PAYMENT FOR REHABILITATIVE MENTAL HEALTH AND TARGETED CASE MANAGEMENT SERVICES

A. GENERAL APPLICABILITY

Payment for rehabilitative mental health and targeted case management services provided by Eligible Providers will be limited to the fee schedule developed by the State.

B. Definitions

"Day Services" means Day Treatment Intensive, Day Rehabilitation, Crisis Stabilization, and Clubhouse Services as those services are defined in Supplement 3 to Attachment 3.1-A.

"Eligible Provider" means a public or private provider enrolled in the Medi-Cal program and certified to provide one or more Rehabilitative Mental Health or Targeted Case Management service as those services are defined in Supplement 1 and Supplement 3 to Attachment 3.1-A of this State Plan.

"Full-Day" means a beneficiary received a face-to-face service in a Day Treatment Intensive or Day Rehabilitation program with services available for more than four hours, or received face-to-face Clubhouse Services for at least three hours in a day.

"Full Month of Service" means an Eligible Provider delivered a service in an Assertive Community Treatment (ACT) or Multisystemic Therapy (MST) program to the same beneficiary on at least six separate days in a month or delivered a service in a Coordinated Specialty Care (CSC) program to the same beneficiary on at least four separate days in a month. At least four of the services delivered in an ACT or MST program must have been face-to-face with the beneficiary, and at least three of the services delivered in a CSC program must have been face-to-face with the beneficiary. Other services may be collateral contacts. If an Eligible Provider delivered a face-to-face service and a collateral contact on the same day, it is counted as two separate days.

"Half-Day" means a beneficiary received face-to-face service in a Day Treatment Intensive or Day Rehabilitation program with services available from three to four

hours.

"Home Health Agency Market Basket Index" means the IHS Global Inc. CMS Market Basket Index Levels for Home Health Agencies.

"Licensed Mental Health Professional (LMHP)" means Licensed Physicians, Licensed Psychologists (includes waivered psychologists); Licensed Clinical Social Worker (LCSW) (includes Waivered/Registered clinical social workers), Licensed Professional Clinical Counselor (LPCC) (includes Waivered/Registered professional clinical counselors), Licensed Marriage and Family Therapist (LMFT) (includes Waivered/Registered marriage and family therapists); Registered Nurses (includes certified nurse specialists and nurse practitioners); Licensed Vocational Nurses; Licensed Psychiatric Technicians; and Licensed Occupational Therapists as those terms are defined in Supplement 3 to Attachment 3.1-A.

"Monthly Service" means Assertive Community Treatment (ACT) and Coordinated Specialty Care (CSC), as those services are defined in Supplement 3 to Attachment 3.1-A of this State Plan; and Multisystemic Therapy (MST).

"Multisystemic Therapy" (MST) means a bundle of rehabilitative mental health services provided to youth beneficiaries and their families. The bundle of rehabilitative mental health services includes Assessment, Treatment Planning, Therapy, Crisis Intervention, and Referral and Linkages, as defined in Supplement 3 to Attachment 3.1-A of this State Plan.

"Outpatient Services" means Mental Health Services, Medication Support Services, Crisis Intervention Services, and Targeted Case Management Services as those services are defined in Supplement 3 and Supplement 1 to Attachment 3.1-A.

"Partial Month of Service" means an Eligible Provider delivered a service in an ACT or MST program to the same beneficiary on four or five separate days in a month or delivered a service in a CSC program to the same beneficiary on two or three separate days in a month. At least three of the services delivered in an ACT or MST program must have been face-to-face with the beneficiary, and at least one of the services delivered in a CSC program must have been face-to-face with the beneficiary. Other services may be collateral contacts. If an eligible provider delivered

a face-to-face service and a collateral contact on the same day, it is counted as two separate days.

"Provider Type" means Clinical Trainee, Licensed Mental Health Professional, Mental Health Rehabilitative Specialist (MHRS), Medical Assistant, Physician Assistant (PA), Pharmacist, Peer Support Specialists, Alcohol and Drug (AOD) Counselor, and Other Qualified Provider as those terms are defined in Supplement 3 to Attachment 3.1-A of this State Plan.

"Rehabilitative Mental Health and Targeted Case Management Services" means Outpatient Services, Day Services, and Twenty-Four Hour Services as those services are defined in Supplement 3 to Attachment 3.1-A of this State Plan.

