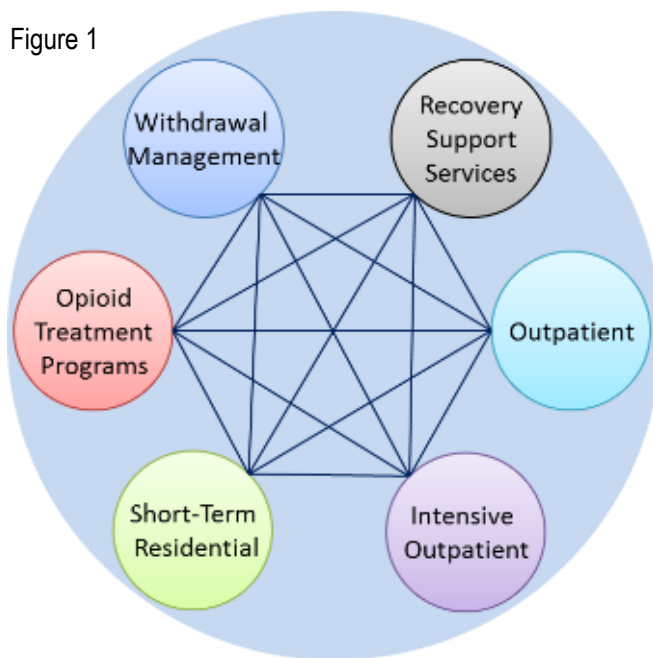


LOS ANGELES COUNTY SUBSTANCE ABUSE PREVENTION AND CONTROL

Establishing a Finance and Rate Structure that Supports Quality and Outcome Focused Services

California's Medi-Cal 2020 1115(a) Drug Medi-Cal (DMC) Organized Delivery System (ODS) Waiver Demonstration Project paves the way for Los Angeles County (LAC) to expand access to a broader range of substance use disorder (SUD) treatment benefits to all Medi-Cal-eligible youth and adults (Figure 1). With the new benefits comes the requirement to improve access and availability of all levels of care (LOC) across LAC, and make placement decisions based on uniform clinical standards and medical necessity. As a result, the Waiver requires that LAC provide care at the most appropriate LOC—the right service, at the right time, in the right setting, and for the right duration—improved transitions between LOCs, use of medication-assisted treatment (MAT), and other treatment services when appropriate. It also requires moving from an episodic to a chronic care model, improving coordination and collaboration with health

Figure 1



and mental health services, redefining relationships with social services and criminal justice, including courts, probation, and jails, as well as designing a single benefit package based on patient treatment needs rather than funding or referral source.

The transition to an SUD treatment system of providers capable of delivering this enhanced standard of care will require a significant investment in clinical and business capacity building, staff training and workforce development, infrastructure and information technology development, and quality improvement, and utilization management. These investments are necessary to effectively address the tremendous human suffering associated with the specific SUD conditions our patients face, as well as un/undertreated SUD conditions that have a high probability of leading to or exacerbating other physical and/or mental health conditions, which have broad social and economic costs for communities.

The following outlines how the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (SAPC) plans to transform the fiscal foundation of the current SUD safety net services into an enhanced, organized, and integrated managed care delivery system. Reimbursing services at rates that reflect the real cost of providing expanded access to effective and quality SUD LOCs will improve health outcomes, and enhance whole-person care and the quality of life in communities. This investment will enable SAPC and its SUD provider network to build the necessary clinical and business capacity to deliver on these expectations, while demonstrating a commitment to the principles of the Mental Health Parity and Addiction Equity Act of 2008. It is through this lens that LAC determined the appropriate rates for the new DMC-ODS services. The following is an overview of how LAC conducted its analysis and ultimately determined its Fiscal Year 2017-2018 DMC-ODS rates.

THE UNDERDEVELOPED SUD SYSTEM AND THE MOVE TO PARITY

To achieve parity with physical and mental health, the SUD system must first establish sufficiently robust rates to sustainably invest in the clinical and technological infrastructure needed to advance the current system of care. Network providers must be assured that new DMC-ODS rates will provide enough capital to hire and/or train a more skilled workforce; implement required evidence-based practices with fidelity; independently implement other EBPs that better serve their patient profile; support physical and technological infrastructure improvements that reflect a modern system of care; and make it cost-effective to implement innovations that improve access to care and health outcomes. The County plans to move towards more performance-based and bundled rates in the next several years. In the interim, however, the ability to settle to cost, not to exceed charges, will enable SAPC to track the investment in clinical capacity at the provider level and enable the County to recoup funds when the rate exceeds treatment-related expenditures.

