MD, PA, NP, RN, Psy, D, LCSW, MFT or Intern registered by Board of Psychology or Behavioral Science Board and supervised by a mental health professional.

² Certified providers must meet the following qualifications: Counselors or registrants certified by an organization who will have 155 hours of formal Education; 160 hours of supervised AOD training; 2,000 hours of work experience in AOD counseling; obtain at least 70% score on a written or oral examination approved by the certifying organization and complete 40 hours of continuing education every two years in order to retain certification.

⁴ Telehealth is defined as specified in Section 2290.5 of the Business and Professions Code. Counseling services may only be conducted via telehealth if the provider has obtained consent from all participants, in accordance with Cal. Business & Professions Code Section 2290.5, and takes the necessary security precautions, in compliance with HIPAA and 42 CFR Part 2.

³ The process of admitting a beneficiary into a Substance Use Disorder Treatment Program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; the assessment of treatment needs to provide medically necessary services; and assistance with accessing community and human services networks. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

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

PNO - Perinatal Outpatient SUD Services

S - Safeguarding Medication; assistance with resident's self-administration of medication.