"Services Provided in a Treatment Foster Home" means a bundle of rehabilitative mental health services provided to children and youth up to 21 years of age who have been placed in a Residential Treatment Foster Home and who meet medical necessity criteria for this service as established by the State. The bundle of rehabilitative mental health services includes Treatment Planning, Psychosocial Rehabilitation, and Crisis Intervention, as those services are defined in Supplement 3 to Attachment 3.1-A of this State Plan.

"Twenty-Four Hour Services" means Adult Residential Treatment, Crisis Residential Treatment, and Psychiatric Health Facility Services as those services are defined in Supplement 3 to Attachment 3.1-A; and Services Provided in a Treatment Foster Home.

C. Outpatient Services Payment Methodology

1. The State pays all eligible providers of Outpatient Services on a fee-for-service basis pursuant to a fee schedule established by the State. Eligible Providers submit claims for payment of Outpatient Services by Provider Type using appropriate Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes. The fee schedule contains a rate for each County where the provider is located and combination of Provider Type and CPT®/HCPCS code.
2. Except as otherwise noted in the State Plan, State-developed fee schedule rates are the same for both governmental and private providers. The fee schedule that is effective July 1, 2023, and annually thereafter, is posted to the following: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules-main.aspx
3. The State will annually increase the per-unit rates for HCPCS and CPT Codes effective July 1, 2023, by the percentage change in the four-quarter average Home Health Agency Market Basket Index. The updated rates will be posted to the following webpage annually: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules-main.aspx

D. Day Services Payment Methodology

1. The State pays all Eligible Providers of Day Services on a fee-for-service basis pursuant to a fee schedule established by the State. Day Treatment Intensive and Day Rehabilitation are paid a Half-Day rate when the beneficiary participates in the day treatment intensive or day treatment program for at least 3 hours and less than 4 hours. Eligible Providers of Day Treatment Intensive and Day Rehabilitation services are paid a Full-Day rate when the beneficiary participates in the Day Treatment Intensive or Day Rehabilitation program for at least 4 hours. Eligible Providers of Clubhouse Services are paid a Full-Day rate when the beneficiary participates in Clubhouse Services for at least three hours. Eligible Providers of Crisis Stabilization Services are paid an hourly rate not to exceed twenty-three hours of service in one day. The fee schedule contains a rate for each County where the provider is located and for each Day Service.
2. Except as otherwise noted in the State Plan, State-developed fee schedule rates are the same for both governmental and private providers. The fee

3. schedule for Day Treatment Intensive and Day Rehabilitation services that is effective July 1, 2023, and annually thereafter; and for Clubhouse Services that is effective January 1, 2025, July 1, 2025, and annually thereafter, are posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
4. The county-based bundled rate for Clubhouse Services is paid to Eligible providers for the following service components as those services are defined in Supplement 3 to Attachment 3.1-A of this State Plan.
    a. Employment and Education Support Services
    b. Medication Support Services
    c. Psychosocial Rehabilitation
    d. Referral and Linkages
    e. Treatment Planning
5. A Clubhouse provider must render at least one of the following Clubhouse Service components during a face-to-face encounter with a beneficiary to be paid a bundled rate.
    a. Employment and Education Support Services
    b. Medication Support Services
    c. Psychosocial Rehabilitation
    d. Referral and Linkages
    e. Treatment Planning
6. Any Clubhouse Services provider delivering services through a bundle will be paid through a bundled payment rate and cannot bill services provided through the bundle separately. Providers delivering separate services outside of the bundle may bill for those separate services in accordance with the State's Medicaid billing procedures.
6. The State will periodically monitor the actual provision of Clubhouse Services paid under a bundled rate 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 bundle.
7. The July 1, 2025 rate will be equal to the January 1, 2025 rate increased by the percentage change in the Home Health Agency Market Basket Index from Q1 of 2024 to Q3 of 2025. The State will annually increase the day service rates by the percentage change in the four-quarter average Home Health Agency Market Basket Index.