Provider Workload and Staffing Needs

Network providers will need to evaluate existing management and staffing structures, as well as clinical and operational procedures, to ensure their ability to meet new clinical, data, fiscal, and quality assurance requirements. To achieve the Waiver outcomes, significant financial investment will be required at the provider level and DMC-ODS reimbursement rates must support the required expansion of clinical and business capacities, as well as incentivize new provider participation in the DMC network. Provider-level workforce and clinical enhancements could include:

- Hire medical director(s) for new/expanding DMC agencies and/or redefining the role of the medical director to allow for a transition of select responsibilities to Licensed Practitioners of the Healing Arts (LPHA).
- Hire or train LPHAs to meet the requirement that an LPHA determine medical necessity before initiating DMC-ODS treatment, as well as to provide more complex services, such as family counseling.
- Reconfigure and expand staffing structures to align with the new range and complexity of clinical responsibilities and to provide newly reimbursable services.
- Train staff to implement clinical best practices (e.g. motivational interviewing and cognitive behavioral therapy), American Society of Addiction Medicine (ASAM) based LOC placements, and standardized assessment/treatment plan formats.
- Implement a broader biopsychosocial treatment model, especially when newly required services (e.g., MAT) and standards (e.g., practitioner expertise/level) may be in conflict with existing practice.

While the County, in collaboration with stakeholders, will define some of these new clinical and staffing expectations, network providers will need to determine what makes the most business sense when considering expectations to deliver services that help individuals achieve long-term positive health outcomes. There are several implications for providers' business processes:

- Hire/train staff or consultants to manage accountability-related tasks, such as developing, implementing, and evaluating a quality improvement (QI) and utilization management (UM) plan.
- Conduct strategic planning efforts such as organizational and staffing assessments to ensure readiness to fully participate in the system transformation and new service design.
- Upgrade technology to enhance capabilities to interface with County automated systems and implement an electronic health record (EHR) or adopt SAPC's managed care information system (MCIS); and
- Refine/define corresponding policies and procedures in response to new treatment documentation, authorization, and data collection requirements.

SAPC Workload and Staffing Needs

To effectively implement the DMC-ODS terms and conditions locally as outlined in SAPC's *Implementation Plan for the DMC-ODS Waiver* will require a significant shift from how services are managed today to how they will be managed in the future. SAPC will use the 15 percent DMC administrative overhead allowance to fund its program efforts in four major categories: business development, infrastructure development, clinical development, and system of care development. For the County, this overhaul will include designing and implementing major new infrastructure development and capacity-building projects over the next three years, including:

Business Model Development Efforts:

- Collaborate with the health, mental health, social services and criminal justice systems to improve coordination of services and revise existing practices to comport with new standards.
- Provide technical assistance and training for SUD network providers to support repositioning their agencies to succeed in the new system of care and apply for DMC certification/licensure.
- Conduct a coordinated outreach effort to encourage existing SUD providers to expand the number of service locations and LOCs, while expanding the SUD network to include other partner agencies.

Infrastructure Development Efforts:

- Adopt a MCIS that can interface with, or be used in lieu of, a provider purchased EHR.
- Develop electronic systems to improve efficiencies (e.g., bed and treatment slot registry, all-provider automated appointment system) and enable better management of financial resources (e.g., risk management system).
- Refine contract development and monitoring processes to efficiently and effectively ensure contract compliance and support providers via technical assistance.

Clinical Services Development Efforts:

- Implement the new quality improvement (QI) and utilization management (UM) programs, including related policies, procedures and forms that can ensure delivery and documentation of clinically effective services, appropriate utilization at the right LOC, and service authorization.
- Implement new preauthorization and reauthorization processes for residential treatment admissions.
- Develop requirements and a corresponding training program to support providers' in implementing and using the ASAM Criteria for clinical placement decisions, Motivational Interviewing and Cognitive Behavioral Therapy.

