DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group/ Division of Reimbursement Review

April 7, 2020

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

RE: TN 20-0001

Dear Ms. Cooper:

We have reviewed the proposed amendment to Attachment 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 20-0001. The proposed amendment was submitted to the Centers for Medicare & Medicaid Services on January 14, 2020. This SPA will add a new reimbursement methodology for the Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Disorder (SUD) services reflecting the distinct Upper Payment Limit (UPL) requirements related to the Regional Model as authorized through the state's Section 1115 demonstration waiver. The eight counties included in the Regional Model are: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano and Trinity.

Based upon the information provided by California, we have approved the amendment on April 7, 2020 for incorporation into the official California State Plan with an effective date of July 1, 2020. A copy of the CMS-179 and the approve plan pages are enclosed with this letter.

If you have any questions, please contact Blake Holt at 415-744-3754 or by email at Blake.Holt@cms.hhs.gov.

Sincerely,

Todd McMillion
Director

Enclosures

cc: Lindy Harrington, Department of Health Care Services (DHCS)
Charles Anders, DHCS
Brenda Grealish, DHCS
Rafael Davtian, 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: 2 0 — 0 0 01

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: ~~March 1, 2020~~ 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 Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2019-20 $ 0
b. FFY 2020-21 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Pages 38-41f

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-B, Pages 38-41c

10. SUBJECT OF AMENDMENT

To establish a cost-based reimbursement methodology for Drug Medi-Cal (DMC) services rendered through providers that contract with one or more of eight specific counties in California.

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: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: January 14, 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: January 14, 2020

18. DATE APPROVED: April 7, 2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: Todd McMillion

22. TITLE: Director, Division of Reimbursement Review

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.
Box 4: CMS pen and ink change to change the effective date per state request in email dated 3/25/20.

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) services" include Outpatient Drug Free Treatment, Intensive Outpatient Treatment, Perinatal Residential Substance Use Disorder Services, and Naltrexone Treatment.

"Narcotic Treatment Program (NTP) services" include 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 ~~be~~ 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.

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 Medi-Cal 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	Minimum of three hours per day, three days per week.
Outpatient Drug Free Treatment	Individual (50-minute minimum session) or group (90-minute minimum session) Counseling.
Perinatal Residential Substance Use Disorder Services	24-hour structured environment per day (excluding room and board)
Naltrexone Treatment	Face-to-face contact per calendar day for counseling and/or medication services.

Narcotic Treatment Programs (consist of two components):

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 methadone daily dose 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.

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 that are not 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 of the county operated Legal Entities that direct contract with DHCS cost report. 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 service, and Section B.2 for 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 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 Medicare cost reimbursement principles (42 CFR 413), OMB A-87, and Medicaid non-institutional reimbursement principle; 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 that are not 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 principle, and the statistical data used to determine the unit of service rate reconcile 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
2. Alpine
3. Amador
4. Butte
5. Calaveras
6. Colusa
7. Contra Costa
8. Del Norte
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