E. Twenty-Four Hour Services Rate Methodology

1. The State pays all Eligible Providers of Twenty-Four Hour Services on a fee-for-service basis pursuant to a fee schedule established by the State. Eligible Providers of Twenty-Four Hour Services are paid a per diem rate. The fee schedule contains a rate for each County where the provider is located and each Twenty-Four Hour Service.
2. Except as otherwise noted in the State Plan, State-developed fee schedule rates are the same for both governmental and private providers. The fee schedule for Twenty-Four Hour Services that is effective July 1, 2023, and annually thereafter, is posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules-main.aspx
3. The State will annually increase the per-unit rates for 24-hour services effective July 1, 2023, by the percentage change in the four quarter average Home Health Agency Market Basket Index.
4. The fee schedule rate for Services Provided in a Treatment Foster Home is a bundled rate.
    a. Any provider delivering Services Provided in a Treatment Foster Home will be paid through the bundled rate and cannot bill separately.
    b. Any providers delivering services outside of a treatment foster home may bill for those separate services pursuant to this State Plan.
    c. The bundled rate for Services Provided in a Treatment Foster Home does not include costs related to room and board.
    d. The State will periodically monitor the actual provision of services paid under the bundled rate 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 bundle.

F. Community-Based Mobile Crisis Intervention Services Rate Methodology

1. Community-Based Mobile Crisis Intervention Encounters
    1. Except as otherwise noted in the State Plan, State-developed fee schedule rates are the same for both governmental and private providers. The State establishes a county-based bundled rate for each encounter. The county-based bundled rates effective July 1, 2023, and annually thereafter, are posted to the following webpage:

https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.

2. The State pays all Eligible Providers the county-based bundled rate based upon the county where the provider is located.
3. The county-based bundled rate is paid for the following service components as those components are defined in Attachment 3.1-A of this State Plan:
    - Assessment
    - Mobile crisis response
    - Crisis planning
    - Referral to ongoing supports
    - Follow up check ins
4. A provider must render at least one of the following service components during an encounter to be paid the bundled rate:
    - Assessment
    - Mobile crisis response
    - Crisis planning
    - Referral to ongoing supports
5. Any provider delivering services through a bundle will be paid through that bundled payment rate and cannot bill separately. Providers delivering separate services outside of the bundle may bill for those separate services in accordance with the State's Medicaid billing procedures.
6. The State will annually increase the county-based bundled rates effective July 1, 2023, by the percentage change in the four quarter average Home Health Agency Market Basket Index.
7. The State will periodically monitor the actual provision of services paid under a bundled rate 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 bundle.

2. Facilitation of a warm handoff
    a. The State will pay providers for Facilitation of a warm handoff, as that service component is defined in Attachment 3.1-A of this State Plan, pursuant to a fee schedule established by the State. The fee schedule will include a rate for each county and the following aspects of the service component:

b. Providing and/or arranging for a beneficiary's transportation to an alternative setting to receive urgent treatment. The State will pay providers the standard mileage rate per mile for use of an automobile for medical care as established by the Internal Revenue Service.
c. Staff time spent providing and/or arranging for transportation to an alternative setting to receive urgent treatment. The State will pay Eligible Providers based upon the provider type providing and/or arranging for transportation. The rates for this aspect of Facilitation of a Warm Handoff effective July 1, 2023, and annually thereafter, are posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.

3. The State will annually increase the fee schedules described in paragraphs 1 and 2 by the percentage change in the four-quarter average Home Health Agency Market Basket Index.

G. Monthly Services Rate Methodology

1. The State establishes a county-based bundled rate for a Full Month of Service and a county-based bundled rate for a Partial Month of Service for each Monthly Service. Except as otherwise noted in the State Plan, State-developed fee schedule rates are the same for both governmental and private providers. The county-based bundled rates effective for services provided on or after January 1, 2025, July 1, 2025, and annually thereafter, are posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules-FY24-25.aspx
2. The State pays all Eligible Providers the county-based bundled rate for each Full Month of Service and Partial Month of Service based upon the county where the provider is located.
3. The county-based bundled rate for ACT is paid for the following service components as those components are defined in Supplement 3 to Attachment 3.1-A of this State Plan.
    - Assessment
    - Crisis Intervention
    - Employment and Education Support Services
    - Medication Support Services
    - Peer Support Services
    - Psychosocial Rehabilitation
    - Referral and Linkages
    - Therapy
    - Treatment Planning
4. The county-based bundled rate for CSC is paid for the following service components as defined in Supplement 3 to Attachment 3.1-A of this State Plan.
    - Assessment
    - Crisis Intervention
    - Employment and Education Support Services
    - Medication Support Services
    - Peer Support Services
    - Psychosocial Rehabilitation
    - Referral and Linkages
    - Therapy
    - Treatment Planning