System of Care Development Efforts:

- Manage a new beneficiary access line with an automated screening tool and referral/appointment system.
- Draft new standards of care for each LOC in coordination with SUD network providers and other stakeholders to develop a high-quality and standardized system of care for youth and adults.
- Implement improved care coordination with physical and mental health services to address the comprehensive health needs of SUD patients, and deliver case-management services that provide linkages to the necessary services to sustain recovery and support delivery of whole-person care.

Financing the System Improvements

Establishing SUD provider payment rates that mirror those of mental health is key to enabling the SUD system to become a more equal partner with the physical and mental health systems, to deliver on expectations to effectively coordinate the health and social needs of SUD patients, and to ultimately achieve desired treatment outcomes in a more integrated health system. Adopting rates that reflect the real cost of providing high-quality care will allow SUD providers to make the needed investments for which financial resources were not available prior to the DMC-ODS Waiver. The County and SUD provider network are committed to building this modern system of care and ensuring that these higher rates directly contribute to achieving the goals of the DMC-ODS Waiver.

FOUNDATION FOR ESTABLISHING EQUITABLE RATES

SAPC, in coordination with Advocates for Human Potential, Incorporated (AHP), conducted background research and analysis on the following to establish appropriate DMC rates for allowable services within each reimbursable LOC:

- (1) Usual, customary, and reasonable (UCR) payment rates in the SUD and mental health fields, including what other jurisdictions pay for similar services by Healthcare Common Procedure Coding System (HCPCS) code.ⁱ
- (2) Expected population growth by race and ethnicity through 2060 and the Medi-Cal-eligible population.
- (3) Historical utilization based on claims, payment, number of unique and duplicated admissions, and duration of stay by current LOC and projections for new LOCs and services.
- (4) Expected frequency of services and/or limits based on historical claims data, clinical best practices, clinical experience, and standards/requirements.

With this information, AHP in coordination with SAPC built a modifiable, proprietary spreadsheet that could be adjusted based on projected persons served by year, frequency of transitions in care, duration of care, and number of services received and/or capped by HCPCS code per episode. It also enabled the County to establish a cost for each HCPCS code, and then bundle HCPCS codes by LOC or service category. SAPC then adjusted figures based on local experience, provider payment rates within the County's specialty mental health plan (Los Angeles County Department of Mental Health - DMH), and built in the costs of new investments needed to deliver services under DMC-ODS in order to establish the proposed rates by LOC and service. A fuller description of the specific rate-setting methodology is below.

Rates for Similar Services in Other Systems/Jurisdictions

Prior to initiating rate-setting analyses for DMC-ODS, SAPC conducted a rate study in 2011 to establish fee-for-service rates for non-DMC adult services. MGT of America Inc. conducted a comprehensive analysis that included (1) conducting four focus groups with over 30 contracted providers to understand how services are currently defined and structured; (2) provider validation (22% participation) of Fiscal Year 2009-2010 cost report information and provision of additional information where appropriate; and (3) supplemental research and analysis of comparable jurisdictions to augment local data. Data from this rate study were used to provide a foundation for the analysis described below.

To supplement data from the rate study, AHP also conducted an analysis on what is considered usual, customary and reasonable (UCR) for similar services by compiling cost-of-living adjusted Medicaid rates for approximately 400 HCPCS codes and associated modifiers (if applicable) in six other systems/jurisdictions across the nation. With the exception of LAC-DMH, rates were largely unavailable from jurisdictions that closely resembled the social, economic and geographic variation of LAC. Based on this analysis, it was determined that LAC-DMH rates were approximately 1.52 times higher than LAC-SAPC rates.

While SUD treatment is a distinct field and specialty apart from mental health, no clinical justification exists for consistently setting the costs of and payment for SUD services below those associated with specialty mental health services. However, it is precisely the disparity of resources – both financial and otherwise – that has contributed to the underdevelopment of the SUD system as a whole: SUD practitioners often receive less education or training, and by extension lower salaries, than those who deliver specialty mental health treatment; access to services is often limited not because of need or willingness to open new programs but for lack of ongoing and non-population restricted funds; and the LAC safety net specialty mental health delivery system has both an electronic information system and an established managed care delivery system while the SUD delivery system has neither. Lack of parity with LAC-DMH rates also creates a perverse incentive to seek reimbursement through LAC-DMH for patients with co-occurring SUD and mental health conditions in situations when it may not be clinically appropriate. Medical necessity, not unintended payment incentives, ought to govern providers’ decisions about referrals and billing.

Reducing the human and social costs of SUD requires making proper investments that will eliminate these disparities. These investments ought to include the creation of a service delivery system with cost structures and provider payment rates at parity with those of specialty mental health. SAPC seeks to use the tools and opportunities of the DMC-ODS to move toward this aim. Importantly, parity in payment rates would motivate more current and potential-entrant providers, many of whom may currently be safety net mental health service providers, to obtain the required DMC certification/licensure by the July 2017 deadline, and increase service access in SAPC’s delivery system.

Projections for the Population to be Served

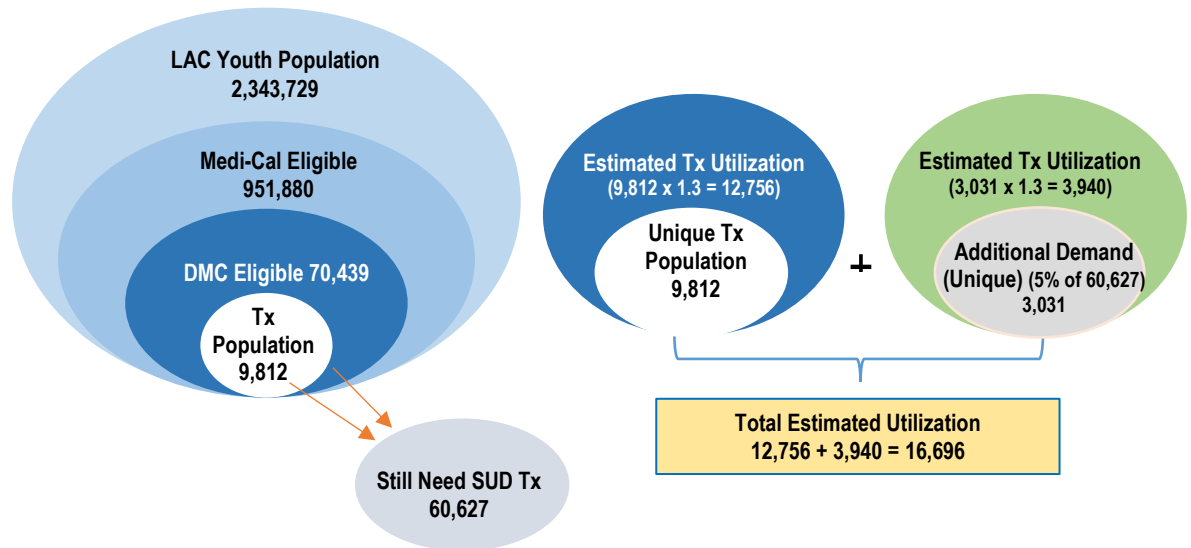
SAPC conducted an analysis to project SUD service utilization given the expansion of Medi-Cal eligibles and LOCs reimbursable under DMC-ODS. Based on 2013 census data, approximately 2.8 million people are living at or below 138 percent of the federal poverty limit (FPL) and potentially eligible for Medi-Cal in LAC. Of those, about 951,880 are estimated to be youth and 1.8 million adults (Table 2). The estimated prevalence of SUDs is about 7.4 percent among youth and 13.0 percent among adults according to the National Survey on Drug Use and Health (NSDUH) data. Using these figures, SAPC estimates that approximately 70,439 youth and 236,338 adults are DMC eligible and need SUD treatment services.