5. The county-based bundled rate for MST is paid for the following service components as defined in Supplement 3 to Attachment 3.1-A of this State Plan.
    - Assessment
    - Crisis Intervention
    - Referral and Linkages
    - Therapy
    - Treatment Planning
6. Any provider delivering services through a bundle will be paid through that bundled payment rate and cannot bill services provided through the bundle separately. Providers delivering separate services outside of the bundle may bill for those separate services in accordance with the State's Medicaid billing procedures.
7. The July 1, 2025, rate will be equal to the January 1, 2025 rate increased by the percentage change in the Home Health Agency Market Basket Index from Q1 of 2025 to Q3 of 2025. Beginning on July 1, 2025, the State will annually increase the county based bundled rates for a Full Month of Services and a Partial Month of Services by the percentage change in the four-quarter average Home Health Agency Market Basket Index.
8. The State will periodically monitor the actual provision of services paid under a bundled rate 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 bundle.

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

REIMBURSEMENT FOR MEDI-CAL PERSONAL CARE SERVICES

A. GENERAL PROVISIONS

Medi-Cal Personal Care Services (referred to in this document as Personal Care Services) are services provided pursuant to 42 Code of Federal Regulations 440.167 in accordance with the rules and regulations of the California Department of Health Care Services and the California Department of Social Services.

B. REIMBURSEMENT RATE LIMITATIONS FOR PERSONAL CARE SERVICES

(1) A county may contract with an agency of a city, county, or city and county, a local health district, a voluntary nonprofit agency, a proprietary agency, or an individual for the purpose of providing personal care services. The rate of reimbursement will be negotiated between the county and its contractor or its contractors, consistent with applicable regulations promulgated by the California Department of Social Services or the Department of Health Care Services.

(2) The rate of reimbursement for individual providers will be negotiated between the provider union and the individual county, or the provider union and the public authorities/non-profit consortiums, as applicable.

(3) The Individual Provider Rate includes Wages, Payroll Tax, Benefits, Administrative Costs, and Paid Time Off within the negotiated rate.

C. PUBLICATION OF INDIVIDUAL AND CONTRACTED PROVIDER RATES OF PERSONAL CARE SERVICES

State approved county governmental, contracted, and private individual provider rates are documented in a fee schedule and that fee schedule was last updated July 1, 2018, and is effective for services provided after that date. This fee schedule is published on the California Department of Social Services website at:
http://www.cdss.ca.gov/Portals/9/IHSS/IHSS_Sick_Leave_Rate_as_of_July-1-2018.pdf?ver=2018-10-10-165722-833

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

D. PAYMENTS AND UNITS OF SERVICE

(1) Reimbursements for services will be made only to providers authorized by the California Department of Social Services to provide Personal Care Services to beneficiaries. The rates will be based upon a time-based unit of service. The time-based unit of service is per minute based on 60 minutes per hour.

(2) The methodology for determining the beneficiary's service budget is based on the assessment of needs for the beneficiary and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for such services under the state plan and is adjusted to account for the self-directed services delivery model served in the Sec. 1915 [42 U.S.C. 1396n] G) program.

In cases where the beneficiary chooses not to have the assessed Personal Care Services of meal preparation, meal cleanup and/or shopping for food services provided in-home, the beneficiary can choose to have their service budget reduced by the amount calculated based on hours allocated for these services and reimbursement of $15.50 per week per person or $31 per week per couple is provided for meal preparation, meal cleanup and/or shopping for food related activities in the Sec. 1915 (42 U.S.C. H96n] (j) program.

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

C. PUBLICATION OF INDIVIDUAL AND CONTRACTED PROVIDER RATES OF PERSONAL CARE SERVICES

State approved county governmental, contracted, and private individual provider rates are documented in a fee schedule and that fee schedule was last updated on October 1, 2009, and effective for services provided after that date. This fee schedule is published on the California Department of Social Services website at www.cdss.ca.gov/agedblinddisabled/PG1996.htm.

State Plan Under Title XIX of the Social Security Act

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CALIFORNIA

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