Table 2

LOS ANGELES COUNTY ESTIMATES		
	Youth (12-17)	Adults (18+)
Total LAC Population	2,343,729	7,675,633
Estimated Medi-Cal Eligible	951,880	1,817,982
↳ Estimated Drug Medi-Cal Eligible	70,439 (7.4%)	263,338 (13.0%)
↳ Estimated Annual Admissions within 3 Years of Launch	16,696 (+55%)	88,698 (+47%)

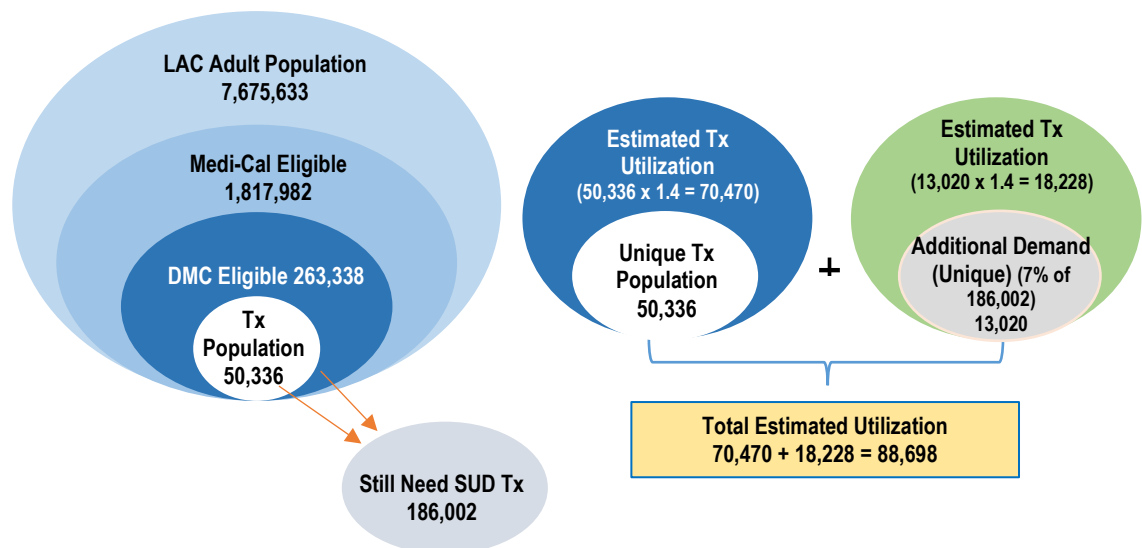
Averaging historical youth (12-17) utilization data over the past 10 years, the annual unique patients served amounted to 9,812 with an average of 1.1 readmissions per patient. The projected utilization assumed either stable (low – 1.1) or increased (medium – 1.3; high – 1.6) readmissions per patient to the same or different LOC given increased access to appropriate care and improved care coordination. Using the readmission variables to estimate total utilization and applying them to the aforementioned DMC eligible estimates, the medium estimated number of duplicated youth served annually is 16,696 of which 63 percent (10,518) are expected to need outpatient services, 27 percent (4,508) intensive outpatient services, and 10 percent (1,670) residential; another 60,627 youth are expected to need but not seek SUD services (Figure 2). This range is 10,793 (low readmission estimate) to 20,549 (high readmission estimate)

Figure 2: Medium Utilization Estimation for Youth



For adults (18+), the annual unique patients served amounted to 50,336 with an average of 1.2 readmissions per patient. The projected utilization assumed either stable (low –1.2) or increased (medium – 1.4; high – 1.8) readmissions per patient. The medium estimated number of duplicated adults served is 88,698 annually of which 41 percent (36,366) are expected to need outpatient services, six percent (5,322) intensive outpatient services, 16 percent (14,192) residential, seven percent (6,209) residential medical detox, and 24 percent (21,288) opioid treatment; another 186,002 adults are expected to need but not seek SUD services (Figure 2). The range is 60,403 (low readmission estimate) to 114,041 (high readmission estimate).

Figure 3: Medium Utilization Estimation for Adults



The utilization ranges show anticipated volume from the early through late phases of the DMC-ODS waiver, with the expectation that utilization would increase over the life of the pilot. This also assumes enhanced access to SUD services and flow between LOCs once individuals become aware of the SUD benefits, jail diversion programs are implemented, care coordination and case-management improves, and stigma declines.

Projections for Utilization Informed by Historical Claims

To establish baselines for utilization and expenditures, SAPC examined 10 years of historical data by LOC/service where available, and irrespective of reimbursement source (e.g., DMC, AB109, SAPT Block Grant) since it is anticipated that most individuals accessing publicly funded SUD treatment will meet Medi-Cal and DMC eligibility requirements. These data informed (1) volume of services used by LOC; (2) average length of stay by LOC; (3) number of duplicated and unduplicated admissions; and (4) utilization patterns by provider, population and region. Since the SUD delivery system of the future will look drastically different than the system of today there are several limitations in using this information to project future utilization: (1) Medi-Cal expansion enables more individuals to access services as an entitlement benefit and thereby reduces reliance on limited population-specific funding sources for core treatment services; (2) all LAC SUD providers must become DMC-certified for contracted LOCs and sites thereby enabling service expansion based on need and not funding restrictions; and (3) new LOCs and services are now available to the DMC-eligible populations that may not have existed previously or been significantly limited throughout the County due to budget limitations. For these reasons, and the desire to achieve parity, SAPC did not solely rely on historical service claims or cost reports to project future utilization or expenditures.

Establishing Service Utilization Calculations for Each Level of Care

To supplement historical claims data and address some of the previously described limitations, SAPC developed the expected frequency of services delivered (e.g., group counseling, individual counseling, assessment, lab analysis) per episode and LOC based on these figures and adjusted it according to clinical best practice, clinical experience and standards/requirements. To obtain these calculations, SAPC first estimated the percentage of initial admissions and transitions by LOC based on the assumption that 87 percent of DMC-eligible youth (n=8,836) and adults (n=43,792) would be actively enrolled at any given time. This resulted in an estimated 104,228 (52,329 new admissions and 51,900 LOC transitions) for total year-one admissions.

Example of Utilization by Initial Admissions and Transitions in Care: Under ASAM Level 2.1 – Intensive Outpatient Services, it is expected that 10 percent of patients will either enter (n=5,233) the SUD this LOC or transition into (n=5,358) it from a higher or lower LOC hereby resulting in approximately 10,591 annual admissions. When considering the impact of improved case-management on supporting patient transitions to higher or lower LOCs, it is projected that:

- (1) Of those transitioning out of ASAM 2.1, 20 percent will step-up in care (of which 5% go to ASAM 3.1 and 95% to ASAM 3.5), 50 percent will step-down in care (of which 100% go to ASAM 1.0), and 30 percent will not transition at all; and
- (2) Of those transitioning into ASAM 2.1, 10 percent of ASAM 1.0 (n=2,093), 2.5 percent of OTP (n=314), 18% of ASAM WM-1 (n=188), 6 percent of ASAM WM 3.2 (n=251), 30 percent of ASAM 3.1 (n=157), 30 percent of ASAM 3.3 (n=785), 30 percent from ASAM 3.5 (n=1,570) LOCs will transition into ASAM 2.1.
- (3) Of those who receive ASAM 2.1 services at any given time, 50 percent will ultimately transition to recovery support services.

Within each LOC, SAPC then estimated the clinically appropriate median length of stay and units of service per HCPCS code and by level of staff required to deliver the services. Services available within each LOC and service component include:

- Outpatient, Intensive Outpatient, and Residential: Assessment (H0001), treatment plan (T1007), group counseling by a clinician (H0005), behavioral health counseling and therapy (H0004), 30 minute physical evaluation/exam (99203), lab analysis (H0003), alcohol/drug testing (H0048), skills development (T1012) non-emergency transportation – residential only (T2001), peer services – residential only (H0038).
- Withdrawal Management (WM): Assessment (H0001), subacute detoxification per day residential (H0010) or outpatient (H0012), and alcohol/drug screening (H0049).
- Case Management: Case-management services (H0006), assessment (H0001), and treatment plan (T1007).
- Recovery Support Services: Behavioral health counseling and therapy (H0004), group counseling by a clinician (H0005), peer services (H0038), and targeted case-management (T1017).
- Physician Consultation: Diagnostic evaluation with (90792) and without medical (90791).

Example of a Utilization Calculation for a Single Billing Code: Under ASAM 2.1, it is expected that a patient would receive treatment in this LOC for a median of 90 days, and in that time period would receive one full ASAM assessment (estimated at eight 15-minute units) where:

- Approximately 60 percent of individuals would receive that assessment from a registered or certified counselor and 40 percent directly from an LPHA.
- For the 60 percent who received an assessment from a registered or certified counselor, the LPHA would need to conduct three units of service for face-to-face reviews to establish initial medical necessity for new assessments (44%) and two units of service for re-assessment reviews (16%).

Considering that 10,591 individuals are expected to receive this LOC, this utilization of assessment service estimate translates to approximately 102,101 15-minute units. This exercise is repeated for each service listed under ASAM 2.1

This calculation was repeated for each HCPCS code for each service within each LOC, according to expected utilization and level of staff performing and/or supervising the service.

PROPOSED RATES FOR WAIVER YEAR ONE

Creating Service Bundles to Establish Rates

The first step in building the bundled rates was to determine the total projected persons served for Fiscal Year 2017-2018 by each ASAM LOC. Historical admission and claims data were used for current LOCs, and projections were used for new LOCs. This included establishing (a) transition rules (expected step-up and step-down for each LOC to the next higher and lower LOC), (b) a clinically appropriate median length of treatment for each LOC and (c) the median number of units of each service delivered by the appropriate practitioner/staff during that length of treatment - all of which were based on historical data, clinical best practices, clinical experience, and standards/requirements. This established the projected initial load or new episodes of care (n=52,329) and LOC transitions (n=51,900) for the total annual admissions (n=104,228) and total estimated units for each LOC and its service components. (See the *Foundation for Establishing Equitable Rates* section for further detail.)

The second step was to determine the actual rate per allowable service (HCPCS) code within each LOC and service component (i.e., recovery support services, case-management, physician consultation). SAPC applied a multiplier of 1.52 to its current non-DMC rates to reflect the median disparity between SAPC and LAC-DMH rates for comparable services, and added an additional 10 percent increase to account for the provider cost of building the clinical and operational infrastructure necessary for DMC-ODS, and a 2.4 percent inflation factor. An exception to this approach is Level 3.2-WM, where a 2.4 percent inflation factor was applied to the current rate since this service exists only with the SUD and not mental health system. These rates are essential to enabling DMC-ODS providers to make the necessary investments, reimbursement for real costs to ensure equitable access to effective care, and the recruitment of new DMC-ODS network providers. Year one rates will be the same for youth and adults due to lack of available data on differential costs, and because the new rates should support services for this and other special populations. (See *The Underdeveloped SUD System and Move to Parity* section for more information).

The third step was to bundle the billable HCPCS codes within each ASAM LOC or service component:

- For 15 minute increment rates, the estimated number of service units for each allowable HCPCS code within a LOC or service component was determined based on historical claims data, clinical standards, and experience, and then coded into 15-minute increments (e.g., an assessment generally takes one hour thereby resulting in an estimated four 15-minute units over the treatment duration) based on the provider survey. Next, the total costs of the median number of 15-minute units of service for all HCPCS codes in a bundle were summed and then divided across projected 15-minute billable increments for outpatient, intensive outpatient, case management, and recovery support services LOCs for a median clinically appropriate length of treatment for each LOC.
- For day rates, the estimated number of service units for all allowable HCPCS codes within a LOC was determined based on historical claims data, clinical standards, and experience, and then divided by the expected length of stay for that LOC to determine the average number of services (either in full or part) per day (e.g., an assessment generally takes one hour and will occur one time within a ASAM 3.5 stay [1 unit/60 days = 0.02 per day]). Next, day units for all allowable service codes were multiplied by the actual rate for the corresponding service codes and summed to calculate the overall bundled day rate. Of the total day rate, 75 percent is attributed to clinical treatment costs and 25 percent to room and board (R&B) costs.

Example of Bundling a LOC: Under ASAM 2.1, the units of service per HCPCS code (Assessment-H0001, treatment plan-T1007, group counseling by a clinician-H0005, behavioral health counseling and therapy-H0004, 30-minute physical evaluation/exam-99203, lab analysis-H0003, alcohol/drug testing-H0048, and skills development-T1012) were summed, with the individual service rate varying by staffing level (L1 – registered or certified counselor, L2 – LPHA, non-MD, and L3 – Licensed Physician). The total estimated ASAM 2.1 cost divided by the total number of units of service was used to determine the bundled rate (\$32.01) per 15-minute increment.

Bundled Rates by Level of Care and Service Type

Based on the methodology described above, SAPC established rates for each ASAM LOC and Service Type outlined in LAC's DMC-ODS Implementation Plan. The total projected expenditure assumes that all persons projected to access SUD treatment services will do so, and that the projected length of stay, frequency of services (e.g., individual counseling) and transitions in care (e.g., step-up, step-down LOC) will occur. Therefore, while this reflects the ideal scenario, it is likely that it will take time for the new SUD system of care to effectively outreach, engage, retain and transition beneficiaries in the intended manner. SAPC will submit DMC claims to DHCS at the bundled rates outlined in Table 3 below.

Table 3

Los Angeles County DMC Rates for Fiscal Year 2017-2018			
ASAM LOC/Service	Unit of Service (UOS)	Interim Rate per UOS	Projected Persons Served
1.0 Outpatient	15-minute (except group which is per session)	\$29.63	25,667
2.1 Intensive Outpatient	15-minute (except group which is per session)	\$32.01	10,591
3.1 Residential	Day Rate	\$145.71 (includes \$36.43 for R&B, non-DMC funds)	1,648
3.3 Residential	Day Rate	\$187.85 (includes \$46.96 for R&B, non-DMC funds)	3,244
3.5 Residential	Day Rate	\$166.70 (includes \$41.47 for R&B, non-DMC funds)	10,026
1-WM Withdrawal Management	Day Rate	\$210.46	1,047
3.2-WM Withdrawal Management	Day Rate	\$381.37 (includes \$95.34 for R&B, non-DMC funds)	4,186
Case-Management	15-minute	\$33.83	24,511
Recovery Support Services	15-minute	\$20.89	10,748
Physician Consultation (SAPC Only)	15-minute	\$138.97	3,677

LAC SUD network providers will submit reimbursement claims by HCPCS code and using the staff modifier (L1, L2, and L3) to assist SAPC in affirming whether utilization projections are accurate and to serve as a basis for future rate adjustments. However, SUD network providers will also be reimbursed at the bundled interim rate and not at the staff modifier or service unit (HCPCS code) rate.

Provider Cost Reports and Maximum Payment

As outlined herein, these rates are designed to provide the necessary financial investment to build a modern SUD system of care and achieve parity with how mental health services are delivered and funded. Providers will be reimbursed at the bundled rate and not a service/HCPCS rate.

At the end of the fiscal year, SAPC will settle to cost with its network providers up to, and not to exceed, the total bundled rate for ASAM LOCs and services (Table 3: *Los Angeles County DMC Rates for Fiscal Year 2017-2018*) that were delivered to DMC beneficiaries and determined to be medically necessary based on established QI/UM and contract monitoring procedures. SAPC's contract, budget and cost reporting procedures/documents will also be updated to manage this transition and enable providers to claim costs associated with allowable clinical and infrastructure improvements such as those outlined in the *Underdeveloped SUD System and Move to Parity* section.

DEVELOPING LOS ANGELES' COUNTY'S NEW SUD MANAGED CARE MODEL

The *START-ODS (DMC-ODS) Implementation Plan* and now the *START-ODS Finance and Rates Plan* create the necessary foundation to build a modern SUD system of care in LAC; the opportunity to more fully achieve parity with the physical and mental health systems; and the ability to transition to a managed care plan that supports the delivery of quality services that meet patient needs while achieving improved patient outcomes. This will be a monumental transition for SAPC and its SUD network providers and will require significant clinical and infrastructure development to achieve the expectations of the Waiver and those outlines in LAC's plan. These enhanced rates will be a key factor in the system's ability to implement this new vision for high-quality and effective SUD services in LAC cities and communities.

LIMITS ON DISCLOSURE

This explanatory document may be further shared within the California Department of Health Care Services (DHCS) and with other California counties with written permission from SAPC. Any additional information, including the spreadsheet used to generate the rates, shall not be released by DHCS and for any purpose other than for obtaining approval of the Drug Medi-Cal Organized Delivery System Implementation Plan and Finance and Rates Plan.

ⁱ HCPCS Codes are categorized into two levels: Level 1 is the numeric coding system to identify medical services and procedures performed by physicians and other health care professionals, and is used to bill public and private insurance plans whereas Level 2 is the numeric coding system to identify products, supplies and services used outside of the medical/physician's office. For more information visit www.cms.gov.